Public Health England

Immunisation and Countermeasures Division
National Infection Service
Public Health England
61 Colindale Avenue
London NW9 5EQ

SECTION A: About your child

We want to know how coronavirus affects everybody so it will be helpful to know a bit more about your child.

Child ID: __ __ __ __ __ Contact email address: _____

1. Child's first name: 2. Child's surname?
3. What is the date of birth of your child? *(DD/MM/YYYY)* ____/____ /_____
4. Please tell us your relation to the child:

☐ Parent ☐ Guardian ☐ Carer Other *(please specify):*_____

5. What was your child's sex at birth? ☐ Male ☐ Female ☐ Prefer not to say

6. What is your child's ethnic group? *Choose one option that best describes your child's ethnic group or background*

- ☐ White: English/Welsh/Scottish/Northern Irish/British
- ☐ White: Irish
- ☐ White: Gypsy or Irish Traveller
- ☐ White: any other White background
- ☐ Mixed/Multiple: White and Black Caribbean
- ☐ Mixed/Multiple: White and Black African
- ☐ Mixed/Multiple: White and Asian
- ☐ Mixed/Multiple: any other mixed/multiple ethnic background
- ☐ Asian/Asian British: Indian
- ☐ Other ethnic group *(please describe):* _____
- ☐ Asian/Asian British: Pakistani
- ☐ Asian/Asian British: Bangladeshi
- ☐ Asian/Asian British: Chinese
- ☐ Asian/Asian British: any other Asian/Asian British background
- ☐ Black/African/Caribbean/Black British: African
- ☐ Black/African/Caribbean/Black British: Caribbean
- ☐ Black/African/Caribbean/Black British: any other Black/African/Caribbean background
- ☐ Other ethnic group: Arab
- ☐ Prefer not to say

7. Which type of educational setting does your child usually attend? *Please tick all that apply*

- ☐ Playgroup
- ☐ Day nursery
- ☐ School nursery
- ☐ Primary School
- ☐ Other *(please describe):* _____
- ☐ Secondary School
- ☐ Special Education School
- ☐ Home school
- ☐ Does not attend playgroup/nursery or school

8. Was your child in playgroup/nursery/school at any time in the 2 weeks before their coronavirus test or illness? ☐ Yes ☐ No ☐ Don't know or unsure ☐ Not applicable

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9. How many people live in the household **in addition** to the child who is the subject of the survey (where the child spends most of the time)? _____

By household, we mean the people (both adults and children) living in the same residence, even if they are not related (e.g. occupants of a shared house). For this purpose, if any person lives between more than one household, please include members of all households in the total count.

The following table is related to the number of adults (older than 16 years old) and children (16 years or younger) living in the same household as the child.

Question	**Household member 1**	**Household member 2**	**Household member 3**	**Household member 4**
Adult or child	▢ Adult ▢ Child	▢ Adult ▢ Child	▢ Adult ▢ Child	▢ Adult ▢ Child
Age				
Gender	▢ Female ▢ Male ▢ Non-binary ▢ Prefer not to say	▢ Female ▢ Male ▢ Non-binary ▢ Prefer not to say	▢ Female ▢ Male ▢ Non-binary ▢ Prefer not to say	▢ Female ▢ Male ▢ Non-binary ▢ Prefer not to say
Relation to child	▢ Parent ▢ Sibling ▢ Grandparent ▢ Other	▢ Parent ▢ Sibling ▢ Grandparent ▢ Other	▢ Parent ▢ Sibling ▢ Grandparent ▢ Other	▢ Parent ▢ Sibling ▢ Grandparent ▢ Other
Did this person have any COVID-19 like symptoms?	▢ Yes ▢ No ▢ Don't know	▢ Yes ▢ No ▢ Don't know	▢ Yes ▢ No ▢ Don't know	▢ Yes ▢ No ▢ Don't know
Did this person have a positive COVID-19 test result?	▢ Yes ▢ No ▢ Don't know	▢ Yes ▢ No Don't know	▢ Yes ▢ No ▢ Don't know	▢ Yes ▢ No ▢ Don't know
If yes, date of the COVID-19 test	___/__/____ *DD/MM/YYYY*	___/__/____ *DD/MM/YYYY*	___/__/____ *DD/MM/YYYY*	___/__/____ *DD/MM/YYYY*

Question	**Household member 5**	**Household member 6**	**Household member 7**	**Household member 8**
Adult or child	▢ Adult ▢ Child	▢ Adult ▢ Child	▢ Adult ▢ Child	▢ Adult ▢ Child
Age		▢	▢	▢
Gender	▢ Female ▢ Male ▢ Non-binary ▢ Prefer not to say	▢ Female ▢ Male ▢ Non-binary ▢ Prefer not to say	▢ Female ▢ Male ▢ Non-binary ▢ Prefer not to say	▢ Female ▢ Male ▢ Non-binary ▢ Prefer not to say
Relation to child	▢ Parent ▢ Sibling ▢ Grandparent	▢ Parent ▢ Sibling ▢ Grandparent	▢ Parent ▢ Sibling ▢ Grandparent	▢ Parent ▢ Sibling ▢ Grandparent

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	▢ Other	▢ Other	▢ Other	▢ Other
Did this person have any COVID-19 like symptoms?	▢ Yes ▢ No ▢ Don't know	▢ Yes ▢ No ▢ Don't know	▢ Yes ▢ No ▢ Don't know	▢ Yes ▢ No ▢ Don't know
Did this person have a positive COVID-19 test result?	▢ Yes ▢ No ▢ Don't know	▢ Yes ▢ No Don't know	▢ Yes ▢ No ▢ Don't know	▢ Yes ▢ No ▢ Don't know
If yes, date of the COVID-19 test	___/__/____ *DD/MM/YYYY*	___/__/____ *DD/MM/YYYY*	___/__/____ *DD/MM/YYYY*	___/__/____ *DD/MM/YYYY*

10. If your child tested positive for COVID-19, Where do you think your child may have got their coronavirus infection from? *Please, tick all that apply*

- ▢ Someone in the household
- ▢ At school/nursery/playgroup
- ▢ On public transport
- ▢ In a shop or supermarket
- ▢ I don't know
- ▢ Other. *Please tell us more*: _____
- ▢ Someone else outside the household
- ▢ I don't think they've had coronavirus

SECTION B: About your child's health. We will ask some questions about your child's health before and after the COVID-19 test.

11. Is your child usually healthy? *Prior to their coronavirus illness or test* ☐ Yes ☐ No

Does your child have any of the following (known about or diagnosed prior to their COVID-19 test?) *Please tick all that apply*

- ▢ Asthma
- ▢ Diabetes
- ▢ Immunodeficiency (medically diagnosed poor immune system)
- ▢ Heart condition
- ▢ Lung condition (other than asthma)
- ▢ Chronic fatigue
- ▢ Fainting (syncope)
- ▢ Neurological condition (e.g. Neurological condition
- ▢ Haematological condition
- Hypermobility (e.g. epilepsy)
- ▢ Haematological condition (e.g. sickle cell)
- ▢ Hypermobility (joint pain)
- ▢ Other, *please tell us more*: _____

12. Do you consider your child to have any disability? *Please tick all that apply*

- ▢ None
- ▢ An education and health care plan (EHCP)
- ▢ A learning disability
- ▢ Autistic spectrum disorder (ASD)
- ▢ A physical disability

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- ☐ Prefer not to say
- ☐ Other, *please tell us more:* _____

13. Why was your child tested for coronavirus (COVID-19)? *Please tick all that apply*
    - ☐ My child was unwell with symptoms of COVID-19
    - ☐ Someone in the household was ill with COVID-19
    - ☐ Someone at school/nursery/playgroup was ill with COVID-19
    - ☐ My Child was identified as a contact of someone who was ill with COVID-19, not in the home or school
    - ☐ My child was part of a research study
    - ☐ Other, *please tell us more:* _____

14. If your child was unwell at the time of their coronavirus test, what symptoms did they have? *Please tick all that apply*

	Less than one day	1-2 days	3-4 days	4-7 days	1-2 weeks	2-4 weeks	Over 4 weeks	Did not have this symptom
Fever	☐	☐	☐	☐	☐	☐	☐	☐
Chest Pain	☐	☐	☐	☐	☐	☐	☐	☐
Cough	☐	☐	☐	☐	☐	☐	☐	☐
Shortness of breath/difficulty breathing	☐	☐	☐	☐	☐	☐	☐	☐
Loss of taste and/or smell	☐	☐	☐	☐	☐	☐	☐	☐
Sore throat	☐	☐	☐	☐	☐	☐	☐	☐
Swollen glands	☐	☐	☐	☐	☐	☐	☐	☐
Rash	☐	☐	☐	☐	☐	☐	☐	☐
Headache	☐	☐	☐	☐	☐	☐	☐	☐
Muscle aches	☐	☐	☐	☐	☐	☐	☐	☐
Diarrhoea	☐	☐	☐	☐	☐	☐	☐	☐
Tummy ache	☐	☐	☐	☐	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	☐	☐	☐	☐
No eating or off their food	☐	☐	☐	☐	☐	☐	☐	☐
Tiredness	☐	☐	☐	☐	☐	☐	☐	☐
Floppy or difficulty rousing	☐	☐	☐	☐	☐	☐	☐	☐
Constantly crying	☐	☐	☐	☐	☐	☐	☐	☐
Twitching or tics	☐	☐	☐	☐	☐	☐	☐	☐

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If other, please describe and specify the duration of these symptoms:

_____

If your child had a rash, please answer the following questions:

15. Where was your child's rash? *Please tick all that apply*

- ▢ Head
- ▢ Face
- ▢ Tummy
- ▢ Back
- ▢ Arms
- ▢ Legs
- ▢ All over
- ▢ Don't know or unsure
- ▢ Other, please tell us more: _____

16. What did the rash look/feel like? *Please tick all that apply*

- ▢ Red
- ▢ Pink
- ▢ Spots
- ▢ Spots merging together
- ▢ Blisters
- ▢ Peeling
- ▢ Don't know or unsure

17. Was your child admitted to hospital (overnight) in the two weeks before or after the positive **COVID-19 test?** ☐ Yes ☐ No

What was the date of the admission? *(DD/MM/YYYY)* ____/____/____
How many days was your child in hospital? _____
Was your child admitted for COVID-19 infection? ☐ Yes ☐ No

Was your child admitted to Intensive Care Unit (ICU)? ☐ Yes ☐ No

If yes, please state how many days and reason for admission:

_____

SECTION C: We now have some questions about the progression of your child's illness

18. How many days in total was your child unwell with COVID-19 symptoms? _____
19. If you could remember exactly **one month** after your child's COVID-19 test:
    - ▢ My child recovered completely
    - ▢ My child got better but then became more unwell again (a second illness)
    - ▢ My child was still unwell from initial illness one month after the COVID-19 test
    - ▢ My child did not have any symptoms

20. At **one** month after your child had the COVID-19 test, did your child have any of the following neurological symptoms?

	Never	1-2 times	3-4 times	5 +times	Every day

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Tiredness	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Sleep disturbance	☐	☐	☐	☐	☐
Collapse	☐	☐	☐	☐	☐
Twitching of fingers/toes	☐	☐	☐	☐	☐
Tingling/numbness/needle pains in arms/legs	☐	☐	☐	☐	☐
Confusion/brain fog/trouble focusing attention	☐	☐	☐	☐	☐
Forgetfulness	☐	☐	☐	☐	☐
Short-term memory loss	☐	☐	☐	☐	☐
Trouble trying to form words	☐	☐	☐	☐	☐
Headache	☐	☐	☐	☐	☐
Hallucinations *(seeing/hearing/smelling/feeling things that weren't there)*	☐	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐	☐
Faintness	☐	☐	☐	☐	☐
Vertigo/World Spinning	☐	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	☐
Pins and needles	☐	☐	☐	☐	☐

If other, please describe and specify the duration of these symptoms: _____

21. At **one** month after your child had the COVID-19 test, did your child have any of the following skin problems?

	Never	1-2 times	3-4 times	5 +times	Every day
Dry/scaly skin	☐	☐	☐	☐	☐
Itchy skin	☐	☐	☐	☐	☐
Random bruising	☐	☐	☐	☐	☐
Rashes	☐	☐	☐	☐	☐
Hives *(itchy raised red rash)*	☐	☐	☐	☐	☐
Swollen toes and/or fingers	☐	☐	☐	☐	☐
Purple mottled feet	☐	☐	☐	☐	☐

If other, please describe and specify the duration of these symptoms: _____
_____

22. At **one** month after your child had the COVID-19 test, did your child have any of the following sensory problems? *(smell, taste, speech, vision, hearing)*

	Never	1-2 times	3-4 times	5 +times	Every day
Loss of taste	☐	☐	☐	☐	☐
Loss of smell	☐	☐	☐	☐	☐
Loss of appetite	☐	☐	☐	☐	☐

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Seeing flashing lights	☐	☐	☐	☐	☐
Ringing/buzzing in the ears	☐	☐	☐	☐	☐
Blurred vision	☐	☐	☐	☐	☐
Eye pain	☐	☐	☐	☐	☐
Sensitivity to light	☐	☐	☐	☐	☐
Slurred speech	☐	☐	☐	☐	☐
Metallic taste in the mouth	☐	☐	☐	☐	☐
Earache	☐	☐	☐	☐	☐

If other, please describe and specify the duration of these symptoms: _____

_____

23. At **one** month after your child had the COVID-19 test, did your child have any of the following problems with their chest/breathing:

	Never	1-2 times	3-4 times	5 +times	Every day
Cough	☐	☐	☐	☐	☐
Fits of coughing	☐	☐	☐	☐	☐
Coughing when lying down	☐	☐	☐	☐	☐
Chest tightness/pain	☐	☐	☐	☐	☐
Palpitations	☐	☐	☐	☐	☐
Breathlessness at rest	☐	☐	☐	☐	☐
Breathlessness after small amount of activity	☐	☐	☐	☐	☐
Sore throat	☐	☐	☐	☐	☐
Asthma attack	☐	☐	☐	☐	☐
Having to sleep sitting upright	☐	☐	☐	☐	☐

If other, please describe and specify the duration of these symptoms:

_____

24. At **one** month after your child had the COVID-19 test, did your child have any of the following gastrointestinal problems relating to digestion/eating/drinking and going to the toilet**:**

	Never	1-2 times	3-4 times	5 +times	Every day
Tummy pain	☐	☐	☐	☐	☐
Feeling sick/nausea	☐	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	☐
Bloating	☐	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	☐
Diarrhoea	☐	☐	☐	☐	☐

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Bowel incontinence/unable to control bowels	☐	☐	☐	☐	☐

If other, please describe and specify the duration of these symptoms: _____

_____

25. At **one** month after your child had the COVID-19 test, did your child have any of the following mental health problems:

	Never	1-2 times	3-4 times	5+ times	Every day
Difficulty sleeping at night or getting to sleep	☐	☐	☐	☐	☐
Sleep disturbance	☐	☐	☐	☐	☐
Sadness	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐

If other, please describe and specify the duration of these symptoms:

_____

26. At **one** month after your child had the COVID-19 test, did your child have any of the following other problems:

	Never	1-2 times	3-4 times	5+ times	Every day
Unable to control bladder/leaking wee	☐	☐	☐	☐	☐
Muscle aches	☐	☐	☐	☐	☐
Joint pain	☐	☐	☐	☐	☐
Fever	☐	☐	☐	☐	☐
Back pain	☐	☐	☐	☐	☐
Neck/ shoulder pain	☐	☐	☐	☐	☐
Hair loss	☐	☐	☐	☐	☐

You can provide more information here or tell us of any other problems your child has had:

_____

_____

_____

Is there anything else that you would like to tell us about your child's illness?

_____

_____

_____

Thank you for your participation