

# Penicillin Allergy Test

## Patient permission form to be signed if proceeding with test

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**I have read and understood the information in the patient information leaflet (including the benefits and risks) and wish to proceed with an oral penicillin challenge test.**

- I have had the opportunity **to discuss** the test with the medical team
- I **agree** to the procedure described in the patient information leaflet.

You have the right to change your mind at any time, including after you have signed this form.  
Please speak to your medical team if you have any concerns.

### Patient

Signature .....

Date .....

Print name .....

### Doctor

Signature .....

Date .....

Print name .....