Evidence of Blood Lead Testing

Child's Name _____

Child's Date of Birth _____

The above named child received a Venous/Capillary blood lead test on : _____ (Please circle one).

Test was administered by: _____
(Signature of Medical Professional)

Medical Provider's Address (City, State, Zip Code, Phone Number):

_____

_____

_____

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 however to my child being blood lead tested in order to determine if he/she is lead poisoned.

Reason for Refusal _____

_____

Signature: _____ Date: _____

Relation to Child _____

Parent/Guardian Address (City, State, Zip Code, Phone Number):

_____

_____