Student Health Services
The Ohio State University
1875 Millikin Road
Columbus, OH 43210
Fax 614-292-7042

Last	First	MI
ID		
(Place patient label here)		

ADMINISTRATION INFORMATION FOR ALLERGEN IMMUNOTHERAPY FORM

Please print or type the following information:

Patient Name _____
Last First Middle Initial

Date of Birth _____/_____/_____
Month Day Year

Diagnosis	
History (including previous reactions)	
Date and Amount of Last Injection(s)	
Content, Dilution	
Expiration Date of Vial(s)	
Interval between Injections	
Recommended Dosage	
Dosage Reduction for New Vials	
Dosage Reduction for Lateness	

Allergist Signature _____ Date _____

Printed Name _____ Phone _____

Address _____

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Revised 6/2022