THE UNIVERSITY OF
SCRANTON
A JESUIT UNIVERSITY

Dear Medical Provider,

Your patient, _____ (DOB: _____), has requested that The University of Scranton Student Health Services (SHS) participate in their care by providing allergy injections that you prescribe for them.

Immunotherapy is administered by trained staff with a medical provider (MD or NP) on-site. For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, please complete and sign the attached forms and return to our office.

The first dose of each vial **must be administered at the prescribing allergist's office, especially during the build-up phase.**

Allergists must provide us with all the information needed as stated below. Also, note serum vials are to be hand delivered to Health Services. Serums are not to be mailed unless properly stored during delivery. Allergy serums will also be picked up during breaks and at the end of the academic year. The Student Health Center does not mail serum vials back to the allergist's office.

In order for Student Health Services (SHS) to safely administer injections, the information below on this checklist is required to accompany all serums.

- **Patients Name/ Date of Birth**
- **Allergy practice/ Allergist name, phone number and fax**
- **# of vials**
- **Expiration dates**
- **Frequency of injections**
    - **Build-up instructions and vial color sequence clearly identified**
    - **Maintenance dose proper instructions**
- **Instructions if late/missed doses**
    - **For build-up**
    - **Maintenance**
- **Instructions for management of local reactions and any dose changes if needed depending on size of reaction.**
- **Instructions for dosing following adverse reactions.**

Pre-Injection information

Patient Name: DOB:

Ordering Physician: Phone: Fax:

Is Peak flow required prior to injection? If yes, peak flow must be >_____L/min

Is student required to take an antihistamine prior to injection?

Does the student have any chronic/severe illness that could affect his/her general health or desensitization schedule?

If yes, explain_____

Has your patient experienced **significant local or systemic reactions** to antigens in the past?

If yes: Indicate the type of reaction, to what antigen, when reaction occurred and treatment required:

_____

Allergy injections will not be administered to student's who have a history of an anaphylactic reaction to allergy serum.

Does the student have an EPIPEN to carry with them at all times?

If the student does not have an EPIPEN but requires it, no allergy injections will be administered.

All the information needs to be on file in our office before we can begin administering injections.

Please complete Standardized Allergy Immunotherapy form attached.

Signing below, I agree to allow The University of Scranton's Student Health Services, trained medical staff to provide immunotherapy as prescribed by me to the patient named above:

Medical Provider Name: _____

Medical Provider Signature: _____ Date: _____

Address: _____

Telephone: _____ Fax: _____