Wyoming Department of Health

Maternal and Child Health Unit
Public Health Division
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Stefan Johansson
Director

Mark Gordon
Governor

Infant's Name:	Date of Birth:
Mother's Name:	Address:
Phone:	

I understand the screening of my infant for metabolic and genetic conditions. I have read and comprehend the informational brochure on Newborn Screening and understand the nature and purpose of the test. I know that metabolic and genetic screening may be obtained by having a blood sample taken by a qualified healthcare professional. I am aware that there could be a charge assessed which may or may not be covered by insurance. I agree to pay for the screening if it is not covered by insurance. I understand that this information will be used to ensure that appropriate and timely medical services are made available to my child.

I authorize this screen:

_____
Signature, Date

_____
Relationship to Infant

I do not authorize this screen:

_____
Signature, Date

_____
Relationship to Infant

I understand the pulse oximetry screening of my infant for critical congenital heart disease (CCHD). I have read and fully understand the informational brochure on CCHD and accept responsibility for choosing not to have this screening performed. I am aware that there could be a charge assessed which may or may not be covered by insurance. I agree to pay for the screening if it is not covered by insurance. I understand that this information will be used to ensure that appropriate and timely medical services are made available to my child.

I authorize this screen:

_____
Signature, Date

_____
Relationship to Infant

I do not authorize this screen:

_____
Signature, Date

_____
Relationship to Infant

If the parent chooses to waive any portion of the screen, the completed consent/waiver form MUST be returned to the Wyoming Department of Health within 10 days of birth.