

Consent for Minor to Donate Whole Blood

Ref: 05-13-03

Must use ink pen only

Section 1 *(to be completed by parent or guardian)*

By completing and signing this form, I am giving permission for:

Print donor's full name: _____ Date of birth: _____

to donate blood to Stanford Medical School Blood Center on _____

Printed name of parent/guardian _____ Signature _____

Date _____ Phone number where you can be reached during normal business hours: _____

Section 2 *(to be completed by school (or Blood Center) representative)*

Signature verified by _____ Date: _____

Section 3 *(to be completed by prospective blood donor):*

I understand that my parent(s) or guardian may be notified of test results that are important to my health or which may affect my eligibility to donate blood, including the results of testing for HIV (the AIDS virus).

Donor signature _____ Date: _____