

Blood Donation Consent

PERSONAL INFORMATION

Full Name

Gender

Blood Unit No.

Telephone

License No.

Mobile

Birth Date

E-mail

Age

Occupation

Your Blood Group

☐ Have you donated previously?

When last?

☐ Did you have any discomfort during/after donation?

☐ Do you feel well today?

☐ Did you sleep well last night?

☐ Have you any reason to believe that you may be infected: By Hepatitis, Malaria, HIV and/or venereal disease (virinjay)?

In the last 6 months have you had any history of the following?

☐ Unexpected Weight Loss

☐ Repeated Diarrhea

☐ Swollen Glands

☐ Continuous Low-Grade Fever

In the last six months have you had any?

☐ Tattooing

☐ Ear piercing

☐ Dental extraction

Do you suffer from or have suffered from any of the following diseases?

- ☐ Heart disease
- ☐ Cancer/Malignant Disease
- ☐ Diabetes
- ☐ Hepatitis B/C
- ☐ Sexually Transmitted Diseases
- ☐ Typhoid (last 1 year)
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Allergic Disease
- ☐ Kidney Dis
- ☐ Epilepsy
- ☐ Abnormal Bleeding Tendency
- ☐ Jaundice (last 1 year)
- ☐ Malaria (6 months)
- ☐ Fainting Spells

Are you taking or have you taken any of these in the past 72 hours?

☐ Antibiotics

☐ Steroids

☐ Aspirin

☐ Vaccinations

☐ Rabies Vaccine

Is there any history of surgery or blood transfusion in the past six months?

☒ Yes

☐ No

For woman donors:

Are you pregnant?

☐ Yes

☐ No

Have you had an abortion in the last three months?

☐ Yes

☐ No

Do you have a child less than one year old?

☐ Yes

☐ No

Would you like to be informed about any abnormal test result at the address furnished by you?

☐ Yes

☐ No

Have you read and understood all the information presented and answered all the questions truthfully? As any incorrect statement or concealment may affect your health or may harm the recipient?

☐ Yes

☐ No

General Physician Examination:

Weight:

Pulse:

Temperature:

Parental Consent:

By signing below, I authorize my child to donate blood. Further, unless indicated by checking the box below, I authorize my child to do so utilizing apheresis technology as described on the reverse of this sheet.

Parent/Guardian Name:

Parent/Guardian Number:

I have understand that Blood donation is a totally voluntary act and no inducement or remuneration has been offered. Donation of Blood/components is a medical procedure and that by donating voluntarily. I accept the risks associated with this procedure. My blood will be tested for Hepatitis B/C, Malaria parasite, HIV/AIDS and venereal diseases in addition to any other screening tests required to ensure blood safety. I prohibit any information provided by me or about my donation to be disclosed to any individual or government agency without any prior permission.

Signatures

By signing below, the applicable signer confirms the consent and acknowledgement stated above.

Parent/Guardian

Name:

Date:

Blood Donor

Name:

Date: