



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 may 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 also have the option of having my child screened and having his or her bloodspot and test results destroyed within two years. *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