Fairfield University Student Health Center

Allergy Desensitization Injection Clinic Mandatory Physician Form

This form must be completed by the prescribing physician to allow administration of allergy immunotherapy at the Student Health Center.

Patient Name: _____ **D.O.B.** _____

This patient is receiving allergy immunotherapy for the treatment of:

☐ allergic rhinitis ☐ allergic conjunctivitis ☐ asthma ☐ other_____

Please list any chronic or severe illness that might affect allergy immunotherapy administration:

_____

Has this patient experienced significant local or systemic reactions to antigens? (If yes, please indicate type of reaction, to which antigens and previous treatment.) _____

_____

Is this patient taking a beta-adrenergic blocking agent? _____

Regarding anaphylactic reactions:

- A nurse practitioner is always on-site to manage anaphylactic reactions. (Our collaborating physician is not always on-site.)
- Epinephrine 1:1000 0.3 ml IM will be administered in the anterior lateral thigh. A repeat dose may be given in 5 to 15 minutes if patient is still symptomatic.
- The patient will be transferred via ambulance to the local hospital emergency department.
- Additional On-Campus resources include: injectable and oral Benadryl, oxygen, AED and support from Public Safety Officers (E.M.T. certified).

Any specialized instructions for systemic /anaphylactic reaction (beyond the standard management described above) must be listed here:

M.D. Signature: _____ Date: _____

M.D. Printed Name: _____ M.D. Phone Number: _____

Please deliver to Fairfield University Student Health Center
1073 North Benson Rd Fairfield, CT 06824

Phone: 203-254-4000 x2241
Fax: 203-254-4263