

OhioHealth Mothers' Milk Bank

Please return this form with your milk

Thank you for your donation and for keeping us updated

Today's Date: _____

Date of oldest milk in this donation: _____

Name: _____

Donor #: _____

Is this your final donation? Yes _____ No _____

Do you need storage bags? Yes _____ No _____ Please circle one: 50 100

For Milk Bank use only:	
Condition of milk on arrival	
Date:	Initials:
Frozen	Other:
Comments:	

If you are shipping via Fedex: Do you need more boxes? Yes _____ No _____ if yes/how many _____

Please Remember: Do not ship on Friday or the day before a Holiday

Since your last screening, have you:

1. Experienced any infectious or communicable diseases for yourself, sexual partner(s), or household members, including your baby?
2. Had any breast infections or problems? If yes, please give a brief explanation, including dates:
3. Had any medical procedures (e.g. surgery, dental work, x-rays or anesthesia)? If yes, please give a brief explanation, including dates:
4. Had any medication changes to include prescribed, over-the-counter, vitamins or herbal supplements, and immunizations? If so, please list them here:
5. Had any changes in Alcohol consumption or Nicotine use?
6. Had any lifestyle changes that increase your risk for bloodborne disease transmission, such as piercings, tattoos, permanent makeup, blood transfusions, incarceration (of self or sexual partner), accidental needle stick, or a new sexual partner?
7. Had any changes in milk collection routines, hygiene or storage?