(\*\*\*Hospital headed paper\*\*\*)

*Patient name:*

*Patient study identifier* ([\_\_\_][\_\_\_][\_\_\_] -[\_\_\_][\_\_\_][\_\_\_][\_\_\_])

## YOUNG CHILD (<12 YEARS OLD) ASSENT FORM

**ISARIC/WHO Clinical Characterisation Protocol**

### Please tick the boxes if you agree. If you don’t agree, leave the boxes empty.

I have been told about the study and given the information sheet about it and have had the chance to ask questions.

I know I don’t have to take part. If I do, I can change my mind – the doctors and nurses will still look after me.

I do not mind if someone doing the research looks at my medical records and collects my information - I know the people doing the study will keep personal things about me private.

I understand samples for the study may be collected from me when I am in hospital.

I agree to take part.

Name of Patient Date Signature

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

(Legal Guardian/Carer Name in Block Letters)

Name of Person taking consent Date Signature

(Research team member or health professional trained in taking consent for this study)

Researcher Date Signature

**1 copy for patient; 1 for researcher; 1 to be kept with hospital notes**