



Health Services is a proud part of the Division of Student Affairs.

**Allergen Immunotherapy  
 Prescribing Physician Form**

Student Name: \_\_\_\_\_

UID: \_\_\_\_\_

The Student Health Services on the Tarleton State University Campus strives to provide the highest quality care to the students who utilize our services. We thank you for allowing us to share in the care for our mutual patient. In order to initiate allergen immunotherapy through the health center, the physicians at the health center require the following information prior to authorizing the injections. Please note that the health center policy states that each student is responsible for retrieving his/her serum vial(s) at the end of each semester. Due to the large student population for which we provide service, **the health center is NOT able to mail vials of serum.** Your timely response to the items below is greatly appreciated. The physician must be fully aware that an MD is only on the premises Monday through Friday 1:00-2:00 PM. An APRN or PA is available during all clinic hours.

**Prescribing Physician Name:** \_\_\_\_\_

**Office Name:** \_\_\_\_\_ **Office Hours:** \_\_\_\_\_

**Office Address:** \_\_\_\_\_

**Office Telephone:** \_\_\_\_\_ **Office Fax:** \_\_\_\_\_

In addition, policy requires that:

- Each vial is labeled with the student's name, date of birth, and expiration date prior to our receiving the vial(s).
- Peak Flow Needed (circle one): Yes No
- Baseline peak flow: \_\_\_\_\_
  - o The patient should provide their own peak flow meter and bring to each visit. Use of health center supplies will generate additional charges.
- Whether or not the vial requires refrigeration and the acceptable length of time during mailing for non-refrigeration is identified.  
 \_\_\_\_\_
- The student health center **does not give the initial dose of allergen immunotherapy.** Please give the date of most recent injection given at your office.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      Arm: R / L      Reaction: \_\_\_\_\_

Please circle which applies:    Initial Dose      Routine Injection      Dose Given: \_\_\_\_\_

- Instructions for administration of immunotherapy should include:
  - o Injection frequency: \_\_\_\_\_
  - o Injection dose \_\_\_\_\_
  - o Incremental dose increase (in mL) \_\_\_\_\_
  - o How to handle missed doses that exceed acceptable interval:  
 \_\_\_\_\_
  - o How to handle immediate or delayed local reactions in terms of subsequent dosing:  
 \_\_\_\_\_
- Any student that experiences a significant systematic reaction will not be able to receive subsequent injection at the health center until evaluated by the prescribing physician and written recommendations are provided to the health center for subsequent dosing.
- For any student with history of anaphylaxis or systematic reaction to allergen exposure, a prescription for Epi-Pen is required. The student should be able to demonstrate understanding of when and to use Epi-Pen.
  - o Have you prescribed Epi-Pen?      Yes / No
  - o Has your office instructed the student about Epi-Pen usage?      Yes / No

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Prescribing Physician's Signature      **(Required)**      Date

**THIS FORM MUST BE TURNED IN PRIOR TO RECEIVING INITIAL CONSULTATION VISIT.**