UNIVERSITY OF MARYLAND
UNIVERSITY HEALTH CENTER

University Health Center
Building 140, Campus Drive
College Park, Maryland 20742

Tel.301.314.8115 Fax.301.314.5234
Revision Date: February 2025

Dear Allergy Clinic Physician,

The following patient would like to receive injections at the University of Maryland University Health Center:

Name:_____ **DOB:**_____

We need the following information to determine acceptance of your patient into our Allergy Clinic for the administration of their allergy injections.
Please note that the patient must have received at least one dose in your office before we can accept them in our clinic. We will administer a maximum of 3 injections per patient.

- Please include sufficient serum to last the patient for 4 months.
- Does your patient have a history of **asthma**? **Yes / No**
- History of **Anaphylaxis**? **Yes / No**
- Does your patient use antihistamine therapy prior to receiving allergy injections? **Yes/ No**
- Is your patient on beta-blockers? **Yes / No** Do you require a peak flow? **Yes / No**

Allergy injections will not be administered without a physician being in the Health Center. A mandatory 30-minute wait after receiving injection(s) is enforced. **We do not mail allergy serum back to the patient or MD office.**

Physician Immunotherapy Chart **(2nd required form): Please list the content, concentration, vial color and expiration date of each vial the patient will be receiving.**

Date of last injection	**Dose administered**	**Vial #/Color**	**Number of Vials sent**

FREQUENCY OF INJECTIONS: DURING BUILD UP	**DURING MAINTENANCE**

Instructions if patient is late for injections during *BUILD UP*:		
One week	**Two weeks**	**Three weeks**
When your office must be notified:		

Instructions if patient is late for injections during *MAINTENANCE*:	
One Injection	**Two Injections**
When your office must be notified:	

Physician Signature: _____ Date: _____