[Study Title, Research Institution/Facility Name]

CONSENT FORM

Name: ______________________________

Study ID Number: ______________________________

Date of Birth: ______________________________

What is your family origin? You can tick more than one box.

[Use local population examples- random South African examples provided]

☐ **Xhosa** ☐ **Zulu** ☐ **Ndebele** ☐ **Swazi** ☐ **Other**

Other: ______________________________

1. Do you agree for us to collect this [*blood, genetic, etc*] sample and your health information for **this study** we have described about what affects the symptoms and level of illness in people with COVID-19?

   ☐ **YES** ☐ **NO**

2. Do you agree for us to collect this [*blood, genetic, etc*] sample and your health information for **other studies in [*country name*] in the future** about what affects the symptoms and level of illness in people with COVID-19?

   ☐ ***YES*** ☐ ***NO***

3. Do you agree for us to share your [*blood, genetic, etc*] sample together with your health information for **International studies** being done to better understand COVID-19?

   ☐ **YES** ☐ **NO**

4. Do you agree for us to use your [*blood, genetic, etc*] sample together with your health information for other studies in the future to study the effect of genes **on other health conditions**?

   ☐ **YES** ☐ **NO**

______________________________ ______________________________
Signature **Date**

Consent taken by:

______________________________ ______________________________
Signature *Name*