**“BLIS PROBIOTICS TO HELP STOP SORE THROATS IN WHAKATANE CHILDREN”**

**CONSENT FORM**

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| **PARENT/CAREGIVER CONSENT FORM** |
|  **YES**, I give my consent for my child to take part in the study. *(Please read, then complete and sign this form).*  |  **NO**, I do not give my consent |
| **By saying YES to the BLIS PROBIOTIC study, I understand what the study is about and:*** My child will receive BLIS each day at school for four weeks, and weekend doses provided
* My child will have **four swabs**, **two** at the beginning of the study and **two** after taking BLIS (**one** at the end of the four weeks, and the other three months later)
* My child will be offered the appropriate antibiotics if they have a positive throat swab result for Group A Streptococcus/*strep throat* during the course of the study **(FREE)**
* Research staff in the study can collect information about my child’s history of sore throats from my child’s doctor, and or the laboratory services
* I may be randomly chosen to answer a few short questions about sore throat knowledge and what my child thought about BLIS
* **ALL information about my child will be kept confidential to the research team**
* I can contact the research team at any time about the study
* I can withdraw my child from the study at any time
* Feedback will be available after the completion of the study
* My child’s doctor will be informed about my child’s study participation.
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| **PARENT/CAREGIVER DETAILS** |
| **NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****HOME PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_** |
| **RELATIONSHIP: *I am the child’s:*** (Please tick one)Mother Father Grandmother Grandfather Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **YOUR CHILD’S DETAILS** |
| **SURNAME/LAST NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**FIRST NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MIDDLE NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**SCHOOL:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ROOM NUMBER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE OF BIRTH:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **SEX: Boy** **Girl** |
| **Ethnic Groups: (Please tick)** |
| Māori  | NZ European | Other *(please print):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Your Child’s Health: (Please tick)** |
| Has this child ever had a serious medical condition or heart problem? **If YES** please state condition and medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No  |
| Does this child have any allergies (example: medication, food allergies etc) **If YES** please state allergy and medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No |
| Has this child been admitted to hospital with a serious illness in the last 12 months:  **If YES** Please state reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No |
| **Your Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Medical Centre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

*This study has been approved by the Central Health and Disability Committee:* Ref No.