IVita Wellness, LLC

Medical Clearance Form For IV Hydration/IM Injection Therapies

Name: _____ Phone number:_____

Email: _____

Address: _____

DOB: _____

Primary Care Physician: _____

Primary Care Physician phone number:

_____

Allergies Drug & Non-drug (vitamins) or food or environmental:

_____

Past Medical History: _____

Past Surgical History: _____

Family Medical History: _____

Medications taking or prescribed: _____

Vitamins taking or over the counter:

_____

Please answer yes or no if yes explain

1. Frequent/severe headaches or migraines?_____
2. Fainting, dizzy episodes, or syncope?_____
3. Stroke, TIA or head injury?_____
4. Epilepsy, seizures or other neurologic disorders?_____
5. Eye or vision problems?_____
6. Ear, nose, throat problems; hearing loss, hoarseness?_____
7. Allergies or history of anaphylactic reaction?_____
8. Shortness of breath, asthma, or COPD?_____

9. History of abnormal chest x-ray?_____
10. History of positive TB skin test, IGRA, or tuberculosis?_____
11. Aneurysm, blood clot or pulmonary embolism?_____
12. High blood pressure?_____
13. Murmurs, palpitations, or other heart problems?_____
14. Are you a former or current smoker?_____
15. Stomach, esophageal, or other intestinal problems?_____
16. Jaundice, hepatitis, or other liver disease?_____
17. Intestinal, rectal problems or hernia?_____
18. Urinary or kidney problems, blood in urine?_____
19. Diabetes, thyroid, or other endocrine disorders?_____
20. Joint or back pain/injury?_____
21. Rheumatologic disorder?_____
22. Anemia?_____
23. Blood transfusion?_____
24. Malaria, tropical or other infectious disease?_____
25. Any skin or nail disorders? _____
26. Cancer of any type?
27. Any thickening or lump in breast or testicles? _____
28. Have you consumed at any one time in the past year, more than 5 alcohol drinks for males or 4 drinks for females? _____
29. Have you used marijuana, amphetamines, narcotics, cocaine, or hallucinogenic drugs or any other type of drug?_____

I _____ certify that I have answered all of the questions on the form to the best of my ability and knowledge. In doing so I will not hold IVita Wellness liable for any false information that has been provided on this form. This agreement does not expire.

IV Vitamin infused Hydration/IM injection

IV vitamin infused hydration therapy can help with symptoms of fatigue, hangovers from alcohol consumption, vitamin & mineral deficiencies, and dehydration.

Key benefits

1) The infusion enters the bloodstream immediately and is available to the tissues
2) Higher doses of vitamins can be given via the vein versus orally
3) The gastrointestinal tract is not affected and upset stomach is avoided
4) IV Vitamin infused Hydration/IM injection can be used in combination with oral vitamins, dietary and lifestyle modifications as well.

IV fluids are usually very well tolerated however there are risks associated with receiving IV infusions/IM injections such as:

1) Pain, swelling (phlebitis), soreness, bleeding, bruising, potential scarring, and infection can occur
2) Metabolic disturbances
3) Fluid overload
4) IV infiltration
5) Allergic reactions including anaphylaxis, cardiac arrest and death (rare).

Procedure

During the treatment a needle will be placed into your vein in order for the IV infusion to go into the bloodstream. Majority of patients feel an improvement in their symptoms following IV hydration however results may vary and there is no guarantee that symptoms will improve or fully resolve.

During an IM injection a needle will be inserted into your muscle usually in your arm (deltoid) in or the posterior buttocks (gluteus maximus) the site preference will depend on the vitamin.

I have informed the staff at IVita Wellness of any known allergies to drugs or other substances, or of any past allergic reactions. _____

I have informed the staff of all current medications and substances that I am taking. _____

I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. _____

I understand that these procedures are solely elective. _____

Your signature below means that:

I understand and have fully read the information provided on this form. I understand that sometimes unforeseeable events can happen with these procedures. I have received all of the information and have asked all the questions I need regarding IV therapy and IM injections and I hereby authorize/consent IVita Wellness, LLC or any delegated associates to perform IV/IM therapies

Patient name printed: _____ Date:_____

Patient name signature :_____

Parental guardian if minor:_____

Provider name printed:_____ Date:_____

Provider name signature:_____