**SOP 03-V 4 / ANX 09-V 3.1**

**Institutional Human Ethics Committee**

**PSG Institute of Medical Sciences and Research, Coimbatore**

**Parental Consent Form**

**Title of Study:**

**Name of the Principal Investigator:**

**Department:**

Your (son/daughter/child/infant/adolescent youth) is invited to participate in a study of (describe the study).

My name is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and I am a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at PSG Institute of Medical Sciences and Research, Coimbatore. This study is (state how study relates to your program of work or your supervisor’s program of work).

I am asking for permission to include your (son/daughter/child/infant/adolescent youth) in this study because

I expect to have ……… (Number) participants in the study.

If you allow your child to participate, (state who will actually conduct the research) will (describe the procedures to be followed.)

Any information that is obtained in connection with this study and that can be identified with your (son/daughter/child/infant/adolescent youth) will remain confidential and will be disclosed only with your permission. His or her responses will not be linked to his or her name or your name in any written or verbal report of this research project.

**Reimbursement or compensation for the inconvenience: Yes/No**

If yes describe the plan

**Emergency Medical Treatment:** If applicable, add here along with available medical treatment in case of complications.

**Compensation for protocol Related Injury: Yes/No**

If yes describe the details of compensation or insurance for protocol related injury to the study participant. Explain who will bear the cost in case of trial related injury?

Your decision to allow your (son/daughter/child/infant/adolescent youth) to participate will not affect your or his or her present or future relationship with PSGIMS&R or PSG Hospitals or (include the name of any other institution connected with this project). If you have any questions about the study, please ask me. If you have any questions later, call me at ………………… If you have any questions or concerns about your (son/daughter/child/infant/adolescent youth)’s participation in this study, call…………………………………..

You may keep a copy of this consent form.

You are making a decision about allowing your (son/daughter/child/infant/adolescent youth) to participate in this study. Your signature below indicates that you have read the information provided above and have decided to allow him or her to participate in the study. If you later decide that you wish to withdraw your permission for your (son/daughter/child/infant/adolescent youth) to participate in the study, simply tell me.

You may discontinue his or her participation at any time. *This will not affect in any way your future treatment in this hospital.*

Printed Name of (son/daughter/child/infant/adolescent youth)

Kindly check the box whichever is applicable to you:

[ ]  My child is in the age group of 7 to 12 years and the researcher has obtained verbal consent from my child in my presence

[ ]  My child is in the age group of 13 to 18 years and the researcher has obtained written consent from my child in my presence

Signature of Parent(s) or Legal Guardian with Date Signature of Investigator with Date