**CONSENT FORM**

The University of Connecticut Health Center
Department of Mental Health and Addiction Services (DMHAS)

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| Who is conducting this study? | Robert H. Aseltine Jr. Ph D<br>Intstitute for Public Health Research<br>University of Connecticut<br>99 Ash Street, MC-7160, East Hartford, CT 06108 |
| Who is funding this study? | Substance Abuse & Mental Health Services Administration |
| What is the title of the Study? | Evaluation of the SOS suicide prevention program |
| How long will it last? | Your child's participation will be completed in 4 months |

Student's Name (please print) _____

I. A. **Purpose of Study**: ROBERT ASELTINE and his staff are conducting a study to evaluate the Signs of Suicide (SOS) program that is used in your child's school system. We expect a total of 5,000 6th through 12th grade students in 44 schools will participate in this project.

B. **Procedures**: Your child will complete 2 questionnaires over a 4 month period. Questionnaires will be distributed and collected by study staff in a manner that protects the confidentiality of your child's responses. Each questionnaire will be administered during class time.

II. **Discuss the possible risks to study participants and safeguards used for their protection**:
The only thing your child will do in this study is complete 2 questionnaires at two points in time. A sample copy of the questionnaire will be available for your review at the school. The questionnaires include items about past feelings of depression and/or suicidal ideas. There are no questions about current thoughts or feelings. If the questions bring up feelings of sadness or distress in your child, the mental health professionals in your child's school (counselors, school psychologists and social workers) will be available to speak with him or her. These school based mental health professionals will also be available to speak with you if you are concerned about your child and can help you get other assistance if appropriate.

The answers you child provides will be kept strictly confidential. This means that no one but the investigator and his study staff will have access to your child's responses. No one at your child's school will have access to this information.

III. **Possible benefits to you or others to be expected from your child's participation in this study**:

**A**. The school will benefit by learning whether the SOS program is effective and whether this program should be continued at your child's school.

**B.** The creators of the SOS program can evaluate and improve the program using the information from this study.

**C.** All 6-12th grade students returning a signed consent form to their counselors by September 30, 2008 will be entered into a prize drawing for a $50.00 gift card or a portable DVD player. Your child does not have to participate in the study to be eligible for these prizes. They will be entered into the drawing even if you check the "NO" box below, as long as they return the form with your signature.

IV. **The investigator will answer any questions you may have concerning this study**. You may call Robert H. Aseltine Jr. Ph D (860) 679-3282 or the project manager at (860) 679-2021 or toll free (866) 705-6623.

V. If you have questions regarding your child's rights as a study participant at UConn Health Center, you may contact the UConn Health Center Institutional Review Board (IRB) Representative at (860) 679-1019 or (860) 679-4851.

VI. **Your child's participation is voluntary and you may refuse to allow your child to participate or withdraw your consent and stop your child's participation in the project at any time without penalty or loss of any benefits to which your child is otherwise entitled**. This means that your decision whether or not to participate will not affect your child's grade in this class or standing in school or your child's future medical care at the University of Connecticut Health Center/John Dempsey Hospital. To withdraw your consent you must send a letter to Robert H. Aseltine Jr. Ph D, Intstitute for Public Health Research, University of Connecticut, 99 Ash Street, MC-7160, East Hartford, CT 06108. All data collected up to the date of withdrawal will be used in the analysis.

VII. **The confidentiality of your child's records will be maintained in accordance with the National Institutes of Health Guidelines** We will not make your child's responses available to you, the school or anyone else who is not involved in the collection or analysis of data or the protection of records for this study. Your child's name will be stored separately from his or her answers. The questionnaires will be identified by a code to protect their names. The master file that links the code to your child will be maintained in a locked cabinet. A confidential password will protect access to any computer that contains information from this study.

VIII. At the conclusion of this study the Dr. Aseltine and his colleagues intend to publish an article on their findings. Information will be presented in summary form and your child will not be identified in any publications or presentations. We will only share identifiable information with authorities who must ensure that this investigation meets legal, institutional and/or accreditation requirements and safeguards.

IX. **Will you find out the results of this study?** You may request a copy of the final report or publication from Robert Aseltine by calling 860-679-3282 or email aseltine@uchc.edu.

X. **Consent to Participation**: Please keep one copy of this form at home and return one signed and dated to the school. By signing this form you acknowledge that you have read (or have had read to you) this informed consent document, that you have been given the opportunity to ask questions and have them answered to your satisfaction and that you voluntarily consent to have your child participate in this project as described on this form. Your child will also be asked to agree to participate in the study. Please check the appropriate box and sign below:

☐ **YES** I **DO** give permission for my child to be part of this study. This authorization will expire at the conclusion of the project on June 30, 2009.
☐ **NO** I Do **NOT** give permission

| Role | Printed Name | Signature | Date |
|---|---|---|---|
| Parent/Guardian | | | |
| Student | | | |