DAVIDSON

To our Allergy Injection Patients:

One of the goals at the Davidson College Center for Student Health and Well-Being is to provide care to our patients in the safest way possible. Our allergy clinic serves quite a few students referred by many different allergists all with their own unique order and administration forms. As you can imagine, utilizing many different forms is challenging and has a significant potential for error. Therefore to maximize the safety for our patients, our clinic has developed an allergy immunotherapy order form that we will utilize for every patient in our allergy clinic.

In order to continue your allergy injections, we will need the attached forms completed. New order forms will need to be completed each time new serum is sent and/or at the beginning of each academic year. We will also make these forms available on the Student Health webpage.

- **Student Request to Receive Allergy Immunotherapy** (completed by you)
- **Information needed for Allergy Clinic** (completed by your Allergist)
- **Physician Order for Allergy Immunotherapy** (completed by your Allergist)

You will need to bring these forms, along with your allergy serum, to the Health Center before you come in for your first appointment. We ask that all students who wish to receive allergy injections here in the health center, **make an appointment at least the day before** you want to come in. To schedule an appointment, please call us at **704-894-2300**.

Please do not hesitate to contact us if you have any questions.

Kathy Carstens, BSN, RN-BC
Associate Director
Center for Student Health and Well-being

Davidson College Center for Student Health and Wellbeing

Student Request to Receive Allergy Immunotherapy

I request to receive my allergy injections at the Davidson College Student Health Center and agree to the following:

1. I understand that the prescription and mixing of my serum, the content of my vials, the concentration of my serum and the dosage schedule are the responsibility of my allergist, Dr. _____
2. I understand that the serum vials must be hand delivered by me to the Health Center. **Allergy vials should not be mailed directly to the Student Health Service.** Further, I am responsible for ordering my own serum.
3. I understand that I must request a copy of my injection record and vials to take to my allergist during holidays, breaks and other absences. I understand the importance of keeping my serum refrigerated in transit. Allergy serum can not be mailed out by the Health Center to me or my allergist at any time.
4. I understand that my allergist must complete and submit the ***Information for Allergy Clinic*** and the ***Physician Order for Allergy Immunotherapy*** forms prior to my receiving allergy injections. These can be found on the webpage at https://www.davidson.edu/about/campus-spaces/student-life-facilities/student-health-center.
5. I understand that allergy injections are given by appointment only Monday through Friday from 1:00-4:30 during times that there is a healthcare provider (MD, PA or NP) in the health center.
6. I understand that there is a fee for allergy injections based on the number of injections that I receive per visit:

    a. 1 injection: $5.00/visit
    b. 2 or more injections: $8.00/visit

7. I understand that I am **required to wait 30 minutes after my injection(s). I must check in with the nurse prior to my leaving the health center.** Failure to do so may result in discontinuation of service for allergy injections.
8. I understand that I will be asked to present a form of identification (either CAT card or another form of picture ID) at time of service to provide a safety check of right serum given to right patient at right time.
9. I understand that certain medications for eye problems, headaches and blood pressure contain Beta Blockers which can increase sensitivity to allergens and potentiate severe reactions. I understand that if I am taking any new prescription or over the counter mediations since my last visit to the Health Center, I must inform the nurse prior to receiving my injection(s).
10. I understand that I should inform the nurse of any current illness or of any delayed reaction from the previous injection. **If I am ill with fever, asthma or respiratory illness, I will not be able to receive my injection until symptoms have improved.**
11. I understand that it is recommended that I not perform any strenuous exercise for 2 hours after the allergy injection as the exertion can lead to rapid absorption of the antigens and can result in increased reactions.

In signing this statement, I acknowledge that I have fully read, understand and will abide by the information that it contains.

_____ _____

Student Name (print) Student Signature

_____ _____ _____

Date Graduation Year Student ID

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Information needed for Allergy Injection Clinic:

Patient Name_____ **DOB** ___/___/___ **Student ID** _____

To: Allergy Physician:

The Davidson College Center for Student Health and Wellbeing looks forward to working with you and your patient. To help us better serve your patient, and to maximize safety, we require the attached **PHYSICIAN ORDER FOR ALLERGY IMMUNIOTHERAPY** be completed and signed for each allergy serum before we can continue allergy injections. This form will decrease the chance of miscommunication and resultant allergy administration errors.

Please complete the following information for your patient:

1. Does your patient have a history of Asthma? **YES / NO**
2. History of Anaphylaxis? **YES / NO**
3. Does your patient use antihistamine prior to receiving allergy injections**?** **YES / NO**
4. Do you require a Peak Flow prior to injections**?** **YES / NO** If **YES**, peak flow must be > _____L/min
5. A mandatory 30 minute wait time will be enforced after injections.

Please note:

- Every patient's initial injection(s) must be performed at the Allergist's office.
- Each vial must be clearly labeled with the patient's name, dilution and expiration date.
- No expired serum will be administered.
- New allergy serum vials must be sent directly to the patient, NOT the Student Health Center
- Allergy injections will not be administered in the Student Health Center without a medical provider (MD, PA or NP) being in the clinic.
- For any systemic reactions, Epinephrine (1:1000) is given IM 0.3 IM, in anterolateral thigh, and if hives or itching of skin/mucosal membrane or runny nose are present, Diphenhydramine (Benadryl) 50mg is given IM in the deltoid. The allergist's office will be notified of the event and request further instructions and orders.

MD Signature_____ Date _____

Printed MD Name _____

We look forward to working with you and your office in providing care for your Davidson College student.

Sincerely,

Kathy Carstens, RN-BC
Associate Director

DAVIDSON COLLEGE CENTER FOR HEALTH AND WELLBEING

514 North Main Street, PO Box 7188
Davidson, NC 28035
(ph) 704-894-2300 (f) 704-894-2615

PHYSICIAN ORDER FOR ALLERGY IMMUNIOTHERAPY

For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form must be completed to provide standardization and prevent errors. Failure to complete this form may delay or prevent the patient from utilizing our services. Form can be delivered by the patient, mailed, or faxed (see address and fax above).

Patient Name:_____Date of Birth: _____

Physician:_____Practice Name:_____

Office Phone:_____Fax:_____

PRE-INJECTION CHECKLIST:

- Is peak flow required prior to injection? ☐ NO ☐ YES **If yes,** peak flow must be > _____L/min to give injection.
- Is student required to have taken an antihistamine prior to injection? ☐ NO ☐ YES

Allergy Vials

Vial	Vial contents	Last dose given	Dilution of vial	Date of last dose
Example: Vial A	*Cat, Dog, Grass*	*0.3*	*1:100*	*5/1/18*

INJECTION SCHEDULE:

	Frequency of injections
BUILD UP:	Every _____ days
MAINTENANCE:	Every _____days or _____weeks

Dilution					
Vial Cap Color					
Expiration Date(s)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	Go to next Dilution	ml	ml	ml	ml
		Go to next Dilution	ml	ml	ml
			Go to next Dilution	ml	ml
				Go to next Dilution	ml
					ml

PLEASE SEE REVERSE SIDE

MANAGEMENT OF MISSED INJECTIONS: (According to # of days from ***LAST*** injection)

During Build-Up Phase	*After Reaching Maintenance*
▪ ____to____days – continue as scheduled	▪ ____to____weeks – give same maintenance dose
▪ ____to____days – repeat previous dose	▪ ____to____weeks – reduce previous dose by_____(ml)
▪ ____to____days – reduce previous dose by_____(ml)	▪ ____to____weeks – reduce previous dose by_____ (ml)
▪ ____to____days – reduce previous dose by_____(ml)	▪ Over____weeks – contact office for instructions
▪ Over____ days – contact office for instructions	

REACTIONS:

At next visit: **Proceed** with next dose if swelling is < _____mm
Repeat next dose if swelling is > _____mm and < _____mm
Reduce next dose by _____ml if swelling is > _____mm
Call the office if >_____mm or systemic reaction.

Other Instructions:

_____

_____

_____

Physician Signature: _____ Date: _____

Office Address: _____

The Davidson Student Health Center nursing staff will call your office for any clarifications in orders prior to giving injections.