

**ORAL FOOD/DRUG CHALLENGE/ALLERGY TESTING/SAMPLE MEDICATION
PATIENT CONSENT FORM**

An oral food, drug challenge or allergy test should be administered at a medical facility with a medical physician present since occasional reactions may require immediate therapy. These reactions may consist of any or all the following symptoms: itchy eyes, nose or throat; nasal congestion; runny nose; tightness in throat or chest; coughing; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the last under extreme conditions. Reactions, even though unusual, can be serious and rarely, fatal.

You are required to wait in the medical facility during the entire oral challenge. If the patient is 17 years of age or younger, a parent or legal guardian must be present during the waiting period.

Any medication(sample) that you have not taken, before given to you by our office according to Dr Mardiney' medical decision, also presents the possibility of an adverse event.

I have been given the opportunity to ask questions regarding the potential risks and side effects of an oral challenge 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 with the challenge that the physician in charge has permission to treat said reaction. I also agree that I will not hold the office or physician responsible for any adverse reaction.

Patient Name _____ **DOB** _____

Signature _____ **Date** _____

Relationship to Patient _____

Witness _____ **Date** _____