**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?
   1. Male
   2. Female
   3. Transgender male
   4. Transgender female
   5. Another gender identity
   6. Refused
7. What is your race (select all that apply):
   1. American Indian or Alaska Native
   2. Asian
   3. Black or African American
   4. Native Hawaiian or Other Pacific Islander
   5. White
   6. Prefer not to answer
8. Do you identify as Hispanic? Y/N/Prefer not to answer
9. Last night, did you sleep (select one):
   1. In a shelter
   2. Outside (including in a tent or in a car)
   3. In a hotel or motel room
   4. In a private residence with friends or family
   5. In your own private residence
10. In the past two weeks, have you spent at least one night (select all that apply):
    1. In a shelter
    2. Outside (including in a tent or in a car)
    3. In a hotel or motel room
    4. In a private residence with friends or family
    5. 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):
    1. Feeling feverish
    2. Headaches
    3. Cough
    4. Chills or shivering
    5. Sweats
    6. Sore throat or scratchy throat
    7. Runny or stuffy nose
    8. Feeling more tired than usual
    9. Muscle or body aches
    10. Increased trouble with breathing
    11. Ear pain or ear discharge
    12. Diarrhea
    13. Nausea or vomiting
    14. Rash
    15. Loss of smell or taste
    16. None of the above
13. a. Have you received  COVID vaccination/s?  Y/N
14. How many have you received?
15. When did you receive your last COVID vaccine? (approximate date)
16. 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: