COVID-19 & other acute respiratory infections **Initial** Follow Up Survey

FOR CHILDREN AND YOUNG PEOPLE

(less than 18 years of age)

The question on our minds

This is for people like you, or your child who has had Covid-19 or another respiratory illness. We would like your help to answer a question that is on our minds and may be on yours: "What does Covid-19, or other common respiratory infections, mean for the long-term health and well-being of children?" We are also interested in if there are other factors that may influence recovery. This can help inform prevention and care to improve long term health and wellbeing for all. To be able to answer these questions we need to compare health and wellbeing of those that have been affected by Covid-19 with children affected by other common respiratory illnesses.

How you can help

Covid-19 is a new illness. Being included in this survey means you can help us build a better understanding of the acute and long-term care and support needed for Covid-19 and other common respiratory infections globally. By comparing Covid-19 with other respiratory illnesses it will help us understand how these may affect us in the long term. As far as possible, we do not want to leave anyone out. Our aim is that every child and teenager affected by Covid-19 or other respiratory infection has a chance to take part, whether they have been treated in hospital or at home. We do not know how long symptoms in children will last, so, to find out, we would like to repeat this survey asking you about your child's health in three to six months' time.

Completing the survey

Please complete this survey. For young children, parents may help them complete the survey on their behalf. Covid-19 and other respiratory infections may affect people differently, so our survey has to cover a range of issues. Please do not worry if several questions do not feel relevant to you. If you feel unable to answer any question, just move on to the next. Equally, if the survey highlights issues you or your child have not had a chance to deal with, please take good care and raise these issues with a health professional. Please also find advice on: **(add local health information website).**

Protecting your information

In this follow-up survey, we will use information that you provide. We will only use information that we need to inform our research. We will let very few people know your and your child's name or contact details, and only then if they really need it for this study. Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules. We will make sure no one can work out who you or your child are from any reports. Your answers will only be used in ways that do not identify you or your child, for example in summary reports or scientific journals to educate health care professionals. Please feel free to read more about the privacy policy at our website, (***add link to ISARICs or a local website***) where you can also download the online version or further paper copies of this form.

Our thanks to you

Thank you for helping answer this important question, at the forefront of our minds.

PARTICIPANT IDENTIFICATION #: [__][__][__][__][__]-[__][__][__][__]

SURVEY TIMEPOINT (to be completed by the team before sending or administering the survey):

3m [__] 6m [__] 12m [__] 24m [__] 36m [__]

Survey completed: ❑ Self-assessment ❑ Staff/research led assessment
Completed by ❑ Telephone ❑ Post ❑ Clinic ❑ Online

The questions were answered by the:
❑ Young person/child ❑ Parent or carer ❑ Other If *other*, please specify _____

Your permission to proceed

Thank you for coming this far. Now to take part, please read the statements below, and initial the boxes if you are happy to go ahead.

PLEASE MARK YOUR INITIALS AGAINST EACH STATEMENT WITH WHICH YOU AGREE:	*Add your Initials or tick the box:*	
I give my consent for the information I provide in this study to be used as advised.		
I would like to continue to be sent this survey via email, post or to be contacted via telephone follow up every 3 to 6 months for a maximum of 3 years after my respiratory illness,. If yes, please enter your contact details here: E-mail:_____ Mobile phone number: _____ Home telephone number: _____	YES	NO

Please enter your details

Your first name:_____Surname: _____

Town/City of residence:_____Postcode:_____

Your signature:_____

If you are completing the survey on behalf of your child please also enter your details below:

Your first name: _____Surname:_____

Your signature:_____

Local hospital ID:_____

ISARIC **PARTICIPANT IDENTIFICATION** #: [__][__][__][__][__]-[__][__][__][__]

The child is included in the study as ❑ Case (post-Covid19 onset) ❑ Control (non Covid-19 ARI)

1. About you (<u>if the survey is completed by an adult or carer, all questions relates to the child)</u>

Sex/Gender: ❑ Male ❑ Female ❑ Non-binary ❑ Prefer not to say

Ethnicity (tick all that apply): ❑ White ❑ Arab ❑ Black ❑ East Asian ❑ South Asian ❑ West Asian

❑ Latin American ❑ Aboriginal/first nation ❑ Other (specify):_____ ❑ Prefer not to say

How many members regularly live in your household, including yourself: [_Number_]

2. About <u>your Covid-19 or other</u> respiratory infection

(if the survey is completed by an adult or carer, all questions relates to the child)

Date you completed this survey (DD/MM/YYYY): [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_2_][_Y_]

What is your date of birth (DD/MM/YYYY): [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

2a. Do you believe that you have had Covid-19? ❑ Yes ❑ No ❑ Not sure, <u>if no skip to question 2b</u>.

If yes, approximately, what day did you first experience symptoms of Covid-19?

[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ❑ No symptoms

How were you diagnosed with Covid-19?

□ Laboratory confirmed (positive test) □ Physician/doctor confirmed □ Self-diagnosed

Estimated date of your most recent positive SARS-CoV-2 /Covid-19 test:

[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_2_][_Y_] ❑ Not applicable

2b. Have you been diagnosed with another recent respiratory infection? If yes, please state which one:

□Common cold □ RSV □ Rhinovirus □ Bocavirus □Adenovirus □Influenza □Streptococcus pneumoniae

□Streptococcus pyogenes □Epstain-Barr Virus □No isolated pathogen but radiological evidence of respiratory infection □Other (please clarify) :_____ □ Not sure □ Not applicable

Approximately, what day did you first experience symptoms of this respiratory illness?

[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_2_][_Y_] □ Not applicable

2c. What symptoms did you experience at onset of Covid-19 (cases), OR onset of other respiratory infection (controls)?

What symptoms did you experience in the first 14 days of your illness?

(tick all that you experienced when you first became unwell) ☐Fever ≥ 38°C ☐Runny nose ☐ Headache

☐Sore throat ☐Muscle pain ☐Abdominal pain ☐Vomiting ☐Diarrhoea

☐ Cough ☐Shortness of breath ☐ Fatigue ☐ Pain on breathing ☐Chest pain ☐Loss or disturbed smell

☐Loss or disturbed taste ☐Confusion ☐Brain fog* ☐Other symptoms:_____

☐No symptoms

*Brain fog (often described as a feeling 'foggy', confusion, short term memory problems, indecisive, not being able to think clearly)

3. Hospitalisation

Have you been admitted to hospital due to this illness (Covid-19 (case) or other ARI (control group))?
❑ Yes ❑ No If yes complete the below, if no skip to question 4.

Roughly at what date were you first admitted to hospital? [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_2_][_Y_]

Roughly at what date were you first discharged from hospital? [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_2_][_Y_]

Did you spend any time in an Intensive Care Unit (P/ICU)? ❑ Yes ❑ No ❑ Not sure

Did your receive oxygen (e.g. via a mask, or nose cannula)? ❑ Yes ❑ No ❑ Not sure

Have you been re-admitted to hospital after the first acute illness? ❑ Yes ❑ No

If yes, how many times : [_Number_] please specify main reason/reasons:_____

4. Covid-19 vaccination

Have you been vaccinated against Covid-19? ❑ Yes ❑ No if yes complete the below, if no skip to question 5a.

If yes, how many times have you had the Covid-19 vaccine? [_Number_]

Which type of Covid-19 vaccine did you receive (if different types indicate all those you have received):

❑ AstraZeneca ❑ Pfizer-BioNTech ❑ Imperial ❑ Janssens ❑ Moderna's ❑ Sinopharm ❑ Sputnik V

❑ Other (name): _____ ❑ Not sure

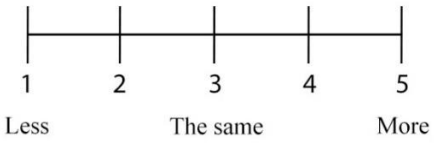
Estimated date of the most recent Covid-19 vaccine dose received: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_2_][_Y_]

5a. About your emotional wellbeing, social relationships and activities today compared to before illness onset.

To answer the following questions, please **mark an X** on the lines below that match your opinion on the question

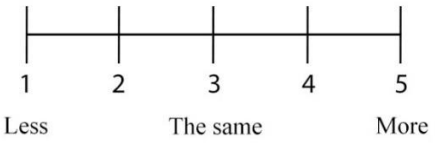
A. Compared to before your illness onset, how much are you now doing/experiencing the following

Eating



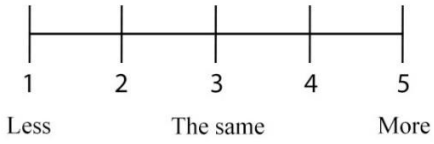
❑ Unsure

Sleeping



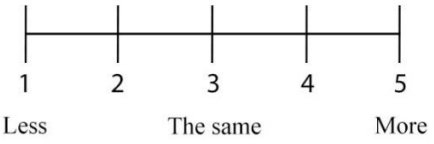
❑ Unsure

Physical Activity



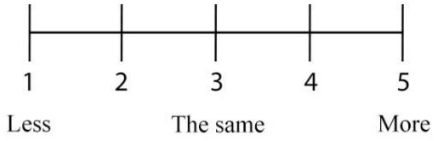
❑ Unsure

Fatigue



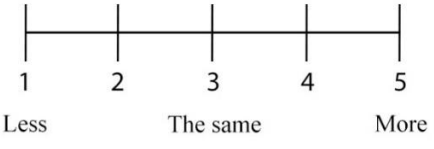
❑ Unsure

Spending time with friends in-person



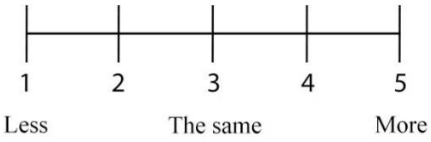
❑ Unsure

Spending time with friends remotely (e.g., online, social media, texting)



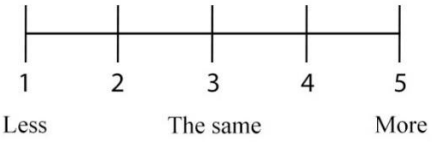
❑ Unsure

Spending time watching TV, playing video/computer games, or using social media <u>for educational purposes</u>, including school/nursery work



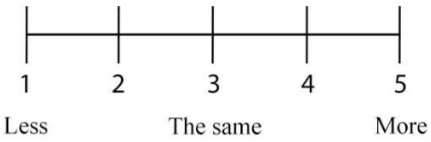
❑ Unsure

Spending time watching TV, playing video/computer games, or using social media <u>for non-educational purposes</u>,



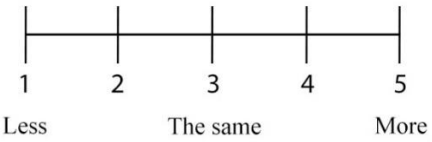
❑ Unsure

Spending time outside



❑ Unsure

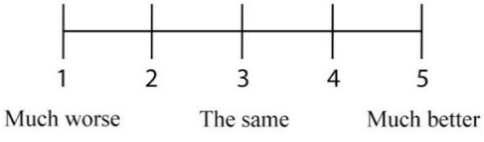
Attending nursery/school/university/work



❑ **Not applicable**

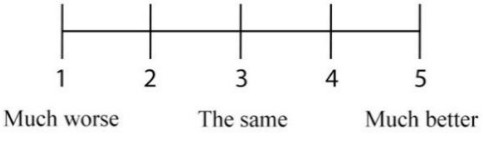
B. Compared to before your illness onset: Have there been changes in your …

… CONNECTEDNESS with others…



❑ Unsure

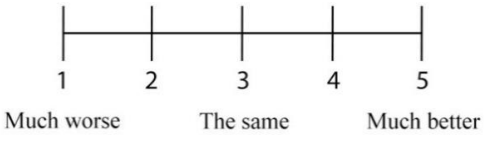
…EMOTIONS?



❑ Unsure

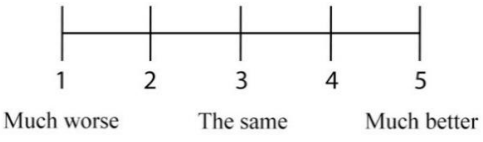
Compared to before your illness onset: Have there been changes in your …

…BEHAVIOUR?



❑ Unsure

…RELATIONSHIPS, in how they get on with others?



❑ Unsure

C. Have you asked for help from a health professional because of consequences to your EMOTIONS, BEHAVIOUR OR RELATIONSHIPS due to your illness?

❑ Yes ❑ No, if yes what kind of service did you ask for help from_____

D. If you have replied MUCH WORSE to any of the options above, OR IF YOU HAVE ASKED FOR HELP for these problems (please, answer the following questions):

Do these difficulties upset or distress you?

❑ Not at all ❑ Only a little ❑ Not sure ❑ Quite a lot ❑ A great deal

E. Since first onset, how many school/nursery or work weeks (online or in person) in total did you miss because of persisting symptoms? [_Number_] **in weeks** ❑ None

5b. About your state of health before you were diagnosed with Covid-19 (cases) OR other respiratory illness (controls):

Have you been physicians diagnosed or received treatment/support for any of the following prior to onset of your illness that are still ongoing? (answer with a tick in the box)

	Yes	No		Yes	No
Neurological/Neuro-disability			Immune system diseases		
Gut/stomach problems			Genetic conditions		
Heart diseases			Diabetes (if yes indicate type: □ Type 1 □ Type 2)		
Respiratory diseases (not including asthma)			Other endocrine illness (not diabetes)		
Asthma (doctors diagnosed)			Renal/Kidney problems		
Allergic rhinitis/hay fever			Excessive weight or obesity		
Food allergy			Malnutrition		
Atopic dermatitis/Eczema			Depression		
Rheumatological disease *(e.g. arthritis, or inflammation of the joints)*			Anxiety		
Sickle cell disease			HIV		
Haematological disease *(other blood diseases)*			TB (tuberculosis)		
Oncology (cancer, including lymphoma)			Other (please indicate):		

Were you born prematurely (<37 weeks)? ❑ Yes ❑ No ❑ Not sure

Have you ever sought support from a child /adolescent mental health/psychological services before the Covid-19 pandemic? ❑ Yes ❑ No

Prior to Covid-19 or other respiratory illness onset, how was your <u>physical health</u> in general?
❑ Very poor ❑ Poor ❑ Ok ❑ Good ❑ Very good

Prior to Covid-19 or other respiratory illness onset, how would you describe your <u>mental /psychological health</u> in general? ❑ Very poor ❑ Poor ❑ Ok ❑ Good ❑ Very good

6. About your <u>current</u> health

Have you felt feverish recently? ❑ Yes ❑ No ❑ Not sure

If yes indicate when you felt feverish (tick all that apply)

❑ Within the last 7 days ❑ 1-2 weeks ago ❑ >2-4 weeks ago ❑ >1-2 months ago ❑ >2-3 months ago

❑ >3-6 months ago ❑ Since Covid-19/other respiratory illness onset

If yes, what was the most likely cause of your most recent feverish illness?

❑ Covid-19 ❑ Other respiratory infection (cough/cold/sore throat) ❑ TB

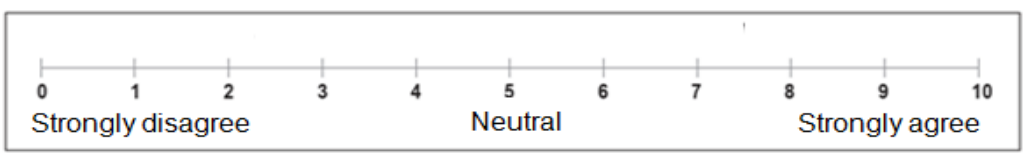
❑ Stomach infection (diarrhea/vomiting) ❑ Urinary infection ❑ Other (specify): _____

❑ Unknown ❑ Prefer not to say

How much do you agree with the following statement?

"I have fully recovered from my infection"

Please **mark an X** on the line below that match your opinion on the question as of **TODAY:**



7. We would like to know more about any problems you have had with feeling tired, weak or lacking in energy in the LAST MONTH. Please answer ALL the questions by ticking the answer which applies to you most closely. If you have been feeling tired for a long while, then compare yourself to how you felt when you were last well

	less than usual	***no more than usual***	***more than usual***	***much more than usual***
Do you have problems with tiredness?				
Do you need to rest more?				
Do you feel sleepy or drowsy?				
Do you have problems starting things?				
Do you lack energy?				
Do you have less strength in your muscles?				
Do you feel weak?				
Do you have difficulties concentrating?				
Do you make slips of the tongue when speaking?				
Do you find it more difficult to find the right word?				
	better than usual	***no worse than usual***	***worse than usual***	***much worse than usual***
How is your memory?				

8. Within the **last seven days,** have you had any of these symptoms**,** which **were NOT present** before start of your Covid-19 / other respiratory illness (control group)? (Indicate if you have a symptom (tick Yes) or if you do not have a specific symptom (tick no))

Symptoms	**Tick Yes/No**	Indicate duration of symptoms (***in months***) and severity
Nasal congestion / rhinorrhea	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Difficulty breathing /chest tightness	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Chest pain	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Persistent cough	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Problems with balance	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Persistent muscle pain	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Joint pain or swelling	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Headache	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Dizziness/ light headedness	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe

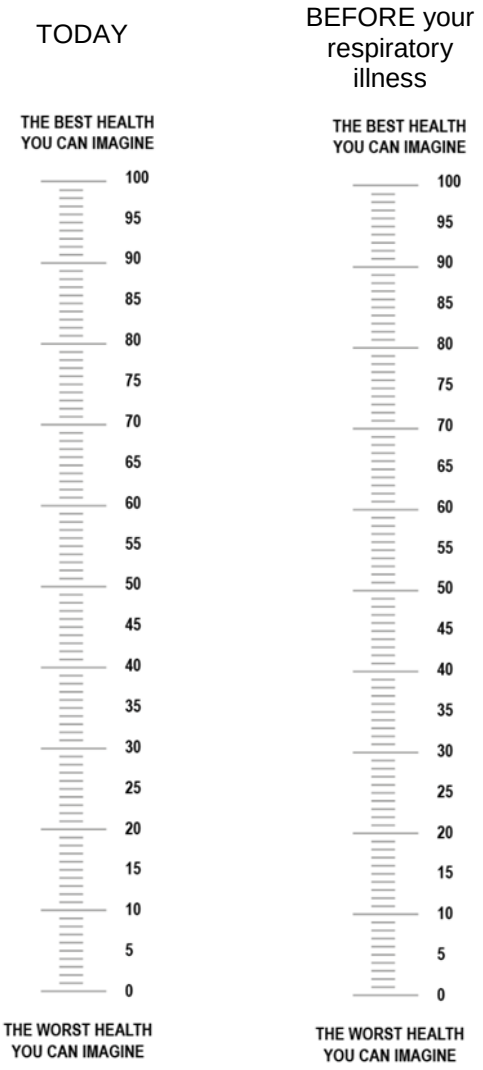
Problems seeing/blurred vision	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Disturbed smell/Loss of smell	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Disturbed taste/Loss of taste	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Insomnia *(hard to fall asleep, hard to stay asleep)*	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Hypersomnia *(excessive daytime sleepiness or prolonged nighttime sleep)*	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Tingling feeling/"pins and needles"	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Fainting/black outs	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Confusion/loss of concentration	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Fatigue	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Poor appetite	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Diarrhea	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Stomach/ abdominal pain	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Feeling nauseous/persistent vomiting	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Constipation	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Palpitations (heart racing)	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Variations in heart rate (tachycardia or bradycardia)	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Skin rash	❑ Yes ❑ No	□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe
Other New Symptoms, if yes, specify:		indicate duration of symptoms (***in months***) and severity
		□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □≥12 □ mild □ moderate □ severe □ very severe
		□ < 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ ≥12 □ mild □ moderate □ severe □ very severe

9. Since having Covid-19 or the other respiratory infection you declared, have you been diagnosed with any of the following?

	YES	NO		YES	NO
Asthma			Depression		
Pulmonary embolism /micro emboli *(PE, "Clot in lung")*			Anxiety		
			Diabetes If yes, ❑ Type 1 ❑ Type 2		
Kawasaki disease			Shock / Toxic shock syndrome		
Multisystem inflammatory syndrome (MIS-C/PIMS-TS)			Coagulopathy *(excessive bleeding or clotting)*		
Respiratory failure			Kidney problems		
Reduced lung function			Other condition (if yes, specify):		
Myocarditis *(inflammation of the heart muscle)*					

10. Your overall health status

- We would like to know how good or bad your health is
  - This line is numbered from 0 to 100
  - 100 means the best health you can imagine.
    0 means the worst health you can imagine.
  - Please mark an X on the line that shows how your health is TODAY and how it was BEFORE your illness.



11. Health and wellbeing For Children and Teenagers from 8 to 17 years old

If you/your child is under 8 years old skip to question 12.

Describe your health **TODAY**

Under each heading, please tick the ONE box that describes your health TODAY

Mobility (walking about)	Looking after myself
❑ I have no problems walking about	❑ I have no problems washing or dressing myself
❑ I have some problems walking about	❑ I have some problems washing or dressing myself
❑ I have a lot of problems walking about	❑ I have a lot of problems washing or dressing myself

Describe your health **TODAY**

Under each heading, please tick the ONE box that describes your health TODAY

Doing usual activities (for example, going to school, hobbies, sports, playing, doing things with family or friends) ❑I have no problems doing my usual activities ❑ I have some problems doing my usual activities ❑ I have a lot of problems doing my usual activities	Having pain or discomfort ❑ I have no pain or discomfort ❑ I have some pain or discomfort ❑I have a lot of pain or discomfort
Feeling worried, sad or unhappy ❑ I am not worried, sad or unhappy ❑ I am a bit worried, sad or unhappy ❑ I am very worried, sad or unhappy	

Describe your health **BEFORE onset of your Covid-19 or the other respiratory illness you declared**

Under each heading, please tick the ONE box that describes your health BEFORE onset of your respiratory illness

Mobility (walking about) ❑I had no problems walking about ❑ I had some problems walking about ❑I had a lot of problems walking about	Looking after myself ❑I had no problems washing or dressing myself ❑I had some problems washing or dressing myself ❑ I had a lot of problems washing or dressing myself
Doing usual activities (for example, going to school, hobbies, sports, playing, doing things with family or friends) ❑I had no problems doing my usual activities ❑ I had some problems doing my usual activities ❑ I had a lot of problems doing my usual activities	Having pain or discomfort ❑I had no pain or discomfort ❑ I had some pain or discomfort ❑ I had a lot of pain or discomfort
Feeling worried, sad or unhappy ❑I was not worried, sad or unhappy ❑ I was a bit worried, sad or unhappy ❑ I was very worried, sad or unhappy	

12. Please let us know of any additional comments about your respiratory illness (Covid-19 or other declared):

End of survey

Thank you for your time!