



Parent Consent Form

Please read carefully and then complete and sign with blue ink or any color other than black.

Your signature on this form indicates your consent for your son or daughter to participate in enforcement and evaluation activities conducted for _____ (your agency's name), under the Stop Tobacco Access to Kids Enforcement (STAKE) Act. Your son or daughter will be required to purchase tobacco products at retail businesses under the supervision of adult staff members or volunteers to determine if sales of cigarettes or other tobacco products are being made to persons under 18 years of age. They will be driven by the staff member or volunteer to the various businesses, where attempts to purchase tobacco will be made.

Any data that may be collected or published by _____ (your agency's name), will not reveal the name of your son or daughter unless we have your permission. Your permission will also be requested if your child is asked to participate in any media events related to the state evaluation program. Participation in the tobacco purchase evaluation activity is voluntary. Your son or daughter has the right to stop at any time.

I hereby give my consent to my son/daughter _____ to participate in the survey which will require my son or daughter to purchase tobacco products from retail businesses. As the parent/guardian of the above-named youth, I certify my child's birthdate to be ____/____/____ (month/day/year).

I also give my consent to having the above signed participant be treated by a physician or surgeon in case of a sudden illness or injury while participating in the survey at my expense. If a personal physician is listed below, every effort will be made to contact the physician. However, the location of the activities or the nature of the illness or injury may require the use of emergency medical personnel.

Do not sign in black ink.

Signature of Parent or Guardian

Date

Telephone Number (in case of emergency)

Please provide us with the information below, if applicable. Please print.

Name of Family Physician or Medical Group

Telephone Number

Medical Insurance Coverage

Medical Group Number