Student Health Services
The Ohio State University
1875 Millikin Road
Columbus, OH 43210

Last	First	MI
ID	(Place patient label here)	

REQUIRED INFORMATION FOR THE ADMINISTRATION OF ALLERGEN IMMUNOTHERAPY

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 07/2016