COASTAL CAROLINA
UNIVERSITY

Office of Student Health Services

Patient's Name_____

Student ID: _____ Patient's DOB: _____

STUDENT HEALTH CENTER REQUEST FOR ALLERGY INJECTION THERAPY

NOTE: *This form and the requested information below MUST BE COMPLETED IN DETAIL by the physician before allergy injections will be administered at the Student Health Center.*

1. Patient's medical history including any chronic or severe illness that could affect the desensitization schedule.
2. Current injection log showing most recently administered injections and allowing for subsequent injection documentation.
3. Specific instructions on dosage adjustment if the patient is late for an injection or deviates from the prescribed schedule.
4. Schedule for build-up of dosages if applicable.
5. Maintenance schedule to include dosage adjustment when starting a new maintenance vial.
6. Specific instructions indicating conditions/illness that may warrant withholding or reducing dosages.
7. Has the patient experienced previous significant local or systemic reactions to allergy injections? ___YES ___NO If yes, indicate date, reaction, which extract and the treatment administered.

8. Is the patient presently taking any medications? ___YES ___NO If yes, please list:

9. We require a written order from the prescribing physician before we administer allergy injections to your patient and in the event a deviation from the original order is required.

PHYSICIAN'S SIGNATURE_____DATE_____

PHYSICIAN'S NAME (please print) _____

OFFICE ADDRESS_____

_____

TELEPHONE NUMBER_____

FAX NUMBER_____

Rev: 6/16, 6/17, 6/18