OMB Control # 0920-XXXX
Expiration Date XX/XX/XXXX

ORCHARDS Household study form

ID

ORCHARDS HOUSEHOLD STUDY FORM

School ID: _______________

Participant ID: ____________

HOUSEHOLD MEMBER NAME: ______________________

RELATIONSHIP TO STUDENT: ______________________

Age: _____ **Do you work outside the home?** Yes No **Number of bedrooms:** _____

Gender: F M **Do you attend school?** Yes No **Do you attend Daycare?** Yes No

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TODAY Day 0 (___ / ___ / ___)

Did you receive an influenza vaccine this year (after August 1, 2016)? Yes No

Have you had cold or flu-like symptoms in the past 7 days? Yes No (if **No**, then you are done until next week)

If yes: How many days ago did your symptoms start? _______

How severe are/were your symptoms? Mild Moderate Severe

What symptoms have you had in the past 7 days? (circle all that have been present)

Fever Chills Cough Runny Nose Sore Throat

Tiredness Body Aches Headache Poor Appetite Nasal Congestion

Were you seen by a healthcare provider? Yes No **Where?** Usual Clinic Urgent Care ER

What diagnosis were your given? _____________________

Were you given an antibiotic or antiviral medication? Yes No _______________________

Were you sent to the hospital? Yes No

Did you miss school or Work? Yes No **If yes, how many days did you miss?** ______

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FOLLOW-UP Day 7 (___ / ___ / ___)

Have you had cold or flu-like symptoms in the past 7 days (since our previous visit)? Yes No

If yes: How many days ago did your symptoms start? _______

How severe are/were your symptoms? Mild Moderate Severe

What symptoms have you had in the past 7 days? (circle all that have been present)

Fever Chills Cough Runny Nose Sore Throat

Tiredness Body Aches Headache Poor Appetite Nasal Congestion

Were you seen by a healthcare provider? Yes No **Where?** Usual Clinic Urgent Care ER

What diagnosis were your given? _____________________

Were you given an antibiotic or antiviral medication? Yes No _______________________

Were you sent to the hospital? Yes No

Did you miss school or Work? Yes No **If yes, how many days did you miss?** ______

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions and completing and reviewing the collection of information. An agency may not conduct or sponsor this survey, and a person is not required to respond to a collection of information, unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-XXXX.