

**STUDENT HEALTH SERVICES**  
**BUTLER BUILDING**  
**NIAGARA UNIVERSITY, NEW YORK 14109-1923**  
**TEL. (716) 286-8390      FAX: (716) 286-8391**

## INSTRUCTIONS FOR ALLERGY SERUM ADMINISTRATION

Your patient has requested to continue with receiving their allergy serum at the Student Health Center while attending Niagara University. Vaccines are given according to their allergist's schedule and protocol. Please provide all of the necessary information on this form and mail or fax this document to Niagara University's Student Health Services. Your patient will also be speaking with you concerning transporting their allergy serum to the university clinic.

**PATIENT INFORMATION: (Please Print)**

<b>NAME:</b>	<b>DATE OF BIRTH:</b>
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**ALLERGY VACCINE ADMINISTRATION INFORMATION:**

<b>VACCINE SPECIFICS INCLUDING CONCENTRATION, DOSE &amp; EXPIRATION DATE OF SERUM:</b>
Expiration Date: _____
_____
_____

**INSTRUCTIONS FOR MIXING OF SERUMS:**

_____
_____

**SCHEDULE OF ADMINISTRATION:**

_____
_____

**INSTRUCTIONS FOR MISSED DOSES: (1, 2, 3, 4 WEEKS LATE)**

_____
_____
_____
_____

**EMERGENCY INSTRUCTIONS FOR SEVERE REACTIONS:**


**VACCINE RE-ORDER DATE:** \_\_\_\_\_

**DATE OF FOLLOWUP APPOINTMENT WITH ALLERGIST:** \_\_\_\_\_

**OTHER INFORMATION:**


**PHYSICIAN INFORMATION: (Please Print)**

<b>NAME:</b> _____		
<b>ADDRESS:</b> _____		
<b>PHONE NUMBER:</b> (_____) _____		
<b>PHYSICIAN SIGNATURE</b>	<b>STAMP</b>	<b>DATE</b>