ORCHARDS HOUSEHOLD STUDY FORM

School ID: ______________

Participant ID: ___________

NASAL SWAB

ID

HOUSEHOLD MEMBER NAME: ____________________

RELATIONSHIP TO STUDENT: ______________________

Age: _____ **Do you work outside the home?** Yes No **Number of bedrooms:** _____

Gender: F M **Do you attend school?** Yes No **Do you attend Daycare?** Yes No

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TODAY Day 0 (___/___/___)

-Did you receive an influenza vaccine this year (after August 1, 2019)? Yes No

Have you had cold or flu-like symptoms in the past 7 days? Yes No (if **No**, then you are done until next week)

If yes: How many days ago did your symptoms start? _______

How severe are/were your symptoms? Mild Moderate Severe

What symptoms have you had in the past 7 days? (circle all that have been present)

Fever Chills Cough Runny Nose Sore Throat

Tiredness Body Aches Headache Poor Appetite Nasal Congestion

Were you seen by a healthcare provider? Yes No **Where?** Usual Clinic Urgent Care ER

What diagnosis were your given? ____________________

Were you given an antibiotic or antiviral medication? Yes No ______________________

Were you sent to the hospital? Yes No

Did you miss school or Work? Yes No **If yes, how many days did you miss?** ______

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FOLLOW-UP Day 7 (___/___/___)

Have you had cold or flu-like symptoms in the past 7 days (since our previous visit)? Yes No

If yes: How many days ago did your symptoms start? _______

How severe are/were your symptoms? Mild Moderate Severe

What symptoms have you had in the past 7 days? (circle all that have been present)

Fever Chills Cough Runny Nose Sore Throat

Tiredness Body Aches Headache Poor Appetite Nasal Congestion

Were you seen by a healthcare provider? Yes No **Where?** Usual Clinic Urgent Care ER

What diagnosis were your given? ____________________

Were you given an antibiotic or antiviral medication? Yes No ______________________

Were you sent to the hospital? Yes No

Did you miss school or Work? Yes No **If yes, how many days did you miss?** ______