ECHO Environmental influences on Child Health Outcomes A program supported by the NIH	**COVID-19 Questionnaire – Child Parent-Report Version** ECHO-wide Cohort Version 01.30 / April 9, 2020	**Form C19-cPR** Page **1** of **5**

COHORT ID	SITE ID	PARTICIPANT ID	PIN	COHORT VISIT ID	FORM COMPLETED
_ _ _ _ _	_ _ _ _	_____	_ _ _	_____	_ _ /_ _ /_ _ _ _ *mm dd yyyy*

ECHO LIFE STAGE		RESPONDENT	
☐ 01 Prenatal	☐ 02 Perinatal	☐ 01 Participant	☐ 02 Biological Mother
☐ 03 Infancy	☐ 04 Early Childhood	☐ 03 Biological Father	☐ 04 Other Respondent
☐ 05 Middle Childhood	☐ 06 Adolescence		→ Code: _ _

STUDY STAFF INSTRUCTION: This form should be completed by the primary caregiver of a child enrolled in an ECHO cohort during the life stages of infancy, early childhood, middle childhood, and adolescence through age 12 years. The child's ID should be used in the header for the participant ID.

INSTRUCTIONS:

This form has 2 sections:

- *Section A: COVID-19 Infection*
- *Section B: Impacts of the COVID-19 Outbreak on the Child Enrolled in ECHO*

Please complete Sections A and B if the child is 12 months old or older. Please complete Section A only if the child is less than 12 months old.

These questions are about the child's experience with COVID-19, or the coronavirus. For each question, do the best you can to remember the details requested.

Section A. COVID-19 Infection

For the following questions, healthcare provider means a doctor, nurse practitioner, physician assistant or anyone you go to for medical care. All questions are about the child enrolled in ECHO.

1. Has a healthcare provider ever told you that the child has, or likely has, COVID-19 (Coronavirus)?

- ☐ 01 Yes
- ☐ 02 No

2. Which of the following symptoms has the child had at any point in time since March 1, 2020? (***Mark all that apply***)

- ☐ 01 Fever or chills
- ☐ 02 Cough
- ☐ 03 Shortness of breath
- ☐ 04 Sore throat
- ☐ 05 Headache
- ☐ 06 Muscle or body aches
- ☐ 07 Runny nose
- ☐ 08 Fatigue or excessive sleepiness
- ☐ 09 Diarrhea, nausea, or vomiting
- ☐ 10 Loss of sense of smell or taste
- ☐ 11 Itchy/red eyes
- ☐ 12 None of the above ➔ ***skip to Section A, Question 3.***

2.a. Which of the following occurred as a result of the child's symptoms? (***Mark all that apply***)

- ☐ 01 The child was kept overnight in a hospital because a healthcare provider thought he/she had COVID-19
- ☐ 02 The child saw a healthcare provider in person, such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED)
- ☐ 03 You/the child spoke to a healthcare provider over the phone, by email, or online
- ☐ 04 You/the child self-isolated or quarantined at home
- ☐ 05 None of the above

2.b. In the two weeks before the child had symptoms, did he/she: (***Mark all that apply***)

- ☐ 01 Have contact with someone who tested positive for COVID-19
- ☐ 02 Have contact with someone who likely had COVID-19 (e.g., was not tested but had symptoms; was told by a healthcare provider that he/she likely had it)
- ☐ 03 Travel to a different state or country (please specify: _____)
- ☐ 04 None of the above

Section A. COVID-19 Infection (continued)

3. Has the child had the nose swab test for the virus that causes COVID-19? (***Mark all that apply***)

- ☐ 01 No, I never tried to get the child tested
- ☐ 02 No, I tried to get the child tested but was not able to
- ☐ 03 Yes, and the child is waiting for the results

  If yes ➔ **3.a.** When was the date of the child's most recent test? __ __ /__ __ __ __ (mm / yyyy)
- ☐ 04 Yes, and the test showed that the child does not have it ("**negative**" test)

  If yes ➔ **3.b.** When was the date of the child's most recent **negative** test? __ __ /__ __ __ __ (mm / yyyy)
- ☐ 05 Yes, and the test showed that the child does have it ("**positive**" test)

  If yes ➔ **3.c.** When was the date of the child's most recent **positive** test? __ __ /__ __ __ __ (mm / yyyy)

4. Has the child had a blood test to see whether he/she already had the COVID-19 virus ("serology")? (***Mark all that apply***)

- ☐ 01 No, I never tried to get the child tested
- ☐ 02 No, I tried to get the child tested but was not able to
- ☐ 03 Yes, and the child is waiting for the results

  If yes ➔ **4.a.** When was the date of the child's most recent test? __ __ /__ __ __ __ (mm / yyyy)
- ☐ 04 Yes, and the test showed that the child did not have it ("**negative**" test)

  If yes ➔ **4.b.** When was the date of the child's most recent **negative** test? __ __ /__ __ __ __ (mm / yyyy)
- ☐ 05 Yes, and the test showed that the child did have it ("**positive**" test)

  If yes ➔ **4.c.** When was the date of the child's **positive** test? __ __ /__ __ __ __ (mm / yyyy)

5. In what ways has the COVID-19 outbreak affected the child's overall healthcare? (***Mark all that apply***)

- ☐ 01 The child did not go to healthcare appointments because I was concerned about the child entering the healthcare provider's office
- ☐ 02 The child's healthcare provider canceled appointments
- ☐ 03 The child's healthcare provider changed to phone or online visits
- ☐ 04 The child's healthcare provider told him/her to self-isolate or quarantine
- ☐ 05 None of these apply

6. To route you through the remaining questions, is the child 12 months or older?

- ☐ 01 Yes
- ☐ 02 No ➔ ***If marked, skip to END.***

Setting	Mode
☐ 01 Clinic or site ☐ 02 Phone ☐ 03 Other location	☐ 01 Self-administered ☐ 02 Staff-administered