NORTHWEST ASTHMA & ALLERGY CENTER

ORAL MEDICATION CHALLENGE CONSENT

What is an oral challenge to a medication?

An oral medication challenge tests whether you or your child can take a medication that may have caused a reaction in the past. It is carried out under close medical supervision. The challenge procedure involves ingesting a tiny dose of the medication and being observed for some time. If no reaction occurs, a larger amount of the medication will be given with an additional observation period. This procedure is typically done over several steps.

The benefit of an oral challenge is that if you or your child do not experience any allergic symptoms, then we can be confident that you or your child can take the medication in the future if needed.

I understand that an oral challenge procedure is not without risk. Risks of this procedure include:
Immediate (allergic) reactions: itching, rash, hives, lip/tongue/throat swelling, chest pain or tightness, shortness of breath, wheezing, abdominal pain, nausea, vomiting, diarrhea, palpitations, dizziness, confusion, anaphylaxis, and death
Treatment for allergic reactions may involve the 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: rash, itching, liver or kidney involvement, fever, chills, joint pains, and ulcerations

Alternatives to an oral challenge are to continue strict avoidance of the suspect medication.

I give my informed consent for *me / my child* **(circle)** to undergo an oral challenge to:

_____.

The purpose, risks, benefits, and alternatives of an 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.

_____ Patient's Name	_____ Date of Birth
_____ Patient Signature	_____ Date
_____ Responsible Party/Guarantor Printed Name ☐ same as above	_____ Relationship to Patient
_____ Responsible Party/Guarantor Signature	_____ Date
_____ Healthcare Provider's Signature	_____ Date