Allergy Patient Dosage Recording Sheet

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MUST BE COMPLETED AND RETURNED

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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.