ALLERGY CONSENT FORM

1. Our designated **"injection hours"** are:
   Monday through Friday, 9:00am-12:00noon, and 2:00pm-4:00pm.
   During HOLIDAYS, contact our office for modified hours.

2. YOU MUST WAIT **20-30 MINUTES** AFTER THE ALLERGY INJECTION.
   If you are unable to wait the full time, we will not be able to give the shot.

3. If patient has a fever, wheezing or active hives, they should not receive an allergy injection. If symptoms need to be treated, please call and schedule an appointment with a provider.

4. During injection times, the nurses giving injections cannot be expected to refill medications or get samples for patients. If you need prescriptions or have any other questions, give the information to the front desk staff.

5. Allergy injections are given as a courtesy for our patients. They are given when time allows the nurses to work them in while seeing scheduled patients.
   Please be understanding if your wait time has been extended.

6. The signs and symptoms of a **systemic reaction** include: cough, flushing, sneezing, itching, shortness of breath, tightness in the chest, hives, runny nose, light headedness, hoarse voice, abdominal cramps, nausea, diarrhea, swelling of lips, itchy throat or mouth, severe nasal congestion or a sense of impending doom. ***These can be life threatening if not treated promptly*;** notify nurse/physician in office immediately. If these symptoms occur after office hours, go to the nearest Emergency Room.

7. The signs and symptoms of a **local reaction** are pain, redness, and/or swelling at the injection site. Ice and/or topical hydrocortisone may be helpful. If this occurs, please notify one of the nurses.

8. If an allergy shot has been missed, call our office so we can get new instructions from your allergist.

9. Children under 12 years old must have an adult present after an injection at all times. Patients 12 years and older may be brought in by someone 16 years or older who also must remain with the patient after an injection. Any patient who is not accompanied by their parent must have the ***"Permission to Treat Anaphylaxis Reaction"*** consent signed below by a parent prior to the injection.

_____
Patient Name / DOB / chart number

_____
Parent/Guardian Signature / Date

_____
Permission to Treat Anaphylaxis Reaction / Date