ALLERGY ASSOCIATES of Western Michigan PC

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CONSENT FOR FOOD ORAL IMMUNOTHERAPY (OIT)

I understand that due to the severity of my child's food allergy, the providers at Allergy Associates of Western Michigan have recommended treatment with oral immunotherapy to reduce the risk of experiencing an allergic reaction to this food.

I understand that this procedure involves giving increasing doses of the food to which my child is allergic in order to achieve a state of immunologic tolerance (desensitization). I understand that the immunologic changes that will occur are mostly due to the daily doses that I will be supervising at home after the progressive oral challenges in the office.

I further understand that the oral immunotherapy procedure carries a significant risk of causing a serious allergic reaction, including hives, swelling, bronchospasm with difficulty breathing, loss of consciousness and shock, which may require emergency treatment and hospitalization, or even death. In order to desensitize an individual they will be ingesting the food itself that they are allergic to, starting at very very low doses. Our protocols are based on protocols that have been shown to be successful previously. I understand that the providers and staff at Allergy Associates of Western Michigan will make every effort to minimize the risk of a serious reaction but that a reaction may still occur. Because of these risks, my child will be assessed before each dose is given and vital signs will be taken as indicated. In consideration of these risks, I agree to carefully follow my provider's instructions and precautions before, during and after this procedure. I recognize that a key part of this procedure involves giving doses of the desensitizing food at home once a day, every day. I will inform the Allergy Associates of Western Michigan staff if there have been any missed doses. I also agree to provide constant adult supervision for my child during this procedure. I understand that oral immunotherapy is a long process that will take months to accomplish and that office visits once a week will be required. I agree to maintain an appropriate schedule of visits as directed by the providers at Allergy Associates of Western Michigan.

Once achieved, the desensitized state can be maintained indefinitely as long as one continues to eat the food on a daily basis. I understand that failing to continue consuming this food in the recommended quantities on a daily basis may result in loss of the desensitized state and thus, an allergic reaction may

occur if the food is eaten some time later. Therefore, I agree to notify Allergy Associates in the event that I forget or decide to stop feeding my child this food on a daily basis.

I understand that oral immunotherapy for food is not FDA approved and I agree to be responsible for the cost, which is $1000 at the first visit and $500 every 3 weeks for three payments ($2500 total for one food, additional foods will be extra at 50% off each set of capsules), besides what is billed to my insurance for office visits, oral challenges or other covered expenses.

I have reviewed the above information with my provider and all questions have been answered to my satisfaction on this date: _____.

_____	_____
Patient	Signature (if 12 yrs of age or older)
_____	_____
Parent	Signature
_____	_____
Provider	Signature

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