

# Dallas Allergy Immunology

## MEDICATIONS TO AVOID DURING IMMUNOTHERAPY

Some medications taken for other medical conditions (especially **Beta Blockers** taken for high blood pressure, migraines or glaucoma, and **MAO inhibitors** taken for depression) may increase the risk of a life-threatening allergic reaction to the allergy shots, and should therefore be avoided while receiving immunotherapy. If you are currently taking any of the following medications or if you are prescribed one of these medicines by another physician while you are receiving I.T., **it is very important that you inform your doctor or nurse prior to starting or continuing allergy shots:**

<u>GENERIC NAME</u>	<u>TRADE NAME</u>	<u>GENERIC NAME</u>	<u>TRADE NAME</u>
Propranolol	Inderal, Inderide	Labetolo	Normodyne, Trandate
Timolol	Blocarden, Timolide, Timoptic	Penbutolol	Levatol
Metoprolol	Lopressor, Toprol	Levobunol	Betagen
Nadolol	Corgard, Corzide	Carteolol	Cartrol, Ocupress
Atenolol	Tenormin, Tenoretic	Isocarboxazid	Marplan
Pindolol	Visken	Phenelzine	Nardil
Acebutolol	Sectral	Tranylcypromine	Parnate
Betaxolol	Betoptic Ophthalmic Drops	Carvedilol	Coreg
Levobetaxolol	Betaxon	Bisoprolol	Zebeta, Ziac
Nebivolol	Bystolic		

## CONSENT FOR TREATMENT I M M U N O T H E R A P Y

I have read and understand fully the attached **Allergy Shot Information** and **Instructions For Patients Receiving Allergen Immunotherapy**. I agree to abide by these instructions in order to minimize the risks of a life-threatening allergic reaction associated with allergy shots. I have had the opportunity to ask additional questions regarding the anticipated benefits and potential risks of immunotherapy. These questions have been answered to my satisfaction.

I hereby give consent for myself / my child to receive immunotherapy injections (allergy shots) and authorize treatment of any reactions that may occur as a result of an allergy shot.

\_\_\_\_\_  
Patient's Name (Print)

\_\_\_\_\_  
Parent/Guardian's Name (Print)

\_\_\_\_\_  
Signature (Patients >12 years old)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (Patients <18 yrs old)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Name (Print) / Signature

\_\_\_\_\_  
Date