THE ALLERGY and ASTHMA CLINIC
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PREPARATION OF ANTIGEN VIALS CONSENT FORM

I have been made aware that my immunotherapy antigen vials have been depleted or have expired. I am aware that to continue my allergy immunotherapy program new antigen vials need to prepared. With my signature, I am authorizing the preparation of my personalized immunotherapy vials. If for any reason, I decide not to continue my allergen immunotherapy program I will be responsible for any charges incurred with preparation of my vials.

Patient Signature	**Print Name**	**Date**

If the patient is a minor, please fill out the following:

Child's Name	**Parent Signature**	**Date**

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