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Allergy Injections

Student Instructions and Responsibilities

The student is responsible for the following:

Providing Documentation:

Giving their allergist a copy of the letter explaining UHC policy on receiving Immunotherapy (IT, or allergy shots). All necessary information must be received and reviewed by UHC nurses prior to starting injections.

- ***Note:*** The UHC will not administer injections from inadequately labeled vials or if a physician's instructions are missing or incomplete.
- *Note:* If a student has a history of severe reactions, the UHC reserves the right to refuse to administer injections and will refer the student to local allergists.

Medical Clearance:

Meeting with a UHC medical provider to be cleared for allergy shots (required for all new Allergy Clinic patients). All necessary information must be reviewed during this appointment.

Appointments and Fees:

Making and keeping allergy shot appointments during allotted times at the UHC. A $25 cancellation fee will apply to missed appointments.

Ordering Antigen:

Ordering antigens from their allergist and bringing the antigen(s) to the UMD UHC:

- **Serum Check-Out:** Checking out their serum and a copy of their record during holiday periods and at the end of the academic year.
- **Travel:** Arranging their own injections while they are away from campus.
- **Complying with Instructions:** Reading and understanding the Allergy Immunotherapy Instructions.
- **Alerting Nurse to Reactions:** Alerting the nurse of any reaction to the allergy shot, both immediate and delayed.
- **Post-Injection Observation:** Remaining in the clinic for 30 minutes after the injection so UHC staff can observe for a reaction.
- **Injection Limit:** The UHC will administer a maximum of 3 injections per patient.

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Allergy Shot Reactions and Complications

General/Mild Reactions

Shot reactions are generally mild and include:

- Burning or itching at the injection site
- Swelling or hives at the injection site
- Generalized hives (welts)
- Nasal congestion and/or "runny nose" with itching of ears, nose, or throat and/or sneezing
- Itchy watery or red eyes
- Swelling of tissue around the eyes, the tongue or throat
- Stomach or uterine (menstrual-type) cramps

More Severe Reactions

- **Occasional Severe Reactions:** Wheezing, cough, and shortness of breath.
- **Rare Complications:**
  - Abnormalities of the heart beat
  - Loss of ability to maintain blood pressure and pulse
  - Severe reactions involving the heart, lungs, and blood vessels could be fatal. However, if recognized and treated early the risk is reduced.

"Beta Blocker" Drug Warning

I am aware that allergy injections **MUST NOT** be given to patients taking or using "Beta Blocker" drugs. These drugs increase the likelihood of systemic reactions and make such reactions more difficult to reverse.

I certify that I am not taking or using these drugs now, and if in the future these drugs are prescribed for me, I agree to inform the Allergy Clinic Nurse at that time.

Examples of "Beta Blockers"

- Betapace
- Betoptic (Bexaxotol Propranolol)
- Blocadren (Timolol)
- Cartol
- Corgard (Nadolol)
- Corzide (Nadolol & Bendroflumethiazide)
- Inderal (Propranolol)
- Inderide (Propranolol & Hydrochlorthiazide)
- Kerlone
- Levatol
- Lopressor (Metoprolol)
- Normdyne
- Sectral
- Tenoretic (Atenolol & Chlorthalidone)
- Tenormin (Atenolol)
- Timolide (Timolol & Hydrochlorthiazide)
- Timoptic (Timolol)
- Trandate
- Visken (Pindolol)
- Zebeta
- Ziac

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Informed Consent and Acknowledgment

I hereby give consent to the University of Maryland Health Center for allergy immunotherapy. I further consent to the performance of such additional procedures as are indicated or considered necessary in the judgment of the treating physician to treat any reactions to the allergy injections.
I have been fully informed of the risks connected with the performance of allergy immunotherapy. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the allergy immunotherapy.

Acknowledgment Section

I have read the above and agree to comply with the above policy:

STUDENT NAME:	UID NUMBER:	DATE: