BRONSON CHILDREN'S HOSPITAL	Affix Patient Label
	Patient Name: Date of Birth:

The Michigan Department of Community Health requires that my child be tested for some disorders under the Newborn Screening.

I have been given information about the test and the disorders.

I know:

- The disorders can have a very bad effect on my child's mental and physical health.
- My child can die from these disorders.

I have had a chance to ask questions. I do not want my child tested.
Michigan Department of Health, Newborn Screening Program, this hospital, the attending physician and the person collecting the specimen are not responsible for any injury or illness because of my refusal.

Parent/Guardian Signature:_____Date:_____Time:_____

Parent/Guardian Signature:_____Date:_____Time:_____

Witness signature:_____Date:_____Time:_____

cc. Michigan Department of Community Health
Newborn Screening Program
201 Townsend Street CV-4
Lansing, MI 48909
Faxed signed copy to: (517) 335-9419

Complete form - **Signed Original** *to Chart* - **Copy** *to Patient*