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IMMUNOTHERAPY PATIENT CONSENT FORM

Allergen immunotherapy or "allergy shots" involves the subcutaneous injection of various environmental allergens in order to modify the immune system and improve one's symptoms of allergic rhinitis and/or asthma. The reason to be treated with allergy immunotherapy is to improve symptoms not alleviated with common allergy/asthma medications.

Allergy shots should be administered at a medical facility with a physician present since occasional reactions may require immediate treatment. 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; wheezing; light-headedness; faintness; nausea and vomiting; hives; generalized itching; uterine cramps and hypotensive shock, the last under extreme conditions. Reactions, even though unusual, can be serious but rarely fatal (approximately 5 deaths/year in the United States).

In order to reduce the risks of immunotherapy, the following precautions should be taken:

1) The patient should remain in the office for 20-30 minutes (recommendation of AAAAI) after receiving the injection (if patient is less than 17, a parent or legal guardian must be present). It has been well documented that most severe reactions occur within 20-30 minutes of injections.
2) The patient is prescribed and instructed how to use an Epi-Pen (adrenaline)/ Epi-Pen Jr. syringe should a severe reaction occur after leaving the office
3) The patient should not receive an injection if he/she is ill or has worse asthma or menstrual symptoms than usual
4) The patient should always mention to us a prior allergic reaction to the last injection received
5) Patients on allergy immunotherapy should NOT be on beta-blockers such as atenolol or metoprolol as these medications may cause greater risks of untoward reactions from immunotherapy

I have read the Patient Information Sheet on immunotherapy and understand it. The opportunity has been provided 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 this reaction.

NOTE: I acknowledge that with my signature I am authorizing the office to bill for allergen vaccines, even if for any reason I decide not to initiate the allergen immunotherapy program after the vaccine has been prepared. Vaccines may be prepared up to 1 ½ weeks prior to my appointment. I agree to contact my insurance to obtain prior authorization, if needed for this therapy.

PATIENT: ____ DATE: ________________

PARENT or LEGAL GUARDIAN: ________________________________ DATE: ______________

As a parent or legal guardian I understand that I must accompany my child throughout the entire 20-30 minute wait.

WITNESS: ____ DATE:_____________________