ORCHARDS HOUSEHOLD STUDY FORM

Participant ID: _____________

School ID: 4k P N B R M H

Age: ________

ID

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

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TODAY Day 0 (___ / ___ / ___)

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 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?** ________

ID

ORCHARDS HOUSEHOLD STUDY FORM

HOUSEHOLD MEMBER NAME: ______________________

RELATIONSHIP TO STUDENT: ________________________

Participant ID: _____________

School ID: 4k P N B R M H

Age: ________

- -

TODAY Day 7 (___ / ___ / ___)

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 <u>currently</u> 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?** ________

ID

ORCHARDS HOUSEHOLD STUDY FORM

Participant ID: ____________

School ID: 4k P N B R M H

Age: ________

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

- -

TODAY Day 14 (___/___/___)

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 <u>currently</u> 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?** ________