KENTUCKY CHRISTIAN UNIVERSITY

CAMPUS HEALTH CENTER

ALLERGY INJECTION INTAKE FORM

To be completed before beginning allergy injection administration at KCU Campus Health.

Name: _____ Date: _____

When did you begin allergy injections? _____

Date of last injection: _____

During what months are symptoms worse? _____

Does the serum include insect venom? _____

Do you have heart disease or abnormality? Yes _____ No _____ If yes, please explain.

_____

Have or do you have asthma? Yes _____ No _____

Have you ever been hospitalized for asthma treatment or gone to the Emergency Department for asthma treatment? Yes _____ No _____

Have you ever had wheezing or asthma attack post allergy injection? Yes _____ No _____

Have you had rashes, hives or any kind of reaction to a allergy injection? Yes _____ No _____
Please explain: _____

Are you taking any medicines, including over the counter? Yes _____ No _____

Please list: _____

_____