**Name:** ________________________________________ **Date of Birth:** _________________ **Student ID #:** ___________________

# Student Agreement for Allergy Immunotherapy Administration

**Instructions:** Read carefully prior to completing Student Agreement. Students requesting allergy immunotherapy administration at the Atlanta University Colleges Consortium (AUCC) Student Health and Wellness Clinic are required to complete this form prior to receiving injections at our clinic.

**Name: ________________________________________ Date of Birth: _**