Northwest Asthma & Allergy Center, P.S.

FOOD ORAL CHALLENGE CONSENT FORM

What is a Food Oral Challenge?
A Food Oral Challenge procedure involves eating a serving size of an allergic food in a slow, graded fashion under medical supervision over several hours. It is considered the "gold standard" and can help to confirm that a food allergy exists or to determine if a previously diagnosed food allergy has resolved. The decision to proceed with a Food Oral Challenge is complex and is influenced by medical history, age of the patient, skin prick testing, lab testing and assessment by an allergist.

While the benefit of a Food Oral Challenge has the potential to liberalize you or your child's diet, there is **always** the risk of an allergic reaction – such allergic reactions could be severe, even life-threatening. In the United States, during the past four decades, there has been a single fatality during a Food Oral Challenge, and therefore, the physicians at NW Asthma & Allergy Center are committed to adhering to very strict safety standards including graded exposures and careful observation.

Treatment for 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.

Alternatives to a Food Oral Challenge are to continue strict avoidance of the food from the diet.

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

_____.

The purpose, risks, benefits and alternatives of a Food Oral Challenge procedure have been explained to my satisfaction. I understand that there is **always** a possibility of a reaction to a particular food. 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.

_____ 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