## Allergy Patient Dosage Recording Sheet

**Allergist Office:**

**Doctor Name:**

**Address:**

**Phone:**  
**Fax:**

**Hours:**

### Parameters for injections: (ex: every 3-7 days)

<table>
<thead>
<tr>
<th>Date</th>
<th>Initials</th>
<th>Health Screen Normal?</th>
<th>Antihistamine Taken?</th>
<th>Peak Flow</th>
<th>Epi Pen</th>
<th>Arm</th>
<th>Dose</th>
<th>Reaction</th>
<th>Arm</th>
<th>Dose</th>
<th>Reaction</th>
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<th>Dose</th>
<th>Reaction</th>
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**Vials Expire:**

<table>
<thead>
<tr>
<th>Vial Name</th>
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**Dilution:**

- Vial Top Color:  
- Content:  

**Dilution:**

- Vial Top Color:  
- Content:  

**Vials Expire:**

- Vial Name:  
- Vial Top Color:  
- Content:  

**Vials Expire:**

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**Vials Expire:**

- Vial Name:  
- Vial Top Color:  
- Content:  

**Vials Expire:**

- Vial Name:  
- Vial Top Color:  
- Content:  

**Health Screen:** Increased allergy or asthma symptoms? URI symptoms? Beta Blocker use? Change in health status, including pregnancy? Adverse reaction to previous dose?

For Dosage Instructions, Build-up or Maintenance Schedules, Guidelines for Local Reactions, or Instructions for Missed Scheduled Injections, see Patient Instruction Sheet.