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SUBLINGUAL IMMUNOTHERAPY (SLIT)
CONSENT FOR TREATMENT

- I hereby state that I am NOT presently taking a Beta Blocker medication used for glaucoma, migraine headaches, blood pressure or heart problems.
- I hereby state that I will immediately inform SOENTS Allergy office if a Beta Blocker is prescribed to me for any reason.
- I have read and have had my questions regarding the administration of sunlingual drops for immunotherapy satisfactorily answered. I understand how to take the drops and will follow the instructions.
- I understand that it is the policy for Southwest Ohio ENT Specialists, Inc. that I have my emergency epinephrine available every time I take my drops.
- I understand that it is the policy of Southwest Ohio ENT Specialists, Inc. that I see my SOENTS physician at least once a year for a check up.
- I understand I must bring my treatment record with me when I come for the first administration of any new bottle of drops.

I have read the information in this consent form and understand it. The opportunity has been provided for me to ask questions regarding the potential risks of immunotherapy and these questions have been answered to my satisfaction. I understand that precautions consistent with the best medical practice will be carried out to protect me from adverse reactions to my immunotherapy. I do hereby give consent for the patient designated below to be given immunotherapy over an extended period of time and at specific intervals, as prescribed by my doctor. I further hereby have given authorization and consent for treatment, by my doctor and their staff, of any reactions that may occur as a result of immunotherapy.

_____

Patient Name (Printed) Date of Birth

_____

Signature of patient or parent/authorized person to consent for a minor patient Date

For office use only: I certify that I have counseled this patient and or authorized legal guardian concerning the information in this Consent for Immunotherapy and that it appears to me that the signee understands the nature, risks and benefits of the proposed treatment plan.

Staff Signature_____ Date_____