Dallas**Allergy**Immunology

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 IT 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**Immunolog,y* ***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 _____