



# ARCHBISHOP MOLLOY HIGH SCHOOL

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## 2010 Annual Blood Drive

### CONSENT FORM

\_\_\_\_\_ Yes, I want to give blood. (Please Check)

Height \_\_\_\_\_ Weight \_\_\_\_\_

Name: \_\_\_\_\_ Student ID# \_\_\_\_\_

Address: \_\_\_\_\_ Student H.R. \_\_\_\_\_

Emergency Contact # \_\_\_\_\_

Date of Birth: \_\_\_\_\_

This is to certify that the above named student is 16, 17 or 18 (Please Circle) years old.

I give my consent for my child to donate blood.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- Eat well before your donation
- All donors must show school ID