Place Patient Label here

Colorado Allergy and Asthma Centers, P.C.
Adult and Pediatric Allergy and Asthma

Patient Consent for Environmental Allergy Immunotherapy (Allergy Injections)

1. I have reviewed the immunotherapy information of Colorado Allergy and Asthma Centers, P.C. with my physician, ___________________________, and I am acquainted with 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 of my symptoms.

2. I am required to be observed for a period of at least 20 minutes following an injection in a medical setting. I also understand that I must report any problems that I might recognize or suspect as resulting from an allergy injection to the office staff before receiving any additional immunotherapy. If a minor child is on immunotherapy and comes into the office unaccompanied by an adult for an injection, it remains the parent's responsibility to inform our office of any problems with the previous injection that the minor child received.

3. I understand that allergy injections should be administered under the supervision of a physician or physician's assistant. I understand that there are risks associated with receiving allergy injections. The major risk is having a reaction to the injection. These reactions may include but are not limited to local reactions at the injection site and uncommonly anaphylaxis (severe allergic reaction). In very rare cases deaths have been reported.

4. I further understand that if I am to continue on immunotherapy, I will make myself available for at least annual assessment of my clinical condition in order to allow the physician to determine if the therapy should be continued or altered. I also agree to promptly inform the staff of any significant changes in my overall health, including pregnancy.

5. I understand that patients receiving immunotherapy may be at increased risk when taking certain medications. For this reason, I agree to notify my CAAC physician and staff of new medicines, and particularly medicine used in the treatment of high blood pressure, that may be started by another physician while I am on immunotherapy. .

6. **Before receiving your injection, please notify the allergy injection staff if you have started a new medication.**

7. **PATIENT'S CONSENT:** I have read this consent form and fully understand this information. I understand that I should not sign this form if all items, including all of my questions, have not been explained or answered to my satisfaction, or if I do not understand any of the terms or words contained in this consent form.

   IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS CONCERNING THE PROPOSED TREATMENT, ASK YOUR DOCTOR NOW **BEFORE SIGNING THIS CONSENT FORM**.

   DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM!

______________________________ ______________________________ ______________
Patient's Printed | Patient/Responsible Party Signature | Date

______________________________ ______________________________
Witness Signature | Date

PHYSICIAN'S DECLARATION: I have explained the contents of this document to the patient and have answered all the patient's questions, and, to the best of my knowledge, I feel the patient has been adequately informed and has consented.

______________________________ ______________________________
Physician's Signature | Date