Dickinson
Wellness Center
Health Services
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717-245-1663 (phone) 717-245-1938 (fax)

ALLERGY INJECTIONS

The Dickinson College Wellness Center's goal is to provide care needed by our student patients in the safest way possible. Your assistance with this goal is not only required but also greatly appreciated.

Our Allergy Clinic serves many patients referred by various allergy specialists. Each allergy specialist has a unique form they use in their office. As you can imagine, navigating different forms is very challenging and has significant potential for error. Therefore, to maximize the safety margin for the student patients, our clinic has developed our own allergen immunotherapy administration form that we will utilize for every student patient in our allergy clinic.

In order for student patients to receive allergy immunotherapy at the Dickinson Wellness Center, we require the following:

1) Every student patient's initial injection(s) must be performed at the Allergist's office.

2) We will not mix or dilute any extracts; this must be done by the prescribing allergist. We will store extracts in the Allergy clinic.

3) Each vial must be clearly labeled with:

a. Patient's name

b. Name of the antigen(s)

c. Dilution

d. Expiration date

4) The Dickinson College Wellness Center's Allergen Immunotherapy administration form MUST be completed and provided to the Allergy clinic prior to a student patient receiving injections.

5) There are nominal charges associated with injections. While we do not participate in or bill any insurance plans, we do provide receipts to submit to insurance companies for reimbursement.

These requirements are purely for the safety of our student patients. Failure to comply could delay and potentially prevent utilization of our services.

Sincerely,

Dickinson Wellness Center

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 at the end of the academic year.

ALLERGY IMMUNOTHERAPY CHECKLIST

The Dickinson Wellness Center's goal is to provide care needed by our student patients in the safest way possible. Your assistance with this goal is not only required but also greatly appreciated.

IT IS <u>IMPERATIVE</u> 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 form **must** be completed yearly and **signed** by the prescribing physician.
- The Dickinson Wellness Center Allergen Immunotherapy administration form MUST be correctly completed and provided to the Wellness Center prior to a patient receiving injections. We WILL NOT accept "see attached" which refers us to use your office forms.
- Every student patient's initial injection(s) must be performed at the Allergist's office.
- Mixing and diluting extracts must be done by the prescribing allergist.
- Each vial must be clearly labeled with:
    1. Patient's name
    2. Vial number
    3. Name of the antigen(s)
    4. Dilution
    5. Expiration date
- Vials will be returned if not labeled properly, which will delay patients getting their immunotherapy.

<u>TO BE COMPLETED AND SIGNED BY THE PRESCRIBING PHYSICIAN:</u>

Our facility has a part-time physician four 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, my patient may receive injections in the Dickinson College Wellness Center.

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 Contact:_____ Physician Name:_____
Phone No: _____ FAX No. _____
Address: _____

ALLERGY IMMUNOTHERAPY INSTRUCTION SHEET AND CONSENT

1. Since the immune system is unpredictable, you must remain at Health Services for **30 minutes** after receiving your allergy injection. You must also have the **injection site checked** by the nurse practitioner before you leave. If these safety requirements are not adhered to, we reserve the right to refuse to provide this service. **There are no exceptions.**

2. While waiting the 30 minutes after the injection, notify the nurse if you experience any of the following: runny nose, wheezing, sneezing, coughing, itching, flushing, shortness of breath, facial swelling, hives, anxiety, or nasal congestion.

3. Although you may not experience any reaction within the 30 minutes after the injection, it is possible to react later in the day. If a reaction occurs:

    a. Take an antihistamine as recommended by your allergist.
    b. Record the type, time, and size of the reaction and how long it lasts.
    c. If symptoms continue or worsen, return to the Wellness Center or go to the emergency room.
    d. Report this to the nurse practitioner before receiving your next injection(s).

4. If possible, try to schedule your injection times on the same day each week.

5. Certain prescription medications for eye problems, headaches, and blood pressure problems contain ***Beta Blockers***. Beta Blockers can increase the sensitivity to allergens and also can cause a life-threatening reaction. If you have been prescribed any such medication, it is imperative you inform the nurse practitioner before receiving any allergy injections.

6. If you will need your injections over time periods away from campus, please come to the Wellness Center to sign out your serum. You are responsible for making arrangements to receive your injections while you are away from campus. You must also keep the extracts refrigerated. Failure to do so may destroy the extract.

Informed Consent to Receive Allergy Immunotherapy

I, _____(please print) request that I receive allergy shots from the Dickinson College Wellness Center. I understand that my shot record and specific information about managing problems and progression of shots must be received prior to obtaining allergy shots at Health Services.

I understand I must remain in Health Services for thirty minutes after receiving the injections, and the sites must be evaluated by a nurse prior to leaving the facility. If I leave without the nurse checking and recording results, I may no longer receive my immunotherapy at Health Services. I have been informed that serious reactions can occur and could be potentially life threatening. I hereby give consent for treatment of serious reactions with the use of epinephrine and other appropriate treatments deemed necessary by the Dickinson College Wellness Center staff.

I have read and understand this information and consent to receive my allergy injections.
Date: _____

Signature: _____ D.O.B.: _____

Witness_____

Allergen Immunotherapy Order Form

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 will 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: Office Phone: Secure Fax:

Office Address:

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

INJECTION SCHEDULE:

Begin with ___ (dilution) at ___ml (dose) and increase according to the schedule below.

Dilution					
Vial Cap Color					
Antigen Name					
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
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	Go to next Dilution	*Go to next Dilution*	*Go to next Dilution*	*Go to next Dilution*	ml

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

During Build-Up Phase	***After Reaching Maintenance***
▪ ____ to ____ days – continue as scheduled	▪ ____ to ____ days – 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: Repeat dose if swelling is > mm and < mm.

Reduce by one dose increment if swelling is > mm.

Physician Signature: _____ Date: