James Madison University Health Center
724 S. Mason St. MSC 7901
Harrisonburg, VA 22807

UNIVERSITY HEALTH CENTER
JAMES MADISON UNIVERSITY
BE WELL • STAY WELL • DO WELL

The James Madison University Health Center's goal is to provide care needed by our student patients in the safest way possible. Your assistance with this goal is not only required but also greatly appreciated.

Our Allergy Clinic now serves over 150 student patients referred by over 80 different allergy specialists. Each allergy specialist has a unique form they use in their office. As you can imagine, navigating over 80 different forms is very challenging and has significant potential for error. Therefore, to maximize the safety margin for the student patients, our clinic has developed our own allergen immunotherapy administration form that we will utilize for every student patient in our allergy clinic.

In order for student patients to receive allergy immunotherapy at the JMU Health Center Allergy clinic, we require the following:

1) Every student patient's initial injection(s) must be performed at the Allergist's office.
2) We will not mix or dilute any extracts; this must be done by the prescribing allergist. We will store extracts in the Allergy clinic.
3) Each vial must be clearly labeled with:
    a. Patient's name
    b. Name of the antigen(s)
    c. Dilution
    d. Expiration date
4) **The James Madison University Health Center Allergen Immunotherapy administration form MUST be completed and provided to the Allergy clinic prior to a student patient receiving injections.**
5) There are nominal charges associated with injections. While we do not participate in or bill any insurance plans, we do provide receipts to submit to insurance companies for reimbursement. Please visit the JMU Health Center website https://www.jmu.edu/healthcenter/StudentCare/allergy.shtml.

We are grateful for your collaboration and your understanding that completion of the James Madison University Immunotherapy Administration form is required for the Health Center to deliver this service safely. Please do not hesitate to contact me if you have any questions.

Sincerely,

David S. Switzer, MD, FAAFP Medical Director
James Madison University Health Center
MSC7901 724 South Main Street
Harrisonburg, VA 22807
540-568-6113
Switzedx@jmu.edu

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JAMES MADISON UNIVERSITY HEALTH CENTER

724 S. Mason St. MSC 7901, Harrisonburg, VA 22807
Secure FAX: 540-568-6176

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Allergen Immunotherapy Order Form

For your 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. Failure to complete this form will delay or prevent the patient from utilizing our services. Form can be delivered by the patient, mailed or faxed (see address and fax above).

Patient Name: _____ Date of Birth: _____

Physician: _____ Office Phone: _____ Secure Fax:_____

Office Address: _____

PRE-INJECTION CHECKLIST:

- Is peak flow required prior to injection? NO ☐ YES ☐ **If yes**, peak flow must be **≥** _____L/min to give injection.
- Is student required to have taken an antihistamine prior to injection? NO ☐ YES ☐

INJECTION SCHEDULE:

Begin with _____ (dilution) at _____ml (dose) and increase according to the schedule below.

Dilution					
Vial Cap Color					
Expiration Date(s)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	Go to next Dilution	*Go to next Dilution*	*Go to next Dilution*	*Go to next Dilution*	ml

MANAGEMENT OF MISSED INJECTIONS: (According to number of days from ***LAST*** injection)

During Build-Up Phase	***After Reaching Maintenance***
▪ ___ to ___ days – continue as scheduled	▪ ___ to ___ days – give same maintenance dose
▪ ___ to ___ days – repeat previous dose	▪ ___ to ___ weeks – reduce previous dose by _____ (ml)
▪ ___ to ___ days – reduce previous dose by _____ (ml)	▪ ___ to ___ weeks – reduce previous dose by _____ (ml)
▪ ___ to ___ days – reduce previous dose by _____ (ml)	▪ Over ___ weeks – contact office for instructions
▪ Over _____ days – contact office for instructions	

REACTIONS:

At next visit: Repeat dose if swelling is >_____mm and <_____mm.

Reduce by one dose increment if swelling is >_____mm.

Other Instructions: _____

_____

Physician Signature: _____ Date: _____