 [Insert Department]

PARENT/GUARDIAN PERMISSION Form

[Insert Title of Study]

***Note to investigators:*** *this template encompasses all of the required and some additional elements of informed consent, as required by federal regulations. These requirements can be found on the* [*IRB’s website*](https://irb.okstate.edu/consent-process)*.*

*In the header above, enter the appropriate information for your department and title of your study.*

*Text that does not apply to your research should be deleted or modified as appropriate. The text is intended to be instructional rather than declarative. Be sure to delete all instructive text, which is in red, italicized font throughout the document, before submitting the informed consent for IRB review. Sections highlighted in dark grey are fillable text fields you are expected to complete.*

*Key Information: Informed consent documents that are longer than 4 pages are required to begin with a concise and focused presentation of the key information that is most likely to assist a prospective participant in understanding the reasons why one might or might not want to participate. Skip this section for now. If once you complete modifying this template, the final consent form is less than four pages long, delete this section. If the final consent form is longer than four pages, enter the following information, and delete this instructional text:*

**Key Information**

Study Purpose:

Major Procedures of the Study:

Duration of Participation:

Significant Risks:

Potential Benefits:

Compensation:

### Background Information

Your child is being invited to be in a research study of [Insert a general statement about the study]. Your child is being selected as a possible participant because [Explain how participant was identified]. We ask that you read this form and ask any questions you may have before agreeing for your child to be in the study. Your child’s participation is entirely voluntary.

**This study is being conducted by:** [Name of researcher, department (indicate University affiliation)]

***\*\*****If the Researcher is a Student, add the following:* ,under the direction of [Name of Faculty Adviser, department (indicate University affiliation)].

**Procedures**

**If you agree for your child to be in this study, we would ask your child to do the following things:** *Provide a detailed description of what participants will be asked to do, taking care to use easily understandable language and terms. It may be helpful to use pictures, tables, and/or flowcharts to improve participant comprehension of the procedures involved. If the participant will be photographed, audio taped, or video taped, include a description in this section. If your study involves deception, please give as much information as possible without using false statements.*[Procedures]

*Sample Procedure Language:*

**Ultrasound:**

Ultrasound (or sonography) is a test that uses high-frequency sound waves to show what is inside your body. Your child will lie on a cushioned table and gel will be applied to their skin; the gel acts as a conductor. A transducer, a hand-held device that sends and receives ultrasound signals, is moved over the area of the body being imaged. Images instantly are seen on a television-like monitor and sent to film or videotape for a specialist to review and interpret. Depending on the type of exam, it can take anywhere from 20-60 minutes.

**DEXA Scan:**

A DEXA is a type of x-ray used to measure bone strength. During this test, X-ray pictures of your child’s body will measure how much fat and muscle are present. Your child will lie flat on a table and a machine will take pictures of different areas of the body. This test will last about 15 minutes.

**Biopsy:**

During a biopsy a small piece of skin or muscle is removed from [site] and looked at under the microscope for: [state use]. First your child will be given [state numbing medicine] to numb the area and reduce the pain. Then a small cut will be made in the skin.

**Caliper Test:**

A tool called a caliper (like a pincher) grasps a small fold of flesh on the back of the arm, shoulder blade, or waist to measure the amount of body fat.

**EEG:**

An electroencephalogram (EEG) measures the electrical activity in the brain (brain waves) using electrodes (small metal discs or sensors) placed on the head with gel. The test does not hurt and usually takes about an hour.

**EKG/ECG**:

An electrocardiogram (EKG) is a test that gives us a measure of the heart’s electrical activity. Your child will be asked to lie flat on a table and several small electrode pads (like stickers) will be placed on the body. This test takes about 10 minutes.

**Participation in the study involves the following time commitment:** *If the study includes multiple sessions, describe the amount of time that is required for each task, session, experiment and the total time for all sessions.*[Time Required]

*If using Biospecimens:*

**Biospecimen Sampling for Research:**

Research using biospecimens (saliva, blood, tissues, etc.) is an important way to try to understand human disease and functioning. There are several things you should know before allowing your child’s biospecimens to be studied.

The type of specimens that will be stored and where they will be stored: [Sample Storage] *Example: Your blood and saliva will be stored at a facility located on the OSU-Stillwater campus.*

Identifiability of Biospecimens: [Sample Identifiablility] . *Describe how samples will be labelled and how samples will be linked - e.g., under diagnosis and medical record, code number, no link to names, etc*. *Example: The sample will be assigned a code that does not contain your name, initials, SSN, date of birth or any other unique identifier. The sample will be linked to your survey responses via a random code.*

The length of time your child’s biospecimen will be stored until they are destroyed: [Sample Storage Time] *For example: your samples will be stored until the analyses are completed, but no longer than 5 years after completion of the study. At that time, they will be destroyed.*

How to withdraw your child’s biospecimens from the study:

If linked: You have the right to refuse to allow your child’s biospecimen to be studied. You may withdraw your child’s specimen from this study at any time by contacting the Principal Investigator.

OR

If unlinked: Because your child’s samples will not be linked to their name after they are stored, you cannot withdraw your consent to the use of the samples after they are taken.

*Include the following language if samples in study will be used for genetic testing or if future research on samples will include genetic testing.*

**Biospecimen Sampling for Genetic Testing:**

As part of the analysis on your samples, the investigators [may/will] do genetic testing. Genetic research is research that studies genes, including gene characteristics and gene versions that are transmitted by parents to children. Genetic research may include looking at information, such as personal appearance and biochemistry, gene sequences, genetic landmarks, individual and family medical histories, reactions to medications and responses to treatment. Genetic research raises certain questions about informing you of any results. Possible risks of knowing results include: anxiety; other psychological distress; and the possibility of insurance and job discrimination. A possible risk of not knowing includes being unaware of the need for treatment. These risks can change depending on the results of the research and whether there is a treatment or cure for a particular disease.

Sometimes patients have been required to furnish information from genetic testing for health insurance, life insurance, and/or a job. A Federal law, the Genetic Information Nondiscrimination Act of 2008 (GINA), generally makes it illegal for health insurance companies, group health plans, and employers with 15 or more employees to discriminate against you based on your genetic information. This law does not protect you against genetic discrimination by companies that sell life insurance, disability insurance, or long-term care insurance.

When results will be given to you: The results of the study of your child’s samples will be used for research purposes only and you will not be told the results of the tests. Or You will be told the results of tests that are part of your child’s clinical care, but you will not be told the results of the research tests, including any future research tests.

**Future Use of Biospecimens:**

*Include the following language if samples in study will be used in future research:*

Information or specimens for this research may be used for future research studies or shared with other researchers for future research. If this happens, information which could identify your child will be removed before any information or specimens are shared. Since identifying information will be removed, we cannot ask for your additional consent.

The types of analyses/studies the biospecimens will be used for: [Future Use] *Example: Your child’s samples will be used to study proteins in the blood that could indicate heart disease.*

 \_\_\_\_\_ I consent for my child’s samples to be saved for future research

 \_\_\_\_\_ I do not consent for my child’s samples to be saved for future research

*Include the following language if samples in study will NOT be used in future research:*

Information or specimens collected from your child will not be used for future research studies or shared with other researchers for future research. All extra biospecimens not needed for this study will be destroyed after analysis is complete.

### Risks and Benefits of being in the Study

**The study involves the following foreseeable risks:** *Describe the risks and what you will do to minimize the risks. Include all possible physical, psychological, professional or personal risks and/or hazards for the participants in this section. Any risks listed in the protocol must be addressed in the consent form. However, it is important to not overstate the risks as well.*[Risk(s)]. In order to assist with the offset of these risks, [Protections] will be provided. *If physical injuries or mental health risks are present, a sentence must be included that states whether treatment will be provided from the research team or from the research team’s resources. [Delete if not applicable.].* In case of injury or illness resulting from this study, emergency medical treatment will be available [State how and where]. No funds have been set aside by Oklahoma State University to compensate you or your child in the event of illness or injury.

*OR*

*If no risks:*

There are no known risks associated with this project, which are greater than those ordinarily encountered in daily life.

*If in person procedures are being used and involve devices the following should be included:*

**Disinfecting materials:** When feasible, researchers will clean and disinfect surfaces between participants, using an EPA-registered disinfectant or a bleach solution (5 tablespoons of regular bleach per gallon of water) for hard materials and by laundering soft materials. Disinfected materials will be handled using gloves, paper towel, plastic wrap or storage bags to reduce the chance of re-contamination of materials.

**Electronics:** Alcohol-based wipes or sprays containing at least 70% alcohol will be used to disinfect shared touch screens, mice, keyboards, etc.

*Include the following language if appropriate.*

**Psychological Risks:**

Some of the questions asked may be upsetting or may make your child feel uncomfortable answering them. If your child does not wish to answer a question, they may skip it and go to the next question. OR

There could be a risk of discomfort and harm [Risk(s)] (Example: to psyche, reputation, employability, insurability, social status, criminal or civil liability) that may occur as a result of participation. If your child does not wish to answer a question, they may skip it and go to the next question.

**Blood Draw/Insertion of IV Catheter/Heplock:**

A blood draw may lead to lightheadedness or fainting. It may also cause bruising, prolonged bleeding, and infection at the site where the blood was drawn. In order to minimize these risks, we will swab the site of the blood draw with alcohol to disinfect the area, use disposable sterile needles and tubes to collect blood, and apply pressure to the site following the blood draw to minimize bruising. *If applicable:* The longer an IV catheter is left in place, the more common it is for redness or infection to develop.

To protect against infection, we will also provide instructions on how to care for the wound and watch it for signs of infection. It is important to know that these blood tests performed in the study are strictly for research purposes. The researcher using your child’s blood sample is not a physician and therefore not qualified to make clinical recommendations. Furthermore, no physicians will review the results of these blood tests, as the researchers are not using this test to make a diagnosis.

**Finger Stick:**

**There is a minor risk associated with this project in that you may experience slight pain when we pierce the skin on your child’s finger; however the puncture and blood collecting equipment are part of the commercially available s**ystems that have been approved by the FDA.

Drawing blood from a finger stick may, in rare cases- cause discomfort, bruising, prolonged bleeding and infection at the site of puncture. To minimize risk, we will swab the site of puncture with alcohol to disinfect the area, use disposable lancet and capillary tubes to collect blood and apply pressure to the puncture site following the blood draw to minimize bruising. We will cover the puncture with appropriate dressing and provide you with information on how to monitor for signs of infection.

**Electrocardiogram (EKG/ECG):**

This is a small risk of that redness or swelling could develop from the ECG electrodes (pads) that will be placed on your child’s chest. The test may cause some itching where the pads are placed.

**Flow Mediated Dilation (FMD):**

Occlusion of blood flow is required for the assessment of vascular vessel function via FMD. The process of occlusion may cause pain, including a numb feeling in the arm. It is possible that bruising may occur as a result of this procedure.

**Ultrasound:**

The gel may be sticky, but the test should not cause any pain or discomfort.

**Biopsy:**

The biopsy may cause some pain and discomfort. It is possible, but not likely that your child could get an infection. In very rare cases, people might have an allergic reaction to the numbing medicine. The allergic reaction could include rash/hive, flushing of the face, itching, wheezing and tightness in the throat. There will be a small scar from the biopsy.

**Caliper Test:**

There might be a little pain or discomfort from a pinch.

**EEG:**

The gel used to put the discs on your child’s head is sometimes sticky and the discs may scratch a little bit.

*Include the following language if appropriate. The Radiation Safety Officer at OSU may require modification and/or additions to this sample language as deemed appropriate in your application to the Radiation Safety Committee for this study.*

**Use of Radiation:**

In this study, your child will be exposed to a small amount of radiation called "ionizing radiation," which is like x-rays. Studies have shown that getting a lot of radiation at one time or getting many small doses over time may cause cancer. The risk of getting cancer from the small radiation dose in this study is very small. The amount of radiation you will get in the study is [state amount] mrem (a “mrem” is how we measure radiation dose). In comparison, one regular chest x-ray would give you 10 mrem. The natural radiation we are exposed to all the time – like from the sun – gives you about 300 mrem each year. Neither chest x-rays nor background radiation have been found to harm most healthy adults. At doses much higher than you will receive, radiation is known to increase the risk of developing cancer after many years. At the doses your child will receive, it is unlikely that your child will see any effects at all.

Tell us now if your child has been in other research studies where they have had ionizing radiation. Also tell us if your child has been exposed to radiation in other ways, like in radiation therapy. If your child is pregnant or nursing, they cannot be in this research study because the radiation may harm their baby. If your child is able to have a baby and is not pregnant now, and they want to be in this study, we will give them a free pregnancy test. Use if appropriate for longer term studies: If your child joins in this study, they should use contraception to keep from getting pregnant while they are in the study. If they get pregnant while they are in this study, or if you think they are pregnant, please tell the researchers right away.

**The benefits to participation are:** *List direct benefits to subjects. This section must be consistent with the benefits as explained in the protocol submitted to the IRB. DO NOT include compensation, payments, or extra credit in this section.* The benefits which may reasonably be expected to result from this study are[Direct Benefits to Participants]. We cannot guarantee or promise that you or your child will receive any benefits from this study.

*OR*

*If no direct benefits:*

There are no direct benefits to you or your child. More broadly, this study may help the researchers learn more about [Topic(s)] and may help [future populations with a similar issues/future researchers design interventions to help with a topic].

**Compensation**

*If participants will receive a small token or chance in a drawing, include that information here. Explain when disbursement will occur and conditions of payment. For example, if monetary benefits will be prorated due to early withdraw. If using a Drawing: Describe the odds of winning the drawing. If using Extra Credit: If participants will receive class points, please note the number of points as a percentage of the grade and include the alternative assignment.* You and/or your child will receive [Describe Compensation] as compensation for your participation.You and/or your child will receive payment [Include payment or reimbursement information here.] *If compensation is over $100:* You and/or your child may need to provide your social security number to receive payment. *If necessary:* To be eligible to receive the compensation, your child will need to [Describe Prorated Payment].

*OR*

*If no compensation:* You and/or your child will receive no payment for participating in this study.

*If biospecimens collected as part of this research project will be used for the research team or institution’s commercial profit, you must include the following statement. Delete if not applicable:*

Your child’s biospecimens, even once de-identified, may be used for [research team’s/sponsor’s/institution’s] commercial profit. You and/or your child [will/will not] share in that commercial profit. *OR* Your child’s de-identified biospecimens will not be used for commercial profit.

**Confidentiality**

*Use this section to describe how you will keep the participant’s data private and confidential. This should include a brief statement about how you will collect their data, store it, and use it in your study.* *Select the text appropriate for your particular study. Address then delete instructional text once complete. These examples will not cover all situations, please adjust as needed for your study.*

*Anonymous. Reseacher does not know who completed the study:*

The information your child will give in the study will be anonymous. This means that their name will not be collected or linked to the data in any way. The researchers will not be able to remove their data from the dataset once their participation is complete.

*Anonymous Results But Researchers Can Identify Who Participated:*

The information your child will give in the study will be stored anonymously. This means that their name will not be collected or linked to the data in any way. Only the researchers will know that they have participated in the study. The researchers will not be able to remove their data from the dataset once their participation is complete.

*Coded Data/Pseudonym linked with identifying information:*

The information that your child gives in the study will be handled confidentially. Their information will be assigned a code number/pseudonym. The list connecting their name to this code will be kept in a locked file. When the study is completed and the data have been analyzed, this list will be destroyed. You and your child’s name will not be used in any report.

*Confidentiality cannot be Guaranteed:*

*In some cases it may not be possible to guarantee confidentiality (e.g. an interview of a prominent person, a focus group interview, ethnographic research, oral history projects).*

Because of the nature of the data, I cannot guarantee your child’s data will be confidential and it may be possible that others will know what they have reported. The researchers will make every effort to ensure that information about them remains confidential, but cannot guarantee total confidentiality. Their identity will not be revealed in any publications, presentations, or reports resulting from this research study. *If applicable:* However, it may be possible for someone to recognize their particular story/situation/response. *If your research is in a group setting:* While we will ask all group members to keep the information they hear in this group confidential, we cannot guarantee that everyone will do so.

We will collect your information through *(Examples: interviews, audio recordings, online surveys, paper surveys, e-mail, etc.)* [Data Collection Method]. This [information/data] will be stored *(Examples: a locked drawer in a restricted-access office, on an encrypted flash drive/external hard drive, in a restricted access folder on Dropbox.com, an encrypted, cloud-based storage system, etc.)* [Data Storage]. *If the data has identifiers that will be separated and destroyed, state the timeframe for doing so:* When the study is completed and the data have been analyzed, the code list linking names to study numbers will be destroyed. This is expected to occur no later than [State Time Frame]. *If the data has audio/visual recording, please state the timeframe for destruction of the recording and what, if anything, will be kept:* The audio/video recording will be transcribed. The recording will be deleted after the transcription is complete and verified. This process should take approximately [State Time Frame]. *OR* The audio/video recording will be kept as part of the study records *(example: indefinitely until no longer useful, for five years, etc.)* [State Time Frame].This informed consent form will be kept for [State Time Frame] *(Required minimum is 3 years)* years after the study is complete, and then it will be destroyed. Your child’s data collected as part of this research project, [may/will not] be used or distributed for future research studies.

*Include the following text if using an online survey or data collection tool. Delete if not:*

The research team works to ensure confidentiality to the degree permitted by technology. It is possible, although unlikely, that unauthorized individuals could gain access to their responses because they are responding online. However, their participation in this online survey involves risks similar to a person’s everyday use of the internet. If you have concerns, you should consult the survey provider privacy policy at [insert link to online privacy policy].

*If the study is an FDA-regulated or NIH-funded clinical trial, insert the following:* A description of this clinical trial will be available on [ClinicalTrials.gov](http://clinicaltrials.gov/), as required by U.S. law. This website will not include information that can identify you or your child. At most, the website will include a summary of the results. You can search this website at any time.

*Use if you HAVE NOT received an NIH Certificate of Confidentiality: This will be for most studies.*

It is unlikely, but possible, that others responsible for research oversight may require us to share the information your child give us from the study to ensure that the research was conducted safely and appropriately. We will only share your information if law or policy requires us to do so. *If working with children, the elderly, disabled persons, or other vulnerable populations that carries a reporting requirement, please modify the bracketed language appropriately and include the following statement:* If the researchers learn that you or your child are [abusing/neglecting/going to engage in self-harm/intend to harm another], state law requires the researchers report this [behavior/intention] to the authorities. Finally, confidentiality could be broken if materials from this study were subpoenaed by a court of law.

*OR*

*Use if you HAVE received an NIH Certificate of Confidentiality: this section below is required for all NIH funded research, and any other research, with a NIH Certificate of Confidentiality.*

**Certificates of Confidentiality**

To help us protect you and your child’s privacy, we have a Certificate of Confidentiality from the National Institutes of Health (NIH). With this Certificate, we can’t be forced by a court order or subpoena to disclose information that could identify your child in any civil, criminal, administrative, legislative or other proceeding.

There are circumstances where the Certificate doesn’t protect against disclosure of your personally identifiable information:

* when the US government is inspecting or evaluating federally-funded studies
* when information must be disclosed to meet FDA requirements
* if you give someone written permission to receive research information or you voluntarily disclose your child’s study information
* if the researcher reports that you or your child threatened to harm themselves or others
* in cases of child abuse reported by the researcher
* if the investigator reports cases of contagious disease (such as HIV) to the state

You should understand that a Confidentiality Certificate does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in this research. This means that you and your family must also actively protect your own privacy. Finally, you should understand that the investigator is not prevented from taking steps, including reporting to authorities, to prevent serious harm to yourself or others.

*Include the following text if your study involves the use of protected health information (PHI) at a HIPAA covered entity. On the OSU-Stillwater campus, only 3 locations are subject to HIPAA: University Health Services, OSU Psychological Services Center, and OSU Speech Language Center. Other locations off campus may require use of this language; please check with the specific facility to determine if they are HIPAA covered entities. Delete if not needed. You may condense this information as long as all the information is included.*

**HIPAA Authorization for Release of Health Information for Research Purposes**

The Health Insurance Portability and Accountability Act (HIPAA) allows a hospital or doctor’s office to use or release protected health information (PHI) for the purposes of treatment, payment or health care operations. Health care operations activities include such things as audits, quality assurance initiatives, audits from insurance companies, treating physicians, legal advisors, insurers and data storage companies.

This HIPAA authorization gives permission from you to use or release your child’s PHI for research purposes. A HIPAA authorization is in addition to your consent to participate in this research study.

**What will be done with your protected health information?**

Your child’s protected health information (PHI) will be [State how data will be collected]. (*Example: collected and entered in a database along with the information from other people taking part in this study.)*

**Why are you being asked to release it*?***

Your child’s protected health information (PHI) will be used to [Use of HIPAA protected information].

**What will be released?**

To complete this research study, we will need to collect and release (disclose) information about your child. This information may include: *Be very specific. Delete from list what is not needed and add any additional records that may be released.*

* + Your child’s date of birth, name, contact information, social security number, medical record number, and insurance information.
	+ Existing medical records and medical history.
	+ New health information collected for purposes of this study.
	+ Full-face photographic images and any comparable images.
	+ Biometric identifiers, such as fingerprints and voiceprints.

**Who will use it or share it?** O*nly include those that are applicable to your study.*

* The researcher and his/her research study staff
* Oklahoma State University staff or its agents
* The IRB and staff
* Food and Drug Administration (FDA)
* Department of Health and Human Services (DHHS)
* National Institutes of Health (NIH)
* The Sponsor(s) of the research or its agents (monitors, auditors)
* Other collaborating institutions

Once your child’s protected health information (PHI) has been disclosed, it is possible that anyone who receives that information may re-disclose it. Because some of these individuals who receive your child’s PHI may not be required by law to keep their information confidential, we cannot guarantee that their information will not be released or made available to another party once it leaves Oklahoma State University. Therefore, we share their information only if necessary and we use all reasonable efforts to request that those individuals who receive their information take steps to protect their privacy.

**How long will this authorization last?**

This authorization will last until the research study is complete.

**Can you stop your protected health information (PHI) from being used?**

You can tell us to stop collecting health information that can be traced to your child at any time. We will stop, except in very limited cases if needed to comply with law, protect your safety, or make sure the research was done properly. If you have any questions about this, please ask.

If you want us to stop, you must tell us in writing. Write or email [insert contact information].

**What happens if you do not want us to collect and release your information?**

If you decide not to authorize release of their protected health information (PHI) as part of this study, your decision will in no way affect their medical care or cause you to lose any benefits to which you are entitled. They cannot participate in this research study if you do not authorize the use or release of their PHI.

**When will it be destroyed?**

We do not know when their information will no longer be used therefore the information will be kept for an indefinite length of time.

*If an investigator has a financial interest in this research insert the following statement:*

**Financial Interest Disclosure**

One or more individuals involved in this research may benefit financially from this study. The Institutional Review Board (an ethics committee that helps protect people involved in research) has reviewed the possibility of financial benefit. The Board believes that the possible financial benefit is not likely to affect your safety and/or the scientific integrity of the study. If you would like more information, please ask the researchers or study staff.

**Voluntary Nature of the Study**

Your child’s participation in this research is voluntary. There is no penalty for refusal to participate, and your child is free to withdraw their consent and participation in this project at any time. The alternative is for them to not participate.Your child can stop and quit the research study at any time they become uncomfortable or just want to stop. *(If applicable)* Their decision whether or not to participate in this study will not affect their *(Example:* *medical care; grades in school, etc.)* [Description].

*Delete the following sections if not applicable:*

**Appropriate alternatives:**

[Disclose any appropriate alternative procedures or courses of treatment that may be advantageous to the participant.]

**Termination of Participation:**

Your child’s participation may be terminated by the investigator without regard to your consent in the following circumstances: [Early Termination Reasons].

You will be told about new information that may affect their health, welfare, or willingness to stay in the study. This study may be terminated by [Insert Sponsor/Investigator] if [State reason for possible premature termination].

**Contacts and Questions**

The Institutional Review Board (IRB) for the protection of human research participants at Oklahoma State University has reviewed and approved this study. If you have questions about the research study itself, please contact the Principal Investigator at [Phone number], [E-mail address]. If you have questions about your rights as a research volunteer or would simply like to speak with someone other than the research team about concerns regarding this study, please contact the IRB at (405) 744-3377 or irb@okstate.edu. All reports or correspondence will be kept confidential.

***You will be given a copy of this information to keep for your records.***

**Statement of Consent**

I have read the above information. I have had the opportunity to ask questions and have my questions answered. I consent for my child to participate in the study.

*Include the following if applicable. Add or delete statements as needed.*

Indicate Yes or No:

I give consent for my child to be audiotaped during this study.

 \_\_\_Yes \_\_\_No

I give consent for my child to be videotaped during this study:

 \_\_\_Yes \_\_\_No

I give consent for my child’s data to be used in future research studies:

 \_\_\_Yes \_\_\_No

I give consent to be contacted for follow-up in this study or future similar studies:

 \_\_\_Yes \_\_\_No

I give consent for my child’s PHI to be used as part of this study:

 \_\_\_Yes \_\_\_No

Name of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent and/or Guardian Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

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

*Use the following if a Legally Authorized Representative is signing in place of the participant:*

Signature of Legally Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Signature of Investigator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_