U.S. Department of Health and Human Services (HHS)
Centers for Disease Control and Prevention (CDC)

OMB Control # 0920-XXXX
Expiration Date XX/XX/XXXX

ORCHARDS Household study form

ID

ORCHARDS HOUSEHOLD STUDY FORM

School ID: _______________

Participant 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, 2016)? 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?** ______