UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

PAEDIATRIC PHYSICAL EXAMINATION SKILLS MOOC: PHOTOGRAPHY AND VIDEO RECORDING CONSENT FORM

Patient's Details Name: ____ Address: ______________________________________ ____	Age: [0-6 yrs] [7-18 yrs] Contact numbers: ____

Consent:
I, the undersigned,

____(Name/Surname)

____(Relationship to the Patient)

1. acknowledge and declare that:
   I hereby give free and informed permission to the University of the Witwatersrand, Johannesburg, acting through the **Open**-Access **Pae**diatric **T**echnology **A**ssisted **L**earning (Open Petal) Project ("University"), for medical photographs being taken and/or video recordings being made ("Recordings") of my child/my dependent/my ward ("Patient") for the purposes of including the Recordings in an open-access online training course (''Paediatric Physical Examination Skills MOOC") and its iterations. I further consent to the use of the Recordings by the University for teaching and learning purposes.

2. I understand that:
   - 2.1 no money will be paid to me**/**the Patient for the use of the Recordings;
   - 2.2 more than 1 (one) Recording of the Patient may be needed and I understand that the University will, in so far as this may be reasonably possible, endeavour to make every effort to reduce the time needed to take the Recordings and to minimize the discomfort to the Patient;
   - 2.3 in so far as it may be reasonably possible, the Patient's anonymity will be preserved and facial features will be disguised;
   - 2.4 I understand further that the University will take all reasonable precautions to protect my/the Patient's privacy and to prevent the Recordings from being disseminated beyond the intended purpose;
   - 2.5 the Recordings will be securely stored on an off-line drive at a secure site;
   - 2.6 the Recordings will not be used for advertising and marketing purposes;
   - 2.7 I will be present during the photography and/or video recording sessions and that I will be allowed to immediately view the Recordings. Further, I have the right at any time to request to view the Recordings, including the edited Recordings, and that the University will, at my request, arrange a suitable time and venue for the viewing.

3. I/the Patient may at any time withdraw this consent by notifying the University. The contact details are:
   The Director,
   Centre for Learning, Teaching and Development
   University of the Witwatersrand, P/Bag 3, Wits 2050
   Tel: (011) 717-7171
   Email: Gerrit.Wissing@wits.ac.za

4. <u>I acknowledge that I have read and understood the contents of this Consent in every respect, or that the contents have been read to me, and I accept these as binding upon me.</u>

This document has been drafted to assist organisations wishing to create their own consent form and procedures. The University does not provide any warranty or assurance of merchantability or fitness for a particular purpose with respect to this consent form.

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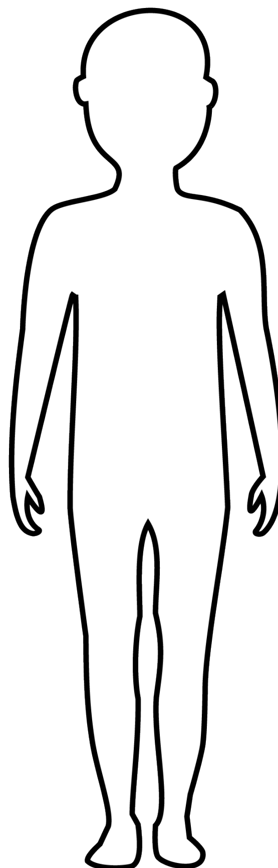
<table>
<tr><td>Would you like parts of the photograph/video recording to be hidden? [YES / NO]

If "Yes", please indicate on the adjacent picture which areas should be hidden in the final photograph/video recording.</td><td></td></tr>
<tr><td colspan="2">Signature/ Thumbprint of Parent/Guardian:

____ Date

Signature/ Thumbprint of Patient, duly assisted by the parent/guardian in so far as this may be necessary:

____ Date

Name and Signature of Doctor:

____ Date

Name and Signature of Witness:

____ Date

Name and Signature of Translator (if applicable)

____ Date</td></tr>
<tr><td colspan="2">Note: The CEO of the hospital has consented in writing to the photographs being taken and the video recordings being made.</td></tr>
</table>

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