Towson University Health Center
Phone: (410) 704-2466 | Fax: (410) 704-3715

Allergy Immunotherapy Policy

Dear Student,

There has been a restructuring of the Health Center and a change in our allergy injection policy is now warranted. Our new allergy injection hours are Tuesdays and Thursdays between 9:00am and 3:30pm.

ELIGIBILITY: Any registered TU student with proper documentation, serum identification, and completion of the standardized injection form from a private allergist is eligible to receive allergy shots at the Health Center. The HC staff reserves the right to refuse to give these injections to any student if, in their opinion, it would result in undue risk to the patient.

DOSE SCHEDULES: Your allergist will determine the most suitable schedule for you to follow. We do expect you to keep your appointments according to the appointed immunotherapy schedules. Chronic lateness and missed injections may make you ineligible to receive this service from the Health Center. You will then be provided the names of local allergists where you may receive your injections.

VISIT: Appointments are required for allergy injections. Please follow these simple directions each time you come to the HC for an allergy injection.

- Sign in at the reception window.
- After your injection you must remain in the HC for 30 minutes. There is a seating area outside the lab.
- You must have your arm checked by a health center staff member before you leave.
- Return to the check out window to check out and make future appointments.

Note: Make sure to allow enough time for these appointments. Plan on being here for a minimum of 45 minutes.

PHYSICIAN CONTACT: On occasion, it is necessary for the Health Center staff member to speak to your allergist. If there is an emergent problem, the health center staff member will contact your doctor immediately. For all non-emergent issues, the health center will request that you call your doctor and have him/her fax us the order changes.

SERUM REFILLS: The Health Center staff member will advise you when your serum is low. It is your responsibility to contact your doctor to obtain the new serum. The Health Center cannot be held responsible for breakage/loss of serum. We will provide storage for your serum during the semester.
All bottles received must be labeled from doctor with:

- Your full name
- Serum identification name
- Date prepared and expiration date

Note: Bottles improperly labeled will not be used!

PAPERWORK: Allergy injections will not be given unless the following is on file for each patient:

- MD consent form signed by your allergist (form enclosed)
- Your personal immunotherapy schedule completed on the Health Center's standardized form
- Your signed consent form

BREAKS: When you leave for break, you will be given the original serum administration sheet. Your doctor is to chart the doses you receive on this form. After the break, please return the original to us for your records.

Thank you for your cooperation,

Suzanne Caccamese, MD
Medical Director

Towson University Health Center
Phone: (410) 704-2466 | Fax: (410) 704-3715

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. Allergy serum cannot be sent to the Health Center directly. Our packages go to the main University loading dock and we cannot guarantee the temperature will be appropriate for the serum. The serum must be sent to the student directly.

*Please note that we require patients to wait in the office for 30 minutes after receiving an allergy injection. Additionally, if we have any questions about the serum or dose and are unable to reach your office for a consult, we will not give the patient their injection.

Patient Name: _____ Date of Birth: _____
Allergist Name: _____
Office Address: _____
Office Phone: _____ Secure Fax: _____
Business Days/Hours: _____

Pre-Injection Checklist:

Does the patient have a history of anaphylaxis? Y / N
Does the patient have a history of asthma? Y / N
Is peak flow required prior to injection? Y / N If yes, peak flow must be ≥ _____ L/min to give injection.
Is the patient required to premedicate with an antihistamine prior to the injection? Y / N
Is switching arms/injection sites required? Y / N

Injection Schedule:

Last injection: was _____ ml of _____vial/dilution, administered on _____ date (including reaction) as follows: _____

Next injection: Begin with _____ dilution/vial at _____ ml (dose) and increase according to the schedule below.
Injections during the build-up phase should be administered every _____ days.

Vial Name/#:	_____	_____	_____	_____
Vial Cap Color:	_____	_____	_____	_____
Expiration Date:	_____	_____	_____	_____
	_____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

Once the patient reaches _____ml, they should begin the next dilution.
Does patient need to return to the allergy office for administration of the first dose of a new vial? Y / N
Maintenance dose is _____ml of _____ dilution/vial.
Once patient reaches maintenance dose, injections should be administered every _____ days.
Additional instructions: _____
_____
_____

Towson University Health Center
Phone: (410) 704-2466 | Fax: (410) 704-3715

Management of Local Reactions:

a. Negative: Raised wheal up to ____mm, proceed according to schedule
b. Wheal ____ to ____mm, repeat previous dose
c. Wheal ____ to ____mm, reduce by _____
d. Wheal >____mm, contact the allergy office
e. Additional instructions: _____
_____

Management of Missed/Late Injections:

Build-up Phase:

a. If ____ days or less since last injection, proceed as scheduled
b. If ____ to ____ days since last injection, repeat previous dose
c. If ____ to ____ days since last injection, reduce dose by 1
d. If ____ to ____ days since last injection, reduce by ____ doses
e. If >____ days since last injection, contact the office for instructions

Maintenance Phase:

a. If ____ days or less since last injection, repeat regular maintenance dose
b. If ____ to ____ days since last injection, reduce dose by ____
c. If ____ to ____ days since last injection, reduce dose by ____
d. If > ____ days since last injection, contact the office for instructions

*When dose is reduced, follow the buildup schedule until again reaching the maintenance dose
*Inform the allergy office of any systemic reactions. Do not administer any further injections until given specific instructions on how to proceed.

Allergist Signature: _____

Date: _____

Towson University Health Center
Phone: (410) 704-2466 | Fax: (410) 704-3715

Informed Consent For Allergy Immunotherapy

Allergy immunotherapy contains water extracts of pollen, mold, or dust to which a patient has been shown to be allergic by skin testing. With this type of injection there may be a local reaction. These are generally mild and include:

Burning or itching at the injection site
Swelling or hives at the injection site
Generalized hives (welts)
Nasal congestion and/or "runny nose" with itching of ears, nose, or throat and/or sneezing
Itchy, watery, or red eyes
Swelling of tissue around the eyes, the tongue or throat
Stomach or uterine (menstrual type) cramps

Occasionally, more severe reactions occur such as wheezing, cough, and shortness of breath.
Rare complications include irregular or abnormal heart rhythm and sudden drop of blood pressure.
Severe reactions involving heart, lungs, and blood vessels could be fatal. However, if recognized and treated early, the risk is reduced.

Allergy injections MUST NOT be given to patients taking "Beta Blocker" drugs. These drugs increase the likelihood of systematic reactions and make such reactions more difficult to reverse.

☐ I certify that I am not on these drugs now and if, in the future, these drugs are prescribed for me, I agree to inform the Allergy Clinic Nurse at that time. Some examples of "beta blockers" are: Lopressor Propranolol, Tenormin, and Metoprolol.

☐ I hereby give consent to Towson University Health Center for allergy immunotherapy and I further consent to the performance of such additional procedures as are indicated or considered necessary in the judgment of the treating physician, to treat any reactions to allergy injections.

☐ I understand that the Health Center is not responsible for serum that is lost, frozen, or for broken bottles of serum.

☐ I understand that the Health Center may refuse to give me an allergy injection if I have not taken any premedication prescribed by my allergist.

☐ I acknowledge that I have fully read and understand the information on this form. I have been given the opportunity to have and questions or concerns addressed by the Health Center staff

_____

Patients Signature (parent or guardian if patient is a minor)

Witness: _____

Date: _____

Towson University Health Center
Phone: (410) 704-2466 | Fax: (410) 704-3715

Allergy Patient Medical Questionnaire

Name: _____ TU ID #: _____

		YES	NO
1.	Have you ever had a severe reaction to your allergy shots? If yes, describe the reaction and when it occurred.	☐	☐
	_____		
	_____		
	_____		
2.	Do you have asthma? If yes, answer the questions below:	☐	☐
3.	Have you ever been treated in the emergency room for asthma?	☐	☐
4.	Were you ever hospitalized for the treatment of asthma?	☐	☐
5.	Were you in the intensive care unit at the hospital for asthma?	☐	☐
6.	Have you ever taken or do you now take oral Prednisone for your asthma?	☐	☐
7.	When was the last time you were on Prednisone?	☐	☐
	_____		
8.	What are your current asthma medications for an acute asthma attack? (List All)	☐	☐
	_____		
	_____		
9.	Do you currently take any other medications for any reason? If yes, list name and dosage:	☐	☐
	_____		
	_____		
10.	Do you have any allergies to medications? If yes, list the drug and the reaction:	☐	☐
	_____		
	_____		

I verify that the above information is accurate and complete.

Signature: _____ Date: _____

Towson University Health Center
Phone: (410) 704-2466 | Fax: (410) 704-3715

Immunotherapy Check List and Contract

	YES	NO
1. Immunotherapy schedule of patient's orders complete	☐	☐
2. Vials of serum labeled with:		
• Patient's Name & DOB or TU ID#	☐	☐
• Expiration date (MM/DD/YYYY)	☐	☐
• Bottle Number or ID code	☐	☐
3. Appointment schedule reviewed	☐	☐
4. Billing/Payment/Fees discussed with patient	☐	☐
5. Discussion of patient's responsibility for obtaining new orders(by fax or in writing) if needed	☐	☐
6. Patient's phone number/demographics are up to date	☐	☐
7. Contract reviewed by patient and provider	☐	☐

_____ _____

(Patient Signature) (Date)

_____ _____

(Provider Signature) (Date)

Towson University Health Center
Phone: (410) 704-2466 | Fax: (410) 704-3715

Allergy Administration Sheet

Place Label Here

Date	Vial	Dose	Given by*	Verified By*	Arm R/L	Reaction	Comments

**The RN administering the dose and the dose verifier are responsible for checking the accuracy (correct patient, vial, dose, and expiration date).*

Towson University Health Center
Phone: (410) 704-2466 | Fax: (410) 704-3715

Progress Note

Place Label Here

Date	Note