Newborn Screening Program
302-651-5079
Fax: 302-295-0719

PARENT REFUSAL OF NEWBORN SCREENING

_____ I choose not to have Blood Spot screening for my child. I understand that this screening checks for more than 50 metabolic, hematologic, endocrinologic, or immunologic disorders. I understand that such screening is recommended by local, national, and international Public Health authorities.

_____ I choose not to have my infant's Hearing screening done.

_____ I choose not to have my infant receive a heart screening, which checks for critical congenital heart disorders.

I, the parent or guardian of the infant named below, understand that:

1. 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 only several weeks before the onset of symptoms, which may not appear until several weeks or months after birth.

Name of child: _____ Birth date: _____

Hospital or Midwife: _____

Parent or guardian signature: _____

Parent or guardian printed name: _____

Relationship to child: _____ Date of Refusal: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Send completed form to: Nemours Newborn Screening Program
1600 Rockland Road
Fax: 302-295-0719
Phone: 302-651-5079

Nemours

DELAWARE HEALTH