**Next Century Medical Care**

**VENOM ALLERGY SHOT CONSENT FORM**

Immunotherapy, hyposensitization, or venom allergy shots must be administered at the Next Century Medical Care office with a healthcare provider present *since anaphylaxis can occur at any time*. 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.* Your venom allergy shots are from stock bottles and cannot be “Taken-out” to another medical office to be administered. You are required to wait for **20 to 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. I verify that I/patient am not taking beta blocker medications or that if I am,I have discussed the risks/benefits of doing so with my healthcare provider.

I have read “Venom Allergy Immunotherapy Injection Information”, have had my questions answered and understand the potential risks and benefits of venom allergy shots. 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 healthcare provider-in­-charge has permission to treat said reaction, *which may include transport to the local emergency room for advanced care and monitoring.* Leaving before the **20 to 30-minute** waiting time is not advised and understand that it is my responsibility to adhere to this recommendation.

I acknowledge the fact with my signature that I am authorizing the office to *bill for venom allergen vaccines.* I agree to obtain prior authorization, if needed, from my insurance plan.

**PATIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT or LEGAL GUARDIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**As parent or legal guardian, I understand that I must accompany my child throughout the entire 20 to 30-minute wait**.

**WITNESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**