TIDEWATER
ALLERGY & ASTHMA

Allergen Immunotherapy Patient Consent Form

Immunotherapy, or allergy injections should be administered at a medical facility with a medical provider present because occasional reactions may require immediate therapy. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; coughing; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives, generalized itching; and shock, the last under extreme conditions. Reactions, even though unusual, can be serious, and, rarely, fatal. You are required to wait in in the medical facility in which you receive the injections for 30 minutes after each injection. If the patient is 17 years of age or younger, a parent or legal guardian must be present during the waiting period. I verify that I (or patient) am not taking beta blocker medications or that if I am, I have discussed the risks/benefits of doing so with my physician.

I have read the *Allergen Immunotherapy Patient Information* Sheet on immunotherapy and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of immunotherapy and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions. I also agree that if I have an allergic reaction to the injections that the physician-in-charge has permission to treat said reaction.

I acknowledge the fact with my signature that I am authorizing the office to bill for allergen immunotherapy serum, even if, for any reason, I decide not to initiate the allergen immunotherapy program after the serum vaccine has been made. I understand that there is an additional charge for these allergen serum vaccines and that I am responsible for my copay, deductible, and/or co-insurance, and any other amount not paid by my insurance. The allergen extract will be mixed in the physician's office under the appropriate conditions.

Patient Name _____Date:_____

Parent or Legal Guardian Printed Name _____

Signature of Patient/Guardian_____Date: _____

If I am a parent or legal guardian of a patient, I understand that I must accompany my child throughout the entire 30-minute wait period.

Witness Signature _____Date:_____

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