

LONDON  
SCHOOL of  
HYGIENE  
& TROPICAL  
MEDICINE



## **Y-Check: Evaluating the effectiveness of adolescent health check-ups - SCHOOLS**

### **CHECK-UP VISIT –PARENTAL/GUARDIAN CONSENT FORM FOR 15-19 YEAR OLDS**

Name of child: \_\_\_\_\_

I \_\_\_\_\_ (in block letters) being the parent/legal guardian of the above named minor have received information at this school about the nature, conduct, risks and implications involved in participating in the check-up visit. I have been informed in detail about the following:

- What is the check-up visit that is being delivered through the school?
- Benefits of screening for psychosocial issues, risky behaviours, poor oral hygiene, vision, hearing and physical impairment, schistosomiasis (Bilharzia), and growth and nutrition.
- Details about the screening tests: questionnaire, examination; a test for anaemia which involves a finger prick blood sample; and a test for Schistosomiasis (Bilharzia) which involves a urine sample.
- Details about what will happen if my child screens positive for a condition
- Possible risks and adverse events following the screening tests and treatments;
- What to do if there are any complications or problems after check-up services;
- An emergency contact number and information about where to go in an emergency;

I have had sufficient opportunity to ask questions and to consider whether I want my adolescent to proceed with the visit.

I have discussed all of the above information with my adolescent and he fully understands it and is in agreement.

I hereby authorize the conduct of screening tests (questionnaire, examination and measurement, blood test for anaemia, urine test for schistosomiasis (bilharzia)) on my adolescent aged.....

(15 years and above).

I hereby authorize you to, if necessary, provide my child with on-the-spot treatment or referral to specialist services.

I commit myself to assist my child to comply with the recommendations of the school nurse and to attend to all the reviews as advised.

I hereby agree that the results of the test (or treatment) may be anonymously used for purposes of research and/or data-collection purposes, provided that such information is de-identified with sufficient safeguards. I know that I am, at any stage, free to withdraw my consent to undergo the tests/treatments.

Name or parent/guardian..... Date.....

Signature (or Thumb Print\*) of parent/guardian .....

Time.....

**If illiterate:** I have witnessed the accurate reading of the information sheet and consent form to the parent/guardian of the child participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of witness\*.....

Signature of witness\* .....

(\*Required only if participant is illiterate)

Cell phone.....

National ID Number of child.....

School name .....

Name of participant..... Date.....

Signed ..... Time.....