Follow on study of two swine 'flu vaccines in children – Consent Form

Child's full name:..... Study number: |____| |____| |____| |____|

If you agree with the statement, please initial the box next to it

I confirm that I have read the *Information booklet Influenza A H1N1 (Swine Flu) Vaccine Follow on Study Version 2 dated 26th October 2010.* I have had the opportunity to consider the information, discuss the study, to ask questions and have had these answered satisfactorily. ☐

I understand that data collected during the study may be looked at by authorised individuals from the University of Oxford, MHRA, ORH NHS Trust and study monitors, where it is relevant to my child taking part in this research. I permit these individuals access to my child's research records. ☐

I understand that blood samples and data collected during the study may be sent outside the European Union ☐

I understand that I am free to withdraw my child from the study at any time, without having to give a reason for leaving and without affecting his/her medical care. ☐

I agree to you informing my GP and Child Health Department of my child's participation in this study. ☐

I agree to my child being examined by a study doctor as required for this study. ☐

I agree to you taking and storing blood samples from my child as required for this study. ☐

I agree that my child's medical records may be read by study investigators. ☐

Please initial ONLY ONE of the following statements:

EITHER I voluntarily agree to my child having one blood test ☐

OR I voluntarily agree to my child having one blood test and one dose of seasonal influenza vaccine, followed by a second blood test ☐

For children over 7 years of age:
The study has been discussed with my child and they are happy to participate. ☐

Please note that your child can still participate in the study whether or not you agree to the following statements:

I agree that a genetic sample from my child may be stored and analysed to help understand how my child's immune system responds to vaccines. ☐

I agree that any remaining blood from my child may be stored and used in future research related to vaccines and infectious diseases (with the exception of the Human Immunodeficiency Virus [HIV]). ☐

Name:..... .....

Relationship to Child: .....

Signature:..... Date: |___ ___| |___ ___| |___ ___|

Investigator/Study nurse's name (*please delete as appropriate*): .....

Signature: ..... Date: |___ ___| |___ ___| |___ ___|