

PARENT REFUSAL OF NEWBORN SCREENING

_____ I choose not to have Blood Spot screening for my child. I understand that this screening checks for more than 50 metabolic, hematologic, endocrinologic, or immunologic disorders. I understand that such screening is recommended by local, national, and international Public Health authorities.

_____ I choose not to have my infant's Hearing screening done.

_____ I choose not to have my infant receive a heart screening, which checks for critical congenital heart disorders.

I, the parent or guardian of the infant named below, understand that:

1. Choosing not to have my newborn screened for heritable and congenital disorders may result in delayed treatment of the onset of symptoms which may be detected only several weeks or months after birth.

Name of child: _____ Birth date: _____

Hospital or Midwife: _____

Parent or guardian signature: _____

Parent or guardian printed name: _____

Relationship to child: _____ Date of Refusal: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Send completed form to: Nemours Newborn Screening Program
1600 Rockland Road

Fax: 302-295-0719
Phone: 302-651-5079