Dickinson
Wellness Center
Health Services

P.O. Box 1773, Carlisle, PA 17013
717-245-1835 (phone) 717-245-1938 (fax)

ALLERGY INJECTIONS

STUDENT INSTRUCTIONS AND RESPONSIBILITIES

The Wellness Center will administer allergy injections on the written order of your allergist who has provided you with the appropriate serum.

1. The student is responsible for taking the **Allergy Immunotherapy Checklist** to their physician and assuring their vials and instructions are in compliance with the Wellness Center policy. We will not administer injections from inadequately labeled vials or if physician's instructions are missing or incomplete.

2. The student is responsible for having current instructions, schedules, and serums at the Wellness Center. They are also responsible for adhering to their schedule and obtaining refill serum as needed.

3. The student is responsible for making their appointments for allergy injections at the Wellness Center. Allergy forms will be reviewed by the nurse practitioner at the first visit. The student will be given the **Allergy Immunotherapy Instruction Sheet** and the **Consent for Allergy Immunotherapy** at their first visit**.** The student is responsible for reading and understanding the instruction sheet and by signing the consent agrees to the policies of the Wellness Center.

4. The student is responsible for arranging their own injections while they are away from campus.

5. The student is responsible for checking out their serum and a copy of their record during the holiday periods and <u>at the end of the academic year.</u>

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ALLERGY IMMUNOTHERAPY CHECK LIST

IT IS IMPERATIVE THAT THE FOLLOWING INFORMATION BE PROVIDED IN ORDER FOR YOUR PATIENT TO RECEIVE ALLERGY INJECTIONS AT THE DICKINSON WELLNESS CENTER.

Student _____ D.O.B._____

- This **checksheet must** be completed yearly and **signed** by the prescribing physician.
- It is the **responsibility** of the prescribing physician to assure the vials are properly labeled and prescribing orders are complete.
- Vials will be returned if not labeled properly, which will delay patients getting their immunotherapy.
- **All Vials must be labeled with the following information: Patient Name, Expiration Date & Vial Number**

TO BE COMPLETED AND SIGNED BY THE PRESCRIBING PHYSICIAN:

Our facility has a part-time physician three hours/week and is staffed full time with certified registered nurse practitioners (CRNP) who are CPR certified. Emergency equipment is present and protocols are posted. The local hospital emergency department is two miles from campus. Given this information, please check one of the following:

❒ **My patient may receive injections while the Certified Registered Nurse Practitioners are present.**
❒ **My patient must receive allergy injections ONLY when the physician is present.**

1. Does the patient have any chronic or severe illness which might affect general health or desensitization schedule? ❒yes ❒no Specify: _____
2. Do you alternate arms with each injection? ❒yes ❒no
3. How long must your patient wait to exercise after receiving allergy injections? _____hours
4. Is your patient permitted to have their injections > once a week? ❒yes ❒no
   What is the minimum number of days allowed between injections? _____days
5. Has the patient had previous severe local or systemic reactions to antigen? ❒yes ❒ no
   If yes, please indicate type and treatment: _____
6. May your patient receive a flu vaccine during the week of allergy injection(s)?
   ❒yes ❒no ❒must wait _____ days between the two.

Physician's Signature_____Date_____

*All information is updated yearly. All information is checked routinely when new vials of antigens are used.

Allergy RN Contact:_____ Physician Name:_____
Phone No: _____ FAX No. _____
Address: _____
City State Zip _____