**Workshop - School Wellness**

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| **Participant Consent Form** | | | Yes | No |
| 1 | I have understood the information about the project, and the researchers have explained it to me. | |  |  |
| 2 | I understand that the personal information I have provided for this study will be treated confidentially. | |  |  |
| 3 | I give my consent to use the collected data for publication purposes with the personally identifiable information removed. I understand that in any report on the results of this research, my identity will remain anonymous. | |  |  |
| 4 | I understand that I will not have any personal benefit from the research, but it would benefit the school education system. | |  |  |
| 5 | I understand that I am free to contact any of the people involved in the research to seek further clarification and information. | |  |  |
| 6 | I have the right to withdraw the data I have provided at any time, to the extent that they have not been used in any publication at the time of withdrawal. | |  |  |
| Contact information of the researchers:  Dr. Erunika Dayaratna - 0766986500  Ms. Kamani Sylva - 0777905850 | | Contact information of the Supervisor:  Prof. Rasnayaka Mudiyanse  0777844220 | | |
| 10 | Participants Name: | Signature: | Date: | |
| 11 | Name of Researcher | Signature: | Date: | |