Hoxworth
BLOOD CENTER
UNIVERSITY OF CINCINNATI

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 Name: ______________________________ Age: _____ Birthdate: ____________

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 Academic Health Center. 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.