PARK CITIES
ALLERGY & ASTHMA

**Informed Consent for Penicillin Testing**

I, _____, am requesting to be tested for penicillin allergy. I understand that the testing involves skin prick tests to my forearm, followed by intradermal testing to my upper arm. I acknowledge that I have not taken any antihistamines (oral, nasal, or topical) in the past five days or oral/injected steroids in the past seven days. I am aware that no testing can offer 100% accuracy in diagnosing a penicillin allergy. If the skin testing results are negative, I will be asked to take an oral dose of Amoxicillin and remain under observation for an additional hour to monitor for any symptoms.

Although adverse reactions to penicillin testing are rare, occasionally patients may develop local inflammation at the test sites or generalized allergic reaction. Symptoms of a generalized reaction may include: itchy eyes, nose, or throat; nasal congestion; sneezing; runny nose; throat or chest tightness; coughing; wheezing; lightheadedness; faintness; nausea/vomiting; abdominal cramping; rash; hives; swelling of any part of the body; and in extreme cases, shock or death. In the event you develop any symptoms of a generalized reaction, immediately report the symptoms to the staff so that proper treatment can be initiated.

I acknowledge that I have read or had read to me the information in this consent. I have had an opportunity to ask questions which were answered to my satisfaction. I hereby request and give my consent for the patient designated below to undergo penicillin testing. I further hereby give authorization and consent for treatment by the physician of Park Cities Allergy & Asthma and their staff, for any reactions that may occur as a result of this testing.

| _____ | _____ | _____ |
|---|---|---|
| Printed Name of Patient | Patient Signature (or legal guardian) | Date Signed |

| _____ | _____ |
|---|---|
| Witness to Signature | Date Signed |

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