Responsibilities as a Child Care Provider in an Area at High-Risk for Lead Poisoning*

**What are my Responsibilities?**

1. Beginning January 1, 2002, the department of health and senior services shall, subject to appropriations, implement a childhood lead testing program which requires every child less than six years of age to be tested for lead poisoning in accordance with the provisions of sections 701.340 to 701.349. In coordination with the department of health and senior services, every health care facility serving children less than six years of age, including but not limited to hospitals and clinics licensed pursuant to chapter 197, shall take appropriate steps to ensure that their patients receive such lead poisoning testing.

2. The test for lead poisoning shall consist of a blood sample that shall be sent for analysis to a laboratory licensed pursuant to the federal Clinical Lab Improvement Act (CLIA). The department of health and senior services shall, by rule, determine the blood test protocol to be used.

3. Nothing in sections 701.340 to 701.349 shall be construed to require a child to undergo lead testing whose parent or guardian objects to the testing in a written statement that states the parent's or guardian's reason for refusing such testing.

* Nodaway Count is considered high-risk for lead poisoning

This information is offered as highlights regarding lead legislation. The full text of the legislation can be found on the website: [http://www.moga.mo.gov/statutes/c701.htm](http://www.moga.mo.gov/statutes/c701.htm)
Evidence of Blood Lead Testing

Child’s Name: ________________________________________________

Child’s DOB: ______________________________________________

Receipt of Test
Received a Venous/Capillary blood lead test (circle one) on _____________ (date).

Blood Lead Level was ________________.

Test was administered by:
____________________________________________________________

(Signature of Medical Provider)

Medical Provider Address (City, State, Zip Code):


Refusal of Test
I verify that I have been made aware of the serious and long-term health effects of lead poisoning on children under the ages of six years. I do object to my child being blood test in order to determine if he/she is lead poisoned.

Reason for Refusal: ____________________________________________

Signed: ________________________________________________ Date: ________________

(Parent/Guardian)

Relation to Child: ____________________________________________

Parent/Guardian Address (City, State, Zip Code):


Provide Patient with two copies: One for record
One for child care provider

One copy should be retained in patients chart.