Allergy Patient Dosage Recording Sheet

MUST BE COMPLETED AND RETURNED

Beth Rupp MD, Jerri Adkins RN, Kelsey Vaughn RN, Alicia Marte, RN

INDIANA UNIVERSITY STUDENT HEALTH CENTER
600 NORTH JORDAN AVENUE, BLOOMINGTON, IN 47405
Phone: 812-855-7514 **Fax: 812-856-8729**

Rev. 6/17

Patient:	**Allergist Office:**
	Doctor Name:
DOB:	**Address:**
Diagnosis:	
History:	**Phone:** **Fax:**
	Hours:

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

Vials Expire:

EpiPen Expiration:

						Vial name:			**Vial name:**			**Vial name:**			**Vial name:**			**Vial name:**		
						Dilution:			**Dilution:**			**Dilution:**			**Dilution:**			**Dilution:**		
						Vial top color:			**Vial top color:**			**Vial top color:**			**Vial top color:**			**Vial top color:**		
						Content:			**Content:**			**Content:**			**Content:**			**Content:**		
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 Instuctions, Build-up or Maintenance Schedules, Guidelines for Local Reactions, or Instructions for Missed Scheduled Injections, see Patient Instruction Sheet.