IOWA Health and Human Services

Refusal of Iowa Newborn Blood Spot Screening

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:

PLEASE CHECK:

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

□ 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, and may occur without a history of other family members having a disorder.

□ I have been informed and I understand that newborn screening blood spots are stored by the newborn screening program for newborn screening purposes only, including further testing on the newborn and development of new testing methods. The newborn screening blood spots are not released to researchers or law enforcement unless the parent or guardian has provided consent, or a court of law orders the release. The newborn screening blood spots are stored for 5 years and are then destroyed.

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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 (optional): _____

_____

I hereby release, waive, discharge, and covenant not to sue:

_____,
(NAME OF HOSPITAL OR BIRTH CARE PROVIDER)

the Iowa Department of Health and Human Services, 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 blood spot 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 Iowa testing panel.

_____ _____
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

_____
PRINT NAME OF PARENT OR LEGAL GUARDIAN

Return to: NBS Follow-up Program

Email: iowanewbornscreening@uiowa.edu

Fax 319-384-5116

If you need help completing this form or want to request an accommodation, contact access@hhs.iowa.gov. Business hours are Monday-Friday, 8:00 am – 4:30 pm.