ROBERT WOOD JOHNSON
UNIVERSITY HOSPITAL

RWJ

CONSENT FOR PEDIATRIC TESTING

I , ______________________, consent for ______________________, to undergo sleep
(print name of parent/legal guardian) *(print name of pediatric patient)*
testing and video recording of the procedure for clinical purposes. I understand that all information will be kept strictly confidential as part of the patient's medical record, in compliance with HIPAA regulations.

I understand that I am responsible for staying with the patient during the testing procedure if he/she is under 18 years of age. If the patient is younger than 13 years of age, I must stay in the room during the setup procedure and may be required to remain in the bedroom throughout the entire duration of the study. If space permits, I will be able to stay overnight in an adjacent room, so as not to interfere with testing procedures.

I also understand that I am responsible for bringing the patient to the testing facility and that I will also be the party responsible for meeting the patient after testing is completed. **All pediatric patients must be escorted to and from the facility by a parent or a legal guardian. Valid photo identification for adult escort must be given at time of registration at the Sleep Center.**

_________________________________ ____________________
Signature of Parent/Legal Guardian Date

_________________________________ ____________________
Signature of Witness Date