### Food Challenge Consent Form

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose, risks, benefits, and alternatives of a food challenge procedure have been explained to my satisfaction. I understand that there is always a possibility of reacting to a particular food. I also understand that, as with every procedure, there is a possibility of unexpected complications. I authorise the Royal United Hospital Allergy team to treat me / my child (circle) should an allergic reaction occur.

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare Provider’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Food Challenge: Parent Checklist

|  |  |  |
| --- | --- | --- |
| **Patients Name:** *Click or tap here to enter text.* | | |
| **Date of Birth:***Click or tap here to enter text.* | | |
| **Food being challenged for:**  *Click or tap here to enter text.* | | |
| **Please tick yes/no as appropriate** (note \* = as appropriate to child’s age) | **YES** | **NO** |
| The food challenge process has been explained fully to me |  |  |
| My child\* and I understand why the test has been advised |  |  |
| My child\* and I understand the benefits and risks of the test |  |  |
| My child\* is happy to try the food on the challenge day, and if tolerated, will continue to eat on a regular basis thereafter |  |  |
| I understand that my child cannot have any antihistamines for three days before the challenge |  |  |
| I am aware that for the challenge to go ahead my child must be well, with no signs of diarrhoea, vomiting, wheeze or temperature |  |  |
| I will bring my child’s emergency allergy medications to the challenge appointment with them (including their adrenaline pens, if they have them, their inhalers and antihistamine) |  |  |
| I understand that if I do not bring my child’s emergency medication to the appointment, it may have to be rearranged |  |  |
| I will provide the food (and any condiments to hide taste if needed) and bring it to the appointment with us. The allergy team will advise what food to is suitable |  |  |
| I am happy for a photo to be uploaded to my child’s medical record on the day of the challenge to record baseline and any allergic reactions. |  |  |
| **I am happy for my child’s details to be put on the waiting list for a food challenge** |  |  |
| **Name of person completing form:***Click or tap here to enter text.*  **Date:** *Click or tap to enter a date.* | | |

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