

# DallasAllergyImmunology

## PHYSICIAN'S CONSENT TO ADMINISTER ALLERGY SHOTS

I have reviewed the recommendations for giving allergy shots to my patient, \_\_\_\_\_, as provided by DallasAllergyImmunology in the *Guidelines for Injection 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 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 DallasAllergyImmunology 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 DallasAllergyImmunology. \_\_\_\_\_
10. I or the nurse / medical assistant under my supervision will notify DallasAllergyImmunology three (3) 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