NC Central University
Student Health Center

Dear Allergy Injection Patient:

Our records indicate that you currently receive allergy injections. If you would like to continue your allergy immunotherapy at Eagle Health, you and your allergist's office must complete the following forms **before** you will be enrolled in our program:

- **Student Request to Receive Allergy Immunotherapy** - to be completed by you
- **Provider Order for Allergy Immunotherapy** - to be fully completed by your allergist's office

Please note:

- We cannot accept outside treatment plans, handwritten notes, or orders that reference "see attached." Your allergist must complete our official order form **in full**, including all required dosages, scheduling details, and reaction orders. This is necessary to ensure patient safety and provide consistent care.
- Your first allergy injection must be given at your allergist's office before we can continue the therapy here at Eagle Health
- Venom immunotherapy, mixed vespid and whole body extracts will not be administered at Eagle Health.
- Please have your allergist's office fax the completed forms to North Carolina Central University Health Center, **919-530-7969.**
- We require a minimum of 2 business days to review your documentation prior to administering any injection(s).

If you have any questions or concerns, please reach out to our office prior to your arrival.

Sincerely,
Eagle Health Center

NC Central University
Student Health Center

Student Request to Receive Allergy Immunotherapy

I request to receive my allergy injections at the North Carolina Central University Eagle Health and agree to the following:

1. I understand that the prescribing and mixing of my serum, the content of my vials, the concentration of my serum and the dosage schedule are the responsibility of my allergist, Dr._____. There is not an allergist on staff at Eagle Health.
2. I understand that the serum vials must be hand delivered by me to Eagle Health. **Allergy vials should not be mailed directly to Eagle Health.**
3. I understand that I must request a copy of my injection record and vials to take to my allergist during holidays, breaks and other absences. I understand the importance of keeping my serum refrigerated in transit. Allergy serum cannot be mailed out by Eagle Health to me or my allergist at any time.
4. I understand that my Allergist must complete and submit the ***Provider Order for Allergy Immunotherapy*** forms prior to my receiving allergy injections at Eagle Health. These can be found on the Eagle Health webpage at https://www.nccu.edu/dsa/health-wellness/student-health-center/clinical-services under the "Injection" tab.
5. I understand that allergy injections are given by appointment only. Call 919-530-6317 to schedule **during the regular academic year. (Service not offered during the Summer sessions)**
6. I understand that I must bring an EpiPen auto-injector with me to each injection appointment or I will not be able to receive the injection. I will obtain the EpiPen prescription from my allergist.
7. I understand that there is a fee for allergy injections based on the number of injections that I receive.
   A. 1- 2 injections: $15 B. 3 or more injections: $30
8. **I understand that I am required to wait for no less than 20 minutes after my injection(s), unless otherwise specified by my allergist. I must check in with the allergy nurse prior to leaving Eagle Health.**
9. I understand that expired allergy serum will not be used and will be discarded, unless otherwise indicated by my allergist.
10. I understand that certain medications for eye problems, headaches and blood pressure contain Beta Blockers which can increase sensitivity to allergens and potentiate anaphylaxis. I understand that if I am taking any new prescription or over-the-counter medications since my last visit to Eagle Health, I must inform clinical staff prior to receiving my injections.
11. I understand that venom, mixed vespid and whole body extracts will not be administered by Eagle Health Staff.
12. I understand that I should report any reaction to my last allergy injection, any increase in allergy symptoms, or any change in my health status prior to receiving allergy injections. **If I am ill with fever, experiencing an asthma exacerbation, or respiratory difficulties, I will not be able to receive my injection until symptoms have improved.**
13. I understand that it is recommended that I not perform any strenuous exercise during the 2 hours before or after my allergy injections.
14. In the event of a power outage or disaster that destroys my medication, I do not hold Eagle Health responsible.
15. I understand that it is my allergist's responsibility to complete all required paperwork. Failure to complete paperwork as requested will exclude me from allergy services at Eagle Health.

In signing this statement, I acknowledge that I have fully read, understand, and will abide by the information that it contains.

_____ _____
Student Name (print) Student Signature

_____ _____
Date NCCU Student ID

NC Central University
Student Health Center

Dear Allergist Office,

North Carolina Central University Student Health looks forward to collaborating with you to continue allergy immunotherapy for your patient while they are enrolled at North Carolina Central University. To ensure safe and effective administration of allergy injections, please complete attached **PROVIDER ORDER FOR ALLERGY IMMUNOTHERAPY** form in its entirety. This form must be submitted **before** we can continue immunotherapy. Incomplete forms will be returned or clarified, which may delay or disrupt your patient's treatment.

Please review the following important requirements:

Patient's initial injection(s) must be performed at an allergist's office.

- Each vial must be **clearly labeled** with **the patient's name, date of birth, dilution, expiration date, and specific allergen(s) contained within.**
- No expired serum will be administered. Exceptions must be explicitly noted on the order form (e.g. "Okay to use serum one month beyond expiration date.")
- **New serum vials must be sent directly to the patient,** not Eagle Health.

In the event of a systemic reaction, epinephrine 0.3mg (1:1000) intramuscular (IM) will be administered.

- Patients must carry and present a non-expired epinephrine auto-injector to each appointment. **Students who do not have epinephrine in their possession at the time of the visit will not receive their injection.** Please ensure your patient has a current prescription.
- If symptoms such as hives, mucosal itching, or rhinorrhea develop after immunotherapy administration, diphenhydramine 50mg IM will be given, unless otherwise specified by your office on the **order form.**
- The allergist's office will be notified in the case of a systemic reaction. **No further immunotherapy injections will be given until the patient is reevaluated by the allergist and new orders are received and approved**.
- Allergy injections will not be administered if the patient is ill, febrile, wheezing, has an upper respiratory infection, or has hives or an undiagnosed rash.
- Allergy injections will only be administered when a medical provider is on site. While a physician is usually present, there may be times when only advanced practice providers are available.

Please fax completed forms to Eagle Health at **919-530-7969**.

Exclusion criteria

Patients on a beta-blocker or monoamine oxidase inhibitor (MAOI).
Patients receiving venom immunotherapy, including mixed vespid and whole body extracts.
Eagle Health reserves the right to discontinue this service and refer back to you for management should any safety concerns develop while under care.

Sincerely,
Eagle Health

Provider Order for Allergy Immunotherapy

For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form must be completed to provide standardization and prevent errors. Failure to complete this form may delay or prevent the patient from utilizing our services. This form can be delivered by the patient, mailed, or faxed (see address and fax below).

Patient Name: _____ Date of Birth: _____
Provider: _____ Practice Name: _____
Office Phone: _____ Fax: _____

Pre-Injection Checklist:

- Does your patient have a history of asthma? **YES** ❑ **NO** ❑
- History of anaphylaxis? **YES** ❑ **NO** ❑
- Do you require your patient to take an antihistamine prior to receiving allergy injections? **YES** ❑ **NO** ❑
- Do you require a peak flow prior to injections? **YES** ❑ **NO** ❑
  - If **YES**, peak flow must be >_____ L/min.
- Length of time the patient must remain in the clinic after injection: _____ minutes.

Allergy Vials:

Vial	**Vial Contents (Allergens)** *Do not use abbreviations*	**Vial Dilution**	**Last Dose Given (mL)**	**Date of Last Dose**
Ex: Vial A	Cat, Dog, Grass	1:100	0.3	5/1/2022

Injection Schedule:

	Frequency of Injections
Build Up	Every _____ days.
Maintenance	Every _____ days or _____ weeks.

Management of Missed Injections: (according to time elapsed since ***LAST*** injection)

During Build-Up	**During Maintenance**
____ to ____ days – continue as scheduled	____ to ____ weeks: give same maintenance dose
____ to ____ days – repeat previous dose	____ to ____ weeks: reduce dose by _____
____ to ____ days – reduce previous dose by _____	____ to ____ weeks: reduce dose by _____
____ to ____ days – reduce previous dose by _____	____ to ____ weeks: reduce dose by _____
Over ____ days: contact office for instructions	Over ____ weeks: contact office for instructions

Dilution					
Vial Cap Color					
	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	**Maintenance**
	mL	mL	mL	mL	**Dose will be:**
	Next dilution	Next dilution	Next dilution	Next dilution	mL

Maintenance New Vial Instructions: _____

_____

Reactions:

At next visit:

Repeat previous dose if swelling is > _____mm.
Reduce previous dose by _____ if swelling is >_____ mm.
Reduce previous dose by _____ if swelling is >_____ mm.
Call the office if swelling >_____ mm or for systemic reaction.

Other Instructions:

_____

_____

Provider Signature: _____ Date: _____

Office Address: _____

North Carolina Central University Student Health will call your office if clarifications are needed.