Xavier University McGrath Health and Counseling Center  
Allergy Immunotherapy Check list  

ALLERGIST TO COMPLETE WITH EACH NEW VIAL

Patients Name_________________________ Date of Birth______  Date______

In Accordance with the statement developed by the Drugs and Anaphylaxis Committee of  
the ACAAI, Position Statement on the Administration of Immunotherapy Outside the  
Prescribing Physician’s Office, allergy instructions, vials and shot records must be clear  
and easily understood.

The purpose of the request you to complete the checklist is to ensure the safe  
administration of allergy shots to your patient.

All the following information must be provided before allergy injections are given.  
The information on the check list must be completed by the prescribing allergist office  
whenever new vials of serum are brought to the Health and Wellness Center.

1. Vial is labeled with patient full name and date of birth  Yes____  No___
2. Vials are labeled/coded as to Concentration  Yes____  No___
3. Vials are labeled/coded as to Antigen content  Yes____  No___
4. Vials are coded by number, letter or color  Yes____  No___
5. An explanation of the coding system is included  Yes____  No___
6. Vaccine expiration date is noted  Yes____  No___
7. Schedule indicates the amount and frequency of injections  Yes____  No___
8. Schedule indicates minimum amount of time between injections  Yes____  No___
9. Instructions for reactions are provided  Yes____  No___
10. Instructions for missed/late injections are present  Yes____  No___
11. Number of vials:  1 2 3 4 5 6 Other____
12. Is patient in the process of building up to maintenance?  Yes___  No___
13. Is the build up progression indicated?  Yes___  No___
14. Is the patient receiving his/her maintenance concentration?  Yes___  No___
15. Has the patient had a previous significant local or systemic  reaction?  Yes___  No___
16. If yes, please describe

16. Does the patient have any chronic or severe illness which might affect general health  
or desensitization schedule/ if yes please indicate ___Asthma ___Cardiac___  
Other_____  

Allergist name

Allergist signature or office stamp  
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