SBMF
South Bend Medical Foundation

INFORMED CONSENT – BLOOD DONATION BY MINOR (must be 16 years old)

For Staff Use Only ☐ Photo ID checked ☐ Deferral Log checked (if no computer)

Minor's Information (please print)

Name (Last, First, Middle)	Date of Birth:	Gender: ☐ Male ☐ Female
Street Address:		
City, State, Zip:		
Mobile Phone: ( ) -- Does this phone have texting capability? ☐ Yes ☐ No		Home Phone: ( ) --
E-mail address:		
Blood Donation Date:	Blood Donation Location:	

Parent/Guardian Information

Name :	Phone : ( ) --
Address (street, city, state, zip):	

INDIANA LAW (I.C. 16-36-1-3) REQUIRES THAT ALL BLOOD DONORS LESS THAN 17 YEARS OF AGE HAVE WRITTEN PARENTAL/GUARDIAN CONSENT BEFORE DONATING BLOOD.

I authorize the minor above, who is my son, daughter or someone for whom I am a legal guardian, to provide a blood donation at the above listed location on the above listed date.

The donation process:

- Sensitive and personal information will be obtained from the donor prior to any donation as part of the routine donor screening process. Based on the information provided by the donor, South Bend Medical Foundation, Inc. will determine the suitability of the donor to donate a safe blood product. I understand that this information will not be provided to me, as South Bend Medical Foundation, Inc. must ensure donor confidentiality in order to protect the donor's rights, to protect the patient, and to ensure candid disclosure by the donor. Furthermore, I confirm that I am not aware of any reason or circumstance which would make my minor son, daughter, or individual for whom I am a legal guardian an unsuitable blood donor.
- While the blood donation process is normally a pleasant experience, it is possible that short-term side effects can occur such as dizziness, skin irritation, bruising, or fainting. Although remote, it is also possible that bruising around the vein, an infection, or nerve damage can develop during or after phlebotomy. On rare occasions, more severe reactions can occur with more serious and long-term complications.
- Donated blood will undergo testing for viral agents and diseases including, but not limited to, HIV and Hepatitis C. Abnormal tests results will be reported to the donor, to the donor's legal guardian, to the donor's physician listed above, and to any other person or entity required by Indiana law to be provided with the same. This information is confidential and will not be disclosed to any additional parties unless specifically authorized by the donor and the donor's legal guardian.
- The medical and personal information and results of testing will be held by South Bend Medical Foundation, Inc. in strict confidence and will not be disclosed to anyone without the donor's consent and consent of the donor's legal guardian, except where authorized by law.

I acknowledge that I have read and understand the information provided in this document, and I authorize the minor listed above to donate blood at the listed donation location on the listed donation date.

Parent/Guardian Signature: _____ Date _____

Donor: _____ Date _____