

**CONSENT FORM**  
**Denver Health and Hospitals**  
**University of Colorado Denver**

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**TITLE:** Digital Storytelling to Reduce Pediatric Influenza Vaccination Disparities: A Pilot Pragmatic Trial

**PROTOCOL NO.:** 21-3985

**PI:** Joshua Williams

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**Who is sponsoring this study?**

This research is being paid for by the National Institute of Health.

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**Will I be paid for being in this study?**

The site must choose statement that applies, deviations from this text are acceptable. This institution requires that a statement that a subject will not be paid be in the consent form:

You will be paid \$15/hour for each bootcamp session and \$27.50 for each in-person Digital Storytelling workshop meeting. This will add up to a total of \$400 if you complete all of the meeting sessions. Additional incentives may include childcare, reimbursement for mileage, and food at Digital Storytelling workshop meetings. If you leave the study early, or if we have to take you out of the study, you will be paid only for the portion you have completed. Payment for participation in a study is taxable income.

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**Will I have to pay for anything?**

You will not be charged for participating in the study.

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**Who do I call if I have questions?**

If you have questions, you can call the Colorado Multiple Institutional Review Board (COMIRB) office at 303-724-1055 or the principal investigator, Joshua Williams at 303-602-8377.

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**Who will see my research information?**

Denver Health and the University of Colorado Denver and the hospital(s) it works with have rules to protect information about you. Federal and state laws including the Health Insurance Portability

and Accountability Act (HIPAA) also protect your privacy. This part of the consent form tells you what information about you may be collected in this study and who might see or use it. The institutions involved in this study include:

- Denver Health

We cannot do this study without your permission to see, use and give out your information. You do not have to give us this permission. If you do not, then you may not join this study. We will see, use and disclose your information only as described in this form and in our Notice of Privacy Practices; however, people outside Denver Health, the UCD and its affiliate hospitals may not be covered by this obligation.

We will do everything we can to maintain the confidentiality of your personal information but confidentiality cannot be guaranteed.

The use and disclosure of your information has no time limit. You can cancel your permission to use and disclose your information at any time by writing to the study's Principal Investigator (PI), at the name and address listed below. If you do cancel your permission to use and disclose your information, your part in this study will end and no further information about you will be collected. Your cancellation would not affect information already collected in this study.

PI Name and Mailing Address:

Joshua Williams  
Wellington Webb Clinic  
301 W 6th Avenue, MC 1911  
Denver, CO 80207

Both the research records that identify you and the consent form signed by you may be looked at by others who have a legal right to see that information, such as:

- Federal offices such as the Food and Drug Administration (FDA) and the Office of Human Research Protections (OHRP) that protect research subjects like you.
- People at the Colorado Multiple Institutional Review Board (COMIRB)
- The study team.
- National Institute of Health, who is the company paying for this research study, and its agents who perform services in conjunction with the study.
- Officials at the institution where the research is conducted and officials at other institutions involved in this study who are in charge of making sure that we follow all of the rules for research

We might talk about this research study at meetings. We might also print the results of this research study in relevant journals. But we will always keep the names of the research subjects, like you, private.

You have the right to request access to your collected information from the Investigator.

The investigator (or staff acting on behalf of the investigator) will use your information for the research outlined in this consent form. They will also make all or some of the following information about you collected in this study available to public via internet:

- Recorded videos, photos and/or voice

**Information about you that will be seen, collected, used and disclosed in this study:**

- Name and Demographic Information (age, sex, ethnicity, phone number, etc.) for communication between you and the study team ONLY

**What happens to Data collected in this study?**

Scientists at Denver Health and the hospitals involved in this study work to improve influenza vaccination. The data collected from you during this study are important to this study and to future research. If you join this study:

- The data are given by you to the investigators for this research and so no longer belong to you.
- Both the investigators and any sponsor of this research may study your data collected from you.
- If data are in a form that identifies you, Denver Health or the hospitals involved in this study may use them for future research only with your consent or IRB approval.
- Any product or idea created by the researchers working on this study will not belong to you.
- There is no plan for you to receive any financial benefit from the creation, use or sale of such a product or idea.

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**CONSENT FORM: DIGITAL STORYTELLING TO REDUCE PEDIATRIC INFLUENZA VACCINATION DISPARITIES**

By signing this consent, you agree to share ownership rights of the videos and associated material produced in Digital Storytelling Workshops. The photographs, video clips and sound recordings may be used by the project leader and members of Denver Health for any educational, institutional, scientific, or informational purposes whatsoever, but not for any commercial uses. A copy of videos produced in the project will be provided to you upon completion of the study.

This project is designed to benefit you directly by helping you tell a story about your relationship to the influenza vaccine, and it is also designed to benefit others who may be encouraged to get an influenza vaccine after hearing your story / reasons for getting a shot. Your participation in this project is voluntary.

**Digital Storytelling Workshops may take 2-3 months to complete**, as they will be a total of up to 6 half-day sessions that can be spread out across 2-3 months which will last 3 hours each.

Digital storytelling activities in workshops include:

- Recording your voice with reading your story
- Creating a visual picture of your story before editing in the computer
- Selecting personal photographs and video clips
- Choosing music and sound effects
- Using video editing software such as WeVideo, provided to you in the project
- Applying transitions and other effects in the video editing program
- Adding a title and closing credits with logos from Denver Health
- Watching the digital stories with other project participants or alone with the researcher

Regarding the digital story you create, you will be given a choice to blur your face and disguise your voice both prior to and after recording. **It is possible for you to participate in the project completely anonymously, without the risk of personally identifiable exposure.** Videos and digital stories created in the project will be uploaded on the Internet, likely on YouTube, where anyone with a WIFI connection may view the videos.

Also, if you join the project, you may be asked to be a discussant on a panel with ten or more project participants in a showing of creative work produced by project participants. Up to 15 people overall will attend Digital Storytelling Workshops.

Your consent to the use of the photographs, video and sound recordings and your image, likeness, appearance, and voice is for forever. The photographs, video and sound recordings may be used in whole or in part, alone or with other recordings. The photographs, video and sound recordings may be used for any educational, institutional, scientific, or informational purposes whatsoever, but not for any commercial uses. **You may request at any time that we remove your video and images from the Internet after posting but we can't guarantee that others did not copy.**

What are the possible discomforts/risks of participating in the project? Emotional discomfort is a possible risk.

**If you have questions or concerns about this project, contact the Principal Investigator, Joshua Williams at [joshua.williams@dhha.org](mailto:joshua.williams@dhha.org) or 303-602-6753.**

Agreement to be in this evaluation project. I have read this consent form about the project. I understand the possible risks and benefits of this study. I know that being in this project is voluntary. I chose to be in the project. By checking the statements below, I agree to the following:

I agree to participate in a series of **digital storytelling half-day workshop**

I agree to create a **digital story recording (which could include both audio and images or video)** about influenza vaccination or influenza.

I agree to have my digital story screened and discussed in a meeting.

Print name \_\_\_\_\_ Signature \_\_\_\_\_

Telephone  
Number \_\_\_\_\_ Date \_\_\_\_\_

Email \_\_\_\_\_ Initials of person administering this form \_\_\_\_\_