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| Patient Identification Number for this trial | | | |
| **WP3 PARENT CARER CONSENT FORM** | | | |
| **Study Title: Mental Health in children with epilepsy trial** | | | |
| Name of researchers: Prof. Roz Shafran, Prof. Helen Cross | | | |
|  | | | Please  initial all  boxes |
| 1. I confirm that I have read and understand the information sheet dated 16/05/2018 version number 2 for the above study. My child and I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | | |  |
| 1. I understand that my participation is voluntary and I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. | | |  |
| 1. I understand that my child’s participation is voluntary and that they are free to withdraw at any time without giving any reason, without their medical care or legal rights being affected. | | |  |
| 1. I give permission for my child’s hospital and educational records to be accessed. | | |  |
| 1. I understand that relevant sections of my child’s medical notes, hospital and educational records, and data collected during the study may be looked at by individuals from the research team, from regulatory authorities or from the NHS Trust, where it is relevant to their taking part in this research. I give permission for these individuals to have access to my child’s records. | | |  |
| 1. I agree to allow information, including medical information, about my child and I to be entered on a confidential computer database held at the Institute of Child Health, University College London and a Great Ormond Street Hospital database. I understand that personal data will be contained within a hard copy file that will be kept in a locked cabinet. I understand that personal data contained on research databases (for example my contact address) will be kept in a separate database to study data. I understand that study data will be held either electronically or in paper form, and will be anonymised. | | |  |
| 1. In the event that my child or I disclose any information that suggests a risk of harm to my child, myself or others, I agree for this information to be disclosed to the relevant bodies. | | |  |
| 1. I agree to my child’s GP and other health professionals involved in their care being informed of their participation in the study. | | |  |
| 1. I consent to my and my child’s direct quotes being used anonymously, for example in reports, publications and presentations. | | |  |
| 1. In the event that my child or I decide to stop taking part in the study, I agree to the information I have previously provided and that my child has previously provided being used in the analysis of the study results. | | |  |
| 1. I understand that taking part in the study does not mean that my child and/or I will receive the new treatment and that whether or not my child and/or I receive the new treatment will be decided by chance. | | |  |
| 1. I agree to any interviews, and assessments or therapy sessions, including (those face-to-face and telephone/skype calls), being video/audio recorded. | | |  |
| 1. I agree to my child and I taking part in the above study. | | |  |
| Name of participant | Date | Signature | |
| Name of person taking consent | Date | Signature | |
| *This document presents independent research funded by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research Programme (Reference Number* RP-PG-0616-20007*). The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.* | | | |