

## Blood Lead Level (BLL) History Form (to be completed by child/student's health care provider)

To the Attention of the Parent/Guardian: (Please complete this section)

Child/student's Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

To the Attention of the Health Care Provider: (Please answer the following questions)

1. What was the age and blood lead level when diagnosed with elevated BLL (BLLs  $\geq$  5mcg/dL)? \_\_\_\_\_
2. What is the highest BLL this child/student has had? \_\_\_\_\_
3. What was the duration of exposure to lead (if known)? \_\_\_\_\_
4. What was the duration of the child/students' BLL? \_\_\_\_\_
5. What kind of treatment did the child/student have? \_\_\_\_\_ AND  
How many courses of treatment? \_\_\_\_\_

Please complete this section by listing all documented BLL results for this child/student (continue over)

Blood Lead Test Date	Blood Lead Results ( <i>Indicate if venous or capillary</i> )
	_____ mcg/dL _____ Venous or _____ Capillary
	_____ mcg/dL _____ Venous or _____ Capillary
	_____ mcg/dL _____ Venous or _____ Capillary
	_____ mcg/dL _____ Venous or _____ Capillary
	_____ mcg/dL _____ Venous or _____ Capillary
	_____ mcg/dL _____ Venous or _____ Capillary
	_____ mcg/dL _____ Venous or _____ Capillary
	_____ mcg/dL _____ Venous or _____ Capillary

Name of Health Care Provider: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_

