ALLERGY SKIN TEST/ALLERGY IMMUNOTHERAPY

Allergy skin tests are a method of testing for allergic antibodies.

A test consists of introducing small amounts of the suspected substance, or allergen, into the skin with a plastic pick. The chemical "histamine" is used as a positive control, and water, as a negative control, in order to ensure that the testing is valid and reproducible. A positive reaction (which consists of a small wheal "swelling/redness" at skin test site), may occur within several minutes. This response will aid in evaluating your individual sensitivities to the allergen tested. The results are read 10-20 minutes after application of the allergen.

Occasionally local swelling and/or itching at a test site will occur after the test is applied. The use of topical cream, ice compresses, and the occasional use of antihistamine will help to reduce any residual itchiness or swelling that may occur at the skin testing area. Large local and generalized reactions to the skin test, although relatively uncommon may occur (hives, cough, asthma attack, anaphylaxis, etc.)

SKIN TESTING Desire to undergo allergen skin testing. I understand the nature and purpose of the procedure and possible alternative methods of evaluation (blood test, i.e. RASTS) as explained by Dr. Persaud. By my signature, I give consent to have allergy skin testing performed. I have had the opportunity to ask questions about any matter which I did not understand and have received satisfactory explanations.

XXXXX _____ _____ _____

Patient Name **Parent/Guardian Signature** **Date**

Immunotherapy (Allergy Injections) is a treatment used to relieve allergy symptoms such as hay fever or asthma by giving injections of small quantities of allergic substances, i.e. pollen, mold spores, dust particles, pet dander, or insects, to which an individual has been found to be allergic by allergy skin tests and/or RASTS (Blood tests). Allergy injections have been shown to lead to the formation of "protective antibodies" and a gradual decrease in the allergy antibody level. During the "buildup" phase, increasing doses of allergy injections are given usually once a week until a MAINTENANCE dose is achieved. This may take 4-8 months. Once a maintenance dose is reached, shots are given usually every 2-3 weeks. About 80% of allergic individuals get significant improvement of their symptoms. Improvement in allergy/asthma symptoms usually require 4-6 months before any relief is noticed, and may take 12 months for the maximum benefit to occur. In a small percentage of patients there is no improvement, and in this case, immunotherapy is discontinued.

Local reactions may include: swelling, itching, or tenderness at the site of injection. These local reactions usually subside in a day or less. The application of cool compresses will provide local comfort and help to dissipate any inflammation at the injection site. Large local reactions and generalized reactions may occur in 1-5% of patients receiving allergy injections and usually occur during the buildup phase, although they can occur at any time during the course of treatment. These reactions will require an adjustment of dosage. While most systemic reactions are not life-threatening if treated promptly, this fact does stress the importance of being in good health on those days when shots are given, inform the physician/nurse if you are having any worsening and/or an increase in frequency in asthma attacks. However, rare cases of deaths have occurred.

It is also recommended that the facility that gives allergy injections should be equipped to treat any reactions that may occur. As an added precaution, you must wait in the medical facility where you receive your injection at least 20-30 minutes after each injection so that in the unlikely event of a generalized reaction you can be quickly treated and observed, thereby reducing the likelihood of a more severe reaction.

CONSENT FOR ALLEGEN IMMUNOTHERAPY (ALLERGY SHOTS)

I do hereby give consent for Allergy Injections to be given over an extended period of time, and at specified intervals as prescribed. I have read the above allergy shot information/guidelines and agree to follow them. I also understand the risks that may be involved in receiving allergy shots. I have been given the opportunity to ask any and all questions by Dr. Persaud, that I may have had and am satisfied that they have been fully answered. I consent and authorize the treatment of any reactions that may occur as a result of an allergy injection.

XXXXX_____ _____ DATE_____

Patient Name **Parent/Guardian Signature**