Northwest Asthma & Allergy Center, P.S.

# DRUG/MEDICATION ORAL CHALLENGE

**What is an Oral Challenge to a Drug/Medication?**

A Drug Oral Challenge procedure is done to see if you or your child can take a medication or drug that may have caused a reaction in the past. The challenge procedure involves ingesting a small amount of the medication and being observed for a period of time. If no reaction occurs, a larger amount of the drug will be given with an additional observation period. This is normally done in 2 or 3 steps.

I understand that a Drug Oral Challenge procedure is not without risk. Risks of this procedure include: immediate (allergic) reactions, delayed reactions, and other drug-related reactions.

**IMMEDIATE REACTIONS:**

The risks of an immediate allergic reaction include: itching, rash, hives, swelling of the lips, tongue, or throat; chest pain, chest tightness, shortness of breath, wheezing; abdominal pain, nausea, vomiting, diarrhea; palpitations, dizziness, confusion, anaphylaxis, shock, and death.

Treatment for allergic reactions may involve administration of antihistamines, epinephrine and/or corticosteroids, observation for up to several hours, a visit to an emergency department or admission to the hospital.

**DELAYED REACTIONS:**

Symptoms of delayed reactions can include: rash, itching, liver or kidney involvement, fever, chills, joint pains, and ulcerations.

Alternatives to a Drug Oral Challenge are to continue strict avoidance of the suspect drug/medication.

I give my informed consent for *me / my child* **(circle)** to undergo a Drug Oral Challenge to:

_____.

The purpose, risks, benefits and alternatives of a Drug Oral Challenge procedure have been explained to my satisfaction. I understand that there is **always** a possibility of a reaction to a particular medication. I also understand that, as with every procedure, there is a possibility of unexpected complications. I authorize the doctors and staff of NW Asthma & Allergy Center to treat *me / my child* **(circle)** should an allergic reaction occur.

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|---|---|
| _____ Patient's Name | _____ Date of Birth |
| _____ Responsible Party/Guarantor Printed Name | _____ Relationship to Patient |
| _____ Patient/Responsible Party/Guarantor Signature | _____ Date |
| _____ Healthcare Provider's Signature | _____ Date |