Refusal of Testing for Congenital Cytomegalovirus
Iowa Department of Public Health

INFANT'S NAME:

DATE OF BIRTH:

INFANT'S ADDRESS:

PARENT'S NAME(S):

PLACE OF BIRTH (FACILITY NAME):

HEALTH CARE PROVIDER:

I have received and read the parent informational flyer "Congenital Cytomegalovirus (cCMV) Information for Parents, Sample Collection and Testing" 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 _____
(HEALTH CARE PROVIDER)

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

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

Reason for refusal: (please explain) _____

I hereby release, waive, discharge, and covenant not to sue _____
(NAME OF HOSPITAL OR HEALTH 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 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.

_____ _____
SIGNATURE PARENT OR LEGAL GUARDIAN DATE

_____
PRINT NAME OF PARENT OR LEGAL GUARDIAN