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

<table>
<thead>
<tr>
<th>Unique household code</th>
<th>Participant date of birth</th>
<th>Unique participant code</th>
<th>Date/time of visit</th>
</tr>
</thead>
</table>

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
   - Social care
   - Retail sector (incl. wholesale)
   - Food production and agriculture (incl. farming)
   - Information technology and communication
   - Manufacturing or construction
   - Armed forces
   - 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/customers 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, vape/e-cigarettes
   - Yes, cigar
   - Yes, pipe
   - Hookah/shisha pipes
   - 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: DD/MM/YY

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