**Consent Form Addendum for Research During COVID-19 Pandemic**

For Off-Campus Research

I certify that:

[ ] I have not tested positive for COVID-19 within the last 10 days.

[ ]  In the past 10 days, I have not been in contact with someone who has received a positive COVID-19 test result.

[ ]  [ ]  I am not experiencing any of the following symptoms:

Fever or feeling feverish

Sore throat

New cough (not related to a chronic condition)

New nasal congestion or new runny nose (not related to seasonal allergies)

Muscle aches

New loss of smell

Shortness of breath

[ ]  I do not have any of the following conditions:

Diabetes

Cardiovascular disease

Chronic lung, liver or kidney disease on renal dialysis

Asthma

Severe obesity

Immunocompromising conditions or on immunosuppressing medications

Resident in a nursing home or a long-term care facility

[ ]  I agree to immediately report to the principal investigator of this studyif, within 2 weeks of my participation in the study, I or anyone in my living group has any of the above COVID-19 symptoms or a positive COVID test.

[ ]  I agree to participate in contact tracing if requested at any time after my participation in this study.

I understand that despite precautions being taken to minimize the risk of becoming infected with COVID-19, my participation in this study entails some risk that I may become infected.

I understand that:

1. My participation is completely voluntary;
2. I am under no obligation to participate during the pandemic;
3. I must comply with all applicable rules and protocols pertaining to the spread of COVID-19, including local requirements; and
4. If I choose to be in the study, I further understand that I may subsequently withdraw from the study at any time for any reason without penalty or consequences of any kind.
5. I understand this information will be maintained by the research team and maybe shared with others at MIT who have legitimate need to know this information to maintain the health and safety of the MIT community and possibly other local health authorities.

**Name of subject completing this form:**

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Name

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Signature

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