**Instructions:**

* **Use this assent form for children ages 7-10.**
* **Update the version date in the header each time you make a change.**
* **Blue highlighting: This is for your reference only. Delete before submitting to the IRB.**
* **Yellow highlighting: Insert the requested information, or choose the appropriate response and delete the other options.**
* **Delete all << >> marks in the document as you go.**

Subject name: Subject date of birth:

# Aurora Health Care, Inc.<<or other institution name>>

# MY “YES” OR “NO” LETTER

# (Assent form for children ages 7-10)

|  |  |
| --- | --- |
| **Study Title** | <<title (must match protocol)>> |
| **Study Investigator** | <<principal investigator name>><<phone number (daytime)>> <<phone number (24-hour contact number)>> |
| **Sponsor<<delete if n/a>>** | <<insert name>> |

My name is .

I have <<disease or condition>>. I have talked with about a research study at <<study location >> for kids who have <<disease or condition>>.

This study will help doctors learn more about <<disease or condition>> and how to help other kids who have it. I will take a medicine called <<drug name>>. It might <<state desired effect, such as “help my asthma”>>, but it might not. Being in this study might make my <<disease or condition>> better or it might not.

I will be going to the doctor a lot of times over <<length of study>>. I will have some special <<list study activities the child will receive, such as “breathing tests”>> tests that should not hurt. I will have a blood test <<number of blood draws>> times over <<length of study>>, and this might hurt a little bit.

My doctor has talked to me about all these things:

* What this study is for and what I would have to do
* The good things and bad things that might happen to me
* What other medicine I can get if I don’t want to be in this study
* That I can ask questions anytime before, during, or after the study
* I don’t have to do this if I don’t want to
* I can stop being in this study after I start, but I should talk to my doctor first

My parents/guardians have said that it’s OK for me to be in this study.

Mark an X by your choice:

 YES, I want to be in this study.

 NO, I do not want to be in this study.

Write your name here How old are you? Write today’s date

*To be completed by the person obtaining assent:*

This is the name of the person who explained this study to me

Name of person obtaining assent (print) Title Phone number

Signature of person obtaining informed consent Date

**FILE A SIGNED COPY OF THIS FORM IN THE PATIENT’S MEDICAL RECORD (if applicable).**

**Keep the original in the investigator’s research records.**

***Form IC 701D v. 5-2-13***