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NORTERRA
FAMILY MEDICINE

2060 W. Whispering Wind Drive, #173
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Allergy Test Consent

1. I hereby authorize ________________________ 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 ______________________________ 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? (Benadyl,Claritan, Zyrtec ,Allegra,etc.) in the past three days?
   ☐ Yes ☐ No

Date: ___________________________ Time: ___________________________

Patient Name (please print): ____

Signature of Patient/Parent/ or Guardian____

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