



Dear Doctor,

The Wesleyan University Davison Health Center is happy to assist with administration of allergy immunotherapy to your patient. We have been providing this service to students for a number of years, and find the experience rewarding and enjoyable. To keep it so, we do have specific requirements detailed below.

Our health center is equivalent to a typical outpatient community physician's office. We always have an MD on site during allergy injections. Students experiencing an apparent adverse reaction or otherwise suffering complication of allergy immunotherapy are immediately evaluated by a physician. When indicated, epinephrine, IM diphenhydramine and other available intervention as prescribed by the Allergist may be administered. We do have Oxygen, but do not have IV therapy. Middlesex Hospital, the local community hospital, is less than a mile away and EMT services are very responsive to our calls. In the event of a severe reaction or other true emergency, we would call 911 and provide Basic Life Support until the arrival of emergency medical services.

If your patient qualifies for allergy immunotherapy services within the context of our level of care, please complete the included documentation (which will need to be updated on an annual basis). Any special details should be included on the sheet. For students with unusual needs, please contact one of us.

Thank you for your assistance with these protocols. We look forward to assisting with the care of your patient.

Davis Smith MD
Medical Director
pdsmith@wesleyan.edu

Joan Ecklund RN
Allergy Immunotherapy Clinic Nurse
jecklund@wesleyan.edu

Davison Health Center
Wesleyan University
327 High Street
Middletown, CT 06459
Telephone: (860) 685-2470
FAX: (860) 685-2471

Davison Health Center
Wesleyan University

ALLERGY IMMUNOTHERAPY CHECK SHEET
To Be Completed by Allergist

STUDENT: _____ SS# _____

- All the following information **MUST BE PROVIDED BEFORE** allergy injections are given.
- The check sheet will be completed yearly and whenever new vials of extract are brought in.
- It is the **STUDENT'S RESPONSIBILITY** to assure the vials are properly labeled and physician's orders are complete **WHEN THEY PICK UP THEIR EXTRACTS FROM THEIR PHYSICIAN.**

1. Vials are labeled/coded as to **CONCENTRATION** YES NO
2. Vials are labeled/coded as to **ANTIGEN CONTENT** YES NO
3. **EXPIRATION DATES** of the antigens are indicated YES NO
4. Number of vials: 1 2 3 4 5 6 Other: _____ YES NO
5. Vials are coded by **NUMBER, LETTER OR COLOR**
to correspond with MD's written orders YES NO
6. Schedule indicating the **AMOUNT AND FREQUENCY**
of each injection is present YES NO
7. **SINGLE DOSE VIALS ARE NUMBERED OR DATED**
to correspond with MD's written orders YES NO
Is the **NUMBER OF VIALS** indicated? YES NO
Is the **CONTENT** indicated? YES NO
Is the **STRENGTH** indicated? YES NO
Is the **EXPIRATION DATE** indicated? YES NO
8. Instructions for **MISSED/LATE** injections are present YES NO
9. Instructions are present for adjusting schedule after **LOCAL REACTION** YES NO
10. Does the patient have any chronic or severe illness which might affect general
health or desensitization schedule? YES NO
IF YES, please indicate Asthma Cardiac Other _____
11. Has the patient had previous significant local or systemic reactions to antigens? YES NO
IF YES, please indicate type of reaction, to what antigen(s), and previous type of
treatment for the adverse reaction _____
12. **IF NEW VIALS OF MAINTENANCE** antigens are to be used, are **NEW VIAL**
ORDERS (reduced dosage with progression to maintenance) present? YES NO

OFFICE CONTACT PERSON:

PHONE NUMBER:

FAX NUMBER:

Date: _____ NURSE: _____

Davison Health Center
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INSTRUCTIONS AND INFORMED CONSENT FOR ALLERGY IMMUNOTHERAPY
To Be Completed by Student

I request to receive my allergy immunotherapy at the Davison Health Center (DHC) and agree to the following:

1. Allergy injections are only given by appointment by calling 860-685-2470. There is a \$25.00 fee for the initial consultation and \$10 for each appointment thereafter. The student is responsible for bringing the allergy extract and the allergist's instructions to DHC. Serums must not be mailed to DHC.
2. The first allergy shot must be administered in the allergist's office. DHC will not administer immunotherapy for hymenoptera (stinging insects).
3. A student receiving allergy injections must remain in the view of the nurse for 20 to 30 minutes after receiving the injection.
4. After the 20-30 minute observation period, the student must have the injection sites evaluated by the immunotherapy nurse before leaving the facility. If a student leaves without being cleared to do so by the nurse, the student may no longer receive immunotherapy at DHC. There are no exceptions to this policy.
5. It is the responsibility of the student to pick up the extracts and a copy of their record during semester breaks and at the end of the academic year and to bring these materials upon return to campus. The DHC **will not** mail extracts left in the Health Center. Vials in transit should not be exposed to temperature extremes (freezing or extreme heat) because this could decrease extract potency.
6. It is the student's responsibility to arrange continuation of allergy immunotherapy while away from campus.

I, _____, have read and fully understand the above statements.

I understand that the prescription, i.e., the content, the concentration and the dosage schedule of my extract, is the responsibility of my private physician, Dr. _____.

I understand that in order to receive allergy immunotherapy at DHC I must comply with the instructions and protocol requirements as listed above. The signature of a DHC physician only authorizes the continuation of immunotherapy as prescribed by your allergist and is not an endorsement of the regimen.

I have read and understand these instructions and responsibilities and have been given the opportunity to ask questions.

Signature: _____

Date: _____

Witness: _____

DOB: _____