UChicago Student Wellness

Allergy Immunotherapy Administration Information

UChicago Student Wellness is pleased to administer allergy injections to University of Chicago students who are under an immunotherapy regimen. Our goal is to administer allergy injections to students who are currently under the care of a board-certified allergist and have already started allergy injections with their allergist. You will need to receive your first 2 injections at your allergist office after testing has been completed and not have had more than 4 months layoff from immunotherapy (injections).

UChicago Student Wellness administers allergy shots/immunotherapy as a service to our students. Student Wellness does not have an Allergist on-staff, therefore allergy testing, mixing of extract, immunotherapy education and instruction, and the initial injection(s) from your extract(s) **MUST** be done by your local allergist. As part of your immunotherapy, we may need to contact your allergist to clarify or adjust dosages, or to request additional information. If a new order or change in your existing order is needed, a written order must be signed by your allergist and faxed to Student Wellness. We **CANNOT** receive telephone orders from the nurse or office staff. If a written order is not received, it may cause an additional delay in receiving your allergy shots.

How to start the process:

- Complete the **Student Allergy Immunotherapy Administration Agreement Form**
- Complete the **Student Allergy Injection Intake Form**
- Have your allergist complete the **Referring Allergist Agreement** and **Allergen Immunotherapy Order Form** and send records
- Sign a **medical release of information via my.WellnessPortal** that will allow UChicago Student Wellness to obtain and/or release information to your allergist.
- Schedule an initial consult appointment with a UChicago Student Wellness medical provider.

All required forms and accompanying documents must be completed and received prior to or brought in by the student to the Student Wellness Clinic for their first appointment. The allergy agreement form and order will expire August 31st of each year. New release forms must be completed to continue immunotherapy.

About Your Initial Visit:

You will need to schedule an initial consult appointment with a Student Wellness medical provider prior to receiving your first allergy injections through Student Wellness. The provider will review your medical history, allergies, current medication and your allergist's plan of care. An EpiPen will be prescribed at this visit, if you do not already have one.

Allergy Vial Supply, Storage, and Labeling:

Allergy serum must be ordered through your allergist's office, as needed. All serum must be shipped directly to your home/campus address and **NOT** to Student Wellness. **We are unable to accept any allergy serum shipped directly to the Student Wellness Center.** You are welcome to drop off serum you have received during our regular business hours. Student Wellness will store your serum as a courtesy and convenience to you in our temperature monitored refrigerator. You also have the option to keep your own serum and bring the serum with you to each scheduled appointment.

Please note: Ordering a new supply of vaccine when a vial is empty is the responsibility of the student. Each antigen vial must be clearly labeled with the following information: student name, birthdate, contents, dilution, and expiration date.

Potential Reactions:

Your allergy shots will be administered under a medical provider's supervision and emergency treatment will be provided in case of a reaction to your allergy shots.

Although you may have received certain allergy extracts in the past, a reaction can occur at any time. Some reactions (itching, redness, and swelling) at the injection site is common. The nurse will document any reactions after your 30 minute observation period and the dosage may be adjusted according to your physician's guidelines.

If you experience a Severe (Systemic) Reaction:

- Use your EpiPen if you have already left Student Wellness
- Go to the nearest Emergency Room or call 911 when on or off campus

Any student who experiences a systemic reaction while at Student Wellness and has received epinephrine may be transported to the UCMC Emergency Room for further observation. Student Wellness will continue future immunotherapy injections **ONLY** after consultation with your allergist and approval by a Student Wellness medical provider.

Allergy (Immunotherapy) Student Scheduling:

Your allergy injections will be scheduled on the Student Wellness injection schedule Monday through Friday. You may call 773.834.9355 to schedule your appointments.

- It is recommended that you schedule your visits in advance. Please cancel any appointments that you are unable to keep so that other students may utilize the appointment slot.

- For your own safety, Student Wellness will require that you remain in the clinic for 30 minutes after receiving your injections in order for the nurse to observe for any potential reactions. Please plan accordingly when scheduling your appointment.

Injection Administration Guidelines:

YOU MUST HAVE AN EPIPEN AND BRING IT EACH TIME YOU ARE RECEIVING ALLERGY INJECTIONS. Students who do not have their EpiPen at the time of their appointment will be asked to reschedule.

1. It is recommended that you schedule appointments for the entire quarter during your first visit to secure a routine time for your injections.
2. Please allow 45 minutes for each appointment. Medications, drug allergies and questions related to health status will be reviewed at each visit.
3. Please check-in at the reception desk at each visit. You will be asked to verify demographic and insurance information at each visit.
4. **All students are required to wait at Student Wellness a minimum of 30 minutes** after the injections are administered for observation and to check out with the nurse before leaving the clinic. The nurse will inspect the injection site(s) and record any local reaction. If you have a history of adverse reactions, you may be asked to wait longer.
5. Do not interrupt your allergy shot schedule for a minor illness. If you feel ill on the day of your allergy visit, please inform the nurse. If you have any questions about whether you can receive your injection, call the nurse at 773.834.0776 to discuss your concerns prior to your scheduled appointment.
6. If you are unable to keep an appointment, please call as far in advance as possible. Call 773.834.9355 anytime to cancel.

Breaks/Summer Vacation:

If your schedule requires an injection during a period of time when you are away from campus, the following instructions apply:

1. Notify a nurse that you will be away from campus so that you may pick up your allergy extract(s) and instructions.
2. Notify Student Wellness if you discontinue your allergy regimen so that your unused serum may be returned or discarded.
3. Make plans to keep the extract refrigerated. Do not freeze extracts.
4. When you return to campus, bring your refrigerated extract, updated shot records and new orders. This should include injection dates, dosage given, and signature of the physician or nurse who administer the injections while you were away.

Disclaimer:

UChicago Student Wellness reserves the right to decline to administer allergy shots to any student who has a perceived higher than average risk for severe/systemic reaction to immunotherapy or who does not abide by Student Wellness instructions/requirements for receiving immunotherapy.

Reasons for declination could include, but are not limited to chronic lateness for injections, refusing to remain at Student Wellness for 30 minutes following allergy shots, and/or leaving Student Wellness during the wait time.

The success and effectiveness of your immunotherapy program depends on you adhering to your allergist's recommended schedule as much as possible.

UChicago Student Wellness

Student Allergy Immunotherapy Administration Agreement

Student Name: _____ DOB: _____

Student ID Number: _____ Date: _____

Instructions: Please review carefully and sign.

Allergy Extract Vials and Storage:

- I will be responsible for bringing my own clearly labeled immunotherapy vials and letter from my allergist with the following information:
  - My name and identifying information
  - Physician's name, address, and phone number
  - Instructions on administering the injections with specific vaccine, (starting dose, target maintenance dose, and schedule).
- The Student Wellness nurse will notify me when I need new serum and I will be responsible for contacting my allergist for additional vials.
- Vials **CANNOT** be shipped to UChicago Student Wellness.
- UChicago Student Wellness will store my extracts in a temperature monitored medication refrigerator between 3^0C-6^0C (37.4^0F and 42.8^0F) to reduce rate of potency loss.
- I will not hold University of Chicago responsible for the integrity of the extract in the event of a power failure, storage equipment failure or catastrophic event that may corrupt the integrity of the vial extract.

Injection Schedule:

- I am responsible for keeping scheduled appointments necessary to maintain my prescribed regimen. If I am unable to keep my appointment, I will contact UChicago Student Wellness to cancel/reschedule my appointment.
- I understand that if immunotherapy injections are frequently missed, the risk for reactions increase. Immunotherapy injections may need to be discontinued at the discretion of UChicago Student Wellness staff after consultation with my referring allergist.

Risks, Side Effects, and Observation Period:

- I will have my EpiPen with me for my visit.
- I will remain in Student Wellness for the required 30 minutes post-injection period and will not leave before being discharged by the Student Wellness nurse.
- If I cannot wait the full period, I agree to notify the medical staff that I should not receive my allergy injection.
- If a reaction occurs after leaving the clinic, I will report the reaction at my next office visit.
- I understand if I experience a severe reaction after receiving any injections, I will be required to obtain clearance from an allergist prior to receiving additional injections.
- I have reviewed the risks and benefits of allergy injections with my allergist. I understand the purpose and will follow-up with him/her yearly to evaluate the treatment of my allergic condition.
- All generalized reactions require immediate evaluation and medical intervention. Generalized reactions may be one or more of the following types:
  - Hives/urticarial reactions
  - Swelling/Angioedema reactions
  - Anaphylactic shock-including acute asthma, low blood pressure, unconsciousness, and potentially death

- I understand the risk of anaphylaxis and possible death with allergy injections. I consent to the risk and will allow UChicago Student Wellness to administer my allergy injections when the appropriate conditions are met.

Agreement (valid from August 31st until the following year):

I agree to notify UChicago Wellness staff if I start any new prescription medications particularly those for high blood pressure, migraine headaches, or glaucoma or if I become pregnant while on immunotherapy.

I have read and understand the UChicago Student Wellness Allergy Injection Agreement. I have been given the opportunity to ask questions of the Student Wellness nursing staff and my questions have been answered to my satisfaction.

I request that the UChicago Student Wellness administer Allergy Immunotherapy as prescribed by my referring allergist.

I have elected the following (please check one):

- ☐ I will maintain my own serum and bring the refrigerated serum to each appointment. It is my responsibility to maintain the serum at the appropriate recommended refrigerated temperature to ensure efficacy.

- ☐ I would like UChicago Student Wellness to store my serum. I understand UChicago Student Wellness cannot be held responsible for any unexpected damage to my serum. UChicago Student Wellness is not financially responsible for any damage to my serum.

_____	_____	_____
Printed Name	Signature	Date

UChicago Student Wellness

Referring Allergist Agreement

Patient Name: _____ Date: _____ DOB:_____

Request for Allergy/Immunotherapy:

Your patient has requested UChicago Student Wellness to administer immunotherapy (allergen extract or biologics) as ordered by you. We are pleased to provide this service to your patient while they are a student at the University of Chicago. We require the treating allergist to supply the allergen extracts and explicit instructions for administration. Patients requesting allergy immunotherapy administration at UChicago Student Wellness are required to have their allergist complete and return this form.

PHYSICIAN ACKNOWLEDGEMENT

My signature below acknowledges that:

1. The UChicago Student Wellness will administer allergen immunotherapy, and management of both local and systemic reactions to allergen immunotherapy.

2. The referring allergist completes and submits the Allergy Immunotherapy Order form. If patient misses injections, or experiences reactions to the allergen immunotherapy extract, or if there are any changes in the lot, manufacturer, vaccine type or component allergens and their respective concentration in the extract, we will require a new Allergy Immunotherapy Order form. Phone calls with changes will **NOT** be accepted.

3. Extract vials must be hand delivered by the patient and may **NOT** be mailed or directly forwarded to UChicago Student Wellness. Allergy extracts must be properly labeled with patient name, date of birth, antigen content, concentration and the expiration date. Student Wellness clinic staff cannot take verbal orders to extend the expiration date.

4. The referring allergist or designated allergy clinic staff member will be available for phone consultation as needed and continue to remain responsible for the management of this patient's immunotherapy and modification of doses during therapy.

5. The patient should be evaluated by allergist every year.

Acknowledged and agreed to by:

Physician name (Please Print): _____

Address: _____

Phone: _____ Fax: _____ **E-mail address**: _____

Physician Signature: _____ **Date**: _____

UChicago Student Wellness

Allergen Immunotherapy Order

Student Information	
Last Name	First Name
Middle Name	Preferred Name
Date of Birth (MM/DD/YYYY)	

Allergist Office	
Last Name	First Name
Office Phone	Office Fax
Office Address	

This form **must** be completed, signed, and faxed to UChicago Student Wellness **773-834-3438**. UChicago Student Wellness **must** receive this form and the **Referring Allergist Agreement** via fax before our mutual patient can schedule an appointment for injection. For the patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form **must** be completed to provide standardization and prevent errors. **Do not attach order form.** Failure to complete this form will delay or prevent the patient from utilizing our service.

Pre-injection

Is peak flow required prior to injection? No or Yes

Hold injection if less than _____ L/min

Is student required to take an antihistamine prior to injection? No or Yes

Date of last allergy injection(s) _____ **(Attach visit notes from last appointment)**

Vial(s) and dose(s) given for last allergy injection	

Injection Schedule

Begin with _____ **(dilution)** at_____ mL **(dose)** and increase according to the schedule below.

Increase according to schedule every _____ to _____ days/weeks **(circle one).**

(Please attach build-up and maintenance schedule)

Once maintenance dose of _____mL is reached, repeat every _____days/weeks **(circle one).**

Allergen Immunotherapy Order

UChicago Student Wellness

Student Information	
First Name	Last Name
Preferred Name	DOB (MM/DD/YYYY)

Missed Injections

Time Since Last Injection	Dose Recommendation

Reactions

Reaction/Swelling	Management

Additional Instructions

I attest that I have read and signed the **Referring Allergist Agreement** document from UChicago Student Wellness. I have discussed the above schedule and the risks, benefits, complications alternative treatment and associated risks, and expected results with my patient, _____ (Patient's name and DOB).

The patient, guardian, or authorized representative indicated they have been adequately informed and agree to this allergy injection procedure.

Ordering Clinician Signature: _____ Time: _____ Date: _____

Ordering Clinician Printed Name: _____

NPI #: _____

Phone numbers and name of allergy nurse to contact directly for questions:

_____

UChicago Student Wellness

Allergen Immunotherapy Order

Student Information	
First Name	Last Name
Preferred Name	DOB (MM/DD/YYYY)

Reactions

Reaction/Swelling	Management

Additional Instructions

I attest that I have read and signed the **Referring Allergist Agreement** document from UChicago Student Wellness. I have discussed the above schedule and the risks, benefits, complications alternative treatment and associated risks, and expected results with my patient, _____ (Patient's name and DOB).

The patient, guardian, or authorized representative indicated they have been adequately informed and agree to this allergy injection procedure.

Ordering Clinician Signature: _____ Time: _____ Date: _____

Ordering Clinician Printed Name: _____

NPI #: _____

Phone numbers and name of allergy nurse to contact directly for questions:

_____

UChicago Student Wellness

Student Allergy Injection Intake Form

Name:	SID:	DOB:

1.When did you start allergy injections:	
2. When was your last injection:	
3. During what months are your allergy symptoms worse:	
4: Have you ever used an Epipen: (return demo)	

	Yes	No	If Yes, please describe
5. Do you have any kind of heart disease or abnormality?			
6. Have you ever been admitted to the hospital for asthma?			
7. Have you ever had wheezing, or respiratory reaction to an allergy injection?			
8. Have you ever had a generalized reaction to an allergy injection such as hives or rashes?			
9. Are you taking any medication (prescribes or OTC)?			

Student Signature: _____ Date: _____

Reviewing Nurse Signature: _____ Date: _____