Beth Israel Lahey Health
Mount Auburn Hospital

Erythromycin Administration Waiver

REFUSAL OF RECOMMENDED NEWBORN TREATMENT

STAMP PATIENT PLATE HERE

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I request that the administration of erythromycin eye ointment for the treatment of possible newborn eye infections not be performed on _____ prior to discharge from Mount Auburn Hospital.

I refuse Erythromycin eye ointment which is used for the prevention of Chlamydia and gonorrhea infection in my infant's eyes that can cause infection and in some cases permanent eye injury and blindness. I have been informed that this treatment is required by the Massachusetts Department of Public Health in accordance with Massachusetts General Laws, Chapter 111, Section 109A.

I am aware that this action is not consistent with the medical standards for newborns established by the Center of Disease Control (CDC) and the American Academy of Pediatrics (AAP) and is against the advice of my infant's attending physician. I have been informed of the purpose and benefits of the Erythromycin eye ointment for the treatment of newborn eye infection and the risks and complications that may result from refusal of Erythromycin administration for my infant.

I hereby release Mount Auburn Hospital, its employees, staff, physicians, officers, directors and agents from liability for any harm and other consequences related to my refusal of the administration of the Erythromycin eye ointment for my infant. I agree and accept responsibility for informing my infant's pediatrician and other health care providers that specific administration of Erythromycin eye ointment has **not** been performed.

I have read this document in its entirety, have had the opportunity to ask questions, and fully understand it.

Nevertheless, I have decided at this time to decline administration of Erythromycin eye ointment for my newborn. I know that failure to follow this recommendation by the CDC and the AAP may endanger the health and well-being of my baby.

Parent or Authorized Person's Signature:

_____ _____ ___/___/___ _____:_____

Parent *(or person authorized to sign for patient)* | Print Name | Date | Time *(24 hours)*

Witness to Parent or Authorized Person's Signature:

_____ ❒ **RN** ❒ **MD** _____ ❒ **RN** ❒ **MD** ___/___/___ _____:_____

Witness Signature | Print Name | Date | Time *(24 hours)*