



McKINLEY HEALTH CENTER
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

place label here

Name: _____

UIN: _____

Date: _____

Allergy Injection Therapy Orders

Please complete orders for the following vials:

Vial #	Contents	Strength	Frequency	Expiration Date	Date of Last Injection

Is a 20-minute post-injection waiting period acceptable to you or should we require your patient to wait longer?

Yes No If no, how long? _____

Please tell us the minimum number of days permissible between shots: _____

Adjustment for Missed Injections: _____

Building (Series) Adjustments: _____

Maintenance Adjustments: _____

Instructions for Local Reactions: _____

Instructions for Systemic Reactions: _____

Physician Name (printed)		Office Phone	Office Fax
Office	Street	City, State	Zip Code
Please give us your office hours when we may call with questions or therapy issues:			

Physician Signature _____ Date _____

Mail form along with vials to:
Immunization & Travel Clinic
McKinley Health Center
1109 So. Lincoln Ave.
Urbana, IL 61801
Hours: Monday-Friday 8:00 a.m. to 5:00 p.m.
Phone (217) 333-2702 • Fax (217) 244-6495

Reviewed by _____ Date _____