*(INSERT HOSPITAL/INSTITUTION LOGO HERE)*

Site Name: <<insert site name or site number>>

Patient study ID: <<insert patient study number>>

**CONSENT FORM: PARENTS OR LEGAL GUARDIANS**

Name of Study: ICONIC**:** **I**mproving outcome through **C**ollaboration in **O**steosar**C**oma

**IRAS no.: 254908**

Name of Principal Investigator: <<insert name of Principal Investigator>>

**Please initial boxes**

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| 1. | I confirm that I have read and understand the information sheet dated 24 May 2023 (version 6) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. |  |  |  |
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| 2. | I understand that my child’s participation is voluntary and that my child is free to withdraw at any time, without giving any reason and without their medical care or legal rights being affected. |  |  |  |
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| 3a. | I understand that relevant sections of my child’s medical notes, and data collected during the study, may be viewed at the hospital/trial site or remotely by individuals from the study Sponsor, University College London and its representatives, including: CR UK and UCL Cancer Trials Centre (UCL CTC), my NHS Trust/Health Board and relevant regulatory authorities.  |  |  |  |
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| 3b. | I understand that routine data may continue to be collected about my child after their active participation in the study has finished and that my child won’t need to attend any study visits for this.  |  |  |  |
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| 3c. | In addition, data collected may also be looked at by individuals at central laboratories that are processing, analysing and storing samples for this study. I understand that, for such sharing, UCL CTC would ensure that personal data items that could allow researchers to identify my child directly are removed and a code used to link the information instead.  |  |  |  |
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|  | I give permission for these individuals to have access to my child’s data. |  |  |  |
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| 4. | I agree to my child’s GP being informed of my child’s participation in the study and providing information about my child’s health (relevant to my participation in the study) to the hospital research team. |  |  |  |
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| 5. | I understand that the information collected about my child may be used to support other ethically approved research in the future, and may be shared with other researchers in the UK or abroad, in which case items that could directly identify my child would be removed and a code used to link information. |  |  |  |
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| 6a. | I agree to give tumour tissue samples from my child’s surgery and/or biopsy, together with Germline DNA and CTC blood samples (where applicable) taken throughout my child’s treatment and at follow up, for use in research related to this study. If this research leads to a new commercial discovery, such as the development of a new treatment or medical test, I understand I will not benefit financially from this.If research blood samples cannot be taken at the same time as routine bloods please indicate your preference below:**Please tick Yes if you agree to samples still being taken:** Yes**Please tick No if you do not agree to samples still being taken:** No |  |  |  |
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| 7a. | ***This is optional. Please tick yes/no as appropriate and initial the box on the right.***I agree to my child donating optional ctDNA blood samples for use in research related to this study. I understand that giving my child’s samples is voluntary and that my child is free to withdraw their approval for their use at any time without giving any reason and without my child’s medical treatment or legal rights being affected. If this research leads to a new commercial discovery, such as the development of a new treatment or medical test, I understand my child will not benefit financially from this.**Please tick Yes if you agree to this:** Yes**Please tick No if you do not agree to this:** No |  |  |  |
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| 7b | ***[UCLH to include the following blue text and renumber subsequent row accordingly. All other sites to delete]******Chemotherapy patients only:******This is optional. Please tick yes/no as appropriate and initial the box on the right.***I agree to my child donating additional optional PBMC blood samples for use in research related to this study. I understand that giving my child’s samples is voluntary and that I and my child are free to withdraw approval for their use at any time without giving any reason and without my child’s medical treatment or legal rights being affected. If this research leads to a new commercial discovery, such as the development of a new treatment or medical test, I understand my child will not benefit financially from this.**Please tick Yes if you agree to this:** Yes**Please tick No if you do not agree to this:** No |  |  |  |
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| 7b/c. | ***This is optional. Please tick yes/no as appropriate and initial the box on the right.***I agree that my child’s research samples and optional blood samples can be stored for use in future ethically and scientifically approved research in the UK or abroad, including genetic studies. If this research leads to a new commercial discovery, such as the development of a new treatment or medical test, I understand my child will not benefit financially from this.**Please tick Yes if you agree to this:** Yes**Please tick No if you do not agree to this:** No |  |  |  |
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| 8. | ***This is optional. Please tick yes/no as appropriate and initial the box on the right.***I consent to a biopsy of my child’s cancer if the cancer comes back or spreads after treatment. I have had sufficient information and chance to discuss my child having a biopsy related to this research study, and have had the risks to my child explained to me.**Please tick Yes if you agree to this:** Yes**Please tick No if you do not agree to this:** No |  |  |  |
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| 9. | I agree to genetic analyses of my child’s blood and tissue samples. |  |  |  |
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| 10a. | I understand that results of genetic tests may include chance findings about my child’s health, or the health of my child’s blood relatives. |  |  |  |
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|  | I understand that myself and my child will be told about any results that could affect my child’s **treatment**. |  |  |  |
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| 10b. | ***This is optional. Please tick yes/no as appropriate and initial the box on the right***I would like to be told about chance findings about my child’s **health**.**Please tick Yes if you agree to this:** Yes**Please tick No if you do not agree to this:** No |  |  |  |
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| 10c. | ***This is optional. Please tick yes/no as appropriate and initial the box on the right***I would like to be told about chance findings that may affect the health of my child’s blood relatives.**Please tick Yes if you agree to this:** Yes**Please tick No if you do not agree to this:** No |  |  |  |
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| 11. | **I agree that my child can take part in the above study.** |  |  |  |
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| Name of Patient |  | Date: |  | Signature of assent if appropriate: |
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| Name of Parent/Guardian:  |  | Date: |  | Signature: |
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| Name of person taking consent (designated responsible person): |  | Date: |  | Signature: |
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***Instructions to site: when completed take 2 copies.***

***Original and 1 copy to be kept in medical notes and investigator site file,***

***and a copy to be given to the patient’s parent/legal guardian***