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## **IMMUNOTHERAPY CONSENT FORM**

I certify by signing this consent form that I understand the following:

1. Allergy immunotherapy is a form of treatment designed to reduce or eliminate my allergy symptoms. I desire to begin this form of treatment because my allergy problems have developed to a point where I wish something to be done, in addition to avoidance of my allergens and medications, to reduce them.
2. **I am responsible for payment of antigen mixture made for me even if I fail to initiate or complete a full allergy treatment plan** and regardless of any unforeseen circumstance. Signing this consent form initiates the preparation of an antigen mixture for allergy treatment that is custom formulated for me and cannot be used for any other purpose.
3. **I agree that I will not attempt to administer antigen to myself nor will I permit anyone who is not a licensed physician or under the supervision of a licensed physician to administer it to me.**
4. **Allergy immunotherapy has risks which include anaphylaxis (shock) and death. These risks are minimized by taking an antihistamine prior to every injection** and advancing immunization strength in very small increments. **Although such risks of severe reactions are extremely small, it is MANDATORY to wait in the doctor's office for a minimum of 30 minutes after each injection** is administered to ensure your safety and the proper treatment of possible reactions. **Notify the shot nurse IMMEDIATELY if you have any of the following symptoms after your injection:**
  - } **Any itching not at the injection site**
  - } **Sneezing**
  - } **Stuffy nose**
  - } **Cough, wheeze or shortness of breath**
  - } **Light headedness, feeling faint, nausea or cramping**
5. **I accept all responsibility for any adverse reactions that may occur from receiving allergy injections if I fail to wait for the prescribed 30 minutes in the doctor's office following each injection. Although very infrequent, allergic reactions from allergy injections can occur up to two hours later, so I must remain near a medical facility for that time period.**

**(Please See to Reverse Side)**

6. **I must notify the injection nurse prior to each injection of any reaction from a previous injection, ANY NEW MEDICAL CONDITION I might have (including pregnancy or infection) and ANY NEW MEDICATIONS I am currently taking.** This is especially important for any blood pressure medication. There are some blood pressure medications that can cause dangerous interactions with your immunotherapy program and should be avoided. The injections nurse has a list of those medications. If there are any questions about any medication I am taking that may effect my reaction to allergy injections, I must call the doctor and discuss it.
  
7. There are no guarantees for the outcome of therapy, occurrence of adverse events or the requirement for additional treatment.

|               |                    |      |
|---------------|--------------------|------|
| Patient Name  | Patient Signature  | Date |
| Guardian Name | Guardian Signature | Date |

By witnessing this document, I acknowledge that I have discussed the contents with the patient/patient's guardian and all questions were answered to their satisfaction. It is my assessment that the patient understands the document contents fully.

|              |                   |      |
|--------------|-------------------|------|
| Witness Name | Witness Signature | Date |
|--------------|-------------------|------|

**Office Use Only**

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Account No.: \_\_\_\_\_ Insurance: \_\_\_\_\_

Last Testing Date: \_\_\_\_\_ Antigen Expiration Date: \_\_\_\_\_ Vials (circle one):    Low    Empty