Clinic name
Informed consent for Allergy Skin Prick Testing

I, _____, hereby give consent to ***Doctors name***, or one of the clinic assistants trained in administration of Allergy Skin Prick Testing, and under the guidance of a licensed and certified physician at ***Clinic name***, to perform Allergy Skin Prick Testing for the purpose of identifying offending allergens. I understand that 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, or loss of consciousness), and anaphylactic shock (itching and burning skin, eye swelling, lip swelling, dizziness, severe headache, pounding in ears, weakness and fainting, tightness in chest, airway obstruction, anxiety, nausea and vomiting, diarrhea).

I understand that certain medications will interfere with the results obtained by Allergy Skin Prick Testing. These medications include tricyclic antidepressants, antihistamines, Astemizol, Chlorphenamine, Certirizine, and Loratidine I understand that the period I must be off the previous drugs so as not to interfere with the testing is 1 month for Astemizol, 72 hours for the tricyclic antidepressants and antihistamines, and 48 hours for the others. I also understand that I should be in a general healthy state (not in acute allergic response), not pregnant, not on beta blockers, and older than 3 years of age.

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 that I have had the opportunity to ask any questions of 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.

Date: _____ _____
Patient's signature

_____
Patient's name (printed)

Date: _____ _____
Physician's signature

_____
Physician's name