Indiana Department of Health | 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.