Fordham University Health Services

In order for your patient to receive allergy immunotherapy in Fordham University Health Services, we require:

- The **Referring Allergist Agreement** completely filled out, signed and dated yearly.
- Instructions that include **dose and frequency, late/missed doses, local reactions, systemic reactions and re-ordering new vials**.
- Vials that are clearly labeled with the **patient's name, name of allergen(s), concentration/dilution and expiration date.**
- Students who are required to carry an epi-pen or use an inhaler/spacer must have it with them at each appointment.

In addition, we require that each student receives his/her first injections at your office.

If you are unable to provide the above requirements, your patient will not be able to receive allergy immunotherapy in our office.

If you have any questions or concerns, please call University Health Services at the Rose Hill Campus at 718-817-4160 or at the Lincoln Center Campus at 212-636-7160.

Fordham University Health Services

Student Agreement for Allergy Immunotherapy Administration

Students requesting allergy immunotherapy administration from Fordham University Health Service must complete this form.

I understand that Fordham University Health Services (FUHS) does not initiate immunotherapy treatment and that my first injection must be received at my allergist's office.

I understand that it is my responsibility to provide completed and signed documents each academic year and/or as my treatment is changed by my allergist.

Injection Schedule

- I agree to abide by the injection schedule prescribed by my referring allergist.
- I understand that if allergy injections are frequently missed that this may increase my risk of allergic reactions. Under such circumstances, the Fordham University Health Service may not be able to continue my injections.
- **If my allergist prescribes an epinephrine auto injector and/or antihistamine to take prior to my injection(s), I agree to carry my epinephrine auto injector and/or take an antihistamine as prescribed by my allergist prior to injections(s).**

Risk and Side Effects

- I understand that there are risks associated with receiving allergy injections including both local reactions and systemic reactions including but not limited to **shortness of breath, nasal congestion, wheezing, flushing, hives, coughing, runny nose and anaphylaxis.** All systemic reactions require immediate evaluation and intervention and transport to the local emergency room for further evaluation, treatment and monitoring.
- **I have received and reviewed the wallet card for signs and symptoms and actions to take in the event of anaphylaxis.**

Observation Period

- Systemic reactions are unpredictable and may occur after the first injection or after several doses have been given over a period of time. It is very unpredictable. This is why it is mandatory after an allergy injection that you remain in the UHS for monitoring for 30 minutes. If you cannot wait the required amount of time following your injection, you need to inform the staff and your appointment will need to be rescheduled.
- **I agree to remain visible in the Allergy Clinic waiting area for a 30-minute observation period. I will notify the nurse immediately if I experience itchy eyes, nose or throat; nasal congestion; itching; hives; shortness of breath; wheezing; flushing; sneezing; coughing; or any other symptoms that arise.**

- **I agree to notify FUHS of any delayed reactions that I experience once I leave. I understand that without exception, if I leave during the 30-minute observation period or before having my injection site(s) assessed by a nurse, I will no longer be permitted to receive my allergy immunotherapy at FUHS.**
- **I understand that I must avoid strenuous activity for two hours after receiving my allergy injection(s).**

New Information

- I agree to notify the Fordham University Health Service if I start any new medications. Some medications used for high blood pressure, migraines, depression, or glaucoma are contraindicated while on allergy immunotherapy.
- I agree to notify the UHS if I become pregnant so that a revised schedule for dosing can be obtained from your allergist.

Extract Storage

- Fordham University Health Service will store my extracts in a monitored refrigerator between 3-6 degrees Celsius.
- I agree that I will not hold Fordham University Health Service responsible for the integrity of the extract in the event of a power failure, storage equipment failure, or catastrophic event that may damage the extract.

Limits of Responsibility

- Fordham University Health Service cannot guarantee the integrity of any extract shipped overnight by your referring allergist.
- Fordham University Health Service is not my allergist and does not take the place of your medical management and follow up visits from your referring allergist. If I have any questions or concerns regarding my therapy, I will contact my referring allergist.

Student Agreement:

I request that Fordham University Health Service administer my allergy immunotherapy as ordered by my referring allergist. I understand that Fordham University is administering me my allergy immunotherapy as a service while I am on campus and because my referring allergist is not on staff.

Patient or Guardian Signature: _____ **Date:**_____

Fordham University ID_____**LPN/RN/NP**_____

Fordham University Health Service
441 East Fordham Road Bronx, NY 10458
Phone: (718) 817-4160 Fax: (718) 817-3218

Referring Allergist Agreement

My patient _____ DOB_____, requests that Fordham University Health Service administers allergy immunotherapy prescribed by my office.

Please be advised: Fordham University Health Service has a part-time physician four hours/week* and is staffed full-time with Certified Nurse Practitioners who hold CPR certification. Basic Life Support equipment is on site and protocols are posted. The local hospitals' emergency rooms are blocks from either campus. The Rose Hill campus in the Bronx has on-site volunteer Emergency Medical Technicians (EMT's), and a New York State Certified Ambulance.

Given this information, please check one of the following:

_____ My patient may receive allergy immunotherapy while the Certified Nurse Practitioners are present.

_____ My patient may receive allergy immunotherapy **ONLY** when the physician is present.*

Has your patient **ever had an anaphylaxis reaction** and if they did what treatment did they receive and did they have to be hospitalized? Please indicate date(s):

_____

_____

Patient has been receiving immunotherapy in my office since: _____

Is the patient required to carry an **epinephrine auto injector?** □ YES □ NO

Is the patient required to take an **antihistamine** prior to allergy immunotherapy? □ YES □ NO

Hydrocortisone Cream 1% may be applied by UHS staff following allergy immunotherapy: □ YES □ NO

Does the patient have any chronic or severe illness which might affect their general health or desensitizing schedule? □ YES □ NO
If yes, please indicate: □ Asthma □ Cardiac □ Other_____
Please list **all allergies** to medication, food, and materials including their reactions:

_____

_____

Medications patient is taking including dosage and frequency (attach medication list if necessary):

_____

_____

Reviewed 5/2023 AS/MK

I agree that:

- I will provide allergy immunotherapy extract in adequately labeled vials for administration at Fordham University Health Center. Vials must be labeled with the patient's name, serum concentration, antigen content, and expiration dates.
- I will provide detailed instructions regarding dosing schedule for build-up phase and maintenance phase of injections and any adjustments to the schedule that may be warranted due to: use of new vial of extract, if the concentration of the extract has changed, including changes in vaccine type; if the patient has missed doses; and if reactions occurred with prior dosage of allergy extract as well as instructions for a systemic reaction.
- I will continue to be responsible for the management of my patient's allergy immunotherapy and for any changes in management during therapy.
- I will reevaluate my patient every 6-12 months.
- I will be available by phone to Fordham University Health Service should any questions arise with this patient's allergy immunotherapy.

Please note: Patients who have never received allergy injections before, who are resuming injections after an extended lay-off should receive their first injection from their referring allergist.

Referring Allergist Signature: _____ **Date:** _____

Referring Allergist Print Name: _____**Phone:** _____

Fax Number:_____ **Office Hours:** _____