### COVID-19 Questionnaire – Child Self-Report Alternate Version

**ECHO-wide Cohort Version 01.30 / April 9, 2020**

<table>
<thead>
<tr>
<th>COHORT ID</th>
<th>SITE ID</th>
<th>PARTICIPANT ID</th>
<th>PIN</th>
<th>COHORT VISIT ID</th>
<th>FORM COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ECHO LIFE STAGE**

- ☐ 01 Prenatal
- ☐ 02 Perinatal
- ☐ 03 Infancy
- ☐ 04 Early Childhood
- ☐ 05 Middle Childhood
- ☐ 06 Adolescence

**RESPONDENT**

- ☐ 01 Participant
- ☐ 02 Biological Mother
- ☐ 03 Biological Father
- ☐ 04 Other Respondent

**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.

**INSTRUCTIONS:**

This form has 2 sections:
- Section A: COVID-19 Infection
- Section B: Impacts of the COVID-19 Outbreak on You

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.
### 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 A. COVID-19 Infection (continued)

3. Have you had the nose swab test for the virus that causes COVID-19? (Mark all that apply)
   - [ ] 01 No, I never tried to get tested
   - [ ] 02 No, I tried to get tested but was not able to
   - [ ] 03 Yes, and I am waiting for the results

   If yes  3.a. When was the date of your most recent test? __ __ /__ __ __ __
   mm  yyyy

   - [ ] 04 Yes, and the test showed that I do not have it ("negative" test)

   If yes  3.b. When was the date of your most recent negative test? __ __ /__ __ __ __
   mm  yyyy

   - [ ] 05 Yes, and the test showed that I do have it ("positive" test)

   If yes  3.c. When was the date of your most recent positive test? __ __ /__ __ __ __
   mm  yyyy

4. Have you had a blood test to see whether you already had the COVID-19 virus ("serology")? (Mark all that apply)
   - [ ] 01 No, I never tried to get tested
   - [ ] 02 No, I tried to get tested but was not able to
   - [ ] 03 Yes, and I am waiting for the results

   If yes  4.a. When was the date of your most recent test? __ __ /__ __ __ __
   mm  yyyy

   - [ ] 04 Yes, and the test showed that I did not have it ("negative" test)

   If yes  4.b. When was the date of your most recent negative test? __ __ /__ __ __ __
   mm  yyyy

   - [ ] 05 Yes, and the test showed that I did have it ("positive" test)

   If yes  4.c. When was the date of your positive test? __ __ /__ __ __ __
   mm  yyyy

5. Has anyone else living in your home had, or probably had, COVID-19?
   - [ ] 01 Yes
   - [ ] 02 No
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

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:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Less</th>
<th>Same amount</th>
<th>More</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Eating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Sleeping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Physical activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Spending time outside</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Spending time with friends in-person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Spending time with friends remotely (e.g., online, social media, texting)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Spending time watching TV, playing video/computer games, or using social media for <em>educational</em> purposes, including school work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Spending time watching TV, playing video/computer games, or using social media for <em>non-educational</em> purposes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

---

<table>
<thead>
<tr>
<th>Setting</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 01 Clinic or site</td>
<td>☐ 01 Self-administered</td>
</tr>
<tr>
<td>☐ 02 Phone</td>
<td>☐ 02 Staff-administered</td>
</tr>
<tr>
<td>☐ 03 Other location</td>
<td></td>
</tr>
</tbody>
</table>