University of Vermont
Center for Health & Wellbeing
Student Health Services
Mutual Allergy Patient Agreement

UVM Student Health Services is NOT an Allergy office, but we do offer students the ability to continue allergy desensitization injections. Because we deal with a multitude of allergists' offices, please take the time to fill in the following information and attach all requested documents to allow us to provide the best care possible to our mutual patients**.

Patient Name _____ DOB _____

Initiating Allergist's Name and Credentials _____

Contact Information of Office Where Injections are Administered:

Practice Name _____ Specific Site/Location (if applicable) _____

Street Address _____ City _____ State _____

Phone _____ Fax _____ *Inside Phone Line/Contact Name _____

Checklist of Required Documents:

- ☐ Documentation of patient's initial allergy injections by an allergist
- ☐ Well-Defined Dosing Regimen
- ☐ Late Protocol **(*Please specify from Date of last injection or Due Date)**
- ☐ Patient specific protocol for Local / Systemic Reactions

Patient specific requirement

MD/DO **required** to be onsite at time of injection(s)? ☐ Yes ☐ No

OK to administer 1st injection from new vials at UVM? ☐ Yes ☐ No

Antihistamine day of injection? _ _ _ _ _ _ _ _ _ _ _ ☐ Yes ☐ No

Antihistamine day prior to injection? _ _ _ _ _ _ _ _ ☐ Yes ☐ No

Needs to carry an Epi Pen? _ _ _ _ _ _ _ _ _ _ _ _ _ ☐ Yes ☐ No

Alternate arms? (for injection sites) ☐ Yes ☐ No ☐ Patient preference

Asthmatic Patient? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ ☐ Yes ☐ No

If Yes, is peak flow required? _ _ _ _ _ _ _ _ ☐ Yes ☐ No

If Yes, Give Peak Flow Parameters: _____

Checklist of Vial Labeling Requirements:

- ☐ Patient's Name/DOB
- ☐ Name of Antigen
- ☐ Dilution
- ☐ Expiration Date

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