MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for children born before January 1, 2015 who do not need a lead test (children must meet the conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet the conditions of Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

BOX A-Parent/Guardian Should Complete for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME _____ / _____ / _____
LAST FIRST MIDDLE

CHILD'S ADDRESS _____ / _____ / _____ / _____
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ☐Male ☐Female BIRTHDATE ____/____/____ PHONE _____

PARENT OR GUARDIAN _____ / _____ / _____
LAST FIRST MIDDLE

_____ / _____ / _____ / _____
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

BOX B – Parent/Guardian to Complete for All Children

Is this child enrolled in Maryland HealthyKids/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program: ☐ YES ☐ NO

IF YES, HAVE HEALTH CARE PROVIDER COMPLETE BOX C AND DO NOT FINISH BOX B.

IF NO, CONTINUE TO NEXT QUESTION, BELOW.

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Was this child born on or after January 1, 2015? ☐ YES ☐ NO

Has this child ever lived in one of the areas listed on the back of this form? ☐ YES ☐ NO

Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ☐ YES ☐ NO

IF THE ANSWER TO ANY OF THESE QUESTIONS IS YES, DO NOT SIGN BOX B. INSTEAD, HAVE HEALTH CARE PROVIDER COMPLETE BOX C OR BOX D.

IF ALL ANSWERS ARE NO, SIGN BELOW AND RETURN THIS FORM TO THE CHILD CARE PROVIDER OR SCHOOL.

Parent or Guardian Name (Print): _____ **Signature:** _____ **Date:** _____

BOX C – DOCUMENTATION AND CERTIFICATION OF LEAD TEST RESULTS BY HEALTH CARE PROVIDER

Test Date	Type (V=venous, C=capillary)	Result (mcg/dL)	Comments

Comments:

Person completing form: ☐Health Care Provider/Designee OR ☐School Health Professional/Designee

Printed Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address:

BOX D – Religious Objection

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

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This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: ☐ YES ☐ NO

Printed Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: