STUDY – Corona Child

Form 1a-c

Form 1 a-c, Baseline questionnaire, to be filled at Day 0

a) Index case
b) Child contacts
c) Adult contacts

1a) To be filled by the index case and their parent(s) / legal guardian(s)

1. Demographic factors – child testing positive for COVID-19	
Date (DD/MM/YYYY)	___/___/___
F-nummer	
This questionnaire has been filled out by	□ *Mother* □ *Father* □ *Other legal guardian, namely*_____
Gender	□ *Female* □ *Male*
Date of birth (DD/MM/YYYY)	___/___/___
Country of birth	□ *Norway* □ *Other, specify* _____
Country of birth mother	□ *Norway* □ *Other, specify* _____
Country of birth father	□ *Norway* □ *Other, specify* _____
Household size in the last 7 days	*Number*
Composition household (age)	*N numeric fields based on previous question*
2. Clinical information	
Please identify if you had any of the following symptoms in the last 7 days?	
▪ Fever	*No / Yes / Unknown*
▪ More tired, or exhausted	*No / Yes*
▪ Sore throat	*No / Yes*
▪ Cough	*No / Yes*
▪ Runny or stuffy nose	*No / Yes*
▪ Vomiting	*No / Yes*
▪ Diarrhea	*No / Yes*
▪ Stomach pain	*No / Yes*
▪ Sneeze	*No / Yes*
▪ Lack of appetite	*No / Yes*

▪ Other	*No / Yes, specify _____*
When did your first symptoms start?	*DD/MM/YY*
How many days in total did you have any of these symptoms?	*____ days / still ill*
How do you feel today?	□ *As usual* □ *More tired than usual, but up most of the time* □ *Need a lot of rest, but up some of the time* □ *Bedridden and need some help* □ *Bedridden and need a lot of help*
Have you had contact (in person or by phone/digital) with any medical professional? ▪ GP ▪ COVID-19 clinic ▪ Hospital ▪ Emergency clinic ▪ Other	 *No / Yes* *No / Yes* *No / Yes* *No / Yes* *No / Yes, specify _____*
Have you been admitted to hospital*?* If yes: what date were you admitted?	*No / Yes* *DD/MM/YY*
You tested positive for COVID-19; how do you think you were infected?	*Free text – limited to 75 characters*
Do you have hay fever or other allergies that can cause respiratory issues?	*No / Yes*
Do you have any medical conditions for which you take medication routinely?	*Free text – limited to 75 characters*
3. Risk factors	
Have you travelled internationally in the 7 days?	*No / Yes, specify country_____*
Does any household member work as health care provider in direct patient care?	*No / Yes*
Did you go to school / day care in the last 7 days	*No / Yes*
How many days did you need to stay at home? *(0 if none)*	*_____ days*
Has anyone else in your household had respiratory symptoms in the last 7 days?	*No / Yes*
Has anyone else in your household had fever in the last 7 days?	*No / Yes*
Has anyone else in your household tested positive for COVID-19 in the last 7 days?	*No / Yes*
Have you been in contact with a known case of COVID-19 outside of your household in the last 7 days?	*No / Yes*

1b) To be filled by child contacts and their parent(s) / legal guardian(s)

1. Demographic factors	
Date (DD/MM/YYYY)	___/___/___
Gender	□ *Female* □ *Male*
Date of birth (DD/MM/YYYY)	___/___/___
Country of birth	□ *Norway* □ *Other, specify* _____
Country of birth mother	□ *Norway* □ *Other, specify* _____
Country of birth father	□ *Norway* □ *Other, specify* _____
Household size in the last 7 days	*N*
Composition household (age)	*N numeric fields based on previous question*
2. Clinical information	
Did you have symptoms that could be COVID-19 in the last 7 days? If NO, jump to question about hay fever	*No / Yes*
Please identify if you had any of the following symptoms in the last 7 days Fever More tired, or exhausted Sore throat Cough Runny or stuffy nose Vomiting Diarrhea Stomach pain Sneeze Lack of appetite Other	 *No/ Yes / Unknown* *No / Yes* *No / Yes* *No / Yes* *No / Yes* *No / Yes* *No / Yes* *No / Yes* *No / Yes* *No / Yes* *No / Yes* *if Yes, specify* _____
When did your first symptoms start?	*DD/MM/YY*
How many days in total did you have any of these symptoms?	____ *days / still ill*
How do you feel today?	□ *As usual* □ *More tired than usual, but up most of the time* □ *Need a lot of rest, but up some of the time* □ *Bedridden and need some help*

	□ *Bedridden and need a lot of help*
Have you had contact (in person or by phone/digital) with any medical professional? GP COVID-19 clinic Hospital Emergency clinic Other	 *No / Yes* *No / Yes* *No / Yes* *No / Yes* *No / Yes* *if Yes, specify _____*
Have you been admitted to hospital*?* *If yes: what date?*	*No / Yes* *DD/MM/YY*
Do you have hay fever or other allergies that can cause respiratory issues?	*No / Yes*
Do you have any medical conditions for which you take medication routinely?	*Free text – limited to 75 characters*
Have you ever been tested for COVID-19? If yes, what was the date and result from you last test?	*No / Yes* *DD / MM / YY* *Negative / Positive / Unknown*
3. Risk factors	
Have you travelled internationally in the last 7 days?	*No / Yes* *if Yes, specify country_____*
Does any household member work as health care provider in direct patient care?	*No / Yes*
Did you go to school / day care in the last 7 days	*No / Yes*
How many days did you need to stay at home? *(0 if none)*	_____ *days*
How many days have you been in quarantine in the last 10 days? *(0 if none)*	_____ days
Has anyone else in your household had respiratory symptoms in the last 7 days?	*No / Yes*
Has anyone else in your household had fever in the last 7 days?	*No / Yes*
Has anyone else in your household tested positive for COVID-19 in the last 7 days?	*No / Yes*
Have you been in contact with a known case of COVID-19 outside of your household, school or day care in the last 7 days?	*No / Yes*

1c) To be filled by adult contacts

1. Demographic factors	
Date (DD/MM/YYYY)	___/___/___
Gender	□ *Female* □ *Male* □ *Prefer not to state*
Date of birth (DD/MM/YYYY)	___/___/___
Country of birth	□ *Norway* □ *Other, specify* _____
Household size in last week	*N*
Composition household (age)	*N numeric fields based on previous question*
2. Clinical information	
Did you have symptoms that could be COVID-19 in the last 7 days? If NO, jump to question about hay fever	*No / Yes*
Please identify if you had any of the following symptoms in the last week?	
▪ Fever	*No / Yes / Unknown*
▪ Chills	*No / Yes*
▪ Headache	*No / Yes*
▪ Muscle and / or joint pain	*No / Yes*
▪ Chest pain	*No / Yes*
▪ More tired, or exhausted	*No / Yes*
▪ Reduced or altered sense of taste	*No / Yes*
▪ Reduced or altered sense of smell	*No / Yes*
▪ Lack of appetite	*No / Yes*
▪ Nausea	*No / Yes*
▪ Vomiting	*No / Yes*
▪ Diarrhea	*No / Yes*
▪ Stomachache	*No / Yes*
▪ Runny or stuffy nose	*No / Yes*
▪ Sneezing	*No / Yes*
▪ Sore throat	*No / Yes*
▪ Shortness of breath	*No / Yes*
▪ Cough	*No / Yes*
▪ Other	*Specify* _____
When did your first symptoms start?	*DD / MM / YY*
How many days in total did you have any of these symptoms?	____ *days / still ill*
How do you feel today?	□ *As usual* □ *More tired than usual, but up most of the time*

	□ *Need a lot of rest, but up some of the time* □ *Bedridden and need some help* □ *Bedridden and need a lot of help*
Have you had contact (in person or by phone/digital) with any medical professional? ▪ GP ▪ COVID-19 clinic ▪ Hospital ▪ Emergency clinic ▪ Other	 *No / Yes* *No / Yes* *No / Yes* *No / Yes* *No / Yes, specify _____*
Have you been admitted to hospital*?* *If yes: what date?*	*No / Yes* *DD/MM/YY*
Do you have hay fever or other allergies that can cause respiratory issues?	*No / Yes*
Do you take any medication routinely for any of the following underlying conditions? ▪ High blood pressure ▪ Cardiovascular disease ▪ Lung disease (excluding mild or well-controlled asthma) ▪ Cancer ▪ Diabetes ▪ Other	 *No / Yes* *No / Yes* *No / Yes* *No / Yes* *No / Yes* *No / Y, specify _____*
Have you ever been tested for COVID-19? If yes, what was the date and result from you last test?	*No / Yes* *DD / MM / YY* *Negative / Positive / Unknown*
3. Risk factors	
Have you travelled internationally in the last 7 days?	*No / Yes, specify country_____*
Does any household member work as health care provider in direct patient care?	*No / Yes*
How many days have you been in quarantine in the last 10 days? *(0 if none)*	_____ days
Did you go to work in the last 7 days?	*No / Yes*
How many days did you need to stay at home? *(0 if none)*	
Has anyone else in your household had respiratory symptoms in the last 7 days?	*No / Yes*
Has anyone else in your household had fever the last 7 days?	*No / Yes*
Has anyone else in your household tested positive for COVID-19 positive in the last 7 days?	*No / Yes*
Have you been in contact with a known case outside of your household or school in the last 7 days?	*No / Yes*

STUDY– Corona child Form 2a-b

d) Form 2 a-b, Daily symptom registration, to be filled at Day 0-10. a) Child contacts, b) adult contacts

2a) To be filled by child contacts and their parent(s) / legal guardian(s)

Daily reporting symptoms	
Date (DD/MM/YYYY) – *date of day 0*	___ /___ /___
F-number	

Day	Check if you have none of the symptoms	Fever	More tired, or exhausted	Sore throat	Cough	Runny or stuffy nose	Vomiting	Diarrhea	Stomach pain	Sneeze	Lack of appetite	Other symptoms*	Contact medical care	Tested for covid-19	Result (if taken)
0	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
1	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
2	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
3	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
4	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
5	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
6	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
7	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
8	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
9	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
10	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg

*Specify other symptoms:_____(limited to 75 characters)

2b) To be filled by adult contacts

Daily reporting symptoms																							
Date (DD/MM/YYYY) – *The date of day 0, when you provided spit sample*																	___ /___ /___						
F-number																							
Day	None of the symptoms	Fever	Chills	Headache	Muscle, joint pain	Chest pain	More tired, or exhausted	Reduced or altered sense of taste	Reduced or altered sense of smell	Lack of appetite	Nausea	Vomiting	Diarrhea	Stomachache	Runny or stuffy nose	Sneezing	Sore throat	Shortness of breath	Cough	Other	Contact medical care	Tested for covid-19	Result (if taken)
0	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
1	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
2	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
3	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
4	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
5	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
6	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
7	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
8	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
9	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg
10	None	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Pos / Neg

*Specify other symptoms:_____(limited to 75 characters)

STUDY– Corona child Form 3

Form 3, Questionnaire, final outcome, to be filled at Day 10, all participants

To be filled by all participants (or parents/legal guardians)

1. Demographic factors	
Date (DD/MM/YYYY)	___/___/___
F-number	_____
How many days have you been in quarantine or isolation in the last 10 days? *(0 if none)*	_____ days
Has anyone else in your household had respiratory symptoms in the last 10 days?	*No* *Yes*
Has anyone else in your household had fever in the last 10 days?	*No* *Yes*
Has anyone else in your household been tested for COVID-19 in the last 10 days?	*No* *Yes, negative* *Yes, positive* *Yes, outcome unknown*
Have you been in contact with a known case of COVID-19 outside of your household or school/day care in the last 10 days?	*No* *Yes*
Have you travelled internationally in the last 10 days?	*No* *Yes, specify country_____*

STUDY– Corona child Form 4 and 5

Form 4. Interview guide for educational facility including after school care

This document provides an interview guide for collection of information from the educational facility about the general structure of the facility. Focus on general information of the whole facility

Building
Description of the educational facility. Consider information on the following aspects

- Does the educational facility have multiple locations
- How many structures that are part of the educational facility at the specific location
- Number of class rooms/rooms at this facility
- Number and description of other rooms
- Description of outdoor space, including type of toys, equipment etc

People
Description of the individuals at this educational facility. Consider information on the following aspects

- Total number of children and employees per type of function
- Number of children and employees in each units / departments / class
- Do employees work on different locations?

Infection prevention and control measures for COVID-19
Understanding the infection prevention and control measures implemented for COVID-19. Consider the following aspects

- How did you limit the number of contacts, think of smaller groups, different break times etc
- Recommendations for parents bringing children to school
- Recommendations for children during school, such as washing hands, playing together etc
- Cleaning of building

Form 5. Interview guide for teacher of index case and contacts

This document provides an interview guide for collection of information from the primary teacher of the index/primary case and focusses on understanding the interactions between children, adults and the infection prevention and control measures during school time.

People and classroom
Description of the individuals in the class/cohort/unit of the index/primary case. Consider information on the following aspects

- Description of the department/unit, including the number of children in each cohort, number of teacher for each group
- Interaction with different groups in the same room or other places, such as outside and gym
- Hours per day spent outdoors (average)
- Did the case have any direct contact with anyone outside the class room, think about extra education such as reading hour

- Description of the classroom, specifically in relation to interaction between children and adults in the classroom

Infection prevention and control measures for COVID-19

Understanding the infection prevention and control measures implemented for COVID-19 specifically for the index/primary case class. Consider the following aspects

- What are the routines concerning washing hands, food, drinks?
- Do children share toys / equipment with others, are there specific arrangements with cleaning