Exton Allergy & Asthma Associates
www.extonallergy.com
Angela D'Urso, MD, FACAAI
Soheil Chegini, MD, FAAAAI, FACAAI
656 West Lincoln Highway
Exton, PA 19341
Phone: (610) 269-3066
Fax: (610) 269-8615

CONSENT TO RECEIVE ALLERGEN IMMUNOTHERAPY (ALLERGY INJECTIONS)

Patient's Name _____ **DOB** _____ **Age** _____

I hereby authorize Exton Allergy & Asthma Associates to treat me/my child's condition with allergen immunotherapy (allergy injections). I have received and read the "Information about Allergen Immunotherapy" sheet and a physician has explained to me the nature of this treatment, its risks and benefits as well as the treatment alternatives.

I understand that this procedure involves the injection of allergens in stepwise increments. During the build-up phase weekly injections are necessary to advance to a higher level. Once the maintenance dose is reached, injections are given once a month.

I am aware that the allergen is prescribed and mixed specifically for me/my child and cannot be used for anyone else. One year's supply of allergen extract is prepared at the time of mixing and my insurance carrier will be billed for the entire year's supply at the time the allergen is prepared. It is expected that the maintenance dose is reached in one year before the current supply expires and a new supply of allergen extract is needed.

By receiving allergen immunotherapy I/my child will be at risk of an allergic reaction, the symptoms of which may include itching, hives, difficulty breathing, cough, shortness of breath, difficulty swallowing, light headed or faint feeling and very rarely (less than one chance in a million) anaphylactic shock.

Trained professionals will be present to supervise and provide both appropriate precautionary measures as well as treatment of any complications that may occur. I understand that in the event of any adverse reaction, treatment may be necessary and I authorize whatever treatment is necessary in the judgment of the attending physician(s).

I acknowledge that I must remain under medical observation in the office for 30 minutes after each and every allergy injection and to inform a staff member immediately in case I/my child experience(s) an allergic reaction after an allergy injection. I understand that an allergic reaction to allergen immunotherapy, if not attended to by the office staff will expose me/my child to the risk of a fatal outcome. I will be taking that risk, if I do not adhere to the office rules described above.

I have been given the opportunity to ask questions that have been answered to my satisfaction. I am aware that I have the right to withdraw from the treatment at any time. I hereby sign this document indicating that I have read the entire document and agree to its contents.

_____ _____

Signature of Patient or Parent/Guardian Date

If patient is unable to sign or is a minor, please complete the following:

_____ _____

Printed Name of Parent or Guardian Signature of Physician or Nurse