1400 Philadelphia Pike
Suite A4
Wilmington, DE 19809
(302) 375-6746

Take-Out Consent for Allergy Shots

To be completed by the healthcare provider administering the allergy shots:

I will be giving allergy shots to the undersigned patient. I have emergency anaphylaxis medications, including epinephrine readily available. I have informed the patient of the availability or lack thereof to additional resuscitation equipment and medications, including oxygen and intravenous fluids. I will not provide the patient with the allergy shots to take to self-administer or to be administered elsewhere.

_____

Healthcare provider name/office name

_____

Administration address and phone number

_____

Printed healthcare provider name administering allergy shots, including credentials

_____

Healthcare provider signature Date

To be completed by the patient requesting to take-out allergy shots:

Best practices for administering allergy shots is in a medical office with access to healthcare providers capable of treating anaphylaxis, a severe allergic reaction that could result in death. I agree to adhere to this recommendation and take full responsibility for any consequences of receiving allergy shots outside of the Next Century Medical Care office, including replacement cost if my allergy shots become lost or damaged and insurance does not cover replacement.

_____

Printed patient name Patient/guardian signature Date

_____

Printed witness name Witness signature Date