IOWA | Health and Human Services
Public Health

Parental Refusal of Newborn Hearing Screening

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:

Congratulations on the birth of your baby! You have indicated an objection to the hospital conducting a hearing screening test on your baby. We want to ensure you understand some facts prior to signing this refusal form.

First, the hearing screening test would not hurt your baby. Most babies sleep through the test and you are welcome to watch the screening being performed.

Second, hearing loss is considered a **Developmental Emergency** according to the American Academy of Pediatrics. Hearing loss occurs in approximately two out of every 1,000 born in the United States.

Third, if your baby does have a hearing loss, it is important to know about it as soon as possible. A delay in identifying hearing loss may lead to delays in language and other developmental skills. Early detection of hearing loss and enrollment in early intervention before six months of age has been demonstrated to be highly effective in facilitating a child's language and communication development.

Finally, you should not rely on your own ability to determine whether your baby has hearing loss. Reliance on parental recognition to detect hearing loss has not been successful. Your refusal to allow your baby to be screened for hearing loss could have significant consequences for your baby's future development.

I have been told about the importance of having my baby's hearing tested. I have read and fully understand the above facts. I will make arrangements with my baby's care provider or pediatric audiologist if I want to have my baby's hearing tested at a later date.

I hereby release, waive, discharge, and covenant not to sue _____ [insert name of provider/facility], the Iowa Department of Health and Human Services, the State of Iowa, and all employees, officials, staff, and agents of any of these entities for any liability, claim, and/or cause of action arising out of my refusal to allow this hospital to conduct newborn hearing 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 hearing loss.

_____
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.