TIDEWATER
ALLERGY & ASTHMA

Allergen Immunotherapy Serum Release Agreement

I, _____ (name of patient or guardian) give my permission for Tidewater Allergy and Asthma to release the allergen immunotherapy serum formulated for _____ (name of patient) to _____ (name of person picking up the serum).

I am aware that the extract should be kept cool (on ice) while transporting, **but it should not be frozen.** I accept full responsibility for the serum after it leaves Tidewater Allergy and Asthma.

I agree that the patient will get their injections at a doctor's office and or other medical facility where a doctor is present. I am aware that there is an increased potential for reactions from allergy injections when I receive the first injection from a refill vial of allergen immunotherapy extract serum. I also understand that I need to stay at the medical facility for 30 minutes after my injections.

Printed Name: _____

Signature: _____ Date: _____

Patient Date of Birth: _____

Witness: _____

Note to Staff: Please make a copy of the patient's most recent AIT injection schedule, showing the most recent injection, and send it along with the patient.

Tidewater Allergy & Asthma, LLC
4543 Bonney Road, Suite B, Virginia Beach, VA 23462
516 Innovation Drive, Suite 306, Chesapeake, VA 23320
757-499-4101