



CHAPMAN UNIVERSITY

DEPARTMENT OF BIOLOGICAL SCIENCE

CONSENT FORM

Characterization of Bone Health in Orange County Residents

DEPT. BIOLOGICAL SCIENCES
CHAPMAN UNIVERSITY
ONE UNIVERSITY DRIVE
ORANGE, CA 92866

RESPONSIBLE INVESTIGATOR: Frank Frisch PhD

I have been asked to participate in a research study that evaluates the bone health of Orange County residents. The goal of the study is to identify persons at risk for bone loss by examining the bone density, assessing the nutritional status, and metabolic status of each participant and by analyzing chemical markers found in the blood. I may stop participating at any time.

I understand that I may refuse to participate in or I may withdraw from this study at any time without any negative consequences. The investigator may also stop the study at any time. I understand that no information that identifies me will be released without my separate consent and that all identifiable information will be protected to the limits allowed by law. If the study design or the use of the data is to be changed, I will be so informed and my consent re-obtained. I understand that if I have any questions, comments, or concerns about the study or the informed consent process, I may write or call the Office of the Chancellor, Chapman University, One University Drive, Orange, CA 92866; Telephone (714) 997-6826. I acknowledge that I have read a copy of this form and the Research Participant's Bill of Rights.

In participating in this study, I agree to complete a nutritional/exercise survey honestly and to the best of my knowledge. I consent to an X-ray of the lower spine region, and allow a small amount of blood to be collected from my finger or arm for chemical analysis. I understand that the technicians are both trained and certified to perform these tasks. I realize that the X-rays produce a minimal amount of radiation comparable to that produced by a tube television.

Donating this small amount of blood will not add any risks to that of any surgery or procedures I have had or may have in the future. When blood is collected, a trained technician, nurse or doctor will obtain the blood samples. I will be checked closely to see if complications due to blood drawing occur. Any problems that may arise as a result of blood collection are typically minimal and may include bruising, swelling, fainting, and infection. Medical care will be available if the need arises. I will receive all data collected from my blood sample and X-ray free of charge.

I understand that:

- a) The possible risks of this procedure include bruising, swelling, fainting, and infection from the blood collection and small amounts of radiation from the X-ray.



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- b) I understand that I may refuse to participate or may withdraw from this study at any time without any negative consequences. Also, the investigator may stop the study at any time.
- c) I also understand that no information that identifies me will be released without my separate consent and that all identifiable information will be protected to the limits allowed by law. If the study design or the use of the data is to be changed, I will be so informed and my consent re-obtained. I understand that if I have any questions, comments, or concerns about the study or the informed consent process, I may write or call the Office of the Chancellor, Chapman University, One University Drive, Orange, CA 92866; Telephone (714) 997-6826.
- d) The possible benefits of this study to me are the knowledge of my bone density and knowledge about my risk of osteoporosis.
- e) I understand that I will receive a dietary analysis based on a three (3) day survey I completed.
- f) Any questions I have concerning my participation in this study will be answered by Frank Frisch PhD at (714) 997-6573.
- g) Blood values and X-rays, as they pertain to this study will be provided to me free of charge.
- h) There may be exercise and dietary recommendations made, but I am at no obligation to comply.
- i) This study is supported by funding from the Irvine Health Foundation.
- j) I acknowledge that I have received a copy of this form and the Research Participant's Bill of Rights.

I have read the above and understand it and hereby consent to participate in this study.

Name (Printed)		Phone Number	
Signature of Participant or Responsible Party			Date
Signature of Parent (if participant is younger than 18 years)			
Address	City	State	Zip