NC STATE UNIVERSITY

Student Health Services
Campus Box 7304
Raleigh, North Carolina 27695-7304
Phone (919) 515-2563
Fax (888) 972-4158

Physician Order for Allergy Immunotherapy

Allergist: Please read the information below and sign your name at the bottom acknowledging the following:

1. As the allergy physician for_____, I hereby authorize NC State University
   (Student name-please print)
   Student Health Services to administer allergy immunotherapy to the student according to the instructions and schedules submitted by me.

2. When new orders are requested, they will be sent via fax to (888)972-4158. **NC State Student Health does not accept phone orders**. All orders must be signed by a physician in your practice.

3. New allergy serum vials will be sent directly to the patient, NOT to Student Health.

4. No expired serum will be administered.

5. The initial allergy injection will be given at my office, not at NC State Student Health.

6. This patient has experienced any systemic reaction(s) to serum: **Yes**_____ **No**_____

   If yes, I will forward any information regarding the reaction. I understand that NCSU Allergy Clinic requires that the patient return to my office for at least one injection after any systemic reaction experienced at Student Health.

7. Indicate if patient has any specific requirements prior to receiving allergy injections, including:

   ___ Patient must carry Epi-pen to injection visit.
   ___ Patient must take pre-medication day of injection visit.
   ___ Peak flows must be completed before and/or after injections
   A week equals _____ days

Allergist signature: _____ Date: _____

Printed Allergist name: _____

NC State Student Health Only

My signature below acknowledges that my staff and I will administer allergen subcutaneous immunotherapy injections for this patient in a supervised medical setting (immediate physician availability). Furthermore, I acknowledge the following facts: one- that my staff and I are trained in the recognition and management of both local and systemic reactions to the allergen immunotherapy, two- that my staff and I understand that you or your staff will be available for phone consultation as needed but will not be responsible for the training and supervision of my clinic personnel for procedures performed within my clinic or for any quality control measures within my clinic, and three- that I understand that the patient may return to you at any time for continuation of immunotherapy, if so requested by myself or by the patient.

Acknowledged and agreed by:

_____ Date: _____

Julie Casani, MD, MPH
Director and Medical Director, Student Health Services