



Division of  
**Lead &  
Healthy Homes**

## Blood Lead Test Refusal Attestation

Child's Name (Please Print): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician Name (Please Print): \_\_\_\_\_

As the legal parent/guardian of the child identified above, I refuse to let the provider identified above test my child's blood for the presence of lead.

\_\_\_\_\_  
Parent/Legal Guardian Name (Please Print)

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Please retain a digital or hard copy of this completed form in the patient's record.