FROSTBURG STATE UNIVERSITY

BRADY HEATLH CENTER
101 Braddock Road
Frostburg, MD 21532
Phone: 301-687-4310
Fax: 301-687-7050

INFORMATION REQUIRED FOR STUDENTS RECEIVING ALLERGY INJECTIONS AT THE BRADY HEALTH CENTER.

1. Name of Patient: Birthdate:

2. Diagnosis:

3. Summary of sensitivities/Composition of serum: ☐ Summary is on allergy adminsitration forms with serum

Please document any high degree of allergan sensitivity that we should be aware of:

4. Dosage and schedule: ☐ Schedule is on allergy administration forms with serum

5. Directions for care: ☐ Directions for reactions are on allergy administration forms with serum
   A. If local reaction occurs:

   B. If systemic reaction occurs:

6. If patient is late for scheduled injection, maximum length of time without dosage change:
   ☐ Directions for late injections are with allergy administration form with serum
   A. If on increasing (build-up) dose:

   B. If on maintenance dose:

I have read the attached letter, understand the content and have completed the above information. I agree to permit my patient to receive allergy injections at the Brady Health Center.

(PLEASE PRINT) Physician Name:
Address:

Phone Number:

Signature of Physician: Date:

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