



Patient Label

Allergy Immunotherapy Informed Consent Form

I hereby give my consent and authorize the staff at the Johns Hopkins Student Health and Wellness Center (SHWC) to administer allergy immunotherapy (allergy injections) to me in accordance with the protocol provided by my allergist.

1. I understand that allergy injections are a treatment to relieve allergy symptoms by administering injections of substances such as pollens, mold spores, dust mites, animal dander, or insects to which an individual has been found to be allergic by skin testing or other laboratory methods. The probability of success was explained to me by my allergist prior to initiating therapy.
2. I understand that this procedure is generally safe, but that certain risks accompany any treatment. Local reactions are common. General (systemic) reactions are less common but can be serious and can even be fatal. Risks associated with the allergy injection include but may not be limited to the following:
 - Pain or discomfort from the injection
 - Local reaction (e.g. swelling, itching, tenderness at the site of injection)
 - Generalized reactions (e.g. itchy eyes, nose, or throat, runny nose, nasal congestion, sneezing, tightness in the throat or chest, coughing, wheezing, lightheadedness, faintness, sudden nausea, vomiting, and diarrhea, hives, unexpected swelling of eyelids, face, or limbs, itchy skin, flushing or feeling of intense warmth, and under extreme conditions, shock and even death).
 - Failure to obtain the desired effect
 - Need for additional therapy

I understand that I need to remain in the SHWC for thirty (30) minutes after the injection(s), since any reaction of significance will generally occur within this time period. For delayed reaction, my allergist has instructed me how to respond when I leave the health center (taking antihistamines such as diphenhydramine, calling 911, or going to the ER).

3. I understand that I can choose not to have any treatment. I also understand that there are alternatives to this procedure, including allergen avoidance, various prescriptions and other over the counter medications, nasal steroid sprays, decongestants, and referral back to the allergist. The benefits, risks, and side effects of alternatives have been explained to me by my allergist. I have received a copy of the SHWC allergy injection information letter.
4. I understand that the prescription for and mixing of my serum, the contents of my vials, the concentration of my serum, the dosage schedule, the dose adjustment instructions for missed or late injections and/or local reactions, and any other instructions are the responsibility of my allergist, Dr. _____ My

allergist can be reached at (phone#)_____. My allergist and I have provided the SHWC with written documentation of this information.

I realize that the SHWC will store, administer, and assist with reordering of my serum. When the serum is in my possession during transport, I am responsible for the maintenance of the vial(s) according to my allergist's recommendations and for the safety and integrity of the contents.

5. I acknowledge that the nature and purpose of allergy injections, the risks involved, alternatives, and the possibility of complications have been explained to me by my allergist and by the staff of the SHWC. If during the procedure, other conditions are discovered which, in the best judgment of the clinical staff, require something to be done in addition to the procedure or different from the procedure, I consent to the additional or different activity being performed. All my questions have been answered to my satisfaction. If I have further questions, I have the right to have those questions answered. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee has been made as to the results of allergy injections.

6. Because allergy serum is temperature sensitive, we cannot mail or ship your serum to you or to your allergist.

I agree to have allergy immunotherapy at SHWC. I have identified to the provider any restrictions on the sharing of information learned from the treatment. I have not given up my right to refuse treatment at any time.

I allow/do not allow (circle one) observers or technical advisors to be present during the procedure.

I am entitled to a copy of this consent after I sign it.

Clinician's signature _____ Date _____ Time: _____
Patient's signature _____ Date _____ Time: _____

Clinician's signature _____ Date _____ Time: _____
Patient's signature _____ Date _____ Time: _____

Clinician's signature _____ Date _____ Time: _____
Patient's signature _____ Date _____ Time: _____

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Patient's signature _____ Date _____ Time: _____