

Appendix I. Consent forms

MRC Human Nutrition Research

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CONSENT FORM FOR THE NATIONAL INFANT DIET AND HEALTH STUDY

Serial Number:

First Name:

Sex Male 1 **Date of birth:** DAY MONTH YEAR

 Female 2

PHYSICAL MEASUREMENTS

MREC Reference Number: 09/H0305/101
Name of Lead Investigator: Alison Lennox

I _____ being the legal parent/guardian of _____
(subsequently referred to as "child") hereby give my permission fully and freely for my child to participate in the Infant Diet and Health study.

- | | Please initial the relevant box | |
|--|---------------------------------|--------------------------|
| | YES | NO |
| 1. I confirm that I have read and understand the information sheet entitled 'National Infant Diet and Health Study' – Information for parents dated 30 October 2009 (version 1.0) for the above study. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. The purpose and procedures have been explained to me by the interviewer. I have had the opportunity to ask questions and have had these answered satisfactorily. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I agree for my child to have body weight measurements taken as part of the above study. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I agree for my child to have body length measurements taken as part of the above study. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I agree for my child to have head circumference measurements taken as part of the above study. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. <i>I understand that my child's participation is voluntary and that I am free to withdraw him/her at any time, without giving any reason.</i> | <input type="checkbox"/> | <input type="checkbox"/> |

Name of Parent/guardian <i>(Please print)</i>	Date	Signature
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Name of Interviewer	Date	Signature
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National Infant Diet and Health Study

CLINIC CONSENT FORM

MREC Reference Number: 09/H0305/101

Lead Investigator: Alison Lennox

Study ID Number

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I _____ being the legal guardian of _____ (subsequently referred to as child) hereby give my permission fully and freely for my child to participate in the National Infant Diet and Health Study.

GENERAL STATEMENTS

Please initial relevant box

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. I confirm that I have read and understand the information sheet entitled 'National Infant Diet and Health Study' – Information about the clinic visit dated 08 August 2010 (version 3.0) , had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I understand that my child's participation is voluntary and that I am free to withdraw from any stage of the study, at any time, without giving any reason, and without our medical care or legal rights being affected in any way. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I consent to my general practitioner (GP) being notified of my child's participation in this research and to be informed of the results. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I give permission that my own (if applicable) and my child's anonymised (blood and/or urine) samples taken as part of this study may be analysed in another laboratory outside of MRC Human Nutrition Research for the purpose of nutritional assessment. I can withdraw consent at any time by asking investigators in writing to remove and destroy samples. | <input type="checkbox"/> | <input type="checkbox"/> |

Name of Parent/Guardian
(Please print)

Date

Signature

Name of Research Team Member Date

Signature

National Infant Diet and Health Study

CLINIC CONSENT FORM – continued page 2

Study ID Number

RESEARCH CLINIC VISIT - OPTIONS

Please initial relevant box

A) PHYSICAL/SKINFOLD MEASUREMENTS

5. I agree for my child to have **physical measurements** taken by a trained person as part of the above study.
6. I agree for my child to have **skinfold measurements** taken by a trained person as part of the above study.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

B1) MEASUREMENT OF BREAST MILK INTAKE (breastfeeding only)

7. I confirm that I have read and understand the information sheet entitled '**National Infant Diet and Health Study' – How much breast milk and/or other fluid does your baby drink dated 31 August 2010 (version 4.0)**, had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
8. I give permission for my child to have **breast milk intake, fluid intake and body composition measured**.

or

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

B2) MEASUREMENT OF BODY COMPOSITION

9. I confirm that I have read and understand the information sheet entitled '**National Infant Diet and Health Study' – How much breast milk and/or other fluid does your baby drink dated 31 August 2010 (version 4.0)**, had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
10. I give permission for my child to have **fluid intake and body composition measured**.

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Name of Parent/Guardian
(Please print)

Date

Signature

Name of Research Team Member Date

Signature

National Infant Diet and Health Study

CLINIC CONSENT FORM – continued page 3

Study ID Number

RESEARCH CLINIC VISIT – OPTIONS continued

C) BLOOD SAMPLE

Please initial relevant box

- | | Yes | No |
|--|--------------------------|--------------------------|
| 11. I confirm that I have read and understand the information sheet entitled ' National Infant Diet and Health Study' – Why provide a blood sample? dated 02 November 2009 (version 2.0) , had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. I agree for my child to have a blood sample taken by a trained person as part of the above study. | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. I agree to being informed of my child's blood results. | <input type="checkbox"/> | <input type="checkbox"/> |

D) CONSENT FORM IF RESULTS NOT BEING SENT TO GP, PARENT OR GUARDIAN

Please initial box

14. This is to clarify that against the advice of the National Infant Diet and Health Study team. I do not want to receive my child's clinically relevant examination results.
15. I agree to the study's clinical survey doctor contacting me to discuss, if necessary, any results that are directly relevant to my child's health. The best contact number for the clinical survey doctor to use is: _____

Name of Parent/Guardian (Please print) Date Signature

Name of Research Team Member Date Signature