Student Health Center
Immunotherapy Check List for Allergy patients

__________ **I have signed the Services Utilization Policy Statement.**

__________ **I have a copy of the "Dear Allergist" letter for my allergist.**

__________ **I have a blank copy of the form entitled "Immunotherapy Orders" to have my allergist complete.**

__________ **My allergist has completed the "Student Emergency Action Plan" and renewed my prescription for epinephrine (i.e., EPI pen).**

__________ **I have read and signed the "Student Instructions and Responsibilities" form.**

__________ **I have completed the "campus contact" information sheet.**

__________ **I have returned the "Student Instructions and Responsibilities", campus contact information, and "Immunotherapy orders" to the Health Center.**

__________ **I have made arrangements to deliver my allergy serum to the Health Center and have scheduled my first immunotherapy appointment (219-464-5060).**

Health Center
Immunotherapy Program
Services Utilization Policy

Due to the high demand for health services and the limited number of appointments available for immunotherapy, if you are unable to attend an appointment, please call ahead of time to cancel your appointment. If you miss an appointment you will be subject to a $25 "no-show charge". If you fail to call and miss two appointments in a row, or if you miss a number of intermittent appointments throughout the term, you will become ineligible for services for the rest of the academic year. Regular attendance at your immunotherapy appointments is important in order for you to progress with your therapy. In the event that you become ineligible for services, we will refer you to an allergist in the area where you may make arrangements to continue receiving your immunotherapy.

I certify that I have read and understand the above Health Center Immunotherapy services Utilization Policy and hereby consent to treatment consistent with the guidelines and limitations described therein.

I also understand that I have the right to withdraw this consent at any time.

Signed: ____Date:__________________________
(Expires at end of current academic year)

I certify that I have read and understand the Immunotherapy policy and hereby consent to treatment consistent with the guidelines and limitations described therein:

Signed: ____Date:__________________________
(Expires at end of current academic year)

I will to be contacted via portal regarding immunotherapy appointments. All portal communications become a part of your medical record.

Signed: ____Date: _________________________
(Expires at end of current academic year)

Health Center
CAMPUS CONTACT
55 University Drive, Suite 102
Valparaiso, Indiana 46383
(219) 464-5060

Please Print Clearly:

Name: ____

Campus address/Residence Hall: ____

UNIT# ____________________ ROOM# __________________

Home Address: ____

____

Cell Phone: ____

Campus Phone: ____

DOB: _________________________________ Age: _____________________

E-mail Address: ____

Valparaiso University Health Center
55 University Drive, Suite 102
Valparaiso, IN 46383

Phone: 219.464.5060
Fax: 219.464.5410
Health.Center@valpo.edu
www.valpo.edu/healthcenter

Dear Allergist:

One of your patients is a student at Valparaiso University and is requesting that we administer his/her allergy injections while residing on campus. In order to lessen the confusion of multiple practitioners' guidelines and to maintain quality care, we are providing you with forms for your immunotherapy orders. Copies of these forms are enclosed.

A physician or nurse practitioner is always present at the time of administration. If you require that a physician be present during allergy injections please check the box on the immunotherapy orders. Please note, this may limit the availability of immunotherapy appointments available to your patient.

We will follow our anaphylaxis protocol for treating reactions both local and generalized, to ensure appropriate treatment during a potential emergency. If a systemic reaction occurs, after preliminary emergent care, the student will be transported by EMS to Northwest Health Porter Hospital Emergency Department, which is less than five minutes from the Health Center.

Please review and complete the enclosed forms with your orders for this student, and return to the Health Center via fax **(219) 464-5410** or mail with the patient's serum. Please feel free to call the Health Center with any questions, **(219) 464-5060**.

Valparaiso University Health Center

HEALTH CENTER
IMMUNOTHERAPY ORDERS

(**To be completed by Physician or appointed staff. Orders m***ust be** *signed by physician on page 2)*

Student name:____DOB:__________

Name of allergist:____________________________

Phone: ________________________________

Fax: ________________________________

Office Stamp:

Address____

Diagnosis: (include all significant diagnosis(es) for which student is receiving immunotherapy)

____
____
____
____

How long has patient been receiving immunotherapy? ____

Has the patient had previous significant local or systemic reactions to antigen(s)? Yes ☐ No ☐

If yes, give details of reaction / treatment

____
____
____
____

Allergies (drug / other):

____
____
____
____

Medications: (*students receiving beta blockers/ MAO inhibitors cannot receive immunotherapy at the HC*)

____
____
____

VALPARAISO UNIVERSITY

Student Name: ____DOB _________________

☐ It is acceptable to have a nurse practitioner, not a physician on site during administration of immunotherapy

☐ Must have a physician on site to administer immunotherapy

☐ See the attached Treatment Schedule for Allergen Immunotherapy from my office

Please fill in dosage for all vial injections	VIAL #1 Contents __________________ __________________	VIAL #2 Contents __________________ __________________	VIAL#3 Contents __________________ __________________	VIAL #4 Contents __________________ __________________
	Expiration Date __________________	Expiration Date __________________	Expiration Date __________________	Expiration Date __________________
	Interval __________________ Maintenance Dose __________________	Interval __________________ Maintenance Dose __________________	Interval __________________ Maintenance Dose __________________	Interval __________________ Maintenance Dose __________________
1				
2				
3				
4				
5				

Instructions for Missed Doses: ____

____

Instructions for Local Reactions: ____

____

Physician (print name): ____

PHYSICIAN SIGNATURE: ____ **Date:** _________________

VALPARAISO UNIVERSITY

ANAPHYLAXIS ACTION PLAN

NAME:____ **AGE:** ____________________

ALLERGY TO: ____

ASTHMA: ☐ **YES (High risk for severe reaction)** ☐ **No**

OTHER HEALTH PROBLEMS BESIDES ANAPHYLAXIS:____

CURRENT MEDICATIONS, IF ANY: ____

____

Symptoms of anaphylaxis include:

Mouth: Itching, swelling of lips or tongue
Throat: Itching, tightness/closure, hoarseness
Skin: Itching, hives, redness, swelling
Gastrointestinal: Vomiting, diarrhea, cramps
Lungs: Shortness of breath, coughing, wheezing
Heart: Weak pulse, dizziness, passing out

What to do:

1) **Call 9-1-1**
2) **Inject epinephrine into the thigh**
3) **Other medications (dose/route):**
   - **a)**
   - **b)**
   - **c)**
4) **Have a friend or roommate call your emergency contact:**
   - **a) Emergency Contact #1: Home**__________________ **Work:** ________________**Cell:** __________________
   - **b) Emergency Contact #2: Home**__________________ **Work:** ________________**Cell:** __________________
   - **c) Emergency Contact #3: Home**__________________ **Work:** ________________**Cell:** __________________

Provider's Signature **Patient's Signature (Parent/Guardian for individuals under age 18)**

DATE____________________ **DATE**____________________

It is recommended that a copy of this plan be on provided to the Health Center for your allergy file and that you review this emergency plan with friends and/or your roommate.