OFFICE OF STUDENT LIFE
STUDENT HEALTH CENTER
600 N Eagleson Ave, Bloomington, IN 47405 Phone 812.855.7514 Fax: 812.856.8729

Allergen Immunotherapy Order Form (Rev 5/29/25)

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

DIAGNOSIS CODES: _____

PRE-INJECTION

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 ☐

INJECTION SCHEDULE:

Begin with _____ (dilution) at _____ mL (dose) and increase according to the schedule below.

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

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
	Go to next Dilution	Go to next Dilution	Go to next Dilution	Go to next Dilution	Go to next Dilution

MANAGEMENT OF MISSED INJECTIONS: (According to number days from LAST injection)

During Build-Up Phase	*After Reaching Maintenance*
• ___ 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	

REACTIONS:

At next visit: Repeat dose if swelling is >_____mm and <_____mm

Reduce by one dose increment if swelling is >_____mm.

**SYSTEMIC REACTION CALL ALLERGIST

Other Instructions: _____

Physician Signature: **Date:**

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