

**PATIENT CONSENT FOR ALLERGY SKIN TESTING**

I authorize Dr. \_\_\_\_\_ and such assistants as he may designate, to perform upon me the following diagnostic procedure: Percutaneous Testing and/or Intradermal Testing for the detection of possible aeroallergen allergies.

I understand that certain medications (such as antihistamines – see attached) , may interfere with the validity of the test. To the best of my knowledge I am not currently on antihistamines.( see attached list).

I have been made aware of certain risks and complications that may be associated with the allergy skin testing. These include but are not limited to: aggravation of allergic symptoms (runny nose, itchy eyes, hives) and in rare cases, anaphylactic reactions. If any of these complications arise, I hereby give consent to any necessary emergency treatment. I understand that certain medications such as Beta Blockers (see attached list) may interfere with the desired output of emergency treatment in case of anaphylaxis. To the best of my knowledge I am not currently taking any such medications for blood pressure, heart conditions, migraine headaches, or glaucoma.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this procedure.

This form has been fully explained to me and I certify that I understand its content.

\_\_\_\_\_  
Patient, Parent, or Guardian

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date