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CONSENT FOR ALLERGEN IMMUNOTHERAPY

Patient Name (or legal representative) ________________________ Relation _____________

DOB: ___________________________ MRN: ___________________________

I understand that there are risks associated with receiving allergy injections and the following possible reactions have been fully explained to me:

- Common, *local reactions* consisting of swelling and itching at the injections site(s)
- Rare, more severe, *systemic reactions* involving difficulty breathing, swelling of the throat, hives, severe itching, abdominal cramping, drop in blood pressure, and light-headedness. These types of reations, although rare (approximately 1 in 100,000 allergy injections) usually require treatment with antihistamines, epinephrine, and other interventions as necessary to maintain breathing comfort and blood pressure
- Even less likely are fatal reactions due to systemic reactions

For these reasons, I understand that it is **always** necessary to wait in the office of the health care professional for **30 minutes** of observeation after **every** injection.

I understand that once I consent to start Immunotherapy, allergen extract will be prepared specifically for me, and that after extract is prepared there can be no reversal or refund of the extract if I change my mind or fail to adhere to the shot schedule of appointments. I will be responsible for paying any balance due after insurance for extract that is unused due to non-adherence on my part.

The risks and benefits of allergen Immunotherapy as well as alternative therapies have been fully explained to me and I give my consent for this treatment.

Name of patient (or legal representative) ______________________________________

Signature of patient (or legal representative) ______________________________________

Date ___________________________

Revised 11/2020