



Latex Allergy Physician Release

(Complete ONLY if you have latex allergies)

I, (print name) _____, do hereby authorize

(name of office/clinic) _____ to release any medical information regarding my latex allergy to Signature Healthcare for employment reasons.

EMPLOYEE SIGNATURE

DATE

Physician to Complete. All items must be addressed.

Type of allergy (must check one): latex powder

_____ 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 always associate it with latex gloves. The rash may persist for 7 – 10 days, and is usually limited to the area where the skin came into contact with the latex. May also include contact pruritus, erythema, vesicular lesions, eczema and contact urticaria.

_____ IgE-mediated hypersensitivity (type I), immediate reactions within 30 – 60 minutes 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.

Exposure limits: (circle one) direct contact environmental

Accommodations: Describe in detail all special accommodations that are needed.

(Must be complete) _____

Limitations: (Please Describe) _____

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, with the above listed accommodations and limitations.

Physician Signature

Date

Physician Name (Printed)

Date of Examination