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).

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BOX A-Parent/Guardian Should Complete for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade									
CHILD'S NAME_	LAST			/					
CHILD'S ADDRES	SS	/	FIRST	MIDD /	MIDDLE /				
	STREET ADDRESS (with Apartme	nt Number)	CITY	STATE	ZIP				
SEX: □Male □F	Temale BIRTHDATE	/ / / I	PHONE						
PARENT OR	LAST		ETDOR	_/					
GUARDIAN 			FIRST		MIDDLE /				
	STREET ADDRESS (with Apartme	nt 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. ***********************************									
BOX C - DOCUMENTATION AND CERTIFICATION OF LEAD TEST RESULTS BY HEALTH CARE PROVIDER									
BOX C - DOC	TUMENTATION AND CERTIFIC	CATION OF LEAD TH							
				BY HEALTH CARE					
BOX C - DOC	CUMENTATION AND CERTIFIC Type (V=venous, C=capillary)	CATION OF LEAD THE Result (mcg/dL)							
				BY HEALTH CARE					
				BY HEALTH CARE					
Test Date Comments:		Result (mcg/dL)	EST RESULTS	BY HEALTH CARE Comments					
Test Date Comments: Person completing for	Type (V=venous, C=capillary)	Result (mcg/dL)	Professional/De	BY HEALTH CARE Comments					
Test Date Comments: Person completing for	Type (V=venous, C=capillary) rm: □Health Care Provider/Designe	Result (mcg/dL)	Professional/De	BY HEALTH CARE Comments					
Test Date Comments: Person completing for Printed Name:	Type (V=venous, C=capillary) rm: □Health Care Provider/Designe	Result (mcg/dL)	Professional/De	BY HEALTH CARE Comments					
Test Date Comments: Person completing for Printed Name: Date:	Type (V=venous, C=capillary) rm: □Health Care Provider/Designe	Result (mcg/dL)	Professional/De	BY HEALTH CARE Comments					
Test Date Comments: Person completing for Printed Name: Date: Office Address: I am the parent/guar lead testing of my cl	Type (V=venous, C=capillary) rm: □Health Care Provider/Designe BO dian of the child identified above. B	Result (mcg/dL) e OR □School Health Signature: X D – Religious Objected and the second of my bona fide	Professional/Des Phone: etion religious beliefs	Comments Signee and practices, I object	t to any blood				
Test Date Comments: Person completing for Printed Name: Date: Office Address: I am the parent/guar lead testing of my cl Parent or Guardian N ***********************************	Type (V=venous, C=capillary) rm: □Health Care Provider/Designe BO dian of the child identified above. B nild.	Result (mcg/dL) e OR School Health Signature: Signature: Signature: signature: tre provider: Lead risk p	Professional/Des Phone: etion religious beliefs ***********************************	Comments Comments Signee and practices, I object Date:	t to any blood **********************************				
Test Date Comments: Person completing for Printed Name: Date: Office Address: I am the parent/guar lead testing of my cl Parent or Guardian N ***********************************	Type (V=venous, C=capillary) rm: □Health Care Provider/Designe BO dian of the child identified above. B nild. ame (Print): ***********************************	Result (mcg/dL) e OR School Health Signature: Signature: Signature: signature: tre provider: Lead risk p	Professional/Des Phone: etion religious beliefs ************************************	Signee and practices, I object Date: ***********************************	t to any blood ************ ne: □ YES □ NO				

ALL

HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born BEFORE January 1, 2015)

<u>Allegany</u> ALL	Baltimore Co. (Continued) 21212	<u>Carroll</u> 21155	Frederick (Continued) 21776	<u>Kent</u> 21610	Prince George's (Continued) 20737	Queen Anne's (Continued) 21640
	21215	21757	21778	21620	20738	21644
Anne Arundel	21219	21776	21780	21645	20740	21649
20711	21220	21787	21783	21650	20741	21651
20714	21221	21791	21787	21651	20742	21657
20764	21222		21791	21661	20743	21668
20779	21224	<u>Cecil</u>	21798	21667	20746	21670
21060	21227	21913			20748	
21061	21228		Garrett	Montgomery	20752	Somerset
21225	21229	Charles	ALL	20783	20770	ALL
21226	21234	20640		20787	20781	
21402	21236	20658	Harford	20812	20782	St. Mary's
	21237	20662	21001	20815	20783	20606
Baltimore Co.	21239		21010	20816	20784	20626
21027	21244	Dorchester	21034	20818	20785	20628
21052	21250	ALL	21040	20838	20787	20674
21071	21251		21078	20842	20788	20687
21082	21282	Frederick	21082	20868	20790	
21085	21286	20842	21085	20877	20791	Talbot
21093		21701	21130	20901	20792	21612
21111	Baltimore City	21703	21111	20910	20799	21654
21133	ALL	21704	21160	20912	20912	21657
21155		21716	21161	20913	20913	21665
21161	<u>Calvert</u>	21718				21671
21204	20615	21719	Howard	Prince George's	Queen Anne's	21673
21206	20714	21727	20763	20703	21607	21676
21207		21757		20710	21617	
21208	Caroline	21758		20712	21620	Washington
21209	ALL	21762		20722	21623	ALL
21210		21769		20731	21628	
						Wicomico
						ALL
						Worcester

Lead Risk Assessment Questionnaire Screening Questions:

- 1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
- 2. Ever lived outside the United States or recently arrived from a foreign country?
- 3. Sibling, housemate/playmate being followed or treated for lead poisoning?
- 4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
- 5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
- 6. Contact with an adult whose job or hobby involves exposure to lead?
- 7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
- 8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.