Last Update: May 1, 2018

Results of this research will be used for the purposes described in this study. This information may be published, but you will not be identified. Information that is obtained concerning this research that can be identified with you will remain confidential to the extent possible within State and Federal law. The investigators associated with this study, the sponsor, and the MUSC Institutional Review Board for Human Research will have access to identifying information. All records in South Carolina are subject to subpoena by a court of law.

In the event that your child is injured as a result of participation in this study, you should immediately take your child to the emergency room of the Medical University Hospital, or in case of an emergency go to the nearest hospital, and tell the physician on call that your child is in a research study. They will call your child’s study doctor who will make arrangements for your child’s treatment. If the study sponsor does not pay for your child’s treatment, the Medical University Hospital and the physicians who render treatment to your child will bill your insurance company. If your insurance company denies coverage or insurance is not available, you will be responsible for payment for all services rendered to your child.

Your participation in this study is voluntary. You may refuse to take part in or stop taking part in this study at any time. You should call the investigator in charge of this study if you decide to do this. Your decision not to take part in the study will not affect your current or future medical care or any benefits to which you are entitled.

The investigators and/or the sponsor may stop your participation in this study at any time if they decide it is in your best interest. They may also do this if you do not follow the investigator’s instructions.

**Volunteers Statement**

I have been given a chance to ask questions about this research study. These questions have been answered to my satisfaction. If I have any more questions about my child’s participation in this study or study related injury, I may contact ***PI NAME at PHONE NUMBER***. I may contact the Medical University of SC Patient and Family Care Liaison (843) 792-5555 concerning medical treatment.

If I have any questions, problems, or concerns, desire further information or wish to offer input about my child’s rights as a research subject in this study, I may contact the Medical University of SC Institutional Review Board for Human Research IRB Manager or the Office of Research Integrity Director at (843) 792-4148. This includes any questions about my rights as a research subject in this study.

I agree to participate in this study. I have been given a copy of this form for my own records.

*If you wish to participate, you should sign below.*

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

Signature of Person Obtaining Consent Date \*Name of Participant

Participant’s Personal Representative(if applicable):

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

Name of Personal Representative *(Please print)*

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

Signature of Personal Representative Date

Relationship:  \_\_\_ Spouse       \_\_\_ Parent               \_\_\_Next of Kin         \_\_\_Legal Guardian\* \_\_\_\_ DPOA for Healthcare\*

*\*(If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient)*

\*12-17 years of age:

“My participation has been explained to me, and all of my questions have been answered. I am willing to participate.”

Signature: