SCHOOL OF REHABILITATION AND BEHAVIORAL SCIENCES
VINAYAKA MISSION'S RESEARCH FOUNDATION
(Deemed to be University)
Vinayaka Mission's Medical College and Hospital
Karaikal – 609609.

CONSENT FORM

(For participants less than 18 years of age)

Parent/Legally acceptable representative (LAR)

Title of the project:

Participant's name: **DOB:** **Age:**

Address:

Parent/LAR's name:

The details of the study have been provided to me in writing and explained to me in my own language. I confirm that I have understood the purpose of the above study and had the opportunity to ask questions. I understand that my child/ward's participation in the study is voluntary and that I am free to withdraw my child/ward at any time, without giving any reason. I agree not to restrict the use of any data or results that arise from this study provided such a use is only for scientific purpose(s). I have been given an information sheet giving details of the study. I fully consent for the participation of my child/ward in the above study.

Signature of the parent/ LAR: _____ Date: _____

Signature of the witness: _____ Date: _____

Name and address of the witness:

Signature of the investigator: _____ Date: _____