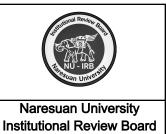
Consent Form

(For Participants Aged 13 - 17 years)



Protocol	
Title:	
Consent	Date
DayYearYear	
I,	
//r./Mrs./Miss	
\ddress	
I have read the details from the participant information	sheet
ittached on[Date]	
I voluntarily consent to participate in this research study	
I have received a copy of the signed consent form for re-	search
participation, along with the participant information sheet.	
Before signing the consent form for this research, I was provide	ed with
n explanation by the investigator regarding:	
- The research objectives	

- The potential benefits of the research

research or the use of medications

The duration of the research

The research methods

- Detailed alternative treatment options

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Date	

The potential risks or side effects that may arise from the

I have had sufficient time and opportunity to ask questions and address any concerns until I fully understand. The investigator has willingly and openly answered all my questions, leaving me fully satisfied.

I acknowledge that the investigator has informed me that if any harm arises from the research study, I 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, and I want 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).

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	and fully understood the above statement, and I wi with full consent. Therefore, I have signed this doct eement.	0,
	Particip	ant
Signature	()Name	of
Participant	Date	
	LAR/Pa	ırent
Signature	()Name	of
LAR/Parent	Relations	ship of
the LAR/ Participant	Parent	to the
potential risks, a research or the umay result from	Date	m the s that e are
Się Investigator	gnature ()Name o	
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IF 04/6.0

NU-IRB#

NU-IRB# Date	IF 04/6.0
This witness signature is only for participants who are unable to	<u>read or</u>
write. In case you are unable to read or write, you must have one withe and the witness must not be involved in the research study in an	•
Wit	tness
signature ()Na	me of
witness	
Date	
Note*: If you wish to retain the remaining biological samples for research, please attach document AF 05-10, the Consent form for Requesting permission for the future use of remaining biological (in addition to the main research study).	or

Version

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Date