Newborn Screening Program of BC
Department of Pathology and Laboratory Medicine
4480 Oak Street, Room 2F27
Vancouver, BC
V6H 3V4
Fax: 604-875-3836

Dear Newborn Screening Program Administrator:

Please send me the Blood Spot Test Cards that are stored for my children as part of the Newborn Screening Program of B.C. immediately. I was not advised that you were storing the cards indefinitely, nor was I told that there could be medical research done with these cards or that they would be available to government or law enforcement for other purposes. I do not consent to your storage of the cards or the use of the cards for any purpose other than that disclosed to me, namely testing for specific named genetic disorders for the purposes of treating my child.

I have legal authority to act on behalf of the following children, as either parent or legal guardian, and all children are under the age of 18:

My child(ren)'s name(s) is/are:

Child #1 Name: ______________________________________

Care Card #: _________________________________

Date of Birth: ________________________________

Child #2 Name: ______________________________________

Care Card #: _________________________________

Date of Birth: ________________________________

Please send the cards to me at the following address:

Name ____

Street ____

City/Postal Code____

Phone # ____

I certify that I am the parent or legal guardian for the above-noted children and that I have full legal authority to act on behalf of those children for the purposes of this request.

______________________________ ______________________________

Signature Date

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Witness Signature