

# Next Century Medical Care

## ALLERGY SHOT CONSENT FORM

Immunotherapy, hyposensitization, or allergy shots should be administered at a medical 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. You are required to wait in the medical facility in which you receive the injections 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 "Allergy Immunotherapy Injection Information", have had my questions answered and understand the potential risks and benefits of 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. It is recommended to have the first shot out of any new vials in our office.

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 allergy shots after the vaccine has been made. The allergen extract will be mixed based on my skin or laboratory testing results in the healthcare provider's office under the appropriate standards and will be prepared in advance. Vaccines may be prepared several weeks prior to starting allergy shots. 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 \_\_\_\_\_