SAN DIEGO
EAR, NOSE & THROAT SPECIALISTS

ALLERGY TESTING CONSENT FORM

I give consent for assistants trained in administration of Allergy Skin Prick Testing, and under the guidance of a licensed and certified physician at San Diego Ear, Nose and Throat Specialists, to perform Allergy Skin Prick Testing for the purpose of identifying possible allergens.

I understand Allergy Skin Prick Testing is a standard method of determining IgE reactions to standard allergens. I have been informed of possible risks and side effects including, but not limited to: discomfort, itchiness, redness, and swelling at the test site or sites, vasovagal syncope, nausea, weakness, visual blurring, sweating, faintness, dizziness, loss of consciousness and anaphylaxis.

I understand certain medications will interfere with the results obtained by Allergy Skin Prick Testing. These medications include some antidepressants, antianxiety, antihistamine, herbal supplements and some other miscellaneous medications. I have read the "Medications to Avoid Prior to Allergy Testing" handout and agree I have been compliant with its instructions.

I desire to undergo this testing after having considered the information contained in this document, the information provided to me through conversations with my treating physician, and through materials provided to me by the clinic to educate me about the testing.

I acknowledge I have had the opportunity to ask any questions with my physician with respect to the proposed testing, and the procedures to be utilized, and all of my questions have been answered to my full satisfaction.

Print Patient Name: _____

Guardian/Patient Signature: _____ Date: _____