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CONSENT FORM – Parent / Guardian donors

Title of Project: *The causes of clonal blood cell disorders*

Name of Lead Researcher: *Professor A.R .Green, Department of Haematology, University of Cambridge*

Please initial box

1. I confirm that I have read and understand the Parent / Guardian donor information sheet dated **20/7/2007 (version 2)** for the above study and have had the opportunity to ask questions. ☐

2. I understand that my child's participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my child's medical care or legal rights being affected. ☐

3. I understand that any samples my child donates will be treated as gifts to the research team and I waive my rights to benefit from any developments (including commercial) resulting from the research. ☐

4. I understand that sections of any of my child's medical notes may be looked at by responsible individuals from the Department of Haematology or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to these records now and for the duration of the study. ☐

5. I understand that the handling, storage and destruction of data will be in accordance with the Data Protection Act 1998. Data will be destroyed on withdrawal from or at the end of this study (2012), or at the end of subsequent ethically approved studies ☐

6. I agree to take part in the above study ☐

PLEASE CONSIDER POINT 7 SEPARATELY:

7. I wish / do not wish (please delete as appropriate) for any samples my child donates and which are not used up in this study to be stored for use in future medical research of this kind (i.e. research into the causes of clonal haematological disorders). ☐

Name of Research Subject *(Please print)*	Date	Signature

Name of Research Team member *(Please print)*	Date	Signature