University Health Center
Student Affairs
UNIVERSITY OF GEORGIA

NAME: _____

UGA ID#:_____

Date of Birth:_____

Allergy & Travel Clinic
University Health Center
Athens, GA 30602-1755
Phone: (706) 542-5575
Fax: (706) 583-8255

Dear Provider,

Your patient will be a student at UGA, and the RN staff at University Health Center are happy to continue providing your patient's prescribed immunotherapy. Thank you for assisting us to make this a smooth transition for your patient. Please feel free to contact us with any questions.

The following UHC guidelines establish requirements for our care, and are designed with your patient's safety in mind.

- All vials must be clearly labeled with the patient's name, date of birth, contents, dilution, and expiration date.
- Instructions must include build-up and maintenance schedule, dose, frequency, and directions for dose adjustments if needed for local reactions or if the patient is off-schedule.
- Provide a definition of what you identify as a local reaction and instructions if one should occur.
- Attach a copy of the signed informed consent for immunotherapy from your office. This must accompany these forms before any injections can be administered.
- Include contact information below for a licensed individual in the practice (other than the physician).
- Vials and required forms may be hand delivered or mailed to the address above. Please contact the Allergy & Travel Clinic in advance to ensure the student health center will be open to receive the vials.
- All allergy injections at UHC are provided by RNs. A physician and ACLS emergency equipment are available at all times allergy injections are scheduled.

Current Medications:	
Food/other allergies:	
Drug allergies:	
Past Medical History:	
Does the patient require pre-medication?	Name of medication:
Do you require a peak flow measurement?	If so, minimum to receive allergy injection?
Has the patient been instructed to carry an EpiPen with them on injection days?	
Date of first immunotherapy injection:	Date of most recent injection:
Hx of anaphylaxis (for any reason):	

Physician Name (please print):_____

Physician signature:_____**Date**:_____

Office contact:_____**Phone**:_____ **Fax**:_____

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