

PEDIATRIC ALLERGY / IMMUNOLOGY ASSOCIATES, P.A.
ALLERGY & ASTHMA ASSOCIATES OF NORTH TEXAS
dba

DallasAllergyImmunology

PHYSICIAN'S CONSENT TO ADMINISTER ALLERGY SHOTS

I have reviewed the recommendations for giving allergy shots to my patient, _____, as provided by Pediatric Allergy / Immunology Associates, P.A. in the *Guidelines for Injections of Allergen Extracts*. After having reviewed these recommendations and having any related questions answered to my satisfaction, I agree to the following (please initial each item):

Initials

1. The patient will remain in my office for 30 minutes after every allergy shot to observe for any adverse reactions. _____
2. Either I or another licensed physician who is responsible for this patient will be remain on site for 30 minutes following the administration of allergy shots to be available to treat any adverse reactions. _____
3. I have the equipment and medications required to treat anaphylaxis available in my office (e.g., injectable epinephrine, oxygen, nebulized bronchodilators, intravenous fluids and diphenhydramine). _____
4. I or the nurse / medical assistant under my supervision will completely document the required safety checks on the *Allergy Shot Administration Record* at each allergy shot visit, including peak flows measured before and 30 minutes after allergy shots (applies only to patients with asthma); the concentration and dose of each allergy shot; and any reactions occurring after allergy shots. _____
5. I will not permit allergy shots to be given if the patient is taking beta-blocker medications, is having active asthma symptoms, or has peak flows below the recommended cutoff value (80% of personal best peak flow). _____
6. I or the nurse / medical assistant under my supervision will notify Pediatric Allergy Immunology Associates, P.A. of any systemic allergic reactions following allergy shots or any questions regarding the *Allergen Immunotherapy Administration Guidelines*. _____
7. The patient's allergen extract will remain refrigerated in my office at all times. _____
8. I will not permit the patient to take allergy shots at home. _____
9. I will not permit the patient to transport the allergen extract to another medical facility without the written consent of Pediatric Allergy / Immunology Associates, P.A.. _____
10. I or the nurse / medical assistant under my supervision will notify Pediatric Allergy / Immunology Associates, P.A. three weeks before the allergen extract supply expires or is used in its entirety. I will provide a current copy of the *Allergy Shot Administration Record* at the time of re-ordering allergen extract. _____

Physician's Name

Physician's Signature

Date

PATIENT CONSENT TO RECEIVE ALLERGY SHOTS AT AN OUTSIDE MEDICAL FACILITY

I have requested that allergy shots be given to me / my child at the medical facility listed below for reasons of convenience. I understand that I must follow the same safety precautions at this facility as recommended by Dallas Allergy / Immunology, specifically:

- A licensed physician will be available at this facility when allergy shots are being given and during the required 30 minute waiting period thereafter.
- I will indicate to the nurse whether or not I / my child am / is taking beta-blocker medications prior to receiving allergy shots at every visit. I understand that allergy shots must be held if beta-blocker medications are being taken (see I.T. Consent - ***Medications to Avoid During Immunotherapy***).
- Peak flows will be checked before and 30 minutes after allergy shots (applies only to patients with asthma).
- I will report any reactions to the nurse or physician at this facility during the required 30 minute waiting period.
- I will report any late reactions that occur after leaving this facility to the nurse or physician.

I understand that I am responsible for the delivery of allergen extract to this medical facility by one of two methods recommended by Dallas Allergy / Immunology, either (check preferred transport option):

- I will personally transport the extract in insulated packaging to be kept in a refrigerator at the medical facility below within 24 hours of leaving this office.
- I will pay shipping and handling fees for Dallas Allergy / Immunology to deliver the extract to the medical facility below by 12:00 noon the next day.

I understand that the allergen extract is to remain at the medical facility listed below at all times, that it may not be transferred to another medical facility without the written consent of Dallas Allergy / Immunology, and that I may not administer allergy shots to myself / my child at home.

I understand that ***I am responsible for re-ordering allergen extract*** from Dallas Allergy / Immunology ***three (3) weeks*** before the current extract expires or is used in its entirety. I will provide a current copy of the ***Allergy Shot Administration Record*** at the time of re-ordering. ***Payment or predetermination of insurance benefits is required prior to mixing allergen extract.***

My / my child's allergy shots will be given at the medical facility below:

Physician's Name	Clinic Name	()	Phone Number
Address	City	State	Zip Code
Patient's Name (Print)	Parent/Guardian's Name (Print)		
Signature (Patients >12 years old)	Parent/Guardian Signature (Patients <18 yrs old)		
Witness Name (Print)	/	Signature	Date