**“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**, **one** at the beginning of the study and three after taking BLIS (**one** at the end of the four weeks, then the **remaining two swabs** spaced out over the next three months) * 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. | |
| **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.