ROTARY COMMUNITY BREAST MILK BANK

Health screening for breast milk donation

	Yes	No
I am willing to donate breast milk	θ	θ
I agree to be screened for the following blood borne infections: HIV 1 & 2 (twice) / Hepatitis B & C / HTLV 1 & 2 / Rubella / Syphilis-	θ	θ
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	θ	θ

Do you have, or have you ever had?

Insulin dependent diabetes?	θ	θ
Any long-term illnesses? If yes, details	θ	θ
A tattoo in the last six months	θ	θ
Intimate contact with anyone, to your knowledge, who has any of the above blood borne infections.	θ	θ
A blood transfusion in the last four months. If yes, the stand down period is the four months	θ	θ

Are you taking?

Any long-term prescribed medication or antibiotic? (Excluding oral progesterone-only contraceptive pill, thyroxine, insulin or asthma inhaler.)	θ	θ
Taking any herbal remedies or health supplements/vitamins? If yes, details	θ	θ
Growth hormones – including in the past (e.g., as a child)	θ	θ

Do you

Drink more than three cups of coffee or caffeinated drinks per day (eg 'V', Demon, Coca Cola)?	θ	θ
Drink alcohol? If yes, how much? (Drinking alcohol does not necessarily preclude you from donating milk)	θ	θ
Tobacco usage: (circle those that apply) Non-smoker Smoker Nicotine replacement E cigarette Vaping		
Consume non- prescribed or recreational drugs?	θ	θ
Are you a vegan? If yes, is your diet supplemented with Vitamin B12?	θ	θ
I am aware that all information will be kept confidential, and the Rotary Milk Bank will keep the records.	θ	θ

Donor's name

Donor's signature…… Date……/……/……

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