

# Fordham University Health Services

## Student Agreement for Allergy Immunotherapy Administration

Students requesting allergy immunotherapy administration from Fordham University Health Service must complete this form.

### Injection Schedule

- I agree to abide by the injection schedule prescribed by my referring allergist.
- I understand that if allergy injections are frequently missed that this may increase my risk of allergic reactions. Under such circumstances, the Fordham University Health Service may not be able to continue my injections.

### Risk and Side Effects

- I understand that there are risks associated with receiving allergy injections including both local reactions and systemic reactions which can be very serious. All systemic reactions require immediate evaluation and intervention and transport to the local emergency room for further evaluation, treatment and monitoring.

### Observation Period

- Systemic reactions are unpredictable and may occur after the first injection or after several doses have been given over a period of time. It is very unpredictable. This is why it is mandatory after an allergy injection that you remain in the UHS for monitoring for 30 minutes. If you cannot wait the required amount of time following your injection, you need to inform the staff and your appointment will need to be rescheduled.

### New Information

- I agree to notify the Fordham University Health Service if I start any new medications. Some medications used for high blood pressure, migraines, depression, or glaucoma are contraindicated while on allergy immunotherapy.
- I agree to notify the UHS if I become pregnant so that a revised schedule for dosing can be obtained from your allergist.

### Extract Storage

- Fordham University Health Service will store my extracts in a monitored refrigerator between 3-6 degrees Celsius.
- I agree that I will not hold Fordham University Health Service responsible for the integrity of the extract in the event of a power failure, storage equipment failure, or catastrophic event that may damage the extract.

### Limits of Responsibility

- Fordham University Health Service cannot guarantee the integrity of any extract shipped over night by your referring allergist.
- Fordham University Health Service is not my allergist and does not take the place of your medical management and follow up visits from your referring allergist. If I have any questions or concerns regarding my therapy, I will contact my referring allergist.

### Student Agreement:

I request that Fordham University Health Service administer my Allergy Immunotherapy as ordered by my referring Allergist. I understand that Fordham University is administering me my vaccine as a service while I am on campus and because my referring Allergist is not on staff.

**Patient or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Fordham University ID** \_\_\_\_\_ **LPN/NP** \_\_\_\_\_

**Fordham University Health Service**  
441 East Fordham Road Bronx, NY 10458  
Phone: (718) 817-4160 Fax: (718) 817-3218

**Referring Allergist Agreement**

My patient \_\_\_\_\_ DOB \_\_\_\_\_, requests that Fordham University Health Service administers allergy immunotherapy prescribed by my office.

**Please be advised:** Fordham University Health Service has a part-time physician three hours/week and is staffed full-time with Certified Nurse Practitioners who hold CPR certification. Basic Life Support equipment is on site and protocols are posted. The local hospital's emergency rooms are blocks from either campus. The Rose Hill campus in the Bronx has on-site volunteer EMT's and a New York State Certified Ambulance.

**Given this information, please check one of the following:**

\_\_\_\_\_ My patient may receive allergy immunotherapy while the Certified Nurse Practitioners are present.

\_\_\_\_\_ My patient may receive allergy immunotherapy **ONLY** when the physician is present.

**Does the patient have any chronic or severe illness which might affect their general health or desensitizing schedule?**    YES    NO

If yes, please indicate:    Asthma    Cardiac    Other \_\_\_\_\_

**Has the patient had previous significant local or systemic reactions to antigen?**    YES    NO

If yes, please indicate type of reaction and treatment \_\_\_\_\_

**I agree that:**

- I will provide allergy immunotherapy extract in adequately labeled vials for administration at Fordham University Health Center. Vials must be labeled with concentration, antigen content, and expiration dates.
- I will provide detailed instructions regarding dosing schedule for build-up phase and maintenance phase of injections and any adjustments to the schedule that may be warranted due to: use of new vial of extract; if the concentration of the extract has changed, including changes in vaccine type or manufacturer; if the patient has missed doses; and if reactions occurred with prior dosage of allergy extract.
- I will continue to be responsible for the management of my patient's allergy immunotherapy and for any changes in management during therapy.
- I will reevaluate my patient every 6-12 months.
- I will be available by phone to Fordham University Health Service should any questions arise with this patient's allergy immunotherapy.

**Please note:** Patients who have never received allergy injections before, who are resuming injections after an extended lay-off, or who are new to receiving Hymenoptera (insects, bees, wasps, and ants) desensitization should receive their first injection from their referring allergist.

**Referring Allergist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Referring Allergist Print Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Fordham University Health Service**

**Allergy Immunotherapy Check Sheet**

Student Name \_\_\_\_\_ DOB \_\_\_\_\_

Student ID# \_\_\_\_\_ Cell Phone # \_\_\_\_\_

This form is completed yearly and whenever new vials of extract are checked into the Allergy Clinic by Fordham UHS LPN/RN/NP.

- Referring Allergist Agreement Completed and signed  YES  NO
- Student Agreement for Allergy Immunotherapy Administration signed  YES  NO
- Vials are labeled as to concentration  YES  NO
- Vials are labeled as to allergen content  YES  NO
- Expiration Dates of allergy extracts are indicated on vials  YES  NO
- Instruction schedule indicates the AMOUNT & FREQUENCY of each injection and is signed by the Referring Allergist  
 YES  NO
- Instructions for MISSED/LATE injections are included  YES  NO
- Instructions for increasing dosages if the patient has a local reaction  YES  NO
- Orders enclosed for ordering new vials  YES  NO

COMPLETE \_\_\_\_\_ INCOMPLETE \_\_\_\_\_ #1 \_\_\_\_\_ #2 \_\_\_\_\_

Date: \_\_\_\_\_ Date: \_\_\_\_\_

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Date: \_\_\_\_\_ Date: \_\_\_\_\_

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Date: \_\_\_\_\_ Date: \_\_\_\_\_