Evidence of Blood Lead Testing

Child's name: ______________________________

Child's Date of Birth: ______________

Receipt of Test

Received a Venous / Capillary blood lead test on ______________(date).
(Circle one.)

Test was administered by: ______________________________
(Signature of Medical Provider)

Medical Provider Address (City, State, Zip Code)

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Refusal of Test

I verify that I have been made aware of the serious and long-term health effects of lead poisoning on children under the age of six years. I do object to my child being blood tested in order to determine if he/she is lead poisoned.

Reason for Refusal ______________________________

Signed ______________________________ Date: __________
(Parent/Guardian)

Relation to Child: ______________________________

Parent/Guardian Address (City, State, Zip Code)

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Provide patient with two copies: One for record
One for child-care provider

One copy should be retained in patient's chart.