LISA SULLIVAN, M.D.

Specializing in Pediatric and Adult Allergy, Asthma and Immunology

ALLERGEN IMMUNOTHERAPY PATIENT CONSENT FORM

Immunotherapy, hyposensitization, or allergy injections should be administered at a medical facility with a medical physician present since occasional reactions may require immediate therapy. These reactions may consist of any or all the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; coughing; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the last under extreme conditions. Reactions, even though unusual, can be serious and rarely, fatal. You are required to wait in the medical facility in which you receive the injections for 30 minutes after each injection. If the patient is 17 years of age or younger, a parent or legal guardian must be present during the waiting period. A physician visit will be scheduled a minimum of three times during the build-up phase to monitor your progress and a physician visit will be scheduled every 6 months or as needed during the maintenance phase to evaluate and individualize your treatment plan.

I have read (if new patient) or re-read (if established patient) and understand the patient information sheet on immunotherapy. The opportunity has been provided for 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 my permission to treat said reaction.

I acknowledge the fact with my signature that 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 made. Vaccines may be prepared up to 1½ weeks prior to my appointment. I agree to obtain prior authorization, if needed, from my insurance plan.

PATIENT NAME_______________________________________ **DATE**__________

PATIENT SIGNATURE________________________________ **DATE**__________

PARENT / GUARDIAN_____________________________ **DATE** ______________

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

WITNESS_______________________________________ **DATE** ______________

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