Bucknell Student Health Center – Allergy/Immunotherapy Directions

Telephone: 570-577-1401 Fax: 570-577-3570

Dosage & frequency orders must be completed and signed by the prescribing physician before injections can be administered. *Student Health does not give the initial dose of allergen immunotherapy*.

NAME: _____ D.O.B:_____

Hx of systemic or other serious reaction? Yes (describe)

If yes, do you have a prescribed epi pen? Yes No

Current Medications:

Date of last injection: Dose: Reaction:

Pre-medication:

Make sure vials are labeled with contents, concentration and expiration date.

Contents Vial #1_____ Exp_____ Mix date:_____

Dosage, Frequency, Maintenance Order	Date	Site	Signature	Reaction 0 1 2 3 4

Contents Vial #2_____ Exp_____ Mix date:_____

Dosage, Frequency, Maintenance Order	Date	Site	Signature	Reaction 0 1 2 3 4

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Contents Vial #3_____ Exp_____ Mix date:_____

Dosage, Frequency, Maintenance Order	Date	Site	Signature	Reaction 0 1 2 3 4

Contents Vial #4_____ Exp_____ Mix date:_____

Dosage, Frequency, Maintenance Order	Date	Site	Signature	Reaction 0 1 2 3 4

Doctor's orders if overdue by:
1 week: _____.
2 weeks: _____.
3 weeks: _____.
4 weeks: _____.

Orders for local/systemic reactions:

Grading Reactions:
0 – no redness or swelling
1+- 5mm redness
2+-0-5mm wheal, or 10-20mm redness
3+-5-10mm wheal, or 21-30mm redness
4+->10mm wheal, or >30mm redness

Physician Name Address

Tel # Fax # MD Signature