

**ROCHESTER INSTITUTE OF TECHNOLOGY**  
**STUDENT HEALTH CENTER**  
**Allergy Immunotherapy Check Sheet To be Completed by Allergist's Office**

Student: \_\_\_\_\_ DOB \_\_\_\_\_

- All the following information **MUST BE PROVIDED BEFORE** allergy injections are given.
- The check sheet will be completed annually and whenever new vials of extract are brought in.
- It is the **student's responsibility** to assure the vials are properly labeled and the physician's orders are complete **when they pick up their extracts from their physician.**

1. Vials are labeled with the **patient's name**..... Yes  No
2. Vials are labeled/coded as to **concentration**..... Yes  No
3. Vials are labeled/coded as to **antigen content**..... Yes  No
4. **Expiration dates** of the antigens are indicated..... Yes  No
5. Number of vials 1 2 3 4 5 6 Other: \_\_\_ (Please circle)
6. Vials are coded by **number, letter or color** to correspond with doctor's written orders..... Yes  No
7. Schedule indicating the **amount and frequency** of each injection is present..... Yes  No
8. **Single dose vials are numbered or dated** to correspond with doctor's written orders..... Yes  No 
  - Is the **number of vials** indicated?..... Yes  No
  - Is the **content** indicated?..... Yes  No
  - Is the **strength** indicated?..... Yes  No
  - Is the **expiration date** indicated?..... Yes  No
9. Instructions for **missed/late** injections are present..... Yes  No
10. Instructions are present for adjusting schedule after **local reaction**..... Yes  No
11. Does the patient have any chronic or severe illness which might affect general health or desensitization schedule?..... Yes  No

**If yes**, please indicate    asthma \_\_\_    cardiac \_\_\_    other \_\_\_

12. Has the patient had previous significant local or systemic reactions to antigens?..... Yes  No

**If yes**, please indicate type of reaction, to what antigen(s), and previous type of treatment for the adverse reaction: \_\_\_\_\_

13. **If new vials of maintenance** antigens are to be used, are **new vial orders** (reduced dosage with progression to maintenance) present?..... Yes  No
14. Is date/amount of **last injection** indicated on instruction sheet?..... Yes  No
15. Attached allergy consent form is completed and signed..... Yes  No

Office contact person: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number \_\_\_\_\_

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_