MOTHERS' MILK ALLIANCE, Inc. Donor History & Statement of Health

local wealth for local health

First Name:_____ Last Name:_____

Phone:_____ Email:_____

Address:_____ Your Date of Birth:_____

Infant's Date of Birth:_____ Infant's Gestational Age at Birth:_____

Mothers' Milk Alliance, Inc. (MMA) is deeply grateful for your enormous gift to infants in our community. Answering "yes" to questions below does not necessarily rule out your milk for donation. Your answers may offer opportunities for clarification, discussion, and/or education.

All information provided on this form is strictly confidential.

		Yes	No
1.	Many milk recipients ask to send the donor a "thank you." Are you comfortable sharing your contact information with recipients?	☐	☐
2.	Are you comfortable sharing your pumped milk directly with a recipient (having it picked up from your home or dropping it off at the recipient's home)?	☐	☐
3.	Do you now have or did you have at time of pumping any member of your family with HIV, Hepatitis B, Hepatitis C, Syphilis, Lyme Disease, or any other serious illness? If yes, please explain:_____ _____	☐	☐
4.	Do you now have or did you have at time of pumping any known or suspected infection such as active genital or oral herpes, breast yeast, mastitis, skin sores, shingles, or any other infection? If yes, please explain:_____	☐	☐
5.	Do you consume more than 24oz of caffeinated drinks per day?	☐	☐
6.	Do you now or did you at time of pumping smoke cigarettes or chew tobacco?	☐	☐
7.	Do you now or did you at time of pumping use alcohol, marijuana, cocaine, ecstasy, LSD, or other recreational or social substances?	☐	☐
8.	Are you now or were you at time of pumping taking any nutritional supplements or herbs, such as prenatal vitamins, iron, vitamin D, fish oil, herbal teas, fenugreek, etc.? If yes, please give names and doses of all supplements and herbs you were taking:_____ _____	☐	☐
9.	Are you now or were you at time of pumping taking any medications, such as hormonal contraception, an anti-depressant, anti-anxiety medication, antibiotic, anti-fungal, thyroid medication, laxatives, allergy medicine, etc? If yes, please give names, doses, and dates of your medications: _____ _____	☐	☐

10. In the past 12 months, have you had any vaccinations, inoculations, or shots? ☐ ☐
If yes, please explain:_____

11. In the past 12 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, or anyone who has multiple sexual partners)? ☐ ☐

12. In the past 12 months, have you had a sexual partner who has had tattoos, permanent makeup supplied with needles, ear or other body part pierced, or been accidentally stuck with a contaminated needle? ☐ ☐

13. In the past 12 months, have you received a blood transfusion, blood products, an organ or tissue transplant, ear or body part piercing, tattooing, permanent make-up applied with needles, or an accidental stick with a contaminated needle? ☐ ☐

14. Have you ever had a positive TB test? ☐ ☐

15. Have you ever had acupuncture or electrolysis with non-sterile needles? ☐ ☐

16. Have you ever injected drugs, or had an intimate relationship with someone who has injected drugs? ☐ ☐

By my signature below, I confirm my understanding of and agreement with all of the following:

All information reported on this form is true and correct to the best of my knowledge.

The sharing of human breast milk carries inherent risks and maintaining optimal health practices, including safe handling and storage of pumped milk, is paramount. I agree to notify Mothers' Milk Alliance 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. In the event of health status changes, I agree to refrain from donating unless cleared to do so by MMA. I have read and fully understand the MMA document, "Donor Guidelines for Pumping and Handling". I have also read the MMA document, "Recipient Waiver and Release".

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 Mothers' Milk Alliance, Inc.

_____

Signature Date

For Office Use Check one: One-time Donation _____On-going Donation_____Unsure _____
Lab results obtained/verified:_____
Special donor circumstances or milk qualities:_____
_____
Other notes:_____
_____
_____