

# Allergy Patient Dosage Recording Sheet

**INDIANA UNIVERSITY STUDENT HEALTH CENTER**

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<b>Patient:</b>	<b>Allergist Office:</b>
<b>DOB:</b>	<b>Doctor Name:</b>
<b>Diagnosis:</b>	<b>Address:</b>
<b>History:</b>	<b>Phone:</b> <span style="float: right;"><b>Fax:</b></span>
	<b>Hours:</b>

<b>Parameters for injections:</b> (ex: every 3-7 days)	<b>Vials Expire:</b>					<b>EpiPen Expiration:</b>				
	<b>Vial name:</b>	<b>Vial name:</b>	<b>Vial name:</b>	<b>Vial name:</b>	<b>Vial name:</b>					
	<b>Dilution:</b>	<b>Dilution:</b>	<b>Dilution:</b>	<b>Dilution:</b>	<b>Dilution:</b>					
	<b>Vial top color:</b>	<b>Vial top color:</b>	<b>Vial top color:</b>	<b>Vial top color:</b>	<b>Vial top color:</b>					
	<b>Content:</b>	<b>Content:</b>	<b>Content:</b>	<b>Content:</b>	<b>Content:</b>					

Date:	Int.	Health Screen?	Allergy Med?	Peak Flow	Epi Pen?	Arm	Dose	Reaction	Arm	Dose	Reaction	Arm	Dose	Reaction	Arm	Dose	Reaction	Arm	Dose	Reaction

**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.