Allergen Immunotherapy Treatment Consent

Immunotherapy, hyposensitization, or allergy injections should be administered at a medical facility with a licensed medical provider. Occasional reactions may occur and require immediate therapy. These reactions may consist of, but not limited to, the following symptoms: itchy eyes, nose, or throat, nasal congestion, runny nose, tightness in the throat or chest, coughing, increased wheezing, lightheadedness, fainting, nausea and vomiting, hives, generalized itching and shock (under extreme circumstances). Even though reactions are unusual, they can be fatal. You are medically required to remain 30 minutes after you have received your injection/s since the majority of serious reactions occur within that time frame. If the patient is a minor, a parent or legal guardian must remain with the patient during the waiting period.

____ Standard build-up

____ Cluster build-up

Injections to be received at which location (please circle):

South County **West County** **Swansea** **Other** ______________________

My Provider is (please circle): **Dr. Borts** **Dr. Dixit** **Dr. Esswein** **Dr. Vitale** **Dr. Warrier** **Dr. Waterhouse** **Laura Kahle, PA-C** **Lauren Davis, PA-C**

I verify that I have discussed the usage of beta blocking medication with my physician and understand the associated risk.

I have read and understand the mentioned medical requirements and have had the opportunity to have my questions answered.

In case of an allergic reaction, I understand I will be treated by a physician or advanced practice provider.

____ _____/_____/_____

Patient Name Date of Birth

____ _____/_____/_____

Signature of Patient or Legal Guardian Date of Signature