IOWA | Health and Human Services
Public Health

Parental Refusal of Testing for Congenital Cytomegalovirus

Infant's Name:

Date of Birth: Time of Birth:

Infant's Address:

Parent's Name(s):

Parent's Phone Number:

Parent's Email Address:

Place of Birth (Facility Name):

Infant's Provider Who Will Be Overseeing Well-Baby Checks:

I have received and read the parent informational flyer **Iowa Newborn Screening Program Brochure** which describes the newborn testing for Congenital Cytomegalovirus (cCMV). I understand that a urine sample or a cheek swab may be taken from my baby for this test, and this test does not harm my baby.

I have been informed and I understand that it is the law of the state of Iowa that all newborns who fail their newborn hearing screening shall be offered testing for the presence of cCMV in their newborn.

I have been informed and I understand that this testing is done to detect cCMV because when symptoms appear the baby may already be in distress, and that it is important to get regular health care visits for my baby to check for any changes to my baby's health, should my baby test positive for cCMV.

I have discussed this testing with: _____ [insert name of healthcare provider] and I understand the risks to my child if this testing is not completed.

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

I hereby release, waive, discharge, and covenant not to sue _____ [name of hospital or health 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 health care provider to conduct testing for congenital cytomegalovirus 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 tested.

_____

Print Full Name of Parent/Legal Guardian

_____ _____

Signature of Parent/Legal Guardian Date

Original to be filed with the Medical/Education record of this baby and upload a copy to the baby's record in the EHDI Database (Iowa Newborn Screening Information System) or fax the signed form 515-242-6013.

470-0326 (05/26)