If appropriate for this study, a scanned copy of the signed consent form should be uploaded to the participant’s Epic/EMR record.

Patient I.D. Plate

# **CONSENT FOR CONTINUED PARTICIPATION IN A RESEARCH STUDY BY A PARTICIPANT WHO HAS REACHED AGE 18**

1. **What is the purpose of this consent form?**

You are currently taking part in this research study with the permission of your parents or a legally authorized representative (LAR). Now that you have reached 18, we are asking for your consent to continue participation in this study. Your participation is voluntary and you may choose to stop taking part now or at any time in the future.

|  |  |  |
| --- | --- | --- |
| Study Number | Study Title | PI Name, Phone Number, Address and Fax Number |
|  |  |  |

We will give you a copy of the consent form for the study, which was signed by your parents or LAR. Please read it carefully and take as much time as you need and ask questions about anything you do not understand.

1. **What you should know about participation in this research study?**

If you decide to continue as a participant in this research, you will participate in all parts of the study (like collecting blood or taking study drugs), as well as any follow-up procedures that are part of the study.

If you decide to stop taking part in the research, you can choose to allow us to continue to collect information about your current and future health or you can choose to have no further information collected by us.

Johns Hopkins may use or give out your health information it has already collected if the information is needed for this study or any follow-up activities***.***

1. **Consent or withdrawal of consent to continue in the research study:**

**Please check one of the boxes below and sign your full signature under the statement.**

**To continue in the research study:**

* I have been given a copy of the original research consent signed by one or both of my parents or my legally authorized representative. I agree to remain in this study, and to have my personal health information collected for research purposes, and to allow information on my health to be submitted to any sponsor of this study. I understand that I can change my mind about taking part at any time.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date/Time**

**To stop further research procedures but allow us to share data about your current and future health:**

**€** I am withdrawing my consent to continue in this research study. I understand that no further personal health information will be collected for research purposes; however, information that is collected for regular clinical care about my current and future health can still be reviewed by the research team and given to the sponsor of this study.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date/Time**

**To stop taking part in the research study:**

**€** I am withdrawing my consent to continue in this research study. I understand that no further personal health information will be collected for research purposes, and that no more information on my health will be submitted to the sponsor of this study.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date/Time**

1. **Future use of biospecimens collected for this study:**

During the time you have been in this study, some biospecimens (such as blood or tissue) may have been collected. Some of these samples may have been saved or sent to other researchers for research testing as part of future studies.

**€ Not applicable; there were no biospecimens collected for this study.**

**€ Biospecimens were collected for this study but direct identifiers are now removed.**

If your biospecimens were collected and the direct identifiers were removed your study doctors have no way of determining which stored sample is yours. You will not be able to withdraw them from being used for future research.

**€ Biospecimens were collected for this study and can still be identified as belonging to you.**

If your samples can be identified as belonging to you (identifiable), you can decide whether you will allow the study doctors to continue to save or use your biospecimens for future research.

**To allow continued use of your biospecimens**

**€** I agree to continue to allow researchers to use my identifiable biospecimens for future research purposes. I understand that I can change my mind about this at any time.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date/Time**

**To not allow continued use of your biospecimens**

**€** I request that my identifiable biospecimens be destroyed. I do understand that biospecimens that have already been used cannot be destroyed.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date/Time**

1. **Who you should contact if you have questions:**

Call, email or fax the principal investigator listed on the first page of this consent form. If you cannot reach the principal investigator or wish to talk to someone else, call the IRB office at 410-502-2092.

1. **What does your signature on this consent form mean?**

Your signature on this form means that:

* you understand the information given to you in this form
* you have made your choices about continuing in the study and about the use of your biospecimens

You will not give up any legal rights by signing this consent form.

**WE WILL GIVE YOU A COPY OF THIS SIGNED AND DATED CONSENT FORM**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Participant (Print) Date/Time**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Person Obtaining Consent (Print) Date/Time**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Physician/Mid-Level Provider (Print) Date/Time**

**(if required)**

**NOTE: A COPY OF THE SIGNED, DATED CONSENT FORM MUST BE KEPT BY THE PRINCIPAL INVESTIGATOR AND A COPY MUST BE GIVEN TO THE PARTICIPANT. IF APPROPRIATE FOR THIS STUDY, A SCANNED COPY OF THE SIGNED CONSENT FORM SHOULD BE UPLOADED TO THE PARTICIPANT’S EPIC/EMR RECORD (UNLESS NO MEDICAL RECORD EXISTS OR WILL BE CREATED).**