VERMONT
DEPARTMENT OF HEALTH
healthvermont.gov

SICKLE CELL REQUEST FORM FOR INDIVIDUALS BORN IN VERMONT

IF THE INDIVIDUAL WAS NOT BORN IN VERMONT, PLEASE CONTACT THE NEWBORN SCREENING PROGRAM FOR THE STATE IN WHICH THE INDIVIDUAL WAS BORN

The NCAA, U.S. Military, and other entities require those participating in strenuous activities to provide proof of their sickle cell trait status. Newborn screening provides information about the newborn's risk of having a congenital or inherited condition. Newborn screening does not provide diagnostic testing, and newborn screening results are not confirmation of a congenital or inherited condition. Newborn screening is not intended to provide information about an adult's risk for a condition. We instead recommend the individual work with their provider to obtain a diagnostic test and receive appropriate counseling regarding the results. By requesting these results the individual below acknowledges the risk in relying on newborn screening results as a means of verifying sickle cell status.

SECTION I (*please print)*

Student/Individual's Name: _____ Birth Order (if a twin/multiple birth): _____

Birth Parent's Full Name at Time of Individual's Birth: _____

Date of Birth: _____ Hospital of Birth: _____

_____

Please fax Sickle Cell Screening Results to: ☐ Individual ☐ Parent ☐ Health Care Provider ☐ Organization listed in Section III

Please send report to fax #: _____

Phone # for follow up questions: _____

IF YOU ARE REQUESTING YOUR OWN RECORD (OR ARE THE PARENT/GUARDIAN OF THE INDIVIDUAL IF UNDER 18 YEARS OF AGE) AND YOU WANT US TO SEND THE REPORT TO YOU, STOP HERE AND FAX REQUEST TO 802-951-1218

Health Care Providers: By making this request, you certify that you are the current health care provider for this individual.

Practice Name: _____ Attn: _____

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IF YOU ARE A PROVIDER, STOP HERE AND FAX REQUEST TO 802-951-1218

Sections II-VI must be completed if report is to be sent to a party other than the individual or health care provider

Individuals who want the **Vermont Newborn Screening Program** to share information about them with another person or organization, must fill out all the sections below and fax both pages of this release form. If any sections are left blank, the permission will not be valid, and we will not be able to share information with the person(s) or organization you listed on this form.

SECTION II (*please print name)*

I, _____, give my permission to The Vermont Newborn Screening Program of the Vermont Department of Health, 280 State Dr., Waterbury, VT. 05671-8360, Phone: 802-951-5180 and Fax: 802-951-1218, to share only my newborn sickle cell screening results with the person(s) or organization that I list in Section III below.

SECTION III – Who May Receive My Information

The Vermont Newborn Screening Program may share **my newborn sickle cell screening results** with this person(s) or organization:

Name:_____

Organization:_____

Address:_____

Fax: _____ Phone: _____

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION IV – Signature **Please sign and date this form and print your name.**

_____ _____

Individual's Signature **Date**

_____

Print Individual's Name

If this form is being filled out by someone who has the legal authority to act for the individual (such as the parent of a minor child, a court appointed guardian or executor, or health care agent), please

Print the name of the person filling out this form: _____

Signature of the person filling out this form: _____

Relationship to the individual: _____

Please provide any documents setting forth the legal authority, for example copies of an official birth certificate.

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SECTION V – Reason for Sharing this Information:

Participation in Athletics: _____ Other: _____

SECTION VI – How Long This Permission Lasts

This permission to share my information is good until (indicate date): _____

If I do not list a date, this permission will last for one year from the date it is signed.

I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to **The Vermont Newborn Screening Program of the Vermont Department of Health, 280 State Dr., Waterbury, VT. 05671-8360, Phone: 802-951-5180 and Fax: 802-951-1218.** If the information has already been given out by the Vermont Newborn Screening Program, I understand that it is too late for me to change my mind and cancel the permission.