Minor of age participant INFORMATION SHEET

(Participants aged between 12 and 15)

STUDY TITLE	Prospective, randomised, double-blind, placebo-controlled multicenter clinical trial of efficacy and safety with *Dermatophagoides pteronyssinus* and *Dermatophagoides farinae* mannan-conjugated allergoids in patients with rhinitis/ rhinoconjunctivitis, allergic to *Dermatophagoides pteronyssinus* and/or *Dermatophagoides farinae*
STUDY CODE	MM09-SIT-063
SPONSOR	INMUNOTEK S.L.
STUDY DOCTOR	
CENTRE	
CONTACT Email/telephone	
24-HOUR CONTACT Telephone	

[redacted]



Minor of age participant INFORMEDASSEMT

(Participants aged between 12 and 15)

I, ...

(participant's first name and surname)

..... years old.

- ✓ I understand everything I have read or that has been read to me in the information sheet.
- ✓ My study doctor has answered all the questions I asked.
- ✓ I know that I can say I do not wish to take part and that this is fine.
- ✓ I know that I can ask my study doctor any questions, either now or later.
- ✓ I know that later, if I no longer wish to take part in this study, I can say so and nobody will hold it against me.
- ✓ I confirm that I have received a signed and dated copy of this information sheet and the informed consent form.

I wish to take part in the clinical trial.

PARTICIPANT'S SIGNATURE	Signature of **the STUDY DOCTOR**
Date: ___/___/____	Date: ___/___/____

(Handwritten signature and date)

The study doctor will tick the relevant box:

The minor has understood everything I have explained to them	YES □ NO □
Have the parents/guardians signed the informed consent form?	YES □ NO □

INFORMED ASSENT in the presence of witnesses

STUDY TITLE: Prospective, randomised, double-blind, placebo-controlled multicenter clinical trial of efficacy and safety with *Dermatophagoides pteronyssinus* and *Dermatophagoides farinae* mannanconjugated allergoids in patients with rhinitis/rhinoconjunctivitis, allergic to *Dermatophagoides pteronyssinus* and/or *Dermatophagoides farinae*

I, ... (witness's first name and surname)

in my capacity as a witness, hereby declare that, in my presence, Mr/Ms .....

(participant's first name and surname)

- read (or had it read to them, in the event that the participant cannot read) and understood the information sheet provided to them.
- They were given the opportunity to ask questions about the study.
- You have received sufficient information about the study.

You spoke to: ..... (researcher's first name and surname)

You understand that your participation is voluntary and that you may withdraw from the study:

1. Whenever you wish.
2. Without giving any reason.
3. Without this affecting your medical care.

Within the limits of the law, you authorise the access, use and sharing of your personal data, as described in the section 'Protection of personal data'.

The participant has received a signed and dated copy of this information sheet and the informed consent form. Yes ☐ No ☐

The participant wishes to be informed of incidental findings that may affect them. Yes ☐ No ☐

The participant wishes to be informed about incidental findings that have implications for their family. Yes ☐ No ☐

The participant agrees that their attending doctor should be informed about incidental findings. Yes ☐ No ☐

The participant freely consents to taking part in the study. Yes ☐ No ☐

WITNESS'S SIGNATURE *(As per ID card)* Date: ___/___/____	Signature of **the STUDY DOCTOR** Date: ___/___/____

(Handwritten signature and date)