XXXXXXXXXXX STUDY
Subject Assent Form

Both of my eyes do not see as well as they should, and my doctor thinks that it is because of a condition called amblyopia, or “lazy eye”. I want to be in this study to see if my eyesight can be improved.

I understand that if I am in the study:

1. The eye doctor will give me a new pair of glasses. Once the eye doctor tells me to begin wearing the new glasses, I will need to wear the glasses all the time that I am awake.

2. If my vision is still below normal when I put on the new glasses, I will see the eye doctor at least 4 times over the next year. If my vision gets better quickly in both eyes, I will see the eye doctor less often.

3. If one of my eyes sees much better or much worse than the other eye, the eye doctor may tell me that I need to wear a patch or put an eye drop in one eye.

4. I will be in the study for about one year.

5. I understand that my personal health information may be used by people connected with the study.

You don’t have to be in this study if you don’t want to. If you are in the study, you can stop being in it at any time by telling this to the eye doctor or your parent/guardian. Nobody will be upset with you if you don’t want to be in the study or if you want to stop being in the study. The doctors and their helpers will take care of you just as they have before. If you have any questions or don’t like what is happening, please tell the eye doctor or your parent/guardian. Your parent or guardian knows about this study. You have had it explained to you and you have been given a chance to ask questions about it. By writing your name below, you are saying that you know what will happen to you in the study and that you want to be in it.

_____ _____
Signature of Child (if capable) Date

_____
Printed Name of Child

_____ _____
Investigator's Signature Date

Protocol No. Assent 3
Last Revision Date: Patient Initials_____