

# **Infant and Child European Cryoablation Project**

ClinicalTrials.gov study ID: 18BB37



**CONFIDENTIAL**

## **Parent/Guardian consent form**

Date of most recent review: 16<sup>th</sup> November 2020

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## PARENT/GUARDIAN CONSENT FORM

Please Initial the Boxes

1. I confirm that I have read and understand the information sheet(s) dated 05/10/2018 version 1 for the above study, have been informed of the nature, significance, implications and risks associated with it and have had the opportunity to ask questions. ☐
2. I understand that my child's participation is voluntary and that I am free to withdraw at any time, without giving any reason, without his/her medical care or legal rights being affected. ☐
3. I understand that sections of any of my child's medical notes may be looked at by responsible physicians or authorised persons from sponsor organisation, regulatory authorities or hosting organisations where it is relevant to my/my child's taking part in research. I give permission for these individuals to have access to his/her records ☐
4. I agree to take part in the above study. ☐
5. I agree that I might be contacted in the future for a long-term follow-up ☐

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

Name of Parent/Guardian	Date	Signature
Relationship with Child		
Name of person taking consent (if different from Investigator)		
Name of Investigator		
Name of Interpreter (if applicable)		

1 copy for patient, 1 for researcher, 1 copy to be kept with hospital notes