Galactosemia Newborn Screening Consent Form

Newborn Information

Baby's Name:

Date of Birth:

Time of Birth:

Hospital/Birth Place:

Parent/Guardian Information

Name:

Relationship to Newborn:

Contact Number:

Information About Galactosemia Screening

Consent

☐ I consent to have my newborn screened for Galactosemia.

Parent/Guardian Signature:

Date:

For Staff Use Only

Staff Name:

Date Collected: