

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 Health Service. We must have a signature from your physician before administering injection. This serum will be kept refrigerated. **Please note that Gustavus Health Service will NOT be responsible for mailing serum back to the allergist's office.**
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 noncompliant, 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. Health Service offers allergy injections on Monday, Tuesday and Thursday.
8. Inform medical personnel if you have started on any new medication.
9. Avoid strenuous exercise 1 hour before AND 1 hour after injections.
10. **You must remain in Gustavus Health Service office 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.)
11. 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.
12. Arrangements will have to be made **BY YOU** to pick up your serum and receive your allergy injections elsewhere during breaks.

If a serious systemic reaction occurs after leaving Gustavus Health Service, call 911.

Allergy injections are given by appointment only. Appointments are available on Monday, Tuesday and Thursday.

Patients who are NONCOMPLIANT will not be allowed to continue receiving allergy injections at Gustavus Health Service.

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If you are unable to receive your allergen immunotherapy injections at Health Service below is the contact information for other resources in the surrounding area.

Mankato Clinic
Wickersham Health Campus
1421 Premier Drive
Mankato, MN 56001

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.

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MAKE YOUR LIFE COUNT

GUSTAVUS 
GUSTAVUS ADOLPHUS COLLEGE

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.

*Gustavus Health Service will **NOT** be responsible for mailing serum back to the allergist's office.

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: _____