**FACULTY OF MEDICINE RAMATHIBODI HOSPITAL**

**CONSENT BY SUBJECT FOR PARTICIPATION IN A RESEARCH PROTOCOL**

**STUDY TITLE:………………………………………………………………………………………..**

**INVESTIGATORS: …………………………………………………………………………………..**

**Name of participant …………………………………………………………. Age………………….**

**Consent by parents/ guardian**

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parents or guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (participant’s name), have been clearly informed of the details of the research project, including benefits and risks of the participation. I am aware that I can contact the study investigators if questions or concerns arise. The participation is voluntary and I do not have to sign this form if I do not want my child to be involved in the study. The personal information collected will be kept confidential and will only be use for research publications or presentations. Your child’s name and other identifying information will be removed before this data is used. Identifying information may be reviewed by the institution in case of academic necessity only.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent or guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness

 Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consenting Investigator**

I have explained and disclosed the nature and purpose of the study and the risks involved to the parent/guardian of the participant, with no undisclosed information.

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 Signature of Investigator

 Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_