

**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: \_\_\_\_\_