

ALLERGY TESTING CONSENT FORM

I authorize Dr. Stephen Dent, and any such assistants as they may designate to perform upon _____, the following diagnostic procedures: Prick skin testing for detection of possible allergies.

I further consent to the performance of such other or additional procedures different from that now contemplated, whether or not arising from presently foreseen conditions, which the above named doctors, or their assistants, may consider necessary or advisable in the course of the procedure. I have been aware of the certain risk and complications that are associated with the allergy testing procedure.

I have also been informed that there are other risks associated with skin testing and treatment. These include, but are not limited to, hypertensive episodes, aggravation of allergic symptoms (itchy eyes, hives, runny nose), and in rare cases anaphylactic reaction (a severe form of allergic reaction that may be fatal). 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 or treatment.

I also understand, that due to the length of time reserved for my allergy testing, 24 hours advanced notice is required to cancel my test, or a charge of \$50 will be applied.

This form has been fully explained to me and I certify that I understand its contents fully and agree with all of the above.

Patient signature (or parent)

Relationship to patient

Print name

Date

Witness