DEPARTMENT OF HEALTH

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 box or boxes that apply.)

Refusal of screening

- ☐ I choose not to have my child receive newborn blood spot screening from the Minnesota Department of Health for the diseases screened for by the Newborn Screening program.
- ☐ I choose not to have my child screened for hearing loss.
- ☐ I choose not to have my child screened for critical congenital heart disease.

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

Choosing not to have my newborn screened for heritable and congenital disorders may result in delayed treatment if my child 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 mental retardation, 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:
Minnesota Department of Health
Newborn Screening
P.O. Box 64899
St. Paul, MN 55164-0899

Phone: (800) 664-7772
Fax: (651) 215-6285
Email: health.newbornscreening@state.mn.us
Website: www.health.state.mn.us/newbornscreening

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