

ECHO Environmental influences on Child Health Outcomes A program supported by the NIH	COVID-19 Questionnaire – Child Self-Report Alternate Version ECHO-wide Cohort Version 01.31 / June 8, 2020				Form C19-cAV Page 1 of 6	
	COHORT ID	SITE ID	PARTICIPANT ID	PIN	COHORT VISIT ID	FORM COMPLETED
_____	_____	_____	_____	_____	____/____/____ <i>mm dd yyyy</i>	
ECHO LIFE STAGE			RESPONDENT			
<input type="checkbox"/> ₀₁ Prenatal	<input type="checkbox"/> ₀₂ Perinatal	<input type="checkbox"/> ₀₁ Participant	<input type="checkbox"/> ₀₂ Biological Mother			
<input type="checkbox"/> ₀₃ Infancy	<input type="checkbox"/> ₀₄ Early Childhood	<input type="checkbox"/> ₀₃ Biological Father	<input type="checkbox"/> ₀₄ Other Respondent			
<input type="checkbox"/> ₀₅ Middle Childhood	<input type="checkbox"/> ₀₆ Adolescence			Code: ____		

STUDY STAFF INSTRUCTION: This form should be completed by the 13- to 21-year-old child enrolled in an ECHO cohort during the adolescence life stage. The child’s ID should be used in the header for the participant ID.

<p>INSTRUCTIONS:</p> <p>This form has 2 sections:</p> <ul style="list-style-type: none"> Section A: COVID-19 Infection Section B: Impacts of the COVID-19 Outbreak on You <p>These questions are about your experience with COVID-19, or the coronavirus. For each question, do the best you can to remember the details requested.</p>
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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.

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

₀₁ Yes

₀₂ No

2. Which of the following symptoms have you 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 your symptoms? (**Mark all that apply**)

₀₁ I was kept overnight in a hospital because a healthcare provider thought I had COVID-19

₀₂ I saw a healthcare provider in person, such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED)

₀₃ I spoke to a healthcare provider over the phone, by email, or online

₀₄ I self-isolated or quarantined at home

₀₅ None of the above

2.b. In the two weeks before you had symptoms, did you: (**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 B. Impacts of the COVID-19 Outbreak on You

1. In what ways has the COVID-19 outbreak affected your overall healthcare? (**Mark all that apply**)

- ₀₁ I did not go to healthcare appointments because I was concerned about entering my healthcare provider's office
- ₀₂ My healthcare provider canceled appointments
- ₀₃ My healthcare provider changed to phone or online visits
- ₀₄ My healthcare provider told me to self-isolate or quarantine
- ₀₅ None of these apply

2. Did your school close because of the COVID-19 outbreak?

- ₀₁ Yes
- ₀₂ No → **Skip to Section B, Question 3**
- ₀₃ I am not enrolled in any school → **Skip to Section B, Question 3**

2.a. Do you usually receive free meals at school?

- ₀₁ Yes
- ₀₂ No → **Skip to Section B, Question 2.b**

2.a.1. Has your school offered meals during the school closure from COVID-19?

- ₀₁ Yes
- ₀₂ No → **Skip to Section B, Question 2.b**

2.a.1.a. Have you been able to get the school-provided meals during the COVID-19 associated closure?

- ₀₁ Yes
- ₀₂ No

2.b. Has your school offered online learning while closed?

- ₀₁ Yes
- ₀₂ No → **Skip to Section B, Question 3**

2.b.1. Has your school provided either of the following to support online learning?

- a. Free home internet access ₀₁ Yes ₀₂ No
- b. Free computer or tablet ₀₁ Yes ₀₂ No

Section B. Impacts of the COVID-19 Outbreak on You (continued)

3. What type of internet access do you have at home? (*Mark all that apply*)

- ₀₁ High-speed broadband internet (“WiFi”) (e.g., DSL, cable, fiber optic)
- ₀₂ Dial-up internet (not WiFi)
- ₀₃ Smartphone not connected to WiFi network at home (e.g., use cellular, LTE, mobile hotspot, neighbor’s WiFi)
- ₀₄ I do not have internet access at home

} → **Skip to Section B, Question 4**

3.b. Did you have high-speed broadband internet access at home prior to March 1, 2020?

- ₀₁ Yes
- ₀₂ No

For rows 4.a through 4.h below, please mark ‘Less’, ‘Same amount’, or ‘More’ for how much you are now engaged in the activity compared to before the COVID-19 outbreak.

4. Compared to before the COVID-19 outbreak, how much are you now doing the following:

	Less	Same amount	More
a. Eating	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
b. Sleeping	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
c. Physical activity	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
d. Spending time outside	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
e. Spending time with friends in-person	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
f. Spending time with friends remotely (e.g., online, social media, texting)	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
g. Spending time watching TV, playing video/computer games, or using social media for <u>educational</u> purposes, including school work	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
h. Spending time watching TV, playing video/computer games, or using social media for <u>non-educational</u> purposes	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃

5. Compared to before the COVID-19 outbreak, do you feel ...

- ₀₁ much less socially connected
- ₀₂ less socially connected
- ₀₃ slightly less socially connected
- ₀₄ slightly more socially connected
- ₀₅ more socially connected
- ₀₆ much more socially connected

Section B. Impacts of the COVID-19 Outbreak on You (continued)**6. What have you done to cope with your stress related to the COVID-19 outbreak? (*Mark all that apply*)**

- ₀₁ Meditation and/or mindfulness practices
- ₀₂ Engaging in more family activities (e.g., games, sports)
- ₀₃ Eating more often, including snacking
- ₀₄ Increasing time reading books, or doing activities like puzzles and crosswords
- ₀₅ Drinking alcohol
- ₀₆ Using tobacco (e.g., smoking; *do not* include vaping)
- ₀₇ Using marijuana (e.g., smoking, edibles; *do not* include vaping) or cannabidiol (CBD)
- ₀₈ Vaping marijuana
- ₀₉ Vaping other substances (e.g., using e-cigarettes, e-juice)
- ₁₀ Talking to my healthcare providers more frequently, including mental healthcare provider (e.g., therapist, psychologist, counselor)
- ₁₁ Volunteer work
- ₁₂ I have not done any of these things to cope with the COVID-19 outbreak

7. Please indicate the extent to which you view the COVID-19 outbreak as having either a positive or negative impact on your life.

- ₀₁ Extremely negative
- ₀₂ Moderately negative
- ₀₃ Somewhat negative
- ₀₄ No impact
- ₀₅ Slightly positive
- ₀₆ Moderately positive
- ₀₇ Extremely positive

Setting

- ₀₁ Clinic or site ₀₂ Phone ₀₃ Other location

Mode

- ₀₁ Self-administered ₀₂ Staff-administered