

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

If you are enrolling a child in child care, pre-kindergarten, kindergarten or first grade, you must complete and submit this form (COMAR 10.11.04.05, 13A.17.03.02.D). **PLEASE PRINT CLEARLY.**

CHILD'S NAME _____ / _____ / _____
 LAST FIRST MIDDLE
 CHILD'S ADDRESS _____ / _____ / _____ OR
 ADDRESS CITY STATE ZIP
 SEX: MALE FEMALE BIRTHDATE _____ / _____ / _____

PARENT _____ / _____ / _____ OR
 GUARDIAN _____ / _____ / _____
 ADDRESS CITY STATE ZIP

CERTIFICATION INFORMATION

Complete Box A if the child has had blood lead testing, Box B if testing was not required (see conditions in Box B), OR Box C if testing declined on religious grounds.

BOX A

Check at least one:

- This child was born on or after January 1, 2015 AND lives in Maryland.
- This child was born before January 1, 2015 AND is enrolled in Medicaid EPSDT.
- This child was born before January 1, 2015 AND has lived in an "at risk" ZIP code (see list on reverse).
- This child was born before January 1, 2015 AND has at least one risk factor for lead exposure, as determined by the health care provider.

RECORD OF BLOOD LEAD TEST RESULTS

Test #1. _____ Date: _____
 Test # 2. _____ Date: _____
 Comments: _____

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

Printed Name: _____

Signature: _____

Date: _____

Office Address _____

Phone: _____

BOX B

BLOOD LEAD TESTING NOT REQUIRED

- This child does not and has never lived in an at-risk area (see ZIP codes on facing page) AND was born before January 1, 2015.

Parent or Guardian Name (Print) _____

Signature _____
 Parent or Guardian

Date: _____

BOX C

Complete the section below if the child is exempt from lead testing on religious grounds. A lead risk assessment questionnaire must be administered by a health care provider if the child is exempt from lead testing on religious grounds:

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.

To be completed by Parent or Guardian:

Parent or Guardian Name (Print) _____

Signature _____
 Parent or Guardian

Date: _____

To be completed by a Health Care Provider:

Lead risk poisoning risk assessment questionnaire done: YES NO

Printed Name: _____

Signature: _____

Date: _____