Parental Refusal of Newborn Screening

By signing this form, I understand that I am choosing NOT to have my child receive newborn screening.

(Parent or guardian: Check below the box or boxes that apply.)

Refusal of screening

☐ I choose not to have my child receive newborn bloodspot screening from the Minnesota Department of Health for the diseases screened for by the Newborn Screening Program.

☐ I choose not to have my child screened for hearing loss.

(Parent or guardian: Read and initial each statement below.)

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

Choosing not to have my newborn screened for heritable and congenital disorders may result in delayed treatment if she or he has a disease that can be detected by newborn screening. *Initial here:* ______

Delayed treatment for diseases detected by newborn screening may result in my child suffering permanent damage which may include profound mental retardation, growth failure, hearing loss, and or death.
Initial here: ______

I further understand that diseases detectable by newborn screening may cause permanent health problems prior to the onset of symptoms, which may not appear until several weeks or months after birth. *Initial here:* ______

I am aware that if I were to have my newborn screened, the remaining bloodspot would be destroyed after 71 days and test results destroyed after 24 months. *Initial here:*_____

Name of infant:	Birth date:
Hospital or place of birth:	

Parent or guardian signature: ____

Parent or guardian printed name: ____

Relationship to child: ______________________________Date: ______________

Street address: ____

City: ___________________________Zip: ____________ Phone: ____________

Send completed form to:

Minnesota Department of Health
Newborn Screening Program
P.O. Box 64899
St. Paul, MN 55164-0899

Phone: (800) 664-7772
Fax: (651) 201-5471
E-mail: newbornscreening@health.state.mn.us
Website: www.health.state.mn.us/newbornscreening