Biomedical Recommended Measures

Subject Number _____

COVID-19 Pediatric Biomedical Recommended Measures

The following document includes the Biomedical Pediatric Working Group's recommended instruments for collecting information on the Group's Tier 1 and Tier 2 data elements, organized by Domain.

Document Notes:
- Navigation: You may use the Navigation Pane to efficiently navigate the document. To do so, click "View" on the top of the Word doc and check the box labeled "Navigation Pane" under "Show."

- Endnotes: References are marked by endnotes; you may hover over or click on the endnote to display the reference, and modifications to the source if applicable.

- Tiers: Tier 1 elements are marked in Blue, Tier 2 elements are marked in Green

Common Data Elements (CDE) User Guidance:

- Unless specified, the units for specified age groups are in years.

Please click the link below to download the document.

[Attachment: "Data Harmonization to Accelerate COVID-19 Pediatric Research_vF.pdf"]

Baseline Child Health

Date participant was enrolled in study (protocol specific) _____

Underlying Conditions

Significant underlying medical conditions at the time of COVID-19 testing or diagnosis:

- ☐ Diabetes type I
- ☐ Diabetes type II
- ☐ Obesity
- ☐ Asthma
- ☐ Bronchopulmonary dysplasia (BPD)
- ☐ Cystic fibrosis
- ☐ Obstructive sleep apnea
- ☐ Tracheomalacia
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Hematopoietic cell recipient/bone marrow transplant recipient
- ☐ Solid organ transplant recipient
- ☐ Rheumatologic conditions (e.g. rheumatoid arthritis, systemic lupus erythematosus, vasculitis)
- ☐ Hypertension
- ☐ Congenital heart disease
- ☐ Heart failure
- ☐ Cardiomyopathy
- ☐ History of Kawasaki Disease (not a current diagnosis)
- ☐ History of MIS-C (not a current diagnosis)
- ☐ Inflammatory bowel disease

Significant underlying medical conditions at the time of COVID-19 testing or diagnosis:

- ☐ Feeding tube dependent
- ☐ Sickle cell disease
- ☐ Thrombotic disorders
- ☐ Chronic liver disease
- ☐ Chronic kidney disease
- ☐ Seizure disorder/epilepsy
- ☐ Eczema
- ☐ Physical disability (including cerebral palsy)
- ☐ Down syndrome
- ☐ Congenital syndromes/anomalies or genetic conditions including other chromosomal syndromes
- ☐ Premature or neonatal conditions
- ☐ Pregnancy (if of reproductive age)
- ☐ Other conditions (specify)

Specify Other _____

Premature and Neonatal Conditions (Tier 2)

- ☐ Fetal malnutrition
- ☐ Extreme immaturity
- ☐ Cerebral hemorrhage at birth
- ☐ Spinal cord injury at birth
- ☐ Birth asphyxia
- ☐ Respiratory diseases
- ☐ Hypoxic-ischemic encephalopathy
- ☐ Other

Specify other _____

Family History Comorbidities (Tier 2)

Have any family members (parent/sibling) been diagnosed with any of the following medical conditions currently or in the past?

Obesity	◯ Yes	◯ No	◯ Unknown
Diabetes type I	◯ Yes	◯ No	◯ Unknown
Diabetes type II	◯ Yes	◯ No	◯ Unknown
Fibromyalgia (amplified pain syndrome)	◯ Yes	◯ No	◯ Unknown
Rheumatologic conditions (e.g. rheumatoid arthritis, systemic lupus erythematosus, vasculitis)	◯ Yes	◯ No	◯ Unknown
Thrombotic disorders	◯ Yes	◯ No	◯ Unknown
Other significant comorbidity (specify)	◯ Yes	◯ No	◯ Unknown

Specify other significant comorbidity _____

	Yes	No	Unknown	Prefer Not to Answer
If the participant is in first year of life, did the participant's mother test positive for COVID-19 while pregnant or nursing?	◯	◯	◯	◯
If participant is in first year of life, did the participant's father or other caregiver test positive for COVID-19?	◯	◯	◯	◯

Health Status (Height/Weight)

Height

_____ (cm)

◯ Not available

Weight

_____ (g)

◯ Not available

Head Circumference (Only for children less than two years of age) (Tier 2)

_____ (cm)

◯ Not available

Breastfeeding (Tier 2)

	Yes	No	Unknown	Prefer Not to Answer
If the participant is in first year of life, is he or she being breastfed or fed pumped milk?	◯	◯	◯	◯

COVID-19 Vaccination History

	Yes	No	Unknown	Prefer Not to Answer
Has the participant received a COVID-19 vaccine?	◯	◯	◯	◯

Which vaccine brand/type did the participant receive?

◯ Pfizer
◯ Moderna
◯ Johnson and Johnson
◯ AstraZeneca
◯ Unknown
◯ Other (specify)

Specify Other

_____

Did the participant receive the second dose of the COVID-19 vaccine?

◯ Yes
◯ No
◯ N/A
◯ Unknown
◯ Prefer Not to Answer

1st Date of vaccination

_____

2nd Date of vaccination

_____

Did the participant have any adverse reactions or side effects?

- ◯ Yes
- ◯ No
- ◯ N/A
- ◯ Unknown
- ◯ Prefer Not to Answer

PASC Symptom Resolution (Tier 2)

If the participant had long COVID/post-acute sequelae of COVID-19 (PASC) symptoms at the time of vaccination, did those symptoms change?

- ◯ Yes, full resolution of symptoms
- ◯ Yes, some improvement in symptoms
- ◯ Yes, worsening of symptoms
- ◯ No, no significant change

Maternal COVID-19 Vaccination History (Tier 2)

	Yes	No	Unknown	Prefer Not to Answer
If participant is in first year of life, did the participant's mother receive vaccination for COVID-19 while pregnant or nursing?	◯	◯	◯	◯

Current Vaccination Status (Tier 2)

Parent Report About Child

	Yes	No	Unknown	Prefer Not to Answer
Are the patient's immunizations up to date for their age at the time of COVID-19 diagnosis/assessment?	◯	◯	◯	◯

If immunizations are not up to date, what is/are the reason(s) for not being up to date? (Check all that apply)

- ☐ Clinic was closed because of COVID-19
- ☐ Child had symptoms of COVID-19, so you cancelled appointment
- ☐ You cancelled appointments to avoid being around others/in a healthcare setting
- ☐ Other reasons related to COVID-19
- ☐ Other reasons not related to COVID-19
- ☐ Refused to answer

	Yes	No	Unknown	Prefer Not to Answer
Has the patient received any MMR vaccinations?	◯	◯	◯	◯
Has the patient received the current seasonal influenza vaccine?	◯	◯	◯	◯
Has the patient received palivizumab for prevention of respiratory syncytial virus (RSV)?	◯	◯	◯	◯

Has the patient received the BCG vaccination?	◯	◯	◯	◯

Date of most recent vaccination (excluding vaccination for COVID-19) _____

Baseline Medications/Treatment

Current medication name including birth control medications and injections (repeat for each medication)

Current Medication Name 1 _____

Current Medication Name 2 _____

Current Medication Name 3 _____

Respiratory support prior to onset of COVID-19? ◯ Yes ◯ No

Specify, check all that apply (Tier 2)

☐ Non-invasive respiratory support (e.g., CPAP, BiPAP)
☐ Invasive respiratory support (e.g. mechanical ventilation via tracheostomy)
☐ Tracheostomy
☐ Supplemental oxygen
☐ Unknown/Uncertain

Manifestations: Clinical

Vital signs are routinely collected as part of the baseline visit to determine eligibility to participate in a trial, to serve as a reference point to select vital signs which may be trended during the trial, and to reveal potential indicators of severity and risk that may not otherwise be obvious. Thus, the Working Group recommends transmitting baseline vital signs as a common data point and encourages researchers to supplement this list with other vital signs as dictated by specific criteria in their individual trials.

The Working Group is not currently recommending frequency for documentation of vital signs. Study sites should provide any core vital sign data that are collected for routine monitoring of participants. For example, vital sign data for ICU patients are typically charted every hour, and these data should be available through the electronic health record.

For outpatient studies, core vital sign data elements should be taken with any in-person assessment. However, the reference time period for vital signs should be a 24-hour clock from midnight to midnight (00:00-23:59) to allow for consistency across studies.

Date and Time of Vital Signs

Date

_____ (MM/DD/YYYY)

Time

_____ (HHMM)

Vital Sign Timepoints

Baseline (e.g., at admission, at initial encounter if not admission)

◯ Admission
◯ Initial Encounter if not admission

Protocol specific timepoints (e.g., Day 1 AM, Day 1 PM, Day 2 AM, at discharge, etc.)

◯ Day 1
◯ Day 2
◯ Discharge

◯ Unknown

Vital Signs

Body temperature

_____ (Celsius)

◯ Unknown ◯ N/A ◯ Not Reported

Heart rate

_____ (beats/min)

◯ Unknown ◯ N/A ◯ Not Reported

Systolic blood pressure

_____ (mmHg)

◯ Unknown ◯ N/A ◯ Not Reported

Diastolic blood pressure

_____
(mmHg)

◯ Unknown ◯ N/A ◯ Not Reported

Respiratory rate

_____
(breaths/min)

◯ Unknown ◯ N/A ◯ Not Reported

Oxygen saturation

_____
(%)

◯ Unknown ◯ N/A ◯ Not Reported

Supplemental oxygen ◯ Yes ◯ No

Symptoms/Physical Findings

Additional Guidance: Note that the two lists below are separated into an acute COVID-19/MIS-C symptom list and a Long COVID/PASC list (which includes the acute COVID-19/MIS-C list).

Which of the following were experienced during current illness and/or confirmed by physical exam?

For each symptom indicate Yes/No/Unknown

Acute COVID/MIS-C

	Yes - Experienced	Yes - Experienced and Confirmed by Physical Exam	No	Unknown
Abdominal pain	◯	◯	◯	◯
Bleeding	◯	◯	◯	◯
Chest pain	◯	◯	◯	◯
Cough	◯	◯	◯	◯
Cyanosis (bluish lips/face)	◯	◯	◯	◯
Diarrhea	◯	◯	◯	◯
Fatigue	◯	◯	◯	◯
Fever - documented	◯	◯	◯	◯

Duration in days

_____

	Yes - Experienced	Yes - Experienced and Confirmed by Physical Exam	No	Unknown
Headache	◯	◯	◯	◯
Muscle or body aches	◯	◯	◯	◯
Nasal congestion or runny nose	◯	◯	◯	◯
Nausea/vomiting	◯	◯	◯	◯
Neck pain	◯	◯	◯	◯
New loss of taste or smell	◯	◯	◯	◯
Palpitations	◯	◯	◯	◯
Shortness of breath or difficulty breathing	◯	◯	◯	◯
Skin rash	◯	◯	◯	◯
Sore throat	◯	◯	◯	◯
Subjective fever/chills/rigors/night sweats	◯	◯	◯	◯
Swollen glands	◯	◯	◯	◯

If confirmed by physical exam, cervical lymphadenopathy (at least 1.5 cm in diameter) ?

◯ Yes ◯ No ◯ Unknown

	Yes - Experienced	Yes - Experienced and Confirmed by Physical Exam	No	Unknown
Conjunctivitis (Red/pink eye(s))	◯	◯	◯	◯
Oral mucosal change	◯	◯	◯	◯

If confirmed by physical exam were swollen, red, or cracked lips, strawberry tongue, and/or erythema of the oral/pharyngeal mucosa present?

◯ Yes ◯ No ◯ Unknown

	Yes - Experienced	Yes - Experienced and Confirmed by Physical Exam	No	Unknown
Changes in hands and feet (Peripheral extremity changes)	◯	◯	◯	◯
Other symptom(s)	◯	◯	◯	◯

Specify

_____

Long COVID/PASC, including above acute COVID/MIS-C symptoms list plus the following:

	Yes - Experienced	Yes - Experienced and Confirmed by Physical Exam	No	Unknown
Allodynia (pain out of proportion to the stimulus)	◯	◯	◯	◯
Altered level of consciousness/confusion	◯	◯	◯	◯
Anorexia (decrease in appetite)	◯	◯	◯	◯
Anxiety	◯	◯	◯	◯
Cannot move and/or feel one side of body or face	◯	◯	◯	◯
Depressed mood	◯	◯	◯	◯
Dizziness/lightheadedness/black outs	◯	◯	◯	◯
Exertional fatigue	◯	◯	◯	◯
Forgetfulness	◯	◯	◯	◯
Irritability	◯	◯	◯	◯
Orthostasis (dizziness/lightheadedness/black outs on sitting up or standing)	◯	◯	◯	◯

If yes, confirmed by changes in heart rate/blood pressure? [Tier 2] ◯ Yes ◯ No ◯ Unknown

	Yes - Experienced	Yes - Experienced and Confirmed by Physical Exam	No	Unknown
Joint pain	◯	◯	◯	◯
Hallucinations (seeing or hearing things others do not see or hear) [should not be completed for children < 15 years old]	◯	◯	◯	◯
Hypersomnia	◯	◯	◯	◯
Insomnia (difficulty sleeping)	◯	◯	◯	◯
Malaise (including post-exertional malaise)	◯	◯	◯	◯
Muscle weakness	◯	◯	◯	◯
Paresthesia (numbness or tingling somewhere in the body)	◯	◯	◯	◯
Persistent cough	◯	◯	◯	◯

If yes, productive? ◯ Yes ◯ No ◯ Unknown

	Yes - Experienced	Yes - Experienced and Confirmed by Physical Exam	No	Unknown
Problems with balance	◯	◯	◯	◯
Problems with gait/falls	◯	◯	◯	◯
Toe rashes (red/purple sores or blisters on the feet, including the toes)	◯	◯	◯	◯
Trouble concentrating or difficulty thinking ("brain fog")	◯	◯	◯	◯
Weight loss	◯	◯	◯	◯
Failure of expected weight gain	◯	◯	◯	◯
Failure of expected linear growth	◯	◯	◯	◯
Other symptom(s)	◯	◯	◯	◯

Specify _____

Infant-Specific Symptoms/Physical Findings (Tier 2)

In addition to the above, which of the following were experienced by the infant during illness?

For each symptom indicate Yes/No/Unknown

Dehydration ◯ Yes ◯ No ◯ Unknown

Date Symptoms Presented

_____
(MM/DD/YYYY)

Date Symptoms Resolved

_____
(MM/DD/YYYY)

◯ Ongoing

Full or bulging fontanelle ◯ Yes ◯ No ◯ Unknown

Date Symptoms Presented

_____
(MM/DD/YYYY)

Date Symptoms Resolved

_____
(MM/DD/YYYY)

◯ Ongoing

Fussiness ◯ Yes ◯ No ◯ Unknown

Date Symptoms Presented

_____
(MM/DD/YYYY)

Date Symptoms Resolved

(MM/DD/YYYY)

◯ Ongoing

Increased work of breathing/shallow breathing ◯ Yes ◯ No ◯ Unknown

Date Symptoms Presented

(MM/DD/YYYY)

Date Symptoms Resolved

(MM/DD/YYYY)

◯ Ongoing

Lethargy ◯ Yes ◯ No ◯ Unknown

Date Symptoms Presented

(MM/DD/YYYY)

Date Symptoms Resolved

(MM/DD/YYYY)

◯ Ongoing

Poor feeding ◯ Yes ◯ No ◯ Unknown

Date Symptoms Presented

(MM/DD/YYYY)

Date Symptoms Resolved

(MM/DD/YYYY)

◯ Ongoing

Complications/Conditions

Did the patient develop any of the following complications/conditions since the diagnosis of COVID (organized by organ system):

Fibromyalgia/amplified pain syndrome ◯ Yes ◯ No ◯ Unknown

Date of Onset/Diagnosis (Tier 2)

(MM/DD/YYYY)

Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Post viral fatigue syndrome	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Seizure	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Stroke: intracerebral hemorrhage	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Stroke: ischemic cerebrovascular accident	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing

Diabetic Ketoacidosis (DKA)	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
New onset diabetes	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Pancreatitis	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Acute respiratory distress syndrome (ARDS)	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Bronchiolitis	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)

Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Deterioration of prior chronic pulmonary diseases	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Lung fibrosis	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Pneumonia	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Pulmonary embolism	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing

Cardiac arrhythmias	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Cardiac failure	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Cardiomyopathy	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Coronary artery abnormalities	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Myocarditis/pericarditis/ pericardial effusion	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)

Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Myositis	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Shock	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Arthritis	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Physical disability/muscular weakness	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing

Acute kidney injury	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Acute liver dysfunction	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
End stage renal disease (ESRD)	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Bleeding events	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Deep vein thrombosis	◯ Yes ◯ No ◯ Unknown
If there is a venous thrombosis, where is it located? (Tier 2)	◯ Intracranial ◯ Extracranial ◯ Both ◯ Unknown or not reported

Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Appendicitis	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Gastroesophageal reflux disease (GERD)	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Gastrointestinal hemorrhage	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Gastrointestinal perforation	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)

	◯ Ongoing
Peritonitis	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Bacteremia	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Pulmonary aspergillosis	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Toxic shock syndrome (TSS)	◯ Yes ◯ No ◯ Unknown
Date of Onset/Diagnosis (Tier 2)	_____ (MM/DD/YYYY)
Date of Resolution (Tier 2)	_____ (MM/DD/YYYY)
	◯ Ongoing
Other (specify)	◯ Yes ◯ No ◯ Unknown
Specify other	_____

Date of Onset/Diagnosis (Tier 2)

_____
(MM/DD/YYYY)

Date of Resolution (Tier 2)

_____
(MM/DD/YYYY)

◯ Ongoing

Manifestations: Laboratory

Labs at Diagnosis (work up of condition)

Additional Guidance: The Tier 1 lab values include, but are not limited to, those parameters necessary for the diagnosis of MIS-C (including markers of inflammation) and other conditions associated with acute and long COVID/PASC. Inclusion in Tier 1 does not suggest that all of these labs are recommended to be performed in all pediatric patients/studies, but rather that the test values or Not Done should be reported when performed.

Similar to vital signs, the Working Group is not currently recommending frequency for documentation of specific clinical labs. Study sites are encouraged to provide any lab data that are collected for routine monitoring of participants in addition to the value at diagnosis (i.e., work up of condition), which will vary between outpatient and inpatient settings. However, the reference time period for labs should be a 24-hour clock from midnight to midnight (00:00-23:59) to allow for consistency across studies.

Lab tests performed? ◯ Yes ◯ No ◯ Unknown

Date of Lab Sample Collection

_____ (MM/DD/YYYY)

Time of lab sample collection

_____ (HHMM)

Date of Lab Sample Collection

_____ (MM/DD/YYYY)

Time of lab sample collection

_____ (HHMM)

Date of Lab Sample Collection

_____ (MM/DD/YYYY)

Time of lab sample collection

_____ (HHMM)

Date of Lab Sample Collection

_____ (MM/DD/YYYY)

Time of lab sample collection

_____ (HHMM)

Date of Lab Sample Collection

_____ (MM/DD/YYYY)

Time of lab sample collection

_____ (HHMM)

Date of Lab Sample Collection

_____ (MM/DD/YYYY)

Time of lab sample collection

_____ (HHMM)

For each of the below, report test value at diagnosis (i.e., work up of condition) or trial entry with units or "Not Done"

Any lab tests performed? (Tier 1)

	Yes	No	Unknown	Not Performed
White blood cell count (WBC)	○	○	○	○

Result

_____ ([unit type])

	Yes	No	Unknown	Not Performed
Absolute lymphocyte count (ALC)	○	○	○	○

Result

_____

	Yes	No	Unknown	Not Performed
Absolute neutrophil count (ANC)	○	○	○	○

Result

_____

	Yes	No	Unknown	Not Performed
Platelets	○	○	○	○

Result

_____

	Yes	No	Unknown	Not Performed
C-reactive protein (CRP)	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Erythrocyte sedimentation rate (ESR)	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Procalcitonin	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Ferritin	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
LDH	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Albumin	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Glucose	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Sodium	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Creatinine	○	○	○	○
Result		_____		
Blood urea nitrogen (BUN)	○	○	○	○
Result		_____		
Aspartate aminotransferase (AST)	○	○	○	○
Result		_____		
Alanine transaminase (ALT)	○	○	○	○
Result		_____		
D-dimer	○	○	○	○
Result		_____		
Fibrinogen	○	○	○	○
Result		_____		
Troponin (TNI)	○	○	○	○
Result		_____		
BNP/NT-Pro-BNP	○	○	○	○
Result		_____		
Lactate	○	○	○	○
Result		_____		

Tier 2 Labs

	Yes	No	Unknown	Not Performed
Absolute eosinophil count	○	○	○	○
Result		_____		
Absolute monocyte count	○	○	○	○
Result		_____		
Absolute basophil count	○	○	○	○
Result		_____		
Hemoglobin	○	○	○	○
Result		_____		
Total bilirubin	○	○	○	○
Result		_____		
Prothrombin time (PT)	○	○	○	○
Result		_____		
International normalized ratio (INR)	○	○	○	○
Result		_____		
Activated partial thromboplastin time (aPTT)	○	○	○	○
Result		_____		

	Yes	No	Unknown	Not Performed
IL-6	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Complement	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Hemoglobin A1C	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
pH	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
pCO2	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
paCO2	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Calcium	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Cerebrospinal fluid (CSF) WBC	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
CSF red blood cell count (RBC)	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
CSF Protein	◯	◯	◯	◯

Result

_____

	Yes	No	Unknown	Not Performed
CSF Glucose	◯	◯	◯	◯

Result

_____

	Yes	No	Unknown	Not Performed
Other, Specify	◯	◯	◯	◯

Specify other

_____

Result

_____

Most Abnormal Labs (Tier 2)

Any labs repeated during admission that were more abnormal than initial values? ◯ Yes ◯ No ◯ Unknown

	Yes	No	Unknown	Not Performed
White blood cell count (WBC)	◯	◯	◯	◯

Result

_____

	Yes	No	Unknown	Not Performed
Absolute lymphocyte count (ALC)	◯	◯	◯	◯

Result

_____

	Yes	No	Unknown	Not Performed
Absolute neutrophil count (ANC)	◯	◯	◯	◯

Result

_____

	Yes	No	Unknown	Not Performed
Platelets	◯	◯	◯	◯

Result

_____

	Yes	No	Unknown	Not Performed
C-reactive protein (CRP)	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Erythrocyte sedimentation rate (ESR)	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Procalcitonin	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Ferritin	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
LDH	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Albumin	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Glucose	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Sodium	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Creatinine	○	○	○	○
Result		_____		
Blood urea nitrogen (BUN)	○	○	○	○
Result		_____		
Aspartate aminotransferase (AST)	○	○	○	○
Result		_____		
Alanine transaminase (ALT)	○	○	○	○
Result		_____		
D-dimer	○	○	○	○
Result		_____		
Fibrinogen	○	○	○	○
Result		_____		
Troponin (TNI)	○	○	○	○
Result		_____		
BNP/NT-Pro-BNP	○	○	○	○
Result		_____		
Lactate	○	○	○	○
Result		_____		

Tier 2

	Yes	No	Unknown	Not Performed
Absolute eosinophil count	○	○	○	○
Result		_____		
Absolute monocyte count	○	○	○	○
Result		_____		
Absolute basophil count	○	○	○	○
Result		_____		
Hemoglobin	○	○	○	○
Result		_____		
Total bilirubin	○	○	○	○
Result		_____		
Prothrombin time (PT)	○	○	○	○
Result		_____		
International normalized ratio (INR)	○	○	○	○
Result		_____		
Activated partial thromboplastin time (aPTT)	○	○	○	○
Result		_____		

	Yes	No	Unknown	Not Performed
IL-6	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Complement	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Hemoglobin A1C	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
pH	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
pCO2	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
paCO2	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Calcium	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
Cerebrospinal fluid (CSF) WBC	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
CSF red blood cell count (RBC)	○	○	○	○

Result _____

	Yes	No	Unknown	Not Performed
CSF Protein	◯	◯	◯	◯

Result

_____

	Yes	No	Unknown	Not Performed
CSF Glucose	◯	◯	◯	◯

Result

_____

	Yes	No	Unknown	Not Performed
Other, Specify	◯	◯	◯	◯

Specify other

_____

Result

_____

Other Viral/Bacterial/Fungal Test Positive (Tier 2)

Any other viral testing positive? ◯ Yes ◯ No

List other viral tests that were positive

Specify other positive viral test

_____

Specify other positive viral test

_____

Specify other positive viral test

_____

Specify other positive viral test

_____

Specify other positive viral test

_____

Specify other positive viral test

_____

Blood Cultures

Positive blood cultures?	◯ Yes ◯ No
Organism	_____
Date	_____ (MM/DD/YYYY)
Organism	_____
Date	_____ (MM/DD/YYYY)
Organism	_____
Date	_____ (MM/DD/YYYY)
Organism	_____
Date	_____ (MM/DD/YYYY)
Organism	_____
Date	_____ (MM/DD/YYYY)
Organism	_____
Date	_____ (MM/DD/YYYY)

Manifestations: Cardiopulmonary Diagnostic Assessments

Additional Guidance: Similar to vital signs and clinical labs, the Working Group is not currently recommending frequency for documentation of specific cardiopulmonary assessments. Study sites are encouraged to provide any cardiopulmonary assessment data that are collected for monitoring of participants, in addition to the data reporting abnormality.

Cardiovascular Diagnostic Assessment Abnormalities

Did the patient have any cardiovascular diagnostic assessments performed (beyond physical exam) ? ◯ Yes ◯ No ◯ Unknown

	Yes - abnormalities detected	Yes normal	No - not performed	Unknown
ECG (Tier 2)	◯	◯	◯	◯

Cardiovascular Diagnostic Assessment Date _____

Was there
◯ Abnormal function
◯ Pericardial effusion
◯ Coronary artery abnormalities

	Yes - abnormalities detected	Yes normal	No - not performed	Unknown
ECHO (Tier 2)	◯	◯	◯	◯

Cardiovascular Diagnostic Assessment Date _____

Was there
◯ Abnormal function
◯ Pericardial effusion
◯ Coronary artery abnormalities

	Yes - abnormalities detected	Yes normal	No - not performed	Unknown
Cardiac MRI (Tier 2)	◯	◯	◯	◯

Cardiovascular Diagnostic Assessment Date _____

Was there
◯ Abnormal function
◯ Pericardial effusion
◯ Coronary artery abnormalities

	Yes - abnormalities detected	Yes normal	No - not performed	Unknown
Other test	◯	◯	◯	◯

Specify test

_____

Cardiovascular Diagnostic Assessment Date

_____

Was there

◯ Abnormal function
◯ Pericardial effusion
◯ Coronary artery abnormalities

Pulmonary Diagnostic Assessment Abnormalities

Did the patient have any pulmonary diagnostic testing (beyond physical exam and radiographic imaging)

◯ Yes
◯ No
◯ Unknown

Additional Guidance: Please note that while the 6-Minute Walk Test (6-MWT) is currently grouped with the Pulmonary Diagnostic Assessments, it is also used as a Cardiovascular Diagnostic Assessment.
Please refer to the footnote for 6-MWT assessment in MIS-C patients.

	Yes - abnormalities detected	Yes normal	No - not performed	Unknown
6-Minute Walk Test (Tier 2) [only ages 6+]	◯	◯	◯	◯

Pulmonary Diagnostic Assessment Date

_____ (MM/DD/YYYY)

	Yes - abnormalities detected	Yes normal	No - not performed	Unknown
Pulmonary Function Test (Tier 2) [only ages 6+]	◯	◯	◯	◯

Pulmonary Diagnostic Assessment Date

_____ (MM/DD/YYYY)

	Yes - abnormalities detected	Yes normal	No - not performed	Unknown
Co-oximetry (Tier 2)	◯	◯	◯	◯

Pulmonary Diagnostic Assessment Date

_____ (MM/DD/YYYY)

	Yes - abnormalities detected	Yes normal	No - not performed	Unknown
2-Minute Walk Test (Tier 2)	○	○	○	○

Pulmonary Diagnostic Assessment Date

_____
(MM/DD/YYYY)

	Yes - abnormalities detected	Yes normal	No - not performed	Unknown
Other tests (specify test) performed (Tier 2)	○	○	○	○

Specify other

_____

Pulmonary Diagnostic Assessment Date

_____
(MM/DD/YYYY)

Manifestations: Imaging

Radiographic Imaging Abnormalities

Additional Guidance: Similar to vital signs and clinical labs, the Working Group is not currently recommending frequency for documentation of specific radiographic imaging. Study sites are encouraged to provide any radiographic imaging data that are collected for monitoring of participants, in addition to the data reporting abnormality.

	Yes - abnormalities detected	Yes normal	No - not performed	Unknown
Did the patient have a chest x-ray performed?	◯	◯	◯	◯

Date of Chest X-Ray

_____ (MM/DD/YYYY)

Time of Chest X-Ray

_____ (MM/DD/YYYY)

Tier 2

Did the patient have any other radiographic imaging performed? ◯ Yes ◯ No ◯ Unknown

	Yes - abnormalities detected	Yes - normal	No - not performed	Unknown
CT Brain	◯	◯	◯	◯

Date of CT Brain

_____ (MM/DD/YYYY)

	Yes - abnormalities detected	Yes - normal	No - not performed	Unknown
CT Chest	◯	◯	◯	◯

Date of CT Chest

_____ (MM/DD/YYYY)

	Yes - abnormalities detected	Yes - normal	No - not performed	Unknown
CT Abdomen	○	○	○	○

Date of CT Abdomen

_____
(MM/DD/YYYY)

	Yes - abnormalities detected	Yes - normal	No - not performed	Unknown
Lung Ultrasound	○	○	○	○

Date of Lung Ultrasound

_____
(MM/DD/YYYY)

	Yes - abnormalities detected	Yes - normal	No - not performed	Unknown
Vascular Ultrasound	○	○	○	○

Date of Vascular Ultrasound

_____
(MM/DD/YYYY)

	Yes - abnormalities detected	Yes - normal	No - not performed	Unknown
Abdominal Ultrasound	○	○	○	○

Date of Abdominal Ultrasound

_____
(MM/DD/YYYY)

	Yes - abnormalities detected	Yes - normal	No - not performed	Unknown
Neonatal Ultrasound Brain (Only performed on infants with open anterior fontanelle)	○	○	○	○

Date of Neonatal Ultrasound (brain)

_____
(MM/DD/YYYY)

	Yes - abnormalities detected	Yes - normal	No - not performed	Unknown
MRI Brain	○	○	○	○

Date of MRI Brain

_____
(MM/DD/YYYY)

	Yes - abnormalities detected	Yes - normal	No - not performed	Unknown
MRI Spine	○	○	○	○

Date of MRI Spine

_____
(MM/DD/YYYY)

	Yes - abnormalities detected	Yes - normal	No - not performed	Unknown
MRI Abdomen	○	○	○	○

Date of MRI Abdomen

_____
(MM/DD/YYYY)

	Yes - abnormalities detected	Yes - normal	No - not performed	Unknown
Other radiographic imaging (specify test) performed	○	○	○	○

1. Specify test

_____

1. Date of Other Radiographic Imaging (Tier 2)

_____
(MM/DD/YYYY)

2. Specify test 2

_____

2. Date of Other Radiographic Imaging (Tier 2)

_____
(MM/DD/YYYY)

3. Specify test 3

_____

3. Date of Other Radiographic Imaging (Tier 2)

_____
(MM/DD/YYYY)

Diagnosis

SARS-CoV-2 Tested

Has the participant been tested for SARS-CoV-2?

◯ Tested
◯ Not Tested
◯ Unknown

What was the result?

◯ Positive
◯ Negative
◯ Unknown

What tests were performed?

Molecular amplification test (RT PCR, NAAT) - SARS-CoV-2 RNA level Quantitative ◯ Yes ◯ No ◯ Unknown

	Detected	Not Detected	Not detected in pooled specimen	Inconclusive	N/A or Not reported	Unknown
Result	◯	◯	◯	◯	◯	◯

Date of test _____

Molecular amplification test (RT PCR, NAAT) - SARS-CoV-2 RNA detection Qualitative ◯ Yes ◯ No ◯ Unknown

	Detected	Not Detected	Not detected in pooled specimen	Inconclusive	N/A or Not reported	Unknown
Result	◯	◯	◯	◯	◯	◯

Date of test _____

SARS-CoV-2 Antigen - SARS-CoV-2 Rapid Antigen ◯ Yes ◯ No ◯ Unknown

	Detected	Not Detected	Not detected in pooled specimen	Inconclusive	N/A or Not reported	Unknown

Result	◯	◯	◯	◯	◯	◯

Date of test _____

Serology - SARS CoV-2 IgM ◯ Yes ◯ No ◯ Unknown

	Detected	Not Detected	Not detected in pooled specimen	Inconclusive	N/A or Not reported	Unknown
Result	◯	◯	◯	◯	◯	◯

Date of test _____

Serology - SARS CoV-2 IgG or Neutralizing Antibody/Serologic ◯ Yes ◯ No ◯ Unknown

if yes, what is the antibody to?
◯ Spike protein antibody
◯ Nucleocapsid antibody

	Detected	Not Detected	Not detected in pooled specimen	Inconclusive	N/A or Not reported	Unknown
Result	◯	◯	◯	◯	◯	◯

Date of test _____

Other ◯ Yes ◯ No ◯ Unknown

Specify other test performed _____

	Detected	Not Detected	Not detected in pooled specimen	Inconclusive	N/A or Not reported	Unknown
Result	◯	◯	◯	◯	◯	◯

Date of test _____

Sample Type Collected (Tier 2)	☐ Nasal ☐ Nasopharyngeal ☐ Saliva ☐ Endotracheal aspirate ☐ Bronchoalveolar lavage (BAL) fluid ☐ Blood ☐ Stool ☐ Cord Blood ☐ Unknown

Treatment

Highest level of care received during the COVID-19 episode?

◯ Admitted to the intensive care unit (ICU)
◯ Admitted to the hospital
◯ Emergency Department assessment
◯ Outpatient (in-person and telemedicine)
◯ Self-care alone/over-the-counter medications
◯ Unknown

Date of current or any previous hospital admission for COVID-19 _____

Date of discharge _____

Were any of the following conditions listed as a discharge diagnosis for this COVID-19 related admission?

☐ Acute COVID
☐ MIS-C
☐ Kawasaki Disease
☐ Long COVID/Post-Acute Sequaelae of COVID (PASC)
☐ None of the above

Date of current or any previous ICU Admission _____

Date of ICU Discharge _____

Medications of Interest (Acute COVID/MIS-C/Long COVID (PASC) Directed)

What medications did the patient take or receive to treat Acute COVID-19/MIS-C/Long COVID (PASC)

	Yes	No	Unknown	Not Reported
Anti-coagulant - Heparin	◯	◯	◯	◯

Date Medication Started _____ (MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped _____ (MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Anti-coagulant - Enoxaparin	◯	◯	◯	◯

Date Medication Started _____ (MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Anti-coagulant - Warfarin	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Anti-coagulant - Direct oral anticoagulant (DOAC)	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Anti-coagulant - Antiplatelets/Aspirin therapy	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Systemic antibiotic	◯	◯	◯	◯

Specify Antibiotic

_____

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Immune modulators/Immunosuppresants - Anakinra	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Immune modulators/Immunosuppresants - Tocilizumab	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Immune modulators/Immunosuppresants - Convalescent plasma	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Immune modulators/Immunosuppresants - SARS-CoV-2 monoclonal antibodies	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Immune modulators/Immunosuppresants - Intravenous immunoglobulins (IVIG)	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Immune modulators/Immunosuppresants - Interferon	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported

Immune modulators/Immunosuppresants - Tumor necrosis factor (TNF) inhibitors (i.e. infliximab, etanercept, adalimumab)	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Immune modulators/Immunosuppresants - NSAID-Ibuprofen	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Anti-viral/Anti-COVID - Remdesivir	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Anti-viral/Anti-COVID - Ribavirin	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Diabetic Medications - Insulin	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Inhaled Medications - Inhaled steroids	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Inhaled Medications - Albuterol	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Inhaled Medications - Ipratropium	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Systemic Steriods - Dexamethasone	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Systemic Steriods - Methylprednisolone	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Systemic Steriods - Prednisone/Prednisolone	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Systemic Steriods - Hydrocortisone	◯	◯	◯	◯

Date Medication Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____ (MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Systemic Steriods - Fludrocortisone	◯	◯	◯	◯

Date Medication Started

_____ (MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____ (MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Other medications	◯	◯	◯	◯

Specify other

_____

Date Medication Started

_____ (MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Medication Stopped

_____ (MM/DD/YYYY)

Timing of medications, particularly immune modulators/immunosuppressants, may be important for assessing other relevant data elements, such as lab values. Therefore, as appropriate, the Working Group recommends documenting the time as well as the date when these specific medications are administered.

Intensive Intervention (Treatment/Device)

	Yes	No	Unknown	Not Reported
Invasive mechanical ventilation (e.g., endotracheal intubation, mechanical ventilation via tracheostomy)	◯	◯	◯	◯

Date Invasive Treatment Started

_____ (MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Invasive Treatment Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
New tracheostomy	◯	◯	◯	◯

Date Invasive Treatment Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Invasive Treatment Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Noninvasive mechanical ventilation (e.g., CPAP, BiPAP, NIPPV)	◯	◯	◯	◯

Date Invasive Treatment Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Invasive Treatment Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Extracorporeal membrane oxygenation (ECMO)	◯	◯	◯	◯

Date Invasive Treatment Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Invasive Treatment Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Vasoactive medications	◯	◯	◯	◯

Date Invasive Treatment Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Invasive Treatment Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Arterial catheter placement	◯	◯	◯	◯

Date Invasive Treatment Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Invasive Treatment Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Cardiopulmonary resuscitation with/without return of spontaneous circulation	◯	◯	◯	◯

Date Invasive Treatment Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Invasive Treatment Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Central venous catheter placement	◯	◯	◯	◯

Date Invasive Treatment Started

_____
(MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Invasive Treatment Stopped

_____
(MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Low flow oxygen therapy (e.g. nasal cannula, simple mask, face tent)	◯	◯	◯	◯

Date Invasive Treatment Started

_____
(MM/DD/YYYY)

Ongoing?	◯ Yes ◯ No
Date Invasive Treatment Stopped	_____ (MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
High flow oxygen therapy	◯	◯	◯	◯

Date Invasive Treatment Started	_____ (MM/DD/YYYY)
Ongoing?	◯ Yes ◯ No
Date Invasive Treatment Stopped	_____ (MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Invasive management of thrombosis (e.g., surgical thrombectomy, endovascular thrombectomy, catheter-directed thrombolysis)	◯	◯	◯	◯

Date Invasive Treatment Started	_____ (MM/DD/YYYY)
Ongoing?	◯ Yes ◯ No
Date Invasive Treatment Stopped	_____ (MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Renal replacement therapy (RRT)	◯	◯	◯	◯

Date Invasive Treatment Started	_____ (MM/DD/YYYY)
Ongoing?	◯ Yes ◯ No
Date Invasive Treatment Stopped	_____ (MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Pacemaker placement	◯	◯	◯	◯

Date Invasive Treatment Started

_____ (MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Invasive Treatment Stopped

_____ (MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Left ventricular assist device (LVAD)	◯	◯	◯	◯

Date Invasive Treatment Started

_____ (MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Invasive Treatment Stopped

_____ (MM/DD/YYYY)

	Yes	No	Unknown	Not Reported
Other intensive intervention	◯	◯	◯	◯

Specify other

_____

Date Invasive Treatment Started

_____ (MM/DD/YYYY)

Ongoing? ◯ Yes ◯ No

Date Invasive Treatment Stopped

_____ (MM/DD/YYYY)

Do Not Resuscitate/Limitation of Support

Was there a "Do Not Resuscitate" order or any other limitation of support? ◯ Yes ◯ No ◯ Unknown

Outcomes

Patient Survival	
Did the patient die?	◯ Yes ◯ No ◯ Unknown
Was the death COVID-19 related (including MIS-C)?	◯ Yes ◯ No ◯ Unknown ◯ N/A or not reported
Date of Death	_____
If hospitalized for suspected or diagnosed COVID-19 and survived, to where was the participant discharged?	◯ Home ◯ Rehabilitation Facility/Nursing Facility ◯ Other ◯ Unknown ◯ N/A or not reported
Specify other	_____
What was the COVID-19 severity at time of maximum severity of illness?	◯ Asymptomatic/presymptomatic infection ◯ Mild illness ◯ Moderate illness ◯ Severe illness ◯ Critical illness ◯ Unknown ◯ N/A or not reported

NIH Severity Definitions:

- Asymptomatic or Presymptomatic Infection: Individuals who test positive for SARS-CoV-2 using a virologic test (i.e., a nucleic acid amplification test [NAAT] or an antigen test) but who have no symptoms that are consistent with COVID-19.

- Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhea, loss of taste and smell) but who do not have shortness of breath, dyspnea, or abnormal chest imaging.

- Moderate Illness: Individuals who show evidence of lower respiratory disease during clinical assessment or imaging and who have an oxygen saturation (SpO2) ?94% on room air at sea level.

- Severe Illness: Individuals who have SpO2 < 94% on room air at sea level, a ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) < 300 mm Hg, or lung infiltrates >50%.

- Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

- In pediatric patients, radiographic abnormalities are common and, for the most part, should not be the only criteria used to determine the severity of illness. The normal values for respiratory rate also vary with age in children; thus, hypoxia should be the primary criterion used to define severe COVID-19, especially in younger children.

Psychosocial Recommended Measures

The following document includes the Psychosocial Pediatric Working Group's recommended instruments for collecting information on the Group's Tier 1 and Tier 2 recommended data elements, organized by Domain.

Document Notes:

- Navigation: You may use the Navigation Pane to efficiently navigate the document. To do so, click "View" on the top of the Word doc and check the box labeled "Navigation Pane" under "Show."

- Endnotes: References are marked by endnotes; you may hover over or click on the endnote to display the reference, and modifications to the source if applicable.

- Tiers: Tier 1 elements are marked in Blue, Tier 2 elements are marked in Green

Common Data Elements (CDE) User Guidance:

Unless specified as "Parent Self-Report", questions refer to the child study participant. Studies should choose between you/your child depending on if they are collecting information via child or parent/caregiver report. When information appears in brackets (such as [you/your child]), please choose the option relevant to the questionnaire.

"Parent Self-Report" - refers to parents answering about themselves.

"Parent Report About Child" - refers to parent answering about their child. Please note, sometimes the verbiage "this child" or "the child" is used rather than " your child" to maintain consistency with the language in the original measure.

"Child Self-Report" - refers to children answering about themselves.

Child Self-Report measures are recommended for specific age groups based on the following:

Validated: Recommendation is based on validation data, for example, PROMIS®, NIH Toolbox®, PhenX protocols validated in specified age ranges.

Used in COVID-19 Questionnaires: Recommendation is based on use of the items in pediatric cohort studies, for example, the Adolescent Brain Cognitive Development Study SM (ABCD Study®), Adolescent Behaviors and Experiences Survey (ABES), Environmental influences on Child Health Outcomes (ECHO) COVID-19 Questionnaires.

Modified*: For measures modified from adult questionnaires, this Working Group recommends implementing a 13+ age range. The Working Group has justified this approach using the Report of the ISPOR PRO good research practices for the assessment of children and adolescents task force; comparing the measures to existing measures asked of adolescents; and modifying questions to verify that the subject matter was appropriate for adolescents.

These "modified" age groups will have an asterisk next to them to mark that they are NOT yet validated or specifically used in pediatric populations, but the Working Group has found the recommendation reasonable.

Investigators may choose to consistently add " Prefer not to answer" or " Don't know" response choices to these questions. The Working Group has kept the question responses from the original source and has not added these answer choices uniformly. Participants have the right to refuse or skip any item.

The superscript "t" indicates that the element is " COVID-19 specific" (either a change from before the pandemic or language specific to the pandemic).
Unless specified, the units for specified age groups are in years.

Social Determinants of Health

Highest Education Level/Degree (Parent)

Parent Self-Report

What is the highest grade or level of school you have completed or the highest degree you have received?

- ◯ 8th grade or less
- ◯ 9th to 12th grade; no diploma
- ◯ High school graduate or GED completed
- ◯ Completed a vocational, trade, or business school program
- ◯ Some college credit, but no degree
- ◯ Associate Degree (AA, AS)
- ◯ Bachelor's Degree (BA, BS, AB)
- ◯ Master's Degree (MA, MS, MSW, MBA)
- ◯ Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)
- ◯ Prefer not to answer
- ◯ Don't know

Does this child have another parent or adult caregiver who lives in this household?

◯ Yes ◯ No

What is the highest grade or level of school this caregiver has completed?

- ◯ 8th grade or less
- ◯ 9th to 12th grade; no diploma
- ◯ High school graduate or GED completed
- ◯ Completed a vocational, trade, or business school program
- ◯ Some college credit, but no degree
- ◯ Associate Degree (AA, AS)
- ◯ Bachelor's Degree (BA, BS, AB)
- ◯ Master's Degree (MA, MS, MSW, MBA)
- ◯ Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)
- ◯ Prefer not to answer
- ◯ Don't know

English Proficiency (Parent)

Parent Self-Report

Do you speak a language other than English at home?

◯ Yes ◯ No ◯ Prefer not to answer

Since you speak a language other than English at home, we are interested in your own opinion of how well you speak English.

Would you say you speak English...

- ◯ Very well
- ◯ Well
- ◯ Not well
- ◯ Not at all

Number of Household Members

Parent Self-Report or Child Self-Report (Ages 13+)*

How many people live in your household now?

_____
(Please enter a number)

Please indicate the number of adults living in your household

_____
(Please enter a number)

Please indicate the number of children (< 18 years old) living in your household

_____
(Please enter a number)

Employment Status (Parent)

Parent Self-Report

What is your current employment situation?

◯ Employed full-time
◯ Employed part-time
◯ Working without pay
◯ Not employed, but looking for work
◯ Not employed and not looking for work
◯ Retired
◯ Disabled, permanently or temporarily
◯ Student
◯ Other
◯ Don't know

Specify other

_____

Does this child have another parent or adult caregiver who lives in this household?

◯ Yes ◯ No

Which of the following best describes this caregiver's current employment status?

◯ Employed full-time
◯ Employed part-time
◯ Working without pay
◯ Not employed, but looking for work
◯ Not employed and not looking for work
◯ Retired
◯ Disabled, permanently or temporarily
◯ Student
◯ Other
◯ Don't know

Specify other

_____

Employment Risk for COVID-19 "Frontline Status" (Family) (Tier 2)

Parent Self-Report

Are you or is anyone in your household employed in healthcare and have direct patient contact?	◯ Yes ◯ No ◯ Unknown
Are you or is anyone in your household a frontline or essential worker other than in healthcare (such as employed at a grocery store or factory)?	◯ Yes ◯ No ◯ Unknown

COVID 19 Effect on Work (Tier 2)

Have you, or has anyone in your household, experienced a loss of employment income since the start of the COVID-19 pandemic (since March 2020)?	◯ Yes ◯ No

Changes in Employment Situation

Which of the following changes in employment have occurred due to the COVID-19 pandemic?

Self Partner
(1) Move to remote work, telework _____ _____
(2) Loss of hours _____ _____
(3) Decreased pay _____ _____
(4) Furloughed _____ _____
(5) Loss of job _____ _____
(6) Decreased job security _____ _____
(7) Disruptions due to childcare challenges _____ _____
(8) Increased hours _____ _____
(9) Another change (specify) _____ _____

Financial Strain (Family) (Tier 2)

Parent Self-Report

How difficult is/was it to meet each of the following needs for you and/or your family during the COVID-19 pandemic (since March 2020)?

	Not Difficult	Somewhat Difficult	Very Difficult
Have enough money for food	◯	◯	◯
Have enough money to pay for electricity or heating or water	◯	◯	◯
Have enough money to pay for housing	◯	◯	◯
Get help from community organizations that I trust	◯	◯	◯
Get help from family members and friends	◯	◯	◯

See a healthcare provider if you or your family needs it	◯	◯	◯
Get routine / essential medications	◯	◯	◯
Get transportation when I need it	◯	◯	◯
Use the internet for things like work, school, medical visits, socializing	◯	◯	◯

Thinking about the future, over the next 3 months, because of coronavirus, how challenging will it be to make ends meet?

◯ A lot more challenging than usual
◯ A little more challenging than usual
◯ No more challenging than usual
◯ Less challenging than usual
◯ Don't know

Housing Instability (Family)

Parent Self-Report

Have any of the following occurred during the COVID-19 pandemic (since March 2020)?

Relocation or moving from where you lived before the pandemic (e.g., downsizing, moving in with family, etc.)	◯ Yes	◯ No
Faced possible eviction since March 2020	◯ Yes	◯ No
Loss of your housing, or becoming homeless since March 2020	◯ Yes	◯ No

Food Insecurity (Family)

Parent Self-Report

The following are several statements that people have made about their food situation. Please tell me whether the statement was "often", "sometimes", or "never" true for you and for other members of your household in the last 12 months, since [date 12 months ago]

	Often true	Sometimes true	Never true	Don't know
1. The food that we bought just didn't last, and we didn't have money to get more.	◯	◯	◯	◯
2. We couldn't afford to eat balanced meals.	◯	◯	◯	◯

3. In the last 12 months, since (date 12 months ago) did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?

◯ Yes ◯ No ◯ Don't know

Optional Screener: If any of the first 3 questions are answered affirmatively (i.e., if either Q1 or Q2 are "often true" or "sometimes true" or Q3 is "yes"), proceed to the next question. Otherwise, skip to question 5.

3a. How often did this happen - almost every month, some months but not every month, or in only 1 or 2 months?

◯ Almost every month
◯ Some months but not every month
◯ Only 1 or 2 months
◯ Don't know

4. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money to buy food?

◯ Yes ◯ No ◯ Don't know

5. In the last 12 months, were you ever hungry but didn't eat because you couldn't afford enough food?

◯ Yes ◯ No ◯ Don't know

6.In the last 12 months, if you didn't have enough to eat or what you wanted to eat, why was that? Choose all that apply.
(select all that apply)

☐ Couldn't get out to buy food (for example, didn't have transportation, or had mobility or health problems that prevented you from getting out)
☐ Didn't want to go out to buy food
☐ Afraid to go out because of the chance of contracting COVID-19
☐ Couldn't get groceries or meals delivered to me
☐ The stores didn't have the food I wanted
☐ Other(specify)
☐ I always had enough to eat and what I wanted to eat

Specify other

_____

Breakfast/Lunch from School (Tier 2)

Parent Report About Child

Did your child get breakfast and/or lunch from the school in the 2019-2020 school year before the COVID-19 pandemic?

◯ Yes ◯ No ◯ Don't Know

If yes, did the school continue to provide breakfast and/or lunch during the COVID-19 pandemic (since March 2020)?

◯ No
◯ Yes, less frequently
◯ Yes, same frequency
◯ Yes, more frequently

Household Income
Parent Self-Report

Thinking about members of your family living in this household, what is your combined annual income, meaning the total pre-tax income from all sources earned in the past year?

- ◯ $0 to $9,999
- ◯ $10,000 to $14,999
- ◯ $15,000 to $19,999
- ◯ $20,000 to $34,999
- ◯ $35,000 to $49,999
- ◯ $50,000 to $74,999
- ◯ $75,000 to $99,999
- ◯ $100,000 to $199,999
- ◯ $200,000 or more
- ◯ Don't Know/Not sure
- ◯ Prefer not to answer

Racial/Ethnic Discrimination
Child Self-Report (Ages 13+)

During your life, how often have you felt that you were treated badly or unfairly because of your race or ethnicity?

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Most of the time

Since the start of the pandemic (since March 2020), have you felt that you were treated badly or unfairly because of your race or ethnicity?

- ◯ Less
- ◯ Same amount
- ◯ More
- ◯ Not applicable (N/A)

Coronavirus Racial/Ethnic Bias (Tier 2)
Child Self-Report (Ages 15+)

Please answer the following questions on your beliefs about how the coronavirus is affecting people of your race/ethnicity

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
I believe the country has become more dangerous for people in my racial/ethnic group because of fear of the coronavirus.	◯	◯	◯	◯
People of my race/ethnicity are more likely to lose their job because of the coronavirus.	◯	◯	◯	◯
I worry about people thinking I have the coronavirus simply because of my race/ethnicity.	◯	◯	◯	◯
Most social and mass media reports about the coronavirus create bias against people of my racial/ethnic group.	◯	◯	◯	◯

People of my race/ethnicity are more likely to get the coronavirus.	○	○	○	○
Due to the coronavirus, I have been cyberbullied because of my race/ethnicity.	○	○	○	○
Since the coronavirus, I have seen a lot more cyberbullying of people of my race/ethnicity.	○	○	○	○
Negative social media posts against people of my race/ethnicity have increased because of the coronavirus.	○	○	○	○

Educational Factors

Grade Level (School-age Child)
Parent Report About Child

What is this child's current grade, grade equivalent, or year of school?

If this child is not assigned a specific grade or is homeschooled, mark the grade level of the curriculum the child receives. If between school years, mark the last grade level attended

◯ Child has not yet started kindergarten
◯ Full-day kindergarten
◯ Partial-day kindergarten
◯ 1st grade
◯ 2nd grade
◯ 3rd grade
◯ 4th grade
◯ 5th grade
◯ 6th grade
◯ 7th grade
◯ 8th grade
◯ 9th grade
◯ 10th grade
◯ 11th grade
◯ 12th grade

Child Self-Report (Ages 12+)

Think about the school you [currently/last] [attend/attended]. What grade [are/were] you in?

◯ 4th grade
◯ 5th grade
◯ 6th grade
◯ 7th grade
◯ 8th grade
◯ 9th grade
◯ 10th grade
◯ 11th grade
◯ 12th grade

Current School Type
Parent Report About Child

Is your child's current school a...

◯ A public school, including charter school or magnet school
◯ A private school, including private religious schools
◯ Bureau of Indian Affairs (BIA) or tribal school
◯ Early Childhood Center (school/center includes preschool and/or early elementary grades)
◯ Special Education school - primarily serves children with disabilities
◯ College, community college, or university
◯ Homeschool, including co-ops
◯ Full-time cyber school

Child Self-Report (Ages 13+)*

Is your current school a...

◯ A public school, including charter school or magnet school
◯ A private school, including private religious schools
◯ Bureau of Indian Affairs (BIA) or tribal school
◯ Early Childhood Center (school/center includes preschool and/or early elementary grades)
◯ Special Education school - primarily serves children with disabilities
◯ College, community college, or university
◯ Homeschool, including co-ops
◯ Full-time cyber school

Note: for the remaining elements in this Domain, the questions are primarily for grades K-12:

Accommodations for Learning Difference

Parent Report About Child

Does your child have an Individualized Education Plan (IEP) or 504 plan?	◯ Yes ◯ No ◯ Don't know
If yes, was your child receiving specialized services or resources on an Individualized Education Plan (IEP) or 504 plan in the 2019-2020 school year before the pandemic?	◯ Yes ◯ No ◯ Don't know
During the pandemic (since March 2020) were the child's services less, the same, or more frequent compared to before the pandemic?	◯ Less ◯ Same ◯ More ◯ N/A

Changes to Schooling During Pandemic

Additional Guidance:

This is a high level element to capture predominant forms of schooling during the different school years spanning the COVID-19 pandemic. For studies that want more detailed assessment of the length of time spent in the different forms of schooling during the COVID-19 pandemic, the Working Group proposes two strategies for investigators to consider:

1) using an event history calendar as a visual guide to obtain more specific month to month information on changes to schooling; from parents, and/or

2) obtaining the school district information on changes to schooling during the pandemic, noting this may only be applicable to students attending public schools (i.e., if the student answers Current School Type with 'A public school, including charter school or magnet school').

Parent Report About Child

From March 2020-June 2020, what was the predominant form of schooling for your child:

◯ Attend school in person ONLY
◯ Attend school remotely ONLY
◯ Attend school via a hybrid model that included in person schooling and remote distance learning
◯ Not attend school because school was cancelled
◯ Not attend school because child dropped out
◯ Not attend school for other reason (please specify)
◯ Not applicable (N/A)

From Sept 2020-June 2021, what was the predominant form of schooling for your child:

◯ Attend school in person ONLY
◯ Attend school remotely ONLY
◯ Attend school via a hybrid model that included in person schooling and remote distance learning
◯ Not attend school because school was cancelled
◯ Not attend school because child dropped out
◯ Not attend school for other reason (please specify)
◯ Not applicable (N/A)

From Sept 2021-present, what was the predominant form of schooling for your child:

◯ Attend school in person ONLY
◯ Attend school remotely ONLY
◯ Attend school via a hybrid model that included in person schooling and remote distance learning
◯ Not attend school because school was cancelled
◯ Not attend school because child dropped out
◯ Not attend school for other reason (please specify)
◯ Not applicable (N/A)

School Attendance/Absence (Tier 2)

Parent Report About Child

Additional Guidance: Parent-reported absenteeism may be unreliable. Studies may alternatively seek to use school district records to calculate absences during each school year.

Since start of the current school year (or past school year if on summer break), about how many days did this child miss school (including missing remote learning)?

◯ No missed school days [skip next question]
◯ 1-3 days
◯ 4-6 days
◯ 7-10 days
◯ 11-15 days
◯ 15 or more days
◯ This child was not enrolled in school [skip next question]
◯ Don't know [skip next question]

If more than 1 day was missed, about how many days did this child miss school (including missing remote learning) because of illness of you or a family member from COVID-19?

◯ No missed school days [skip next question]
◯ 1-3 days
◯ 4-6 days
◯ 7-10 days
◯ 11-15 days
◯ 15 or more days
◯ This child was not enrolled in school
◯ Don't know

Perception of Changes to Schooling (Tier 2)
Parent Report About Child

Using a scale of 1-5, where 1 is not at all true, and 5 is completely true:

How true would you say each of the following statements is for your child's school/college, regarding how your experiences were/are during the COVID-19 pandemic (since March 2020)

	1, Not at all true	2	3	4	5, Completely true
Remote learning is as effective as live/traditional classroom lectures for my child.	○	○	○	○	○
My child can meet his/her educational goals with remote learning.	○	○	○	○	○
My child has sufficient social interaction with peers during remote learning.	○	○	○	○	○
It seems my child experiences a lack of interest during remote learning.	○	○	○	○	○
It seems my child experiences frustration during remote learning.	○	○	○	○	○

School Risk and Protective Factors (Tier 2)
Child Self-Report (Ages 12-18)

Teacher Relationships

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
1. Teachers understand my problems	○	○	○	○	○
2. Teachers and staff seem to take a real interest in my future	○	○	○	○	○
3. Teachers are available when I need to talk with them	○	○	○	○	○
4. It is easy to talk with teachers	○	○	○	○	○
5. Students get along well with teachers	○	○	○	○	○
6. At my school, there is a teacher or some other adult who notices when I'm not there	○	○	○	○	○

7. Teachers at my school help us children with our problems	○	○	○	○	○
8. My teachers care about me	○	○	○	○	○
9. My teacher makes me feel good about myself	○	○	○	○	○

School Connectedness

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
10. My schoolwork is exciting	○	○	○	○	○
11. Students can make suggestions on courses that are offered	○	○	○	○	○
12. Students are publicly recognized for their outstanding performances in speech, drama, art, music, etc.	○	○	○	○	○
13. If this school had an extra period during the day, I would take an additional academic class	○	○	○	○	○
14. This school makes students enthusiastic about learning	○	○	○	○	○
15. Students are frequently rewarded or praised by faculty and staff for following school rules	○	○	○	○	○

Academic Support

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
16. I usually understand my homework assignments	○	○	○	○	○
17. Teachers make it clear what work needs to be done to get the grade I want	○	○	○	○	○
18. I believe that teachers expect all students to learn	○	○	○	○	○
19. I feel that I can do well in this school	○	○	○	○	○
20. My teachers believe that I can do well in my school work	○	○	○	○	○
21. I try hard to succeed in my classes	○	○	○	○	○

Order and Discipline

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
22. Classroom rules are applied equally	○	○	○	○	○
23. Problems in this school are solved by students and staff	○	○	○	○	○
24. Students get in trouble if they do not follow school rules	○	○	○	○	○
25. The rules of the school are fair	○	○	○	○	○
26. School rules are enforced consistently and fairly	○	○	○	○	○
27. My teachers make it clear to me when I have misbehaved in class	○	○	○	○	○
28. Discipline is fair	○	○	○	○	○

(Only answer if in-person schooling)

School Physical Environment

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
29. The school grounds are kept clean	○	○	○	○	○
30. My school is neat and clean	○	○	○	○	○
31. My school buildings are generally pleasant and well maintained	○	○	○	○	○
32. My school is usually clean and tidy	○	○	○	○	○

School Social Environment

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
33. I am happy with the kinds of students who go to my school	○	○	○	○	○
34. I am happy, in general, with the other students who go to my school	○	○	○	○	○

Perceived Exclusion/Privilege

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree

35. At my school, the same person always gets to help the teacher	◯	◯	◯	◯	◯
36. At my school, the same kids get chosen every time to take part in after-school or special activities	◯	◯	◯	◯	◯
37. The same kids always get to use things, like a computer, a ball or a piano, when we play	◯	◯	◯	◯	◯

Academic Satisfaction

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
38. I am happy about the number of tests I have	◯	◯	◯	◯	◯
39. I am happy about the amount of homework I have	◯	◯	◯	◯	◯

Academic Performance/Achievement

Child Self-Report (Ages 10+)/Parent Report About Child

In the months before the pandemic (2019-February 2020) how would you describe your/your child's grades in school?

◯ Below average (D's or F's)
◯ Average (C's)
◯ Good (B's)
◯ Very good (A's and B's)
◯ Excellent (A's)
◯ I/my child was not graded
◯ Refused
◯ Don't know

During the current school year (or most recent school year if on summer break) how would you describe your/your child's grades in school?

◯ Below average (D's or F's)
◯ Average (C's)
◯ Good (B's)
◯ Very good (A's and B's)
◯ Excellent (A's)
◯ I/my child was not graded
◯ Refused
◯ Don't know

Childcare (Tier 2)

Parent Self-Report

How has the COVID-19 outbreak affected your regular childcare/supervision of school aged children (K-12)?
(Mark all that apply)

☐ I had difficulty arranging for childcare/supervision
☐ I had to pay more for childcare/supervision
☐ My co-parent or I no longer needed child care
☐ My co-parent or I had to change our work schedule or quit our job to care for our children
☐ My regular childcare/supervision was not affected by the COVID-19 outbreak
☐ I do not have a school-age child who needed regular supervision

Computer and Internet Access

Parent Report About Child

How often is a computer/laptop or other digital device (e.g., tablet) available to your child for educational purposes to support remote distance learning?

◯ Always available
◯ Usually available
◯ Sometimes available
◯ Rarely available
◯ Never available
◯ N/A

Is/are the computer(s) or other digital device(s) ...?
(Select all that apply)

◯ Provided by the child's school or school district to use outside of school
◯ Provided by someone in the household or family, or it is the child's
◯ Provided by another source
◯ N/A

How often is the Internet available to your child for educational purposes to support remote distance learning?

◯ Always available
◯ Usually available
◯ Sometimes available
◯ Rarely available
◯ Never available
◯ N/A

Are Internet services ...?
(Select all that apply)

☐ Paid for by the children's school or school district
☐ Paid for by someone in the household or family
☐ Paid for by another source
☐ N/A

Community, Family, and Peer Factors

Social Connection/Support

Child Self-Report (Age 13+)

Compared to before the COVID-19 outbreak (before March 2020), do you feel

- ◯ Much less socially connected
- ◯ Less socially connected
- ◯ Slightly less socially connected
- ◯ Slightly more socially connected
- ◯ More socially connected
- ◯ Much more socially connected

Parent Report About Child (Age 8+)

Compared to before the COVID-19 outbreak (before March 2020), does your child seem

- ◯ Much less socially connected
- ◯ Less socially connected
- ◯ Slightly less socially connected
- ◯ Slightly more socially connected
- ◯ More socially connected
- ◯ Much more socially connected

Emotional Support/Social Support (Tier 2)

NIH Toolbox Emotional Support FF Ages 8-17 v2.0

Child Self-Report (Ages 8-17)

In the past month, please describe how often...

	Never	Rarely	Sometimes	Usually	Always
I have someone who understands my problems	◯	◯	◯	◯	◯
I have someone who will listen to me when I need to talk	◯	◯	◯	◯	◯
I have someone to talk with when I have a bad day	◯	◯	◯	◯	◯
There is someone around to help me if I need it	◯	◯	◯	◯	◯
I can get helpful advice from others when dealing with a problem	◯	◯	◯	◯	◯
I get useful advice about important things in my life	◯	◯	◯	◯	◯
I have someone to talk with about school problems	◯	◯	◯	◯	◯

Compared to before the COVID-19 pandemic (before March 2020)...

	Less	The same	More
I have someone who understands my problems	○	○	○
I have someone who will listen to me when I need to talk	○	○	○
I have someone to talk with when I have a bad day	○	○	○
There is someone around to help me if I need it	○	○	○
I can get helpful advice from others when dealing with a problem	○	○	○
I get useful advice about important things in my life	○	○	○
I have someone to talk with about school problems	○	○	○

Peer Relationships (Tier 2)

Parent Report About Child (Ages 1-5)

In the past 7 days...

	Never	Almost never	Sometimes	Often	Almost always
My child shared with other kids	○	○	○	○	○
My child played well with other children	○	○	○	○	○
My child laughed and smiled with other children	○	○	○	○	○
My child showed interest in other children	○	○	○	○	○

Compared to before the COVID-19 pandemic (before March 2020)...

	Less	The same	More
My child shares with other kids	○	○	○
My child plays well with other children	○	○	○
My child laughs and smiles with other children	○	○	○
My child shows interest in other children	○	○	○

Parent Report About Child (Ages 5-17)

In the past 7 days...

	Never	Almost Never	Sometimes	Often	Almost Always
My child felt accepted by other kids his/her age	○	○	○	○	○
My child was able to count on his/her friends	○	○	○	○	○
My child was good at making friends	○	○	○	○	○
My child and his/her friends helped each other out	○	○	○	○	○
Other kids wanted to be my child's friend	○	○	○	○	○
Other kids wanted to be with my child	○	○	○	○	○
Other kids wanted to talk to my child	○	○	○	○	○

Compared to before the COVID-19 pandemic (before March 2020)...

	Less	The same	More
My child feels accepted by other kids his/her age	○	○	○
My child is able to count on his/her friends	○	○	○
My child is good at making friends	○	○	○
My child and his/her friends help each other out	○	○	○
Other kids want to be my child's friend	○	○	○
Other kids want to be with my child	○	○	○
Other kids want to talk to my child	○	○	○

Child Self-Report (Ages 8-17)

PROMIS Pediatric Item Bank v2.0 - Peer Relationships - Short Form 8a

In the past 7 days...

	Never	Almost Never	Sometimes	Often	Almost Always
I felt accepted by other kids my age	○	○	○	○	○

I was able to count on my friends	◯	◯	◯	◯	◯
I was able to talk about everything with my friends	◯	◯	◯	◯	◯
I was good at making friends	◯	◯	◯	◯	◯
My friends and I helped each other out	◯	◯	◯	◯	◯
Other kids wanted to be my friend	◯	◯	◯	◯	◯
Other kids wanted to be with me	◯	◯	◯	◯	◯
Other kids wanted to talk to me	◯	◯	◯	◯	◯

Compared to before the COVID-19 pandemic (before March 2020)...

	Less	The same	More
I felt accepted by other kids my age	◯	◯	◯
I am able to count on my friends	◯	◯	◯
I am able to talk about everything with my friends	◯	◯	◯
I am good at making friends	◯	◯	◯
My friends and I help each other out	◯	◯	◯
Other kids want to be my friend	◯	◯	◯
Other kids want to be with me	◯	◯	◯
Other kids want to talk to me	◯	◯	◯

Family Impact/Household Interpersonal Conflict (Tier 2)

Parent Self-Report

How have/were you and your child(ren) (been) getting along during the COVID-19 outbreak (since March 2020) ?

◯ Very well - no problems or tension
◯ Well - occasional tension, some tension, but manageable
◯ Okay - some tension and sometimes things get out of hand (a few heated arguments)
◯ Not very well - tense, lots of arguing, unsettled feeling, definite problems
◯ Terribly

Is this a change from how you were getting along before the outbreak (before March 2020)? ◯ Yes ◯ No

Child Self-report (Ages 13+)

How [have/were] YOU and your parent(s) (been) getting along during the COVID-19 outbreak (since March 2020)?

◯ Very well - no problems or tension
◯ Well - occasional tension, some tension, but manageable
◯ Okay - some tension and sometimes things get out of hand (a few heated arguments)
◯ Not very well - tense, lots of arguing, unsettled feeling, definite problems
◯ Terribly

Is this a change from how you were getting along before the outbreak (before March 2020)? ◯ Yes ◯ No

If study approval and privacy ensured;

INTERVIEWER: IF CONDUCTING PHONE INTERVIEW, PLEASE SAY THE FOLLOWING:

For the next 3 questions, I am going to ask you about some private matters, so please turn your speakerphone off.

During the COVID-19 outbreak (since March 2020), did things ever get to the point where an adult you were living with got physically violent with a child (for example, shoved, hit, kicked, or shook [her/him/them])?	◯ Yes ◯ No
During the COVID-19 outbreak (since March 2020), was an adult in your household ever physically violent with you (for example, shoved, hit, kicked, or shook you)?	◯ Yes ◯ No
During the COVID-19 outbreak (since March 2020), did things ever get to the point where an adult you were living with got physically violent with someone else (for example, shoved, hit, kicked, or shook someone else)?	◯ Yes ◯ No

Additional Guidance: Guidance for conducting child maltreatment research and reporting varies depending on the scope of the project, study participants, setting of the study (school, hospital, etc.) and state mandatory reporting laws. More information on state statutes can be found at the HHS Childwelfare.gov site:

https://www.childwelfare.gov/pubPDFs/manda.pdf (2019). Researchers should consult with their IRBs to minimize risks to study participants, appropriately consent and adhere to ethical practices and regulatory requirements for including vulnerable children in research: https://www.hhs.gov/ohrp/regulations-and-policy/guidance/special-protections-for-children/index.html. Additional NICHD resources for forensic or
evidence-based interviewing of children include: http://nichdprotocol.com/ , https://youth.gov/content/nichdinvestigative-interview-protocol.

Community Support (Cohesion) (Tier 2)

Paren Self-Report

Now I'm going to read some statements about things that people in your neighborhood may or may not do.
For each of these statements, please tell me whether you strongly agree, agree, neither agree nor disagree, disagree or strongly disagree.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
This is a close-knit neighborhood	◯	◯	◯	◯	◯
People around here are willing to help their neighbors	◯	◯	◯	◯	◯

People in this neighborhood generally don't get along with each other	○	○	○	○	○
People in this neighborhood do not share the same values	○	○	○	○	○
People in this neighborhood can be trusted	○	○	○	○	○

For each of the following, please tell me if it is very likely, likely, neither likely nor unlikely, unlikely, or very unlikely that people in your neighborhood would act in the following manner

	Very likely	Likely	Neither likely nor unlikely	Unlikely	Very unlikely
If a group of neighborhood children were skipping school and hanging out on a street corner, how likely is it that your neighbors would do something about it?	○	○	○	○	○
If some children were spray-painting graffiti on a local building, how likely is it that your neighbors would do something about it?	○	○	○	○	○
If a child was showing disrespect to an adult, how likely is it that people in your neighborhood would scold that child?	○	○	○	○	○
If there was a fight in front of your house and someone was being beaten or threatened, how likely is it that your neighbors would break it up?	○	○	○	○	○
Suppose that because of budget cuts the fire station closest to your home was going to be closed down by the city. How likely is it that neighborhood residents would organize to try to do something to keep the fire station open?	○	○	○	○	○

Social Media/Screen Time

Time Spent in Front of a Screen (Tier 2)

Child Self-Report (Ages 13+)*/Parent Report About Child

ON MOST WEEKDAYS, about how much time did [you/your child] spend in front of a TV, computer, cellphone or other electronic device watching programs, playing games, accessing the Internet or using social media? Do not include time spent doing schoolwork.

◯ Less than 1 hour
◯ 1 hour
◯ 2 hours
◯ 3 hours
◯ 4 or more hours

Compared to before the COVID-19 outbreak (before March 2020), how much are [you/your child] now doing of the following:

Spending time watching TV/videos (such as YouTube), playing video/computer games, or using social media for educational purposes, including schoolwork

◯ Less
◯ Same amount
◯ More

Spending time watching TV/videos (such as YouTube), playing video/computer games, or using social media for non-educational purposes

◯ Less
◯ Same amount
◯ More

Well-being Factors

Well-Being

Child Self-Report (Ages 13+)

	Not at all	Rarely	Sometimes	Often	Very often
Since becoming aware of the COVID-19 outbreak, how often have you felt happy and satisfied with your life	◯	◯	◯	◯	◯

Parent about child (Age 1+)

	Not at all	Rarely	Sometimes	Often	Very often
Since becoming aware of the COVID-19 outbreak, how often has your child seemed happy and satisfied with his/her life?	◯	◯	◯	◯	◯

Well-being (Tier 2)
NIH Toolbox Positive Affect Fixed Form v2.0

Child Self-Report (Ages 8-12)

In the past 7 days,

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I felt attentive	◯	◯	◯	◯	◯
I felt delighted	◯	◯	◯	◯	◯
I felt calm	◯	◯	◯	◯	◯
I felt at ease	◯	◯	◯	◯	◯
I felt enthusiastic	◯	◯	◯	◯	◯
I felt interested	◯	◯	◯	◯	◯
I felt confident	◯	◯	◯	◯	◯
I felt energetic	◯	◯	◯	◯	◯
I felt able to concentrate	◯	◯	◯	◯	◯

Child Self-Report (Ages 13-17)

In the past 7 days,

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I felt cheerful	◯	◯	◯	◯	◯
I felt attentive	◯	◯	◯	◯	◯

I felt delighted	○	○	○	○	○
I felt joyful	○	○	○	○	○
I felt at ease	○	○	○	○	○
I felt enthusiastic	○	○	○	○	○
I felt interested	○	○	○	○	○
I felt peaceful	○	○	○	○	○
I felt good-natured	○	○	○	○	○
I felt content	○	○	○	○	○

Parent Report About Child (Ages 3-12)

In the past 7 days,

	Not at all	A little bit	Somewhat	Quite a bit	Very much
My child was cheerful	○	○	○	○	○
My child was delighted	○	○	○	○	○
My child was inspired	○	○	○	○	○
My child was happy	○	○	○	○	○
My child was alert	○	○	○	○	○
My child was joyful	○	○	○	○	○
My child was enthusiastic	○	○	○	○	○
My child was interested	○	○	○	○	○
My child was confident	○	○	○	○	○

Coping Strategies (Tier 2)
Child Self-Report (Ages 13+)

What have you done to cope with your stress related to the COVID-19 outbreak?
(Mark all that apply)

- ☐ Arts and crafts projects
- ☐ Cooking/baking
- ☐ Drinking alcohol
- ☐ Engaging in more family activities (e.g., games, sports)
- ☐ Exercising/walking
- ☐ Increasing time reading books, or doing activities like puzzles and crosswords
- ☐ Meditation and/or mindfulness practices
- ☐ Spiritual/religious practices
- ☐ Talking to my healthcare providers more frequently, including mental healthcare providers (e.g., therapists, psychologists, counselors)
- ☐ Texting, calling or video-calling family members or friends
- ☐ Using tobacco (e.g., smoking), using marijuana (e.g., smoking, edibles), vaping
- ☐ Volunteer work
- ☐ I have not done any of these things to cope with the COVID-19 outbreak

Parent Report About Child (Ages 8+)

Which of the following strategies [have been/were] helpful to YOUR CHILD while staying at home because of the COVID-19 outbreak?

- ☐ Arts and crafts projects
- ☐ Cooking/baking
- ☐ Engaging in more family activities (e.g., games, sports)
- ☐ Exercising/walking
- ☐ Increasing time reading books, or doing activities like puzzles and crosswords
- ☐ Meditation and/or mindfulness practices
- ☐ Spiritual/religious practices
- ☐ Talking to healthcare providers more frequently, including mental healthcare providers (e.g., therapists, psychologists, counselors)
- ☐ Texting, calling or video-calling family members or friends
- ☐ Volunteer work
- ☐ My child has not done any of these things to cope with the COVID-19 outbreak

Loneliness (Tier 2)

Child Self-Report (Ages 13+)*

Is your life lonelier because of the COVID-19 pandemic? ◯ Yes ◯ No

Covid19 Attitudes Behaviors And Experiences

Household COVID-19 Exposure
Parent Report About Child/Child Self-Report (Ages 13+)

During the COVID-19 outbreak (since March 2020), did [you/your child] ever live with someone that was sick with COVID-19?

◯ Yes
◯ No
◯ Not sure, I think someone [I/my child] lived with might have had COVID-19

If yes or not sure, who was this? (select all that may apply)

☐ [My/Child's] Parent
☐ [My/Child's] Sibling
☐ [My/Child's] Grandparent
☐ [My/Child's] Other family members (e.g., aunt, uncle, cousin)
☐ [My/Child's] Roommate
☐ Other

Specify Other

_____

If yes, did any of them die because of COVID-19? ◯ Yes ◯ No

If yes, who died? (select all that may apply)

☐ [My/Child's] Parent
☐ [My/Child's] Sibling
☐ [My/Child's] Grandparent
☐ [My/Child's] Other family members (e.g., aunt, uncle, cousin)
☐ [My/Child's] Roommate
☐ Other

Specify Other

_____

Ability to Isolate (Tier 2)
Parent Self-Report

If it were necessary, could a member of your household isolate themselves from the rest of your household due to suspected COVID-19 infection for as long as needed?

To effectively isolate during a COVID-19 infection, the infected family member would need to stay in a specific "sick room" away from other people or animals and, if possible, use a separate bathroom.

◯ Yes
◯ No
◯ Unknown

Belief That COVID is Serious Disease (Tier 2)
Parent Self-Report/Child Self-Report (Ages 13+)*

I believe that COVID-19 is a serious disease.

◯ Yes
◯ No
◯ Unsure (or don't know)

Adherence to Social Distancing/Face Coverings (Tier 1)
Parent Self-Report/Child Self-Report (Ages 13+)*

To the best of your knowledge, which of the following can protect you and your family from COVID-19? (Mark all that apply)

☐ Standing 6 feet from another person
☐ Wearing a face mask
☐ Working from home
☐ Distance learning (or taking school classes over the computer or remotely)
☐ Vaccination for COVID-19

Vaccine Attitudes (Tier 2)
Parent Self-Report

Which of the following applies to your plans about the COVID vaccine for your child(ren)?

◯ My child(ren) is/are already vaccinated
◯ I plan on getting the COVID vaccine for my child(ren) as soon as it is available
◯ I plan on getting the COVID vaccine for my child(ren) eventually
◯ I do not plan on getting the COVID vaccine for my child(ren)
◯ I am unsure

If you do not plan on getting the COVID vaccine for your child(ren), why not (mark all that apply)?

☐ Not available
☐ Doctor/healthcare provider did not recommend
☐ My friends and family did not recommend
☐ I have read information that suggests it is unsafe
☐ The vaccine was not well tested in ethnically diverse people
☐ The vaccine was not well tested among children
☐ I cannot afford the vaccine
☐ I do not have time to take my child to be vaccinated
☐ My child is at low risk and does not need it
☐ It is riskier to go and get it than to stay at home
☐ Worried about side effects
☐ The vaccine's technology hasn't been tested enough
☐ The vaccine was approved too fast
☐ No long-term safety data available
☐ Concerned about vaccine storage
☐ My child already had COVID-19
☐ Other (please specify):

Specify other reason

COVID-19 Stress and Worry

Worry/Anxiety About COVID-19 (Tier 2)

Child Self-Report (Ages 9+)

During the COVID-19 pandemic (since March 2020)

	Not at all	Slightly	Moderately	Very	Extremely
How worried have you been about coronavirus (COVID-19)?	○	○	○	○	○
How worried have others around you been about coronavirus (COVID-19)?	○	○	○	○	○
How worried have you been about changes to schooling in the 2020-2021 school year (e.g., missing school in-person)?	○	○	○	○	○
How much do you think your life has changed due to coronavirus (COVID-19)?	○	○	○	○	○
How hopeful have you been that the coronavirus/COVID-19 crisis in your area will end soon?	○	○	○	○	○

In the past week:

	Not at all	Slightly	Moderately	Very	Extremely
How worried have you been about coronavirus (COVID-19)?	○	○	○	○	○
How worried have others around you been about coronavirus (COVID-19)?	○	○	○	○	○
How worried have you been about changes to schooling in the 2020-2021 school year (e.g., missing school in-person)?	○	○	○	○	○
How much do you think your life has changed due to coronavirus (COVID-19)?	○	○	○	○	○
How hopeful have you been that the coronavirus/COVID-19 crisis in your area will end soon?	○	○	○	○	○

Stress Related to COVID-19 (Tier 2)

Child Self-Report (Ages 13+)

During the COVID-19 pandemic (since March 2020), how often did you:

	Not at all	Rarely	Sometimes	Often	Very often
Have difficulty sleeping	◯	◯	◯	◯	◯
Startle easily	◯	◯	◯	◯	◯
Have angry outbursts	◯	◯	◯	◯	◯
Feel a sense of time slowing down	◯	◯	◯	◯	◯
Feel in a daze	◯	◯	◯	◯	◯
Try to avoid thoughts and feelings about COVID-19	◯	◯	◯	◯	◯
Try to avoid reading or watching information about COVID-19	◯	◯	◯	◯	◯
Have distressing dreams about COVID-19	◯	◯	◯	◯	◯
Feel distressed when you saw something that reminded you of COVID-19	◯	◯	◯	◯	◯

Health Related Behaviors

Physical Activity (Tier 2)
Parent Report About Child (Ages 5+)

During the past week, on how many days did this child exercise, play a sport, or participate in physical activity (including physical education classes) for at least 60 minutes?

- ◯ 0 days
- ◯ 1-3 days
- ◯ 4-6 days
- ◯ Every day

How has this changed compared to before the COVID-19 outbreak (before March 2020)?

- ◯ Fewer days
- ◯ Same number of days
- ◯ More days
- ◯ Don't know

Sleep Quality
Child Self-Report (Ages 13+)*

How has your quality of sleep changed compared to before the COVID-19 outbreak (before March 2020)?

- ◯ It's gotten a lot worse
- ◯ It's gotten a little worse
- ◯ Stayed the same
- ◯ It's gotten a little better
- ◯ It's gotten a lot better

Additional Guidance: DSM-5 Cross-Cutting Symptom Measure (below) also covers sleep problems and refers to subsequent PROMIS measures for sleep impairment.

Sleep Duration (Tier 2)
Child Self-Report (Ages 13+)*/Parent Report About Child

Consider the question as pertaining to the last week in your/your child's life.

How many hours of sleep did you/your child get on most nights?

- ◯ More than 11 hours
- ◯ 9-11 hours
- ◯ 8-9 hours
- ◯ 7-8 hours
- ◯ 5-7 hours
- ◯ Less than 5 hours
- ◯ Don't know

How has this changed compared to before the COVID-19 outbreak (before March 2020)?

- ◯ Less time
- ◯ Same time
- ◯ More time
- ◯ Don't know

Baseline Child Health [also covered in Joint Group Discussion section]
Parent Report About Child

Has a doctor or other health care provider EVER told you that this child has...

Tourette Syndrome	◯ Yes ◯ No
if yes, does this child CURRENTLY have the condition?	◯ Yes ◯ No
Depression	◯ Yes ◯ No
if yes, does this child CURRENTLY have the condition?	◯ Yes ◯ No
Anxiety problems	◯ Yes ◯ No
if yes, does this child CURRENTLY have the condition?	◯ Yes ◯ No
Autism or Autism Spectrum Disorder (ASD), Asperger's Disorder, Pervasive Developmental Disorder (PDD)	◯ Yes ◯ No
if yes, does this child CURRENTLY have the condition?	◯ Yes ◯ No
Attention Deficit Disorder or Attention Deficit Hyperactive Disorder (ADD/ADHD)*	◯ Yes ◯ No
if yes, does this child CURRENTLY have the condition?	◯ Yes ◯ No
Chronic fatigue	◯ Yes ◯ No
if yes, does this child CURRENTLY have the condition?	◯ Yes ◯ No
Post-traumatic stress disorder (PTSD)	◯ Yes ◯ No
if yes, does this child CURRENTLY have the condition?	◯ Yes ◯ No
Suicidal thoughts or behaviors	◯ Yes ◯ No
if yes, does this child CURRENTLY have the condition?	◯ Yes ◯ No
Mania or bipolar disorder	◯ Yes ◯ No
if yes, does this child CURRENTLY have the condition?	◯ Yes ◯ No

Has a doctor, other health care provider, or educator EVER told you that this child has...	
Behavioral disorder or conduct problems	◯ Yes ◯ No
if yes, does this child CURRENTLY have the condition?	◯ Yes ◯ No
Developmental delay	◯ Yes ◯ No
if yes, does this child CURRENTLY have the condition?	◯ Yes ◯ No
Intellectual disability (formerly known as mental retardation)	◯ Yes ◯ No
if yes, does this child CURRENTLY have the condition?	◯ Yes ◯ No
Speech or other language disorder	◯ Yes ◯ No
if yes, does this child CURRENTLY have the condition?	◯ Yes ◯ No
Learning disability	◯ Yes ◯ No
if yes, does this child CURRENTLY have the condition?	◯ Yes ◯ No

Mental And Behavioral Health

Overall Physical and Mental/Emotional Health

Note: Collect BOTH Parent-Self Report and either Child-Self Report or Parent Report About Child

Parent Self-Report

	Excellent	Very good	Good	Fair	Poor
In general, how is your physical health?	◯	◯	◯	◯	◯
In general, how is your mental or emotional health?	◯	◯	◯	◯	◯

Parent Report About Child

	Excellent	Very good	Good	Fair	Poor
In general, how is your childs physical health?	◯	◯	◯	◯	◯
In general, how is your childs mental or emotional health?	◯	◯	◯	◯	◯

Child Self-Report (Ages 8+)

	Excellent	Very good	Good	Fair	Poor
In general, how would you rate your physical health?	◯	◯	◯	◯	◯
In general, how would you rate your mental health, including your mood and your ability to think?	◯	◯	◯	◯	◯

Current Mental Health Symptoms

Tier 1: DSM-5 Cross-cutting Symptom Measure, PROMIS Depressive Symptoms, PROMIS Anxiety, PROMIS Fatigue

Tier 2: CRIES-8 Trauma, RCADS, PROMIS Pain Interference, Externalizing Symptoms

Additional Guidance: For younger children (Ages 1-5), the Working Group recommends using the PROMIS Early Childhood parent report measures for Anxiety, Anger/Irritability, Depressive Symptoms, Sleep Health, and Global Health found on HealthMeasures. PROMIS Early Childhood does not yet cover Fatigue or Pain Interference.

Organized below by:
1) Parent Report About Child (all measures except Trauma)
2) Child Self-Report

Parent Report About Child: Current Mental Health Symptoms
Tier 1: DSM-5 Cross-Cutting Symptom Measure (Ages 6-17)

The National Institute of Mental Health (NIMH) in consultation with the Wellcome Trust and other funders of mental health research has identified the DSM-5 Cross-Cutting Symptom Measure as part of a minimal list of data collection instruments that would be ideal for use by all mental health researchers conducting clinical research to facilitate and harmonize mental health data collection.

These measures have been selected using either the PhenX consensus process (https://www.phenxtoolkit.org/collections/view/1) or the International Consortium for Health Outcomes Measurement (ICHOM) (https://www.ichom.org/resource-library/category/condition-specific-resources/depression-anxiety/) with additional consideration for successful use of the measures in various countries.

During the past TWO (2) WEEKS, how much (or how often) has your child

	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
1. Complained of stomach aches, headaches, or other aches and pains?	○	○	○	○	○
2. Said he/she was worried about his/her health or about getting sick?	○	○	○	○	○

I. Somatic Symptoms - Highest Domain Score (clinician) _____

II.

	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
3. Had problems sleeping-that is, trouble falling asleep, staying asleep, or waking up too early?	○	○	○	○	○

II. Sleep Problems - Highest Domain Score (clinician) _____

III.

	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	○	○	○	○	○

III. Inattention - Highest Domain Score (clinician) _____

IV.

	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
5. Had less fun doing things than he/she used to?	○	○	○	○	○
6. Seemed sad or depressed for several hours?	○	○	○	○	○

IV. Depression - Highest Domain Score (clinician) _____

V. & VI.

	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
7. Seemed more irritated or easily annoyed than usual?	○	○	○	○	○
8. Seemed angry or lost his/her temper?	○	○	○	○	○

V. Anger & VI. Irritability - Highest Domain Score (clinician) _____

VII.

	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
9. Started lots more projects than usual or did more risky things than usual?	○	○	○	○	○
10. Slept less than usual for him/her but still had lots of energy?	○	○	○	○	○

VII. Mania Highest - Domain Score (clinician) _____

VIII.

	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
11. Said he/she felt nervous, anxious, or scared?	○	○	○	○	○

12. Not been able to stop worrying?	○	○	○	○	○
13. Said he/she couldnt do things he/she wanted to or should have done, because they made him/her feel nervous?	○	○	○	○	○

VIII. Anxiety Highest - Domain Score (clinician) _____

IX.					
	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
14. Said that he/she heard voices - when there was no one there - speaking about him/her or telling him/her what to do or saying bad things to him/her?	○	○	○	○	○
15. Said that he/she had a vision when he/she was completely awake - that is, saw something or someone that no one else could see?	○	○	○	○	○

IX. Psychosis - Highest Domain Score (clinician) _____

X.					
	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	○	○	○	○	○
17. Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	○	○	○	○	○

18. Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	◯	◯	◯	◯	◯
19. Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	◯	◯	◯	◯	◯

X. Repetitive Thoughts and Behaviors - Highest Domain Score (clinician) _____

XI. In the past TWO (2) WEEKS has your child

20. Had an alcoholic beverage (beer, wine, liquor, etc.)?	◯ Yes	◯ No	◯ Don't know
21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	◯ Yes	◯ No	◯ Don't know
22. Used drugs like marijuana, cocaine, or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	◯ Yes	◯ No	◯ Don't know
23. Used any medicine without a doctors prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	◯ Yes	◯ No	◯ Don't know

XI. Substance Use - Highest Domain Score (clinician) _____

XII.

24. In the past TWO (2) WEEKS has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	◯ Yes	◯ No	◯ Don't know
25. Has he/she EVER tried to kill himself/herself?	◯ Yes	◯ No	◯ Don't know

XII. Suicidal Ideation/ Suicide Attempts - Highest Domain Score (clinician) _____

Tier 2: After meeting thresholds

Domain	Domain Name	Threshold to guide further inquiry	DSM-5 Level 2 Cross-Cutting Symptom Measure available online
I.	Somatic Symptoms	Mild or greater	LEVEL 2—Somatic Symptom—Parent/Guardian of Child Age 6–17 (Patient Health Questionnaire 15 Somatic Symptom Severity (PHQ-15)
II.	Sleep Problems	Mild or greater	LEVEL 2—Sleep Disturbance—Parent/ Guardian of Child Age 6–17 (PROMIS—Sleep Disturbance—Short Form)[1]
III.	Inattention	Slight or greater	LEVEL 2—Inattention—Parent/Guardian of Child Age 6–17 (SNAP-IV)
IV.	Depression	Mild or greater	LEVEL 2—Depression—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Depression—Parent Item Bank)
V.	Anger	Mild or greater	LEVEL 2—Anger—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Calibrated Anger Measure—Parent)
VI.	Irritability	Mild or greater	LEVEL 2—Irritability—Parent/Guardian of Child Age 6–17 (Affective Reactivity Index)
VII.	Mania	Mild or greater	LEVEL 2—Mania—Parent/Guardian of Child Age 6–17 (adapted from the Altman Self-Rating Mania Scale)
VIII.	Anxiety	Mild or greater	LEVEL 2—Anxiety—Parent/Guardian of Child Age 6–17 (adapted from PROMIS Emotional Distress—Anxiety—Parent Item Bank)
IX.	Psychosis	Slight or greater	None
X.	Repetitive Thoughts and Behaviors	Mild or greater	None
XI.	Substance Use	Yes/ Don't Know	LEVEL 2—Substance Use—Parent/Guardian of Child Age 6–17 (adapted from the NIDA-modified ASSIST)/LEVEL 2—Substance Use—Child Age 11–17 (adapted from the NIDA-modified ASSIST)
XII.	Suicidal Ideation/ Suicide Attempts	Yes/ Don't Know	None

I. Somatic Symptoms

LEVEL 2 Somatic Symptom Parent/Guardian of Child Age 6-17 (Patient Health Questionnaire 15 Somatic Symptom Severity (PHQ-15)

During the past 7 days how much has your child been bothered by any of the following problems?

	Not bothered at all	Bothered a little	Bothered a lot
Stomach pain	○	○	○
Back pain	○	○	○
Pain in his or her arms, legs, or joints (knees, hips, etc.)	○	○	○
Headaches	○	○	○
Chest pain	○	○	○
Dizziness	○	○	○
Fainting spells	○	○	○
Feeling his or her heart pound or race	○	○	○
Shortness of breath	○	○	○

Constipation, loose bowels, or diarrhea	○	○	○
Nausea, gas, or indigestion	○	○	○
Feeling tired or having low energy	○	○	○
Trouble sleeping	○	○	○

Total/Partial Raw Score: _____

Prorated Score: (if 10 or more items answered) _____

II. Sleep Problems

LEVEL 2-Sleep Disturbance-Parent/ Guardian of Child Age 6-17 (PROMIS-Sleep Disturbance-Short Form)

Instructions to parent/guardian:

On the DSM-5 Level 1 cross-cutting questionnaire that you just completed you indicated that during the past 2 weeks your child receiving care has been bothered by problems sleeping-that is trouble falling asleep staying asleep or waking up too early at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms during the past 7 days.

In the past 7 days

	Not at all	A little bit	Somewhat	Quite a bit	Very much
His/her sleep was restless.	○	○	○	○	○
He/She was satisfied with his/her sleep.	○	○	○	○	○
His/her sleep was refreshing.	○	○	○	○	○
He/she had difficulty falling asleep.	○	○	○	○	○

In the past 7 days

	Never	Rarely	Sometimes	Often	Always
He/she had trouble staying asleep.	○	○	○	○	○
He/she had trouble sleeping	○	○	○	○	○
He/she got enough sleep.	○	○	○	○	○

In the past 7 days

	Very poor	Poor	Fair	Good	Very good
His/her sleep quality was...	◯	◯	◯	◯	◯

Total/Partial Raw Score _____

Prorated Total Raw Score _____

III. Inattention

LEVEL 2 Inattention Parent/Guardian of Child Age 6-17 (SNAP-IV)

Instructions to parent/guardian:
On the DSM-5 Level 1 cross-cutting questionnaire that you just completed you indicated that during the past 2 weeks your child receiving care has been bothered by problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game at a slight or greater level of severity.

The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms during the past 7 days.

In the past 7 days my child

	Not at All	Just a Little	Quite a Bit	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.	◯	◯	◯	◯
2. Often has difficulty sustaining attention in tasks or play activities.	◯	◯	◯	◯
3. Often does not seem to listen when spoken to directly.	◯	◯	◯	◯
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties.	◯	◯	◯	◯
5. Often has difficulty organizing tasks and activities.	◯	◯	◯	◯
6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g. schoolwork or homework).	◯	◯	◯	◯

7. Often loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, books, or tools.)	○	○	○	○
8. Often is distracted by extraneous stimuli.	○	○	○	○

Total/Partial Raw Score: _____

Prorated Total Raw Score: (if 1-2 items left unanswered) _____

Average Total Score _____

IV. Depression

LEVEL 2 Depression Parent/Guardian of Child Age 6-17 (PROMIS Emotional Distress Depression Parent Item Bank)

Instructions to parent/guardian:

On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks your child receiving care has been bothered by not finding interest or pleasure in doing things and/or seeming down, depressed, or hopeless at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms during the past 7 days.

In the past 7 days, my child

	Never	Almost Never	Sometimes	Often	Almost Always
1. Could not stop feeling sad.	○	○	○	○	○
2. Felt alone.	○	○	○	○	○
3. Felt like he/she couldnt do anything right.	○	○	○	○	○
4. Felt lonely.	○	○	○	○	○
5. Felt sad.	○	○	○	○	○
6. Felt unhappy.	○	○	○	○	○
7. Thought that his/her life was bad.	○	○	○	○	○
8. Didnt care about anything.	○	○	○	○	○
9. Felt stressed.	○	○	○	○	○
10. Felt too sad to eat.	○	○	○	○	○
11.Wanted to be by himself/herself.	○	○	○	○	○

Total/Partial Raw Score: _____

V. Anger

Instructions to parent/guardian:

On the DSM-5 Level 1 cross-cutting questionnaire that you just completed you indicated that during the past 2 weeks your child receiving care has been bothered by seeming irritated or easily annoyed and/or seeming angry or lost his/her temper at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms during the past 7 days.

In the past SEVEN (7) DAYS

	Never	Almost Never	Sometimes	Often	Almost Always
1. My child felt mad.	○	○	○	○	○
2. My child was so angry he/she felt like yelling at somebody.	○	○	○	○	○
3. My child was so angry he/she felt like throwing something.	○	○	○	○	○
4. My child felt upset.	○	○	○	○	○
5. When my child got mad, he/she stayed mad.	○	○	○	○	○

Total/Partial Raw Score: _____

Prorated Total Raw Score: _____

T-Score: _____

VI. Irritability

LEVEL 2 Irritability Parent/Guardian of Child Age 6-17 (Affective Reactivity Index)

Instructions to parent/guardian:

On the DSM-5 Level 1 cross-cutting questionnaire that you just completed you indicated that during the past 2 weeks your child receiving care has been bothered by seeming irritated or easily annoyed and/or seeming angry or lost his/her temper at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms during the past 7 days.

In the last SEVEN (7) DAYS and compared to others of the same age how well does each of the following statements describe the behavior/feelings of your child?

Please try to answer all questions.

	Not True	Somewhat True	Certainly True

1. Is easily annoyed by others.	◯	◯	◯
2. Often loses his/her temper.	◯	◯	◯
3. Stays angry for a long time.	◯	◯	◯
4. Is angry most of the time.	◯	◯	◯
5. Gets angry frequently.	◯	◯	◯
6. Loses temper easily.	◯	◯	◯
7. Overall irritability causes him/her problems	◯	◯	◯

Total/Partial Raw Score: _____

Prorated Total Raw Score: (if 1 item is left unanswered) _____

VII. Mania

LEVEL 2 Mania Parent/Guardian of Child Age 6-17 (adapted from the Altman Self-Rating Mania Scale)

Instructions to parent/guardian:

On the DSM-5 Level 1 cross-cutting questionnaire you just completed you indicated that during the past 2 weeks your child receiving care has been bothered by sleeping less than usual but still have a lot of energy and/or only sleeping for a short time at night at a mild or greater level of severity.

The five statement groups or questions below ask about these feelings in more detail.

1. Please read each group of statements/question carefully.
2. Choose the one statement in each group that best describes the way your child has been feeling for the past week.
3. Check the box next to the number/statement selected.
4. Please note: The word occasionally when used here means once or twice; often means several times or more and frequently means most of the time.

Question 1

◯ He/she does not feel happier or more cheerful than usual.
◯ He/she occasionally feels happier or more cheerful than usual.
◯ He/she often feels happier or more cheerful than usual.
◯ He/she feels happier or more cheerful than usual most of the time.
◯ He/she feels happier or more cheerful than usual all of the time.

Question 2

◯ He/she does not feel more self-confident than usual.
◯ He/she occasionally feels more self-confident than usual.
◯ He/she often feels more self-confident than usual.
◯ He/she frequently feels more self-confident than usual.
◯ He/she feels extremely self-confident all of the time.

Question 3

◯ He/she does not need less sleep than usual.
◯ He/she occasionally needs less sleep than usual.
◯ He/she often needs less sleep than usual.
◯ He/she frequently needs less sleep than usual.
◯ He/she can go all day and all night without any sleep and still not feel tired.

Question 4

◯ He/she does not talk more than usual.
◯ He/she occasionally talks more than usual.
◯ He/she often talks more than usual.
◯ He/she frequently talks more than usual.
◯ He/she talks constantly and cannot be interrupted.

Question 5

◯ He/she has not been more active (either socially sexually at work home or school) than usual.
◯ He/she has occasionally been more active than usual.
◯ He/she has often been more active than usual.
◯ He/she has frequently been more active than usual.
◯ He/she is constantly more active or on the go all the time.

Total/Partial Raw Score: _____

Prorated Total Raw Score: (if 1 item is left unanswered) _____

VIII. Anxiety

LEVEL 2 - Anxiety - Parent/Guardian of Child Age 6-17 (adapted from PROMIS Emotional Distress-Anxiety-Parent Item Bank)

Instructions to parent/guardian:

On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks your child receiving care has been bothered by feeling nervous, anxious, or scared, not being able to stop worrying, and/or couldn't do things he/she wanted to or should have done because they made him/her feel nervous at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms during the past 7 days.

	Never	Almost Never	Sometimes	Often	Almost Always
Felt nervous.	◯	◯	◯	◯	◯
Felt scared.	◯	◯	◯	◯	◯
Felt worried.	◯	◯	◯	◯	◯

In the SEVEN (7) DAYS, my child said that he/she					
Felt like something awful might happen.	○	○	○	○	○
Worried when he/she was at home.	○	○	○	○	○
Got scared really easy.	○	○	○	○	○
Worried when he/she was away from home.	○	○	○	○	○
Worried about what could happen to him/her.	○	○	○	○	○
Worried when he/she went to bed at night.	○	○	○	○	○
Was afraid of going to school.	○	○	○	○	○

Total/Partial Raw Score _____

Prorated Total Raw Score _____

T-Score _____

XI. Substance Use

Instructions to parent/guardian:

On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks your child receiving care has been bothered by having an alcoholic beverage; smoking a cigarette, a cigar, or pipe or used snuff or chewing tobacco; using drugs like marijuana, cocaine or crack, club drugs, hallucinogens, heroin, inhalants or solvents, or methamphetamine and/or using any medicine without a doctor's prescription.

The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms during the past two (2) weeks.

During the past TWO (2) WEEKS, about how often did your child...	Not at All	Less Than a Day or Two	Several Days	More Than Half the Days	Nearly Every Day
a. Have an acloholic beverage (beer, wine, liquor, etc.) ?	○	○	○	○	○
b. Have 4 or more drinks in a single day?	○	○	○	○	○
c. Smoke a cigarette, a cigar, or pipe or used snuff or chewing tobacco?	○	○	○	○	○

During the past TWO (2) WEEKS, about how often did your child use any of the following medicines without a doctor's prescription or in greater amounts or longer than prescribed?	Not at All	Less Than a Day or Two	Several Days	More Than Half the Days	Nearly Every Day
d. Painkillers (like Vicodin)	◯	◯	◯	◯	◯
e. Stimulants (like Ritalin, Adderall)	◯	◯	◯	◯	◯
f. Sedatives or tranquilizers (like sleeping pills or Valium)	◯	◯	◯	◯	◯

Or drugs like:	Not at All	Less Than a Day or Two	Several Days	More Than Half the Days	Nearly Every Day
g. Steroids	◯	◯	◯	◯	◯
h. Other medicines	◯	◯	◯	◯	◯
i. Marijuana	◯	◯	◯	◯	◯
j. Cocaine or crack	◯	◯	◯	◯	◯
k. Club drugs (like ecstasy)	◯	◯	◯	◯	◯
l. Hallucinogens (like LSD)	◯	◯	◯	◯	◯
m. Heroin	◯	◯	◯	◯	◯
n. Inhalants or solvents (like glue)	◯	◯	◯	◯	◯
o. Methamphetamine (like speed)	◯	◯	◯	◯	◯

Total/Partial Raw Score: _____

Prorated Total Raw Score: (If 1 item is left unanswered) _____

Additional Guidance: These CDEs include questions that can potentially identify respondents who are at risk of suicide. Investigators implementing this protocol should consult with their IRBs to develop a risk management plan specific to their study to ensure the safety of participants. Investigators should also ensure their studies are compliant with federal, state, and institutional regulations and policies and inform participants of limits of confidentiality when a participant endorses imminent risk of harm to self or others.

The following link provides additional information and guidelines for suicide-related research: https://www.nimh.nih.gov/funding/clinical-research/conducting-research-with-participants-at-elevated-risk-for-suicide-considerations-for-researchers.

Tier 1: Anxiety, Depression, Fatigue PROMIS scales (Parent Proxy Versions)

Due to early research demonstrating the presence of COVID-19/pandemic related mental health symptoms, anxiety, depressive symptoms and fatigue PROMIS measures were designated Tier 1 in addition to the DSM-5 screener.

Parent About Child:

PROMIS Anxiety

Age 1-5 (available not shown)
Age 5-17 (shown)

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
My child felt nervous.	○	○	○	○	○
My child felt scared.	○	○	○	○	○
My child felt worried.	○	○	○	○	○
My child felt like something awful might happen.	○	○	○	○	○
My child worried when he/she was at home.	○	○	○	○	○
My child got scared really easy.	○	○	○	○	○
My child worried about what could happen to him/her.	○	○	○	○	○
My child worried when he/she went to bed at night.	○	○	○	○	○

PROMIS Depressive Symptoms

Age 1-5 (available not shown)
Age 5-17 (shown)

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
My child could not stop feeling sad.	○	○	○	○	○
My child felt everything in his/her life went wrong.	○	○	○	○	○
My child felt like he/she couldn't do anything right.	○	○	○	○	○
My child felt lonely.	○	○	○	○	○
My child felt sad.	○	○	○	○	○
It was hard for my child to have fun.	○	○	○	○	○

PROMIS Fatigue

Age 5-17

	Never	Almost Never	Sometimes	Often	Almost Always
Being tired made it hard for my child to play or go out with friends as much as he/she would like.	○	○	○	○	○
My child felt weak.	○	○	○	○	○
My child got tired easily.	○	○	○	○	○
Being tired made it hard for my child to keep up with schoolwork.	○	○	○	○	○
My child had trouble finishing things because he/she was too tired.	○	○	○	○	○
My child had trouble starting things because he/she was too tired.	○	○	○	○	○
My child was so tired it was hard for him/her to pay attention.	○	○	○	○	○
My child was too tired to do sports or exercise.	○	○	○	○	○
My child was too tired to do things outside.	○	○	○	○	○
My child was too tired to enjoy the things he/she likes to do.	○	○	○	○	○

Tier 2: RCADS Anxiety and Depression Scale (Parent Report About Child)

Due to early research demonstrating the presence of COVID-19/pandemic related mental health symptoms, anxiety, and depression RCADS measures were designated Tier 2 in addition to the DSM-5 screener and Tier 1 PROMIS measures.

Please select the word that shows how often each of these things happens to your child. There are no right or wrong answers.

	Never	Sometimes	Often	Always
1. My child worries about things	○	○	○	○
2. My child feels sad or empty	○	○	○	○
3. When my child has a problem, he/she gets a funny feeling in his/her stomach	○	○	○	○
4. My child worries when he/she thinks he/she has done poorly at something	○	○	○	○

5. My child feels afraid of being alone at home	○	○	○	○
6. Nothing is much fun for my child anymore	○	○	○	○
7. My child feels scared when taking a test	○	○	○	○
8. My child worries when he/she thinks someone is angry with him/her	○	○	○	○
9. My child worries about being away from me	○	○	○	○
10. My child is bothered by bad or silly thoughts or pictures in his/her mind	○	○	○	○
11. My child has trouble sleeping	○	○	○	○
12. My child worries about doing badly at schoolwork	○	○	○	○
13. My child worries that something awful will happen to someone in the family	○	○	○	○
14. My child suddenly feels as if he/she can't breathe when there is no reason for this	○	○	○	○
15. My child has problems with his/her appetite	○	○	○	○
16. My child has to keep checking that he/she has done things right (like the switch is off, or the door is locked)	○	○	○	○
17. My child feels scared to sleep on his/her own	○	○	○	○
18. My child has trouble going to school in the mornings because of feeling nervous or afraid	○	○	○	○
19. My child has no energy for things	○	○	○	○
20. My child worries about looking foolish	○	○	○	○
21. My child is tired a lot	○	○	○	○
22. My child worries that bad things will happen to him/her	○	○	○	○

23. My child can't seem to get bad or silly thoughts out of his/her head	○	○	○	○

Tier 2: Pain, Cognitive Function

Pain Interference Parent Proxy

Age 8-17

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
My child had trouble sleeping when he/she had pain.	○	○	○	○	○
My child felt angry when he/she had pain.	○	○	○	○	○
My child had trouble doing schoolwork when he/she had pain.	○	○	○	○	○
It was hard for my child to pay attention when he/she had pain.	○	○	○	○	○
It was hard for my child to run when he/she had pain.	○	○	○	○	○
It was hard for my child to walk one block when he/she had pain.	○	○	○	○	○
It was hard for my child to have fun when he/she had pain.	○	○	○	○	○
It was hard for my child to stay standing when he/she had pain.	○	○	○	○	○

Cognitive Function Parent Proxy

Age 8-17

In the past 4 weeks

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Your child has to use written lists more often than other people his/her age so he/she will not forget things	○	○	○	○	○
It is hard for your child to pay attention to one thing for more than 5-10 minutes	○	○	○	○	○

Your child has trouble keeping track of what he/she is doing if he/she gets interrupted	○	○	○	○	○
Your child has to read things several times to understand them	○	○	○	○	○
Your child forgets things easily	○	○	○	○	○
Your child has to work really hard to pay attention or he/she makes mistakes	○	○	○	○	○
Your child has trouble remembering to do things like school projects or chores	○	○	○	○	○

Tier 2: Externalizing Symptoms

While prioritized as a Tier 2 measure, this Working Group does not recommend specific measures since the most commonly used measures (Child Behavior Checklist and Strengths and Difficulties Questionnaire) require licensing. The Multidimensional Assessment Profile of Disruptive Behavior (MAP-DB), is available for use as well and does not require a license.

Child Self-Report: Current Mental Health Symptoms

Tier 1: DSM-5 Cross-Cutting Symptom Measure (Ages 11-17)

The National Institute of Mental Health (NIMH), in consultation with the Wellcome Trust and other funders of mental health research, has identified the DSM-5 Cross-Cutting Symptom Measure as part of a minimal list of data collection instruments that would be ideal for use by all mental health researchers conducting clinical research to facilitate and harmonize mental health data collection. These measures have been selected using either the PhenX consensus process (https://www.phenxtoolkit.org/collections/view/1) or the International Consortium for Health Outcomes Measurement (ICHOM) (https://www.ichom.org/resource-library/category/condition-specific-resources/depression-anxiety/) with additional consideration for successful use of the measures in various countries.

I.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
1. Been bothered by stomach aches, headaches, or other aches and pains?	○	○	○	○	○
2. Worried about your health or about getting sick?	○	○	○	○	○

I. - Highest Domain Score (clinician) _____

II.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
3. Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	○	○	○	○	○

II. - Highest Domain Score (clinician) _____

III.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
4. Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	○	○	○	○	○

III. - Highest Domain Score (clinician) _____

IV.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
5. Had less fun doing things than you used to?	○	○	○	○	○
6. Felt sad or depressed for several hours?	○	○	○	○	○

IV. - Highest Domain Score (clinician) _____

V. & VI.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
7. Felt more irritated or easily annoyed than usual?	○	○	○	○	○
8. Felt angry or lost your temper?	○	○	○	○	○

V & VI. - Highest Domain Score (clinician) _____

VII.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
9. Started lots more projects than usual or done more risky things than usual?	○	○	○	○	○
10. Slept less than usual but still had a lot of energy?	○	○	○	○	○

VII. - Highest Domain Score (clinician) _____

VIII.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
11. Felt nervous, anxious, or scared?	○	○	○	○	○
12. Not been able to stop worrying?	○	○	○	○	○
13. Not been able to do things you wanted to or should have done, because they made you feel nervous?	○	○	○	○	○

VIII. - Highest Domain Score (clinician) _____

IX.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
14. Heard voiceswhen there was no one there - speaking about you or telling you what to do or saying bad things to you?	○	○	○	○	○
15. Had visions when you were completely awake - that is, seen something or someone that no one else could see?	○	○	○	○	○

IX. - Highest Domain Score (clinician) _____

X.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
16. Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	○	○	○	○	○
17. Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	○	○	○	○	○
18. Worried a lot about things you touched being dirty or having germs or being poisoned?	○	○	○	○	○
19. Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	○	○	○	○	○

X. - Highest Domain Score (clinician) _____

In the past TWO (2) WEEKS, have you

XI.

20. Had an alcoholic beverage (beer, wine, liquor, etc.)?	◯ Yes ◯ No
21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	◯ Yes ◯ No
22. Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	◯ Yes ◯ No
23. Used any medicine without a doctors prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	◯ Yes ◯ No

XII.

24. In the last 2 weeks, have you thought about killing yourself or committing suicide?	◯ Yes ◯ No
25. Have you EVER tried to kill yourself?	◯ Yes ◯ No

Tier 2: After meeting thresholds

Domain	Domain Name	Threshold to guide further inquiry	DSM-5 Level 2 Cross-Cutting Symptom Measure available online
I.	Somatic Symptoms	Mild or greater	LEVEL 2—Somatic Symptom—Child Age 11–17 (Patient Health Questionnaire Somatic Symptom Severity [PHQ-15])
II.	Sleep Problems	Mild or greater	LEVEL 2—Sleep Disturbance—Child Age 11-17 (PROMIS—Sleep Disturbance—Short Form)[1]
III.	Inattention	Slight or greater	None
IV.	Depression	Mild or greater	LEVEL 2—Depression—Child Age 11–17 (PROMIS Emotional Distress—Depression—Pediatric Item Bank)
V.	Anger	Mild or greater	LEVEL 2—Anger—Child Age 11–17 (PROMIS Emotional Distress—Calibrated Anger Measure—Pediatric)
VI.	Irritability	Mild or greater	LEVEL 2—Irritability—Child Age 11–17 (Affective Reactivity Index [ARI])
VII.	Mania	Mild or greater	LEVEL 2—Mania—Child Age 11–17 (Altman Self-Rating Mania Scale [ASRM])
VIII.	Anxiety	Mild or greater	LEVEL 2—Anxiety—Child Age 11–17 (PROMIS Emotional Distress—Anxiety—Pediatric Item Bank)
IX.	Psychosis	Slight or greater	None
X.	Repetitive Thoughts & Behaviors	Mild or greater	LEVEL 2—Repetitive Thoughts and Behaviors—Child 11–17 (adapted from the Children's Florida Obsessive-Compulsive Inventory [C-FOCI] Severity Scale)
XI.	Substance Use	Yes/ Don't Know	LEVEL 2—Substance Use—Child Age 11–17 (adapted from the NIDA-modified ASSIST)
XII.	Suicidal Ideation/ Suicide Attempts	Yes/ Don't Know	None

I. Somatic Symptoms

LEVEL 2-Somatic Symptom-Child Age 11-17 (Patient Health QuestionnaireSomatic Symptom Severity [PHQ-15])

During the past 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered at all	Bothered a little	Bothered a lot
a. Stomach pain	○	○	○
b. Back pain	○	○	○
c. Pain in your arms, legs, or joints (knees, hips, etc.)	○	○	○
d. Menstrual cramps or other problems with your periods (women only)	○	○	○
e. Headaches	○	○	○
f. Chest pain	○	○	○
g. Dizziness	○	○	○
h. Fainting spells	○	○	○
i. Feeling your heart pound or race	○	○	○
j. Shortness of breath	○	○	○
k. Pain or problems during sexual intercourse	○	○	○
l. Constipation, loose bowels, or diarrhea	○	○	○
m. Nausea, gas, or indigestion	○	○	○
n. Feeling tired or having low energy	○	○	○
o. Trouble sleeping	○	○	○

II. Sleep Problems

LEVEL 2-Sleep Disturbance Child Age 11-17 (PROMIS-Sleep Disturbance-Short Form)

Instructions to the child: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you have been bothered by not being able to fall asleep or stay asleep or by waking up too early at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past 7 days.

In the past 7 days

	Not at all	A little bit	Somewhat	Quite a bit	Very much
My sleep was restless.	○	○	○	○	○

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I was satisfied with my sleep.	○	○	○	○	○
My sleep was refreshing.	○	○	○	○	○

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I had difficulty falling asleep.	○	○	○	○	○

In the past 7 days

	Never	Rarely	Sometimes	Often	Always
I had trouble staying asleep.	○	○	○	○	○
I had trouble sleeping.	○	○	○	○	○

	Never	Rarely	Sometimes	Often	Always
I got enough sleep.	○	○	○	○	○

In the past 7 days

	Very poor	Poor	Fair	Good	Very good
My sleep quality was...	○	○	○	○	○

Total/Partial Raw Score _____

Prorated Total Raw Score _____

T-score _____

IV. Depression

LEVEL 2-Depression-Child Age 11-17 (PROMIS Emotional Distress-Depression-Pediatric Item Bank)

Instructions to the child: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that
during the past 2 weeks you have been bothered by having little interest or pleasure in doing things and/or feeling down, depressed, or hopeless at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past 7 days.

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
I could not stop feeling sad.	○	○	○	○	○
I felt alone.	○	○	○	○	○
I felt everything in my life went wrong.	○	○	○	○	○
I felt like I couldn't do anything right.	○	○	○	○	○
I felt lonely.	○	○	○	○	○
I felt sad.	○	○	○	○	○
I felt unhappy.	○	○	○	○	○
I thought that my life was bad.	○	○	○	○	○
Being sad made it hard for me to do things with my friends.	○	○	○	○	○
I didn't care about anything.	○	○	○	○	○
I felt stressed.	○	○	○	○	○
I felt too sad to eat.	○	○	○	○	○
I wanted to be by myself.	○	○	○	○	○
It was hard for me to have fun.	○	○	○	○	○

V. Anger

LEVEL 2-Anger-Child Age 11-17 (PROMIS Emotional Distress-Calibrated Anger Measure-Pediatric)

Instructions to the child:
On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you have been bothered by feeling irritated or easily annoyed and/or feeling angry or lost your temper at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past 7 days.

In the past 7 days.

	Never	Almost Never	Sometimes	Often	Almost Always
I felt mad.	○	○	○	○	○
I was so angry I felt like throwing something.	○	○	○	○	○
I was so angry I felt like yelling at somebody.	○	○	○	○	○
When I got mad, I stayed mad.	○	○	○	○	○
I felt fed up.	○	○	○	○	○
I felt upset.	○	○	○	○	○

VI. Irritability

LEVEL 2 Irritability-Child Age 11-17 (Affective Reactivity Index)

Instructions to the child:
On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you have been bothered by feeling irritated or easily annoyed and/or feeling angry or lost your temper at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past 7 days.

In the last SEVEN (7) DAYS and compared to others of the same age, how well does each of the following statements describe your behavior or feelings?

Am easily annoyed by others.

◯ Not True
◯ Somewhat True
◯ Certainly True

VII. Mania

LEVEL 2-Mania-Child Age 11-17 (Altman Self-Rating Mania Scale [ASRM])

Instructions to the child:
On the DSM-5 Level 1 cross-cutting questionnaire you just completed, you indicated that during the past 2 weeks you have been bothered by feeling so active that you couldn't settle down and/or finding that you didn't sleep a lot at night at a mild or greater level of severity. The five statement groups or questions below ask about these feelings in more detail.

1. Please read each group of statements/question carefully.
2. Choose the one statement in each group that best describes the way you have been feeling for the past week.
3. Check the box next to the number/statement selected.
4. Please note: The word occasionally, when used here means once or twice; often means several times or more and frequently means most of the time.

Question 1

◯ I do not feel happier or more cheerful than usual
◯ I occasionally feel happier or more cheerful than usual
◯ I often feel happier or more cheerful than usual
◯ I feel happier or more cheerful than usual most of the time
◯ I feel happier of more cheerful than usual all of the time

Question 2

◯ I do not feel more self-confident than usual
◯ I occasionally feel more self-confident than usual
◯ I often feel more self-confident than usual
◯ I frequently feel more self-confident than usual
◯ I feel extremely self-confident all of the time

Question 3

◯ I do not need less sleep than usual
◯ I occasionally need less sleep than usual
◯ I often need less sleep than usual
◯ I frequently need less sleep than usual
◯ I can go all day and all night without any sleep and still not feel tired

Question 4

◯ I do not talk more than usual.
◯ I occasionally talk more than usual
◯ I often talk more than usual
◯ I frequently talk more than usual
◯ I talk constantly and cannot be interrupted

Question 5

◯ I have not been more active (either socially, sexually, at work, home, or school) than usual
◯ I have occasionally been more active than usual
◯ I have often been more active than usual
◯ I have frequently been more active than usual
◯ I am constantly more active or on the go all the time

Total/Partial Raw Score: _____

Prorated Total Raw Score: (if 1 item left unanswered) _____

VIII. Anxiety

LEVEL 2-Anxiety-Child Age 11-17 (PROMIS Emotional Distress-Anxiety-Pediatric Item Bank)

Instructions to the child:
On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you have been bothered by feeling nervous, anxious, or scared, not being able to stop worrying and/or not being able to do things you wanted to or should have done because they made you feel nervous at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past 7 days.

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
I felt like something awful might happen.	◯	◯	◯	◯	◯
I felt nervous.	◯	◯	◯	◯	◯
I felt scared.	◯	◯	◯	◯	◯
I felt worried.	◯	◯	◯	◯	◯

I worried about what could happen to me.	◯	◯	◯	◯	◯
I worried when I went to bed at night.	◯	◯	◯	◯	◯
I got scared really easy.	◯	◯	◯	◯	◯
I was afraid of going to school.	◯	◯	◯	◯	◯
I was worried I might die.	◯	◯	◯	◯	◯
I woke up at night scared.	◯	◯	◯	◯	◯
I worried when I was at home.	◯	◯	◯	◯	◯
I worried when I was away from home.	◯	◯	◯	◯	◯
It was hard for me to relax.	◯	◯	◯	◯	◯

X. Repetitive Thoughts & Behaviors

LEVEL 2-Repetitive Thoughts and Behaviors-Child 11-17 (adapted from the Children's Florida Obsessive-Compulsive Inventory [C-FOCI] Severity Scale)

Instructions to the child:
On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you have been bothered by "thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else", "feeling the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off", "worrying a lot about things you touched being dirty or having germs or being poisoned", and/or "feeling you had to do things in a certain way, like counting or saying special things, to keep something bad from happening" at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past 7 days.

During the past SEVEN (7) DAYS

1. On average, how much time is occupied by these thoughts or behaviors each day?

◯ 0-None
◯ 1-Mild (less than an hour a day)
◯ 2-Moderate (1 to 3 hours a day)
◯ 3-Severe (3 to 8 hours a day)
◯ 4-Extreme (more than 8 hours a day)

1. Clinician use - Item score

_____

2. How much do they bother you?

◯ 0-None
◯ 1-Mild (slightly upsetting)
◯ 2-Moderate (upsetting but still manageable)
◯ 3-Severe (very upsetting)
◯ 4-Extreme (overwhelming distress)

2. Clinician use - Item score

_____

3. How hard is it for you to control them?	◯ 0-None ◯ 1-Mild (usually able to control thoughts or behaviors) ◯ 2-Moderate (sometimes able to control thoughts or behaviors) ◯ 3-Severe (not usually able to control thoughts or behaviors) ◯ 4-Extreme (unable to control thoughts or behaviors)
3. Clinician use - Item score	_____
4. How much do they cause you to avoid doing things, going places or being with people?	◯ 0-None ◯ 1-Mild (occasionally avoids things) ◯ 2-Moderate (regularly avoids doing these things) ◯ 3-Severe (frequently avoids these things) ◯ 4-Extreme (nearly complete avoidance; can't leave the house)
4. Clinician use - Item score	_____
5. How much do they interfere with school, your social or family life, or your job?	◯ 0-None ◯ 1-Mild (slight interference) ◯ 2-Moderate (definite interference with functioning, but can still manage) ◯ 3-Severe (substantial interference) ◯ 4-Extreme (near-total interference)
5. Clinician use - Item score	_____
Total/Partial Raw Score	_____
Prorated Total Raw Score (if 1 item is left unanswered)	_____
Average Total Score	_____

XI. Substance Use

LEVEL 2 - Substance Use - Child Age 11-17 (adapted from the NIDA-modified ASSIST)

Instructions to the child:
On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you have been bothered by "having an alcoholic beverage"; "smoking a cigarette, a cigar, or pipe or used snuff or chewing tobacco"; "using drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)"; and/or "using any medicine ON YOUR OWN, that is, without a doctor's prescription, to get high or change the way you feel."

The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past two (2) weeks.

During the past TWO (2) weeks, about how often did you ...

	Not at All	Less Than a Day or Two	Several Days	More Than Half the Days	Nearly Every Day	Don't know
a. Have an alcoholic beverage (beer, wine, liquor, etc.)?	○	○	○	○	○	○
b. Have 4 or more drinks in a single day?	○	○	○	○	○	○
c. Smoke a cigarette, a cigar, or pipe or use snuff or chewing tobacco?	○	○	○	○	○	○

During the past TWO (2) weeks, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription or in greater amounts or longer than prescribed?

	Not at All	Less Than a Day or Two	Several Days	More Than Half the Days	Nearly Every Day	Don't know
d. Painkillers (like Vicodin)	○	○	○	○	○	○
e. Stimulants (like Ritalin, Adderall)	○	○	○	○	○	○
f. Sedatives or tranquilizers (like sleeping pills or Valium)	○	○	○	○	○	○

Or drugs like:

	Not at All	Less Than a Day or Two	Several Days	More Than Half the Days	Nearly Every Day	Don't know
g. Steroids	○	○	○	○	○	○
h. Other medicines	○	○	○	○	○	○
i. Marijuana	○	○	○	○	○	○
j. Cocaine or crack	○	○	○	○	○	○
k. Club drugs (like ecstasy)	○	○	○	○	○	○
l. Hallucinogens (like LSD)	○	○	○	○	○	○
m. Heroin	○	○	○	○	○	○
n. Inhalants or solvents (like glue)	○	○	○	○	○	○
o. Methamphetamine (like speed)	○	○	○	○	○	○

Total/Partial Raw Score: _____

Total/Partial Raw Score: _____

Additional Guidance:
These CDEs include questions that can potentially identify respondents who are at risk of suicide. Investigators implementing this protocol should consult with their IRBs to develop a risk management plan specific to their study to ensure the safety of participants. Investigators should also ensure their studies are compliant with federal, state, and institutional regulations and policies and inform participants of limits of confidentiality when a participant endorses imminent risk of harm to self or others.

The following link provides additional information and guidelines for suicide-related research: https://www.nimh.nih.gov/funding/clinical-research/conducting-research-with-participants-at-elevated-risk-for-suicide-considerations-for-researchers.

Tier 1: Anxiety, Depression, Fatigue PROMIS scales Pediatric measures

Due to early research demonstrating the presence of COVID-19/pandemic related mental health symptoms, anxiety, depressive symptoms, and fatigue PROMIS measures were designated Tier 1 in addition to the DSM-5 screener.

	Never	Almost Never	Sometimes	Often	Almost Always
I felt like something awful might happen.	○	○	○	○	○
I felt nervous.	○	○	○	○	○
I felt scared.	○	○	○	○	○
I felt worried.	○	○	○	○	○
I worried when I was at home.	○	○	○	○	○
I got scared really easy.	○	○	○	○	○
I worried about what could happen to me.	○	○	○	○	○
I worried when I went to bed at night.	○	○	○	○	○

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
I could not stop feeling sad.	○	○	○	○	○
I felt alone.	○	○	○	○	○
I felt everything in my life went wrong.	○	○	○	○	○
I felt like I couldn't do anything right.	○	○	○	○	○
I felt lonely.	○	○	○	○	○
I felt sad.	○	○	○	○	○
I felt unhappy.	○	○	○	○	○
It was hard for me to have fun.	○	○	○	○	○

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
Being tired made it hard for me to keep up with my schoolwork.	○	○	○	○	○
Being tired made it hard for me to play or go out with my friends as much as I'd like.	○	○	○	○	○
I felt weak.	○	○	○	○	○
I got tired easily.	○	○	○	○	○
I had trouble finishing things because I was too tired.	○	○	○	○	○
I had trouble starting things because I was too tired.	○	○	○	○	○

I was so tired it was hard for me to pay attention.	○	○	○	○	○
I was too tired to do sports or exercise.	○	○	○	○	○
I was too tired to do things outside.	○	○	○	○	○
I was too tired to enjoy the things I like to do.	○	○	○	○	○

Tier 2: RCADS Anxiety and Depression Scale (Ages 8-18)

Due to early research demonstrating the presence of COVID-19/pandemic related mental health symptoms, anxiety, and depression RCADS measures were designated Tier 2 in addition to the DSM-5 screener and PROMIS Tier 1 measures.

Please select the word that shows how often each of these things happens to you. There are no right or wrong answers.

	Never	Sometimes	Often	Always
1. I worry about things	○	○	○	○
2. I feel sad or empty	○	○	○	○
3. When I have a problem, I get a funny feeling in my stomach	○	○	○	○
4. I worry when I think I have done poorly at something	○	○	○	○
5. I would feel afraid of being on my own at home	○	○	○	○
6. Nothing is much fun anymore	○	○	○	○
7. I feel scared when I have to take a test	○	○	○	○
8. I feel worried when I think someone is angry with me	○	○	○	○
9. I worry about being away from my parents	○	○	○	○
10. I get bothered by bad or silly thoughts or pictures in my mind	○	○	○	○
11. I have trouble sleeping	○	○	○	○
12. I worry that I will do badly at my schoolwork	○	○	○	○
13. I worry that something awful will happen to someone in my family	○	○	○	○

	Never	Sometimes	Often	Always
14. I suddenly feel as if I can't breathe when there is no reason for this	○	○	○	○
15. I have problems with my appetite	○	○	○	○
16. I have to keep checking that I have done things right (like the switch is off, or the door is locked)	○	○	○	○
17. I feel scared if I have to sleep on my own	○	○	○	○
18. I have trouble going to school in the mornings because I feel nervous or afraid	○	○	○	○
19. I have no energy for things	○	○	○	○
20. I worry I might look foolish	○	○	○	○
21. I am tired a lot	○	○	○	○
22. I worry that bad things will happen to me	○	○	○	○
23. I can't seem to get bad or silly thoughts out of my head	○	○	○	○
24. When I have a problem, my heart beats really fast	○	○	○	○

	Never	Sometimes	Often	Always
25. I cannot think clearly	○	○	○	○
26. I suddenly start to tremble or shake when there is no reason for this	○	○	○	○
27. I worry that something bad will happen to me	○	○	○	○
28. When I have a problem, I feel shaky	○	○	○	○
29. I feel worthless	○	○	○	○
30. I worry about making mistakes	○	○	○	○
31. I have to think of special thoughts (like numbers or words) to stop bad things from happening	○	○	○	○
32. I worry what other people think of me	○	○	○	○
33. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	○	○	○	○

34. All of a sudden, I feel really scared for no reason at all	○	○	○	○
35. I worry about what is going to happen	○	○	○	○
36. I suddenly become dizzy or faint when there is no reason for this	○	○	○	○
37. I think about death	○	○	○	○

	Never	Sometimes	Often	Always
38. I feel afraid if I have to talk in front of my class	○	○	○	○
39. My heart suddenly starts to beat too quickly for no reason	○	○	○	○
40. I feel like I dont want to move	○	○	○	○
41. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	○	○	○	○
42. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	○	○	○	○
43. I feel afraid that I will make a fool of myself in front of people	○	○	○	○
44. I have to do some things in just the right way to stop bad things from happening	○	○	○	○
45. I worry when I go to bed at night	○	○	○	○
46. I would feel scared if I had to stay away from home overnight	○	○	○	○
47. I feel restless	○	○	○	○

Tier 2

TRAUMA
Age 8-17

CRIES-8

Below is a list of comments made by people after stressful life events. Please tick each item showing how frequently these comments were true for you during the past seven days. If they did not occur during that time, please tick the 'not at all' box.

	Not at all	Rarely	Sometimes	Often

1. Do you think about it even when you don't mean to?	○	○	○	○
2. Do you try to remove it from your memory?	○	○	○	○
3. Do you have waves of strong feelings about it?	○	○	○	○
4. Do you stay away from reminders of it (e.g. places or situations)?	○	○	○	○
5. Do you try to talk about it?	○	○	○	○
6. Do pictures about it pop into your mind?	○	○	○	○
7. Do other things keep making you think about it?	○	○	○	○
8. Do you try not to think about it?	○	○	○	○

PROMIS Pain Interference

Age 8-17

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
I felt angry when I had pain.	○	○	○	○	○
I had trouble doing schoolwork when I had pain.	○	○	○	○	○
I had trouble sleeping when I had pain.	○	○	○	○	○
It was hard for me to pay attention when I had pain.	○	○	○	○	○
It was hard for me to run when I had pain.	○	○	○	○	○
It was hard for me to walk one block when I had pain.	○	○	○	○	○
It was hard to have fun when I had pain.	○	○	○	○	○
It was hard to stay standing when I had pain.	○	○	○	○	○

PROMIS Cognitive Function

Age 8-17

In the past 4 weeks

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
I have to use written lists more often than other people my age so I will not forget things.	○	○	○	○	○
It is hard for me to pay attention to one thing for more than 5-10 minutes.	○	○	○	○	○
I have trouble keeping track of what I am doing if I get interrupted.	○	○	○	○	○
I have to read things several times to understand them.	○	○	○	○	○
I forget things easily.	○	○	○	○	○
I have to work really hard to pay attention or I make mistakes	○	○	○	○	○
I have trouble remembering to do things like school projects or chores	○	○	○	○	○

Tier 2: Externalizing Symptoms

While prioritized as a Tier 2 measure, this Working Group does not recommend specific measures since the most commonly used measures (Child Behavior Checklist and Strengths and Difficulties Questionnaire) require licensing. The Multidimensional Assessment Profile of Disruptive Behavior (MAP-DB), is available for use as well and does not require a license.

Health Care

Health Insurance Status

Parent Report About Child

What is the primary kind of health insurance or health care plan that your child has now?

◯ Child does NOT have health insurance
◯ Private (purchased directly or through employment)
◯ Public (Medicare, Medicaid, Tricare)
◯ Don't know
◯ Prefer not to answer

COVID-19 Changes to Health Insurance

Parent Report About Child

During this pandemic (since March 2020) has this child had a change in their health insurance coverage? ◯ Yes ◯ No

If yes, what changes occurred?

◯ Loss of this child's health insurance
◯ Fewer benefits / less coverage from insurance
◯ Gaining of insurance, for example as part of emergency coverage of Medicaid expansion

COVID-19 Changes to Health Care Access

Parent Report About Child

During the COVID-19 pandemic (since March 2020), was there any time when this child needed health care, but it was not received? By health care, we mean medical care as well as other kinds of care like dental care, vision care, and mental health services ◯ Yes ◯ No

If yes, which types of care were not received? Select all that apply:

☐ Medical Care
☐ Dental Care
☐ Vision Care
☐ Hearing Care
☐ Mental Health Services
☐ Other (Specify)

Specify other _____

Please rate how much the coronavirus pandemic has changed your family's life in each of the following ways

Medical health care access

◯ No change
◯ Appointments moved to telehealth
◯ Delays or cancellations in appointments and/or delays in getting prescriptions or regular vaccinations (e.g., MMR); changes have minimal impact on health
◯ Unable to access needed care resulting in severe risk and/or significant impact

Please rate how much the coronavirus pandemic has changed your family's life in each of the following ways

Mental health treatment access

◯ No change
◯ Appointments moved to telehealth
◯ Delays or cancellations in appointments and/or delays in getting prescriptions or regular vaccinations (e.g., MMR); changes have minimal impact on health
◯ Unable to access needed care resulting in severe risk and/or significant impact

Receiving Behavioral Health/Mental Health Treatment (Tier 2)

Parent Report About Child

During the COVID-19 pandemic (since March 2020), has this child received any treatment or counseling from a mental health professional? Mental health professionals include psychiatrists, psychologists, psychiatric nurses, and clinical social workers

◯ Yes
◯ No, but this child needed to see a mental health professional
◯ No, this child did not need to see a mental health professional

During the COVID-19 pandemic (since March 2020), has this child taken any medication because of difficulties with their emotions, concentration, or behavior?	◯ Yes ◯ No

Services for Developmental Needs (Tier 2)

Has this child EVER received special services to meet their developmental needs such as speech, occupational, or behavioral therapy?	◯ Yes ◯ No
Is/was this child receiving these special services during the pandemic (since March 2020)?	◯ Yes ◯ No
Was this child receiving these special services before the pandemic (before March 2020)?	◯ Yes ◯ No

Demographics

COVID-19 Pediatric Joint Group Discussion Recommended Measures

Sex

What was the participant's sex assigned at birth?	◯ Female ◯ Male ◯ Intersex ◯ None of these describe the participant ◯ Prefer not to answer

Age

[> 2 years] What is the participant's current age in years?	_____ (years)
[< 2 years] What is the participant's current age in months?	_____ (months)

Gestational age at birth (Tier 2)
(Ages 0-2 years)

If < 2 years of age, what was the participant's gestational age at birth (in weeks)?	_____ (weeks)
	◯ Unknown ◯ Refused

Ethnicity

Is the participant of Hispanic, Latino, or Spanish origin?	◯ No, not of Hispanic, Latino, or Spanish origin ◯ Yes, of Hispanic, Latino, or Spanish origin ◯ Prefer not to say

Race

What is the participant's race? Mark one or more boxes	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Some other race ☐ Prefer not to answer

Zip Code

What is the participant's 5-digit zip code?	_____

Additional Guidance: Participant's zip code and birth date are protected health information, please refer to the guidance document for more information.

Gender Identity (Tier 2)

Additional Guidance: The Working Group consulted the NIH Sexual & Gender Minority Research Office (SGMRO) to ascertain whether there is an established measure of Gender Identity validated in children as the PhenX P11801 Measure is for participants 18+ years.

As of now, there is not a preferred pediatric-specific validated measure, and this remains an important gap in the SGM data collection repertoire. There are many ongoing efforts to address this gap, including the work of the Measuring Sexual Orientation and Gender Identity (SOGI) Research Group's Youth Subgroup, and an in-progress NIH-commissioned consensus report from the National Academies of Sciences, Engineering, and Medicine on collecting sex, gender identity, and sexual orientation data. One measure used in ages 9-10 in the ABCD Study® is presented below, and this data element will be amended if future guidance on the topic is updated:

Child Self-Report (Ages 9+)

Are you transgender?

- ◯ Yes
- ◯ Maybe
- ◯ No
- ◯ Did not understand

Parent Report about Child (Ages 9+)

Is your child transgender?

- ◯ Yes
- ◯ Maybe/dont know
- ◯ No
- ◯ Decline to answer

Disability Functional Status

Disability Status (Tier 2)	
Child Self-Report (Ages 15+)	
1. Are you deaf, or do you have serious difficulty hearing?	◯ Yes ◯ No
2. Are you blind, or do you have serious difficulty seeing, even when wearing glasses?	◯ Yes ◯ No
3. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)	◯ Yes ◯ No
4. Do you have serious difficulty walking or climbing stairs? (5 years old or older)	◯ Yes ◯ No
5. Do you have difficulty dressing or bathing? (5 years old or older)	◯ Yes ◯ No
6. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)	◯ Yes ◯ No
Parent Report About Child (As used in National Survey of Children's Health)	
Ages 0-5 Does this child have any of the following?	
Deafness or problems with hearing?	◯ Yes ◯ No
Blindness or problems with seeing even when wearing glasses?	◯ Yes ◯ No
Ages 6-11 Does this child have any of the following?	
Serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition?	◯ Yes ◯ No
Serious difficulty walking or climbing stairs?	◯ Yes ◯ No
Difficulty dressing or bathing?	◯ Yes ◯ No
Deafness or problems with hearing?	◯ Yes ◯ No
Blindness or problems with seeing even when wearing glasses?	◯ Yes ◯ No
Ages 12+ Does this child have any of the following?	

Serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition?	◯ Yes ◯ No
Serious difficulty walking or climbing stairs?	◯ Yes ◯ No
Difficulty dressing or bathing?	◯ Yes ◯ No
Difficulty doing errands alone, such as visiting a doctor's office or shopping, because of a physical mental, or emotional condition?	◯ Yes ◯ No
Deafness or problems with hearing?	◯ Yes ◯ No
Blindness or problems with seeing even when wearing glasses?	◯ Yes ◯ No

Additional Guidance: For studies wanting to collect more than this short 6-item set, it is recommended to use the Washington Group / UNICEF Child Functioning Module, which serves as an international standard for assessing disability in children 2-4, and 5-17: https://www.washingtongroupdisability.com/question-sets/wgunicef-child-functioning-module-cfm/

Special Health Care Needs (Tier 2)

Parent Report About Child

CSHCN: https://www.cahmi.org/projects/children-with-special-health-care-needs-screener/
• Special Health Care Needs 5 Item Screener
https://depts.washington.edu/dbpeds/Screening%20Tools/CSHCN-CAMHIScreener.pdf

1. Does your child currently need or use medicine prescribed by a doctor (other than vitamins)?	◯ Yes ◯ No
1a. Is this because of ANY medical, behavioral or other health condition?	◯ Yes ◯ No
1b. Is this a condition that has lasted or is expected to last for at least 12 months?	◯ Yes ◯ No
2. Does your child need or use more medical care, mental health or educational services than is usual for most children of the same age?	◯ Yes ◯ No
2a. Is this because of ANY medical, behavioral or other health condition?	◯ Yes ◯ No
2b. Is this a condition that has lasted or is expected to last for at least 12 months?	◯ Yes ◯ No
3. Is your child limited or prevented in any way in his or her ability to do the things most children of the same age can do?	◯ Yes ◯ No
3a. Is this because of ANY medical, behavioral or other health condition?	◯ Yes ◯ No

3b. Is this a condition that has lasted or is expected to last for at least 12 months?	◯ Yes ◯ No
4. Does your child need or get special therapy, such as physical, occupational or speech therapy?	◯ Yes ◯ No
4a. Is this because of ANY medical, behavioral or other health condition?	◯ Yes ◯ No
4b. Is this a condition that has lasted or is expected to last for at least 12 months?	◯ Yes ◯ No
5. Does your child have any kind of emotional, developmental or behavioral problem for which he or she needs or gets treatment or counseling?	◯ Yes ◯ No
5a. Has this problem lasted or is it expected to last for at least 12 months?	◯ Yes ◯ No

Guidance: If respondents answer that children have any of these special needs or limitations and that the problem has lasted or is expected to last 12 months or more, children are classified as special needs and are asked more questions than children without special needs. The survey includes information on how often during the past 12 months medical, behavioral, or other health conditions affected the ability of the children identified as having special needs to do things other children of the same age do; how much these conditions affect the children's ability; and how often children's health care needs change.

Normative Physical Functional Status

Child Self Report (Ages 8-17)

When people are sick or not feeling well, it is sometimes difficult for them to do their regular activities.

In the past two weeks, would you have had any physical trouble or difficulty doing these activities?

	No trouble	A little trouble	Some trouble	A lot of trouble	Impossible
1. Walking to the bathroom	◯	◯	◯	◯	◯
2. Walking up stairs	◯	◯	◯	◯	◯
3. Doing something with a friend. (For example, playing a game.)	◯	◯	◯	◯	◯
4. Doing chores at home	◯	◯	◯	◯	◯
5. Eating regular meals	◯	◯	◯	◯	◯
6. Being up all day without a nap or rest	◯	◯	◯	◯	◯
7. Riding the school bus or traveling in the car	◯	◯	◯	◯	◯

Remember, you are being asked about difficulty due to physical health					
	No trouble	A little trouble	Some trouble	A lot of trouble	Impossible
8. Being at school all day	◯	◯	◯	◯	◯
9. Doing the activities in gym class (or playing sports)	◯	◯	◯	◯	◯
10. Reading or doing homework	◯	◯	◯	◯	◯
11. Watching TV	◯	◯	◯	◯	◯
12. Walking the length of a football field	◯	◯	◯	◯	◯
13. Running the length of a football field	◯	◯	◯	◯	◯
14. Going shopping	◯	◯	◯	◯	◯
15. Getting to sleep at night and staying asleep	◯	◯	◯	◯	◯

Developmental Milestones (Tier 2)

- Parent Report About Child (Ages 0-5) by age bands:
- SWYC: https://www.tuftschildrenshospital.org/The-Survey-of-Wellbeing-of-Young- Children/Age-Specific-Forms

Developmental Delay Screening/Surveillance (Tier 1)

Parent Report about Child (Ages 9 months-5 years)

DURING THE PAST 12 MONTHS, did this child see a doctor, nurse, or other health care professional for sick-child care, well-child check-ups, physical exams, hospitalizations, or any other kind of medical care?	◯ Yes	◯ No
DURING THE PAST 12 MONTHS, did you, another family member or a friend have concerns about this child's learning, development, or behavior?	◯ Yes	◯ No
DURING THE PAST 12 MONTHS, did this child's doctors or other health care providers ask if you have concerns about this child's learning, development, or behavior?	◯ Yes	◯ No
DURING THE PAST 12 MONTHS, did you, another family member or a friend have concerns about this child's learning, development, or behavior that wasn't asked about by your provider?	◯ Yes	◯ No
DURING THE PAST 12 MONTHS, did a doctor or other health care provider have you or another caregiver fill out a questionnaire about observations or concerns you may have about this child's development, communication, or social behaviors? Sometimes a child's doctor or other health care provider will ask a parent to do this at home or during a child's visit.	◯ Yes	◯ No

If yes, did the questionnaire ask about your concerns or observations about:

Mark ALL that apply.

☐ How this child talks or makes speech sounds?
☐ How this child interacts with you and others?

If yes, and this child is 2-5 years of age:

Did the questionnaire ask about your concerns or observations about:

Mark ALL that apply.

☐ Words and phrases this child uses and understands?
☐ How this child behaves and gets along with you and others?

Baseline Child Health 2

Underlying Conditions (from Biomedical WG)

Significant underlying medical conditions at the time of COVID-19 testing or diagnosis:

- ☐ Diabetes type I
- ☐ Diabetes type II
- ☐ Obesity
- ☐ Asthma
- ☐ Bronchopulmonary dysplasia (BPD)
- ☐ Cystic fibrosis
- ☐ Obstructive sleep apnea
- ☐ Tracheomalacia
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Hematopoietic cell recipient/bone marrow transplant recipient
- ☐ Solid organ transplant recipient
- ☐ Rheumatologic conditions (e.g. rheumatoid arthritis, systemic lupus erythematosus, vasculitis)
- ☐ Hypertension
- ☐ Congenital heart disease
- ☐ Heart failure
- ☐ Cardiomyopathy
- ☐ History of Kawasaki Disease (not a current diagnosis)
- ☐ History of MIS-C (not a current diagnosis)
- ☐ Inflammatory bowel disease
- ☐ Feeding tube dependent
- ☐ Sickle cell disease
- ☐ Thrombotic disorders
- ☐ Chronic liver disease
- ☐ Chronic kidney disease
- ☐ Seizure disorder/epilepsy
- ☐ Eczema
- ☐ Physical disability (including cerebral palsy)
- ☐ Down syndrome
- ☐ Congenital syndromes/anomalies or genetic conditions including other chromosomal syndromes
- ☐ Premature or neonatal conditions
- ☐ Pregnancy (if of reproductive age)
- ☐ Other conditions (specify)

Specify other

_____

Premature and Neonatal Conditions (Tier 2)

- ☐ Fetal malnutrition
- ☐ Extreme immaturity
- ☐ Cerebral hemorrhage at birth
- ☐ Spinal cord injury at birth
- ☐ Birth asphyxia
- ☐ Respiratory diseases
- ☐ Hypoxic-ischemic encephalopathy
- ☐ Other

Specify other

_____

Underlying Conditions (from Psychosocial WG)

Significant underlying conditions at the time of COVID-19 testing or diagnosis:

- ☐ Tourette Syndrome
- ☐ Depression
- ☐ Anxiety problems
- ☐ Autism, Asperger's Disorder, pervasive developmental disorder or other autism spectrum disorder
- ☐ Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder (ADD/ADHD)
- ☐ Chronic fatigue
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ Suicidal thoughts or behaviors
- ☐ Mania or bipolar disorder
- ☐ Behavioral disorder or conduct problems
- ☐ Developmental delay
- ☐ Intellectual disability (formerly known as mental retardation)
- ☐ Speech or other language disorder
- ☐ Learning disability