Form Approved
OMB Control # 0920-XXXX
Expiration XX/XX/XXXX

Respiratory Illness Among People Experiencing Homelessness in Anchorage, Alaska

Enrollment form, symptom screening, and vaccination status

Complete the Enrollment Consent Form before conducting this survey.

1. Record ID:

2. Date and time:

3. Interviewer name:

4. Site of interview:

5. What is your age:

6. Do you currently describe yourself as male, female, or transgender?
    a. Male
    b. Female
    c. Transgender male
    d. Transgender female
    e. Another gender identity
    f. Refused

7. What is your race (select all that apply):
    a. American Indian or Alaska Native
    b. Asian
    c. Black or African American
    d. Native Hawaiian or Other Pacific Islander
    e. White
    f. Prefer not to answer

8. Do you identify as Hispanic? Y/N/Prefer not to answer

9. Last night, did you sleep (select one):
    a. In a shelter
    b. Outside (including in a tent or in a car)

c. In a hotel or motel room
d. In a private residence with friends or family
e. In your own private residence

10. In the past two weeks, have you spent at least one night (select all that apply):
    a. In a shelter
    b. Outside (including in a tent or in a car)
    c. In a hotel or motel room
    d. In a private residence with friends or family
    e. In your own private residence

11. In the past two weeks, have you been exposed to someone with COVID-19? Y/N/Don't know

12. In the past one week, have you experienced any of these NEW or WORSENING symptoms: (Select all that apply):
    a. Feeling feverish
    b. Headaches
    c. Cough
    d. Chills or shivering
    e. Sweats
    f. Sore throat or scratchy throat
    g. Runny or stuffy nose
    h. Feeling more tired than usual
    i. Muscle or body aches
    j. Increased trouble with breathing
    k. Ear pain or ear discharge
    l. Diarrhea
    m. Nausea or vomiting
    n. Rash
    o. Loss of smell or taste
    p. None of the above

1. a. Have you received COVID vaccination/s? Y/N
   a. How many have you received?
   b. When did you receive your last COVID vaccine? (approximate date)

1. a. Have you received a flu vaccine (flu shot)? Y/N
   b. When did you receive your last flu shot? (approximate date)

If any respiratory symptoms are selected, continue to collect swabs.

Swab Collection:

Date of collection:

Name of individual collecting swab:

Specimen collected:

Laboratory Result: