

## CONSENT TEMPLATE FOR TEENAGERS

**Principal Investigator:**

**Co-Investigator:**

**Study Title: Mathematical Concepts in Pre-Calculus**

**Sponsor: Department of Education**

My name is \_\_\_\_\_ and I am a nursing/doctoral student in the \_\_\_\_\_ program at \_\_\_\_\_ University. I am conducting a research project for my dissertation/other. This form will give you the information you will need to understand why this study is being done and why you are being invited to participate. It will also describe what you will need to do to participate as well as any known risks, inconveniences or discomforts that you may have while participating.

I encourage you to ask questions at any time and to talk to your parents about participating. If you decide to participate, you will be asked to sign this form and it will be a record of your agreement to participate. You will be given a copy of this form to keep.

➤ **PURPOSE AND BACKGROUND**

As part of my study, I would like to \_\_\_\_\_.

➤ **PROCEDURES**

This study will include \_\_\_\_\_.

You will be asked to \_\_\_\_\_.

➤ **RISKS/DISCOMFORTS**

You may feel uncomfortable being (videotaped, recorded, interviewed etc.). If you ever feel too uncomfortable, you can ask not to be taped, recorded etc. at any time. You may also stop your participation in the study at any time and you will continue to receive the same care.

➤ **CONFIDENTIALITY**

Participation in research may involve a loss of privacy; however, your records will be handled as confidentially as possible. Only my dissertation advisor/other and I will have access to your information and videotapes. All information will remain in a locked cabinet in \_\_\_\_\_. When the research project is complete, the information collected will remain locked for three years (per federal regulations) and then destroyed. No individual identities will be used in any reports or publications that may result from this study.

➤ **BENEFITS**

There will be no direct benefit to you from participating in this study. However, the information gained from this research may help \_\_\_\_\_ better understand your disease.

➤ **COSTS**

There will be no cost to you as a result of taking part in this study.

➤ **PAYMENT**

There will be no payment to you as a result of taking part in this study.

➤ **QUESTIONS**

If you have any questions or concerns about participation in this study, you may talk with me or my advisor at ( ) XXX-XXXX.

If you have questions about your rights as a research participant, you may contact the East Tennessee Children’s Hospital’s Institutional Review Board (IRB), which is concerned with the protection of volunteers in research projects, at (865) 541-8290.

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**DOCUMENTATION OF CONSENT**

I have read this form and decided that I will participate in the project described above. Its general purposes, what is will be asked to do and possible risks/benefits have been explained to my satisfaction. I can withdraw at any time. I have received a copy of this form.

I can choose not to participate in this study, or to withdraw from participating at any time. Declining participation will not interfere with my care.

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<b>Printed Name</b> of Study Participant	<b>Signature</b> of Study Participant	<b>Date</b>
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Signature of Person Obtaining Consent	Date
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