Allegheny County Health Department

Lead Testing Record

To be filled out by parent or guardian

Student first and last name: _____

Birthdate: _____/_____/_____

Address: _____ City: _____

State: PA Zip code: _____-_____

Parent or guardian name: _____

To be filled out by health care provider

Date of most recent lead test: ____/_____/____

X _____

Signature (PLEASE CIRCLE - physician, certified registered nurse practitioner, physician assistant, health department staff)

Date: ____/_____/____

If exemption is requested, please fill out back of form.

Other acceptable proof of testing: any written statement by the child's health care provider.

Complete only if exemption is requested

Allegheny County Health Department

Statement of Exemption to Lead Testing Regulation

To be filled out by parent or guardian

Student first and last name: _____

Birthdate: ____/_____/____

Address: _____ City: _____

State: PA Zip code: _____-_____

Parent or guardian name: _____

Religious or Strong Moral/ Ethical Conviction Exemption

State your reason/s for requesting this exemption (required): _____

_____

_____

_____

Signed _____ Date ____/_____/____

(Parent or guardian)

To be filled out by health care provider

Medical Exemption

The physical condition of the above-named child is such that blood lead testing may be detrimental to his/her health.

Signed _____ Date ____/_____/____

(Physician)

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		☐ M ☐ F		

ADDRESS

No. and Street | City or Post Office | Borough or Township | County | State | Zip

REPORT OF EXAMINATION

		TOOTH CHART															
		RIGHT								LEFT							
UPPER		1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER		32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
	UPPER																	Upper
	LOWER																	Lower

Is The Child Under Treatment ☐ Yes ☐ No

Treatment Completed ☐ Yes ☐ No

_____
Date of Dental Examination

_____
Signature of Dental Examiner

_____
Print Name of Dental Examiner

_____
Address