CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

BRADLEY E. CHIPPS, M.D.,
F.A.A.P., F.A.C.A.A.I., F.A.A.A.A.I., F.C.C.P.
Pulmonary & Allergic Diseases
Board Certification:
Pediatrics
Pediatric Pulmonology
Allergy and Clinical Immunology

Medical Director, Cystic Fibrosis Center
Assoc. Medical Director Sleep Laboratory
Medical Director of Respiratory Therapy
Sutter Community Hospitals

NEIL G. PARIKH, M.D.
Clinical Immunology, Allergy, & Research
Board Certification:
Internal Medicine
Allergy and Clinical Immunology

SHEENA K. MAHARAJ, M.D.
Pediatric Pulmonology
Board Certification:
Pediatrics
Pediatric Pulmonology (Board Eligible)

Hannah Choi-Baral, C.P.N.P
Pediatric Nurse Practitioner

Christine Anderson, F.N.P-C
Family Nurse Practitioner

RELEASE OF ANTIGEN CONSENT FORM

PATIENT: _____

I request that my own or my child's allergy extract prepared by Capital Allergy & Respiratory Disease Center (CARDC) be administered under the supervision of _____.

_____
Signature of Patient or Parent Date

By signing this form, the supervising physician acknowledges his or her medical responsibilities. These responsibilities include reading the Allergy Immunotherapy instructions before beginning this therapy, doing patient assessment before giving injections and treatment of untoward local and or systemic allergic reactions for a period of one full year from the date this consent was signed.

Systemic reactions include the skin, respiratory tract, gastrointestinal tract and cardiovascular system (such as anaphylactic shock). Patients are not to receive their allergy injections anywhere except in the physician's office and while the responsible physician or delegate is on the premises. A minimum in office observation period of thirty minutes must be adhered to following injections. Please call our office for any questions. (916) 453-8696

_____ _____
Name of Supervising Physician (print) Date

_____
Signature of Supervising Physician

_____
City State Zip Code

_____
Area Code Phone Number

Please have the physician who will be supervising allergy injections sign and return to our office. Thank you.

CARDC-Physician: BEC_____NGP_____SM_____HC/CTA_____