CHILD CONSENT FORM

Study title: Irish Childhood Diabetes National Register (ICDNR).

I have read and understood the **Information Leaflet** about this research project. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	**Yes** □	**No** □
I have been given a copy of the Information Leaflet and this completed consent form for my records.	**Yes** □	**No** □
I understand that my child does not have to take part in this study and can opt out at any time without us giving a reason for opting out and I understand that opting out won't affect my son's/daughter's future medical care.	**Yes** □	**No** □
I give permission for researchers to look at my child's medical records to get information. I have been assured that information about my son/daughter will be kept private and confidential.	**Yes** □	**No** □
I consent to my son/daughter taking part in this research study having been fully informed of the risks, and benefits.	**Yes** □	**No** □
I give informed explicit consent to have my son's/daughter's data (relating to their health and diagnosis) processed* as part of this research study. *"processed" data refers to data that is held and analysed and used for the purpose of this research as explained and outlined in the information leaflet.	**Yes** □	**No** □
I consent to be contacted by researchers as part of this research study.	**Yes** □	**No** □
I understand and consent to my child's data **being processed further to be fully anonymised** at the age of 16 years or at the end of this project if sooner. (completed in the January of the year they will reach 16 years of age)	**Yes** □	**No** □
OR		
I consent to my child's data **being processed further to be deleted/destroyed** when the register project is complete.	**Yes** □	**No** □

| | DD/MM/YYYY

Patient Name (Block Capitals) | Patient Signature | Date

| | DD/MM/YYYY

Dr. /DNS Name (Block Capitals) Dr. /DNS Signature Date

| | DD/MM/YYYY

Legal Representative/Guardian Name Legal Representative/Guardian Signature Date

To be completed by the Principal Investigator /Diabetes Doctor/ Nurse.

I, the undersigned, have taken the time to fully explain to the above patient the nature and purpose of this study in a way that they could understand. I have explained the risks involved as well as the possible benefits. I have invited them to ask questions on any aspect of the study that concerned them.

| | | DD/MM/YYYY

Name (Block Capitals) | Qualifications | Signature | Date

3 copies to be made: 1 for Patient, 1 for Patient's Medical Chart, and 1 for ICDNR.