BLUEGRASS FAMILY ALLERGY
PERSONALIZED ASTHMA & ALLERGY CARE

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SUBLINGUAL ALLERGEN IMMUNOTHERAPY PATIENT CONSENT FORM

Sublingual immunotherapy (SLIT) is an allergy tablet given under the tongue. SLIT should be taken under the care of a physician who is trained to prescribe the medication and to treat any possible reactions. The first dose is given at the medical office and, as long as this initial dosing is well tolerated, subsequent daily doses are taken at home. For the first week or so, it is not uncommon for you to experience some local reactions in your mouth consisting of minor itchiness or discomfort. These symptoms, should they occur, are typically brief and go away without any special treatment. Some individuals experience mild abdominal discomfort in the first days of treatment. Occasional serious reactions have been reported that may require immediate treatment. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, ears or throat; stuffy nose; sneezing; runny nose; mouth, nose or abdominal discomfort; coughing; swelling of the lips, tongue or throat; difficulty breathing; nausea and vomiting; hives; itching all over your body; and very rarely, a life-threatening systemic reaction known as anaphylaxis. Severe reactions, even though very unusual, may rarely occur at any time during the course of SLIT therapy. Because of the risk of a severe reaction, **you must agree to have self-injectable epinephrine on hand with each dose of SLIT therapy.**

For the initial dosing, you are required to wait in the prescribing doctor's office for at least 60 minutes after using the tablet. If you are 17 years of age or younger, a parent or legal guardian must be present during the waiting period.

I have read (if new patient) or re-read (if established patient) the patient information sheet on sublingual immunotherapy and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of sublingual immunotherapy and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against possible reactions associated with this treatment. I also agree that if I have an allergic reaction to the sublingual medication, I will follow the action plan I was given.

I acknowledge that I am aware of the risks/benefits/alternatives to sublingual immunotherapy and consent/agree to starting this treatment.

PATIENT_____ **DATE** _____

PARENT or LEGAL GUARDIAN_____ **DATE** _____

As parent or legal guardian, I understand that I must accompany my child throughout the entire 60-minute wait.

WITNESS____ **DATE** ________________