Dear Allergist:

The Student Health Service at Connecticut College provides allergy shots that are followed by a community allergist from their hometown. This allows them to continue to benefit from the care of their hometown physician while avoiding the time and expense of going home for each injection. The intent of this letter is to explain our service to community allergists such as yourself so that your patient can continue to receive their injections in a safe and convenient manner. Advanced Practice Providers staff Student Health Services. There is not a physician present.

At any given time, we have patients cared for by many different allergists, each with their own order forms and labeling practices. The following guidelines were written with patient safety as the highest priority.

- **LABELLED ALLERGEN VIALS:** Each vial must be labeled with:
  - Patient Name
  - Allergen/Dilution
  - Expiration Date

- **REACTION PROTOCOLS FOR ALLERGIC REACTIONS** with clear guidance on how to proceed with subsequent dosing for local or delayed reactions

- **ALLERGEN INJECTION ORDERS:** Injection orders must be written on a standardized Connecticut College/Hartford Healthcare form and signed by the Allergist. This requirement reduces the risk of error inherent in the use of multiple different order forms from various offices. Each new vial will require a new written order.

- **FIRST INJECTION FROM A NEW VIAL:** We do not initiate injections from a new vial. This should be done at the prescribing physician’s office.

- **TIMING OF INJECTIONS:** Student Health Services has limited hours. Student Health is closed during winter and summer break and we have limited clinician coverage during the two-week spring break. Please consider this as you plan allergy dosing and appointments for a student residing on campus at Connecticut College in New London, CT. Local Urgent Care Centers DO NOT administer allergy injections and local allergist offices will not administer allergy injections unless they have formulated the serum themselves.

In the interest of safety, we decided to eliminate the possibility of confusion about the sequence and strength of allergen doses by requiring standardized ordering and labeling. I hope you will agree that following these guidelines is worth the additional effort in the interest of increased safety and convenience for your patient. If you have any questions, comments, or suggestions regarding this policy, please contact us.

Thank you,

Student Health Services

Connecticut College
Connecticut College
STUDENT HEALTH SERVICES ALLERGY CLINIC
ALLERGEN TREATMENT FORM

Patient’s Name: ___________________________ DOB: ___________________________

First ___________________________ Last ___________________________

Name of extract in vial #: ___________ Concentrations: ___________ Exp. Date of vial: ___________________________

Physician Name: ___________________________ Phone: ___________________________

Fax: ___________________________

Address: ___________________________

Street ___________________________ City ___________________________ Zip ___________________________

PLEASE NOTE ONE SHEET PER VIAL:
Please compare name on vial, extract, & strength or concentration.

### PRESCRIBED DOSE

<table>
<thead>
<tr>
<th>Interval to next dose in Weeks (please circle)</th>
<th>Strength (Concentration)</th>
<th>Volume Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 Fill in dates</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ACTUAL DOSE GIVEN (Student Health Services Use Only)

<table>
<thead>
<tr>
<th>Date</th>
<th>Strength (Concentration)</th>
<th>Volume Amount</th>
<th>Arm (Right)</th>
<th>Arm (Left)</th>
<th>Peak Flow (Y/N)</th>
<th>Reaction</th>
<th>Initials</th>
</tr>
</thead>
</table>

Physician Signature ___________________________ Date ___________

RN Signature ___________________________ Date ___________

Print name ___________________________

Print name ___________________________
Connecticut College
STUDENT HEALTH SERVICES ALLERGY CLINIC
ALLERGEN TREATMENT FORM

Patients Name: Jimmy Cricket
DOB: 07/07/2003

Name of extract in vial #: dust/mite/cat
Concentrations: 1:100
Exp. Date of vial: 06/30/2023

Physician Name: 
Phone: 
Fax: 

Address: 
Street 
City 
Zip 

PLEASE NOTE ONE SHEET PER VIAL:
Please compare name on vial, extract, & strength or concentration.

<table>
<thead>
<tr>
<th>PRESCRIBED DOSE</th>
<th>ACTUAL DOSE GIVEN (Student Health Services Use Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interval to next dose in Weeks (please circle)</strong></td>
<td>**Strength (Concentration)</td>
</tr>
<tr>
<td>1 2 3 4 Fill in dates</td>
<td>1:100</td>
</tr>
<tr>
<td>03/13/2023</td>
<td>0.25ml</td>
</tr>
<tr>
<td>03/20/2023</td>
<td>0.30ml</td>
</tr>
<tr>
<td>03/21/2023</td>
<td>0.35ml etc.</td>
</tr>
<tr>
<td>04/03/2023</td>
<td></td>
</tr>
<tr>
<td>04/10/2023</td>
<td></td>
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<tr>
<td>05/08/2023</td>
<td></td>
</tr>
<tr>
<td>05/15/2023</td>
<td></td>
</tr>
</tbody>
</table>

Physician Signature Date

RN Signature Date

Print name

Print name