Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Participant ID \_\_\_\_\_\_\_\_\_

**SECTION II: ACE CHILD SURVEY**

**Child Survey Module A: Location/Exposure**

1. Who was [Child’s name] with when he/she was in the highlighted area on the map between [incident date/time] and [end date/time]? Show area on map.

 Respondent

Record name and Participant ID of person with same exposure:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🡺 Go to Question A3

 Someone else who has been interviewed

Record name and Participant ID of person with same exposure:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🡺 Go to Question A3

 Someone who has not been interviewed

Record name of person with same exposure:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I would like to know about each place [Child’s name] went within the highlighted area on the map between [incident date] at [time] and [end date/time] so that I can construct a timeline and understand what happened when he/she was exposed. Record the following answers in the table provided. Fill out the table for one location before continuing on to the next location.

|  | Location 1: | Location 2: | Location 3: |
| --- | --- | --- | --- |
| 1. What is the address where [Child’s name] (first/next) was during the incident? Probe for as much location information as possible. Then, continue to b. Do not ask about all locations first. Collect all information about one location before continuing to the next.
 |  |  |  |
| 1. How long was [Child’s name]in this location? Record whether in minutes or hours.
 |  |  |  |
| 1. Was he/she inside or outside while they were there? If outside, skip questions d, e, and f.
 | In Out | In Out | In Out |
| 1. If inside, were there any open windows while he/she was there?
 | Yes No Unsure | Yes No Unsure | Yes No Unsure |
| 1. If inside, was there any ventilation, such as an [air conditioner/heater] running, while he/she was there?
 | Yes No Unsure | Yes No Unsure | Yes No Unsure |
| 1. If respondent said “yes” for d or e, circle “no” for f and skip to next question. Otherwise, if inside, ask: did he/she shelter in place, meaning staying inside, with doors and windows closed and all ventilation systems turned off?

If yes, ask respondent: Please describe what he/she did to shelter in place. | Yes No Unsure | Yes No Unsure | Yes No Unsure |
| 1. Was [Child’s name] in a [smoke cloud/dust/fog] while he/she was there?
 | Yes No Unsure | Yes No Unsure | Yes No Unsure |

1. Did [Child’s name]evacuate from the highlighted area on the map?

 Yes

 No  Go to Question A5

1. At approximately what time did he/she evacuate?

\_\_\_\_:\_\_\_\_\_ AM PM

 Hour Min

1. How did he/she evacuate?

 Ambulance

 Privately-owned vehicle

 Bus

 Other (Please specify):

1. Is there any additional information that you think we should know about [Child’s name]’s exposure?

 Yes  Record the information on the lines provided below

 No  Go to Question A7

1. Was [Child’s name] decontaminated, meaning their clothing was removed or their body was washed?

 Yes

 No  Go to next module

1. How was [Child’s name] decontaminated? Read all answer choices aloud to the respondent and check all that apply.

 Clothing Removal

 Water

 Soap and Water

 Other (Please specify):

1. Where was he/she decontaminated? If respondent needs clarification, specify that this question is asking for a geographic location, not a place on the child’s body.

1. At approximately what time was [Child’s name] decontaminated?

\_\_\_\_:\_\_\_\_\_ AM PM

Hour Min

**Child Survey Module B: Health Status**

Now I would like to ask you some questions about any symptoms [Child’s name] may have experienced after the incident.

1. Within 24 hours of the incident, did [Child’s name] have any symptoms of an illness?

 Yes

 No  Go to next module

1. I’m going to ask you some questions about symptoms that could be related to the [Chemical] that was released. Fill out the table provided below. Repeat B2 for one symptom and check the boxes that apply before asking about the next symptom.

|  | 1. Did [Child’s name] experience [Symptom] within 24- hours of the incident? If yes, go to ii. If no, repeat i for next symptom.
 | 1. Was

[Child’s name] experiencing [Symptom] before the incident? If yes, go to iii. If no, go to iv. | 1. Was

[Child’s name]’s [Symptom] worse after the incident? Continue to iv (if listed); otherwise; repeat i for next symptom. | 1. Is [Child’s name] still experiencing [Symptom]? Repeat i for next symptom.
 |
| --- | --- | --- | --- | --- |
| Symptom | Yes | No | Yes | No | Yes | No | Yes | No |
| Irritation/pain/ burning of eyes |  |  |  |  |  |  |  |  |
| Increased tearing  |  |  |  |  |  |  |  |  |
| Blurred vision/double vision |  |  |  |  |  |  |  |  |
| Runny nose |  |  |  |  |  |  |  |  |
| Burning nose or throat |  |  |  |  |  |  |  |  |
| Burning lungs |  |  |  |  |  |  |  |  |
| Increased salivation  |  |  |  |  |  |  |  |  |
| Ringing of the ears |  |  |  |  |  |  |  |  |
| Difficulty swallowing |  |  |  |  |  |  |  |  |
| Odor on breath (Gasoline or other, specify) |  |  |  |  |  |  |  |  |
| Headache |  |  |  |  |  |  |  |  |
| Dizziness or lightheadedness |  |  |  |  |  |  |  |  |
| Loss of consciousness/fainting |  |  |  |  |  |  |  |  |
| Seizures |  |  |  |  |  |  |  |  |
| Numbness, pins and needles, or funny feeling in arms or legs |  |  |  |  |  |  |  |  |
| Confusion |  |  |  |  |  |  |  |  |
| Difficulty concentrating |  |  |  |  |  |  |  |  |
| Weakness of arms  |  |  |  |  |  |  |  |  |
| Weakness of legs  |  |  |  |  |  |  |  |  |
| Muscle twitching  |  |  |  |  |  |  |  |  |
| Tremors in arms or legs |  |  |  |  |  |  |  |  |
| Loss of balance  |  |  |  |  |  |  |  |  |
| Breathing slow  |  |  |  |  |  |  |  |  |
| Breathing fast |  |  |  |  |  |  |  |  |
| Difficulty breathing/feeling out-of-breath |  |  |  |  |  |  |  |  |
| Coughing |  |  |  |  |  |  |  |  |
| Increased congestion or phlegm |  |  |  |  |  |  |  |  |
| Wheezing in chest |  |  |  |  |  |  |  |  |
| Slow heart rate/pulse  |  |  |  |  |  |  |  |  |
| Fast heart rate/pulse  |  |  |  |  |  |  |  |  |
| Chest tightness or pain/angina |  |  |  |  |  |  |  |  |
| Blue or gray coloring of ends of fingers/toes or lips |  |  |  |  |  |  |  |  |
| Nausea |  |  |  |  |  |  |  |  |
| Non-bloody vomiting |  |  |  |  |  |  |  |  |
| Non-bloody diarrhea |  |  |  |  |  |  |  |  |
| Bloody vomiting  |  |  |  |  |  |  |  |  |
| Blood in stool/diarrhea |  |  |  |  |  |  |  |  |
| Abdominal pain |  |  |  |  |  |  |  |  |
| Fecal incontinence or inability to control bowel movements |  |  |  |  |  |  |  |  |
| Irritation, pain, or burning of skin |  |  |  |  |  |  |  |  |
| Skin rash |  |  |  |  |  |  |  |  |
| Skin blisters |  |  |  |  |  |  |  |  |
| Sweating  |  |  |  |  |  |  |  |  |
| Cool or pale skin |  |  |  |  |  |  |  |  |
| Skin discoloration |  |  |  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |  |  |  |
| Agitation/irritability |  |  |  |  |  |  |  |  |
| Fatigue/tiredness |  |  |  |  |  |  |  |  |
| Difficulty sleeping |  |  |  |  |  |  |  |  |
| Feeling depressed |  |  |  |  |  |  |  |  |
| Generalized weakness |  |  |  |  |  |  |  |  |
| Diffuse muscle aches and pains |  |  |  |  |  |  |  |  |
| Hallucinations |  |  |  |  |  |  |  |  |
| Urinary incontinence or dribbling pee |  |  |  |  |  |  |  |  |
| Inability to urinate or pee |  |  |  |  |  |  |  |  |
| Any other symptoms? If yes, What was it? Record below. |  |  |  |  |  |  |  |  |
| 1. |  |  |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |  |  |
| 3. |  |  |  |  |  |  |  |  |
| 4. |  |  |  |  |  |  |  |  |

**Child Survey Module C: Fire/Explosion**

1. Was [Child’s name] injured as a result of the fire or explosion?

 Yes

 No  Go to next module

1. I’m going to ask you some questions about injuries that can happen as a result of a fire or explosion. For some of these injuries, I’m going to ask you where on your child’s body they were located. Fill out the table below. Repeat C2 i-ii for one injury and check the boxes that apply before asking about the next injury.

|  | 1. Did [Child’s name] experience [Injury] within 24-hours after the fire or explosion? If yes, go to C2 ii. If no, repeat C2 i for next injury.
 | 1. If Yes, where on his/her body was it located? Repeat C2 i for next injury.
 |
| --- | --- | --- |
| Injury | Yes | No |
| Abrasion/scrape |  |  |  |
| Broken bone/fracture |  |  |  |
| Bruise |  |  |  |
| Cut |  |  |  |
| Dislocation |  |  |  |
| Sprain or strain |  |  |  |
| Burn |  |  |  |
| Crush injury |  |  |  |
| Severe bleeding |  |  |  |
| Ear drum puncture |  |  |  |
| Hearing loss |  |  |  |
| Ringing in ears |  |  |  |
| Whiplash |  |  |  |
| Concussion |  |  |  |
| Bowel perforation |  |  |  |
| Eye injury |  |  |  |
| Any other injuries? If yes, what was it? If applicable, specify where on his/her body was it located? Record below. |
| 1. |  |
| 2. |  |

Child Survey Module D: Medical care

1. Did [Child’s name] receive medical care or evaluation because of the incident?

 Yes 🡺 Go to Question D3

 No

1. Why didn’t you seek medical care for [Child’s name]?

 Did not have symptoms

 Symptoms were not bad enough

 Don’t like to go to the doctor

 Didn’t want to take time

 Worried about who would pay for the medical visit

 Worried about losing job

 Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Unsure

For those individuals who did not seek medical care for the child, go to the next module.

1. Was [Child’s name] provided with care by an EMT or paramedic?

 Yes

 No 🡺 Go to Question D5

1. On what date was he/she provided care by an EMT or paramedic?

\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

 MM DD YYYY

1. Was [Child’s name] provided with care at a hospital?

 Yes

 No 🡺 Go to Question D15

1. On what date was [Child’s name] first provided care at a hospital? If he/she had any additional visits to the hospital, please provide me the dates of those visits. Record the date that the child first went to the hospital and then the date of any subsequent visits.

1st date of hospital visit: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

 MM DD YYYY

2nd date of hospital visit: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

 MM DD YYYY

3rd date of hospital visit: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

 MM DD YYYY

1. What is the name of the hospital(s)?

1. How did [Child’s name] get to the hospital? If the child had more than one hospital visit, tell the respondent that you are referring to the child’s first visit.

 EMS/Ambulance

 Driven by relative, friend, or acquaintance

 Other (Please specify):

1. Was [Child’s name] treated only in the emergency department or was he/she admitted to the hospital?

 Treated in an emergency department (Outpatient) 🡺 Go to Question D15

 Admitted (Hospitalized)

1. How many nights was he/she hospitalized, including any nights in an intensive care unit (ICU)?

\_\_\_\_\_\_\_\_Nights

1. Was he/she placed in an Intensive Care Unit or ICU?

 Yes

 No 🡺 Go to Question D15

1. How many nights was he/she in the ICU?

\_\_\_\_\_\_\_\_ Nights

1. Was he/she on a ventilator?

 Yes

 No 🡺 Go to Question D15

1. How many nights was he/she on a ventilator?

\_\_\_\_\_\_\_\_ Nights

1. Besides at a hospital or by an EMT or paramedic, was [Child’s name] seen by a doctor or other medical professional?

 Yes

 No 🡺 Go to Question D17

1. Read i–iv to the respondent and record information in the table below.

| 1. On what dates was [Child’s name] provided care by a doctor or other medical professional? (mm/dd/yyyy)
 | 1. What is the name of the doctor or medical professional?
 | 1. What service did this doctor or medical professional provide?
 | 1. What is the address of the office?
 |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Was [Child’s name] prescribed any new medicines when he/she was examined after the incident?

 Yes

 No 🡺 Go to Question D19

1. What is the name of the medicine or medicines [Child’s name] was prescribed after being examined? If respondent does not know the name of the medication, ask: What is the medicine for?

1. Please tell me if any of the following describe why you sought medical care for [Child’s name]. Read questions a-c to the respondent and circle the appropriate answer(s).
	1. Were you given instructions to seek medical care for

[Child’s name]? Yes No Unsure

* 1. [Child’s name] experienced health problems or

symptoms within 24 hours of the incident? Yes No Unsure

* 1. You were worried about possible health problems

for [Child’s name] associated with the incident? Yes No Unsure

1. To improve future responses, we try to study medical emergency response as thoroughly as possible. Are you willing to let us get a copy of your child’s medical records for the medical treatment (he/she) received because of the incident?

 Yes 🡺 Review the medical records release form with the respondent and collect their signature

 No

**Child Survey Module F: Medical History**

Now I’m going to ask you a few questions about illnesses your child may have had and the kinds of medicines he/she may have used.

1. Prior to the incident, have you ever been told by a doctor or other health care provider that [Child’s name] has any of the following medical conditions? Fill out the table below. Circle appropriate response and ask the respondent to specify as directed.

| Medical Condition |  |
| --- | --- |
| 1. Allergies?
 | Yes (Please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unsure |
| 1. Asthma?
 | Yes No Unsure |
| 1. Diabetes?
 | Yes No Unsure |
| 1. High blood pressure?
 | Yes No Unsure |
| 1. Physical disability that hinders mobility?
 | Yes (Please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No Unsure |
| 1. Psychological condition such as depression?
 | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No Unsure |
| 1. Cancer?
 | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No Unsure |
| 1. Neurological conditions such as cerebral palsy?
 | Yes No Unsure |
| 1. Developmental conditions such as ADHD/ADD or autism?
 | Yes No Unsure |
| 1. Any other medical conditions?
 | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No Unsure  |

1. Prior to the incident, was [Child’s name] taking any medicines? This includes medicines prescribed by a health care provider and those you might have gotten without a prescription from stores, pharmacies, friends, or relatives.

 Yes

 No Go to next module

 Don’t Know  Go to next module

1. What medicines was [Child’s name] taking? If respondent does not know the name of the medication, ask: What was the medicine for?

**Child Survey Module L: Demographic Information**

Now, I have some general questions about [Child’s name].

1. Do you consider [Child’s name] to be Hispanic or Latino?

 Yes

 No

1. What race do you consider him/her to be?

Check all that apply:

 Black or African American

 White

 Asian

 American Indian or Alaska Native

 Native Hawaiian or Other Pacific Islander

1. If necessary, ask. Otherwise, check appropriate box. Is [Child’s name] male or female?

 Male

 Female

1. What is [Child’s name]’s date of birth?

\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

 MM DD YYYY

**Child Survey Module M: Supplemental Questions**

1. [Insert event specific questions requested by the local health department here].

**Child Survey Module N: Concluding Instructions**

If there are more children under age 13, get a new child survey and ask about next child.

If there are no more children under age 13, return to the General Survey Module N: Conclusion Statements and go to Question N3.