

<u>Allergen Immunotherapy Treatment Consent</u>

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 bui	ld-up				
Cluster build-	-up				
# of vials					
Injections to be receive	ved at which location (p	olease circle):			
South County	West County	Swansea	Other		
My Provider is (pleas	e circle): Dr. Borts Dr. Warrier Dr. Wa	•	wein Dr. Temprano Kahle, PA-C Laurer		-C
I verify that I have ounderstand the ass	liscussed the usage ociated risk.	of beta blocking	medication with my	physician a	ınd
I have read and und to have my question	derstand the mention ns answered.	ed medical requ	irements and have h	nad the opp	ortunity
In case of an allerg provider.	ic reaction, I understa	and I will be treat	ted by a physician or	r advanced	practice
 Name			/ Date of Birth		Patient
Signature of Patien	t or Legal Guardian		/ Date of S	/_ Signature	-