UCF Student Health Services

# Immunotherapy
# Attachment 1

## INFORMED CONSENT TO RECEIVE ALLERGY IMMUNOTHERAPY

I request to receive my allergy immunotherapy at the UCF Health Center and agree to its policies:

1. There is a $14.00 fee for one injection and $17.00 fee for multiple injections.

2. Allergy injections are given every Tuesday and Thursday, from 9 a.m. to 12 p.m. and 1 p.m. to 4 p.m. and Wednesday from 9-12, by appointment only.

3. A student receiving allergy injections must remain in view of the nurse for 30 minutes after receiving the injection. **You may not leave the allergy waiting area during the period of nursing observation**.

4. After the 30 minute observation period, the patient must have the injection sites evaluated by a nurse before leaving the facility. If a patient leaves without the nurse checking and recording results, the patient may no longer receive their immunotherapy at the UCF Health Center. There are no exceptions to this policy.

5. It is the responsibility of the patient to sign out extracts and record copies during holiday absences and to return these materials upon returning to school.

6. It is the responsibility of the patient to pick up extracts at the end of the academic year. The UCF Health Center DOES NOT mail extracts left in the Health Center.

I, _____, have read and fully understand the above statements.

I fully understand that the prescription and mixing of my serum, the content of my vials, the concentration of my serum and the dosage schedule are the responsibility of my private physician, Dr. _____, and I do not hold the UCF Health Center responsible for these factors.

I understand my prescribed allergy treatment must be fully compliant with the policies and protocols of the UCF Health Center in order to receive my injections in this facility and that the signature of a Health Center physician does not constitute endorsement or approval of the regimen prescribed by my private physician.

I have been given Allergy Immunotherapy Instructions sheets. I have read and understand this information and have been given the opportunity to ask questions.

Date: _____ Signature: _____

Witness: _____ PID _____

_____

UCF SHS Physician Signature (Director, if allergist is out of state)

Chart Copy

UCF Student Health Services

# Immunotherapy
# Attachment 2

## SIGNING OUT ALLERGENIC EXTRACTS

1. We recommend that you make arrangements to receive your immunotherapy at a medical facility while you're away from UCF. Systemic reactions can be unexpected and constitute medical emergencies and are best dealt with by trained professionals. Please consider using a General Practice Doctors' office, Allergists' offices, Pediatricians' offices, or free-standing medical clinics while away from UCF. Ask about the charge for the service before receiving injections.

2. Keep your extracts refrigerated as continuously as possible. Each minute they are exposed to room temperature they lose potency.

3. Take a copy of your injection instructions and record sheet with you. It is your responsibility to insure that the health professional that administers your injections records the appropriate information accurately. This includes date, dosage, site, reaction and signature. This prevents delays in receiving your next injection when you return to the UCF Health Center.

## RELEASE FOR SIGNING OUT ALLERGENIC EXTRACTS.

I, _____ removed my allergy extracts and
(PRINT NAME)
instructions /recording papers from the UCF Health Center in order to receive my immunotherapy while off campus. I fully understand it is my responsibility to continue my immunotherapy regimen, to store the extracts appropriately and to return the extracts and records upon my return to UCF.

Date: _____ Signature: _____

PID _____

Witness: _____

Chart Copy
F:\wp51\forms\allergy.frm

UCF STUDENT HEALTH SERVICES

# Immunotherapy
## Attachment 3

## INSTRUCTIONS FOR SIGNING OUT ALLERGENIC EXTRACTS

1. We recommend that you make arrangements to receive your immunotherapy at a medical facility while you're away from UCF. Systemic reactions can be unexpected and constitute medical emergencies. They are best handled by trained professionals. Some of your options for deciding on a facility include General Practice Doctors' offices, Allergists' offices, Pediatricians' offices, or free-standing medical clinics. Remember to ask about the charge for the service before receiving injections.

2. Keep your extracts refrigerated as continuously as possible. Each minute they are exposed to room temperature they lose potency.

3. Take a copy of your injection instructions and record sheet with you. It is your responsibility to insure that the health professional that administers your injections records the appropriate information accurately. This includes date, dosage, site, reaction and signature. This prevents delays in receiving your next injection when you return to the UCF Health Center.

4. If you are arranging to have new vials of serum made, you must bring them in person to the Health Center. ALLERGY SERUM SHOULD **NOT** BE MAILED TO THE HEALTH CENTER. If it must be mailed, it should be sent TO THE STUDENT, who will then bring it to the Health Center. New vials should be clearly labeled as to content, concentration, and expiration date. Vials should be numbered, lettered or color-coded to correspond with the physician's written instructions.

5. It is your responsibility to return your allergy serum and records to the Health Center when you return to school. The allergy clinic is open Tuesday and Thursday, from 9 a.m. to 12 p.m. and 1 p.m. to 4 p.m. and Wednesday from 9 a.m. to 12 p.m.

UCF STUDENT HEALTH SERVICES

# Immunotherapy
# Attachment 4

## ALLERGY IMMUNOTHERAPY INSTRUCTIONS

1. Avoid rubbing or scratching the arms after injections.
2. Avoid vigorous exercise after injections, such as jogging, vigorous walking, gym workouts, etc.
3. Bring an antihistamine medication (as recommended by your allergist) with you when coming for an injection as a safety precaution.
4. Although you may not experience any local reaction within the 30 minutes after injection, it is possible to react later in the day. If a local reaction occurs:

    a. Take an antihistamine.
    b. Record the time and size of the reaction (compare to coin size) and how long it lasts.
    c. Report this to the nurse BEFORE receiving your next injection.

5. **Please wait in the designated allergy wait area for 30 minutes after your injection(s).** Please notify the nurse if you experience any of the following:

| | | | |
|---|---|---|---|
| Runny nose | wheezing | sneezing | coughing |
| Itching | flushing | shortness of breath | facial swelling |
| Hives | anxiety | nasal congestion | |
| "Pins & needles" sensations of the skin | | | |

6. If any of the above symptoms occur after you have received allergy injections and left the health center, take an antihistamine. If the symptoms continue or worsen, return to the Health Center or go to the nearest Emergency Room.

7. You MUST have the injection sites checked after 30 minutes by a nurse. If you leave without being released by the allergy nurse, you may not continue to receive additional injections at the Health Center. The first offense is the only offense. There are no exceptions to this policy.

8. The unpredictable nature of your immune system is the reason you are required to remain at the Health Center for 30 minutes following an injection.

9. If possible, try to schedule your injection times on the same day, at the same time each week. If you come in twice a week, you need at least one day between injections.

10. Allergy injections will never be given without a Physician's presence in the facility. This is for your safety.

11. Certain prescription medications for eye problems, headaches and blood pressure problems contain Beta Blockers. Beta Blockers can increase the sensitivity to allergens and also potentiate anaphylaxis. If you have been prescribed any such medication, it is **IMPERATIVE** you inform the nurse **BEFORE** receiving any allergy injections. List is available at UCF Health Services Allergy Clinic.

12 If you plan a vacation, camp or school change, please come to the Health Center to sign out your extracts. You are responsible for making arrangements to receive you injections while you are away from UCF. You must also keep the extracts refrigerated. Failure to do so may cause them to lose potency.

The UCF SHS form “Signing out allergenic extracts” must be signed.

Patient copy

UCF STUDENT HEALTH SERVICES

Immunotherapy
Attachment 5

# GUIDELINES FOR THE ALLERGIST

PLEASE PROVIDE THE FOLLOWING:

1. A SEPARATE LETTER OF AUTHORIZATION FROM THE PRESCRIBING PHYSICIAN (ALLERGIST) TO UCF STUDENT HEALTH SERVICES or sign Allergist Informed consent.
2 CLINICAL SUMMARY WHICH SHOULD INCLUDE THE THERAPY THE PATIENT IS RECEIVING AND ANY HIGH RISK ASPECTS OF THE PATIENT'S DISEASE and / or skin allergy testing results.
3. THE PHYSICIAN'S ADDRESS, PHONE NUMBER, FAX NUMBER AND OFFICE HOURS.
4. THE INJECTION SCHEDULE TO BE FOLLOWED WITH THE DATE AND DOSAGE OF THE LAST INJECTION RECEIVED. DOCUMENTATION SHOULD BE MADE OF ANY PREVIOUS REACTIONS.
5. INFORMATION ON THE CONTENTS, STRENGTH AND EXPIRATION DATE OF THE EXTRACTS. THE ALLERGY TREATMENT VIALS SHOULD BE LABELED CLEARLY, WITH THE PATIENT'S NAME AND EXTRACT INFORMATION.
6. A PLAN FOR MODIFICATION OF THE DOSAGE IF THE PATIENT IS LATE FOR THE INJECTION(S) OR IN THE EVENT OF A REACTION WITH THE PREVIOUS INJECTION.

Please send these to: **University of Central Florida, Student Health Services**
**Health Information Management Department**
**PO Box 163333**
**Orlando, Fl. 32816-3333**

**Fax: (407) 823-3359**
**Phone: (407) 823-2092**

**Allergist's Copy** F:\wp51\forms\allergy.frm

UCF Student Health Services

# Allergist Informed Consent

**INFORMED CONSENT TO ADMINISTER ALLERGY INJECTIONS:**

**Date:** _____

**Patient Name**: _____

**Patient DOB** _____

The above named patient is currently under my care and is receiving allergy immunotherapy. I authorize UCF Health Center to administer allergy injections as indicated on our record and order sheet. The patient will continue to follow- up with me as directed, as well as obtain allergy serum from our clinic.

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_____
MD Signature

_____ _____
Printed name of MD Affix Clinic Address stamp