ATLANTA ALLERGY & ASTHMA

Allergy Immunotherapy at Outside Medical Facility

Patient Name: _____ DOB: _____

I have requested that allergy injections provided by Atlanta Allergy & Asthma be administered by someone other than employees of Atlanta Allergy & Asthma. I acknowledge that I have been advised by the office that allergy injections should be given only in settings where emergency medicine and equipment, as well as trained personnel, are immediately available to treat reactions that may occur associated with shots. The administration of allergy extract must be supervised by medical personnel trained to treat reactions including anaphylaxis.

I understand that Atlanta Allergy & Asthma will provide the physician designated below with allergy extract and instructions for its administration, but they cannot assume responsibility for the administration of the extract or for any resulting consequences. I understand that Atlanta Allergy & Asthma must be provided with the name and address of the physician who will assume responsibility for the injections.

Name and address of physician where immunotherapy injections will be administered:

THIS SECTION MUST BE COMPLETED PRIOR TO SIGNING

Physician Name: _____ Phone #: _____

Address: _____

_____ _____
(Patient Signature) (Date)

_____ _____
(Signature of Parent/Guardian if patient is a minor) (Date)

_____ _____
(Witness) (Date)