Consent Form – Adult (Participant)

I, _____, consent to take part in this study by signing this document.
(print full name of participant)

1. I have read and understood the participant information sheet.
2. I have been given sufficient time to consider whether or not participate in this study.
3. I have had the opportunity to use a legal representative, whanau/ family support or a friend to help me ask questions and understand the study.
4. I understand that taking part in this study is voluntary (my choice), that I may stop taking part in the study at any time, and this will not affect my current or future health care.
5. I know who to contact if I have any questions about the study.
6. I consent to the research staff collecting and processing my information, including information about my health.
7. I understand my study information may be linked with other data sets which include my information, such as vaccination registries and general practice medical records.
8. I understand that my taking part in this study is confidential. My name, address, and other information that could identify me will not be used in study reports or any study results shared publicly including data that will be posted on the funder (United States National Institutes of Health) website.
9. I consent to my information being sent overseas.
10. I understand that my personal information will be kept confidential, that I will be identified by a unique study code, and that information that identifies me will not be sent overseas.
11. I understand that the privacy of my study information is protected by the laws governing ethical research and Privacy Act 2020 in New Zealand and this study has ethics approval (2024 AM0952) from New Zealand Health & Disability Ethics Committee.
12. I understand that this study has a Certificate of Confidentiality from the United States National Institutes of Health (US NIH) to protect my privacy. The researchers will use this Certificate to resist any demands for information that would identify me, except for reporting of notifiable diseases to the New Zealand Ministry of Health.
13. I understand that this US NIH Certificate of Confidentiality does not protect information in my existing medical records.
14. I agree to an approved auditor appointed by HDEC, or any regulatory authority or their approved representative reviewing my relevant medical records for the sole purpose of checking the accuracy of the information recorded for the study.
15. I understand that study communications will be mainly electronic (email, text/SMS message, and online survey), and that the study will provide koha to recognise this and other study-related costs.
16. I understand the compensation provisions in case of injury during the study.
17. I understand that the study cannot guarantee the security of electronic responses to study communications.
18. I understand samples collected from me will be sent to PHF Science's National Influenza Centre in Upper Hutt.
19. I understand that a small amount of my samples will be sent to the St. Jude Children's Research Hospital in Memphis, Tennessee, U.S.A., for some testing that cannot be done at PHF Science. My name and other identifiable information will be removed, so that overseas researchers will not be able identify me when the samples are sent overseas.
20. I understand that my samples (blood/swab) and the information that I provide will be stored securely for ten years after the study completion and then will be destroyed according to appropriate procedures.
21. I understand if my sample is tested positive for COVID-19, the result will be reported the Medical Officer of Health as COVID-19 is a notifiable disease in NZ.
22. I understand that study staff will tell me my swab test results. I can also ask study staff for these results, if they are available.
23. I understand that information may be collected from my GP medical records, my workplace influenza/COVID-19 vaccination records and from NZ health registries.
24. The overall study findings will be published in medical papers and on the WellKiwis website (www.wellkiwis.co.nz). I know I can contact PHF Science for a copy of the overall findings.

You can choose whether or not you want to consent to the following study activities. ***Please circle your response***

I agree that my samples (blood/respiratory swab) may be tested more to help answer questions about influenza and/or other respiratory viruses, if required for public health action, such as in the case of an epidemic or pandemic.	Yes	No

Participant signature _____ Date: ___ /___ / 2025
dd/mm/yyyy

Thank you for participating in this study
Please feel free to contact the researchers if you have any questions about this study.
For further information please phone: Dr. Sue Huang, WHO National Influenza Centre, Phone 08004WELLKIWI