Allergy& ENT Associates

ALLERGY EXTRACT RELEASE FORM

PATIENT NAME: ____

BIRTHDATE: __________________________

I, ______________________________, accept total responsibility for assuring that my allergy injections are administered in a medical facility with a licensed medical physician present. I understand that rare, but possible reactions to allergy injections may include itching of the skin, hives, coughing, sneezing, wheezing, difficulty breathing, chest tightness, choking, swelling of the eyes or throat, hoarseness, nausea, vomiting, abdominal cramping, weakness, dizziness, drop in blood pressure, anaphylaxis or shock and in rare circumstances, death. I understand that allergy injections must be administered with a medical physician present to treat and provide immediate medical attention to the possible reactions listed above.

ALLERGY EXTRACT REFILLS/ RENEWALS:

I understand that refills of antigen are stronger because the concentration may have been increased and antigen strength decreases with time.

I understand that the next injection must be given within ______ days from the last dose. The schedule must be followed to reach maintenance. If the schedule is not maintained, the dose of the injection may need to be adjusted per the instructions sent with the antigen.

I understand that if these instructions are not followed, the risk of systemic reaction is higher.

DOCTOR'S OFFICE WHERE YOUR INJECTIONS WILL BE ADMINISTERED:

Doctor's Name: ____

Office Address: ____

City/Zip Code: ____

Phone Number: __________________________ **FAX #** ____________________

SIGNED:_________________________________ **RELATIONSHIP:**_____________

DATE: _________________________**WITNESS:**___________________________

CIT03.00.