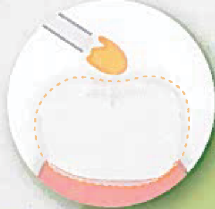


Cynllun Gwên Designed to smile



Bwrdd Iechyd Prifysgol
Cardiff a'r Fro
Cardiff and Vale
University Health Board



Informed Consent Form

(To be completed by person with parental responsibility)

Call 02920 687624
for more information

Title of Study:

Seal or Varnish? A Randomised Study To Determine The Relative Cost And Effectiveness Of Pit And Fissure Sealants And Fluoride Varnish In Preventing Dental Decay.

Tick box:

- I confirm that I have read and understand the information sheet (version 2.1, dated 24 May 2011) for the above study and have had the opportunity to ask questions by telephone with a member of the dental team.
- I understand that my participation and that of my child is voluntary and that I and my child are free to withdraw at any time, without giving any reason, without our medical care or legal rights being affected.
- I agree to my child's dentist being informed about his/her participation in the study.

If your child is not registered with a dentist please tick here

- I understand that relevant sections of my child's notes and the data collected during the study may be looked at by members of the South East Wales Trials Unit (SEWTU), and by the UK medicines regulatory authorities to check that the study is being carried out properly. I give permission for these individuals to have access to my child's records for this purpose.
- I understand that information about me and my child (including names and address) will be held at SEWTU according to the 1998 Data Protection Act. I understand that this information will be kept strictly confidential and that no personal information will be used in the study report or other publications.

- I agree to take part in the above Study and I also agree for my child to take part in the above study.
- I agree for my child to participate in the existing 'Designed to Smile' Fissure Sealant programme if the dental team finds that my child is not suitable for participation in the Seal or Varnish study.
- I understand that I may withdraw my child and I from the study at any time, for any reason. If my child and I withdraw... (please tick which applies)
 - I agree
 - I do not agree

...for a member of the trial team to contact me to try and understand the reasons for withdrawing.

Name of child _____

Child's Date of Birth ____/____/____

Name of person with parental responsibility _____

Signature of person with parental responsibility _____

Date ____/____/____

For Community Dental Service use only:

SID: PID:

P.w./P.C. verified? (initial and date)

v2 1/24May2011

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