

# Yale HEALTH

Welcome to the Yale Health Allergy Department. Yale Health's Allergy Department is for students who have Yale Health Hospitalization/Specialty Care coverage. Our department is staffed by two board certified allergists/immunologists, Florence Ida Hsu, MD, and Ryan Steele, DO, and highly qualified allergy nurses.

If you have already begun allergen immunotherapy and want to continue to receive allergy injections while studying at Yale University we need the following information to safely provide your allergen immunotherapy. Please make an appointment with your home allergist to request the following:

- Immunotherapy extract with proper labeling, including student's name, date of birth, allergens present, and expiration date
- Shipping of your immunotherapy extract under cold storage
- A copy of your administration/injection record or flow sheet
- A copy of your allergy diagnoses and skin and/or blood test results
- A copy of your immunotherapy prescription
- A copy of the last office note from your allergist
- Yale Health Student Allergy Medical Treatment Plan completed and signed by your MD

## Immunotherapy Extract

Your immunotherapy extract must be stored at the clinic.

If you plan to ship your immunotherapy extract please call 203-432-8797 for detailed instructions.

If you bring your immunotherapy extract with you, it must be refrigerated at all times.

## Allergy Injections

**Call 203-432-8797** before you arrive on campus to schedule an initial appointment with the allergy nurse.

At your initial appointment, we will establish a schedule for your injections. Allergy injections are given by appointment on **Mondays, Wednesdays and Thursdays**.

We require all allergy patients to wait in the clinic for **30 minutes** after injections. All patients with a history of systemic reactions are required to carry an epinephrine autoinjector (i.e., EpiPen<sup>®</sup>) on the day of their injections. Please call us with any questions, 203-432-8797. We look forward to meeting you in the fall.

## Fees and Copays

Students with Yale Health Hospitalization/Specialty Care coverage pay a \$25 copay for visits with the allergist. Students who waive Yale Health Hospitalization/Specialty Care coverage are not eligible for these services.

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Allergy Department  
55 Lock Street  
PO Box 208237  
New Haven CT 06520-8237  
Phone: 203-432-8797 Fax: 203-432-0095

Dear Doctor:

Yale Health has an allergy clinic where students who have begun allergen immunotherapy may continue to receive allergy injections while they are studying at Yale University. Your patient has received information about our clinic and the steps they need to take to ensure a smooth transition from home to college.

If you would like your patient to continue to receive allergy injections, please complete the attached medical information form. It is important for you to know that we require all patients with a history of systemic reactions to carry an epinephrine autoinjector (i.e., EpiPen®) on the day of their injections, so you may wish to prescribe this before the student arrives on campus. We also have a 30-minute waiting period following injections.

If you have any questions about our allergy clinic, please call 203-432-8797 to speak with one of us or any of our nurses. We are committed to working closely with you to ensure the safest allergen immunotherapy for your patient.

Sincerely,



Florence Ida Hsu, MD  
Yale Health Allergy



Ryan Steele, DO  
Yale Health Allergy

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## Student Allergy Medical Treatment Plan

2021 – 2022 Academic Year

Due: **August 1, 2021**

**Return by mail to:**

Yale Health  
New Student Forms  
P.O. Box 208237  
New Haven, CT 06520-8237  
Or email: [yhmedicalrecords@yale.edu](mailto:yhmedicalrecords@yale.edu)

Last Name	First Name	
E-mail	Phone	Date of Birth

**Documentation to accompany this form:**

- Diagnoses and skin and/or blood test results
- Administration/injection record or flow chart
- Additional allergy records

***Immunotherapy Extract(s) to Administer***

Vial	Contents	Concentration	Strength	Mix Date	Expiration Date
1					
2					
3					
4					
5					

**History of Significant Reaction**

Date	Type of Reaction (local or systemic)	Treatment

**Order for local reaction:**

**Order for missed or late injection:**

Clinician Signature:	Telephone:	Date
Address:	Fax:	