Suburban Ear, Nose & Throat Associates, Ltd.

CONSENT FOR ALLERGY TESTING

Patient Name:_________________________________Date___________

The risks of allergy testing have been satisfactorily explained to me including the possibility of increased allergy symptoms (i.e. increased congestion, rhinorrhea, itchy eyes, tearing eyes, flushing, itching, asthma), and/or vasovagal reaction (nervous, sweaty, faint feeling) resulting from anxiety concerning numerous needle sticks and severe anaphylaxis resulting in respiratory distress and/or death.

I hereby consent to the administration of the inhalant allergy testing by physicians and/or staff of Suburban Ear, Nose & Throat Associates, Ltd.

Signed:________________________________Date____________

Nurse:________________________________ Date____________