Evaluating the Association between Serum Concentrations of Per- and Polyfluoroalkyl Substances (PFAS) and Symptoms and Diagnoses of Selected Acute Viral Illnesses Child (< 18 years of age) Follow-up

Please complete the survey

below. Thank you!

Form Approved

OMB No. 0923-

0064

Exp. Date 09/30/2025

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Introduction

This is the 1st follow-up survey for the PFAS and Viral Infections Study. The purpose of this study is to improve our understanding of the relationship between the amount of PFAS in a person's blood and susceptibility to acute
(short-term) viral illnesses. This includes the COVID-19 virus as well as other viral illnesses. You enrolled your child in this study and the initial survey was completed around [enter date]. We would now like to invite you to complete this follow-up survey about your child that is asking about the time period from (date) to (date).

Remember to look back at your child's symptom diary as a reminder of any symptoms your child may have experienced in the time period from (date) to (date). The symptom diary will help you and your child complete this survey more easily!

Please enter your child's participant identification number located on the Invitation Letter you received at the start of this study.

____

Section 1. Instructions for completion and submission

This survey is divided into sections and should take about 30 minutes to complete. As you go through each section, read each question carefully and answer as best as you can. If you have questions and would like to speak with a member of the study team, please call xxx-xxx-xxxx or send an email with your question to xxx@xxx.xxx. Thank you for allowing your child to be in this study.

Please remember, this survey is asking about the time period from (date) to (date).

Section 2. Demographic and Health Information

Has your child moved to a different address since completing the last survey?

◯ Yes
◯ No
◯ Prefer not to answer

In the time period from (date) to (date), did your child get an Influenza vaccine (Flu shot)?

◯ Yes
◯ No
◯ Prefer not to answer

When did your child get that Influenza Vaccine (Flu shot)? Please enter month/day/year.

____

In the time period from (date) to (date), did your child get a dose of a COVID-19 vaccine?

◯ Yes
◯ No
◯ Prefer not to answer
◯ Child not eligible due to age

When did your child get that dose of a COVID-19 vaccine? Please enter month/day/year.

____

Which brand did your child get for that dose of COVID-19 vaccine?

◯ Pfizer
◯ Moderna
◯ Johnson & Johnson
◯ Other

In the time period from (date) to (date), did your child get another COVID-19 vaccine?

◯ Yes
◯ No
◯ Prefer not to answer

When did your child get that additional dose of a COVID-19 vaccine? Please enter month/day/year.

____

Which brand did your child get for that additional dose of a COVID-19 vaccine?

◯ Pfizer
◯ Moderna
◯ Johnson & Johnson
◯ Other

In the time period from (date) to (date), has your child received a brand new diagnosis by a doctor or other health care professional of any of the chronic medical conditions listed in the chart below?

	New diagnosis	No new diagnosis	Prefer not to answer
Asthma	◯	◯	◯
Chronic Obstructive Pulmonary Disease (COPD)	◯	◯	◯
Cystic Fibrosis	◯	◯	◯
Other Chronic Lung Disease (please specify below)	◯	◯	◯
Hypertension (high blood pressure)	◯	◯	◯
Congenital (since birth) Heart Disease	◯	◯	◯
Chronic Heart Failure	◯	◯	◯
Coronary Artery Disease	◯	◯	◯
Cardiomyopathy	◯	◯	◯
Other Heart / Cardiovascular Disease (please specify below)	◯	◯	◯
Diabetes (type 1 or 2)	◯	◯	◯
Chronic kidney disease	◯	◯	◯
Liver Disease	◯	◯	◯
Seasonal allergies	◯	◯	◯
Cancer	◯	◯	◯
Currently on chemotherapy	◯	◯	◯
History of bone marrow / stem cell transplant	◯	◯	◯
History of Organ Transplant	◯	◯	◯
Immunocompromised state (weakened immune system)	◯	◯	◯
Sickle Cell Disease (Sickle Cell Anemia)	◯	◯	◯
Inherited Metabolic Disorders	◯	◯	◯
Neurological Disease (epilepsy / seizure disorder)	◯	◯	◯
Intellectual Disability	◯	◯	◯
Cerebral palsy	◯	◯	◯
Other Developmental Disability (please specify below)	◯	◯	◯
Depression	◯	◯	◯
Anxiety	◯	◯	◯

If you selected "Other Chronic Lung Disease" above, please specify:

____

If you selected "Other Heart/Cardiovascular Disease" above, please specify:

____

If you selected "Other Developmental Disability" above, please specify:

____

Section 3. Similar to the survey already completed, the questions in this section relate to how often your child is in situations that may increase the risk of exposure to viruses through close contact with other people.

Please remember: If you are a parent filling this survey out for your child, questions about "anyone else in the household" refers to anyone besides the child you are answering the questions for (including yourself). If your child lives in more than one home, please answer the next series of questions based on the household that qualified the child for the previous ATSDR-funded study (i.e., Exposure Assessment, PEATT Study, or Pease Study). If the child lives in more than one home that qualified for these previous studies, please answer the questions based on the household with the most people.

Including your child, how many people live in your child's household? Please include individuals who sleep in the home at least 2 nights per week; please do not include those who are living away from home for school.

____

How many children less than 5 years old live in your child's household?

____

How many children aged 5-11 years live in your child's household?

____

How many children aged 12-17 years live in your child's household?

____

How many adults aged 18-64 years live in your child's household?

____

How many adults aged 65 years and older live in your child's household?

____

Please answer the next six questions based on your child's average experience in the time period from (date) to (date). If the question does not apply to your child, please enter "0". (Note: the first three questions ask for number of hours per week and the last 3 questions ask for number of times per week)

On average, how many hours per week does your child work or play in an indoor location that is not your child's home?

____

On average, how many hours per week does your child attend school or daycare in person in an indoor classroom setting?

____

On average, how many hours per week is your child in a situation that requires regular close contact (within 6 feet for a total of 15 minutes or more) with people who do not live with your child? Please do not include transportation here; it will be asked in the next set of questions.

____

On average, how many times per week does your child travel by bus or train in which the trip takes 15 minutes or longer?

____

On average, how many times per week does your child ride in a car with people who do not live with your child?

____

On average, how many times per week does your child play sports or participate in other extracurricular activities (band, clubs, camp, etc.) indoors with other people that do not live with your child?

____

Does your child have other children or adults living with him/her who are attending in-person daycare, school, college, or technical/trade school? Please do not include those who are living away from home for school.

◯ Yes
◯ No
◯ Don't know / prefer not to answer

Are there other people living with your child that work in person at an indoor location that is not your child's home?

◯ Yes
◯ No
◯ Don't know / prefer not to answer

Section 4. Viral Illness History

This section relates to symptoms of illness that might have been caused by viruses, as well as medical care or medical testing your child may have received for those illnesses. We are interested in illnesses your child experienced in the time period from (date) to (date) that included fever, chills, respiratory symptoms (such as nasal congestion, runny nose, cough, shortness of breath or sore throat), or gastrointestinal symptoms (such as nausea, vomiting, diarrhea or abdominal pain).

<u>For this section, an Episode of illness is one distinct period of time</u> when your child was sick or experienced a set of symptoms. For example, Episode #1 (first episode) may represent an illness in January and Episode #2 (second episode) may represent a different illness in March. In addition, an Episode of illness would start when your child first started to feel sick and would end when your child felt back to normal, even if the specific symptoms changed during that time (for example, an illness might start with a sore throat and end with a cough).

In the time period from (date) to (date), has your child had any episodes of illness?

◯ Yes
◯ No
◯ Don't know

For the first episode of illness your child had in the time period from (date) to (date), what was the approximate date when the first symptom began?

____

For the first episode of illness your child had in the time period from (date) to (date), did he/she have any of the following symptoms?

	Yes	No
Fever (100 degrees or higher measured with a thermometer)	◯	◯
Felt feverish (even if you did not take your child's temperature with a thermometer)	◯	◯
Chills or repeated shaking with chills	◯	◯
Cough	◯	◯
Shortness of breath or difficulty breathing	◯	◯
Nasal congestion (stuffy or blocked nose)	◯	◯
Runny nose	◯	◯
Sore throat	◯	◯
New Loss of taste or smell	◯	◯
Headache	◯	◯
Fatigue	◯	◯
Muscle pains or body aches	◯	◯
Nausea or stomach upset	◯	◯
Abdominal pain	◯	◯
Vomiting	◯	◯
Diarrhea	◯	◯
Unexplained rash	◯	◯

For this first episode of illness, please enter the number of days that your child had each of his/her symptoms?

____

Fever (100 degrees or higher measured with a thermometer)

____

Felt feverish (even if you did not take your child's temperature with a thermometer)

____

Chills or repeated shaking with chills

____

Cough

____

Shortness of breath or difficulty breathing

____

Nasal congestion (stuffy or blocked nose)

____

Runny nose

____

Sore throat

____

New Loss of taste or smell

____

Headache

____

Fatigue

____

Muscle pains or body aches

____

Nausea or stomach upset

____

Abdominal pain

____

Vomiting

____

Diarrhea

____

Unexplained rash

____

For the first episode of illness your child had in the time period from (date) to (date), did your child travel using the following modes of transportation in the 14 days before onset of symptoms?Please don't include local daily travel for work, school, or routine activities such as grocery shopping.

	Yes	No	Prefer not to answer
Bus	◯	◯	◯
Train	◯	◯	◯
Airplane	◯	◯	◯

For the first episode of illness your child had in the time period from (date) to (date), did you seek and/or receive medical care or testing for your child's symptoms?

◯ Yes
◯ No
◯ Prefer not to answer

If you answered YES to the previous question, please answer the remaining questions in this table.

	Yes	No	Prefer not to answer
Did your child receive in-person care or testing at a physician's or other healthcare provider's office?	◯	◯	◯
Did your child receive care or testing from a physician's or other healthcare provider's office using Telehealth (by phone or computer)?	◯	◯	◯
Did your child receive care or testing at a Pharmacy (testing or treatment by a pharmacist or at a clinic located at/within a pharmacy)?	◯	◯	◯
Did your child receive care or testing at an Urgent Care Clinic?	◯	◯	◯
Did you receive care or testing at a drive-thru/drive-up testing site?	◯	◯	◯
Did your child receive care or testing at a Hospital Emergency Department (ER)?	◯	◯	◯
Was your child hospitalized overnight for his/her symptoms? (not ER)?	◯	◯	◯

Did your child receive a diagnosis from a physician?

◯ Yes
◯ No
◯ Prefer not to answer

If yes, what was the diagnosis?

____

For the first episode of illness, in the time period from (date) to (date), did your child have any of the following tests performed? And what were the results? Please choose one best answer for each of the tests listed. (+) indicates any positive test and (-) indicates only negative tests. For example, if your child had two flu tests performed for this first episode of illness and one was negative and one was positive, please mark the column labeled 'Any positive test (+)'. For the chest x-ray, (+) result means an abnormal result and (-) means a normal result.

	Not done	Any positive test (+)	Only negative tests (-)	Indeterminant or don't know
Influenza (flu) nasal swab test	○	○	○	○
Respiratory Syncytial Virus (RSV) nasal swab test	○	○	○	○
Nasal swab for other viruses (not including COVID-19)	○	○	○	○
Strep test (throat swab)	○	○	○	○
Chest x-ray	○	○	○	○
COVID-19 diagnostic test: nasal swab, nasopharyngeal swab, mouth or throat swab, saliva test	○	○	○	○
COVID-19 blood test (serology or antibody test)	○	○	○	○

Has your child had more than one episode of illness in the time period from (date) to (date)?

○ Yes
○ No
○ Don't know

For the second episode of illness your child had in the time period from (date) to (date), what was the approximate date when the first symptom began?

____

For the second episode of illness your child had in the time period from (date) to (date), did he/she have any of the following symptoms?

	Yes	No
Fever (100 degrees or higher measured with a thermometer)	○	○
Felt feverish (even if you did not take your child's temperature with a thermometer)	○	○
Chills or repeated shaking with chills	○	○
Cough	○	○
Shortness of breath or difficulty breathing	○	○
Nasal congestion (stuffy or blocked nose)	○	○
Runny nose	○	○
Sore throat	○	○
New Loss of taste or smell	○	○
Headache	○	○
Fatigue	○	○
Muscle pains or body aches	○	○
Nausea or stomach upset	○	○
Abdominal pain	○	○
Vomiting	○	○
Diarrhea	○	○
Unexplained rash	○	○

For this second episode of illness, please indicate the number of days that your child had each of his/her symptoms.

Fever (100 degrees or higher measured with a thermometer)

____

Felt feverish (even if you did not take your child's temperature with a thermometer)

____

Chills or repeated shaking with chills

____

Cough

____

Shortness of breath or difficulty breathing

____

Nasal congestion (stuffy or blocked nose)

____

Runny nose

____

Sore throat

____

New loss of taste or smell

____

Headache

____

Fatigue

____

Muscle pains or body aches

____

Nausea or upset stomach

____

Abdominal pain

____

Vomiting

____

Diarrhea

____

Unexplained rash

____

For the second episode of illness your child had in the time period from (date) to (date), did your child travel using the following modes of transportation in the 14 days before onset of symptoms? Please don't include local daily travel for work, school, or routine activities such as grocery shopping.

	Yes	No	Prefer not to answer
Bus	◯	◯	◯
Train	◯	◯	◯
Airplane	◯	◯	◯

For the second episode of illness your child had in the time period from (date) to (date), did you seek and/or receive medical care or testing for your child's symptoms?

◯ Yes
◯ No
◯ Prefer not to answer

If you answered YES to the previous question, please answer the remaining questions in this table.	Yes	No	Prefer not to answer
Did your child receive in-person care or testing at a physician's or other healthcare provider's office?	◯	◯	◯
Did your child receive care or testing from a physician's or other healthcare provider's office using Telehealth (by phone or computer)?	◯	◯	◯
Did your child receive care or testing at a Pharmacy (testing or treatment by a pharmacist or at a clinic located at/within a pharmacy)?	◯	◯	◯
Did your child receive care or testing at an Urgent Care Clinic?	◯	◯	◯
Did you receive care or testing at a drive-thru/drive-up testing site?	◯	◯	◯
Did your child receive care or testing at a Hospital Emergency Department (ER)?	◯	◯	◯
Was your child hospitalized overnight for his/her symptoms? (not ER)?	◯	◯	◯

Did your child receive a diagnosis from a physician?

◯ Yes
◯ No
◯ Prefer not to answer

If yes, what was the diagnosis?

____

For the second episode of illness, in the time period from (date) to (date), did your child have any of the following tests performed? And what were the results? Please choose one best answer for each of the tests listed. (+) indicates any positive test and (-) indicates only negative tests. For example, if your child had two flu tests performed for this second episode of illness and one was negative and one was positive, please mark the column labeled 'Any positive test (+)'. For the chest x-ray, (+) result means an abnormal result and (-) means a normal result.

	Not done	Any positive test (+)	Only negative tests (-)	Indeterminant or don't know
Influenza (flu) nasal swab test	◯	◯	◯	◯
Respiratory Syncytial Virus (RSV) nasal swab test	◯	◯	◯	◯
Nasal swab for other viruses (not including COVID-19)	◯	◯	◯	◯
Strep test (throat swab)	◯	◯	◯	◯
Chest x-ray	◯	◯	◯	◯
COVID-19 diagnostic test: nasal swab, nasopharyngeal swab, mouth or throat swab, saliva test	◯	◯	◯	◯
COVID-19 blood test (serology or antibody test)	◯	◯	◯	◯

Has your child had more than two episodes of illness in the time period from (date) to (date)?

◯ Yes
◯ No (skip to Section 5)
◯ Don't know (skip to Section 5)

For the third episode of illness your child had in the time period from (date) to (date), what was the approximate date when the first symptom began?

____

For the third episode of illness your child had in the time period from (date) to (date), did he/she have any of the following symptoms?

	Yes	No
Fever (100 degrees or higher measured with a thermometer)	◯	◯
Felt feverish (even if you did not take your child's temperature with a thermometer)	◯	◯
Chills or repeated shaking with chills	◯	◯
Cough	◯	◯
Shortness of breath or difficulty breathing	◯	◯
Nasal congestion (stuffy or blocked nose)	◯	◯
Runny nose	◯	◯
Sore throat	◯	◯
New Loss of taste or smell	◯	◯
Headache	◯	◯
Fatigue	◯	◯
Muscle pains or body aches	◯	◯
Nausea or stomach upset	◯	◯
Abdominal pain	◯	◯
Vomiting	◯	◯
Diarrhea	◯	◯
Unexplained rash	◯	◯

For the third episode of illness, please indicate the number of days that your child had each of his/her symptoms?

Fever (100 degrees or higher measured with a thermometer)

____

Felt feverish (even if you did not take your child's temperature with a thermometer)

____

Chill or repeated shaking chills

____

Cough

____

Shortness of breath or breathing difficulty

____

Nasal congestion (stuffy or blocked nose)

____

Runny nose

____

Sore throat

____

New loss of taste or smell

____

Headache

____

Fatigue

____

Muscle pains or body aches

____

Nausea or stomach upset

____

Abdominal pain

____

Vomiting

____

Diarrhea

____

Unexplained rash

____

For the third episode of illness in the time period from (date) to (date), did your child travel using the following modes of transportation in the 14 days before onset of symptoms?Please don't include local daily travel for work, school, or routine activities such as grocery shopping.

	Yes	No	Prefer not to answer
Bus	◯	◯	◯
Train	◯	◯	◯
Airplane	◯	◯	◯

For the third episode of illness your child had in the time period from (date) to (date), did you seek and/or receive medical care or testing for your child's symptoms?

◯ Yes
◯ No
◯ Prefer not to answer

If you answered YES to the previous question, please answer the remaining questions in this table.

	Yes	No	Prefer not to answer
Did your child receive in-person care or testing at a physician's or other healthcare provider's office?	◯	◯	◯
Did your child receive care or testing from a physician's or other healthcare provider's office using Telehealth (by phone or computer)?	◯	◯	◯
Did your child receive care or testing at a Pharmacy (testing or treatment by a pharmacist or at a clinic located at/within a pharmacy)?	◯	◯	◯
Did your child receive care or testing at an Urgent Care Clinic?	◯	◯	◯
Did you receive care or testing at a drive-thru/drive-up testing site?	◯	◯	◯
Did your child receive care or testing at a Hospital Emergency Department (ER)?	◯	◯	◯
Was your child hospitalized overnight for his/heryour symptoms? (not ER)?	◯	◯	◯

Did your child receive a diagnosis from a physician?

◯ Yes
◯ No
◯ Prefer not to answer

If yes, what was the diagnosis?

____

For the third episode of illness, in the time period from (date) to (date), did your child have any of the following tests performed? And what were the results? Please choose one best answer for each of the tests listed. (+) indicates any positive test and (-) indicates only negative tests. For example, if your child had two flu tests performed for this third episode of illness and one was negative and one was positive, please mark the column labeled 'Any positive test (+)'. For the chest x-ray, (+) result means an abnormal result and (-) means a normal result.

	Not done	Any positive test (+)	Only negative tests (-)	Indeterminant or don't know
Influenza (flu) nasal swab test	○	○	○	○
Respiratory Syncytial Virus (RSV) nasal swab test	○	○	○	○
Nasal swab for other viruses (not including COVID-19)	○	○	○	○
Strep test (throat swab)	○	○	○	○
Chest x-ray	○	○	○	○
COVID-19 diagnostic test: nasal swab, nasopharyngeal swab, mouth or throat swab, saliva test	○	○	○	○
COVID-19 blood test (serology or antibody test)	○	○	○	○

Has your child had more than three episodes of illness in the time period from (date) to (date)?

○ Yes
○ No (skip to Section 5)

For the fourth episode of illness your child had in the time period from (date) to (date), what was the approximate date when the first symptom began?

____

For the fourth episode of illness your child had in the time period from (date) to (date), did he/she have any of the following symptoms?

	Yes	No
Fever (100 degrees or higher measured with a thermometer)	◯	◯
Felt feverish (even if you did not take your child's temperature with a thermometer)	◯	◯
Chills or repeated shaking with chills	◯	◯
Cough	◯	◯
Shortness of breath or difficulty breathing	◯	◯
Nasal congestion (stuffy or blocked nose)	◯	◯
Runny nose	◯	◯
Sore throat	◯	◯
New Loss of taste or smell	◯	◯
Headache	◯	◯
Fatigue	◯	◯
Muscle pains or body aches	◯	◯
Nausea or stomach upset	◯	◯
Abdominal pain	◯	◯
Vomiting	◯	◯
Diarrhea	◯	◯
Unexplained rash	◯	◯

For the fourth episode of illness, please indicate the number of days that your child had each of his/her symptoms?

Fever (100 degrees or higher measured with a thermometer)

____

Felt feverish (even if you did not take your child's temperature with a thermometer)

____

Chill or repeated shaking chills

____

Cough

____

Shortness of breath or breathing difficulty

____

Nasal congestion (stuffy or blocked nose)

____

Runny nose

____

Sore throat

____

New loss of taste or smell

____

Headache

____

Fatigue

____

Muscle pains or body aches

____

Nausea or stomach upset

____

Abdominal pain

____

Vomiting

____

Diarrhea

____

Unexplained rash

____

For the fourth episode of illness in the time period from (date) to (date), did your child travel using the following modes of transportation in the 14 days before onset of symptoms?Please don't include local daily travel for work, school, or routine activities such as grocery shopping.

	Yes	No	Prefer not to answer
Bus	◯	◯	◯
Train	◯	◯	◯
Airplane	◯	◯	◯

For the fourth episode of illness your child had in the time period from (date) to (date), did you seek and/or receive medical care or testing for your child's symptoms?

◯ Yes
◯ No
◯ Prefer not to answer

If you answered YES to the previous question, please answer the remaining questions in this table.

	Yes	No	Prefer not to answer
Did your child receive in-person care or testing at a physician's or other healthcare provider's office?	◯	◯	◯
Did your child receive care or testing from a physician's or other healthcare provider's office using Telehealth (by phone or computer)?	◯	◯	◯
Did your child receive care or testing at a Pharmacy (testing or treatment by a pharmacist or at a clinic located at/within a pharmacy)?	◯	◯	◯
Did your child receive care or testing at an Urgent Care Clinic?	◯	◯	◯
Did you receive care or testing at a drive-thru/drive-up testing site?	◯	◯	◯
Did your child receive care or testing at a Hospital Emergency Department (ER)?	◯	◯	◯
Was your child hospitalized overnight for his/heryour symptoms? (not ER)?	◯	◯	◯

Did your child receive a diagnosis from a physician?

◯ Yes
◯ No
◯ Prefer not to answer

If yes, what was the diagnosis?

____

For the fourth episode of illness, in the time period from (date) to (date), did your child have any of the following tests performed? And what were the results? Please choose one best answer for each of the tests listed. (+) indicates any positive test and (-) indicates only negative tests. For example, if your child had two flu tests performed for this fourth episode of illness and one was negative and one was positive, please mark the column labeled 'Any positive test (+)'. For the chest x-ray, (+) result means an abnormal result and (-) means a normal result.

	Not done	Any positive test (+)	Only negative tests (-)	Indeterminant or don't know
Influenza (flu) nasal swab test	○	○	○	○
Respiratory Syncytial Virus (RSV) nasal swab test	○	○	○	○
Nasal swab for other viruses (not including COVID-19)	○	○	○	○
Strep test (throat swab)	○	○	○	○
Chest x-ray	○	○	○	○
COVID-19 diagnostic test: nasal swab, nasopharyngeal swab, mouth or throat swab, saliva test	○	○	○	○
COVID-19 blood test (serology or antibody test)	○	○	○	○

Has your child had more than four episodes of illness in the time period from (date) to (date)?

○ Yes
○ No (skip to Section 5)

For the fifth episode of illness your child had in the time period from (date) to (date), what was the approximate date when the first symptom began?

____

For the fifth episode of illness your child had in the time period from (date) to (date), did he/she have any of the following symptoms?

	Yes	No
Fever (100 degrees or higher measured with a thermometer)	◯	◯
Felt feverish (even if you did not take your child's temperature with a thermometer)	◯	◯
Chills or repeated shaking with chills	◯	◯
Cough	◯	◯
Shortness of breath or difficulty breathing	◯	◯
Nasal congestion (stuffy or blocked nose)	◯	◯
Runny nose	◯	◯
Sore throat	◯	◯
New Loss of taste or smell	◯	◯
Headache	◯	◯
Fatigue	◯	◯
Muscle pains or body aches	◯	◯
Nausea or stomach upset	◯	◯
Abdominal pain	◯	◯
Vomiting	◯	◯
Diarrhea	◯	◯
Unexplained rash	◯	◯

For the fifth episode of illness, please indicate the number of days that your child had each of his/her symptoms?

Fever (100 degrees or higher measured with a thermometer)

____

Felt feverish (even if you did not take your child's temperature with a thermometer)

____

Chill or repeated shaking chills

____

Cough

____

Shortness of breath or breathing difficulty

____

Nasal congestion (stuffy or blocked nose)

____

Runny nose

____

Sore throat

____

New loss of taste or smell

____

Headache

____

Fatigue

____

Muscle pains or body aches

____

Nausea or stomach upset

____

Abdominal pain

____

Vomiting

____

Diarrhea

____

Unexplained rash

____

For the fifth episode of illness in the time period from (date) to (date), did your child travel using the following modes of transportation in the 14 days before onset of symptoms?Please don't include local daily travel for work, school, or routine activities such as grocery shopping.

	Yes	No	Prefer not to answer
Bus	◯	◯	◯
Train	◯	◯	◯
Airplane	◯	◯	◯

For the fifth episode of illness your child had in the time period from (date) to (date), did you seek and/or receive medical care or testing for your child's symptoms?

◯ Yes
◯ No
◯ Prefer not to answer

If you answered YES to the previous question, please answer the remaining questions in this table.

	Yes	No	Prefer not to answer
Did your child receive in-person care or testing at a physician's or other healthcare provider's office?	◯	◯	◯
Did your child receive care or testing from a physician's or other healthcare provider's office using Telehealth (by phone or computer)?	◯	◯	◯
Did your child receive care or testing at a Pharmacy (testing or treatment by a pharmacist or at a clinic located at/within a pharmacy)?	◯	◯	◯
Did your child receive care or testing at an Urgent Care Clinic?	◯	◯	◯
Did you receive care or testing at a drive-thru/drive-up testing site?	◯	◯	◯
Did your child receive care or testing at a Hospital Emergency Department (ER)?	◯	◯	◯
Was your child hospitalized overnight for his/heryour symptoms? (not ER)?	◯	◯	◯

Did your child receive a diagnosis from a physician?

◯ Yes
◯ No
◯ Prefer not to answer

If yes, what was the diagnosis?

____

For the fifth episode of illness, in the time period from (date) to (date), did your child have any of the following tests performed? And what were the results? Please choose one best answer for each of the tests listed. (+) indicates any positive test and (-) indicates only negative tests. For example, if your child had two flu tests performed for this fifth episode of illness and one was negative and one was positive, please mark the column labeled 'Any positive test (+)'. For the chest x-ray, (+) result means an abnormal result and (-) means a normal result.

	Not done	Any positive test (+)	Only negative tests (-)	Indeterminant or don't know
Influenza (flu) nasal swab test	○	○	○	○
Respiratory Syncytial Virus (RSV) nasal swab test	○	○	○	○
Nasal swab for other viruses (not including COVID-19)	○	○	○	○
Strep test (throat swab)	○	○	○	○
Chest x-ray	○	○	○	○
COVID-19 diagnostic test: nasal swab, nasopharyngeal swab, mouth or throat swab, saliva test	○	○	○	○
COVID-19 blood test (serology or antibody test)	○	○	○	○

Has your child had more than five episodes of illness in the time period from (date) to (date)?

○ Yes
○ No (skip to Section 5)

For the sixth episode of illness your child had in the time period from (date) to (date), what was the approximate date when the first symptom began?

____

For the sixth episode of illness your child had in the time period from (date) to (date), did he/she have any of the following symptoms?

	Yes	No
Fever (100 degrees or higher measured with a thermometer)	○	○
Felt feverish (even if you did not take your child's temperature with a thermometer)	○	○
Chills or repeated shaking with chills	○	○
Cough	○	○
Shortness of breath or difficulty breathing	○	○
Nasal congestion (stuffy or blocked nose)	○	○
Runny nose	○	○
Sore throat	○	○
New Loss of taste or smell	○	○
Headache	○	○
Fatigue	○	○
Muscle pains or body aches	○	○
Nausea or stomach upset	○	○
Abdominal pain	○	○
Vomiting	○	○
Diarrhea	○	○
Unexplained rash	○	○

For the sixth episode of illness, please indicate the number of days that your child had each of his/her symptoms?

Fever (100 degrees or higher measured with a thermometer)

____

Felt feverish (even if you did not take your child's temperature with a thermometer)

____

Chill or repeated shaking chills

____

Cough

____

Shortness of breath or breathing difficulty

____

Nasal congestion (stuffy or blocked nose)

____

Runny nose

____

Sore throat

____

New loss of taste or smell

____

Headache

____

Fatigue

____

Muscle pains or body aches

____

Nausea or stomach upset

____

Abdominal pain

____

Vomiting

____

Diarrhea

____

Unexplained rash

____

For the sixth episode of illness in the time period from (date) to (date), did your child travel using the following modes of transportation in the 14 days before onset of symptoms?Please don't include local daily travel for work, school, or routine activities such as grocery shopping.

	Yes	No	Prefer not to answer
Bus	◯	◯	◯
Train	◯	◯	◯
Airplane	◯	◯	◯

For the sixth episode of illness your child had in the time period from (date) to (date), did you seek and/or receive medical care or testing for your child's symptoms?

◯ Yes
◯ No
◯ Prefer not to answer

If you answered YES to the previous question, please answer the remaining questions in this table.

	Yes	No	Prefer not to answer
Did your child receive in-person care or testing at a physician's or other healthcare provider's office?	◯	◯	◯
Did your child receive care or testing from a physician's or other healthcare provider's office using Telehealth (by phone or computer)?	◯	◯	◯
Did your child receive care or testing at a Pharmacy (testing or treatment by a pharmacist or at a clinic located at/within a pharmacy)?	◯	◯	◯
Did your child receive care or testing at an Urgent Care Clinic?	◯	◯	◯
Did you receive care or testing at a drive-thru/drive-up testing site?	◯	◯	◯
Did your child receive care or testing at a Hospital Emergency Department (ER)?	◯	◯	◯
Was your child hospitalized overnight for his/heryour symptoms? (not ER)?	◯	◯	◯

Did your child receive a diagnosis from a physician?

◯ Yes
◯ No
◯ Prefer not to answer

If yes, what was the diagnosis?

____

For the sixth episode of illness, in the time period from (date) to (date), did your child have any of the following tests performed? And what were the results? Please choose one best answer for each of the tests listed. (+) indicates any positive test and (-) indicates only negative tests. For example, if your child had two flu tests performed for this sixth episode of illness and one was negative and one was positive, please mark the column labeled 'Any positive test (+)'. For the chest x-ray, (+) result means an abnormal result and (-) means a normal result.

	Not done	Any positive test (+)	Only negative tests (-)	Indeterminant or don't know
Influenza (flu) nasal swab test	○	○	○	○
Respiratory Syncytial Virus (RSV) nasal swab test	○	○	○	○
Nasal swab for other viruses (not including COVID-19)	○	○	○	○
Strep test (throat swab)	○	○	○	○
Chest x-ray	○	○	○	○
COVID-19 diagnostic test: nasal swab, nasopharyngeal swab, mouth or throat swab, saliva test	○	○	○	○
COVID-19 blood test (serology or antibody test)	○	○	○	○

Section 5. Questions specific to COVID-19

This section relates to COVID-19 or a COVID-19-like illness. The items listed below could have happened more than once. For each question you answer "Yes", please indicate, to the best of your recollection, the number of times and the approximate dates, starting with the earliest, that the item occurred in the time period from (date) to (date). Enter the dates using 2 digits for the month and 4 digits for the year. If you are entering multiple dates for an item, please separate each by a comma. (Example: 01/2020, 02/2020)

For questions below that ask about COVID-19 testing, please note:

There are different types of COVID-19 tests available. Some test for current infection and some test for past infection.

A viral test tells you if your child has a current infection. Two types of viral tests can be used: nucleic acid amplification tests (often called PCR tests) and antigen tests. The viral test involves collecting a specimen with a swab from the nose, nasopharynx, mouth, or throat; or collecting saliva.

An antibody test (also known as a serology test) is a blood test that might tell you if your child had a past infection. Antibody tests are not used to diagnose a current infection.

Please remember: If you are a parent filling this survey out for your child, questions about "anyone else in the household" refers to anyone besides the child you are answering the questions for (including yourself).

Was your child in close contact (defined as within 6 feet for a total of 15 minutes or more) with a person who you know had active COVID-19 that was confirmed with a positive COVID-19 viral test?

◯ Yes
◯ No

If you answered yes, how many times?

____

Please list the approximate dates in month and year (mm/yyyy).

____

◯ Ye
◯ s

If you answered yes, how many

____

Was your child in close contact (defined as within 6 feet for a total of 15 minutes or more) with a person who you suspect had active COVID-19, but who (to your knowledge) did not have COVID-19 confirmed with a positive COVID-19 viral test?

Ye
s

If you answered yes, how many

____

Please list the approximate dates in month and year (mm/yyyy).

____

Have you been advised to quarantine your child (separate your child from others and monitor for signs of infection for 10-14 days) because of exposure to someone with a positive COVID-19 viral test?

◯ Yes
◯ No

If you answered yes, how many times?

____

Please list the approximate dates in month and year (mm/yyyy).

____

Has your child helped to provide care for someone who had a positive viral test for COVID-19 at the time your child helped to provide care?

◯ Yes
◯ No

If you answered yes, how many times?

____

Please list the approximate dates in month and year (mm/yyyy).

____

Has your child had a positive viral test for COVID-19 while having no symptoms?

◯ Yes
◯ No

If you answered yes, how many times?

____

Please list the approximate dates in month and year (mm/yyyy).

____

Has your child had an antibody blood test for COVID-19 (either positive or negative)?

◯ Ye
◯ s

If you answered yes, how many

____

Please list the approximate dates in month and year (mm/yyyy).

____

Has your child had an antibody blood test for COVID-19 that was positive (indicated that he/she had antibodies to COVID-19)?

◯ Yes
◯ No

If you answered yes, how many times?

____

Please list the approximate dates in month and year (mm/yyyy).

____

Besides your child, has anyone else in your child's household had an illness that you suspected was COVID-19 but for which they did not receive testing for COVID-19?

◯ Yes
◯ No

If you answered yes, how many times?

____

Please list the approximate dates in month and year (mm/yyyy).

____

Besides your child, has anyone else in your child's household been tested with a viral test for COVID-19?

◯ Yes
◯ No

If you answered yes, how many times?

____

Please list the approximate dates in month and year (mm/yyyy).

____

Besides your child, has anyone else in your child's household had a positive viral test for COVID-19 while having no symptoms?

◯ Yes
◯ No

If you answered yes, how many times?

____

Please list the approximate dates in month and year (mm/yyyy).

____

Besides your child, has anyone else in your child's household had a positive viral test for COVID-19 while having symptoms?

◯ Yes
◯ No

If you answered yes, how many times?

____

Please list the approximate dates in month and year (mm/yyyy).

____

Date on which survey was completed:

____

Important note before you go:

Please take a moment to start a new symptom diary for your child (attached). Please use this symptom diary to help track your child's symptoms during the time period from (date) to (date). Using the symptom diary in between the surveys will help you complete your child's next survey more easily.

(Attach symptom diary with date span for 2nd follow-up survey to this field)

Please confirm your child's email address (it should be the same email address you provided for this survey) : (Please remember, your child must have his/her own unique email address).

____

Thank you and your child for completing this survey! Be on the look out for the next survey coming in about 3 months.