



Rehabilitation Sciences Institute  
**UNIVERSITY OF TORONTO**

**Informed Consent for Participation in a Research Study**

**Parent Consent / Adolescent Assent (**Concussed**)**

Before participating in the proposed research study, *Investigating Predictors of Recovery Following Concussion in Adolescent Athletes*, I want to make sure you and your child understand your/their rights as a research participant. I want to emphasize that your child's participation in this research study will not change the care they receive from their health care provider. I want to emphasize that your child can stop participating at any time. I would also like to emphasize that the responses provided on your child's questionnaire(s) will be kept confidential.

If you feel comfortable allowing your child to participate in the described study, you can give me permission to collect information about your child by providing your consent below.

By checking the following boxes, I agree that my child and I:

- 1) read the letter of information for this study ☐
- 2) do not have any questions about the study and/or have had all of my questions answered ☐
- 3) understand our rights and responsibilities as a participant in this study ☐
- 4) will assist my child with completing and submitting their questionnaire(s) ☐
- 5) I agree to allow my child's health care provider to release information pertaining to: i) date of concussion diagnosis, ii) date of medical clearance (i.e., return-to-play), and iii) any treatment(s) that were administered to address post-concussion symptoms.

☐ Yes, I agree

☐ No, I do not agree

- 6) Study investigators will need to get in contact with you and your child when it is the right time to complete follow-up questionnaires. In addition to being contacted by email, would you also like to be contacted by telephone?

☐ Yes

☐ No

- 7) I agree to allow the information collected to be used in additional studies about concussion and adolescent athletes. Any additional studies conducted using your child's information would be approved by an ethics board first.

☐ Yes, I agree

☐ No, I do not agree

- 8) My child and I would like to be contacted about participating in future studies conducted within this program of research.

☐ Yes

☐ No

**FACULTY OF MEDICINE**

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Complete Concussion Management 16 Digit Account Number (if applicable): \_\_\_\_\_

\_\_\_\_\_  
Athlete Name

\_\_\_\_\_  
Athlete Email

\_\_\_\_\_  
Athlete Phone Number (optional)

\_\_\_\_\_  
Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Name

\_\_\_\_\_  
Parent Email

\_\_\_\_\_  
Parent Phone Number (optional)

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**Note:** The research study you are participating in may be reviewed for quality assurance to make sure that the required laws and guidelines are followed. If chosen, (a) representative(s) of the Human Research Ethics Program (HREP) may access study-related data and/or consent materials as part of the review. All information accessed by the HREP will be upheld to the same level of confidentiality that has been stated by the research team.