ALLERGY INJECTION CONSENT FORM

I have read the patient information "All About Allergy Shots" and understand it. The opportunity has been provided for me to ask questions regarding the possible side effects and these questions have been answered to my satisfaction. I hereby authorize The Allergy & Arthritis Family Treatment Center physician or nurse to perform allergy immunotherapy on me.

_____

Patient/Guardian Date

_____

Witness Date

I have discussed allergy immunotherapy with this patient (or guardian) and have explained the risks and benefits.

_____

Doctor Date