



**Valparaiso University
Student Health Center
Immunotherapy Check List for Allergy patients**

- _____ **I have read and understood the Immunotherapy policy and procedure. I have signed the Services Utilization Policy Statement.**

- _____ **I have a copy of the “Dear Allergist” letter for my allergist.**

- _____ **I have a blank copy of the form entitled “Immunotherapy Orders” to have my allergist complete.**

- _____ **My allergist has completed the “Student Emergency Action Plan” and renewed my prescription for epinephrine (i.e., EPI pen).**

- _____ **I have read and signed the “Student Instructions and Responsibilities” form.**

- _____ **I have completed the “campus contact” information sheet.**

- _____ **I have returned the “Student Instructions and Responsibilities”, campus contact information, and “Immunotherapy orders” to the Health Center.**

- _____ **I have made arrangements to deliver my allergy serum to the Health Center and have scheduled my first immunotherapy appointment (219-464-5060).**

Valparaiso University Health Center Valparaiso, Indiana	Policy & Procedure
Owner: VU Health Center	Policy Origin Date: 2008
Function: Quality	Effective Date: 10-17-2008
Department(s): Health Center	Reviewed/Recommended By: Health Center Director
Scope: Physician, Registered Nurse, Nurse Practitioner, Medical Assistant	Approved By: Health Center Director:
	Approval Date: 10-17-08; revised 04/07/09; 05-25-2010

Immunotherapy Policy and Procedure

Departments Affected: Health Center

Scope of Practice: All staff.

Policy Statement:

Valparaiso University Student Health Center will administer immunotherapy injections to students presenting with orders from an allergist.

Valparaiso University Procedures:

1. Allergy injections will be given **only if physician or nurse practitioner** is in the building. Some allergists require that a physician be present. If your allergist specifies this on his/her orders and our physician is not available for some reason, we will **not** administer your allergy injection.

2. Allergy information on the chart **must** include the VU Standardized immunotherapy order page (attachment A) , which contains the following:
 - a. Current health history, including list of patient’s allergies and any past reactions.
 - b. Allergy physician’s name, address, phone number, fax number.
 - c. Allergy physician’s orders (must be signed and dated by a physician).
 - d. Vial contents.
 - e. Serum concentration.
 - f. Instructions for missed injections.
 - g. Valparaiso University Health Center guidelines for treatment of serum reactions.
 - h. Instructions for reordering allergy serum.
 - i. A signed copy of the “Student Instructions and Responsibilities for Allergy Injections”.

3. Allergy vials will be stored in the Health Center refrigerator. **The Health Center will not be responsible for loss or damage to allergy serum due to power failure or other causes.**

4. Allergy injections are given on appointment basis only. “Walk-in” appointments are not available for this service. It is the student’s responsibility to schedule immunotherapy appointments at least 24 hours in advance to guarantee availability. It is recommended the student schedule his/her next appointment during their 20 minute wait time following their Immunotherapy injection.
5. Students who schedule immunotherapy appointments and fail to appear for the scheduled appointment without 24 cancellation notice (effective Fall 2009):
 - a. First offense: verbal warning
 - b. Second offense: written warning
 - c. Third offense: students who fail 3 immunotherapy appointments will not be eligible to continue immunotherapy at the student health center. These students will be referred to a local allergist to continue immunotherapy, at their discretion.
6. Students are asked to bring in new serum and physicians order forms several days ahead of scheduled injection appointment. New vials must have new orders.
7. There is a charge per injection payable at the time of service by cash, check or VU ONE CARD. Students may prepay for their allergy injections. The Health Center DOES NOT BILL. Allergy injections are not covered under the student medical plan. Current allergy charges are as follows:

1 – 2 Injections	\$15.00*
3 – 4 Injections	\$20.00*
5 – 6 Injections	\$25.00*
9. **Students are responsible for missed injections, and if the student fails to follow the prescribed schedule, the student is responsible for notifying his/her physicians’ office. The student or his/her physician will be required to provide a new injection schedule to Health Center via fax or mail.**
10. At breaks and end of school years students are responsible to pick up current treatment record and serum vials.
11. *If catch up is required due to a student’s non-compliance with the allergy schedule, the appropriate fees will apply.*

Administration of Immunotherapy

1. Check allergy serum vial and treatment sheet to verify patient's name and allergens (including concentration) are correct. Check expiration date(s). Discard expired serum and inform the student of the need to reorder new vial(s). Check each vial concentration, content(s) with physician orders.
2. Before administering allergy injection, check physician orders for correct dosage and any lapses between injections so as to properly administer extract or make dose modifications as specified by patient's allergy guidelines. Note any reactions documented from previous injection, review allergist's instructions regarding reactions.
3. Question the patient regarding any reactions from his/her last injection and current state of health before administering the extract.
 - a. If patient had late local reaction (1-24hrs), follow physician guidelines for local reactions.
 - b. Do not give injection if: fever, asthma symptoms.
4. Roll vial between palms gently to mix before withdrawing dose with syringe using aseptic technique. Do not inject air into vial.
5. Administer injection with 1cc allergy syringe subcutaneous in the midlateral surface of upper arm. Aspirate before injecting, if blood appears, withdraw needle and prepare a new site.
6. Record date, dosage site and reaction on Health Center Allergy treatment record.
7. Observe student for a minimum of 20 minutes following administering injection.
8. If local reaction occurs, refer to physician's instructions in chart, record millimeters of induration.
9. If systemic reaction occurs, instruct the front desk personnel to call 911. Staff will follow the anaphylaxis protocol.

Valparaiso University Health Center

Allergy Injections

Student Instructions and Responsibilities

1. The student is responsible for providing his/her allergist with the enclosed stapled packet and making sure that it is completed by his/her physician and returned to Valparaiso University Health Center. The packet advises the allergist that we have one standardized form for orders which needs to be completed and signed by the allergist. **We will only accept allergist's orders on the Valparaiso University Immunotherapy Order form. We will not administer injections from inadequately labeled vials or if a physician's instructions are missing or incomplete.** If a student has a history of severe reactions we reserve the right to refuse to administer injections in our clinic. (The student will be referred to local allergists.)
2. The student is responsible for reading and understanding the Allergy Immunotherapy Instructions.
3. The student is responsible for arranging his/her own injections while he/she is away from campus.
4. The student is responsible for checking out his/her serum and a copy of his/her record during the holiday periods and at the end of the academic year.
5. The student is responsible for ordering antigens from his/her allergist and bringing antigen(s) to the VU Health Center.
6. The student is responsible for making appointments at the Health Center for his/her injections at least 24 hours before the injection is due (219) 464-5060. Please read, **SIGN** and return the instruction sheet, along with orders from your allergist to the Health Center.
7. The Health Center will store your serum, however, ***we will not be responsible for loss or damage to allergy serum due to power failure or other causes.***

Allergy Injections will be given on Tuesdays, BY APPOINTMENT ONLY.

Allergy Injection Fees are as follows:

- 1- 2 Injections \$15.00
- 3- 4 Injections \$20.00
- 5- 6 Injections \$25.00

Payment is expected at the time of service. Allergy injections may be pre-paid. We do not bill commercial insurance programs. Payment options include cash, check (payable to Valparaiso University Health Center), or VU One Card. We are unable to accept credit/debit cards for payment.

I have read the above and agree to comply with the above policy:

Student's signature _____ Date _____

**Valparaiso University
Health Center
Immunotherapy Program
Services Utilization Policy**

Health services at Valparaiso University are provided by staff with advanced education and professional experience. Student use of these services is extensive and we are challenged to provide services to all who desire them. Due to the high demand for health services and the limited number of appointments available for immunotherapy, if you are unable to attend an appointment, please call ahead of time to let us know. If you forget an appointment, please notify us within 24 hours to be considered for future appointments. If you fail to call and miss two appointments in a row, or if you miss a number of intermittent appointments throughout the term, you will become ineligible for services for the rest of the academic year. In addition to utilizing our time well, regular attendance at your immunotherapy appointments is important in order for you to progress with your therapy. Also, time scheduled and then not used by one student prevents another student from having that appointment time. In the event that you become ineligible for services, we will refer you to an allergist in the area where you may make arrangements to continue receiving your immunotherapy.

*I certify that I have read and understand the above Health Center Immunotherapy services Utilization Policy and hereby consent to treatment consistent with the guidelines and limitations described therein. **I also understand that I have the right to withdraw this consent at any time.***

Signed: _____ Date: _____
(Expires at end of current academic year)

I certify that I have read and understand the Immunotherapy policy and hereby consent to treatment consistent with the guidelines and limitations described therein:

Signed: _____ Date: _____
(Expires at end of current academic year)

I would like to be contacted by e-mail regarding immunotherapy appointments. I understand that e-mail is not a secure form of communication; thus confidentiality cannot be guaranteed. All e-mail communications become a part of your medical record. By signing below, you allow e-mail communication with Health Center staff.

Signed: _____ Date: _____
(Expires at end of current academic year)

**Valparaiso University Health Center
CAMPUS CONTACT
1406 LaPorte Avenue
Valparaiso, Indiana 46383
(219) 464-5060**

Please Print Clearly:

Name: _____

Campus address/Residence Hall: _____

UNIT# _____ ROOM# _____

Home Address: _____

Cell Phone #: _____

Campus Phone: _____

DOB: _____ Age: _____

E-mail Address: _____



Valparaiso
University

Phone: 219.464.5060
Fax: 219.464.5410
Health.Center@valpo.edu
www.valpo.edu/health

Health Center
1406 Laporte Avenue
Valparaiso, IN 46383

July 2011

Dear Allergist:

One of your patients is a student at Valparaiso University and is requesting that we administer his/her allergy injections while residing on campus. In order to lessen the confusion of multiple practitioners' guidelines and to maintain quality care, we are providing you with forms for your immunotherapy orders. Copies of these forms are enclosed. These forms will replace all other forms that you may have provided to your patient for Valparaiso University Health Center. Valparaiso University's Immunotherapy treatment record will be the only treatment record sent to you when new serum vials are requested.

The Health Center is staffed with a consulting physician, family nurse practitioners, and registered nurses. Either a registered nurse or a nurse practitioner will administer allergy injections. A nurse practitioner or physician will be present at the time of administration. If you require that a physician be present during allergy injections please indicate on the Physicians Immunotherapy order form by checking the appropriate box.

We will follow our anaphylaxis protocol for treating reactions both local and generalized, to ensure appropriate treatment during a potential emergency. If a systemic reaction occurs, after preliminary emergent care, the student will be transported by EMS to Porter Hospital Emergency Department, which is less than five minutes from the Health Center.

Please review and complete the enclosed forms with your orders for this student, and return to the Health Center. You may mail the form in the self-addressed stamped envelope enclosed or fax it to **(219) 464-5410**. Please feel free to call the Health Center with any questions.

Sincerely,

Toni S. Baldwin-Dufour, DNP, MSN, RN, FNP-BC
Director, Student Health Services
Valparaiso University



Valparaiso University

VALPARAISO UNIVERSITY STUDENT HEALTH CENTER
IMMUNOTHERAPY ORDERS - Part I

(*To be completed by Physician or appointed staff. Orders must be signed by physician on page 2)

Student name: _____ D.O.B.: _____

Name of allergist: _____

Phone: _____

Fax: _____

Office Stamp: [Empty box for stamp]

Address _____

Diagnosis: (include all significant diagnosis(es) for which student is receiving immunotherapy)

How long has patient been receiving IT? _____

Has the patient had previous significant local or systemic reactions to antigen(s)? Yes [] No []

IF YES, GIVE DETAILS OF REACTION / TREATMENT

Allergies (drug / other):

Medications: (students receiving beta blockers/ MAO inhibitors cannot receive IT at the SHC)

Continued on Next Page.....

Physician Immunotherapy Orders - PART II

Student Name: _____ D.O.B. _____

Check here if you require that a physician be on site when Immunotherapy injections are given. A Nurse Practitioner is always present when injections are administered. (If you require a physician on site it will limit available appointment times for the student.)

Please fill in dosage for all vials injection 1-10

Dose #	VIAL #1 Contents	VIAL #2 Contents	VIAL#3 Contents	VIAL #4 Contents	VIAL#5 Contents	VIAL#6 Contents
	_____	_____	_____	_____	_____	_____
	Expiration Date	Expiration Date	Expiration Date	Expiration Date	Expiration Date	Expiration Date
	_____	_____	_____	_____	_____	_____
	Interval Maintenance Dose_____	Interval Maintenance Dose_____	Interval Maintenance Dose_____	Interval Maintenance Dose_____	Interval Maintenance Dose_____	Interval Maintenance Dose_____
	_____	_____	_____	_____	_____	_____
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Instructions For Missed Doses: _____

Instructions For Local Reactions: _____

Physician (print name): _____

PHYSICIAN SIGNATURE: _____ **Date:** _____

**Valparaiso University-Student Health Center
ANAPHYLAXIS
STUDENT EMERGENCY ACTION PLAN**

NAME: _____ AGE: _____	
ALLERGY TO: _____	
ASTHMA: <input type="checkbox"/> YES (High risk for severe reaction) <input type="checkbox"/> No	
OTHER HEALTH PROBLEMS BESIDES ANAPHYLAXIS: _____	
CURRENT MEDICATIONS, IF ANY: _____	
Symptoms of anaphylaxis include:	
<p>Mouth: Itching, swelling of lips or tongue Throat: Itching, tightness/closure, hoarseness Skin: Itching, hives, redness, swelling Gastrointestinal: Vomiting, diarrhea, cramps Lungs: Shortness of breath, coughing, wheezing Heart: Weak pulse, dizziness, passing out</p>	
<i>Only a few of these symptoms may be present. The severity of symptoms can change quickly. Allergic reactions can be life-threatening! ACT FAST!!</i>	
What to do:	
1) Call 9-1-1	
2) Inject epinephrine into the thigh using (check one): <input type="checkbox"/> Epipen (0.3mg) <input type="checkbox"/> Twinject (0.3mg)	
3) Other medications (dose/route):	
a) _____	
b) _____	
c) _____	
4) Have a friend or roommate call your emergency contact:	
a) Emergency Contact #1: Home _____ Work: _____ Cell: _____	
b) Emergency Contact #2: Home _____ Work: _____ Cell: _____	
c) Emergency Contact #3: Home _____ Work: _____ Cell: _____	
Provider's Signature _____ Date	Patient's Signature (Parent/Guardian for individuals under age 18) _____ Date
It is recommended that a copy of this plan be on provided to the Health Center for your allergy file and that you review this emergency plan with friends and/or your roommate.	