COMMUNITY
BLOOD SERVICES

970 LINWOOD AVE WEST PARAMUS, NJ 07652

16 YEAR OLD PARENTAL/GUARDIAN PERMISSION FORM

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Name of Donor: ________________________________ Date of Birth: ___________

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My child ________________________ has my permission to voluntarily donate blood
(NAME)
Bergen Community Regional Blood Center D.B.A. Community Blood Services. This blood will be used for treatment of patients, biomedical research or for the study of new diagnostic tests under investigational protocol as deemed advisable. I also realize that this blood will be tested for evidence of exposure to certain infection including, but not limited to HIV, Hepatitis, Syphilis and other infections transmitted by blood. Positive test results will be communicated directly to the donor only.

______________________________ Signature (In ink)

____________________ Print Name

Date: ________________

Address: ________________________

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Relationship to Donor: ______________

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