PA Allergy Relief a
2525 West Main Street Jeffersonville, PA  19403
4/2013

Informed Consent For Anaphylaxis
PA Allergy Relief Laser Center

**Anaphylaxis:** Anaphylaxis is a severe life threatening allergic reaction to food, insect bites, medication or latex. It can also be exercise induced. Anaphylaxis can lead to death.

**Symptoms may include but are not limited to:**

- **Face** - Itchy eyes or nose, flushed face, swelling of tongue and lips, metallic taste
- **Skin** - Itchiness, redness, hives, swelling of skin anywhere on the body
- **Throat** - Itchiness, tightness, hoarseness, hacking cough, difficulty swallowing, choking
- **Lungs** - Difficulty breathing, shortness of breath, repetitive coughing, wheezing
- **Stomach** - Vomiting, nausea, stomach pain, diarrhea
- **General** - Dizziness, unsteadiness, drowsiness, sense of impending doom, loss of consciousness

**Initials:**

_____ I understand that PA Allergy Relief does not treat nor claim to treat anaphylaxis or allergies that can cause anaphylaxis and I will not hold them responsible for any anaphylactic reaction that may occur due to an allergic reaction that causes anaphylaxis.

_____ I understand that anaphylaxis can be a life threatening reaction and I understand the symptoms of an anaphylactic reaction and will in no way hold PA Allergy Relief AT Lifeline Chiropractic Inc. responsible for a future anaphylactic reaction.

_____ If an Epipen has been prescribed, I agree to carry an Epipen with me at all times and will use it according to the manufacture’s recommendations. If I have allergic reactions that resemble anaphylaxis. I agree to keep my prescription up to date for my Epipen.

_____ I agree that if I have any of the previous symptoms of anaphylaxis described above that I will follow the following procedures.

1) Administer epinephrine (adrenaline) injection immediately. Give a second dose in 10-15 minutes if reaction continues or worsens.
2) Call 911 and tell them someone is having a life-threatening allergic reaction.
3) Go to the hospital immediately even if symptoms subside. Remain for observation 4-6 hours.

_____ I agree to stay away from drugs, insects and chemicals that I know I am allergic to especially if they have caused anaphylactic episodes in the past. Even after Laser Allergy treatments are complete I agree to always inform doctors and hospitals if I am allergic to any drugs or foods.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE**

I have read or have had read to me the above explanation and the Laser Allergy and the related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

**Patient Printed Name** ___________________________ **Date** __________

**Patient Signature** ___________________________ **Dr. Signature** ___________________________

The patient had the following questions and was supplied the following answers:

____________________________________  ______________________________________

**It is my clinical opinion this patient is oriented to time and space:**  YES  NO
**It is my clinical opinion this patient understands the language involved:**  YES  NO

PA Allergy Relief at Lifeline Chiropractic, Inc.  2525 West Main Street Jeffersonville, PA  19403

4/2013