WellKiwis
influenza study

CONSENT FORM – Birth Mother

BIRTH MOTHER'S NAME

I, _____ *(Print full name of birth mother)*

consent to take part in this study by signing this document.

PLEASE READ THE FOLLOWING INFORMATION

1. I have read and understood the WellKiwis Influenza Study participant information sheet.
2. I have been able to get the answers to questions I had about this study.
3. I understand that taking part in this study is voluntary (my choice), and I may stop taking part in the study at any time. This will not affect my current or future health care.
4. I understand that taking part in this study is confidential. My name, address, and other information that could identify me personally, will not be used in study reports or any study results shared publically.
5. I understand the privacy of my study information is protected by the laws governing ethical research in New Zealand and this study has ethics approval (NTX11.11.102.AM42) from the NZ Health & Disability Ethics Committee (HDEC).
6. I agree to an approved auditor appointed by HDEC, or any regulatory authority or their approved representative reviewing my relevant medical records for the sole purpose of checking the accuracy of the information recorded for the study.
7. I understand study communications will mainly be electronic (email, text/SMS message, and online surveys), and the study cannot guarantee the security of electronic responses to study communications.
8. I understand the study will provide compensation to cover my time, effort and study-related costs.
9. I understand the compensation provisions in case of injury during the study.
10. I understand the cord blood sample and the information I provide will be stored securely for ten years after the study ends or ten years after my child turns 16 years, and then will be destroyed with appropriate procedures.
11. I understand the cord blood sample will be sent to St Jude Children's Research Hospital (SJCRH) as main testing centre. Some samples may be sent to other collaborators at Universities and Medical Schools such as Mt Sinai, Chicago, Washington, Emory, Rochester and Stanford for some testing that cannot be done at SJCRS. My name and other identifiable information will be removed when the samples are sent overseas.
12. I understand my study data with a unique study number without any identifiable information will be sent to University of Michigan as data centre that will put the data together from all three study sites for analysis.
13. I consent to the WellKiwis study staff to collect and process my information, including information about my health
14. I understand information may be collected from my practice medical records and also from NZ health registries.
15. I understand I have the right to check study information and to ask for that information to be corrected, if I find an error.
16. I know who to contact if I have any questions about the study.
17. I understand the overall study findings will be published in medical papers and on the SHIVERS website (www.shivers.org.nz). I know I can contact ESR for a copy of the overall findings.

YOU CAN CHOOSE WHETHER OR NOT YOU WANT TO CONSENT TO THE FOLLOWING STUDY ACTIVITIES *please tick your response*

I agree the cord blood sample may be tested to help answer questions about influenza and/or other respiratory viruses, if required for public health action, such as in the case of an influenza epidemic or pandemic.	☐ Yes	☐ No
If I decide to withdraw from the study, I agree that the information collected about me up to the point when I withdraw may continue to be processed.	☐ Yes	☐ No

PARENT/GUARDIAN DETAILS

Birth mother or guardian of child participant's signature:

Date:

Relationship to child: ☐ Birth mother/guardian

Name:

OPTIONAL: Parent or guardian of child participant's signature:

Date:

Relationship to child:

Name:

Thank you for participating in this study.
For further information please contact Dr. Sue Huang or other study staff at freephone **0800 493555 (08004WELLKIWI)** or Wellkiwis@esr.cri.nz

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