ALLERGY IMMUNOTHERAPY CHECK SHEET

Wellesley College Health Services
781-283-2810/Fax 781-283-3693

STUDENT: _____ DOB: _____

All the following information **MUST BE PROVIDED BEFORE** allergy injections are given.

The check sheet will be completed yearly and when new vials of serum are checked in.It is the **STUDENT'S RESPONSIBILITY** to assure the vials are properly labeled and physician's orders are complete **WHEN THEY PICK UP THEIR EXTRACTS FROM THEIR PHYSICIAN.**

1. Vials are labeled/coded as to **CONCENTRATION:** YES NO

2. Vials are labeled/coded as to **ANTIGEN CONTENT:** YES NO

3. **EXPIRATION DATES** of the antigens are indicated: YES NO

4. Number of vials: 1 2 3 4 5 6 Other: _____: YES NO

5. Vials coded by **NUMBER, LETTER OR COLOR** to correspond with MD written order: YES NO

6. Schedule indicating the **AMOUNT AND FREQUENCY** of each injection present: YES NO

7. **SINGLE DOSE VIALS ARE NUMBERED OR DATED** to correspond with MD's written orders: YES NO

Is the **NUMBER OF VIALS** indicated? ..... YES NO
Is the **CONTENT** indicated? ..... YES NO
Is the **STRENGTH** indicated? ..... YES NO
Is the **EXPIRATION DATE** indicated? ..... YES NO

*8. Instructions for **MISSED/LATE** injections are present .....YES NO

*9. Does the patient have any chronic or severe illness which might affect general health or desensitization schedule? YES NO
IF YES, please indicate Asthma Cardiac Other _____

*10. Any previous significant local or systemic reactions to antigens? YES NO
IF YES, Please indicate reaction and to which antigen _____

11. Do **NEW VIAL ORDERS** (reduced dosage w/ progression to maintenance) accompany **NEW VIALS OF MAINTENANCE** antigen? YES NO

OFFICE CONTACT PERSON: _____
PHONE: ( ) _____ FAX: ( ) _____
*Information updated yearly. All other information checked when new vials are used.

Date: _____ NURSE: _____