



105 Collier Road Suite 4060 Atlanta, Georgia 30309 404.351.6662 f 404.351.6030 www.piedmontpediatrics.org

INFORMED CONSENT FOR ALLERGY IMMUNOTHERAPY

Allergy Immunotherapy (shots) contain water extracts of pollens, mold, animal dander, or dust components to which a patient has been shown to be allergic by skin testing. With this type of reaction, as with other substances injected into the body, there may be a “shot reaction”. These generally are mild and include:

1. General hives
2. Nasal congestion and/or “runny nose” with itching of ears, nose or throat and/or sneezing
3. Itchy, watery or red eyes
4. Swelling of the tissue around the eyes, tongue or throat, or a sensation of a lump in the throat
5. Stomach or uterine (menstrual-type) cramps

Occasionally, more severe reactions include wheezing, coughing, shortness of breath or chest tightness. Rare complications include abnormalities of the heartbeat and/or a drop in blood pressure. Severe reactions involving the heart, lungs and blood vessels have occasionally been fatal.

It has been shown that patient’s allergy symptoms improve with allergy shots in proportion to the strength of the prescription. It is our philosophy to balance risk versus benefit, to try to get each patient better and off shots in 4 to 5 years while minimizing the unavoidable risk inherent in higher dose therapy as much as possible. To this end, you must receive your allergy shots in location where a physician/nurse practitioner is present. **NO patient will be allowed to self-administer shots.**

Experience has shown that the overwhelming majority of reactions which require emergency treatment occur within 20 minutes of an injection. It is for this reason that all patients who get injections must remain in the office for 20 minutes after receiving their shot(s) until checked out by a clinic nurse or physician. Anyone leaving prior to this does so against medical advice and as such assumes all liability. In case you have a reaction after leaving the office, you will be given a prescription for an epinephrine injector and receive instructions in its use. **In order to get your shot(s) for the day, patients will be required to have their epinephrine injector with them at each visit.**

The overwhelming majority of reactions are mild and easily reversible with treatment with epinephrine and possibly an antihistamine in addition. **If you notice any unusual symptoms after your shot, inform the nurse or doctor or nurse practitioner IMMEDIATELY. Please do not try to “not bother the nurse” or “be sure” before telling us; please let us make the decision as to whether some vague symptoms which you may feel are a genuine reaction.**

In signing this statement, I acknowledge that I have read fully and understand the information that it contains, and that I have been able to have any questions answered by one of the clinical staff or by a physician or nurse practitioner.

MD/NP or COUNSELOR _____

PATIENT (PARENT IF PATIENT IS A MINOR) _____

WITNESS _____ DATE _____

