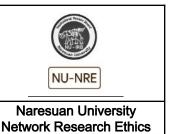
Consent Form

(For Parents/Legally Authorized Representative of Participants Aged 0-12 years)



Protocol Title:							
Consent Day	Month			Year			Date
I,						Mr./N	Mrs./Miss (Pare
•			Representative	e 's	Name	- 5	Surname)
W	/ho	is	the of	[Re	elationshi	p]	
•	articipant		ne) have rea ation sheet da conse	ted	•	e]	and allow
Name-Surn	 ame) to _ا	 participa	te in this resea	arch.		(Pai	rticipant's

I have received a copy of the signed consent form for research participation, along with the participant information sheet.

Before signing the consent form for participation in this research, both the research participants and I received an explanation from the investigator regarding the study's objectives.

- The duration of the research
- The research methods
- Potential risks or side effects that may arise from the research or the use of medications
- The potential benefits of the research

 Detailed alternative treatment options 	
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Date	

I and the research participants have had sufficient time and opportunity to ask all questions until we fully understand. The investigator has willingly answered our questions, ensuring transparency, and we are both satisfied.

I and the research participants acknowledge that the investigator has informed us that, in the event of any harm arising from this research, the participants will receive medical treatment at no cost. (Please specify whether the research sponsor will provide compensation for this medical treatment.).

I have the right to withdraw from participating in the research at any time without providing a reason. The decision to withdraw from this research will not affect my medical care or any other rights I may have in the future.

The investigator certifies that the personal data of the research participants will be kept confidential and will only be disclosed with our explicit consent. Other individuals on behalf of (the company), research sponsors, the Institutional Review Board (IRB), or the Food and Drug Administration (FDA) may be granted permission to access and analyze the personal data of research participants. This will be done solely to verify the accuracy of the information. By agreeing to participate in this research study, I consent to the examination of my medical history data.

The investigator certifies that no additional data will be collected after I request to withdraw from the research, I also request that any documents and/or samples used for verification be completely destroyed and that no traceable information about me be retained.

I understand that I have the right to review or amend my personal information, and I can revoke authorization for the use of my data by notifying the investigator.

I am aware that research data, including undisclosed medical information about me, will undergo various processes such as data collection, recording in forms and computers, verification, analysis, and reporting for academic purposes only (including the potential use in future medical or pharmaceutical research).

I have rea	ad and ful	ly understood t	the above stateme	ent, and I willingly
consent to a	allow		(Participant's	Name-Surname)
Page 2 of 4				Version
Date				

NU-IRB-NRE#F	P4-xxxx/2568	IF 04	/6.0
	to participate in the research. I	have signed	this
consent form.			
		LAD/Dore	n t
Signature		LAR/Pare	HIL
Oignatare	()Name	of
LAR/Parent		, -	
		Relations	hip
of the LAR/		D 1 1 .	0
Participant		Parent to) the
Participant	Date		
potential risks, research or the may result fro	rplained the purpose of the research, readverse effects and any risks that me use of medication, as well as the determ the research. The participants mender a clear understanding, and have with the control of the con	ay arise from ailed benefits itioned above	the that are
		Investiga	tor
	Signature	•	
	() Name of	
Investigator	Data		
	Date		
This witness sign	gnature is only for participants who are ur	nable to read o	
write.			_
•	e unable to read or write, you must have o		•
and the witness	s must not be involved in the research stu	dy in any way.	
		Witness	
	signature		
Page 3 of 4		Version	
Date	•••		

NU-IRB-NRE#P4-x	xxx/2568	IF 04/6.0
	()Name of
witness		
	Date	

Note*: If you wish to retain the remaining biological samples for future research, please attach document AF 05-10, the Consent form for Requesting permission for the future use of remaining biological samples (in addition to the main research study).

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Date