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 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***
- ☐ 02 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	☐ 01	☐ 02	☐ 03
b. Sleeping	☐ 01	☐ 02	☐ 03
c. Physical activity	☐ 01	☐ 02	☐ 03
d. Spending time outside	☐ 01	☐ 02	☐ 03
e. Spending time with friends in-person	☐ 01	☐ 02	☐ 03
f. Spending time with friends remotely (e.g., online, social media, texting)	☐ 01	☐ 02	☐ 03
g. Spending time watching TV, playing video/computer games, or using social media for ***educational*** purposes, including school work	☐ 01	☐ 02	☐ 03
h. Spending time watching TV, playing video/computer games, or using social media for ***non-educational*** purposes	☐ 01	☐ 02	☐ 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	Mode
☐ 01 Clinic or site ☐ 02 Phone ☐ 03 Other location	☐ 01 Self-administered ☐ 02 Staff-administered