Allergy and Asthma Associates, Inc.

CONSENT FORM FOR IMMUNOTHERAPY (ALLERGY SHOTS)

Although your hyposensentization program and vaccine have been prepared with the utmost care and precautions, significant reactions may occur after the injection of substances to which you are allergic. Local reactions are common. Reactions may be local swelling, tenderness, and redness. Reactions can be more generalized to include hives, sneezing watery eyes or nose, wheezing or tightness of the chest, hoarseness, and coughing. Generalized reactions occur rarely, but are the most important because of the potential danger of anaphylactic shock which can include, angioedema, collapse, and death. Please let a staff member in the clinic know if you notice any symptoms.

We have thus recommended that injections be given by a trained person in a facility that is equipped to treat anaphylactic reactions under the supervision of a physician. Since most reactions occur with 30 minutes, we require that you remain the clinical area for 30 minutes after the injection. If at any time you do not wait the 30 minutes following your allergy injection, your signature below will releases Allergy and Asthma Associates, Inc and its staff from any medical liability resulting from an anaphylactic reaction.

Some delayed reactions occur after leaving and may need treatment as well. These are seldom emergencies, but may require medical intervention to relieve discomfort and swelling. Take you regular medication and call the office. All reactions must be reported to the medical personnel before receiving your next shot. Describe how severe the reaction was-the size of the swelling by comparing with the size of a coin or piece of fruit.

We require that you notify the office of any change in your health. If you are on a medication for high blood pressure, your heart, or migraine headaches please discuss this with the allergist before receiving allergy injections. Please also notify the physician if there are any changes in your medications while receiving immunotherapy.

I have read and understand the information. I have been given the opportunity to ask questions and am satisfied that my questions have been fully answered. I understand the risks involved with immunotherapy. I consent and authorize to allergy injections and to the treatment of any reactions that may occur.

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Patient Signature Date

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Parent for Minor Signature Date