# Baseline Child Health

Date participant was enrolled in study (protocol specific) ________________________________

## Underlying Conditions

Significant underlying medical conditions at the time of COVID-19 testing or diagnosis:

- ☐ Diabetes type I
- ☐ Diabetes type II
- ☐ Obesity
- ☐ Asthma
- ☐ Bronchopulmonary dysplasia (BPD)
- ☐ Cystic fibrosis
- ☐ Obstructive sleep apnea
- ☐ Tracheomalacia
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Hematopoietic cell recipient/bone marrow transplant recipient
- ☐ Solid organ transplant recipient
- ☐ Rheumatologic conditions (e.g. rheumatoid arthritis, systemic lupus erythematosus, vasculitis)
- ☐ Hypertension
- ☐ Congenital heart disease
- ☐ Heart failure
- ☐ Cardiomyopathy
- ☐ History of Kawasaki Disease (not a current diagnosis)
- ☐ History of MIS-C (not a current diagnosis)
- ☐ Inflammatory bowel disease

Significant underlying medical conditions at the time of COVID-19 testing or diagnosis:

- ☐ Feeding tube dependent
- ☐ Sickle cell disease
- ☐ Thrombotic disorders
- ☐ Chronic liver disease
- ☐ Chronic kidney disease
- ☐ Seizure disorder/epilepsy
- ☐ Eczema
- ☐ Physical disability (including cerebral palsy)
- ☐ Down syndrome
- ☐ Congenital syndromes/anomalies or genetic conditions including other chromosomal syndromes
- ☐ Premature or neonatal conditions
- ☐ Pregnancy (if of reproductive age)
- ☐ Other conditions (specify)

Specify Other ________________________________

Premature and Neonatal Conditions (Tier 2)

☐ Fetal malnutrition
☐ Extreme immaturity
☐ Cerebral hemorrhage at birth
☐ Spinal cord injury at birth
☐ Birth asphyxia
☐ Respiratory diseases
☐ Hypoxic-ischemic encephalopathy
☐ Other

Specify other ______________________

## Family History Comorbidities (Tier 2)

Have any family members (parent/sibling) been diagnosed with any of the following medical conditions currently or in the past?

| | | | |
|---|---|---|---|
| Obesity | ◯ Yes | ◯ No | ◯ Unknown |
| Diabetes type I | ◯ Yes | ◯ No | ◯ Unknown |
| Diabetes type II | ◯ Yes | ◯ No | ◯ Unknown |
| Fibromyalgia (amplified pain syndrome) | ◯ Yes | ◯ No | ◯ Unknown |
| Rheumatologic conditions (e.g. rheumatoid arthritis, systemic lupus erythematosus, vasculitis) | ◯ Yes | ◯ No | ◯ Unknown |
| Thrombotic disorders | ◯ Yes | ◯ No | ◯ Unknown |
| Other significant comorbidity (specify) | ◯ Yes | ◯ No | ◯ Unknown |

Specify other significant comorbidity ______________________

| | Yes | No | Unknown | Prefer Not to Answer |
|---|---|---|---|---|
| If the participant is in first year of life, did the participant's mother test positive for COVID-19 while pregnant or nursing? | ◯ | ◯ | ◯ | ◯ |
| If participant is in first year of life, did the participant's father or other caregiver test positive for COVID-19? | ◯ | ◯ | ◯ | ◯ |

## Health Status (Height/Weight)

| | |
|---|---|
| Height | ________________ (cm) |
| | ◯ Not available |
| Weight | ________________ (g) |
| | ◯ Not available |
| Head Circumference (Only for children less than two years of age) (Tier 2) | ________________ (cm) |
| | ◯ Not available |

## Breastfeeding (Tier 2)

| | Yes | No | Unknown | Prefer Not to Answer |
|---|---|---|---|---|
| If the participant is in first year of life, is he or she being breastfed or fed pumped milk? | ◯ | ◯ | ◯ | ◯ |

## COVID-19 Vaccination History

| | Yes | No | Unknown | Prefer Not to Answer |
|---|---|---|---|---|
| Has the participant received a COVID-19 vaccine? | ◯ | ◯ | ◯ | ◯ |

| | |
|---|---|
| Which vaccine brand/type did the participant receive? | ◯ Pfizer<br>◯ Moderna<br>◯ Johnson and Johnson<br>◯ AstraZeneca<br>◯ Unknown<br>◯ Other (specify) |
| Specify Other | ________________ |
| Did the participant receive the second dose of the COVID-19 vaccine? | ◯ Yes<br>◯ No<br>◯ N/A<br>◯ Unknown<br>◯ Prefer Not to Answer |
| 1st Date of vaccination | ________________ |
| 2nd Date of vaccination | ________________ |

Did the participant have any adverse reactions or side effects?

- ◯ Yes
- ◯ No
- ◯ N/A
- ◯ Unknown
- ◯ Prefer Not to Answer

## PASC Symptom Resolution (Tier 2)

If the participant had long COVID/post-acute sequelae of COVID-19 (PASC) symptoms at the time of vaccination, did those symptoms change?

- ◯ Yes, full resolution of symptoms
- ◯ Yes, some improvement in symptoms
- ◯ Yes, worsening of symptoms
- ◯ No, no significant change

## Maternal COVID-19 Vaccination History (Tier 2)

| | Yes | No | Unknown | Prefer Not to Answer |
|---|---|---|---|---|
| If participant is in first year of life, did the participant's mother receive vaccination for COVID-19 while pregnant or nursing? | ◯ | ◯ | ◯ | ◯ |

## Current Vaccination Status (Tier 2)

## Parent Report About Child

| | Yes | No | Unknown | Prefer Not to Answer |
|---|---|---|---|---|
| Are the patient's immunizations up to date for their age at the time of COVID-19 diagnosis/assessment? | ◯ | ◯ | ◯ | ◯ |

If immunizations are not up to date, what is/are the reason(s) for not being up to date? (Check all that apply)

- ☐ Clinic was closed because of COVID-19
- ☐ Child had symptoms of COVID-19, so you cancelled appointment
- ☐ You cancelled appointments to avoid being around others/in a healthcare setting
- ☐ Other reasons related to COVID-19
- ☐ Other reasons not related to COVID-19
- ☐ Refused to answer

| | Yes | No | Unknown | Prefer Not to Answer |
|---|---|---|---|---|
| Has the patient received any MMR vaccinations? | ◯ | ◯ | ◯ | ◯ |
| Has the patient received the current seasonal influenza vaccine? | ◯ | ◯ | ◯ | ◯ |
| Has the patient received palivizumab for prevention of respiratory syncytial virus (RSV)? | ◯ | ◯ | ◯ | ◯ |

Has the patient received the BCG vaccination? ○ ○ ○ ○

Date of most recent vaccination (excluding vaccination for COVID-19) ____________________

**Baseline Medications/Treatment**

**Current medication name including birth control medications and injections (repeat for each medication)**

Current Medication Name 1 ____________________

Current Medication Name 2 ____________________

Current Medication Name 3 ____________________

Respiratory support prior to onset of COVID-19? ○ Yes ○ No

Specify, check all that apply (Tier 2)

☐ Non-invasive respiratory support  (e.g., CPAP, BiPAP)
☐ Invasive respiratory support (e.g. mechanical ventilation via tracheostomy)
☐ Tracheostomy
☐ Supplemental oxygen
☐ Unknown/Uncertain