Central Mass Allergy and Asthma Care

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AIT IMMUNOTHERAPY PATIENT CONSENT FORM

Immunotherapy, hyposensitization, or allergy injections should be administered at a medical facility with a medical provider present since occasional reactions may require immediate treatment. 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 but rarely fatal. You are required to wait in the medical facility in which you receive injections for at least 30 minutes after each injection.

I have read (if new patient) or re-read (if established patient) the patient information sheet on immunotherapy and understand it. 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 understand that I will be required to have a six-month follow-up appointment after beginning injections. Thereafter, I must have a yearly follow-up with my provider to review my progress and continue to receive injections. I understand that my allergy serum will not be refilled if I am unable to comply with required appointments.

Patient Printed Name DOB

Patient Signature (or parent if patient is a minor) Date

As parent or legal guardian, I understand that I must accompany my child throughout the entire 30-minute wait or sign an authorization form for unaccompanied minor child.