

# ORCHARDS HOUSEHOLD STUDY FORM

Participant ID: \_\_\_\_\_

School ID: 4k P N B R M H

Age: \_\_\_\_\_

HOUSEHOLD MEMBER NAME: \_\_\_\_\_

RELATIONSHIP TO STUDENT: \_\_\_\_\_

BIRTHDATE: \_\_/\_\_/\_\_\_\_

Race: White American Indian or Alaskan Native Asian Black Native Hawaiian or Other Pacific Islander

Ethnicity: Hispanic Non-Hispanic Gender: Female Male Other: \_\_\_\_\_

Do you work outside the home? Yes No Number of bedrooms in household: \_\_\_\_\_

Do you attend school? Yes No Do you attend Daycare? Yes No

Did you receive an influenza vaccine this year (after August 1, 2020)? Yes No

Have you been tested for COVID-19? Yes (please list test date and result if known) \_\_\_\_\_ No

Have you had cold or flu-like symptoms in the past 14 days? Yes No (if No, stop here)

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

Exposure to a similar illness 1-14 days prior to illness onset? Yes No

Likely Source: Classmate Friend Family Member (Adult/Child) Other: \_\_\_\_\_

Recent Travel? Yes (please list location) \_\_\_\_\_ No

How severe are/were your symptoms? Mild Moderate Severe

What symptoms have you had in the past 14 days? (circle all that have been present)

Fever Chills Cough Wheezing Runny Nose Sore Throat

Fatigue Muscle Pain Joint Pain Headache Stuffy Nose Ear Pain

No Appetite Vomiting Abdominal Pain Diarrhea Conjunctivitis Shortness of Breath

Loss of smell Loss of taste Other: \_\_\_\_\_

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

What diagnosis were you 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? \_\_\_\_\_

ID

Day 0 ( \_\_/\_\_/\_\_ )

TODAY

ID

# ORCHARDS HOUSEHOLD STUDY FORM

Participant ID: \_\_\_\_\_

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Age: \_\_\_\_\_

HOUSEHOLD MEMBER NAME: \_\_\_\_\_

RELATIONSHIP TO STUDENT: \_\_\_\_\_

Have you been tested for COVID-19? Yes (please list test date and result if known) \_\_\_\_\_ No

Have you had cold or flu-like symptoms in the past 14 days? Yes No (if No, stop here)

If yes:

Are these continuing symptoms from Day 0? Yes No (if No, list symptom start date) \_\_\_\_\_

Are you currently experiencing symptoms? Yes No (if No, list symptom end date) \_\_\_\_\_

Exposure to a similar illness 1-14 days prior to illness onset? Yes No

Likely Source: Classmate Friend Family Member (Adult/Child) Other: \_\_\_\_\_

Recent Travel? Yes (please list location) \_\_\_\_\_ No

How severe are/were your symptoms? Mild Moderate Severe

What symptoms have you had in the past 14 days? (circle all that have been present)

- |               |               |                |          |                |                     |
|---------------|---------------|----------------|----------|----------------|---------------------|
| Fever         | Chills        | Cough          | Wheezing | Runny Nose     | Sore Throat         |
| Fatigue       | Muscle Pain   | Joint Pain     | Headache | Stuffy Nose    | Ear Pain            |
| No Appetite   | Vomiting      | Abdominal Pain | Diarrhea | Conjunctivitis | Shortness of Breath |
| Loss of smell | Loss of taste | Other: _____   |          |                |                     |

Were you seen by a healthcare provider? Yes No Where? Virtual visit 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? \_\_\_\_\_

TODAY Day 7 ( \_\_\_ / \_\_\_ / \_\_\_ )

TODAY

# ORCHARDS HOUSEHOLD STUDY FORM

Participant ID: \_\_\_\_\_

School ID: 4k P N B R M H

Age: \_\_\_\_\_

ID

HOUSEHOLD MEMBER NAME: \_\_\_\_\_

RELATIONSHIP TO STUDENT: \_\_\_\_\_

Over the past 2 weeks, have you:

Used a face mask/covering outside of your home (when social distancing is not possible)?

Never Rarely Sometimes Often Always

Practiced social/physical distancing when outside of your home?

Never Rarely Sometimes Often Always

Have you been tested for COVID-19? Yes (please list test date and result if known) \_\_\_\_\_ No

Have you had cold or flu-like symptoms in the past 14 days? Yes No (if No, stop here)

If yes:

Are these continuing symptoms from Day 0? Yes No (if no, list symptom start date) \_\_\_\_\_

Are these continuing symptoms from Day 7? Yes No (if no, list symptom start date) \_\_\_\_\_

Are you currently experiencing symptoms? Yes No (if no, list symptom end date) \_\_\_\_\_

Exposure to a similar illness 1-14 days prior to illness onset? Yes No

Likely Source: Classmate Friend Family Member (Adult/Child) Other: \_\_\_\_\_

Recent Travel? Yes (please list location) \_\_\_\_\_ No

How severe are/were your symptoms? Mild Moderate Severe

What symptoms have you had in the past 14 days? (circle all that have been present)

Fever	Chills	Cough	Wheezing	Runny Nose	Sore Throat
Fatigue	Muscle Pain	Joint Pain	Headache	Stuffy Nose	Ear Pain
No Appetite	Vomiting	Abdominal Pain	Diarrhea	Conjunctivitis	Shortness of Breath
Loss of smell	Loss of taste	Other: _____			

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

What diagnosis were you 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? \_\_\_\_\_

Day 14 ( \_\_\_ / \_\_\_ / \_\_\_ )

TODAY