COVID-19 INFECTION SURVEY: CRF3 INDIVIDUAL PARTICIPANT – COMPLETE AT ENROLMENT FOR EACH CONSENTING PARTICIPANT

IF COMPLETING FOR A CHILD BY A PARENT/CARER PROXY, REMEMBER "YOU" IS THE PARTICIPANT

Unique household code													Participant date of birth	D	D	M	M	M	Y	Y	Y	Y

Unique participant code														Date/time of visit	D	D	M	M	M	2	0	2	Y		h	h	:	m	m

A: RECORDING OF SIGNED CONSENT OPTIONS FROM ICF

1.	Did the participant consent to join the study (Q1-Q7 on consent form)?	☐ Yes ☐ No
2.	Did the participant consent to 5 visits (enrolment plus 4 follow-up) (Q7 on consent form)?	☐ Yes ☐ No
3.	Did the participant consent to 16 visits (enrolment plus 15 follow-up) (Q8 on consent form)?	☐ Yes ☐ No
4.	Did the participant consent to be approached for other studies if they have a positive test in the study (Q9 on consent form)?	☐ Yes ☐ No
5.	Did the participant consent to blood samples (Q10 on consent form)?	☐ Yes ☐ No
6.	Did the participant consent to future use of blood samples (Q11 on consent form)?	☐ Yes ☐ No

B: DEMOGRAPHICS

1. What is your sex? ☐ Male ☐ Female

2. What is your ethnic group? *(select one)*

White
☐ English, Welsh, Scottish, Northern Irish or British ☐ Irish ☐ Gypsy or Irish Traveller
☐ Any other white background, specify _____

Mixed / multiple ethnic groups
☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian
☐ Any other Mixed/multiple background, specify: _____

Asian or Asian British
☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese
☐ Any other Asian background, specify: _____

Black, African, Caribbean or Black British
☐ African ☐ Caribbean
☐ Any other Black, Black British or Caribbean background, specify: _____

Other ethnic group
☐ Arab
☐ Any other ethnic group, specify _____

C: WORK

1. If you are currently working, or currently employed/self-employed but not working at the moment, what is the title of your main job or business? (*e.g., primary school teacher, car mechanic, district nurse, structural engineer, etc.) (write N/A if not currently working or employed/self-employed but not working)*

2. What you mainly do in your main job or business? *(please describe as fully as possible. For example, please indicate if you have any management responsibilities. Write N/A if not working, as above)*

3. Which of these occupations/sectors do you work in? *(select one)*

□ N/A as not currently working and not currently employed/self-employed

□ Teaching and education
□ Health care
□ Social care
□ Transport (incl. storage, logistic)
□ Retail sector (incl. wholesale)
□ Hospitality (e.g. hotel, restaurant, cafe)
□ Food production and agriculture (incl. farming)
□ Personal services (e.g. hairdressers, tattooists)
□ Information technology and communication
□ Financial services incl. insurance
□ Manufacturing or construction
□ Civil service or Local Government
□ Armed forces
□ Arts, entertainment or recreation
□ Other occupation sector, specify_____

4. Do you currently work in a nursing care home or a residential care home? □ Yes □ No

5. Do you currently work in healthcare (providing medical care to individuals or a community)? *(select one)*

□ Yes, in primary care, e.g. GP, dentist
□ Yes, in secondary care, e.g. hospital
□ Yes, in other healthcare settings, e.g. mental health
□ No

6. Does your current role primarily involve direct contact, in person, with patients/clients/residents/service users in a healthcare or social care setting on a day-to-day basis? (*Please answer 'no' if primarily-office-based*) □ Yes □ No

D: YOUR HEALTH STATUS

1. Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more? □ Yes □ No

If yes: (a) Do any of your conditions or illnesses reduce your ability to carry-out day-to-day activities? *(tick one)*

□ Yes, a lot □Yes, a little □ Not at all

2. Have you ever smoked cigarettes regularly? □Yes □No

3. Do you currently smoke or vape at all? (*select all that apply*) □Yes, cigarettes □ Yes, cigar □ Yes, pipe □ Yes, vape/e-cigarettes □No

E: GP DETAILS

1. Do you have a GP? □ Yes □ No

If yes: GP name (if known): .....

GP surgery name: .....

GP surgery address: .....

F: CONTACT DETAILS FOR VOUCHERS AND RESULTS RETURN

1. Email address for vouchers: .....

□ No email address

2. Do you have a mobile number you like to receive test results through when this system is set up (results can be sent to parent/carers mobile number for children, identified by month/year of birth) □ Yes □ No

Mobile number (add country code if non-UK mobile): | | | | | | | | | | | | | | | |

COMPLETED BY: Name (study worker)	Signature (study worker)	Date
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