**ISARIC/WHO Clinical Characterisation Protocol - IRAS Ref. 126600**

**INFORMATION SHEET AND ASSENT FOR CHILDREN YOUNGER THAN 12 YEARS OLD  
- DATA ONLY**

30th August 2022. Version 10.2  
Local lead investigator: **[\*\*\*local\_investigator\_name\*\*\*]**

Parents/guardians/carers are asked to go through this information with their child. Please consider using the cartoon sheet to help explain the study to young children.

**Please ask study staff if you or your child has any questions.**

We want to find out why and how you are unwell so that we can help other children like you.

**What does this mean for me?**

To help us finding out more about what is making you and other children unwell we will collect information from your medical records when you are in hospital.

**Do I have to take part?**

It is up to you and your parents to decide if you would like to take part in helping us.

If you don’t want to take part, then you don’t have to.

Either way, your decision will not affect your care and treatments in any way.

**What will happen to the information and samples?**

All information about you will be kept private. Only the people responsible for your care and for this study will know that you were involved in this study.

**Are there any benefits to taking part in this study?**

No. By helping us find out more about why you are ill, we will be able to help look after children better in the future.

**Who has reviewed this study?**

This study has been reviewed by the **Oxford C NHS Research Ethics Committee – reference number: 13/SC/0149** and **Scotland A Research Ethics Committee (Ref 20/SS/0028)** and they are happy for this study to take place.

PARTICIPANT ID: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_

**ISARIC/WHO Clinical Characterisation Protocol**

**YOUNG CHILD (<12 YEARS OLD) ASSENT FORM – DATA ONY**

30th August 2022. Version 10.2

Please tick the boxes if you agree. If you don’t agree, leave the boxes empty.

|  |  |
| --- | --- |
| I have been told about the study and given the information sheet about it and have had the chance to ask questions. |  |
| I know I don’t have to take part. If I do, I can change my mind – the doctors and nurses will still look after me. |  |
| I do not mind if someone doing the research looks at my medical records and collects my information - I know the people doing the study will keep personal things about me private. |  |
| I agree to take part |  |

Name of Young Participant (PLEASE PRINT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Legal Guardian/Carer (PLEASE PRINT):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_ \_\_ / \_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_

Name of Person taking assent (PLEASE PRINT): \_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Research team member or health professional trained in taking assent for this study)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_ \_\_ / \_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_

**Witnessed Assent**  
*If the assenting person cannot read the form or the completed form is contaminated and cannot be removed from the participant’s room:* I have no interest or involvement in this research study. I have been introduced to the participant and identified as a witness to their assent. I attest that the information concerning this research was accurately read and explained to the participant in language they can understand. I attest that assent was freely given by the participant.

Witness name (PLEASE PRINT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_ \_\_ / \_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_

**Thank you for your contribution to this important global research activity.**