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_____/_____/_____/_____
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: _____