Informed Consent

Allergy Injection Therapy (immunotherapy-hyposensitization)

I have reviewed the subject of allergy injection therapy with my physician of Denver Allergy and Asthma Associates, P.C. and understand the indications (reasons) for this therapy. I recognize that no guarantee has been made that this therapy will in fact result in a cure or resolution for my symptoms.

I understand that allergy immunotherapy does not take the place of avoidance of allergens to which I am known to be sensitized and that the overall effectiveness of this injection treatment program also depends on my complying with recommendations with respect to environmental control, dietary restrictions, and the use of medications.

I understand the allergy injections should be administered under the supervision of a physician. I am required to be observed for a period of at least 20 minutes following an allergy injection in a medical setting and understand that I must report any problems which I might recognize resulting from an allergy shot to the staff of this office before I receive any additional allergy injections.

I recognize that it is important for me or my dependent to understand that whenever anyone is exposed to a substance to which he/she is "sensitive," the possibility of a generalized reaction (anaphylaxis) including: generalized hives, wheezing, difficulty breathing, difficulty swallowing, and in extreme condition, shock, leading to death; although rare, especially in children, a few such cases have occurred. This is also true for any drug administration such as Penicillin, and any other foreign substance.

I understand that I may withdraw from allergy injection therapy at any time without prejudice to my care by the physicians involved. I further understand that if I am to continue on allergy therapy, I will make myself available for periodic assessment of my clinical condition in order to allow the physicians to continue to direct my treatment.

I have been allowed to ask questions about this procedure. In addition, I have read this form and it has been explained to me. I understand the risks involved and intend to undergo allergy injection therapy.

Note: if you have any questions about this therapy, ask them before signing this form.

Patient/Legal Guardian Signature _____

Date _____

Patient's Name (Please Print) _____

Witness _____