

Consent form

Please tick to indicate you consent to the following

I have read the Participant Information Sheet or have had it read to me in a language I understand, and I understand what it says.

I have been given sufficient time to consider whether or not to participate in this study.

I have had the opportunity to use a legal representative, whānau/ family support or a friend to help me ask questions and understand the study.

I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

I understand the blood biomarker result is for research monitoring and will not determine diagnosis, selection, training, or return-to-play decisions.

I consent to the research team collecting and using my study information, including relevant health and HIA-related information, for this research.

I consent to a venous blood sample being collected for testing levels of GFAP and UCH-L1.

I consent to my GP or current health provider being informed about my participation in the study and of any significant abnormal results obtained during the study.

I agree to an approved auditor appointed by the New Zealand Health and Disability Ethics Committees, or any relevant regulatory authority or their approved representative reviewing my relevant medical records for the sole purpose of checking the accuracy of the information recorded for the study.

I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.

I understand the compensation provisions in case of injury during the study.

I know who to contact if I have any questions about the study.

I understand my responsibilities as a study participant.

I wish to receive a summary of the overall results from the study on completion.	Yes ☐	No ☐
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I wish to receive an individual report of my study test results.	Yes ☐	No ☐
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I agree to be contacted by this research team about future studies on concussion/head impacts and longer-term brain health.	Yes ☐	No ☐
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Optional use of data

I agree to Abbott diagnostics (USA) having access to my deidentified data.	Yes ☐	No ☐
I wish to pick up my blood sample after analysis.	Yes ☐	No ☐
I wish for my blood to be destroyed with a karakia.	Yes ☐	No ☐

My GP contact details are: _____

My email for report delivery is: _____

Declaration by participant:

I hereby consent to take part in this study.

Participant's name: _____

Signature: _____

Date: _____

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant and have answered the participant's questions about it.

I believe that the participant understands the study and has given informed consent to participate.

Researcher name: _____ Signature: _____ Date: _____