PARENT APPLICATION FORM
(for inclusion in the E-SEE study)

Guidelines

PRINT IN BLOCK CAPITALS

Please send the completed form using the FREEPOST envelope provided

(FREEPOST RSBY-KCSB-RCJL, Department of Health Sciences, University Of York, YO10 5DD)

If you have any questions about this form please contact:

Nicole Gridley (E-SEE Trial Co-ordinator) Tel: 01904 328152 Email: e-see@york.ac.uk

Details of person with main parental responsibility

First name: ______________________ Family name: ______________________

First language: ______________________ Interpreter required? YES / NO

Home telephone: ______________________ Mobile phone: ______________________

Best time to contact: ______________________ Relationship to child: ______________________

Address and postcode: ____

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Email address: ____

How would you prefer to be contacted?: PHONE-CALL / TEXT / EMAIL Where did you hear about the study?: ______________________

Parental responsibility shared? YES / NO If yes, state relationship of other person to child: ______________________

Would you be willing to give the co-parent a form similar to this one? YES / NO

Details of child

First name: ______________________ Family name: ______________________

Gender: MALE / FEMALE Date of birth: (dd/mm/yyyy) ______________________

Address of child (if different to above): ____

Details of any disability or diagnosis: ____

Consent to pass contact details to research team

Please read each of the statements below, initial each box and sign at the bottom if you agree

I confirm my child is aged 8 weeks or under.	
I agree that my contact details to be forwarded to a researcher at the University of York with the possibility of being invited to participate in the E-SEE study.	
I understand that a member of the research team may contact me with more details of the project and to discuss my possible participation in the research.	
I am aware that I am not obliged to take part in the study and I understand that my details will be protected and stored securely.	
I have been given a brief information leaflet (version 3, 26/10/15) about this study.	

Name of parent/co-parent ____________________ Signature ____________________ Date __________

Name of professional completing this form with the family (if applicable) ____________________ Signature ____________________ Date __________

Details of professional completing form with the family (not applicable if making self referral)

Name: ____

Role/Job title: ____

Organisation/Agency: ____

Telephone number: ____

Email address: ____

Date form completed: ____

For Office Use Only

Date Received: ____________________ **STUDY ID:** ____________________

Site: ____________________