DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

NEWBORN SCREENING PROGRAM
302-608-5735
Fax 302-661-7227

Parental Refusal of Newborn Screening

By signing this form, I understand that I am choosing NOT to have my child receive newborn screening.

(Parent or guardian: Check below the options that apply)

_____ I choose not to have blood spot screening for my child for over 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 have hearing screening

_____ I choose not to have my infant receive screening for Critical Congenital Heart Disorders

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

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 by newborn Screening.

Delayed treatment for diseases detected by newborn screening may result in my child suffering permanent damage which may include profound developmental delay, growth failure, hearing loss, or death.

I further understand that diseases detectable by newborn screening may cause permanent health problems prior to the onset of symptoms, which may not appear until several weeks or months after birth.

Name of Child: _____ Birth Date: _____

Hospital or place of birth: _____

Parent or guardian signature: _____

Parent or guardian printed name: _____

Relationship to Child: _____ Date: _____

Street address: _____

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

Send completed form to: Delaware Division of Public Health
Newborn Screening Program
fax: 302-661-7227
phone: 302-608-5735