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|  | **ROTARY COMMUNITY BREAST MILK BANK** |

**Health screening for breast milk donation**

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|  | Yes | No |
| I am willing to donate breast milk |  |  |

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| --- | --- | --- |
| I agree to be screened for the following blood borne infections:HIV 1 & 2 (twice) / Hepatitis B & C / HTLV 1 & 2 / Rubella / Syphilis |  |  |
| I give consent for my antenatal blood test results to be reviewed by the Rotary Milk Bank staff. I am aware I will be contacted with the results |  |  |

**Do you have, or have you ever had**

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| Insulin dependent diabetes? |  |  |
| Any long term illnesses? If yes, details |  |  |
| A tattoo in the last six months |  |  |
| Intimate contact with anyone, to your knowledge, who has any of the above blood borne infections. |  |  |
| A blood transfusion in the last four months. If yes, the stand down period is the four months |  |  |
| Are you aware of anything preventing you from donating blood/milk? If you have you lived in the United Kingdom, Europe, or the Republic of Ireland between 1980 and 1996 for a cumulative six months or more, due to legal reasons, we cannot accept your donor milk. |  |  |

**Are you taking**

|  |  |  |
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| Any long term prescribed medication or antibiotic? (Excluding oral progesterone-only contraceptive pill, thyroxine or asthma inhaler.) |  |  |
| Taking any herbal remedies? If yes, details |  |  |
| Growth hormones – including in the past (eg as a child) |  |  |

**Do you**

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| Drink more than three cups of coffee or caffeinated drinks per day (eg ‘V’, Demon, Coca Cola)? |  |  |
| Drink alcohol? If yes, how much?  (Drinking alcohol does not necessarily preclude you from donating milk) |  |  |
| Tobacco usage. No smoker Smoker Nicotine replacement therapy E cigarette |  |  |
| Consume illegal or recreational drugs? |  |  |
| Are you a vegan? If yes, is your diet supplemented with Vitamin B12? |  |  |
| I am aware that all information will be kept confidential, and the Rotary Milk Bank will keep the records. |  |  |

Donor’s name

Donor’s signature Date