

FORT4 FITNESS TRAINING CONSENT FORM

For Adults and Children

DESCRIPTION: You are invited to participate in a research study in conjunction with your participation in the Fort4Fitness program for adult and child fitness. The study is being conducted by Dr. Sue Chubinski from the University of Saint Francis, Fort Wayne, IN.

STUDY PURPOSE: We hope to learn more about how your training changes your level of fitness.

NUMBER OF PARTICIPANTS: All the participants of the Fort4Fitness Training are invited to participate in the study. We anticipate there will be about 100 adults and about 300 children invited to participate.

TIME INVOLVEMENT: Your participation in this study will only require about 15 minutes of your time at the beginning and again at the end of your training.

PAYMENT AND COSTS: There is no payment for your participation in this study nor any cost to participate.

PROCEDURE: We would like to collect general health and fitness information. For adults and children this includes height, weight, heart rate, and general fitness (prior activity level, ability to walk/run a set distance, sit ups and sit and reach tests). In addition, for adults, this includes blood pressure, brief health history and a list of current medications. We would like to collect this information at the beginning and the end of your training. This study does not involve any treatment; just the collection of information.

RISKS AND BENEFITS: There are no anticipated risks associated with this study. You will not receive any direct benefit from participation in the study.

PARTICIPANT'S RIGHTS: Your participation is voluntary and you may withdraw your participation at any time without penalty or loss of benefits to which you are otherwise entitled. You have the right to refuse to answer particular questions. Your individual privacy will be maintained in all published and written data resulting from the study.

If you wish to revoke your authorization you may do so in writing or by email. Please provide the written withdrawal to Dr. Sue Chubinski, University of Saint Francis, 2701 Spring Street, Fort Wayne, IN 46808 or by email to schubinski@sf.edu.

HOW IS MY CONFIDENTIALITY PROTECTED: Your privacy is important. All information gathered during the study will be kept private. Your identification as a participant in this study will remain strictly confidential. All published information will be reported as group data only, no individual names will be revealed. Individual participant information will be kept in locked files and accessible only to those directly involved in the study or to those required by law. Only persons such as authorized representatives of Lutheran Hospital, Lutheran Hospital Institutional Review Board, hospital compliance officers will have access.

WHO ELSE MAY RECEIVE OR VIEW YOUR INFORMATION: The parties listed in the preceding paragraph may be required to disclose your health information to the following persons/organizations for their use in connection with this research study:

- The Office for Human Research Protections in the U.S. Department of Health and Human Services

Your information may be re-disclosed by the recipients described above, if they are not required by law to protect the privacy of the information.

If you sign this document, you give permission to Dr. Sue Chubinski to use or disclose your health information that identifies you for this research study such as the general health information you provided.

There is no expirations date on this consent.

POSSIBLE INJURY DURING THE STUDY: If you are injured, and the injury is determined to be a direct result of your participation in this research project, Lutheran Hospital will assist you in obtaining the necessary emergency care for your research-related injuries. If you have medical insurance, your insurance carrier will be billed for these services in the ordinary manner. Any costs that are not covered or that remain after payment by the insurance company, including deductibles, will be your responsibility. The hospital's policy is not to provide financial compensation for lost wages, disability, pain or discomfort, unless required by law to do so. This does not mean that you are giving up any legal rights you are entitled to. You may contact Dr. Sue Chubinski to report injury, or any questions.

STUDY RESULTS: Participants may receive results of the study by contacting the researcher and requesting a copy.

FOR QUESTIONS ABOUT THE STUDY, CONTACT: Dr. Sue Chubinski, from the University of Saint Francis, located at 2701 Spring Street, Fort Wayne, IN 46808, 260-437-7325 or 260-399-7700 ext. 8509.

Print name of participant

Signature of adult participant

Date

If child is participant, signature of parent or guardian

Relationship to child

Offered a copy of consent

Person Obtaining Consent- Witness

I attest that the requirements for informed consent for the medical research project described in this form have been satisfied – that I have discussed the research project with the subject and explained to him or her in non-technical terms all of the information contained in this informed consent form, including any risks and adverse reactions that may reasonably be expected to occur. I further certify that I encouraged the subject to ask questions and that all questions asked were answered.

Signature of Person Obtaining Consent

Date

Accepted copy of consent_____

Declined copy of consent_____