the allergy station
Travis A Miller MD

phone/fax: (916) 238.6238
1478 Stone Point Drive Suite 290
Roseville CA 95661
theallergystation.com

Release of Antigen Consent Form

Patient Name: _____ DOB: _____

I request that my or my child's allergy extract prepared by:

_____

be administered under the supervision of Travis A. Miller, MD.

_____ _____
Signature of Patient/Guardian Date

By signing this form, the supervising physician acknowledges his/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 or local and/or systemic allergic reactions.

Patients will receive their allergy injections in our office and while the responsible physician or delegate is on the premises.

_____ _____
Signature of Supervising Physician Date

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