Drexel Student Health Center
3401 Market Street, Suite 105B
Philadelphia, PA 19104
Phone: (215) 220-4700
Fax: (215) 220-4705

REQUEST AND CONSENT FOR ADMINISTRATION OF ALLERGY IMMUNOTHERAPY

Patient's Name:_____ DOB: _____

Attention Prescribing Allergist's Office:

The above named student requests the Drexel Student Health Center to provide allergy immunotherapy prescribed by you. Patient safety is of the utmost importance; therefore, the prescribing allergist must complete the standardized form below. Please note that the Student Health Center policy states that each student is responsible for retrieving his/her serum vial(s) at the end of each quarter. The Student Health Center is NOT able to mail vials of serum. Your timely response to the items below is greatly appreciated.

ORDERING PROVIDER INFORMATION (Please Print/Type):

Name: _____ Phone Number: _____

Office Address: _____ Fax Number: _____

City:_____ State: _____ Zip Code: _____

Office Hours: _____

In addition, policy requires that

□ Each vial is labeled with the student's name and date of birth

□ A listing of the extracts in each vial accompanies the vial

Vial _____ : _____

Vial _____ : _____

Vial _____ : _____

Vial _____ : _____

Vial _____ : _____

□ The expiration date for each vial is included.

Vial _____: ____/____/_____

Vial _____: ____/____/_____

Vial _____: ____/____/_____

Vial _____: ____/____/_____

Vial _____: ____/____/_____

□ The Drexel Student Health Center does not give the initial dose of allergen immunotherapy. Please give the date of the most recent injection given at your office.

____/____/_____ Arm: Right / Left Reaction: _____

□ Instructions for administration of immunotherapy should include:

1. Injection frequency _____
2. Injection dose _____
3. Incremental dose increase (in mL) _____
4. Acceptable interval for missed doses (from the date of last shot) _____
5. How to handle missed doses that exceed acceptable interval: _____

   _____

   _____

6. How to handle immediate or delayed local reactions in terms of subsequent dosing:

   _____

   _____

□ Any student that has significant systemic reaction will not be able to receive subsequent injection at the Student Health Center until evaluated by the prescribing physician and written recommendations are provided to the health center for subsequent dosing.

□ For asthmatics, baseline peak flow should be provided. _____

□ For any student with a history of anaphylaxis or systemic reaction to allergen exposure, a prescription for Epi-Pen is required. The student should be able to demonstrate understanding of when and how to use the Epi-Pen.

- Have you prescribed Epi-Pen for this patient? **YES / NO** (Please circle)
- Has your office instructed the student about Epi-Pen usage? **YES / NO** (Please circle)
- Has the patient experienced any significant local or systemic reactions to allergy injections? If yes, please give details: _____

_____

_____ _____

Prescribing Physician Signature ***Date***