OFFICE OF STUDENT LIFE
STUDENT HEALTH CENTER

Therapeutic Injections

PATIENT INFORMATION

Name	Date of Birth
Allergies	
Patient Phone #	
Diagnosis/ICD10 Code	

PRESCRIPTION INFORMATION

DRUG NAME AND STRENGTH	DIRECTIONS
_____ DATE OF LAST ADMINISTERED DOSE	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.