



# City of Phoenix

**NEIGHBORHOOD SERVICES DEPARTMENT  
NEIGHBORHOOD REVITALIZATION DIVISION  
LEAD HAZARD CONTROL PROGRAM**

in partnership with the  
Arizona Department of Health Services (ADHS)  
and the  
Maricopa County Department of Public Health Services (MCDPHS)  
and funded by the  
U.S. Department of Housing and Urban Development (HUD)

## **FAMILY CONSENT**

I live in a house or apartment that will have the lead hazards from paint, dust and soil evaluated and controlled under the City of Phoenix Lead Hazard Control Program (LHCP). Participation of my family in the LHCP is completely voluntary and will involve the interview of an adult in the household and blood lead testing of children under six years of age, who live in the home.

### **Services:**

Participation of the family will take place in two phases:

- (1) before the lead remediation of the home,
- (2) about 6 weeks after remediation,

Dust testing and follow-up inspections are mandatory activities under the LHCP and will take place at the same times.

The interview and follow-up inspections will take less than an hour each to complete. They will be scheduled in advance for the mutual convenience of the LHCP and myself. Lead hazards may be identified that will need corrective action. LHCP personnel will advise me about these.

Collection of blood specimens for testing will take place at my home.

The Centers for Disease Control and Prevention recommends that all children under the age of 6 years, especially those who live in housing built prior to 1978, be tested for lead. After my child is tested, I will be notified of the results. If my child's blood lead level is 10  $\mu\text{g}/\text{dL}$  or greater, the Arizona Department of Health Services (ADHS) will be notified, as required by state law. The Maricopa County Department of Public Health Services and the ADHS will assist me, if my child's lead level is 10  $\mu\text{g}/\text{dL}$  or greater.

I will be informed of the results of all environmental testing and follow-up inspections done in connection with the LHCP and of any corrective action I need to take to protect my child from lead.

Temporary relocation may be required at the expense of the LHCP, for safety reasons related to remediation.

**Risks:**

Participation in this program does not pose any risk to me.

Blood collection may cause children to cry for a short time. The blood sample will be drawn, as appropriate, from either the finger or the arm. If drawn from the finger and the analysis of that sample indicates an elevated blood lead level, the result will be confirmed by analyzing blood taken from the arm vein at a later date. The risks of the blood collection processes include: soreness and a small bruise at the site, or sometimes a small blood clot or swelling at or around the vein, or slight bleeding from the site.

Although the LHCP will take all reasonable precautions to protect my family during the lead hazard control work, some risks may be associated with the control of lead hazards in and around my home. Therefore, testing my child's blood is important for his/her safety.

If I am a renter, my child's blood lead results and the interview results will not be shared with my landlord by the LHCP, but the landlord will be informed of all paint, dust, soil, and visual inspection results. Medical information is protected by law and will be handled as confidential by the LHCP, including the ADHS and Maricopa County Department of Public Health Services.

I am free to withdraw from this program at any time.

**PLEASE CIRCLE:**

I DO / DO NOT agree to be interviewed by program personnel.

I DO / DO NOT agree to have my child(ren)'s blood tested for lead.

**CHILDREN ELIGIBLE TO PARTICIPATE IN THE STUDY**

The children under the age of six now living in my household are:

NAME	DATE OF BIRTH	PARTICIPATE
_____	_____	YES/NO

Secondary Addresses:

Child	Property Name	Address	Phone	Approx year constructed	Hours per week at location

**MEDICAL INFORMATION RELEASE**

Results of blood lead tests of my children should be sent to:

Physician/Clinic \_\_\_\_\_

Physician Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

**SIGNATURE:**

\_\_\_\_\_  
Parent/Legal Guardian (Print)

\_\_\_\_\_  
Parent/Legal Guardian (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's/Legal Guardian's Address

\_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
Work Phone Number

\_\_\_\_\_  
Witness - Staff Member

\_\_\_\_\_  
Date