ECHO Environmental influences on Child Health Outcomes A program supported by the NIH	**COVID-19 Questionnaire – Child Self-Report Alternate Version** ECHO-wide Cohort Version 01.30 / April 9, 2020	**Form C19-cAV** Page **1** of **6**

COHORT ID	SITE ID	PARTICIPANT ID	PIN	COHORT VISIT ID	FORM COMPLETED
_ _ _ _ _ _	_ _ _ _	_____	_ _ _	_____	_ _ /_ _ /_ _ _ _ *mm dd yyyy*

ECHO LIFE STAGE		RESPONDENT	
☐ 01 Prenatal	☐ 02 Perinatal	☐ 01 Participant	☐ 02 Biological Mother
☐ 03 Infancy	☐ 04 Early Childhood	☐ 03 Biological Father	☐ 04 Other Respondent
☐ 05 Middle Childhood	☐ 06 Adolescence		→ Code: _ _

STUDY STAFF INSTRUCTION: This form should be completed by the 13- to 21-year-old child enrolled in an ECHO cohort during the adolescence life stage. The child's ID should be used in the header for the participant ID.

INSTRUCTIONS:

This form has 2 sections:

- *Section A: COVID-19 Infection*
- *Section B: Impacts of the COVID-19 Outbreak on You*

These questions are about your experience with COVID-19, or the coronavirus. For each question, do the best you can to remember the details requested.

Section A. COVID-19 Infection

For the following questions, healthcare provider means a doctor, nurse practitioner, physician assistant or anyone you go to for medical care.

1. Has a healthcare provider ever told you that you have, or likely have, COVID-19 (Coronavirus)?

☐ 01 Yes
☐ 02 No

2. Which of the following symptoms have you had at any point in time since March 1, 2020? (***Mark all that apply***)

☐ 01 Fever or chills
☐ 02 Cough
☐ 03 Shortness of breath
☐ 04 Sore throat
☐ 05 Headache
☐ 06 Muscle or body aches
☐ 07 Runny nose
☐ 08 Fatigue or excessive sleepiness
☐ 09 Diarrhea, nausea, or vomiting
☐ 10 Loss of sense of smell or taste
☐ 11 Itchy/red eyes
☐ 12 None of the above ➔ ***skip to Section A, Question 3.***

2.a. Which of the following occurred as a result of your symptoms? (***Mark all that apply***)

☐ 01 I was kept overnight in a hospital because a healthcare provider thought I had COVID-19
☐ 02 I saw a healthcare provider in person, such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED)
☐ 03 I spoke to a healthcare provider over the phone, by email, or online
☐ 04 I self-isolated or quarantined at home
☐ 05 None of the above

2.b. In the two weeks before you had symptoms, did you: (***Mark all that apply***)

☐ 01 Have contact with someone who tested positive for COVID-19
☐ 02 Have contact with someone who likely had COVID-19 (e.g., was not tested but had symptoms; was told by a healthcare provider that he/she likely had it)
☐ 03 Travel to a different state or country (please specify: _____)
☐ 04 None of the above

Section A. COVID-19 Infection (continued)

3. Have you had the nose swab test for the virus that causes COVID-19? (***Mark all that apply***)

☐ 01 No, I never tried to get tested

☐ 02 No, I tried to get tested but was not able to

☐ 03 Yes, and I am waiting for the results

If yes ➔ **3.a.** When was the date of your most recent test? __ __ /__ __ __ __ (*mm* / *yyyy*)

☐ 04 Yes, and the test showed that I do not have it ("**negative**" test)

If yes ➔ **3.b.** When was the date of your most recent **negative** test? __ __ /__ __ __ __ (*mm* / *yyyy*)

☐ 05 Yes, and the test showed that I do have it ("**positive**" test)

If yes ➔ **3.c.** When was the date of your most recent **positive** test? __ __ /__ __ __ __ (*mm* / *yyyy*)

4. Have you had a blood test to see whether you already had the COVID-19 virus ("serology")? (***Mark all that apply***)

☐ 01 No, I never tried to get tested

☐ 02 No, I tried to get tested but was not able to

☐ 03 Yes, and I am waiting for the results

If yes ➔ **4.a.** When was the date of your most recent test? __ __ /__ __ __ __ (*mm* / *yyyy*)

☐ 04 Yes, and the test showed that I did not have it ("**negative**" test)

If yes ➔ **4.b.** When was the date of your most recent **negative** test? __ __ /__ __ __ __ (*mm* / *yyyy*)

☐ 05 Yes, and the test showed that I did have it ("**positive**" test)

If yes ➔ **4.c.** When was the date of your **positive** test? __ __ /__ __ __ __ (*mm* / *yyyy*)

5. Has anyone else living in your home had, or probably had, COVID-19?

☐ 01 Yes

☐ 02 No

Setting	Mode
☐ 01 Clinic or site ☐ 02 Phone ☐ 03 Other location	☐ 01 Self-administered ☐ 02 Staff-administered