Refusal of Iowa Newborn Blood Spot Screening
Iowa Department of Public Health

INFANT NAME: DATE OF BIRTH: TIME OF BIRTH;

INFANT'S ADDRESS:

PARENT'S ADDRESS:

PARENT'S PHONE NUMBER home or cell (circle one): PARENT'S EMAIL ADDRESS:

PLACE OF BIRTH (FACILITY NAME):

ATTENDING BIRTH CARE PROVIDER AT BIRTH:

PROVIDER WHO WILL BE OVERSEEING BABY'S WELL-BABY CHECKS:

I have received and read the parent informational brochure which describes the newborn screening tests currently being performed in the state of Iowa. I understand that these disorders are easily detected by testing a blood sample from my baby's heel.

I have been informed and I understand that it is the law of the state of Iowa that all newborns shall be screened for these disorders.

I have been informed and I understand that this screening is done to detect these disorders because symptoms sometimes do not appear for several days, weeks or months.

I have been informed and understand that, if untreated, these conditions may cause permanent damage to my child, including intellectual disability (mental retardation), growth failure, and death.

I have discussed this screening with _____
(BIRTH CARE PROVIDER)

and I understand the risks to my child if this screening is not completed.

My decision is made freely and I accept the legal responsibility for the consequences of this decision.

Reason for refusal:

_____

_____

_____

I hereby release, waive, discharge, and covenant not to sue _____
(NAME OF HOSPITAL OR BIRTH CARE PROVIDER)

the Iowa Department of Public Health, 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 allow my child's birth care provider to conduct newborn metabolic screening on my baby or arising out of any loss, damage, injury, or illness that occurs as a result of the fact that my baby was not screened for the congenital disorders available in the testing panel.

_____ _____

SIGNATURE PARENT OR LEGAL GUARDIAN DATE

_____

PRINT NAME OF PARENT OR LEGAL GUARDIAN

Return to: State Hygienic Laboratory c/o NBS Follow-up Program
Email: iowanewbornscreening@uiowa.edu Fax 319-384-5116