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**Consent to Allergy Vaccine Therapy**

Allergy vaccine treatment involves the introduction into the body of substances that have been identified through allergy testing, as responsible for my allergic symptoms. This is accomplished by injection therapy with increasing dose of allergy extract at regular intervals.

I am aware that it is possible for an allergic reaction to occur following administration of the allergy vaccine therapy. An allergic reaction has been explained to me and I understand that symptoms can include itching, pain, and swelling at the site of the injection; sneezing; itchy and runny nose; cough; itching of the throat, itching and swelling of the eyes, itching of the palms of hands and soles of feet, difficulty breathing, tightness of the chest, wheezing, severe asthma attack, shock, and very rarely progress to death. It has been estimated that anaphylaxis occur in less than once in 150 allergy injections and only 9% of these are serious. It has been estimated that death occurs once in 2 million injections.

I am aware that the onset of most life-threatening reactions occurs within 30 minutes following the allergy injections. I understand that I must wait a minimum of 30 minutes after receiving my allergy vaccine therapy throughout my treatment program. It has been explained to me that since it cannot be predicted when a reaction is going to occur there is never a safe time to leave the office before 30 minutes post-injection. There have been rare reports of delayed onset of serious reactions starting 6-8 hours after the allergy injections. I have been advised to avoid exposure to extreme heat and strenuous activity for at least two hours in an effort to allow the allergy extract to be absorbed more slowly. Life threatening reactions are rare but delayed local swelling, redness, and pain occur more frequently in certain patients. While this is undesirable it is not dangerous and does not indicate that a more serious reaction is likely to occur in the future.

In the event that I experience any untoward response to allergy vaccine treatment within 24-36 hours following an allergy injection, I will notify the office of this reaction prior to receiving my next allergy injection. I understand that a reaction may influence the dosage of my next allergy injection and that it is my responsibility to advise the medical assistant or Dr. Sabin of this reaction. I realize that if a serious reaction occurs after leaving the office that I must call 911. For less serious reactions I will immediately notify the office of my reaction. On the day of my injection I will notify the office if I am not feeling well in any way including worsening asthma prior to my injection.

I am aware that I am unable to take certain heart medications, such as beta-blockers while receiving allergy injections. Beta-blockers are used to treat elevated blood pressure, irregular hear rate, and migraines. Patients receiving venom treatment must also avoid ace inhibitors, another type of medicine used to treat elevated blood pressure and heart problems. Tricyclic antidepressants are also to be reviewed with Dr. Sabin if you are on allergy injections. There are many different generic and brand names for these three types of medication that can be reviewed by Dr. Sabin. If any physician starts a new medication, please ask if it falls into one of these categories and always advise our office of any new medications.

I fully understand the risks involved in allergy vaccine treatment, the requirement to remain in the office for 30 minutes after receiving the treatment, and understand my responsibility to communicate any adverse reaction to the medical assistant or Dr. Sabin before receiving the next allergy injection. I understand that if I am under the age of 18 I must have a guardian with me at each injection. I have had an opportunity to receive answers for all of my questions in regard to allergy vaccine treatment.

I have agreed to allergy vaccine treatment (allergy injections).

Patient's Name: \_\_\_\_\_

Signature of patient or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_