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. Beginning in August 2020, we will 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. We will no longer be able to do same day appointments. 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](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 medications 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 ____________________________
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 IMMUNOTHERAPY 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 IMMUNOTHERAPY

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

<table>
<thead>
<tr>
<th>Vial</th>
<th>Vial contents</th>
<th>Last dose given</th>
<th>Dilution of vial</th>
<th>Date of last dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Vial A</td>
<td>Cat, Dog, Grass</td>
<td>0.3</td>
<td>1:100</td>
<td>5/1/18</td>
</tr>
</tbody>
</table>

INJECTION SCHEDULE:

<table>
<thead>
<tr>
<th>BUILD UP:</th>
<th>Frequency of injections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every _________ days</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MAINTENANCE:</th>
<th>Every _________ days or _________ weeks</th>
</tr>
</thead>
</table>

Dilution

<table>
<thead>
<tr>
<th>Vial Cap Color</th>
<th>Expiration Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ml</td>
<td>ml</td>
</tr>
<tr>
<td>ml</td>
<td>ml</td>
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<td>ml</td>
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<td>ml</td>
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<tr>
<td>ml</td>
<td>ml</td>
</tr>
</tbody>
</table>

Go to next Dilution

Go to next Dilution

Go to next Dilution

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

<table>
<thead>
<tr>
<th>During Build-Up Phase</th>
<th>After Reaching Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ to ___ days – continue as scheduled</td>
<td>___ to ___ weeks – give same maintenance dose</td>
</tr>
<tr>
<td>___ to ___ days – repeat previous dose</td>
<td>___ to ___ weeks – reduce previous dose by ___ (ml)</td>
</tr>
<tr>
<td>___ to ___ days – reduce previous dose by ___ (ml)</td>
<td>___ to ___ weeks – reduce previous dose by ___ (ml)</td>
</tr>
<tr>
<td>___ to ___ days – reduce previous dose by ___ (ml)</td>
<td>Over ___ weeks – contact office for instructions</td>
</tr>
<tr>
<td>Over ___ days – contact office for instructions</td>
<td></td>
</tr>
</tbody>
</table>

REACTIOINS:  
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.