

Consent for Food Allergy Skin Testing

Date: _____ Patient Name: _____ Age: _____

I understand that I will be undergoing allergy skin testing for food allergies. The method of testing has been reviewed with me and I understand the purpose of and need for this testing. I understand that the testing will take approximately 30 minutes. I have reviewed and understand the medical precautions and handouts that I received prior to testing. I have followed the medication restrictions and have a follow-up appointment scheduled with Dr. Gergits or Kayleigh Parks, PA-C for review of completed testing.

I understand that no testing is without risk. Allergic reactions from the testing injections are anticipated. Itching and burning sensations are common reactions to the allergenic extracts. I understand that if I should experience any of the following symptoms, I will let the Allergy Testing Technologist know *immediately*:

- A tingling sensation or an itch in the throat
- Sweating or dizziness
- Sensation of a lump in the throat
- General feeling of ill-ease
- Tightness in the chest
- Wheezing

I understand that allergy testing is a method developed to test patients by administering actual specific allergens. I confirm that to the best of my knowledge, I do not have an immunodeficiency, a problem with my immune status, or severe asthma. I have been warned of the potential discomfort of allergy skin testing and the possible side effects. I have been informed of and understand the testing process and give my consent to undergo this testing.

Patient Signature: _____ Date: _____
(If patient is under 18, parent/guardian must sign.)

Technician Signature: _____ Date: _____
(Lynn Martz, R.N./Linda Williams)