



Lees-McRae College  
Student Health Clinic  
Phone: 828-898-8798  
Email: [healthservices@lmc.edu](mailto:healthservices@lmc.edu)

We are happy to continue to assist you in receiving injections of medication prescribed by your off campus medical provider. The completion of the enclosed forms will allow us to have the information necessary to administer your medication injections safely. Please have your medical provider read through the Injectable Medication Agreement Form. Once completed and signed by the prescriber, the form may be sent to the Student Health Clinic prior to your next appointment for injection. There is also an agreement form for you to complete which details information important in this process. These forms may be scanned and emailed to the above email address or be mailed to Lees-McRae Student Health Clinic, C/O Office of Student Affairs, PO Box 128, Banner Elk, NC 28604.

The Student Health Clinic hours are from Monday – Friday, from 8:30am-4:30pm. Please call ahead at 828-898-8798 and notify staff of the day and time you need to come by and receive your injection.

Sincerely,  
Tracy Jenkins, FNP-C  
Jenkinst@lmc.edu  
Director of Student Health & Wellness Services



### **Injectable Medication Agreement Form**

The Student Health Clinic at Lees-McRae College is happy to partner with students' medical providers to provide injection services for medications. To provide quality care assurance, we ask prescribing clinicians to provide the following information:

- 1) Completion of the order form below
- 2) Any additional medical records/documentation essential to care for this patient
- 3) We ask that this form be updated annually

Students will be instructed to contact your office to discuss any concerns related to this medication. The Student Health Clinic will notify your office and send records if the patient experiences any adverse effects from this medication. A copy of the record will be provided to the student if they need to obtain injections while home, so that primary providers have appropriate documentation of the date of the last injections.

#### **Injection Order Form**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of medication to be injected: \_\_\_\_\_

Dose and route of administration (i.e. IM, SC): \_\_\_\_\_

Frequency of administration: \_\_\_\_\_

Length of time patient should be observed after injection: \_\_\_\_\_

Diagnosis for which patient is receiving this medication: \_\_\_\_\_

Date of initial order and/or initial injection: \_\_\_\_\_

Date of most recent injection if different from above: \_\_\_\_\_

Number of refills remaining on current prescription: \_\_\_\_\_

Additional Information:

---

---

---

Name of Clinician: \_\_\_\_\_

Address: \_\_\_\_\_

Office phone number: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature of prescribing clinician: \_\_\_\_\_ Date: \_\_\_\_\_



### **Injectable Medication Agreement**

This agreement will be reviewed and signed each year by students requesting administration of medication injections in the Student Health Clinic. Please initial the below items.

- 1) I agree that I will need to work with my medical provider to obtain prescriptions, refills, and guidance regarding the side effects of my medication. \_\_\_\_\_
- 2) I agree that my off campus medical provider will continue to be responsible for managing the medical condition for which I receive this injection. If I prefer to have this medical condition managed by a provider in the health center, I will sign an Release of Information (ROI) to have my medical records released and schedule an appointment with the medical provider to determine if my condition can be adequately managed by the medical staff/resources on campus. \_\_\_\_\_
- 3) I understand and agree to have my medical provider complete and send the "Injectable Medication Agreement Form for Medical Providers" to the Student Health Clinic prior to an appointment to receive my initial injection. This form needs to be updated annually. \_\_\_\_\_
- 4) I understand that I need to call ahead to the Student Health Clinic at least 24hrs in advance of injection, and that injections are only administered Monday-Friday during clinic hours. \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

If student is a minor, Parent/Guardian name: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

**Lees-McRae Student Health Clinic**