BLOODCENTER of WISCONSIN™

CONSENT TO BLOOD DONATION

Please complete the following information in ink

Name of Minor/Ward: _____

Minor/Ward Date of Birth: _____

Address: _____

City/State/Zip: _____

Telephone Number Where Parent/Guardian Can Be Reached During Donation: _____

- The minor listed above is at least 16 years old.
- I have read and understand the information provided to me about blood donation.
- I understand that samples of donated blood will be stored for future testing, and may be used in research (samples used in research will not include identifying information).
- I understand that all donated blood is tested for ABO blood typing, syphilis, HIV (the virus that causes AIDS), West Nile virus, hepatitis B and C, and other tests.
- I consent to blood donation by the minor listed above.

X _____ _____ _____

Signature of Parent/Guardian | Print Name | Date

Disclosure of Screening Test Results. By signing below, I (the minor listed above) authorize the BloodCenter to inform me and my parent/guardian of any positive blood screening test results (including HIV test results). In addition, I understand that if blood screening test results are positive (including HIV test results), the BloodCenter may put my name on a list of ineligible donors and inform certain public health agencies as required by law. I understand that HIV test results may also be disclosed to other authorized persons as governed by Wisconsin law. A list of persons to be notified and reasons that may lead to disclosure of HIV test results is available upon request. I give permission to release HIV test results to BloodCenter doctors and their assistants. This consent to disclosure is effective upon signing. I understand that a new form is required each time I donate.

X _____ _____ _____

Signature of Minor Donor | Print Name | Date

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