**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 administration 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: ________________

Developed June 2001/ Revised June 2005, August 2014