SANJAY SWAMI, MD

IMMUNOTHERAPY PATIENT CONSENT FORM

Immunotherapy, hyposensitization, or allergy injections should be administered in our office since occasional reactions may require immediate therapy. 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 for 30 minutes after each injection. If you are 17 years of age or younger, a parent or legal guardian must be present during the waiting period.

One factor that may increase the chance of serious reactions is the use of drugs known as "beta-blockers." I verify that I am not taking beta blocker medications or that if I am, I have discussed the risks/benefits of doing so with my physician. If you have asthma, your peak flow should be tested prior to each shot. If your peak flow is <80% of its baseline or if you are having asthma symptoms, you should not receive an allergy shot that day.

I have read 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 also agree that if I have an allergic reaction to the injections that the physician-in-charge has permission to treat the reaction.

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 the allergen immunotherapy program after the vaccine has been made. Vaccines may be prepared up to 1½ weeks prior to my appointment. 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 30-minute wait.

WITNESS ______________________________ DATE ____________