Allergy Antigen Administration Record

Patient Name:_____ DOB:_____ Phone:_____

Physician:_____ Practice Name:_____ Phone:_____

Date of last dose/injection:_____ (Please attach recent administration records)

See *Allergen Immunotherapy Order Form* for Injection schedule.

	Vial: Frequency: Dilution: Expiration:			Vial: Frequency: Dilution: Expiration:			Vial: Frequency: Dilution: Expiration:			Vial: Frequency: Dilution: Expiration:			Comments
Date	Dose/mL	Site	Initial	Dose/mL	Site	Initial	Dose/mL	Site	Initial	Dose/mL	Site	Initial	

Allergy Desensitization Maintenance Therapy at Caltech Student Wellness Services (SWS)

This agreement is for students who have successfully completed the initial **Build-Up Phase** of Subcutaneous Immunotherapy (SCIT) with an outside allergist and are transferring to the SWS for maintenance injections. The student must have completed at least (4) maintenance doses without anaphylaxis to continue with SWS for maintenance therapy.

I. Pre-Treatment Requirements

1. **Prior Allergist's Approval:** You must be established in maintenance therapy and have a current, active treatment plan from a board-certified allergist.
2. **Required Documentation:** Prior to your first injection at SWS, you must provide the following documentation from your prescribing allergist:
    a. **Current Allergen Immunotherapy Order Form:** This must clearly state the antigen name(s), the specific concentration/dilution (e.g., 1:1 w/v), the exact dose (volume in mL) for the next injection, and the recommended injection interval (e.g., every 3 weeks).
    b. **Copy of Skin Test Results/Diagnosis:** Documentation confirming the specific allergens you are being treated for.
    c. **Detailed Reaction History:** A record of all previous injection dates, the dose given, and any local or systemic reactions experienced.
3. **Allergen Extract Vials:** Your current, unexpired allergen extract vials must be delivered to SWS by you or your allergist's office.
    a. **Vial Labeling:** Each vial must be clearly and individually labeled with your name, date of birth, antigen name, concentration/dilution, and the expiration date.
    b. **No Mixing/Dilution:** SWS staff will **not** mix or dilute extracts. All preparations must be done by your outside allergist's office.
    c. **Storage:** Vials will be stored in a temperature-monitored refrigerator at the Health Services clinic. A medication storage agreement will need to be signed by you and a SWS provider
4. **Epinephrine Auto-Injector:** You **must** possess a current (non-expired) epinephrine auto-injector (e.g., EpiPen, Auvi-Q) and have it with you at all times including at your appointments.

II. Maintenance Injection Protocol

Procedure	Details
Scheduling	Injections are typically administered by a nursing staff (nurse practitioner, registered nurses, licensed vocational nurses) and/or medical assistance under direct supervision during specific clinic hours and are **by appointment only**. Schedule your next appointment *before* leaving the clinic to ensure proper spacing.

Injection Interval	The frequency is based on your allergist's order, usually **every 2 to 4 weeks**. Deviation from the prescribed schedule may require a dose reduction.
Pre-Injection Assessment	The nurse will perform a pre-injection assessment at every visit, which includes: • Reviewing your current health (no acute illness, fever, or new medications). • Reviewing your asthma status (if applicable): Asthma must be well-controlled. You may be asked to perform a **Peak Expiratory Flow Rate (PEFR)** measurement. The injection will be deferred if PEFR is below your baseline or the prescribed limit. • Checking for any reactions to the previous injection.
Injection Administration	The injection is given subcutaneously (SC), typically in the back of the upper arm. If multiple injections are needed, they are usually given in opposite arms at the same visit.
Post-Injection Observation	This is mandatory for safety. You **must remain in the clinic for a minimum of 30 minutes** after receiving the injection to be monitored for a potential systemic reaction (anaphylaxis).

III. Patient Responsibilities

- **Follow Your Specialist's Order:** The most important rule is to follow the schedule exactly as ordered by your allergist. Their protocol overrides any general guidelines.
- **Timeliness:** Be punctual for your appointment, allowing **45 minutes to 1 hour** for the entire process (check-in, injection, and post-injection required observation).
- **Adherence to Schedule:** If you miss an injection or there is an extended delay, the dose may need to be reduced as per your allergist's protocol to prevent a reaction or we may be unable to administer your injection. It is your responsibility to monitor your schedule.
- **Activity Restrictions: Avoid strenuous exercise, hot showers/baths, and alcohol** for at least **2 hours** following the injection, as these activities can increase blood flow and the risk of a reaction.
- **Medication Management:** Notify the nurse if you are taking any new medications, especially **beta-blockers**, as these are a contraindication to SCIT.
- **Renewals:** You are responsible for monitoring your vial supply and ensuring your allergist sends a new order and new vials *before* the current ones expire or run out.
- **Illness is an Exception:** Do not miss a dose because of a *minor* illness, but **do not receive the injection** if you have a fever, uncontrolled asthma, or a severe infection. In these cases, consult the providers at SWS.

Agreement For Students Receiving Maintenance Allergy Injections at Caltech Student Wellness Services (SWS) - Health Services

I, the undersigned student, understand and agree to the following policies, and I take full responsibility for adhering to the requirements of my Allergen Immunotherapy (SCIT) treatment at the Caltech Student Wellness Center.

1. Responsibility for My Treatment

- I acknowledge that my allergy treatment plan, including the maintenance dose, schedule, and dose adjustments, is **prescribed by my outside, board-certified allergist** (the Specialist). The SWS staff are administering this treatment according to the Specialist's written orders, but SWS is not responsible for prescribing or modifying the core therapy.
- I understand that the effectiveness and safety of my therapy rely entirely on **my commitment to the schedule** and adherence to all policies.
- I understand that **I am solely responsible for ensuring my allergy specialist provides SWS with a current, signed dose adjustment protocol** for missed injections and that I provide all necessary documentation.

2. Responsibility for Scheduling and Compliance

- I understand that my injections are by appointment only, and I will **schedule my appointments in advance** to adhere to the prescribed frequency (e.g., every 4 weeks).
- I understand that **missing a scheduled injection or being significantly late will require a dose reduction**, which may delay my treatment progress and require more frequent visits to build my dose back up, or may result in being unable to receive my injection at SWS
- I agree to inform the SWS staff immediately if I have started or stopped any medications, especially **beta-blockers** (including eye drops), as they are a high-risk contraindication to receiving an injection.
- I understand that I **must not exercise vigorously, take a hot shower/bath, or consume alcohol for at least 2 hours** after receiving the injection.

3. Responsibility for Safety and Observation

- I certify that I will **bring my non-expired epinephrine auto-injector (e.g., EpiPen)** to **every single injection appointment**, and I am trained on how to use it.
- I understand that **I must remain in the SWS clinic for a minimum of 30 minutes** after every injection for observation. I will report any symptoms (itching, swelling, cough, dizziness) immediately to the nurse during this time. I understand that leaving early or failing to report symptoms is a direct violation of this policy and puts my health at risk.

- I understand that the injection will be **deferred (held)** if I have a fever, an acute illness, or if my asthma symptoms are not well-controlled.

In the absence of detailed instructions from the allergist, for any dose that falls outside the window specified on the original allergist's order form (e.g., if the injection is > 6 weeks overdue):

1. **The injection will be held.**
2. **The SWS provider will contact the prescribing allergist's office** to obtain a **new, signed written order** with the exact dose to be administered.

By signing below, I affirm that I have read and understand this agreement, and I accept full responsibility for meeting these requirements throughout my immunotherapy maintenance at the Caltech Student Wellness Services.

Student Signature: _____Date: _____

Student Name (Printed): _____

Student Date of Birth: _____

Caltech Student Wellness Services: Allergen Immunotherapy Administration Guidelines for Providers

Dear Provider,

Caltech Student Wellness Services is committed to providing the **safest and most effective care** possible for our students receiving allergen immunotherapy. Your cooperation with these established safety guidelines is both **required and greatly appreciated**.

To maximize patient safety and minimize the risk of error that comes with reviewing numerous unique forms, the Caltech Student Wellness Services utilizes our own **standardized Allergen Immunotherapy Administration Form**. This form **must** be completed and submitted to our clinic *before* a student patient can begin or continue receiving injections here.

Requirements for Transfer of Allergy Immunotherapy Care to Caltech SWC

To ensure the safety of our students, we have established the following non-negotiable requirements:

1. **Maintenance Phase Only:** We can only administer injections for students who are already on **maintenance vials**. Students in the **building/escalation phase** must transfer their care to a local allergy specialist until they have reached their maintenance dose.
2. **Initial Maintenance Doses:** The student must receive their **initial maintenance injections** in your office. We require that the student receive a **minimum of four (4) maintenance doses** in your care **without experiencing a serious or anaphylactic reaction** before we can assume care.
3. **Severe Reaction History:** We cannot accept care for patients with a history of **more than two (2) anaphylactic reactions** during immunotherapy treatment, or a reaction within the **past four (4) weeks**. These students must be managed by a local allergy/asthma specialist.
4. **Extract Preparation:** The Student Wellness Center **will not mix or dilute** any extracts. This preparation **must** be performed by the prescribing allergist. We will store the pre-mixed extracts in a temperature-controlled refrigerator in our clinic.
5. **Vial Labeling:** Each vial must be **clearly and completely labeled** with the following information:
    a. Patient's Name and Date of Birth
    b. Vial Number and Name of the Antigen(s)
    c. Dilution (e.g., 1:1, 1:10)
    d. Expiration Date
6. **Allergen Immunotherapy Order Form:** The Caltech Student Wellness Services must have a completed allergen immunotherapy order form in order to provide care and injection services to the student. We **DO NOT accept** "see attached" or the use of your office forms.

Caltech Student Wellness Services Procedures

- **Provider Discretion:** We reserve the right to refer any student to a local Allergy Specialist if the Caltech SWS provider determines that it is appropriate and safer for the student. Reasons include, but are not limited to: severe allergic reactions or a high-risk medical history.
- **SWS Clearance:** After all paperwork is submitted, the student will have an appointment with one of our providers to review the documentation and be **cleared** to begin receiving injections at Student Wellness Services.
- **Fees:** We **do not participate in or bill any insurance plans**.

These requirements are based on **patient safety**. Failure to comply with these guidelines will result in delays and may prevent the student from utilizing our services.

Sincerely,

Caltech Student Wellness Services
1239 Arden Road
Mail Code 1-8
Pasadena, CA 91125
626-395-8331
626-585-1132 (fax)

*Please ensure the **Caltech Student Wellness Services Allergen Immunotherapy Order Form** is completed and provided to us prior to the student's arrival.*

Allergen Immunotherapy Order Form

For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form must be completed to provide standardization and prevent errors. ***Patients will only be accepted if they have received at least 4 doses from their maintenance vial with no serious reaction. Patients with history of more than 2 anaphylactic reactions during immunotherapy treatment, or a reaction in the past 4 weeks, should have care transferred to a local allergy/asthma specialist.*** Failure to complete this form will delay or prevent the patient from utilizing our services. Form can be delivered by the patient, mailed, or faxed (see address and fax above).

Patient Name: _____ Date of Birth:_____

Physician:_____ Office Phone:_____ Secure Fax:_____

Office Address: _____

Physician Signature: _____Date:_____

PRE-INJECTION CHECKLIST:

- Is peak flow required prior to injection? NO ☐ YES: ☐
  - **If yes**, peak flow must be ≥ L/min to give injection.
- Is student required to pre-medicate (e.g. with antihistamine) prior to injection? NO ☐ YES ☐
  If Yes, please indicate preferred medication and lead time allowed prior to injection (Ex: Same day, 30-60 min prior, etc.)

INJECTION SCHEDULE:

Frequency- Every___to____days/weeks (circle one)

Vial #/Mix					
Dilution					
Vial Cap Color					
Expiration Date(s)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Dosage	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml

If the patient is ill (wheezing, fever, hives, etc.) the injections should be withheld and rescheduled for when the patient is feeling better/improved.

Required Dose Adjustment Protocol

Please complete the patient-specific protocol below for missed maintenance injections. This specific instruction sheet will be followed by SWS nursing staff.

Tolerance Maintenance Window:

- **Maximum Interval Allowed for Full Maintenance Dose:** Patient may receive the full maintenance dose if the interval since the last injection is ≤ _____ **weeks** (or ≤ _____ **days**).
- *Note: If the interval exceeds this window, the dose must be reduced as per your instructions below.*

Time Since Last Injection (Maximum Interval: _____ days)	**SPECIFIC DOSE ADJUSTMENT ORDER**
Up to __ Weeks (__ days)	❑ **Repeat** the full maintenance dose (_____ mL).
__ to __ Weeks (__ to __days)	❑ **Reduce Dose** to _____ **mL** .
__ to __ Weeks (__ to __ days)	❑ **Reduce Dose** to _____ **mL**.
Over __ Weeks (__+ days)	❑ **DO NOT INJECT.** SWS will contact your office for a **new written order** to restart therapy.

New Maintenance Vial Dose Adjustment Protocol

Please complete the patient-specific protocol below for injections from a new maintenance vial. This specific instruction sheet will be followed by SWS nursing staff.

- **Dose Progression:** Doses should be increased as tolerated.
- **Missed Doses:** If the interval between injections is more than 2 weeks, do not increase the dose; instead, repeat the previous dose.

Injection Phase	**Frequency**	**Dose (ml)**
Escalation	Every ____x per week	____ ml
Escalation	Every ____x per week	____ ml
Escalation	Every ____x per week	____ ml
Maintenance (M)	Every ____x per week	____ ml

Protocol for Managing Injection Reactions

The SWS nursing staff will follow this protocol for immediate treatment. The **Prescribing Allergist must complete the specific dose adjustment plan** below for the next scheduled injection.

A. Local Reactions (LR) / Large Local Reactions (LLR)

Local reactions are confined to the injection site. SWS nursing staff/provider will immediately treat the patient with ice and/or topical steroids, and/or oral antihistamines and observe for 30 minutes.

Reaction Description	**Prescribing Allergist's Dose Adjustment Order for the NEXT Injection (Check one box and fill in required details)**
Local Reaction (LR): Itching, redness, or swelling **≤2 cm** (Dime-sized) at the injection site.	❑ **Repeat** the last dose (_____ mL).
Large Local Reaction (LLR): Swelling or redness **≥2 cm** that resolves within 24 hours.	❑ **Repeat** the last dose (_____ mL). ❑ **Reduce Dose** to _____ **mL** (or _____**%** of the last dose).
Prolonged LLR: Swelling or redness **lasting ≥24 hours.**	❑ **SWS staff MUST contact your office for a new written order.**

B. Systemic Reactions (SR)

Systemic reactions involve symptoms away from the injection site and are treated immediately as an anaphylactic event by the SWS nursing staff/provider on duty.

IMMEDIATE TREATMENT STANDING ORDER: If a Systemic Reaction (generalized hives, wheezing, throat tightness, or low blood pressure) is suspected, the SWS nursing staff/provider will immediately administer **Epinephrine 0.3 mL (1:1000) IM** and call 911/campus emergency services.

Reaction Severity	**Prescribing Allergist's Dose Adjustment Order for the NEXT Injection (Check one box and fill in required details)**
Mild Systemic Reaction: (e.g., localized hives away from site, nasal congestion, mild cough)	❑ **Reduce Dose** to _____ **mL** (This should correspond to a **1-step or 2-step reduction**). ❑ **SWS staff MUST contact your office for a new written order.**
Moderate to Severe Systemic Reaction: (e.g., generalized hives, wheezing, vomiting, dizziness, hypotension)	❑ **DO NOT INJECT. SWS staff MUST contact your office for a new written order to restart therapy at a reduced concentration.**

Prescribing Allergist's Authorization for Reaction Management:

I have reviewed the Caltech SWS immediate treatment protocol for reactions and have provided the specific dose adjustment orders above for the student's ongoing safety.

Physician Name (Print): _____Office Phone: _____

Physician Signature: _____Date Signed: _____

Protocol for Removal and Transport of Allergen Extracts (Serums) from SWS

This protocol outlines the procedure for the safe and documented temporary removal of allergen extract vials (serums) from the Caltech Student Wellness Services (SWS) for transport during academic breaks, travel, or transfer of care.

1. General Requirements and Student Responsibility

1. **Prior Notification:** The student must notify SWS staff **at least one week prior** to the required removal date to allow adequate time for preparation, documentation, and cooling element freezing.
2. **Consent & Responsibility:** The student must sign the **Allergen Serum Removal and Transport Release Form** (See Section 4), acknowledging that they assume all responsibility for maintaining the temperature and integrity of the vials once they leave SWS custody.
3. **No Guarantee of Quality:** SWS staff will assist in packaging the serums correctly, but **cannot guarantee the potency** of the extracts once they have been transported by the student or third party.

2. SWS Staff Preparation Procedure

1. **Verification:** The NP or medical assistant verifies that the student is the owner of the vials and that the vials are correctly labeled with the student's name, DOB, contents, and concentration.
2. **Documentation (Exit Log):** The staff member logs the removal in the student's chart under a Miscellaneous Note, noting the following:

a. **Date and Time of Removal:**

b. **Vials Removed:** List the specific concentration for each vial (e.g., Vial #4, 1:1, Maintenance).

c. **Recipient:** Name of the person picking up the vials (Student or authorized individual).

d. **Purpose:** (e.g., Summer Break, Winter Break, Transfer of Care).

3. **Packaging (Cold Chain):**

a. **Insulated Container:** The vials are placed into a thermally insulated container (e.g., a small cooler, lunch bag, or specialized transport kit) provided by the student.

b. **Cooling Elements:** The vials are packed securely with sufficient frozen gel packs (that SWS may freeze if provided ahead of time) to maintain the cold chain. **Note:** Vials must **not** touch the frozen packs directly to prevent freezing, which can compromise the serum potency. Use a buffer (paper towel or bubble wrap).

c. **Temperature Requirement:** The package must be kept at refrigerator temperature (2°C to 8°C OR 36°F to 46°F).

4. **Final Check:** The staff member reviews the signed Release Form and the student's contact information.

3. Student Guidelines for Transport

The student is verbally instructed on the following critical points:

- **Continuous Refrigeration:** Upon reaching the destination, the serums must be immediately transferred to a refrigerator (2°C to 8°C OR 36°F to 46°F).
- **Avoid Freezing:** Serums should **never be allowed to freeze**, as this destroys the antigen. Keep them away from the freezer compartment or cold spots in the refrigerator.
- **Temperature Extremes:** Serums must **never be exposed to heat** (e.g., left in a hot car, direct sunlight).
- **Next Injection Location:** If receiving injections elsewhere, the student is responsible for contacting the receiving clinic to coordinate dosage and storage requirements

Allergen Serum Removal and Transport Release Form

Caltech Student Wellness Services (SWS)

I. Patient Information

Student Name: _____ Student ID: _____

II. Serum Removal Details

Date of Removal: _____ Intended Destination: _____

Vial Contents Removed (SWS Staff to Complete):

Vial 1 (Concentration/Dilution): _____

Vial 2 (Concentration/Dilution): _____

III. Patient Agreement and Release

I, the undersigned, acknowledge receipt of the allergen extracts listed above. I understand and accept the following:

* I am solely responsible for providing an adequate insulated container and necessary frozen packs for transport.

* I am solely responsible for maintaining the correct temperature (2°C to 8°C OR 36°F to 46°F) of the serums during transport and storage to prevent loss of potency.

* I understand that freezing or heating the serums will destroy their effectiveness, and SWS is not responsible for the clinical outcome if the cold chain is broken.

* I will immediately transfer the vials to a stable refrigerator upon arrival at the destination.

* I release the Caltech Student Wellness Center and its staff from any liability arising from the handling, transport, or storage of these vials after they have been signed out and left the SWS facility.

Student Signature: _____ Date: _____

SWS Staff Signature: _____ Date: _____