

Subject Case Report Forms

CoVPN5002_Version_1.53_AUX_BK_26MAR2021 - ALL

Signature Prompt: I certify that I have ensured the accuracy and completeness of the data reported in the Case Report Forms.

CoVPN5002_Version_1.53_AUX_BK_26MAR2021: ALL

Form: Participant Identifier

Generated On: 29 Mar 2021 01:24:26

Participant ID: _____

Date of questionnaire administration

Interviewer please check one of the following:

- Participant is completing the questionnaire for themselves
- Legally authorized representative is completing this questionnaire on behalf of another person

DEMOGRAPHICS

.Interviewer (read aloud): First, we would like to ask you some questions about you and your household.

1 - .How old are you? (For participants less than 1 years old, enter "0" and then complete "Infant age in months below".) Fixed Unit: yrs

Infant age in months Fixed Unit: months

2 - .What is your ethnicity? (mark one)

- Hispanic or Latino.
- Not Hispanic or Latino.
- Don't Know/ Not sure.
- Prefer not to answer.

3 -
.What is your race? (Check all that apply)

.American Indian or Alaska Native

.Asian

.Black or African American

.Native Hawaiian or other Pacific Islander

.White

.Other

.Don't know/ Not sure

.Prefer not to answer

.If "Other", specify:

4 - .Are you currently a full time or part time student? (13 and older only) Yes-Full time.
Yes-Part time.
No.

5 - .What is the highest level of education you have completed? No formal education.
Pre-kindergarten.
Kindergarten.
Elementary school (1st to 5th grade).
Middle school (6th - 8th grade).

- High school diploma/GED.
- Some college/university.
- College/university degree.
- Post-graduate degree.

- 6 - .What is your marital status (13 and older only)
- Single.
 - Married or Cohabiting.
 - Widowed.
 - Divorced.
 - Separated.
 - Prefer not to answer.

7 - .What is the zip code of your primary residence?

- 8 - .What best describes your current primary residence? (If not "House or apartment", skip to question 10)
- House or apartment.
 - Nursing home or retirement home.
 - Hotel or motel.
 - Drug recovery or transitional house.
 - Shelter for people without homes.
 - Prefer not to answer.
 - Other.

.If "Other", specify:

9 - .How many bedrooms are in the residence?

- 10 - .Do you live alone, with a group, family, or multiple families in you primary residence? (If "Alone", skip to question 12)
- Alone.
 - Group (small, residential facilities located within a community, recovery residence, transitional housing, or roommates)).
 - Single family (parents/guardians, children, grandparents, etc.).
 - Multiple families (two or more families).

11 - .How many people are currently living in your household, including yourself? A household is defined as all the people that occupy a single housing unit such as house, apartment, group of rooms, or single room.

- 12 - .Are you a caregiver to anyone in your family or household? (13 and older only)
- Yes.
 - No.
 - Don't Know/ Not sure.

- 13 - .What best describes your current employment status? (13 and older only)
- Employed – full time.
 - Employed – part time.
 - Homemaker or stay at home parent.
- (If not "Employed-full time", or "Employed-part time", skip to question 16.)

- Not currently employed.
- Retired.
- Disabled (not currently employed due to long- or short-term disability).
- Other.

.If "Other", specify:

- 14 - .Are you an essential worker? (Essential workers are exempt from stay at home and shelter in place orders and must report to their place of work. Essential workers include but are not limited to those working in public health/health care, law enforcement, public safety, first responders, food and agriculture, energy and electricity, petroleum, water and wastewater, transportation, public works, communications and IT, and others.) (13 and older only) (If "No" or "Prefer not to answer", skip to question 16)
- Yes.
 - No.
 - Prefer not to answer

- 15 - .Since March 2020, have you experienced any discrimination (such as being treated badly, harassed, threatened, isolated) from anyone because you are an essential worker? (13 and older only)
- Yes.
 - No.
 - Don't Know/ Not sure.

- 16 - .Is a member of your household an essential worker? Essential workers are exempt from stay at home and shelter in place orders and must report to their place of work. Essential workers include but are not limited to those working in public health/health care, law enforcement, public safety, first responders, food and agriculture, energy and electricity, petroleum, water and wastewater, transportation, public works, communications and IT, and others.
- Yes.
 - No.
 - Don't Know/ Not sure.

- 17 - .Interviewer (read aloud): The next question is about your sex. When I ask about your sex, I am asking about what sex you were determined to be at birth. When babies are born, they are generally labeled by someone as "male" or "female" based on their genitals (sex organs)
- Male
 - Female

.What was your sex assigned at birth?

18 - .Interviewer (read aloud): The next question asks about gender. Gender is the social part of being male or female. It relates to your self-identity. When I ask about gender, I am asking about whether you regard yourself to be male, female, gender non-conforming transgender male, transgender female, or if you identify yourself in an additional category.

.What is your current gender identity? (mark all that apply)

Male.

Female.

Gender non-conforming.

Transgender female.

Transgender male.

Additional category, specify.

Prefer not to answer.

.If "Additional category", specify: _____

.If "Additional category", specify: _____

19 - .What is your sexual orientation? (13 and older only) (select one)

Straight/Heterosexual.

Gay/Lesbian/Homosexual.

Bisexual.

Queer.

Two Spirit.

Additional category.

Don't Know/ Not sure.

Prefer not to answer.

.If "Additional category", specify: _____

20 - .What was your total household income in the past 12 months?

<\$15,000.

\$15,000 - \$24,999.

\$25,000 - \$34,999.

\$35,000 - \$49,999.

\$50,000 - \$74,999.

\$75,000 - \$99,999.

\$100,000 - \$149,999.

\$150,000 - \$199,999.

>\$200,000.

Don't Know/Not sure.

Prefer not to answer.

Note to interviewer: if a person lives with multiple people (e.g. roommate(s)) and does not know the income of everyone else, instruct them to respond with their total personal income.

CoVPN5002_Version_1.53_AUX_BK_26MAR2021: ALL

Form: Enrollment

Generated On: 29 Mar 2021 01:24:26

Was the participant enrolled in the study? Yes
No

Date of Enrollment _____

Recruitment Date _____

Recruitment Time Slot 8:00am-12:00pm
12:00pm-4:00pm
4:00pm-8:00pm

Population cohort Adults residing in nursing homes/assisted living facilities
Adults from outpatient healthcare facilities
Community

Venue code _____

For adults residing in nursing homes/assisted living facilities, is the participant able to complete the questionnaire? Yes
No

Did the participant complete all study procedures at the enrollment visit? Yes
No

If "No", at what date did the participant complete all study procedures? _____

Specimen ID _____

Will the participant be submitting an oral/saliva specimen sample? Yes
No

Did the participant meet all eligibility criteria? Yes
No

Eligibility status Eligible and enrolled
Eligible/Not enrolled
Ineligible
Incomplete screening

If "Eligible and enrolled", or "Incomplete screening", end of form.

Select reason(s) why participant is ineligible.

- I1. Adults residing in nursing homes/assisted living facilities or attending outpatient healthcare facilities - At least 18 years of age
- I2. Adults residing in nursing homes/assisted living facilities or attending outpatient healthcare facilities - Willing and able to provide informed consent or consent has been provided by legal representative (for those with mental incapacity)
- I3. Adults residing in nursing homes/assisted living facilities or attending outpatient healthcare facilities - Recruited from a selected facility
- I4. Adults and children from select neighborhoods of research site communities - Adults and children > 2 months of age
- I5. Adults and children from select neighborhoods of research site communities - For individuals < 18 years old, a guardian must be present
- I6. Adults and children from select neighborhoods of research site communities - Willing and able to provide consent (or assent for individuals < 18 years, parent/guardian will provide consent)
- I7. Adults and children from select neighborhoods of research site communities - Resident of the CRS catchment area or recruited from a selected venue
- E1. Prior or current enrollment in any interventional COVID-19 clinical trial, including studies involving prophylactic, therapeutic or immune modulating agents
- E2. Previous enrollment in this study, either from the same or another CRS community

E3. Any condition that, in the opinion of the study staff, would make participation in the study unsafe, complicate interpretation of study outcome data, or otherwise interfere with achieving the study objectives

If "E3. Any condition that, in the opinion of the study staff, would make participation in the study unsafe, complicate interpretation of study outcome data, or otherwise interfere with achieving the study objectives", specify (max. 200 characters): _____

If eligible, but participant declined enrollment, specify reason: _____

Date of medical record abstraction _____

1 - MEDICAL HISTORY

Yes

Does the participant's medical history include any of the following medical conditions? (Check all that apply)

No

Asthma

Other chronic lung disease

Yes

No

Heart disease

Yes

No

Hypertension (high blood pressure)

Yes

No

Cancer chemotherapy in the last 12 months

Yes

No

Other immunosuppression condition

Yes

No

HIV

Yes

No

Diabetes

Yes

No

Kidney or renal disease

Yes

No

Liver Disease

Yes

No

Sickle cell disease

Yes

No

Obesity

Yes

No

Mental health condition

Yes

No

Substance abuse disorder

Yes

No

Other chronic medical conditions that have not already been mentioned Yes
No

If "Other", specify: _____

2 - Has the participant sought assistance for daily activities because of a physical, mental, or emotional disability? (Check all that apply) Yes
No

Physical disability

Mental disability Yes
No

Emotional disability

Yes
No

3 - Does the participant have any medical conditions that require medication or routine visits to the doctor? Yes
No

4 - Has the participant received a COVID-19 diagnostic test in the past? A diagnostic test is usually a swab in the nose, mouth, or throat. (If "Yes-they tested negative", skip to question 11. If "Never been tested" or "Don't know/Not sure", skip to question 11.) Yes - they tested positive
Yes - they tested negative
Never been tested
Don't Know/Not Sure

5 - What was the date of the positive diagnostic test? _____

6 - Has the participant tested positive for COVID-19 via a diagnostic test more than once? Yes
No
Don't Know/ Not sure

7 - Did the participant seek care after testing positive via diagnostic test? (If "No" or "Don't know/Not sure", skip to question 11) Yes
No
Don't Know/ Not sure

8 - Where did the participant seek medical care ? Yes
No

Visited their primary care provider's office or another doctor's office

Telephone call to their primary care provider's office or doctor's office Yes
No

Telemedicine such as an electronic consultation or video call with a health care provider Yes
No

Retail clinic or pharmacy Yes
No

Urgent care Yes
No

Emergency room Yes
No

Hospital, not in the emergency room Yes
No

Other Yes
No

If "Other", specify:

9 - Did the participant spend at least one night in a hospital after testing positive? (If "No" or "Don't know/Not sure", skip to question 11) Yes
No
Don't Know/ Not sure

10 - How many nights was the participant hospitalized? 1-2 nights
3-5 nights
More than 5 nights

Don't know/ Not sure

11 - Has the participant received a COVID-19 antibody test in the past? An antibody test is usually a blood test. (If "Yes-they tested negative", or "Never been tested" or "Don't know/Not sure", skip to question 13.)

Yes - they tested positive
Yes - they tested negative
Never been tested
Don't Know/Not Sure

12 - What is the date of the positive antibody test? _____

13 - In the past 14 days, has the participant reported any of the following symptoms? Yes

No

Fever or chills

Cough with phlegm or mucus Yes

No

Dry cough with no phlegm or mucus Yes

No

Shortness of breath or difficulty breathing Yes

No

Fatigue/ Feeling tired Yes

No

Muscle or body aches Yes

No

Headache Yes

No

Sudden loss of taste or smell Yes

No

Sore throat Yes

No

Congestion or runny nose Yes

No

Nausea or vomiting Yes

No

Diarrhea Yes

No

Abdominal pain Yes

No

14 - Note to data abstractor: skip to question 17 if "No" to all symptoms?

Yes
No
Don't Know/ Not sure

Is the participant currently experiencing any of these symptoms?

15 - While experiencing these symptoms, did the participant seek care from a healthcare professional? (seeking care includes a getting a test)

Yes
No
Don't Know/ Not sure

If "No" or "Don't know/Not sure", skip to question 17.

16 - Where did the participant seek medical care?

Yes
No

Visited their primary care provider's office or another doctor's office

Telephone call to their primary care provider's office or doctor's office

Yes
No

Telemedicine such as an electronic consultation or video call with a health care provider

Yes
No

Retail clinic or pharmacy

Yes
No

Urgent care

Yes
No

Emergency room

Yes

No

Hospital, not in the emergency room Yes

No

Other Yes

No

If "Other", specify: _____

17 - Note to data abstractor: Recently refers to the last 2 months. Yes

No

Don't Know/ Not sure

In the past month, did the participant interact in person or through direct physical contact, such as touching, hugging, or shaking hands, with someone who recently tested positive for COVID-19?

18 - Has anyone in the participant's household tested positive for COVID-19? Yes

No

Don't Know/ Not sure

19 - In the past month, has a member of your household other than you experienced any symptoms of COVID-19? Yes

No

Don't Know/ Not sure

20 - COVID 19 IMPACT Yes

No

Has the participant smoked or vaped tobacco (including cigarettes and e-cigarettes) in the last 6 months?

21 - Is there a history of alcohol use in the last 6 months? Yes

No

Alcohol _____

CoVPN5002_Version_1.53_AUX_BK_26MAR2021: ALL

Form: Protocol Deviations Y/N

Generated On: 29 Mar 2021 01:24:26

Have any protocol deviations been reported?

Yes

No

If "Yes", update the Protocol Deviations log.

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Form: Protocol Deviations Log

Generated On: 29 Mar 2021 01:24:26

Site awareness date _____

Deviation date _____

Has or will this deviation be reported to local IRB/EC? Yes
No

Type of deviation

- Inappropriate enrollment
- Conduct of non-protocol procedure
- Breach of confidentiality
- Mishandled lab specimen
- Staff performing duties they are not qualified to perform
- Questionnaire administration deviation
- Informed consent process deviation
- Visit completed outside of window
- Other

Description of deviation _____

Plans and/or action taken to address the deviation _____

Plans and/or action taken to prevent future occurrences of the deviation _____

Deviation reported by _____

Was specimen collected? Yes

No

If "No", provide reason and end of form.

Participant declined

Participant unable to provide sample

Primary reason specimen was not collected

Other

If "Other", specify (max. 200 characters): _____

Specimen ID _____

Specimen collection date _____

Specimen collection time _____

Were all requirements of the specimen collection met per the SSP?

Yes

No

If "No", provide explanation in Comments.

Comments (max. 600 characters): _____

Was specimen collected? Yes

No

If "No", provide reason and end of form.

Participant declined

Participant unable to provide sample

Primary reason specimen was not collected

Other

If "Other", specify (max. 200 characters): _____

Specimen ID _____

Specimen collection date _____

Specimen collection time _____

Were all requirements of the specimen collection met per the SSP? Yes

No

If "No", provide explanation in Comments.

Comments (max. 600 characters): _____

CoVPN5002_Version_1.53_AUX_BK_26MAR2021: ALL
Form: Specimen Collection and Storage - Blood
Generated On: 29 Mar 2021 01:24:26

Specimen type Serum

Dried Blood Spot

Was specimen collected? Yes

No

If "No", provide reason and end of form. Participant declined

Participant unable to provide

sample

Other

Primary reason specimen was not collected

If "Other", specify (max. 200 characters): _____

Specimen ID _____

Specimen collection date _____

Specimen collection time _____

Was sample stored? Stored

Not stored

If "No", record reason why sample was not stored (max. 200 characters). _____

Date of study exit

Primary reason for completion/discontinuation

Scheduled exit visit/end of study

Participant is unwilling or unable
to comply with required study
procedures

Lost to follow-up

Protocol deviation

Withdrawal of consent by
participant

Other, specify

If "Other", specify (max. 200 characters):

CoVPN5002_Version_1.53_AUX_BK_26MAR2021: ALL

Form: Informed Consent

Generated On: 29 Mar 2021 01:24:26

Informed consent date _____

Consent obtained for additional nasal swab for viral DNA sequencing

Yes

No

N/A

If the participant has already consented to providing a saliva sample and additional nasal swab, mark "N/A".

Consent obtained for extra samples to be used in other studies

Yes

No

CoVPN5002_Version_1.53_AUX_BK_26MAR2021: ALL

Form: SARS-CoV-2 Test Results

Generated On: 29 Mar 2021 01:24:26

| | |
|--------------------------|---|
| Specimen ID | <hr/> |
| Specimen collection date | <hr/> |
| Test result | Detected <input type="radio"/> |
| | Not Detected <input type="radio"/> |
| | Indeterminate <input type="radio"/> |
| | Not performed/ unacceptable <input type="radio"/> |
| | sample/invalid <input type="radio"/> |

Date of questionnaire administration

Interviewer please check one of the following:

- Participant is completing the questionnaire for themselves
- Legally authorized representative is completing this questionnaire on behalf of another person

.Interviewer (read aloud): We are conducting this study to estimate the number of people who have or have had SARS-CoV-2 or COVID-19 in the United States and better understand how the COVID-19 pandemic affected peoples' lives. We would like to ask you some questions about you, your health, your household, possible exposure to COVID-19 and your thoughts and feelings about COVID-19.

The questionnaire will take about 15-20 minutes to complete. Your participation is completely voluntary, and please be assured that your answers will remain strictly confidential.

Do you have any questions before we begin?

MEDICAL HISTORY

.Interviewer script (read aloud): We are now going to ask about your medical conditions and how they may have been affected by the COVID-19 pandemic. Please answer these questions to the best of your ability.

1 - . Have you ever been diagnosed with any of the following medical conditions? (Check all that apply) Yes.
No.

.Asthma
.Other chronic lung disease Yes.
No.

.Heart disease Yes.
No.

.Hypertension (high blood pressure) Yes.
No.

.Cancer chemotherapy in the last 12 months Yes.
No.

.Other immunosuppression condition Yes.
No.

.HIV Yes.
No.

| | |
|--|----------------------------|
| .Diabetes | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| .Kidney or renal disease | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| .Liver Disease | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| .Sickle cell disease | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| .Obesity | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| .Mental health condition | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| .Substance abuse disorder | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| .Other chronic medical conditions that have not already been mentioned | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| .If "Other", specify: _____ | |
| 2 - . Are you limited in any way in your daily activities because of a physical, mental, or emotional disability? (Check all that apply) | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| .Physical disability | |
| .Mental disability | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| .Emotional disability | |
| | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| .None of the above | |
| | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| .Prefer not to answer | |
| | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |

| | |
|---|----------------------------|
| 3 - . Do you have any medical conditions that require medication or routine visits to the doctor? (If "No", skip to next section) | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |

4 - . Because of the COVID-19 pandemic, were you unable or unwilling to attend scheduled appointments with your health care provider? (If "No" or "Don't Know/Not sure", skip to question 6.)

Yes, I did miss appointments.

No, I did not miss an appointment.

No, I did not have any appointments to miss.

Don't Know/ Not sure.

5 - . What is the main reason you missed appointments with your healthcare provider?

My clinic cancelled my appointment because of COVID-19.

I had symptoms of COVID-19 so did not go.

I felt good, didn't need to go.

I did not have money or insurance.

Inconvenient (location/hours/times, etc.).

Forgot to go/missed appointment.

Disrespected by the office or medical staff.

I could not attend telemedicine visit.

Did not have transportation.

I postponed my appointment until it was safe to go.

Other.

.If "Other", specify:

6 - . Because of the COVID-19 pandemic, were you unable to take any medications?

Yes, I could not get a refill from the pharmacy.

Yes, I did not get my refill from the pharmacy because I was concerned about social distancing/interacting with other/exposure to coronavirus.

Yes, I have medication in my possession, but I forgot to take them.

Yes, I could no longer afford them because of lost employment or insurance.

No.

Don't Know.

Prefer not to answer.

7 - COVID-19 INFECTION HISTORY, RISK , AND EXPOSURE

- Yes – had symptoms.
- No-never had symptoms.
- Don't Know/ Not sure.

.Interviewer script (read aloud): We are now going to ask about any history of COVID-19 symptoms, testing, and illness in you or your household.

. Have you ever had COVID-19 symptoms since November 2019?

8 - .Have you received a COVID-19 diagnostic test in the past? A diagnostic test is usually a swab in the nose, mouth, or throat.

- Yes – I tested positive.
- Yes – I tested negative.
- Never been tested.
- Don't Know/Not Sure/Inconclusive Test.

(If "Yes- I tested positive", skip to question 10. If "Yes-I tested negative", skip to question 16. If "Don't know/Not sure/Inconclusive Test", skip to question 16.)

9 - .What were the reasons you have not gotten a COVID-19 diagnostic test? (Check all that apply)

- Yes.
- No.

.Insurance/ could not afford the test

- .Fear of the test Yes.
- No.

- .Fear of the results Yes.
- No.

- .I did not know where to get tested Yes.
- No.

- .I did not have a reason to get tested Yes.
- No.

- .I was sure I already had COVID-19 (had symptoms or was exposed) Yes.
- No.

- .CDC recommended not testing if you have mild symptoms Yes.
- No.

- .The test was not available near where I live Yes.
- No.

- .I was quarantining/socially distancing Yes.
- No.

- .I was avoiding healthcare facilities Yes.
- No.

10 - Note to interviewer: Skip question 10 - question 15 if participant has never had a COVID-19 diagnostic test.

.What was the date of the positive diagnostic test? _____

11 - .Have you tested positive for COVID-19 via a diagnostic test more than once? Yes.
No.
Prefer not to answer

12 - .Did you seek care after testing positive via diagnostic test? (If "No" or "Prefer not to answer", skip to question 16.) Yes.
No.
Prefer not to answer

13 - .Where did you seek medical care? (Check all that apply) Yes.
No.

Visited your primary care provider's office or another doctor's office.

Telephone call to your primary care provider's office or doctor's office. Yes.
No.

Telemedicine such as an electronic consultation or video call with a health care provider. Yes.
No.

Retail clinic or pharmacy. Yes.
No.

Urgent care. Yes.
No.

Emergency room. Yes.
No.

Hospital, not in the emergency room. Yes.

No.

Other. Yes.

No.

.If "Other", specify: _____

14 - .Did you spend at least one night in a hospital after testing positive? (If "No" or "Prefer not to answer", skip to question 16.) Yes.

No.

Prefer not to answer

15 - .How many nights were you hospitalized? 1-2 nights

3-5 nights

More than 5 nights

Don't know/ Not sure

16 - .Have you received a COVID-19 antibody test in the past? An antibody test is usually a blood test. (If "Yes-I tested negative", or "Never been tested", or "Don't know/Not sure/Inconclusive Test", skip to question 18. Yes - I tested positive.

Yes - I tested negative.

Never been tested.

Don't Know/Not Sure/Inconclusive Test.

17 - .What is the date of the positive antibody test? _____

18 - Note to interviewer: only ask question 18 to people who tested positive for COVID-19 through diagnostic and/or antibody test. Yes.

No.

Don't know/Not Sure.

.Did you experience any discrimination (such as being treated badly, harassed, threatened) from anyone because you were diagnosed with COVID-19 or had a positive antibody test? Prefer not to answer.

Not applicable.

19 - .In the past 14 days, have you had any of the following symptoms? Yes.

No.

.Fever or chills _____

.Cough with phlegm or mucus Yes.

No.

.Dry cough with no phlegm or mucus Yes.

| | | |
|--|-----------------------|-----------------------|
| | No. | <input type="radio"/> |
| .Shortness of breath or difficulty breathing | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Fatigue/ Feeling tired | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Muscle or body aches | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Headache | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Sudden loss of taste or smell | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Sore throat | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Congestion or runny nose | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Nausea or vomiting | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Diarrhea | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Abdominal pain | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| 20 - Note to interviewer: Skip to question 23 if respondent says "No" to all symptoms. | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| | Don't Know/ Not sure. | <input type="radio"/> |
| .Are you currently experiencing any of these symptoms? | | |

| | | |
|---|-----------------------|-----------------------|
| 21 - .While you were experiencing these symptoms, did you seek care from a healthcare professional? (seeking care includes a getting a test) (If "No" or "Don't know/Not sure", skip to question 23.) | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| | Don't Know/ Not sure. | <input type="radio"/> |

22 - .Where did you seek medical care? (Check all that apply) Yes.
No.

Visited your primary care provider's office or another doctor's office.

Telephone call to your primary care provider's office or doctor's office. Yes.
No.

Telemedicine such as an electronic consultation or video call with a health care provider. Yes.
No.

Retail clinic or pharmacy. Yes.
No.

Urgent care. Yes.
No.

Emergency room. Yes.
No.

Hospital, not in the emergency room. Yes.
No.

Other. Yes.
No.

.If "Other", specify: _____

23 - Note to interviewer: If participant asks, recently refers to the last 2 months. Yes.
No.
Don't Know/ Not sure.

.In the past month, have you interacted in person or through direct physical contact, such as touching, hugging, or shaking hands, with someone who recently tested positive for COVID-19?

24 - Note to interviewer: Skip question 24 – question 25, if participant lives alone. Yes.

No.

Don't Know/ Not sure/Inconclusive Test.

.Has anyone in your household tested positive for COVID-19 via nasal swab or antibody test?

25 - .In the past month, has a member of your household other than you experienced any symptoms of COVID-19? Yes.

No.

Don't Know/ Not sure.

KNOWLEDGE, ATTITUDES, AND BEHAVIOR ABOUT COVID-19

.Interviewer (read aloud): We would like to ask about your knowledge, attitudes, and behavior about COVID-19. Please answer to the best your ability.

26 - .On a scale of 1 to 5, 1 being never, 3 being some of the time, and 5 being all of the time, in the last 7 days, how often did you do the following actions? Never.

Almost Never.

Some of the time.

Most of the time.

.Wearing a face mask in public All of the time.

.Wash your hands with soap and water after coming home from a public place Never.

Almost Never.

Some of the time.

Most of the time.

All of the time.

.See a health care provider because you felt sick Never.

Almost Never.

Some of the time.

Most of the time.

All of the time.

.Keep a 6 ft distance between you and others when outside your home Never.

| | | |
|--|-------------------|-----------------------|
| | Almost Never. | <input type="radio"/> |
| | Some of the time. | <input type="radio"/> |
| | Most of the time. | <input type="radio"/> |
| | All of the time. | <input type="radio"/> |

| | | |
|--|-------------------|-----------------------|
| .Sanitize any items coming into the house (i.e. packages, groceries) | Never. | <input type="radio"/> |
| | Almost Never. | <input type="radio"/> |
| | Some of the time. | <input type="radio"/> |
| | Most of the time. | <input type="radio"/> |
| | All of the time. | <input type="radio"/> |

| | | |
|--|-------------------|-----------------------|
| .Spend time in public spaces, gatherings, and crowds | Never. | <input type="radio"/> |
| | Almost Never. | <input type="radio"/> |
| | Some of the time. | <input type="radio"/> |
| | Most of the time. | <input type="radio"/> |
| | All of the time. | <input type="radio"/> |

| | | |
|---|-------------------|-----------------------|
| .Have physical contact with people who could be high-risk (i.e. essential workers, health care workers, elderly individuals, small children, or students who are in institutional/group setting on a daily or near daily basis) | Never. | <input type="radio"/> |
| | Almost Never. | <input type="radio"/> |
| | Some of the time. | <input type="radio"/> |
| | Most of the time. | <input type="radio"/> |
| | All of the time. | <input type="radio"/> |

| | | |
|---|-------------------|-----------------------|
| .Go to restaurants for in-person dining | Never. | <input type="radio"/> |
| | Almost Never. | <input type="radio"/> |
| | Some of the time. | <input type="radio"/> |
| | Most of the time. | <input type="radio"/> |
| | All of the time. | <input type="radio"/> |

| | | |
|-----------------------------------|-------------------|-----------------------|
| .Go to bars for in-person service | Never. | <input type="radio"/> |
| | Almost Never. | <input type="radio"/> |
| | Some of the time. | <input type="radio"/> |
| | Most of the time. | <input type="radio"/> |
| | All of the time. | <input type="radio"/> |

| | | |
|----------------------------|-------------------|-----------------------|
| .Use public transportation | Never. | <input type="radio"/> |
| | Almost Never. | <input type="radio"/> |
| | Some of the time. | <input type="radio"/> |
| | Most of the time. | <input type="radio"/> |
| | All of the time. | <input type="radio"/> |

.Attend indoor religious service

- Never.
- Almost Never.
- Some of the time.
- Most of the time.
- All of the time.

COVID-19 IMPACT

.Interviewer (read aloud): We would like to ask you about the impact COVID-19 has had on your daily life, your household, and how you feel. If no experiences apply to you, please respond with not applicable. Some of these questions may be very personal. Please be assured that your answers will remain completely confidential.

27 - .Did you experience any of the following because of the COVID-19 pandemic? Yes.
No.
N/A

.Financial

.Working or studying from home

.Not working Yes.
No.
N/A

.Reduced work hours Yes.
No.
N/A

.Worrying about paying rent/mortgage Yes.
No.
N/A

.Personal financial loss Yes.
No.
N/A

.Loss of housing Yes.
No.
N/A

.Getting financial support from family, friends, partners, an organization, or someone else Yes.
No.
N/A

.Not having enough basic supplies like toilet paper, paper towels,
bottled water, or soap, etc. Yes.

No.

N/A

.Emotional Yes.

No.

N/A

.Worrying about friends, family, partners, etc.

.More anxiety than usual Yes.

No.

N/A

.More depression than usual Yes.

No.

N/A

.Getting emotional or social support from family, friends, partner, a
counselor, or someone else Yes.

No.

N/A

| | |
|----------------|----------------------------|
| .Interpersonal | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| | N/A <input type="radio"/> |

| | |
|--|----------------------------|
| .Caring for someone at home | |
| .Spending more time with your family or loved ones | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| | N/A <input type="radio"/> |

| | |
|-------------------------------------|----------------------------|
| .Not being able to receive visitors | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| | N/A <input type="radio"/> |

| | |
|---|----------------------------|
| .Not being able to visit elderly or sick relatives because they were not allowed visitors | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| | N/A <input type="radio"/> |

| | |
|---|----------------------------|
| .Not being able to visit incarcerated loved ones because they were not allowed visitors | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| | N/A <input type="radio"/> |

28 - .Have you had any alcoholic drinks in the last 6 months? (If "No" or "Prefer not to answer", skip question 29.)

Yes.

No.

Don't Know/ Not sure.

29 - .What changes, if any, have you noticed regarding your use of alcohol during the COVID-19 pandemic?

I use a lot more.

I use more.

About the same.

I use less.

I use a lot less.

30 - .Have you smoked or vaped tobacco (including cigarettes and e-cigarettes) in the last 6 months? (If "No" or "Prefer not to answer", skip question 31.)

Yes.

No.

Don't Know/ Not sure.

31 - .What changes, if any, have you noticed regarding your use of tobacco during the COVID-19 pandemic?

I use a lot more.

I use more.

About the same.

I use less.

I use a lot less.

WILLINGNESS TO PARTICIPATE IN COVID-19 VACCINE TRIAL

.Interviewer (read aloud): Thank you for responses so far. We are now going to ask about your experience and willingness to participate in a vaccine trial and get a COVID-19 vaccine in the future.

32 - .On a scale of 1 to 5, 1 being very unlikely, 3 being neutral, and 5 being very likely, how likely are you to enroll in a COVID-19 vaccine trial in the future?

Very Unlikely.

Unlikely.

Neutral.

Likely.

Very Likely.

I have already participated in a COVID-19 trial.

.If you have already participated in a COVID-19 vaccine trial, when did you receive your first dose?

33 - .On a scale of 1 to 5, 1 being very unlikely, 3 being neutral, and 5 being very likely, how likely are you to get an approved COVID-19 vaccine in the future?

Very Unlikely.

Unlikely.

Neutral.

Likely.

Very Likely.

I have already received an approved vaccine.

33 - .If you have already received an approved COVID-19 vaccine, when did you receive your first dose?

CoVPN5002_Version_1.53_AUX_BK_26MAR2021: ALL

Form: Questionnaire-Adult

Generated On: 29 Mar 2021 01:24:26

.Interviewer (read aloud): Thank you for taking the time to participate in our study and to complete this questionnaire. The responses your provided are extremely valuable. Do you have any questions for me?

Did the participant finish the questionnaire?

Yes.

No.

Date of questionnaire administration _____

.Interviewer Script (read aloud): We are conducting this study to estimate the number of people who have or have had SARS-CoV-2 or coronavirus the United States and better understand how the COVID-19 pandemic affected peoples' lives. We would like to ask you some questions about you, your health, your home, possible exposure to COVID-19. Your parent or guardian will help you answer the questions, and it is ok to ask them if you are not sure of the answer. You can skip any question you do not want to answer.

The questionnaire will take about 15 minutes to complete. Your participation is completely voluntary, and we will protect the answers you give.

Do you have any questions before we begin? _____

MEDICAL HISTORY

.Interviewer script (read aloud): We are now going to ask about your medical conditions and how they may have been affected by the COVID-19 pandemic. Please answer these questions to the best of your ability. Remember you can ask your parent or guardian to help you answer these questions.

1 - .Have you ever been diagnosed with any of the following medical conditions? (Check all that apply) Yes.
No.

.Asthma
.Other chronic lung disease Yes.
No.

.Heart disease Yes.
No.

.Hypertension (high blood pressure) Yes.
No.

.Cancer chemotherapy in the last 12 months Yes.
No.

.Other immunosuppression condition Yes.
No.

.HIV Yes.
No.

.Diabetes Yes.
No.

.Kidney or renal disease Yes.
No.

.Liver Disease Yes.
No.

.Sickle cell disease Yes.
No.

.Obesity Yes.
No.

.Mental health condition Yes.
No.

.Other chronic medical conditions that have not already been mentioned Yes.
No.

.If "Other", specify: _____

2 - . Are you limited in any way in your daily activities because of a physical, mental, or emotional disability? (Check all that apply) Yes.
No.

.Physical disability
.Mental disability Yes.
No.

.Emotional disability Yes.
No.

.None of the above Yes.
No.

.Prefer not to answer Yes.
No.

3 - . Do you have any medical conditions that require medication or routine visits to the doctor? (If "No", skip to next section) Yes.
No.

4 - . Because of the COVID-19 pandemic, were you unable or unwilling to attend scheduled appointments with your health care provider? (If "No" or "Don't Know/Not sure", skip to question 6.)
Yes, I did miss appointments.
No, I did not miss an appointment.
No, I did not have any appointments to miss.
Don't Know/ Not sure.

5 - . What is the main reason you missed appointments with your healthcare provider?
My clinic cancelled my appointment because of COVID-19.
I had symptoms of COVID-19 so did not go.
I felt good, didn't need to go.

- I did not have money or insurance.
- Inconvenient (location/hours/times, etc.).
- Forgot to go/missed appointment.
- Disrespected by the office or medical staff.
- I could not attend telemedicine visit.
- Did not have transportation.
- I postponed my appointment until it was safe to go.
- Other.

.If "Other", specify:

6 - . Because of the COVID-19 pandemic, did you miss taking any medications?

- Yes, my parent could not get a refill from the pharmacy.
- Yes, my parent did not get my refill from the pharmacy because
- I was concerned about social distancing/interacting with other/exposure to coronavirus.
- Yes, I have medication, but I forgot to take them.
- Yes, my parent could no longer afford them because of lost employment or insurance.
- No.
- Don't Know/ Not Sure.
- Prefer not to answer.

7 - COVID-19 INFECTION HISTORY, RISK , AND EXPOSURE

- Yes – had symptoms.
- No-never had symptoms.
- Don't Know/ Not sure.

.Interviewer script (read aloud): We are now going to ask about any history of COVID-19 symptoms, testing, and illness in you or your household.

. Have you ever had COVID-19 symptoms since November 2019?

CoVPN5002_Version_1.53_AUX_BK_26MAR2021: ALL

Form: Questionnaire-10 to 12

Generated On: 29 Mar 2021 01:24:26

8 - . Have you received a COVID-19 diagnostic test in the past? A diagnostic test is usually a swab in the nose, mouth, or throat. (If "Yes- I tested positive", skip to question 10. If "Yes-I tested negative", or "Don't know/Not sure/Inconclusive Test", skip to question 16.)

Yes – I tested positive.

Yes – I tested negative.

Never been tested.

Don't Know/Not Sure/Inconclusive Test.

9 - . What were the reasons did not get a COVID-19 diagnostic test? (Check all that apply)

Yes.

No.

.Insurance/ could not afford the test

.Fear of the test

Yes.

No.

.Fear of the results

Yes.

No.

.I did not know where to get tested

Yes.

No.

.I did not have a reason to get tested

Yes.

No.

.I was sure I already had COVID-19 (I felt sick or was exposed)

Yes.

No.

.CDC recommended not testing if you have mild symptoms

Yes.

No.

.The test was not available near where I live

Yes.

No.

.I was quarantining/socially distancing

Yes.

No.

.I was avoiding healthcare facilities

Yes.

No.

10 - Note to interviewer: Skip question 10 - question 15 if participant has never had a COVID-19 diagnostic test.

. What was the date of the positive diagnostic test? _____

11 - . Have you tested positive for COVID-19 via a diagnostic test more than once?

Yes.

No.

Prefer not to answer

12 - . Did you seek care after testing positive via diagnostic test? (If "No" or "Prefer not to answer", skip to question 16.)

Yes.

No.
Prefer not to answer

| | |
|--|---|
| | <input type="checkbox"/> |
| 13 - .Where did you seek medical care? (Check all that apply) | Yes. <input type="checkbox"/> No. <input type="checkbox"/> |
| Visited your primary care provider's office or another doctor's office. | |
| Telephone call to your primary care provider's office or doctor's office. | Yes. <input type="checkbox"/> No. <input type="checkbox"/> |
| Telemedicine such as an electronic consultation or video call with a health care provider. | Yes. <input type="checkbox"/> No. <input type="checkbox"/> |
| Retail clinic or pharmacy. | Yes. <input type="checkbox"/> No. <input type="checkbox"/> |
| Urgent care. | Yes. <input type="checkbox"/> No. <input type="checkbox"/> |
| Emergency room. | Yes. <input type="checkbox"/> No. <input type="checkbox"/> |
| Hospital, not in the emergency room. | Yes. <input type="checkbox"/> No. <input type="checkbox"/> |
| Other. | Yes. <input type="checkbox"/> No. <input type="checkbox"/> |
| .If "Other", specify: | |

14 - . Did you spend at least one night in a hospital after testing positive? (If "No" or "Prefer not to answer", skip to question 16.)

Yes.

No.

Prefer not to answer

15 - . How many nights were you hospitalized?

1-2 nights

3-5 nights

More than 5 nights

Don't know/ Not sure

16 - . Have you received a COVID-19 antibody test in the past? An antibody test is usually a blood test . (If "Yes-I tested negative", or "Never been tested", or "Don't know/Not sure/Inconclusive Test", skip to question 18.)

Yes - I tested positive.

Yes - I tested negative.

Never been tested.

Don't Know/Not Sure/Inconclusive Test.

17 - . What is the date of the positive antibody test? _____

18 - Note to interviewer: only ask question 18 to people who tested positive for COVID-19 through diagnostic and/or antibody test.

Yes.

No.

Don't know/Not Sure.

.Did you experience any discrimination (such as being treated badly, harassed, threatened) from anyone because you were diagnosed with COVID-19 or had a positive antibody test?

Prefer not to answer.

Not applicable.

19 - . In the past 14 days, have you had any of the following symptoms?

Yes.

No.

.Fever or chills

.Cough with phlegm or mucus

Yes.

No.

.Dry cough with no phlegm or mucus

Yes.

No.

.Shortness of breath or difficulty breathing

Yes.

No.

.Fatigue/ Feeling tired

Yes.

No.

.Muscle or body aches

Yes.

No.

.Headache

Yes.

No.

.Sudden loss of taste or smell Yes.
No.

.Sore throat Yes.
No.

.Congestion or runny nose Yes.
No.

.Nausea or vomiting Yes.
No.

.Diarrhea Yes.
No.

.Abdominal pain Yes.
No.

20 - .Note to interviewer: Skip to question 23 if respondent says
"No" to all symptoms. Yes.
No.
Don't Know/ Not sure.

. Are you currently experiencing any of these symptoms?

21 - . While you were experiencing these symptoms, did you seek
care from a healthcare professional? (seeking care includes a
getting a test) If "No" or "Don't know/Not sure", skip to question
23. Yes.
No.
Don't Know/ Not sure.

22 - .Where did you seek medical care? Yes.
No.

Visited your primary care provider's office or another doctor's office.

Telephone call to your primary care provider's office or doctor's office. Yes.
No.

Telemedicine such as an electronic consultation or video call with a health care provider. Yes.
No.

Retail clinic or pharmacy. Yes.
No.

Urgent care. Yes.
No.

Emergency room. Yes.
No.

Hospital, not in the emergency room. Yes.
No.

Other. Yes.
No.

.If "Other", specify: _____

23 - Yes.
. In the past month, have you interacted in person or through direct physical contact, such as touching, hugging, or shaking hands, with someone who recently tested positive for COVID-19? No.
Don't Know/ Not sure.

Note to interviewer: If participant asks, recently refers to the last 2 months.

24 - . Has anyone in your home tested positive for COVID-19 via nasal swab or antibody test? Yes.
No.
Don't Know/ Not sure/Inconclusive Test.

25 - . In the past month, has anyone in your home other than you experienced any symptoms of COVID-19? Yes.
No.
Don't Know/ Not sure.

KNOWLEDGE, ATTITUDES, AND BEHAVIOR ABOUT COVID-19

.Interviewer (read aloud): We would like to ask about your knowledge, attitudes, and behavior about COVID-19. Please answer to the best your ability.

26 - . On a scale of 1 to 5, 1 being never, 3 being some of the time, and 5 being all of the time, in the last 7 days, how often did you do the following actions?

.Wearing a face mask in public Never.
Almost Never.
Some of the time.
Most of the time.
All of the time.

.Wash your hands with soap and water after coming home from a public place Never.
Almost Never.
Some of the time.
Most of the time.
All of the time.

.See a health care provider because you felt sick Never.
Almost Never.
Some of the time.
Most of the time.
All of the time.

.Spend time in public spaces, gatherings, and crowds Never.
Almost Never.
Some of the time.
Most of the time.
All of the time.

.Go to restaurants Never.
Almost Never.
Some of the time.
Most of the time.
All of the time.

.Use public transportation Never.
Almost Never.
Some of the time.
Most of the time.
All of the time.

.Attend indoor religious service

Never.

Almost Never.

Some of the time.

Most of the time.

All of the time.

COVID-19 IMPACT

.Interviewer (read aloud): We would like to ask you about the impact COVID-19 has had on your daily life, your household, and how you feel. If no experiences apply to you, please respond with not applicable.

27 - . Did you experience any of the following because of the COVID-19 pandemic?

Yes.

No.

N/A

.Financial

.Loss of housing

.Getting support from family, friends, partners, an organization, or someone else

Yes.

No.

N/A

.Not having enough basic supplies like toilet paper, paper towels, bottled water, or soap, etc.

Yes.

No.

N/A

| | |
|---------------------------------------|----------------------------|
| .Emotional | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| | N/A <input type="radio"/> |
| <hr/> | |
| .Worrying about friends and/or family | |
| .More anxiety | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| | N/A <input type="radio"/> |
| <hr/> | |
| .More depression | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| | N/A <input type="radio"/> |

| | |
|--|----------------------------|
| .Getting emotional or social support from family, friends, partner, a counselor, or someone else | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| | N/A <input type="radio"/> |

| | |
|---|----------------------------|
| .Interpersonal | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| | N/A <input type="radio"/> |
| <hr/> | |
| .Spending more time with your family or loved ones | |
| .Not being able to visit elderly or sick relatives because they were not allowed visitors | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| | N/A <input type="radio"/> |
| <hr/> | |
| .Not being able to spend time with classmates, teammates, or friends | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| | N/A <input type="radio"/> |

WILLINGNESS TO PARTICIPATE IN COVID-19 VACCINE TRIAL

.Interviewer (read aloud): Thank you for responses so far. We are now going to ask about your experience and willingness to participate in a vaccine trial and get a COVID-19 vaccine in the future.

28 - . On a scale of 1 to 5, 1 being very unlikely, 3 being neutral, and 5 being very likely, how likely are you to enroll in a COVID-19 vaccine trial in the future?

Very Unlikely.

Unlikely.

Neutral.

Likely.

Very Likely.

29 - . On a scale of 1 to 5, 1 being very unlikely, 3 being neutral, and 5 being very likely, how likely are you to get an approved COVID-19 vaccine in the future?

Very Unlikely.

Unlikely.

Neutral.

Likely.

Very Likely.

.Interviewer (read aloud): Thank you for taking the time to participate in our study and to complete this questionnaire. The responses you provided are extremely valuable. Do you have any questions for me?

Did the participant finish the questionnaire?

Yes.

No.

Date of questionnaire administration _____

.Interviewer Script (read aloud): We are conducting this study to estimate the number of people who have or have had SARS-CoV-2 or COVID-19 in the United States and better understand how the COVID-19 pandemic affected peoples' lives. We would like to ask you some questions about your child, their health, your household, and possible exposure to SARS-CoV-2. We ask that you answer these questions on behalf of your child to the best of your ability.

The questionnaire will take about 15 minutes to complete. Your participation is completely voluntary, and your answers will remain strictly confidential.

Do you have any questions before we begin?

MEDICAL HISTORY

.Interviewer (read aloud): We are now going to ask about your child's medical history. Please answer these questions to the best of your ability. We would like to assure you that your responses to these questions will remain strictly confidential.

1 - .Has your child ever been diagnosed with any of the following medical conditions? (Check all that apply) Yes.
No.

.Asthma
.Other chronic lung disease Yes.
No.

.Heart disease Yes.
No.

.Hypertension (high blood pressure) Yes.
No.

.Cancer chemotherapy in the last 12 months Yes.
No.

.Other immunosuppression condition Yes.
No.

.HIV Yes.
No.

.Diabetes Yes.
No.

.Kidney or renal disease Yes.

| | | |
|--|---|-----------------------|
| | No. | <input type="radio"/> |
| .Liver Disease | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Sickle cell disease | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Obesity | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Mental health condition | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Other chronic medical conditions that have not already been mentioned | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .If "Other", specify: _____ | | |
| 2 - .Is your child limited in any way in your daily activities because of a physical, mental, or emotional disability? (Check all that apply) | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Physical disability | | |
| .Mental disability | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Emotional disability | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .None of the above | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| .Prefer not to answer | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| 3 - . Does your child have any medical conditions that require medication or routine visits to the doctor? (If "No", skip to next section) | Yes. | <input type="radio"/> |
| | No. | <input type="radio"/> |
| 4 - .Because of the COVID-19 pandemic, did your child miss any scheduled appointments with their health care provider? (If "No" or "Don't Know/Not sure", skip to question 6.) | Yes, they did miss appointments. | <input type="radio"/> |
| | No, they did not miss an appointment. | <input type="radio"/> |
| | No, they did not have any appointments to miss. | <input type="radio"/> |
| | Don't Know/ Not sure. | <input type="radio"/> |
| 5 - . What is the main reason your child missed appointments with your healthcare provider? | Their clinic cancelled their appointment because of COVID-19. | <input type="radio"/> |
| | My child had symptoms of COVID-19 so did not go. | <input type="radio"/> |
| | They felt good, didn't need to go. | <input type="radio"/> |
| | Didn't have money or insurance. | <input type="radio"/> |

- Inconvenient (location/hours/times, etc.).
- Forgot to go/missed appointment.
- Disrespected by the office or medical staff.
- Could not attend telemedicine visit.
- Did not have transportation.
- Postponed their appointment until it was safe to go.
- Other.

.If "Other", specify:

- 6 - . Because of the COVID-19 pandemic, did your child miss taking any medications?
- Yes, I could not get a refill from the pharmacy.
 - Yes, I did not get their refill from the pharmacy because I was concerned about social distancing/interacting with other/exposure to coronavirus.
 - Yes, they have medication in their possession, forgot to take them.
 - Yes, I could no longer afford them because of lost employment or insurance.
 - No.
 - Don't Know.
 - Prefer not to answer.

7 - COVID-19 INFECTION HISTORY, RISK , AND EXPOSURE

- Yes – had symptoms.
- No-never had symptoms.
- Don't Know/ Not sure.

.Interviewer script (read aloud): We are now going to ask about your child's history of COVID-19 symptoms, testing, and illness in them or your household.

. Has your child ever had COVID-19 symptoms since November 2019?

CoVPN5002_Version_1.53_AUX_BK_26MAR2021: ALL

Form: Questionnaire-2mo - 9yr

Generated On: 29 Mar 2021 01:24:26

8 - . Has your child received a COVID-19 diagnostic test in the past?
A diagnostic test is usually a swab in the nose, mouth, or throat. (If "Yes- they tested positive", skip to question 10. If "Yes-they tested negative", or "Don't know/Not sure/Inconclusive Test", skip to question 16.)

Yes – they tested positive.

Yes – they tested negative.

Never been tested.

Don't Know/Not Sure/Inconclusive Test.

9 - . What were the reasons your child did not get a COVID-19 diagnostic test? (Check all that apply)

Yes.

No.

.Insurance/ could not afford the test

Yes.

.Fear of the test

No.

.Fear of the results

Yes.

No.

.I did not know where to take them get tested

Yes.

No.

.They did not have a reason to get them tested

Yes.

No.

.I was sure they already had COVID-19 (had symptoms or was exposed)

Yes.

No.

.CDC recommended not testing if they have mild symptoms

Yes.

No.

.The test was not available near where I live

Yes.

No.

.We were quarantining/socially distancing

Yes.

No.

.We were avoiding healthcare facilities

Yes.

No.

10 - Note to interviewer: Skip question 10 - question 15 if participant has never had a COVID-19 diagnostic test.

. What was the date of your child's the positive diagnostic test? _____

11 - . Has your child tested positive for COVID-19 via a diagnostic test more than once?

Yes.

No.

Prefer not to answer

12 - . Did you seek care for your child after they tested positive via diagnostic test? (If "No" or "Prefer not to answer", skip to question 16.)

Yes.

No.
Prefer not to answer

13 - .Where did you seek medical care? Yes.
No.

Visited your primary care provider's office or another doctor's office.

Telephone call to your primary care provider's office or doctor's office. Yes.
No.

Telemedicine such as an electronic consultation or video call with a health care provider. Yes.
No.

Retail clinic or pharmacy. Yes.
No.

Urgent care. Yes.
No.

Emergency room. Yes.
No.

Hospital, not in the emergency room. Yes.
No.

Other. Yes.
No.

.If "Other", specify: _____

Don't know/ Not sure.

14 - . Did your child spend at least one night in a hospital after testing positive? (If "No" or "Prefer not to answer", skip to question 16.)
Yes.
No.
Prefer not to answer

15 - . How many nights was your child hospitalized?
1-2 nights
3-5 nights
More than 5 nights
Don't know/ Not sure

16 - . Has your child received a COVID-19 antibody test in the past? An antibody test is usually a blood test . (If "Yes-they tested negative", or "Never been tested", or "Don't know/Not sure", skip to question 18.)
Yes – they tested positive.
Yes – they tested negative.
Never been tested.
Don't Know/Not Sure.

17 - . What is the date of your child's positive antibody test? _____

18 - Note to interviewer: only ask question 18 to people who tested positive for COVID-19 through diagnostic and/or antibody test.
Yes.
No.
Don't know/Not Sure.

.Did your child experience any discrimination (such as being treated badly, harassed, threatened) from anyone because you were diagnosed with COVID-19 or had a positive antibody test?
Prefer not to answer.
Not applicable.

19 - . In the past 14 days, has your child had any of the following symptoms?
Yes.
No.

.Fever or chills
.Cough with phlegm or mucus
Yes.
No.

.Dry cough with no phlegm or mucus
Yes.
No.

.Shortness of breath or difficulty breathing
Yes.
No.

.Fatigue/ Feeling tired
Yes.
No.

.Muscle or body aches
Yes.
No.

.Headache
Yes.
No.

| | |
|---|---|
| .Sudden loss of taste or smell | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| <hr/> | |
| .Sore throat | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| <hr/> | |
| .Congestion or runny nose | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| <hr/> | |
| .Nausea or vomiting | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| <hr/> | |
| .Diarrhea | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| <hr/> | |
| .Abdominal pain | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| <hr/> | |
| 20 - .Note to interviewer: Skip to question 23 if respondent says "No" to all symptoms. | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| | Don't Know/ Not sure. <input type="radio"/> |
| <hr/> | |
| . Is your child currently experiencing any of these symptoms? | |

| | |
|---|---|
| 21 - . While your child were experiencing these symptoms, did you seek care from a healthcare professional? (seeking care includes a getting a test) If "No" or "Don't know/Not sure", skip to question 23. | Yes. <input type="radio"/> |
| | No. <input type="radio"/> |
| | Don't Know/ Not sure. <input type="radio"/> |

22 - .Where did you seek medical care? Yes.
No.

Visited your primary care provider's office or another doctor's office.

Telephone call to your primary care provider's office or doctor's office. Yes.
No.

Telemedicine such as an electronic consultation or video call with a health care provider. Yes.
No.

Retail clinic or pharmacy. Yes.
No.

Urgent care. Yes.
No.

Emergency room. Yes.
No.

Hospital, not in the emergency room. Yes.
No.

Other. Yes.
No.

.If "Other", specify: _____

23 - . In the past month, has your child interacted in person or through direct physical contact, such as touching, hugging, or shaking hands, with someone who recently tested positive for COVID-19? Yes.
No.
Don't Know/ Not sure.

Note to interviewer: If participant asks, recently refers to the last 2 months.

24 - . Has anyone in your household tested positive for COVID-19 via nasal swab or antibody test? Yes.
No.
Don't Know/ Not sure/Inconclusive Test.

25 - . In the past month, has anyone in your household other than your child experienced any symptoms of COVID-19? Yes.

No.

Don't Know/ Not sure.

COVID-19 IMPACT

.Interviewer (read aloud): We would like to ask you about the impact COVID-19 has had on your child's daily life and their feeling. If any experiences do not apply to your child, please respond with not applicable.

26 - . Did your child experience any of the following because of the COVID-19 pandemic? Yes.

No.

N/A

.Financial

.Loss of housing

.Needing support from family, friends, partners, an organization, or someone else Yes.

No.

N/A

.Not having enough basic supplies like toilet paper, paper towels, bottled water, or soap, etc. Yes.

No.

N/A

.Emotional Yes.

No.

N/A

.Worrying about friends and family

.More anxiety Yes.

No.

N/A

.More depression Yes.

No.

N/A

.Getting emotional or social support from family, friends, a counselor, or someone else Yes.

No.

N/A

.Confusion about what COVID-19 is, how to prevent it, or why
physical distancing/isolation/quarantines are needed

Yes.
No.
N/A

.Interpersonal

Yes.
No.
N/A

.Spending more time with your family or loved ones

.Not being able to visit elderly or sick relatives because they were
not allowed visitors

Yes.
No.
N/A

.Isolating or quarantining with the family

Yes.
No.
N/A

.Not being able to spend time with classmates, teammates, or
friends

Yes.
No.
N/A

WILLINGNESS TO PARTICIPATE IN COVID-19 VACCINE TRIAL

.Interviewer (read aloud): Thank you for responses so far. We are now going to ask about your willingness to get your child vaccinated against COVID-19 in the future.

27 - . On a scale of 1 to 5, 1 being very unlikely, 3 being neutral, and 5 being very likely, how likely are you to get an approved COVID-19 vaccine for your child in the future?

Very Unlikely.

Unlikely.

Neutral.

Likely.

Very Likely.

.Interviewer (read aloud): Thank you for taking the time to participate in our study and to complete this questionnaire. The responses you provided are extremely valuable. Do you have any questions for me?

Did the participant finish the questionnaire?

Yes.

No.