Chart No:_____

RUSH IMMUNOTHERAPY PATIENT CONSENT FORM

Immunotherapy, hyposensitization, or allergy injections should be administered at a medical facility with a medical physician present since occasional reactions may require immediate therapy. I am aware that 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; and shock, the last under extreme conditions. Reactions, though unusual, can be serious but rarely fatal. I have decided to undergo the rush immunotherapy protocol. I understand that I am at slightly increased risk for reactions to the allergy shots on this rapid protocol. I will take the pretreatment medications as directed and will be prepared to spend the day Dr. Raby and Dr. James office. I will notify the staff of any symptoms, such as itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; coughing; wheezing; lightheadedness; faintness; nausea and vomiting; or hives. I will notify office staff prior to going to the restroom during the course of immunotherapy. I will be monitored clinically throughout the day and will receive multiple allergy injections. I will continue my allergy shots on a weekly basis for 8 weeks before the allergy shots are given at longer intervals.

My signature below indicates that I have read the patient information sheets on immunotherapy and understand them. This signature also indicates my affirmation that I do not have any of the medical conditions described above as contraindications for immunotherapy. If one or more of these conditions is diagnosed by another physician while I am receiving immunotherapy, I will notify Dr. Raby and Dr.James office before I receive any further allergy injections. 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 reaction.

_____

Patient Name Date of Birth

_____

Patient Signature (Parent Signature if Patient Is A Minor Child) Today's Date

_____

Witness Signature Today's Date

Allergy, Asthma, and Clinical Immunology Specialists

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Certified by the American Board of Allergy and Immunology

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