Gateway Asthma and Allergy Relief

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CONSENT FOR IMMUNOTHERAPY

Patient name _____ DOB: _____ MRN _____

If minor, name of parent or guardian (please print) _____

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 injection site
- ☐ Rare, more severe, **systemic reactions** involving difficulty breathing, swelling of the throat, hives, severe itching, cramping, drop in blood pressure, and light-headedness. These types of reactions, although rare (approx. 1 in 100,000 allergy injections), usually require treatment with antihistamines, adrenaline, and other interventions as necessary to maintain breathing comfort and blood pressure.
- ☐ Even less likely are fatal reactions that have been known to occur after 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 observation after **every** injection.

I understand that once I consent to start immunotherapy, allergy extract will be prepared specifically for me, and that after extract is prepared there can be no reversal or refund of the cost of the extract if I change my mind or fail to be compliant with my shot appointments. I will be responsible for paying any balance due after insurance for extract that is unused or discarded due to noncompliance 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 to this treatment.

_____ _____
(Signature of parent/parent or legal guardian) (Date)