Oberlin College Student Health Services
Student Allergy Injection Information and Consent Form

Please read the following information carefully and if you have any questions please call our office (440-775-8180) and speak with our nurse.

1) You must have your prescribing allergist complete and sign the Allergy Immunotherapy Authorization Form, Allergy Immunotherapy Information Form for Prescribing Physician, and the Anaphylaxis Protocol form. We will not administer your allergy injections until we have these completed forms.

2) There is a non-refundable fee of $100.00 each semester for allergy injections at our office. Payment is required prior to starting your allergy immunotherapy.

3) If you are starting a new build-up schedule, you are required to receive the first two allergy injections at the prescribing doctor’s office prior to receiving allergy injections at Student Health. You will be referred back to your prescribing physician if you do not receive the next injection at the appropriate interval at Student Health.

4) Allergy injections are given by appointment only. If you fail to follow your allergy schedule on multiple occasions, we will stop providing these injections and refer you to another physician’s office. You are responsible for making arrangements to receive your allergy injections elsewhere when Student Health is closed for summer or other breaks.

5) Due to the risks involved with allergy immunotherapy, you are required to wait for a minimum of 20 minutes in our office after an allergy injection. You must check-in with the nurse prior to departure. Injections are given with a nurse practitioner or physician present in the office to help manage any reactions. We recommend that you always carry an Epi-Pen and know how to use it. If you need an Epi-Pen prescription or instructions, please notify the nurse so we can help. Most reactions to allergy injections are mild, but more serious reactions can occur. Symptoms such as difficulty breathing, wheezing, hives, and tightness in throat or chest are signs of a systemic reaction or anaphylaxis, and immediate treatment with epinephrine (Epi-Pen) and antihistamines is needed. Many systemic reactions are successfully treated, but some of these reactions do not respond to medication and can result in death. Administer your Epi-Pen and proceed to the emergency room or call 911 if a systemic reaction occurs after leaving Student Health. Please notify our office if you notice any other symptoms after receiving an injection. To lower your risk, please avoid exercise for at least 2 hours after an allergy injection.

6) Throughout your allergy immunotherapy at Student Health, please notify our staff if you have any medical changes such as new medicines, recent or current infections or fever, worsening allergy symptoms or asthma, pregnancy, or any reactions to allergy injections. If you are on a beta-blocker at anytime we cannot administer your allergy injections.

I have read and understand the above information and give my permission to Oberlin College Student Health Services to administer my allergy injections as prescribed by my private allergist.

Patient’s Signature: ____________________________ Date: __________
Patient’s Name (printed): ____________________________
Parent’s signature (if patient is a minor): ____________________________ Date: __________
Parent’s Name (printed): ____________________________
Attention Prescribing Allergist’s Office:

This student requests Oberlin College Student Health Services to provide allergy immunotherapy prescribed by you. The decision of where this patient is to receive immunotherapy must be made by the prescribing allergist after assessing the patient’s risk profile. The prescribing allergist must determine that the patient is not high risk for a severe systemic reaction to allergy immunotherapy prior to the patient being referred here for injections. **Allergy immunotherapy is administered by our nurse, based on your orders, with a supervising nurse practitioner or family physician present in the health center. Please do not refer a patient who requires added expertise of a trained allergist in supervision of the immunotherapy administration.** To insure you are aware of our management plan for severe reactions, please review and sign our anaphylaxis protocol and supplies list prior to making your referral. Please note that we do not carry IV supplies, a vasopressor or glucagon.

It is the responsibility of the prescribing allergist to provide detailed instructions to our office. In your orders please include: (1) adjustment of allergen doses during the buildup phase as well as at maintenance, (2) new vial details, (3) seasonal allergy peaks, (4) missed allergy injection plan, (5) follow-up and adjustments to local and systemic reactions, and (6) date and dose of most recent injection. Please clearly label allergen extract vials with contents, potency, expiration date, patient’s full name and date of birth. Patients must initiate allergy immunotherapy at their prescribing physician’s office and complete a minimum of two injections at the prescribed interval before receiving an allergy injection at our office. If the time since the last injection is beyond the prescribed interval the patient will be referred back to your office for two more injections.

Please sign below to indicate that you have read and understand the above information.

Prescribing Physician’s Signature: __________________________
Physician’s Printed Name: __________________________ Date: __________
Office Address: __________________________________________

Office Phone #: __________________________ Office Fax #: __________________________

*Please fax this form to Oberlin Student Health Services: (440)-775-6404*
Oberlin College Student Health Services
Allergy Immunotherapy Authorization Form

Patient’s Name: ____________________________ DOB: ___________
Home Address: ____________________________________________

I hereby authorize my allergist, Dr. ___________________________ to release the
following information to Oberlin College Student Health and authorize Student Health to
release information pertinent to my allergy treatment to the above allergist.

Allergist’s Address: _______________________________________

_________________________________________________________

Signature of Patient: ____________________________ Date: ___________

*Prescribing Physician: This patient requests to have allergy injections at our office
per your orders. Please send the requested information, complete this form and
sign below. Return this copy in the enclosed envelope or fax to Oberlin College
Student Health Services (Fax #: 440-775-6404).

1. Brief medical history and physical pertinent to allergies, allergy treatment, asthma and
other significant conditions: ____________________________________________

2. Has the patient experienced any significant local or systemic reactions to allergy
injections? If yes, please give details: ____________________________

3. Is this patient taking beta-blockers? Yes ______ No _______
4. Does this patient have asthma? Yes ______ No _______
5. Any other comments or concerns:

Please provide the following information:
- Treatment plan including schedule for increasing buildup dosages or maintenance
schedule and adjustments for new vials.
- Specific instructions on dosage adjustment if patient is late or deviates from prescribed
schedule.
- Specific guidelines when to withhold or reduce dosages due to illness, wheezing,
seasonal allergy peak, increased allergy symptoms, or local or systemic reactions.
- Documentation of most recently administered injections.
- We require an annual written order and treatment plan from the prescribing allergist.
We also require a written order if a deviation from the original order is required.

Prescribing Physician’s Signature: ____________________________ Date: ___________
Physician’s Name (printed): ________________________________
Office Address: ___________________________________________
Telephone #: __________________ Fax #: ______________________
Student Health Services of Oberlin College  
Anaphylaxis Protocol and Supplies List  
Standing Orders for Anaphylaxis  
(Updated May 13, 2010)

Anaphylaxis is a sudden life-threatening reaction to antigens such as bee stings, antibiotics, allergy injections, etc.

Assess the patient for signs and symptoms of anaphylaxis which include:
- Tingling sensation around the mouth or face
- Urticaria
- Warm feeling, flushing
- Vomiting, diarrhea, cramps
- Restlessness
- Itchy skin, throat or mouth
- Tightness of the throat or chest
- Shortness of breath, cough or wheeze
- Weak pulse, dizziness, syncope, hypotension, chest pain

Anaphylaxis Supplies and Equipment List: stethoscope, tourniquet (latex-free), sphygmomanometer, Epi-Pens (1:1,000 for IM injection), oral airway, oxygen, oxygen mask, latex-free gloves, diphenhydramine (oral-12.5mg/5ml), albuterol inhalation solution (2.5mg/3ml), nebulizer.

ACUTE MANAGEMENT OF ANAPHYLAXIS:

The first and most important therapy in anaphylaxis is epinephrine. There are no absolute contraindications to epinephrine in the setting of anaphylaxis.

Inject Epi-Pen (1:1,000 epinephrine 0.3 mg IM), preferably in the anterior or lateral thigh; can repeat every 5 minutes up to three times if symptoms persist.

Call 911 for immediate transfer to emergency room.

While awaiting emergency assistance:
- Place tourniquet, lightly, above allergen injection site.
- Stay with patient and monitor vital signs q 2-5 minutes.
- Place patient in the supine position with feet elevated.
- Give oxygen (6-8 L/min) via mask. Place oral airway if needed.
- Consider diphenhydramine 25 mg PO X 1 for itching and urticaria only.
- Consider albuterol (2.5 mg in 3 ml saline) via nebulizer if patient has bronchospasm.

I am aware of the anaphylaxis protocol at Oberlin College Student Health Services. I have reviewed this protocol and supplies list and agree with their treatment plan of a potential anaphylactic reaction in the following patient: ________________________________

Prescribing Physician’s Signature: ________________________________
Prescribing Physician’s Name (printed): ________________________________
Date: __________________