

Breastfeeding Center Milk Connection Questionnaire and Release for Donor

All of us at The Breastfeeding Center are deeply grateful to you for your important gift to infants in our community. Your donated milk will make a difference that lasts a lifetime.

Thank you for you for giving your time and energy to pump and donate! We will make every effort to distribute your milk to needy families.

Before we can accept your first donation, we will need lab work and a questionnaire.

Required Laboratory Tests

We must have recent laboratory test results from every donor before we can accept any donations so that we can ensure the safety of our babies. This probably will not require that you undergo any additional lab tests because these tests are usually conducted during pregnancy and the results are probably on file with your health care provider. Please note that the test results must be no more than twelve months old at the time of your first donation.

Please provide us with the results from the following tests. If you have these labs from the last twelve months, please email them back with your questionnaire. If you do not, we will arrange for a lab test once your questionnaire is reviewed by a lactation consultant.

HIV I & II

RPR (syphilis)

Hepatitis B (HbsAg)

HTLV I & II

Hepatitis C (HCV)

(Human T-Lymphotropic Virus)

If you have any questions or problems providing test results, please email us at milkconnection@breastfeedingcenter.org for assistance.

Health Questionnaire

Because many of the recipients of donated breast milk are ill or fragile, we must ask for your assistance with some health questions. Please answer each of the following questions, erring on the side of over inclusion. ***When answering the questions, answer “Yes” if the answer is yes today or at any time during which you were pumping for your donation today:***

Please explain ALL questions you answered “yes” to here. Please list with the question number.

1. Have you ever been diagnosed with HIV, Hepatitis B, Hepatitis C, Syphilis, Lyme Disease, or any other serious illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Have you ever been diagnosed with a chronic infection or a systemic disorder of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Have you ever lived with anyone who was diagnosed with HIV, Hepatitis B, Hepatitis C, Syphilis, Lyme Disease, any other serious illness, or any chronic infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. During the past twelve months, have you had (or suspect that you might have) any infections, such as active genital or oral herpes, breast yeast, mastitis, skin sores, or shingles?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Have you ever had a positive TB test?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Have you had any vaccinations, inoculations, or shots within the past twelve months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

7. During the past twelve months, have you consumed more than 24 ounces of caffeinated drinks in a day?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. During the past twelve months, have you smoked cigarettes, chewed tobacco, other tobacco products, or used vaporized cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. During the past twelve months, have you used marijuana, cocaine, ecstasy, LSD, or any other nonprescription drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. During the past twelve months, have you used nutritional supplements or herbs, such as prenatal vitamins, iron, vitamin D, fish oil, herbal teas, fenugreek, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. During the past twelve months, have you taken any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. During the past twelve months, have you used any over-the-counter medications or herbal supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. During the past twelve months, have you used any megadose vitamins and/or pharmacologically-active herbal preparations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. If you keep a vegan diet (i.e., total vegetarian), has there been any two-day period during the past four months during which you did not take B-12 vitamins?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. During the past twelve months, have you received a blood transfusion, blood products (other than Rhogam), or an organ or tissue transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<p>16. During the past twelve months, have you had a sexual partner who has received a blood transfusion, blood products (other than Rhogam), or an organ or tissue transplant?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>17. During the past twelve months, have you received any ear or body-part piercing, tattooing, or permanent make-up applied with a needle?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>18. During the past twelve months, have you had a sexual partner who has received any ear or body part piercing, tattooing, or permanent make-up applied with a needle?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>19. Have you ever injected non-prescription drugs?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>20. Have you ever had a sexual partner who has injected nonprescription drugs?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>21. During the past twelve months, have you been accidentally stuck with a potentially-contaminated needle?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>22. During the past twelve months, have you had a sexual partner who has been accidentally stuck with a potentially-contaminated needle?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<p>23. During the past twelve months, have you had a sexual partner who is at high risk for HIV/AIDS, HTLV, or hepatitis (including anyone with hemophilia, anyone who has used a needle for the injection of illegal or non-prescription drugs, anyone who has multiple sexual partners, and anyone who has taken money or drugs in exchange for sexual favors)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>24. Have you ever had acupuncture or electrolysis with needles which might not have been sterile?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>25. During the past twelve months, have you consumed more than two ounces of hard liquor or its equivalent within any 24-hour period?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>26. Have you spent more than three months in the United Kingdom at any time between 1980 and 1996?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>27. Have you spent more than five years in Europe at any time since 1980?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please read the following and then sign on the next page

I have read and fully understand the terms of this Questionnaire and Release.

I intend my signature to be a complete and unconditional waiver and release of all liability to the greatest extent allowed by law of the BCMC and its donors, employees, volunteers, officers, directors, grant-makers, or agents for any personal injury, disease, illness, sickness, adverse health effect, or risk, including but not limited to risks of property damage or wrongful death, that may result from my donation of milk. I understand that this Waiver and Release will remain in effect unless revoked in writing. I hereby agree to the terms of this Waiver and Release by signing freely and voluntarily.

All information reported on this form is true and correct to the best of my knowledge. Maintaining optimal health practices for donated milk, including safe handling and storage of pumped milk, is paramount. I agree to notify The Breastfeeding Center for Greater Washington in the event that my health status changes, or that I discover exposure to substances, medications, and/or illnesses that may make my milk unsuitable for donation or that may have affected donated milk in the past. If my health status changes, I agree to refrain from donating unless cleared to do so by BCGW. I agree to avoid alcohol for at least 12 hours prior to pumping milk for donation. I agree to use no illegal drugs and to chew or smoke no tobacco for the duration of time I am collecting milk for donation. I hereby freely and voluntarily donate my milk to BCGW/BCMC.

**DO NOT SIGN THIS WAIVER AND RELEASE
UNLESS YOU FULLY UNDERSTAND AND AGREE TO ITS CONTENTS.**

Breastfeeding Center Milk Connection Donor Information

Donor's Name	Name of Donor's Spouse (if any)
Donor's Signature	Donor's Date of Birth
Donor's Telephone Number	Donor's Email Address
Donor's Address	

Additionally, please describe how your milk has been frozen and what the earliest date of pumping/storing was or will be: