Center for Health and Counseling
CREIGHTON UNIVERSITY

Dear Medical Provider,

Your patient, _____ (DOB: _____), has requested that Creighton University Student Health Services (SHS) participate in their care by providing allergy injections that you prescribe for them. Immunotherapy is administered by trained staff with a medical provider (MD, DO, PA, or NP) on-site.

Please complete and sign this form and return to our office. Send your patient's allergy serum and dosing schedule to our office. This information **MUST** be on file in our office before we can begin administering your patient's injections.

- Does the patient have any chronic/severe illness which could affect his/her general health or desensitization schedule? Yes ☐ No ☐

  If Yes: ☐ Asthma ☐ Cardiac Condition ☐ Other _____

  Current Medications:
  _____
  _____

- Has the patient experienced significant local or systemic reactions to antigens? Yes ☐ No ☐

  If Yes: Indicate type of reaction, to what antigen, when reaction occurred and treatment required:
  _____
  _____

Immunotherapy orders must contain:

- Patient allergies
- Pre-treatment requirements
- Instructions for reactions and missed injections
- Your protocol for refilling serum

I agree to allow SHS to provide immunotherapy as prescribed by me to this patient.

Medical Provider Name: _____

Medical Provider Signature: _____ Date: _____

Address: _____

_____ Telephone: _____

_____ Fax: _____

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