OFFICE OF ATTENDING PHYSICIAN

UNITED STATES CAPITOL
WASHINGTON, DC

ALLERGY CONSENT FORM

I understand that my private physician has recommended that I receive allergy injections and advised me of the expected benefits of having these allergy injections. Furthermore, I understand that I may elect not to have these injections. If I do agree to have these allergy injections, I understand that patients receiving allergy injections are at risk for a variety of potential complications including local reactions, exacerbations of existing asthma, serum sickness, and potentially life-threatening anaphylaxis.

For my general information, I understand that the following are symptoms which may potentially result from my allergy injection:

Itching of the hands, roof of the mouth and nose, flushing of the face, sneezing, hives, asthma, weakness, nausea, vomiting, dizziness, fainting, serum sickness, anaphylactic shock, and death.

I understand the nature of the proposed procedures, attendant risks involved, and expected results as described above, and as explained by my private physician, and hereby request that I receive the recommended allergy injections.

_____ _____

(Signature of Patient) *(Date and Time)*

_____

(Signature of Parent or Guardian if under age 18)

_____

(Signature of Witness)

I have counseled the above patient as to the nature of the proposed procedures, attendant risks involved, and expected results.

_____ _____

(Signature of Private Physician) *(Date and Time)*