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Allergy Test Consent

1. I hereby authorize TeAnn Philippis, PA-C to treat the conditions indicated by clinical exam and/or diagnostic studies already performed or to be performed by the diagnostic procedures listed below. The procedure(s) necessary to treat or diagnose my condition have been explained to me by TeAnn Philippis PA-C and I understand the nature of the procedure to be "Allergy Testing" and the "Multi-Test Method".

2. I understand the risks of the procedure include but are not limited to: hives, localized swelling, rash or a minor flare in allergic symptoms, and in rare cases anaphylaxis.

3. I have read and fully understand the above information and have had a chance to have all my questions answered regarding this procedure.

4. Are you taking Beta Blockers? ☐ Yes ☐ No

5. Are you pregnant? ☐ Yes ☐ No

6. Have you taken any antihistamines or antacids such as Benadryl, Claritin, Zyrtec, Allegra, Xyzal, Zantac, Tagamet or Pepcid in the past three days? ☐ Yes ☐ No

Date: _____ Time: _____

Patient Name (please print): _____

Signature of Patient/Parent/ or Guardian_____