



Parent/Guardian Refusal of Blood Lead Testing

Print child's full name: _____

Child's date of birth: _____

I confirm that I am aware of the serious and long-term health effects of lead poisoning on children under six years old. I do object to my child being blood tested to find out if he/she is lead poisoned. I hereby refuse blood lead testing. I am aware that a copy of this will be kept in the medical record.

Reason for refusal _____

Signed _____

Relation to child: _____
(parent or guardian)

Date: _____

Parent/Guardian address:

city state zip

Parent/Guardian phone number _____

Copies:

Provide parent/guardian with copy for their records.
One copy should be retained in chart.

Language Assistance Notice

For assistance in English at no cost, call (855) 699-5557 (TTY: 711) (San Diego) or (800) 605-2556 (TTY: 711) (Los Angeles). Para obtener asistencia en español sin cargo, llame al (855) 699-5557 (TTY: 711) (San Diego) o (800) 605-2556 (TTY: 711) (Los Angeles). 如果需要中文的免费帮助, 请拨打这个号码 (855) 699-5557 (TTY: 711), (800) 605-2556 (TTY: 711) (Los Angeles).

Nondiscrimination Notice

Blue Shield of California Promise Health Plan complies with applicable state laws and federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ethnic group identification, medical condition, genetic information, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, mental disability, or physical disability.

You can get this document for free in other formats, such as large print, braille, and/or audio. Call (855)699-5557 (TTY:711) for San Diego County, (800) 605-2556 (TTY: 711) for LA county.

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association.