The James Madison University Health Center’s goal is to provide care needed by our student patients in the safest way possible. Your assistance with this goal is not only required but also greatly appreciated.

Our Allergy Clinic now serves over 200 student patients referred by over 80 different allergy specialists. Each allergy specialist has a unique form they use in their office. As you can imagine, utilizing over 80 different forms is very challenging and has significant potential for error. Therefore, to maximize the safety margin for the student patients, our clinic has developed an allergy extract administration form that we will utilize for every student patient in our allergy clinic.

In order for student patients to receive allergy serum injections at the JMU Health Center Allergy clinic, we require the following:

1) Every student patient’s initial injection(s) must be performed at the Allergist’s office.
2) We will not mix or dilute any extracts; this must be done by the prescribing allergist. We will store extracts in the Allergy clinic.
3) Each vial must be clearly labeled with:
   a. Patient’s name
   b. Name of the antigen(s)
   c. Dilution
   d. Expiration date
4) The James Madison University Health Center Allergy extract administration form MUST be completed and provided to the Allergy clinic prior to a student patient receiving injections.
5) There is a charge associated with injections. While we do not participate in or bill any insurance plans, we do provide receipts to submit to insurance companies for reimbursement. Please visit the JMU Health Center website [https://www.jmu.edu/healthcenter/StudentCare/allergy.shtml](https://www.jmu.edu/healthcenter/StudentCare/allergy.shtml).

These requirements are purely for the safety of our student patients. Failure to comply will delay and potentially prevent utilization of our services.

Sincerely,

Andrew T. Guertler, MD
Medical Director
James Madison University Health Center
MSC 7901
724 South Main Street
Harrisonburg, VA 22807

Continue to page 2 for the Allergy Extract Administration Form
UHC Allergy Extract Administration Form

For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form must be completed to provide standardization and prevent errors. Failure to complete this form will delay or prevent the patient from utilizing our services. Form can be delivered by the patient or mailed to: 724 S. Mason St. MSC-7901, Harrisonburg, VA 22807

Patient Name: ______________________ Date of Birth: ______________________
Physician: ______________________ Phone: ______________________ Fax:________________
Address: __________________________________________________________________________

PRE-INJECTION CHECKLIST:

- Is peak flow required prior to injection?  [ ] Yes  [ ] No
  - If yes, peak flow should be >_______ to proceed with injection.
- Is student required to have taken an antihistamine prior to injection?  [ ] Yes  [ ] No

INJECTION SCHEDULE:
Begin with __________________(Vial Dilution and Dose) and increase according to the schedule by __________ until a maximum tolerated dose ________ can be achieved.

<table>
<thead>
<tr>
<th>Dilution/Color</th>
<th>Expiration Date(s)</th>
<th>Go to next Dilution/Color</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>/</strong>/__</td>
<td>Go to next Dilution/Color</td>
</tr>
<tr>
<td></td>
<td><strong>/</strong>/__</td>
<td>Go to next Dilution/Color</td>
</tr>
<tr>
<td></td>
<td><strong>/</strong>/__</td>
<td>Go to next Dilution/Color</td>
</tr>
<tr>
<td></td>
<td><strong>/</strong>/__</td>
<td>Go to next Dilution/Color</td>
</tr>
</tbody>
</table>

MANAGEMENT OF MISSED INJECTIONS: (According to # of days from LAST injection)

<table>
<thead>
<tr>
<th>During Build-Up Phase</th>
<th>After Reaching Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ to ___ days – continue as scheduled</td>
<td>___ to ___ days – give same maintenance dose</td>
</tr>
<tr>
<td>___ to ___ days – repeat previous dose</td>
<td>___ to ___ weeks – reduce dose by 25%</td>
</tr>
<tr>
<td>___ to ___ days – reduce previous dose by 25%</td>
<td>___ to ___ weeks – reduce dose by 50%</td>
</tr>
<tr>
<td>___ to ___ days – reduce previous dose by 50%</td>
<td>Over ___ weeks – contact office for instructions</td>
</tr>
<tr>
<td>Over ___ days – contact office for instructions</td>
<td></td>
</tr>
</tbody>
</table>

REACTIIONS:
At next visit: Repeat dose if swelling is >_________mm and <_________mm.
  Reduce by one dose if swelling is >_________mm.

Other Instructions:  __________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Physician Signature: _________________________ Date: ______________________