

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

Last	First	MI
ID#	(Place patient label here)	

Please Print or Type the Following Information:

Patient Name _____
Last First Middle Initial

Date of Birth ____/____/____
Month Day Year

1) Diagnosis _____

2) History (including previous reactions) _____

3) Date and Amount of Last Injection(s) _____

4) Content, Dilution _____
Expiration Date of Vial(s) _____

5) Interval between Injections _____

6) Recommended Dosage _____

7) Dosage Reduction for New Vials _____
Dosage Reduction for Lateness _____

Physician Signature _____ Date _____

Board Certified Allergist: Yes No Licensed in Ohio: Yes No

Printed Name _____ Phone _____

Address _____

**REQUIRED INFORMATION FOR THE
ADMINISTRATION OF ALLERGEN IMMUNOTHERAPY**