

THE FOLLOWING CONSENT MUST BE COMPLETED IN ADVANCE AND PRESENTED ON THE DAY OF THE BLOOD DONATION.

PLEASE COMPLETE THIS CONSENT USING BLUE OR BLACK INK. FORMS COMPLETED IN PENCIL WILL NOT BE ACCEPTED



PLEASE PRINT THE FOLLOWING INFORMATION

Donor Information

Donor Legal Name: _____ Age: _____ Birthdate: _____

Nickname (if applicable): _____

Student's last 4 digits of their SSN: _____ High School (if applicable): _____

By signing this consent, I understand that abnormal results of laboratory testing will be provided to my parent or guardian (if age sixteen), and all appropriate state and local agencies as required by law (regardless of age).

Student Signature: _____ Date: _____

Parent/Guardian Information

Parent/Guardian Name: _____

Street Address: _____

Donor City/State: _____

Zip Code: _____ Daytime/Cell Phone: _____

*By signing this document, I acknowledge that I am the parent or guardian of the student listed above. I also acknowledge that I have read and understand the information on the attached "Dear Parent" letter, acknowledge that additional information is available by phone or internet using the contact number and internet address provided, and hereby consent for this student to make a voluntary blood donation through Hoxworth Blood Center, University of Cincinnati *. This consent includes submission to all tests, examinations and procedures customary in connection with the blood donation process, including the donor consent statement.*

Parent/Guardian Signature: _____ Date: _____

**A signed parental consent must be obtained prior to each time a sixteen year-old donor presents for donation.*

6-2722



Our donors save lives.