



Human Infection with 2019 Novel Coronavirus (nCoV) Household Transmission Investigation (v1.4, 4/27/20) Assent Form – Children between 7-17 years

Household ID: XX-_____ Participant Study ID: XX-_____

We are trying to learn more about a new illness called COVID-19. We are asking people who live in the same home as someone who has COVID-19 to let us ask some questions, take a small amount of blood from your arm, and swab the inside of your nose. Your answers will help us understand more about this illness. We also ask that you tell us how you are feeling every day for 14 days.

Your parent/guardian said it was okay for us to ask you to join. If you agree to join, we will test you for COVID-19. All your results and answers will be kept private but may be shared with your local health department or CDC. If you have COVID-19, we will tell your parent/guardian to let them know and understand what needs to be done. If you have COVID-19, you may have to stay home in your room, not travel, and not go to school. It may take a long time to find out your results.

It is up to you to choose if you want to join, and you may change your mind at any time and decide to stop. If you have any questions now or later, ask your parent/guardian to call us using the numbers we provided to them.

Do you have any questions for me?

- | | | |
|---|------------------------------|-----------------------------|
| Do you agree to us asking you questions? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you agree to have your nose swabbed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you agree to have a small amount of blood taken today? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

COMPLETE REMAINDER OF FORM ONLY IF PARTICIPANT ANSWERED ‘YES’ TO AT LEAST THE QUESTIONS AND THE SWABS

Name of parent/guardian

Date (MM/DD/YYYY)

Name of child

Date (MM/DD/YYYY)

Signature of child Date (MM/DD/YYYY)

Name of person obtaining consent Date (MM/DD/YYYY)



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