

CONSENT FORM FOR 17-YEAR OLD BLOOD DONORS

Son
My Daughter, _____ Age _____
Ward (Print Name)

has my permission to voluntarily donate blood to the **Bergen Community Regional Blood Center of New Jersey**. This blood will be used for the treatment of patients, or as deemed advisable by the Blood Center (biomedical research or for the study of new diagnostic tests under investigational protocol). I hereby release and forever discharge the above mentioned Blood Center, its employees and volunteers from any and all claims, demands and causes of action whatsoever by reason of the giving of blood, or tests, examinations, or procedures for any purpose whatever, to which I have submitted or am about to submit and any consequences resulting directly or indirectly there from.

Signature of Donor (*In Ink*)

Signature of Parent or Guardian (*In Ink*)

Date City-State Zip

**BERGEN COMMUNITY REGIONAL BLOOD CENTER
970 LINWOOD AVE. WEST · PARAMUS, NEW JERSEY 07652
(201) 444-3900**