THE UNIVERSITY OF IOWA
STUDENT HEALTH

Allergy Office
University of Iowa Student Health
4189 Westlawn
Iowa City IA 52242
Phone: 319-335-8365
Fax: 319- 384-1703

Date: _____

Dear Dr. _____,

Your patient, _____, has requested that his/her allergy extract be administered by a Student Health Registered Nurse while they are attending the University of Iowa. We are pleased to be of assistance in providing this service. Students can receive allergy shots Monday through Friday by scheduling an appointment in our Allergy Office.

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, please write "See attached instructions" on each applicable question and indicate on your sheet where the required information can be found.

Each vial of extract must be clearly labeled with the patient's name, vial contents, vial strength, and date of expiration. New extracts must be accompanied by updated orders and dosing schedules.

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 in our clinic. **All students receiving immunotherapy are also required to have an unexpired Epi-Pen with them when they receive their allergy shots. For safety, we require that students remain in our clinic for 30 minutes after receiving allergy shots.** We reserve the right to decline to administer allergy shots in these situations:

- Perceived higher than average risk for a severe/systemic reaction to immunotherapy
- History of a severe reaction requiring use of epinephrine
- Non-compliance with Student Health requirements and guidelines 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.

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 provider or referred back to your office.

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.

Thank you for allowing us to participate in the care of your patient.

Tom Woodward, M.D.
Staff Physician

THE UNIVERSITY OF IOWA

STUDENT HEALTH

1. **Patient's Full Name**: _____

2. **Date of Birth**: _____

3. **Diagnoses:** _____

4. **Is this patient being treated for Asthma?** _____

5. **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: _____

6. **Medication List** (please include all known medications, including those for the treatment of allergies/asthma):

   _____

   _____

7. **Date patient began Immunotherapy**: _____ Date of last shot(s): _____

8. **Is the patient on the build-up or maintenance phase of immunotherapy**?

   _____

9. **What is the patient's injection interval?** (e.g. minimum and maximum intervals)

   _____

10. **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:

    _____

    _____

11. **What are the specific contents of each allergy extract vial?** (Please specify vials if there is more than one.)

    _____

    _____

    _____

12. **What is your protocol when patients are late for injections?**

    _____

    _____

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Student Name _____

Date of Birth _____

13. **What is your protocol for local and/or delayed reactions to injections?**

_____

_____

_____

14. **Your Office Address:**

_____

_____

Phone Number to call for questions: _____ **Fax** _____

Office Hours/Days when someone is available to answer questions/give appropriate orders:

_____

Any particular immunotherapy staff member for whom we should ask?

_____

Name of Prescribing Physician/Provider:

_____

Signature of Prescribing Physician/Provider:

_____ **Date signed** _____

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