**Title of Project: Drug resistant TB contacts registry.**

**Name of PI/Researcher responsible for project: Kate Gaskell**

|  |  |  |
| --- | --- | --- |
| **Child/young person (or if unable to, parent on their behalf) to complete** | **Please circle all you agree with:** | |
| Have you read (or had read to you) information about this project? | Yes | No |
| Has somebody else explained this project to you? | Yes | No |
| Do you understand what this project is about? | Yes | No |
| Do you understand that it is ok to stop taking part at any time? | Yes | No |
| Do you understand you can access your data at any time? | Yes | No |
| Are you happy to take part? | Yes | No |

**If you would like to take part in this project please write your name and today’s date:**

|  |  |
| --- | --- |
|  |  |

Your name Date

**Your parent or guardian must write their name here too if they are happy for you to take part:**

|  |  |  |
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Print name Signature Date

**The doctor who explained this project to you needs to sign too:**

|  |  |  |
| --- | --- | --- |
|  |  |  |

Print name Signature Date

Thank you for your help

