

Carnegie Mellon University

University Health Services

Allergy: New Vial Information/Instructions

We are requesting or have received new allergy serum vial(s) for the student listed below.
Please complete this form for our records.

Patient Name: _____ DOB: _____

Number of New Vials: 1 2 3

Should any existing vials be used in full before starting new vials? Y N

If no, list date to start new vials: _____

VIAL FORMULA

(WE ARE LIMITED TO MAXIMUM OF
3 VIALS)

	NAME of extract vial	Vial Contents	Concentration for each Allergen	Extract Manufacturer	Diluent In ml	Total Volume In Vial	Expiration Date of Vial
1)							
2)							
3)							

New Vial Build-Up Dose & Schedule:

New Vial Maintenance Dose & Schedule:

Allergist Office Name & Phone #: _____

PLEASE RETURN VIA FAX 412-268-6357