Lafayette Pediatrics and Internal Medicine

Allergy Testing Consent Form

Skin testing for allergies may cause allergic reactions. Even though reactions to skin tests are very rare, they can be serious and even fatal. These reactions may consist of any or all of the following symptoms: itchy eyes, nose or throat; nasal congestion; runny nose; tightness in the throat or chest; coughing; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching and shock under extreme conditions. If the patient is 17 years of age or younger, a parent or legal guardian must be present during the allergy test. I verify that I (or the patient) am not taking beta-blocker medications or that if I am, I have discussed the risks/benefits of doing so with my physician.

The opportunity has been provided for me to ask questions regarding the potential risks of skin testing for allergies and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions. I also agree that if I have an allergic reaction to the injections that the physician-in-charge has permission to treat said reaction.

I acknowledge the fact with my signature that I am authorizing the office to bill for allergy testing. I also agree to obtain prior authorization, if needed, from my insurance plan.

As parent or legal guardian, I understand that I must accompany my child throughout the entire allergy-testing visit. (Initials): _____

Patient (Print name):_____

Signature: _____ Date Signed_____

Parent or Legal Guardian: _____Date Signed_____

Witness_____ Date Signed_____