

I, _____, a student at University of West Georgia, am presently under the medical supervision of Dr. _____ of _____. I relieve the State University of West Georgia Infirmary and medical staff of all responsibility, direct or indirect of unfavorable reaction, risk, hazard, shock, or etc., incurred in the administration of allergy injections that have been specifically prepared and furnished to the Infirmary by the above named physician, and to be given at the prescribed intervals by the nursing staff of the infirmary.

Signed:

Student _____
Address _____

If under 18 years of age, signature of parent of guardian is necessary.

Parent _____
Address _____

Please return this form to:

Directory of Health Services
University of West Georgia
1601 Maple Street
Carrollton, GA 30018