

**Student Health Service**

4189 Westlawn  
Iowa City, Iowa 52242-1100  
319-335-8392 Fax 319-335-8249  
<http://studenthealth.uiowa.edu>

Allergy Office Phone: (319)335-8365  
Allergy Office Fax: (319) 384-1703

Date: \_\_\_\_\_

Patient Label

Name: \_\_\_\_\_

Student I.D. \_\_\_\_\_

Dear Dr. \_\_\_\_\_:

Your patient, \_\_\_\_\_, has requested that his/her allergy extract be administered by a Student Health Service nurse. We are pleased to be of assistance to the student in providing this service.

In order to allow our nurses to administer the allergy extracts in a safe manner, we require that this form be completed in its entirety and signed by the prescribing provider. Our nurses have been instructed to administer the allergy extract(s) in accordance with your written and signed instructions and orders. If you have a separate instruction sheet that contains the information we require, please write "Please see attached instructions" on each applicable question and indicate on your sheet where the required information can be found. All students who request to receive immunotherapy at Student Health will be required to see a Student Health provider to review medical history and medications before allergy shots can be given at Student Health. All students receiving immunotherapy are also required to have an epi-pen with them when they receive their allergy shot(s). We reserve the right to decline to administer allergy shots to a student with perceived higher than average risk for a severe/systemic reaction to immunotherapy or who does not abide by Student Health instructions/requirements for receiving immunotherapy.

If the immunotherapy orders or instructions are unclear, or if the nurse has a question about an issue pertaining to a student's health, allergy extract, or administration, the nurse will contact you by telephone, fax, or letter for clarification.

**Please be aware we ONLY accept telephone/verbal orders directly from the Allergist/Prescribing Provider, all other orders must be signed by the Allergist/Prescribing Provider and mailed or faxed to Student Health.**

The Student Health Allergy office fax number is **319-384-1703** (please include a cover sheet with all correspondence). Complete and timely information will help us avoid delays in your patient's allergy extract administration. The nurses will not proceed with scheduled injections until updated instructions have been received in the appropriate manner.

If indicated, the student will be evaluated for any related problem(s) by a Student Health Service provider or referred back to your office. Should the student develop a severe reaction requiring the use of epinephrine, Student Health Service reserves the right to decline to administer future immunotherapy to the student.

If you have any specific questions about our administration policies or related procedures, please feel free to contact me or one of our immunotherapy nurses.

Sincerely,

Renee Nydegger, M.D.  
Staff Physician

**REQUIRED INFORMATION:**

(Please complete the following questions. If you have a separate instruction sheet that contains the information we require, please write "Please see attached instructions" on EACH applicable question and INDICATE on your sheet where the required information can be found.)

Patient Label

Name: \_\_\_\_\_

Student I.D. \_\_\_\_\_

1. Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
2. Diagnosis(es): \_\_\_\_\_  
Is this patient being treated for Asthma? \_\_\_\_\_
3. Medication List (please include all known medications, including those for the treatment of allergies/asthma):  
\_\_\_\_\_  
\_\_\_\_\_
4. Date patient began Immunotherapy: \_\_\_\_\_ Date of last shot(s): \_\_\_\_\_
5. Is the patient on the build-up or maintenance phase of immunotherapy? \_\_\_\_\_
6. What is the patient's injection interval? (e.g. minimum and maximum intervals) \_\_\_\_\_
7. Has the patient experienced any severe or systemic reactions while receiving immunotherapy? Please describe:  
\_\_\_\_\_  
Does the patient have "usual" reactions to allergy shots of which we should be aware? (e.g. "lumps" or delayed reaction)  
Please describe:  
\_\_\_\_\_
8. What are the specific contents of each allergy extract vial? (Please specify vials if there is more than one.)  
\_\_\_\_\_  
\_\_\_\_\_
9. What is your protocol when patients are late for injections? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. What is your protocol for local and/or delayed reactions to injections? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. If the patient has asthma do you want peak flows checked before and after allergy shots? \_\_\_\_\_  
If "Yes," please list baseline peak flow and minimum peak flow acceptable to receive allergy shots:  
Baseline Peak Flow: \_\_\_\_\_ Minimum Peak Flow: \_\_\_\_\_
12. Office Address: \_\_\_\_\_  
Phone Number to call for questions: \_\_\_\_\_ Office Fax Number: \_\_\_\_\_  
Office Hours/Days when someone is available to answer questions/give appropriate orders for immunotherapy:  
\_\_\_\_\_  
Any particular immunotherapy staff member for whom we should ask? \_\_\_\_\_  
Name of Prescribing Physician/Provider: \_\_\_\_\_  
Signature of Prescribing Physician/Provider: \_\_\_\_\_

**OTHER REQUIREMENTS**

1. Patient's name, vial contents, vial strength, and "Date of Expiration" must be clearly labeled on each vial of allergy extract.
2. Students receive allergy shots at Student Health Monday through Friday by appointment only; we do not have a walk-in clinic for allergy shots nor are we open on weekends.
3. ALL students who receive allergy shots MUST remain at Student Health for **30 minutes** following injections. If you require your patients to wait for less than 30 minutes, the student will still have to wait for 30 minutes at Student Health.
4. New extracts MUST be accompanied by updated orders/dosing schedules.
5. We require that all students who receive allergy shots at Student Health carry an Epi-Pen with them on the day of their injection(s) in the event of a delayed severe/systemic reaction. We will provide the student with an Epi-Pen prescription and instructions/indications for use if you have not already provided one. We also provide them with the phone number/location of local emergency treatment centers.