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Piedmont Healthcare  
Assent and Parental Permission for a Minor   
to Participate in a Clinical Study

*See right column for instructions / explanations.*

*Use lay terminology whenever possible and complete or delete blanks as appropriate.*

*This document to be used with assent/information sheet for ages 7-12. Parental signature required.*

*This document is to be signed by both adolescent and parent/guardian for ages 13-17.*

**\*** **You have the option of having your child join a research study. This is both an assent and a parental permission form. The goals of this form are to give you information about what would happen in the study if you choose to have your child take part and to help you decide if you want your child to be in the study. It provides a summary of the information the research team will discuss with you. If you decide that your child can take part in this study, you would sign this form to confirm your decision.**

**\*\*Throughout this document the use of ‘you’ refers to ‘you’ and ‘your child’.**

**What a clinical study is and its purpose.**

A clinical study involves research using human volunteers with the main purpose gaining knowledge that may be used to help others. Clinical studies are not intended to benefit participants directly, though some might.

**What this document is.**

This form is a parental permission document. It will describe the purpose, study risks, procedures, benefits, alternatives, and any costs to you.

Signing this form means that you are willing for your child to take part in the study and allow your child’s health information to be used.

**Why this clinical study is being done.**

This study is being done to \_\_\_\_\_.

**Your child does NOT have to participate.**

Being in this study is entirely up to you and your child. If your child joins this study, you and your can change your mind later on and withdraw from the study.

Taking part in a study is separate from your child’s medical care. The decision to join or not join the study will not affect your child’s status as a patient here at Piedmont Healthcare.

**How long your child would be in the clinical study.**

It is expected that your child’s participation will last \_\_\_\_.

**What you should do next.**

1. Read this form to completion, or have it read to you.
2. Make sure the study doctor or study staff explains the study to you.
3. Ask as many questions necessary to feel you understand what will occur and what is expected of you and your child\_\_\_\_\_\_.
4. Take time to consider the information in this document and the discussion the study team.
5. Talk things over with your child, family, and friends.

**Title:**

**Principal Investigator (The Study Doctor):**

**Sponsor:**

**INTRODUCTION:**

You are being asked to join this research study because …

This form will give you information about the research study for you to consider in order to agree (consent) to be in this study or not be in this study. The decision to join the study is entirely yours. If you decide to join the study you may change your mind at any point and withdraw your consent to participate. You will not lose any medical benefits based on your decision to join or not join the study. If you decide not join this study, your doctor will continue to treat you.

If there are any words or information printed in this consent form that you do not understand, ask your doctor to explain them to you. You are encouraged to take as much time as you need to arrive at an informed decision to join this study.

After signing this informed consent form you will be given a copy of the form for your records.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the sponsor of the study, is paying Piedmont Healthcare [and Dr. \_\_\_\_\_\_\_\_] to perform this research. Dr. \_\_\_\_\_\_\_\_\_ also

**BACKGROUND AND STUDY PURPOSE:**

*[If this study will be registered on clinicaltrials.gov insert the text below. If not delete.]:*

A description of this clinical trial will be available on http://www.Clinical Trials.gov, as required by U.S. Law. This Web site will not include information that can identify you. At most, the Web site will include a summary of the results. You can search this Web site at any time.

***How many people will take part in the study?***

Approximately ***\_\_\_\_\_\_\_*** patients are expected to take part in this study. We are approved to enroll up to \_\_\_\_\_\_\_\_ patients at Piedmont Healthcare.

**STUDY PROCEDURES:**

**STUDY RISKS:**

Piedmont Healthcare, your doctor, and \_\_\_\_\_\_\_\_\_\_\_\_\_ will take steps to protect your confidential information, as discussed on page \_\_. However, there is always a risk that your confidential information could be improperly released or accessed.

There may be side effects from the study drug or procedures that are not known at this time.

The most common risks and discomforts expected in this study are:

The less common risks and discomforts expected in this study are:

Rare but possible risks include:

**If you are a woman**: to protect against possible side effects of the study drug, women who are pregnant or nursing a child may not take part in this study. If you are a woman of childbearing ability, you and the study doctor must agree on a method of birth control to use throughout the study. If you think that you have gotten pregnant during the study, you must tell the study doctor immediately.

**If you are a man:** the effect of the study drug on sperm is not known. To protect against possible side effects, if you are a man you should not get a sexual partner pregnant while taking the study drug and for **\_\_\_\_\_\_\_\_\_\_** days/weeks/months after the last dose. You and the study doctor should agree on a method of birth control to use throughout the study.

If you will be taking the study drug home, keep it out of the reach of children or anyone else who may not be able to read or understand the label. Do not let anyone else take the study drug besides you.

**STUDY BENEFITS**

You may or may not benefit from study participation or your condition may worsen. It is hoped that the knowledge gained from your participation may help others.

**OTHER TREATMENT OPTIONS:**

If you decide not to join this study, there is care available to you outside this research.

Your doctor will discuss these options with you. You do not have to be in this study to be treated for

**CONFIDENTIALITY:**

This section explains how personal health and financial information related to your treatment and follow-up care may be collected and used for this study. Your personal health information includes, but is not limited to, information that is collected for your entry into the study and any information that is collected and/or created during your participation in this study. State law and Federal Privacy Regulations provide safeguards for privacy, security, and authorized access to your confidential information. Piedmont Healthcare, Dr. \_\_\_\_\_\_\_\_\_, and \_\_[the sponsor]\_\_\_ will take steps to protect your confidential information. Should the results of this study be published in scientific journals or presented at medical meetings, your identity will remain confidential.

As part of the study, your doctor and the research team will report the results of your study-related treatment and tests to In addition, your records may be reviewed and copied in order to meet federal or state regulations. Reviewers may include the sponsor its representatives, the United States Food and Drug Administration (FDA), The Office of Human Research Protections (OHRP), the Piedmont Healthcare Institutional Review Board (IRB), the Piedmont Healthcare Office of Research Services (ORS), and other international regulatory authorities. If any research record is reviewed by any of these groups, they may also need to review your entire medical record.

You understand that you will be asked to sign a separate authorization for the use and disclosure of your medical record and confidential information for the purpose of this study. If you do not sign this informed consent and the separate authorization, you will not be able to participate in this study. You will be given a copy of this consent form and the authorization form.

**COSTS:**

Some of the healthcare providers performing services in this facility are independent contractors and are not Piedmont Healthcare employees. These non-Piedmont Healthcare providers may issue separate billing statements for services they provide for you.

**COMPENSATION:**

You will not be paid for participating in this study.

*OR*

**IN CASE OF INJURY:**

Every effort to prevent any injury that could result from this study will be taken by Immediate necessary care, emergency treatment, and professional services will be available to you just as they are to the community generally.

If you think that you have suffered a research related injury, you must let [PI] or a Facility Risk Manager know right away.

***EXTREMELY IMPORTANT!***

*When completing this section of the consent document please choose one of the three paragraphs below* ***WITH confirmation of language from the CTA (when applicable).***

*The sponsor [name] of the study has agreed to pay for the care of certain injuries directly resulting from this research.  If you think that you have suffered a research-related injury, you must contact [PI] right away.  The study doctor can help you obtain more information about the sponsor’s agreement to pay for research-related injuries.*

*If you suffer an unanticipated injury as a direct result of this research and require emergency medical treatment, [Piedmont] will provide such treatment at [Piedmont] at no cost to you.  You must notify [PI] as promptly as possible after your injury in order to receive this care.  An injury is “unanticipated” if it is not one of the known effects of a study drug, medical device or procedure, and is not the result of your disease or condition.*

*[Include the following if Sponsor does not reimburse for subject injury; confirm consistency with CTA.] The costs of any non-emergency care for such an injury will be billed to you or your insurance, or the study sponsor in the ordinary manner. You will continue to be responsible for any copays, deductibles and coinsurance amounts that are required under your insurance plan.*

You are encouraged to discuss your participation in this study with your insurer before agreeing to participate to avoid any unexpected costs.

**Piedmont \_\_\_\_\_\_\_\_\_\_** has not set aside funds for additional payment or compensation, such as for lost wages and/or pain and suffering, to a person who is injured while participating as a subject in a research study. However, by agreeing to participate in the study, you are not giving up your legal rights to seek compensation in the event of malpractice, fault, or blame on the part of those conducting the research study, including Piedmont \_\_\_\_\_\_\_.

**PARTICIPANT RIGHTS AND STUDY WITHDRAWAL:**

You may choose not to be in this study. If you agree to be in the study you may withdraw from the study at any time without penalty or loss of benefits to which you are entitled. Your access to health care at Piedmont \_\_\_\_\_\_\_\_\_\_\_and from your doctor will not be affected by the withdrawal.

It is important to tell the study doctor if you are thinking about stopping so he/she can evaluate any risks from the treatment and discuss what follow-up care and testing could be most helpful for you.

If you withdraw from the study:

* No new data about you will be collected for study purposes unless the data concern an adverse event (a bad effect) related to the study. If such an adverse event occurs, we may need to review your entire medical record. All data that have already been collected for study purposes will be sent to the study sponsor.
* Contact the study doctor or any member of the study team to inform them that you are withdrawing from the study. You may contact the study doctor at:
* We ask that you follow up a verbal withdrawal with a written confirmation by signing the Piedmont Healthcare Research Subject Authorization Revocation Letter that you will be given.
* The date of the verbal notification is the effective date of your withdrawal from the research.
* It is important that you know that the researcher may ask if you are willing to provide continued follow-up and further data collection subsequent to your withdrawal from the intervention portion of the study. This limited participation will consist of follow up associated with clinical outcomes rather than study-related interventions. This limited participation is voluntary and your decision alone. You must indicate your agreement to the limited participation by making the selection on the Piedmont Healthcare Research Subject Authorization Revocation Letter and signing it.

It is also possible that your being part of the study may be stopped at any time without asking you. This might happen if you do not follow the instructions given by the study doctor or if the study is stopped for administrative, medical, or other reasons as determined by the Sponsor **Piedmont \_\_\_\_\_\_\_\_\_\_\_\_\_\_,** the United States Food and Drug Administration (FDA), or other regulatory authorities. In addition, your doctor may remove you from this study, if it is believed to be in your best interest.

**NEW INFORMATION:**

If new findings develop during the course of the study that may affect your willingness to continue taking part in this study, your study doctor will provide this information to you or your legal representative in a timely manner.

**CONTACTS:**

Dr. \_\_\_\_\_\_\_\_the Principal Investigator (study doctor) of the study at ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

* with questions about this research study or your part in it,
* with questions, concerns or complaints about the research study, or
* if you feel you have had a research-related injury or bad effect to the study

If you have any questions regarding your rights as a participant in a research study, or if you are concerned or have complaints about the study, you may contact the Chairman of the Piedmont Healthcare Institutional Review Board at 404-605-3638.

ASSENT AND PARENTAL PERMISSION

If you are willing to allow your child to volunteer for this research, please sign below. By signing this form you do not give up any legal rights your child is entitled to.

Printed Name of Participant (child)

Signature of child (ages 13-17 only) Date

Time (hh:mm)

Printed name of Parent or legal guardian

Signature of Parent or legal guardian Date

Time (hh:mm)

I attest that the participant named above had enough time to consider this information, had an opportunity to ask questions, and voluntarily agreed to be in this study.

Printed Name of Person Explaining Consent

Signature of Person Explaining Consent Date

Time (hh:mm)

I attest that I or my representative discussed this study with the parent/legal guardian named above.

Signature of Principal Investigator or Sub-Investigator Date

*[Genetic and other sample research options]*

***If genetic information is being collected the following statement must be included in the consent:***

*This study involves genetic testing. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits health insurers from using individual’s genetic information in setting eligibility, premium, or contribution amounts and employers from using individual's genetic information in employment decisions such as hiring, firing, job assignments, and promotion. However, GINA does not include protection from genetic discrimination in life insurance, disability insurance, or long-term care insurance.*

*You will be asked to complete a separate Authorization for Use/Disclosure of Protected Health Information from the one you completed and signed when you enrolled in this study in order for us to disclose any information derived from this study to your physician.]*

***[see the ‘Genetic and Other Sample Research Guidance’ document available in IRBNet to additional consent form considerations/additions]***