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CONSENT FOR HYMENOPTERA VENOM/FIRE ANT IMMUNOTHERAPY

- I have completed allergy skin testing. It has been determined that immunotherapy (allergy injections) may be beneficial in the treatment of my allergies. I understand that immunotherapy does not cure my allergic state, but does offer a significant change of improvement. I understand that initial build-up includes receiving injections up to three (3) times per week in a physician's office or clinic. I understand that I must wait **at least 30 minutes** after my injections before leaving the office (due to possible reaction).

  I have been given the opportunity to ask questions and receive answers. I understand that there are risks involved in taking allergy injections. Reactions can be local, systemic (generalized), or even fatal.

- ____ (initial) - I understand that my serum will contain venoms that were positive on my skin test. Venoms to be included in my serum are on my skin test sheet, that is provided by the nursing staff at time of testing.

- I understand that it may be necessary to obtain serum specimens during the course of therapy to evaluate protective and allergic antibody levels. I understanding a minimum of three-five years of treatment is necessary for most people to become desensitized, however, some people require treatment for longer periods of time. I have been given an opportunity to ask questions, and to have those questions answered.

- ____ (initial) – I will be prescribed and Epi-pen in case of a reaction. It is my responsibility to have the prescription filled at my local pharmacy.

- **Do you take a beta-blocker medication such as: Propranolol, Nadolol, Labetalol, Carvedilol or Timolol?** Yes____ No____

- _____ *(initial)* – I give my permission for my minor child (15+) to receive immunotherapy without my presence. Should an emergency occur, I understand that ADAC will follow standard protocol for treatment.

Most insurance providers cover a portion of the cost of immunotherapy, however, there are many coverage variations.
Would you like for someone to contact you regarding your insurance coverage? _____ YES _____ NO

(Please Print - Patients Name)	DOB
Patient/Guardian Signature	Date:
Witness Signature:	Date:

DO NOT WRITE BELOW THIS LINE

_____ HONEY BEE ____ WHITE FACED HORNET ____ FIRE ANT _____ YELLOW JACKET ____ YELLOW HORNET ____ WASP

Provider's Signature _____ Date: _____

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1202 E. Butler Rd.
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