



OFFICE OF STUDENT LIFE

**STUDENT HEALTH CENTER**

**Therapeutic Injections**

**PATIENT INFORMATION**

Name

Date of Birth

Allergies

Patient Phone #

Diagnosis/ICD10 Code

**PRESCRIPTION INFORMATION**

\*If this med is a biologic, biosimilar medications are approved to use    Yes    No

DRUG NAME AND STRENGTH	DIRECTIONS	
	Dose	
DATE OF LAST ADMINISTERED DOSE	Route	Site
	Frequency	

**ORDER VALID**

FROM

UNTIL

**ADDITIONAL INSTRUCTIONS**

**Are there any important tasks that need to be done prior to each injection (i.e. weight check, lab work, etc.):**

**PRESCRIBER INFORMATION**

Signature

Date

Name

Credentials

Address

City

State

Zip

Phone

Fax

**NOTE: THIS ORDER IS NOT VALID UNLESS ALL FIELDS ARE COMPLETED.**

**A new form needs to be submitted each year in order for your patient to continue to receive injections at our facility. The form can be found on the SHC's website under Therapeutic Injections.**