LATEX ALLERGY PHYSICIAN RELEASE

Convenient Home Care Services Inc.

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I, _____, do not have any know latex allergies.

_____ _____
Signature Date

I, _____, hereby authorize Convenient Home Care Services to release any information relevant to my employment regarding my allergy.

_____ _____
Signature Date

PHYSICIAN TO COMPLETE THIS SECTION. ALL ITEMS MUST BE ADDRESSED.

1. Type of allergy (check one): ☐ Latex ☐ Powder
2. Exposure Limits (check one): ☐ Direct Contact ☐ Environmental

Please check one

☐ Irritant Contact Dermatitis

An external agent directly damages the skin, such as sweating and chafing due to prolonged glove use. Usually manifested as dry, crusty lesions where areas are exposed to latex

☐ Allergic Contact Dermatitis (type IV):

Produces skin lesions or a crusty thickened appearance of the skin. The reaction usually appears some time after exposure, so sensitized individuals may not alway sassociate it with latex gloves. The rash may persist for 7-10 days, and is usually limited to the area where the skin cam into contact with the latex. This allergy may also include contact pruritus, erythema, vesicular lesions, eczema and contact urticaria.

☐ IgE-Medicated Hypersensitivity (type I):

Immediate reactions within 30 minutes to 1 hour from exposure may affect the skin, upper respiratory tract, lower respiratory tract or gastrointestinal tract. Skin manifestations include flushing, swelling and contact urticaria. Other manifestations are runny eyes and nose, symptoms of asthma, especially expiratory wheezing, diarrhea and / or vomiting.

Accommodations:

Describe in detail all special accommodations that are needed.

_____

Limitations: _____

Physician's Statement

I have examined the individual named above, and to the best of my knowledge, he / she is able to function in his / her profession as a healthcare professional, with the above listed accommodations and limitations.

_____ _____
Printed Name of Physician Date of Examination

_____ _____
Signature of Physician Date