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

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 _____ Relation to child: _____ Date: _____
(parent or guardian)

Parent/Guardian Address: _____

_____
city state zip

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

One copy should be retained in chart.