CERTIFICATE OF RELIGIOUS EXEMPTION TO TEST CHILDREN FOR LEAD

Child's last name: _____ Child's first name: _____ Middle: _____

Date of Birth: _____
(MM/DD/YYYY)

I, _____, understand that lead poisoning in children is usually caused by lead
Parent or Guardian
paint in homes built before 1960. I also understand that lead poisoning can also be caused by eating non-food items such as dirt, by playing with toys or wearing jewelry manufactured outside the United States, by using home or folk remedies, or by eating food imported from countries where lead is not regulated.

I understand that children exposed to lead do not look sick. Lead-poisoned children may be easily excited, have problems paying attention, complain of stomach aches and headaches, or be more tired than usual. Lead-poisoned children may have learning problems when they start school. Children with very high lead levels may have severe brain damage or even die.

I understand that the only way to know if my child is lead-poisoned is to have their blood tested. However, I refuse to have my child tested for lead poisoning because of my religious belief. I understand that not testing my child for lead could have significant consequences on my child's development and school achievement.

I hereby release, waive, discharge, and covenant not to sue my child's health care provider, the Iowa Department of Public Health, and the state of Iowa, and all employees, officials, staff, agents, and volunteers of these entities and agencies for any liability, claim, and/or cause of action arising out of my refusal to have my child tested for lead poisoning or arising out of any loss, damage, injury, or illness that occurs as a result of the fact that my child was not tested for lead poisoning.

I understand that this religious exemption does not relieve me from an obligation to provide necessary medical treatment for my child who may become sick or injured. I understand that mandated reporters may have a legal duty to report a neglected child of mine if they have reason to believe that my child is being deprived of necessary medical treatment.

Signature: _____ Date: _____
Parent or Guardian — Date (MM/DD/YYYY)

Address: _____ City: _____ State _____

This instrument was acknowledged by: _____
Name of Notary Public

on: _____
Date (MM/DD/YYYY)

Signature of Notary Public: _____

Keep the original with you and file a copy with your child's school and with the Department of Public Health by email rossany.brugger@idph.iowa.gov or by fax: (515) 281-4529.
Be aware that this document will not be valid until you have the Notary Public sign it and stamp it, and you submit the copies as indicated.

Seal or Stamp