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Allergy and Immunotherapy Injection Consent

1. I have reviewed the allergy injection therapy information provided to me by South Georgia Pediatric and Allergy Center and have been informed of the indications for this therapy. Although scientifically, rigorous studies have shown that immunotherapy is effective in select patients with allergic conditions, I recognize that no guarantee has been made that this therapy will, in fact, result in a cure or resolution of my symptoms.
2. I understand that allergy immunotherapy does not take the place of avoidance of allergens to which I am known to be sensitized and that the overall effectiveness of this injection treatment program also depends on my complying with recommendations with respect to environmental controls, dietary restrictions, and the use of medications.
3. I recognize the importance for me or my dependent to understand that whenever a person is exposed to a substance to which he/she is sensitive, the possibility of a generalized reaction (anaphylaxis) including shock and even death, exists; although rare especially in children, a few such cases have occurred. Incidentally, this is also true for any administration such as penicillin and any other foreign substance.
4. I understand that allergy injections should be administered in a medical facility. These injections should be given by a trained medical professional under the supervision of a physician who is immediately available to treat any possible adverse reaction. I am required to be observed for a period of at least twenty (20) minutes following an injection in a medical setting. I also understand that I must report any problems which I might recognize or suspect as resulting from an allergy injection to the staff of this office BEFORE receiving any additional allergy injections.
5. I understand that in order to continue allergy injection therapy, that I will make myself available for periodic assessment of my clinical condition in order to allow the physicians to determine if the therapy should be continued or altered.
6. I understand that allergy injections cannot be given to patients who are currently taking beta-blocker medications. Examples of beta-blockers include but are not limited to Inderal, Lopressor and Tenormin. Beta-blockers may be given for a variety of conditions including hypertension, angina, thyroid disease, arrhythmias, certain psychiatric disorders, and glaucoma. I understand I should consult my physician or pharmacist regarding any uncertainty about a specific medication I may take.
7. If allergy injections are received outside of this office and administered at another medical facility, we believe that the physician or medical professional administering the injection must assume complete responsibility for any side effects or adverse reactions resulting from said allergy injection.

Patient's Consent: I have read and fully understand this consent form and consent to be treated with allergic injection therapy. I understand that I should not sign this for if all items, including all of my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND ITS CONTENTS.

______________________________	____	________________
Print Name of Patient	Signature of Patient/Parent/Guardian	Date

_____________________________________	____	________________
Print Name & Job Title of Witness	Signature of Witness	Date

Facility where injections will be given:____

Physician Declaration: The contents of this document have been explained to the patient and all of the patient's questions have been answered. To the best of my knowledge, I feel the patient has been adequately informed and has consented.

____	________________
Physician Signature	Date