Allergy Injection Information for New Patients

Because of the potential risk of life-threatening reactions, the following procedure is to be followed by all patients utilizing this service:

1. Print *Physician Signed Consent* paperwork from Health Service website.

2. Bring your allergist the paperwork to be completed.

3. Have the serum and detailed instructions (orders from *your* physician) sent or brought to the on-campus Student Health Service. We must have a signature from your physician before administering injection. This serum will be kept refrigerated.

4. After obtaining signed orders from your allergist schedule an appointment with a Health Service provider to review orders before initiating injections.

5. **YOU** are responsible for **ordering and purchasing** your supply of allergy serum.

6. **YOU** are responsible for **maintaining your injection schedule** so that all injections are received on time. If you are late repeatedly, you will be informed that Health Service personnel will not administer further injections. You will be advised to find an alternative health care facility for your injections.

7. Inform medical personnel if you have started on any new medication.

8. Avoid strenuous exercise 1 hour before AND 1 hour after injections.

9. **You must remain in Health Service facility for 30 minutes** following the injections and have the injection site(s) checked by Health Service medical personnel before leaving. (This is to check for a reaction.)

10. You are to become familiar with how to recognize a reaction to the allergy serum. Onset of reaction usually occurs within 10-60 minutes after an allergy injection is given, but can be delayed several hours. If a reaction occurs while in the clinic find a Health Service staff member immediately. Reactions may include:

    a. **Localized Skin Reaction** – may consist of redness, itching and/or swelling at site of injection
    b. **Systemic or Generalized Reaction** – report any distress IMMEDIATELY. Symptoms may include, but not limited to, hives, tightness in chest, coughing, wheezing, excessive sneezing, itching, extreme redness in face and/or eyes, nausea, dizziness, headache, or fainting

If a serious systemic reaction occurs after leaving Health Service, return immediately or call 911.

If you have questions whether treatment is necessary, call us at 507-933-7630.

If Health Service is closed, call the local hospital emergency room at 507-934-7304.

Allergy injections are given by appointment only.

Arrangements will have to be made by you to receive your injection elsewhere during breaks, if you will not be on campus. Health Service hours may differ during breaks, so plan ahead.

(over)
Allergy Injection Information for New Patients

If you are unable to receive your allergen immunotherapy injections at Health Service below are the names and contact information for other resources in the St. Peter community.

Mankato Clinic – Daniels Health Center
1901 N. Old Minnesota Ave
St. Peter, MN 56082
507-934-2325

Mayo Health System – St. Peter Clinic
1900 N. Sunrise Dr.
St. Peter, MN 56082
507-931-2110

River’s Edge Clinic
1900 N. Sunrise Dr.
St. Peter, MN 56082
507-931-2200
TO: PHYSICIAN  Prescribing Allergy Immunotherapy to Gustavus Adolphus College Student

FROM: Gustavus Adolphus College Student Health Service

RE: Allergy Injections

Gustavus Adolphus College Student Health Service provides the service of administering allergy injections to those students who are presently being treated by an Allergist. We will NOT be responsible for skin testing, the initial dose for new patients, altering the dose, or those resuming therapy after an extended delay in treatment. **This service is intended for patients who are on a maintenance dose and have not had previous adverse reactions.**

The administration of allergen immunotherapy is based on the guidelines that you send us. The continuation of therapy requires specific instructions. The following criteria are necessary:

- Date and dose of last injection
- Vials that are labeled/coded with patient name, contents of vial, dilution and expiration date.
- Single dose vials are to be numbered or dated
- Orders that clearly state the recommended doses, interval of injections, route and site of administration. When injections can be given more than once a week, please note specific time frame between doses.
- Specific directions for missed injections.
- Treatment recommendation for local and systemic reactions.
- Name of allergist and a phone number to contact if problems arise.
- A physician’s signature acknowledging the understanding of Gustavus Adolphus College Health Service Guidelines and authorization for continued therapy (See back page).

Injections will be given only when a mid-level provider is on the premises. All patients are expected to remain in our clinic for 30 minutes following the injection(s). Any significant reaction will be reported to you.

If the patient has had a previous systemic reaction we are not able to administer injections at this time.

Optimum results depend on patient compliance plus clear and concise guidelines from you. Together we can provide the best possible care.
Please be informed of the following:
* Gustavus Health Service has diphenhydramine, epi-pens, and an AED. Access to oxygen is available through Campus Safety First Responders.
* Gustavus Health Service does not have any ACLS certified providers. We do not have tools for intubation. The closest Emergency Room is 2 miles from campus.

Should you have any questions regarding our policy and procedure for allergy injections at Health Service, please feel free to contact us at (507) 933-7630.

I have read the above letter and acknowledge the availability and limitations of the Gustavus Health Service providing allergen immunotherapy.

☐ Gustavus Health Service has my permission to administer allergen immunotherapy to

______________________________________, _________________. **Orders are attached.**

Patient DOB


☐ I DO NOT give permission for Gustavus Health Service to administer allergen immunotherapy to

______________________________________, _________________.

Patient DOB

_______________________________________________

Physician Signature Date

_______________________________________________

Printed Name

Facility: ________________________________________

Phone Number: _________________________________