ALLERGY INJECTIONS

For your safety, you must receive your first allergy injection at your allergist. The Student Health Center (SHC) will not initiate injections but will give subsequent injections at the San Marcos location only.

Referring allergist must be licensed to practice in Texas.

Fax Number:	512.245.9288
Mailing Address:	Texas State University 601 University Drive San Marcos, TX 78666-4538
Hand deliver:	Medical Records Department, 2nd floor, Student Health Center, San Marcos campus.

Important information for the Allergy Clinic:

The nurse cannot administer injections until the following are received.

- Specific, clear order **signed by the allergist** that includes the dose schedule, instructions for late injections and reactions.
- Documentation of the last injection(s) is required and must include vial name, strength, date, dose, and the reaction (or 0mm).
- Allergy serum must be labeled with the patient's name, serum, strength, and expiration date.
- Documents can be sent to above address or dropped off by the student at the SHC.

Important information for the Student or Parent:

- **Required to provide:** (1) Allergy serum, (2) Documents from Allergist (3) Intake Information form.
- It's important you continue getting injections until coming to school.
- You must have an epi pen (that has not expired – check expiration date)
- Once allergy serum and all needed documents are received, the SHC nurse will call the student to schedule an appointment.
- Program the SHC number 512.245.2161 into your phone so you recognize the call.
- First appointment will be with SHC physician, and you will see the nurse immediately following to get your injection(s)
- Nurse will schedule future appointments at a time that does not interfere with your class schedule – we do not take walk ins.
- 30-minute observation time is required after injections are given.

TEXAS STATE®
STUDENT HEALTH CENTER

Texas State University Student Health Center
601 University Drive
San Marcos, Texas 78666-4616
Phone: 512-245-2161 www.healthcenter.txst.edu

Intake Information

Name:_____ DOB: _____

Texas State ID:_____ Gender: _____
(if available)

Local Address:_____

_____

Phone: _____ Email: (required)_____

Emergency Contact Information:

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone #: _____

Preferred Pharmacy Information:

Pharmacy Name:_____ Pharmacy Phone #: _____

Pharmacy Address: _____

IF YOU HAVE **MEDICAL INSURANCE**, PLEASE COMPLETE BELOW: *Note: We will only submit your claim if your plan is in network with the Student Health Center. If not, you will be responsible for the charges.*

Medical Insurance Information

Name of **Insured** (Policy Holder): _____

Relationship of Patient to **Insured** (Circle One): Self Child Spouse Other: _____

Insurance Company: _____Insurance Phone #: _____

Insurance Address: _____

Insurance ID #: _____Insurance Group #: _____

Approved 09/12/2023