THE ALLERGY and ASTHMA CLINIC Andrew C. Engler, M.D. Bhushan C. Gupta, M.D. Brooke K. Leon, N.P. Elisabeth M. Denker, N.P.

PREPARATION OF ANTIGEN VIALS CONSENT FORM

Parent Signature	Date	
Child's Name	Date of Birth	
If the patient is a minor, please fill out the following:		
Print Name	Date of Birth	
Patient Signature	 Date	
continue my allergy immunotherapy program, new a authorizing the preparation of my personalized imm	ntigen vials have been depleted or have expired. I am aware that antigen vials need to be prepared. With my signature, I am unotherapy vials. If for any reason, I decide not to continue my ble for any charges incurred with preparation of my vials.	
Please review and sign the following consent to prep	pare new immunotherapy antigen vials:	