



Xavier University of Louisiana
Student Health Services

Dear Physician:

We at Xavier University Student Health Services are pleased to

administer your patient _____prescribed
Allergy immunotherapy. **Initial dose(s) of the allergy serum must be administered in the prescribing physician's office.** To assure our standards of quality care are met, the following information must be provided for all new vials of serum.

Vial Labels must contain patient name, concentration and antigen content, number, letter, or color to correspond with MD's written orders and expiration date.

Doctor's Orders must contain schedule indicating amount and frequency of each injection and the code for any abbreviation, instructions for missed/late injections and number of vials.

Does your patient have any chronic or severe illness that might affect general health or desensitization schedule? YES ___ NO___

If so, please indicate: Asthma ___ Cardiac ___ Other_____

What medication(s) is your patient presently taking? _____

Has the patient had any significant local or systemic reactions to antigens?YES ___ NO ___

If yes, please indicate to what antigen and the treatment you used for the adverse reaction. _____

Your office contact person: Name:_____

Phone Number: _____Fax Number: _____

You may mail the serum to your patient who will bring it to the Student Health Center.

Thank you,

Joseph Labat, M.D., Medical Director
Xavier University of Louisiana



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LOCAL REACTIONS GRADING PROTOCOL:

We observe our students for 30 minutes in order to evaluate their reaction.

Local reactions are graded and managed according to Xavier University Student Health Policy, unless you prefer and enclose your guidelines.

All nurses will use their flexible ruler in assessing reactions.

- | | | |
|----|--|---|
| A. | negative swelling up to 15mm | progress according to schedule |
| B. | swelling 16 – 20mm | repeat the last dose |
| C. | swelling 21 – 25mm | return to last dosage that was negative |
| D. | delayed or persistent swelling, more than 12 hours | return to previous well tolerated dose proceed with caution according to schedule |

If a student sustains a systemic reaction; their allergist must be contacted to provide directions for further injections.



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Allergy Interview Check
Sheet

Date: _____ PHONE # _____

Student: _____ ID/SSN# _____

List any drug allergies

Current Meds

All the following information must be provided before allergy injections are given.
This sheet must be updated yearly or whenever new vials of serum are checked in.

1. Vials are labeled with Patient's Name Yes ___ No ___
2. Vials are labeled/coded as to Concentration Yes ___ No ___
3. Vials are labeled/coded as to Antigen Content Yes ___ No ___
4. Number of vials: 1 2 3 4 5 Other ___
5. Expiration dates of the antigens are indicated Yes ___ No ___
6. Vials are coded by Number, Letter, etc. to correspond with MD's written orders Yes ___ No ___
7. Dosage amount and frequency of each injection is present Yes ___ No ___
8. Instructions for Missed/Late injections are present Yes ___ No ___
9. Does the patient have any chronic/severe illness which might affect general health or desensitization schedule Yes ___ No ___
10. Has the patient had previous significant local or systemic reactions to antigens? If Yes, please indicate type reaction _____ to what antigen _____ and previous type of treatment for adverse reaction _____



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Allergy Interview Check
Sheet

Student: _____ ID/SSN# _____

11. If new vials of maintenance antigens are to be used, are new vial orders (reduced dosage w/ progression to maintenance) present? Yes ___ No ___

12. If patient is new, does he/she have an appointment with physician? Yes ___ No ___

Physician Name: _____

Address: _____

City, State, Zipcode: _____

Office#: _____ Fax#: _____



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Student Instructions for Allergy Injections

1. Serums are to be brought by the student to the Health Center.
2. Vials must be labeled by your private physician.
3. All allergy injections are given by appointment.
4. Please inform nursing staff if you are taking any prescription medication. Some medication that treats eye problems, headaches, and hypertension contain beta-blockers which can dangerously increase allergic reactions to your serum.
5. Reactions to allergy injections may range from mild to severe. Notify the nurse immediately if any symptoms develop. If symptoms occur after you have left the Health Center, immediately take an antihistamine such as Benadryl and follow the instructions below:

MILD

Take an antihistamine.
Call Student Health Center
Symptoms
Itching at the injection site
Runny nose
Sneezing
Nasal congestion
Hives around injection site
Flushing

SEVERE

Notify Dorm Manager
Call 911 or Campus Police
Symptoms
Shortness of breath
Coughing
Overall body itching, hives
Facial Swelling
Wheezing
Difficulty swallowing, itchy
throat
DO NOT ATTEMPT TO DRIVE

6. Inform the nurse of any reaction before receiving any additional injections on your next visit.
7. Students may check out serums and a copy of your record before leaving for the holidays and at the end of the academic year.
8. Students must pick up their serum at the end of the academic year or the serum will be discarded.



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Allergy Injection Consent Form

I have informed my physician to send to me my allergy injection serum to me at my address and I will bring them over to the Student Health Center.

I know that no allergy injections are given on the weekends.

I understand that allergy injections are given only when a physician or nurse practitioner is on duty.

I understand that I will be required to remain in the Student Health Center for 30 minutes for observation after receiving my injection.

I understand after the 30 minute observation period, I must have the injection site(s) evaluated by the nurse before leaving the facility.

I know it is my responsibility to sign out my extracts and a copy of my record during holiday absences. I understand that I need to keep my extracts refrigerated to protect and maintain potency.

I know it is my responsibility to retrieve extracts at the end of the academic year. I understand that any extracts left in the Student Health Center at the end of the academic year will be disposed of.

I fully understand that the prescription and mixing of my serum, the content of my vials, the concentration of my serum and the dosage schedule are the responsibility of my private physician, Dr. _____, and I do not hold Xavier University Student Health Center responsible for these factors.

I understand my prescribed allergy treatment must be fully compliant with the policies and protocols of the Xavier University Student Health Center in order to receive my injections in this facility and that the signature of a Student Health Center physician does not constitute endorsement or approval of the regimen prescribed by my physician.

I have read and understand this information and have been given a copy of the Student Instruction Sheet for Allergy Injections.

I _____ agree to and understand the policies and procedures to have my injections administered in Xavier University Student Health Center.

Date: _____ Signature: _____

The student may begin having allergy injections per Xavier University Student Health Center's protocols as ordered by their private physician.

Date: _____ M.D. Signature: _____

Dr. Joseph Labat, Medical Director

