



Allergen Immunotherapy Order Form (Rev 1/5/26)

Patient Name:	Date of Birth:
Allergist:	Office:
Address:	
Phone:	Fax:

DIAGNOSIS CODES: \_\_\_\_\_

Is student required to take an antihistamine prior to injection? NO ☐ YES ☐

Can student receive a vaccine the same day as an allergy injection? NO ☐ YES ☐

First dose at health center should be \_\_\_\_\_ (dilution) at \_\_\_\_\_ mL (dose) if given by \_\_\_\_\_ (date) and increase according to the schedule below.

\*Please indicate at what vial/dose NEW serum should be ordered: \_\_\_\_\_.

Vial Name					
Dilution					
Vial Cap Color					
Expiration:					
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
Go to next Dilution	Go to next Dilution	Go to next Dilution	Go to next Dilution	Go to next Dilution	

<i>During Build-Up Phase</i>	<i>After Reaching Maintenance</i>
• ___ to ___ days – continue as scheduled	• ___ to ___ days – give same maintenance dose
• ___ to ___ days – repeat previous dose	• ___ to ___ weeks – reduce previous dose by ___ (mL)
• ___ to ___ days – reduce previous dose by ___ (mL)	• ___ to ___ weeks – reduce previous dose by ___ (mL)
• ___ to ___ days – reduce previous dose by ___ (mL)	• Over ___ weeks – contact office for instructions
• Over ___ days – contact office for instructions	

At next visit: Repeat dose if swelling is > \_\_\_\_\_ mm and < \_\_\_\_\_ mm  
Reduce by one dose increment if swelling is > \_\_\_\_\_ mm.

Other Instructions:

Date:

\*By signing this form, you attest that you have read our Allergist Agreement and reviewed the Allergy Clinic Policies and Procedures.