Reset Form

RELIGIOUS WAIVER FOR THE NEWBORN SCREENING PROGRAM

State Form 54102 (R4 / 12-23)
INDIANA DEPARTMENT OF HEALTH

ATTACH LABEL HERE OR COMPLETE DEMOGRAPHICS ON WAIVER.

I have been informed about the Newborn Screening Program for the State of Indiana and have received and read information about the screenings required by law, but I choose to object to the following screens being performed on my child for reasons pertaining to my religious beliefs:

☐ Hearing Screening (for hearing loss) ***If the hearing screen is the only screen refused, fax completed waiver to 317-925-2888.**

☐ Heel Stick Screening (for over 50 rare genetic conditions)

☐ Pulse Oximetry Screening (for critical congenital heart disease)

Newborn's First and Last Name: _____ Date of Birth: ___/___/____

Newborn's Sex: ☐ Female ☐ Male

Mother's First and Last Name: _____ Date of Birth: ___/___/____

Birth Facility/Midwife(ry): _____

_____ _____
Signature of Parent Date *(month/day/year)*

_____ _____
Signature of Witness Date *(month/day/year)*

IF HEEL STICK SCREENING IS REFUSED, but pulse oximetry or hearing screens are performed, use the space below to report all results prior to returning this waiver to IDOH.

Hearing Screening

Initial Screen

Date of Screen ___/___/___

Left Ear:	Right Ear:
☐ Pass	☐ Pass
☐ Refer	☐ Refer

Rescreen

Date of Screen ___/___/___

Left Ear:	Right Ear:
☐ Pass	☐ Pass
☐ Refer	☐ Refer

Risk Factors: *(Check all that apply.)*

☐ Craniofacial anomalies
☐ Family history of congenital hearing loss
☐ Intrauterine infection
☐ Jaundice

Pulse Oximetry Screening

Initial Screen

Date:___/___/___ Time: _____

Location: ☐ Newborn Nursery ☐ NICU ☐ Other *(specify)*:_____

O_2 Saturations: Right Hand _____ Foot _____

Result: ☐ Pass ☐ Did NOT Pass

Rescreen

Date:___/___/___ Time: _____

Location: ☐ Newborn Nursery ☐ NICU ☐ Other *(specify)*:_____

O_2 Saturations: Right Hand _____ Foot _____

Result: ☐ Pass ☐ Did NOT Pass

Echocardiogram

Date:___/___/___ Time: _____

Result: ☐ Normal ☐ Abnormal *(Dx)*_____

Screen not performed due to exception:

☐ Prenatally diagnosed with CCHD
☐ On supplemental O_2/Respiratory support
☐ Echocardiogram performed before screening
☐ Receiving palliative/hospice care

Send completed waiver to IDOH GNBS:
NewbornScreening@health.in.gov
Fax: (317) 234-2995