I ILLINOIS
McKinley Health Center

Immunization & Travel Clinic
1109 S Lincoln Ave, Urbana, IL 61801
Phone (217) 333-2702 Fax (217) 244-3067 Mon-Fri 8am-5pm

Allergy Injection Therapy Orders

This completed form is needed to arrive with new vials received at our facility or with a change in orders, for example changing from building dose to maintenance dose. **<u>See attached is not an acceptable completion of this form</u>. We will be unable to administer allergy injections at our facility without this form completed in full and received by MHC.**

Patient Name: ________________________
Date of Birth: _________________________ Place label here
U of I ID (UIN): ________________________
Allergist Office: ______________________________
Allergist Name: ______________________________ Allergist Phone#: ____________________
Allergist Address: ____________________________ Allergist Fax#: _____________________
____ Allergist office hours:_________________

Vial #	Allergen/Contents/Strength	Vials Expiration	Last Injection Date

Injection Schedule: Begin with ___________ (dilution) at _______ ml (dose) and increase according to the build schedule below. Increase according to schedule every ____ to ____ days ☐ or weeks ☐.
After Maintenance dose of _____ ml is reached, repeat every _____ to ____ days ☐ or weeks ☐.

Vial Color & Dilution in top box (ex- Red 1:1)

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	ml	ml
ml	ml	ml	ml	ml	ml
ml	ml	ml	ml	ml	ml
ml	ml	ml	ml	ml	ml
Next/Reorder	Next/Reorder	Next/Reorder	Next/Reorder	Next/Reorder	Maintenance

*__Please show at what vial/dose NEW serum should be ordered__*__________________

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PRE/POST INJECTION INSTRUCTIONS

Special instructions: ____

(Ex: ep-pen check, vitals. If vitals needed- say what type and parameters of acceptable range)

Student must take antihistamine prior to injections? ___________________________________

(Specify time prior to allergy injections)

Is 48 hours between allergy injections and vaccines acceptable? ____________________________

(Specify time between if longer)

Exercise/Workout precautions: ____

(If so, specify time before and after allergy injections)

Will students need to check their peak flow and report □ before and/or □ after injections? (Mark as needed)

____(Specify acceptable range)

Reactions: ______________________**mm** **Directions:** ______________________ (continue)

________________________**mm** ___________________________ (repeat dose)

________________________**mm** ___________________________ (reduce dose)

________________________**mm** ___________________________ (call allergist)

***All Systemic Reactions will need to see allergist for injection & orders prior to continuing injections**

Interval Since **last** Injection -complete per allergist policy	Patients taking injections once or more weekly	Patients taking injections every 2 weeks	Patients taking injections every 3 weeks	Patients taking injections every 4 weeks	Patients taking injections every 4-6 weeks
Day __-__					
Day __-__					
Day __-__					
Day __-__					
Day __-__					
Day __-__					
Day __-__					
Day __-__					
Day __-__					

Late Schedule: Building □ **Maintenance** □ (mark to select one)

(**Complete accordingly- ex: continue schedule, repeat dose, decrease 1 dose/doses, call allergist office**)

Physician Signature: ____________________________________ Date: ______________________

***Your signature confirms you are a board-certified Allergist and have agreed to our Allergy Injection Procedures**

Reviewed by ____ Date ______________________

(MHC Provider)