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CONSENT TO ALLERGY EVALUATION, TESTING, AND TREATMENT

1. I authorize the performance of allergy evaluation, testing, and treatment upon

   _____

   To begin on: Date _____ Time: _____

2. I consent to:

   a. The testing procedures and treatment

   b. Such procedure and treatment in addition to or different from those now contemplated whether or not arising from presently unforeseen conditions, which the above named doctor or his associates or assistants may consider necessary or advisable in the course of the testing and treatment procedures.

   c. The administration of such medications may be considered necessary or advisable by the doctor or his/her associates responsible for this service.

3. a. I have been explained the nature of all the test and treatment procedures, possible alternative methods of treatment, the risks involved with this treatment, and the possibility of complications such as: localized swelling, irritation, and itching at the injection site. The patient may also experience an increase in his/her allergic symptoms, generalized (whole body) hives and swelling, difficulty breathing, anaphylactic shock, and possible death. No guarantee or assurance had been given by anyone as to the result that may be obtained.

   b. I certify that I have read and fully understand the above consent to allergy testing and treatment thereof, that the explanations therein referred were made, that all blanks or statement requiring insertion or completion were filled in and that inapplicable paragraphs, if any, were stricken before signed.

   Signature of patient:_____

   Signature of Parent, Husband, Wife, If present:_____

4. I am responsible for the payment of this procedure of $_____

   Signature:_____

The foregoing consent was read, discussed, and signed in my presence, and in my opinion the person(s) so signing did so freely with full knowledge and understanding.

Signature of witness: _____

Date:_____