

Interviewer _____ Household ID _____ Participant ID _____

Date _____ Start time _____ End time _____

Participant Name: _____

SECTION I: ACE ADULT SURVEY

General Survey Module A: Location/Exposure

I would like to begin by showing you a map of the areas affected by [Description of Incident] on [Date]. The affected areas are highlighted. From now on, I will refer to the [Description of Incident] on [Date] as "the incident."

After reviewing a map of the exposed area(s), ask respondents the following questions:

A1. Were you in this area at any time between [Incident Date/Time] and [End Date/Time]?

Yes

No → Say to the respondent: Thank you for your time.

Record the end time and do not ask any further questions. This person is not eligible for the survey.

A2. I would like to know about each place you 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 you were exposed.

Record the following answers in the table provided. Fill out the table for one location before continuing on to the next location.

Participant ID:

| | Location 1: | Location 2: | Location 3: |
|--|-----------------------------|-----------------------------|-----------------------------|
| a. What is the address of where you (first/next) were during the incident? <u>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.</u> | | | |
| b. How long were you in this location? <u>Record whether in minutes or hours.</u> | | | |
| c. Were you inside or outside while you were there? <u>If outside, skip questions d, e, and f.</u> | In Out | In Out | In Out |
| d. <u>If inside</u> , were there any open windows while you were there? | Yes No Unsure | Yes No Unsure | Yes No Unsure |
| e. <u>If inside</u> , was there any ventilation, such as an [air conditioner/heater] running, while you were there? | Yes No Unsure | Yes No Unsure | Yes No Unsure |
| f. <u>If respondent said "yes" for d or e, circle "no" for f and skip to next question. Otherwise, if inside, ask: did you shelter in place, meaning staying inside, with doors and windows closed and all ventilation systems turned off? If yes, ask the respondent: Please describe what you did to shelter in place.</u> | Yes No Unsure | Yes No Unsure | Yes No Unsure |
| g. Did you smell an odor? <u>If no or unsure skip questions h and i.</u> | Yes No Unsure | Yes No Unsure | Yes No Unsure |
| h. Can you please describe the odor? | | | |
| i. Would you describe the odor as light, moderate or severe? | Light Moderate Severe | Light Moderate Severe | Light Moderate Severe |
| j. Were you in a [smoke cloud/dust/fog] while you were there? | Yes No Unsure | Yes No Unsure | Yes No Unsure |

Participant ID:

A3. Did you evacuate from the highlighted area on the map?

Yes

No → [Go to Question A5](#)

A4. At approximately what time did you evacuate?

____:____ AM PM

Hour Min

A5. How did you evacuate?

Ambulance

Privately-owned vehicle

Bus

Other (Please specify): _____

A6. Is there any additional information that you think we should know about your exposure?

Yes → [Record the information on the lines provided below](#)

No → [Continue to Question A7](#)

A7. Were you decontaminated, meaning your clothing was removed or your body was washed?

Yes

No → [Go to next module](#)

A8. How were you decontaminated? Read all answer choices aloud to the respondent and check all that apply.

Clothing Removal

Water

Soap and Water

Other (Please specify): _____

A9. Where were you decontaminated? If respondent needs clarification, specify that this question is asking for a geographic location, not a place on their body.

A10. At approximately what time were you decontaminated?

____:____ AM PM

Hour Min

Participant ID:

General Survey Module B: Health status

Now I would like to ask you some questions about any symptoms you may have experienced after the incident.

B1. Within 24 hours of the incident, did you have any symptoms of an illness?

Yes

No → Go to next module

B2. 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.

| | i. Did you experience [Symptom] within 24-hours of the incident? <u>If yes, go to ii. If no, repeat i for next symptom.</u> | | ii. Were you experiencing [Symptom] before the incident? <u>If yes, go to iii. If no, go to iv.</u> | | iii. Was your [Symptom] worse after the incident? <u>Continue to iv (if listed); otherwise, repeat i for next symptom.</u> | | iv. Are you still experiencing [Symptom]? <u>Repeat i for next symptom.</u> | |
|--|---|----|---|----|--|----|---|----|
| 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 (<u>Gasoline or other, specify</u>) | | | | | | | | |
| Headache | | | | | | | | |
| Dizziness or lightheadedness | | | | | | | | |
| Loss of consciousness/fainting | | | | | | | | |

Participant ID:

| | i. Did you experience [Symptom] within 24-hours of the incident? <u>If yes, go to ii.</u> <u>If no, repeat i for next symptom.</u> | | ii. Were you experiencing [Symptom] before the incident? <u>If yes, go to iii.</u> <u>If no, go to iv.</u> | | iii. Was your [Symptom] worse after the incident? <u>Continue to iv (if listed); otherwise, repeat i for next symptom.</u> | | iv. Are you still experiencing [Symptom]? <u>Repeat i for next symptom.</u> | |
|--|---|----|---|----|--|----|---|----|
| Symptom | Yes | No | Yes | No | Yes | No | Yes | No |
| 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 | | | | | | | | |

Participant ID:

| | i. Did you experience [Symptom] within 24-hours of the incident? <u>If yes, go to ii.</u> <u>If no, repeat i for next symptom.</u> | | ii. Were you experiencing [Symptom] before the incident? <u>If yes, go to iii.</u> <u>If no, go to iv.</u> | | iii. Was your [Symptom] worse after the incident? <u>Continue to iv (if listed); otherwise, repeat i for next symptom.</u> | | iv. Are you still experiencing [Symptom]? <u>Repeat i for next symptom.</u> | |
|---|---|----|---|----|--|----|---|----|
| Symptom | Yes | No | Yes | No | Yes | No | Yes | No |
| 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? <u>If yes, What was it? Record below.</u> | | | | | | | | |
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |

Participant ID:

General Survey Module C: Fire/Explosion

C1. Were you injured as a result of the fire or explosion?

Yes

No →

C2. 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 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.

| | i. Did you experience [Injury] within 24-hours after the fire or explosion? <u>If yes, go to C2 ii. If no, repeat C2 i for next injury.</u> | | ii. <u>If Yes, where on your body was it located? Repeat C2 i for next injury.</u> |
|---|---|----|--|
| 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? <u>If yes, what was it? If applicable, specify where on your body was it located? Record below.</u> | | | |
| 1. | | | |
| 2. | | | |

Participant ID:

General Survey Module D: Medical Care

D1. Did you receive medical care or a medical evaluation because of the incident?

- Yes → Go to Question D3
- No

D2. Why didn't you seek medical care?

- 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, go to the next module.

D3. Were you provided with care by an EMT or paramedic?

- Yes
- No → Go to Question D5

D4. On what date were you provided care by an EMT or paramedic?

____/____/____
MM DD YYYY

D5. Were you provided with care at a hospital?

- Yes
- No → Go to Question D15

D6. On what date were you first provided care at a hospital? If you had any additional visits to the hospital, please provide me the dates of those visits. Record the date that the respondent 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

Participant ID:

D7. What is the name of the hospital(s)?

D8. How did you get to the hospital? If the respondent had more than one hospital visit, tell them that you are referring to their first visit.

- EMS/Ambulance
- Drove self
- Driven by relative, friend, or acquaintance
- Other (Please specify): _____

D9. Were you treated only in the emergency department or were you admitted to the hospital?

- Treated in emergency department (Outpatient) → Go to Question D15
- Admitted (Hospitalized)

D10. How many nights were you hospitalized, including any nights in an intensive care unit (ICU)?

_____ Nights

D11. Were you placed in an Intensive Care Unit or ICU?

- Yes
- No → Go to Question D15

D12. How many nights were you in the ICU?

_____ Nights

D13. Were you on a ventilator?

- Yes
- No → Go to Question D15

D14. How many nights were you on a ventilator?

_____ Nights

D15. Besides at a hospital or by an EMT or paramedic, were you seen by a doctor or other medical professional?

- Yes
- No → Go to Question D17

Participant ID:

D16. Read i–iv to the respondent and record information in the table below.

| i. On what dates were you provided care by a doctor or other medical professional? (mm/dd/yyyy) | ii. What is the name of the doctor or other medical professional? | iii. What service did this doctor or medical professional provide? | iv. What is the address of the office? |
|---|---|--|--|
| | | | |
| | | | |
| | | | |
| | | | |

D17. Were you prescribed any new medicines when you were examined after the incident?

Yes

No → Go to Question D19

D18. What is the name of the medicine or medicines you were prescribed? If respondent does not know the name of the medication, ask: What is the medicine for?

D19. Please tell me if any of the following describe why you sought medical care. Read questions a-c to the respondent and circle the appropriate answer(s).

- a. You were given instructions to seek medical care? ..Yes No Unsure
- b. You experienced health problems or symptoms within 24 hours of the incident?.....Yes No Unsure
- c. You were worried about possible health problems associated with the incident?Yes No Unsure

If aged 13–17, read: We will be doing medical chart reviews and will be asking your parent or guardian for permission to review your medical record for the visit related to the incident. Continue to next module.

If aged 18 or older, go to Question D20.

Participant ID:

D20. If aged 18 or older, read: 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 medical records for the medical treatment you received because of the incident?

Yes →

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

No

Participant ID:

General Survey Module E: Occupational History

Now I'm going to ask you some questions about your work experiences—paid, volunteer, or military—from [12 months ago] to [current date]. This includes part-time and full-time jobs that lasted one month or more, such as jobs for pay inside or outside the home or jobs on a farm.

E1. Are you currently employed?

- Yes → [Go to Question E3](#)
 No

E2. Did you have a job in the last 12 months, that is, since [12 months ago]?

- Yes
 No → [Go to Question E4](#)

E3. If you had more than one job in the last 12 months, please tell me about the most recent job first, then the next most recent. Fill-out the table below; complete the information for the first job completely before asking about the next job. Once information about all jobs that the respondent has had in the past 12 months has been collected, go to the next module.

| | Job 1 | Job 2 |
|--|------------------|------------------|
| a. What (is/was) the name of the company you (work/worked) for? | | |
| b. What (does/did) this company make or do? | | |
| c. What (is/was) your job title? | | |
| d. (Does/Did) this job include working with or around any chemicals? <u>If no or unsure, go to f.</u> | Yes No Unsure | Yes No Unsure |
| e. <u>If yes</u> , what chemicals (do/did) you work with or around? | | |
| f. Did you have any other jobs since [12 months ago]? | | |
| i. Yes → <u>Repeat E3 for the next, most recent job (If the interviewee has had more than 2 jobs, write details on a supplemental table). Circle 'yes' if you need to write information about a job on a supplemental table. Circle 'no' if all information collected is contained in this table. Once information about all jobs that the respondent has had in the past 12 months has been collected, continue to Question E4.</u> | | |
| ii. No → <u>Continue to Question F1</u> | | |

Participant ID:

General Survey Module F: Medical History

Now I'm going to ask you a few questions about illnesses you may have had and the kinds of medicines you may have used.

F1. Prior to the incident, have you ever been told by a doctor or other health care provider that you have or had any of the following medical conditions? Fill out the table below. Circle appropriate response and ask the respondent to specify as directed.

| Medical Condition | |
|--|---|
| a. Allergies? | Yes (Please specify) _____ No Unsure |
| b. Asthma? | Yes No Unsure |
| c. Diabetes? | Yes No Unsure |
| d. High blood pressure? | Yes No Unsure |
| e. Chronic obstructive pulmonary disease (COPD) or emphysema? | Yes No Unsure |
| f. Heart Disease? | Yes No Unsure |
| g. Physical disability that hinders mobility? | Yes (Please specify) _____ No Unsure |
| h. Psychological condition such as anxiety, depression or dependence disorder? | Yes (Please specify) _____ No Unsure |

Participant ID:

| Medical Condition | |
|---|---|
| i. Cancer? | Yes (Please specify) _____ No Unsure |
| j. Immune disorders such as lupus, rheumatoid arthritis, or HIV? | Yes No Unsure |
| k. Neurological conditions such as Parkinson's disease or multiple sclerosis? | Yes No Unsure |
| l. Any other medical conditions? | Yes (Please specify) _____ No Unsure |

F2. Prior to the incident, were you 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 Question F4](#)

Don't Know → [Go to Question F4](#)

F3. What medicines were you taking? If respondent does not know the name of the medication, ask: What was the medicine for?

F4. Do you currently smoke cigarettes, cigars, or pipes?

Yes → [Go to instruction box before Question F7](#)

No

Participant ID:

F5. Have you smoked regularly in the past?

Yes

No → Go to instruction box before Question F7

F6. When did you last quit? Was it...Read all choices to the respondent.

Less than one year ago

1–2 years ago

3–4 years ago

5 or more years ago

If respondent is male, go to next module

F7. Are you currently pregnant?

Yes

No

Don't Know

F8. Are you currently breastfeeding?

Yes

No

Participant ID:

General Survey Module G: Emergency Response

G1. Were you a firefighter, police officer, or other professional who responded to the incident? If yes and necessary, probe for type of responder.

- Firefighter
- Police officer
- EMS responder
- Hospital emergency department worker
- Other: Please specify _____
- Not a responder →

G2. What specifically was your role during the response?

If an EMS responder, hospital emergency department worker, or other health care provider, go to Question G4. Otherwise, continue to Question G3.

G3. Please look at this list and tell me what level of PPE you were wearing when you responded to the incident. Present Showcard Side A.

- None
- Level "A"
- Level "B"
- Level "C"
- Level "D"
- Firefighter turn-out gear with respiratory protection.
- Firefighter turn-out gear without respiratory protection.
- Other types of protection (such as gloves, eye protection, hardhat, steel-toed shoes)

If selected, ask: Please specify the type of protection:

Participant ID:

If an EMS responder, hospital emergency department worker, or other health care provider, go to Question G4. Otherwise, continue to next module.

G4. Please look at this list and tell me what type of protection you were wearing.

Present Showcard Side B

- None
- Non-sterile exam gloves
- Surgical gloves
- Face mask without protective shield
- Face mask with protective shield
- Non-splash resistant disposable gown
- Splash resistant disposable gown
- Protective eye glasses/goggles
- Supplied air respirator
- Respirator with cartridge/HEPA filters

If selected, ask: Please specify the type of cartridge/filter:

-
- Other

If selected, ask: Please specify the type of protection:

Participant ID:

General Survey Module H: Communication

If respondent is an emergency responder, go to next module.

Now I would like to ask you a few questions about the communication you may have received regarding the incident.

If respondent is aged 13-17, continue to Question H1. Otherwise, go to Question H2.

H1. If respondent is an adult, skip to Question H2. If respondent is aged 13-17, read: How did you hear about the incident?

Go to Question H3

Participant ID:

H2. Fill in the table below. Ask H2 i and only check the box next to the type of information the respondent received first. Then follow-up with H2 ii for the information the respondent received first. Continue to H2 iii and check all boxes that apply and follow-up with H2 iv for each type of follow-up information the respondent received.

| Source of Information | i. How did you first receive information or instructions about the incident? <u>Check only one box.</u> | ii. Was the information you first received timely? Was it accurate? <u>Write yes, no, or DK (for don't know) in the appropriate box.</u> | | iii. How did you receive follow-up information or instructions about the incident? <u>Check all that apply.</u> | iv. Was the follow-up information you received from [source] timely? Was it accurate? <u>Write yes, no, or DK (for don't know) in the appropriate box.</u> | |
|---|---|--|----------|---|--|----------|
| | | Timely | Accurate | | Timely | Accurate |
| Directly from person in authority (i.e. police, firefighter, Hazmat official, supervisor) | | | | | | |
| TV | | | | | | |
| Radio | | | | | | |
| Two-way radio | | | | | | |
| Newspaper | | | | | | |
| Relative/friend/neighbor/coworker | | | | | | |
| Website | | | | | | |
| Reverse 911 call | | | | | | |
| Phone call | | | | | | |
| Text message on a cell phone | | | | | | |
| Email | | | | | | |
| Community Meeting | | | | | | |
| Other, <u>Specify:</u> | | | | | | |

Participant ID:

H3. In the future, what are the best ways for your local authorities or the health department to reach you with information regarding a chemical incident? Check all that apply:

- TV
- Radio
- Newspaper
- Website
- Phone call
- Text message on a cell phone
- Email
- Community meeting
- Other (Please specify): _____

Participant ID:

General Survey Module I: Needs

If respondent is an emergency responder, go to next module.

I1. As a result of the incident, do you need any of the following...

Read all choices to the respondent.

| | | |
|--------------------------|-----|----|
| a. Medicines or supplies | Yes | No |
| b. Medical care | Yes | No |
| c. Water | Yes | No |
| d. Food | Yes | No |
| e. Shelter | Yes | No |
| f. Utilities | Yes | No |
| g. Anything else | Yes | No |

If yes, please specify: _____

I2. If needs are identified in Question I1, obtain details on exactly what is needed so this can be provided to the state health department. Otherwise, continue to the next module.

Participant ID:

General Survey Module J: Exposure of Other People Present

J1. Were there any other individuals present with you in the highlighted area of the map during the incident? Show highlighted area of the map.

Yes

No →

J2. In order to accurately evaluate the impact of the incident, we are trying to interview as many people who were in the area as possible. Fill in the following table with the information given for Question J2 a-c.

- a. Can you tell me the names of everyone else who was present with you during the incident?
- b. Which are children, and what are their ages?
- c. Can you tell me the phone number and e-mail address of the people who do not live with you?

| Name | Age (if child) | Phone | E-mail |
|------|-------------------|-------|--------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Participant ID:

General Survey Module K: Pets

K1. Did you have any pets or assistance animals that were in the highlighted area of the map during the incident? Show highlighted area of the map.

Yes

No →

K2. How many of your pets or assistance animals were in the highlighted area during the incident?

_____ Pets/Assistance animals

We will ask further questions about your pet(s) or assistance animal(s) separately at the completion of this survey.

Participant ID:

General Survey Module L: Demographic and Contact Information

Now, I have some general questions about you.

L1. Do you consider yourself to be Hispanic or Latino?

- Yes
- No

L2. What race do you consider yourself to be?

Check all that apply:

- Black or African American
- White
- Asian
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander

L3. What is the highest level of education you completed?

- Grade 8 or Less
- Some High School
- High School Graduate or Equivalent
- Some University/College
- Technical or Trade School
- Junior or Community College
- University/College Graduate
- Graduate School or Higher

L4. If necessary, ask. Otherwise, check appropriate box. Are you male or female?

- Male
- Female

If respondent is registered in the Rapid Response Registry (RRR), read and verify RRR information. If changes are needed, enter them into Questions L5–L9, then go to Question L10.
If not in RRR, ask Questions L5–L9, and then continue on to Question L10.

L5. What is your date of birth?

____/____/____
MM DD YYYY

L6. What is your current address?

Street _____ Apt _____
City _____ State __ __ Zip Code: _____

Participant ID:

L7. What is the best telephone number to reach you? Please specify if this is a cellular phone, house phone, or work phone.

(_ _ _) _ _ _ - _ _ _ _

- Cell
- House
- Work

L8. Are there any more telephone numbers where you can be reached?

If yes, collect all other numbers and specify whether cell, house, or work number.

(_ _ _) _ _ _ - _ _ _ _

- Cell
- House
- Work

(_ _ _) _ _ _ - _ _ _ _

- Cell
- House
- Work

L9. Do you have an email address where you can be reached?

- Yes
- No → [Go to Question L10](#)

What is your email address?

Participant ID:

L10. We may want to interview you again in the future to check up on your health.

Keeping in mind that people move, we would like to get a little more information to help us locate you in the future. In case you move to another residence, could we have the names and contact information of three people who live outside of your household and who would always know how to find you?

Yes →

No →

| | Person 1 | Person 2 | Person 3 |
|--|----------|----------|----------|
| First and Last Name | | | |
| Address | | | |
| Phone Number (including area code) | | | |
| Email Address | | | |
| Relationship to you (parent, child, sibling, other relative, friend, other) | | | |

Participant ID:

General Survey Module M: Supplemental Questions

M1. [Insert event specific questions requested by the local health department here].

Participant ID:

General Survey Module N: Conclusion Statements

N1. Is there anything else you want to tell us related to the [chemical] incident?

N2. If Exposure of Other People Present Module did not identify children under the age of 13 that were present, go to Question N3. If children under the age of 13 were identified, read: I would now like to ask you some questions regarding any children you have under the age of 13 that were with you when you were in the highlighted areas of the map.

Refer to Module J to recall child's name and then go to the Child Survey Section

N3. If the Pets Module did not identify that the respondent had a pet or assistance animal in the highlighted area of the map during the incident, go to the "Closing Statement." If pets or assistance animals were identified, read: I would now like to ask you some questions regarding any pets or assistance animals you have that were in the highlighted areas of the map.

Go to the Pet Survey Section

Closing Statement:

That completes this survey. I would like to sincerely thank you for your time. Be sure to record the end time on the first page of this survey.

Child's Name: _____ Participant ID _____

SECTION II: ACE CHILD SURVEY

Child Survey Module A: Location/Exposure

A1. 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:

A2. 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.

Participant ID:

| | Location 1: | Location 2: | Location 3: |
|--|------------------|------------------|------------------|
| k. What is the address where [Child's name] (first/next) was during the incident? <u>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.</u> | | | |
| l. How long was [Child's name] in this location? <u>Record whether in minutes or hours.</u> | | | |
| m. Was he/she inside or outside while they were there? <u>If outside, skip questions d, e, and f.</u> | In Out | In Out | In Out |
| n. <u>If inside</u> , were there any open windows while he/she was there? | Yes No Unsure | Yes No Unsure | Yes No Unsure |
| o. <u>If inside</u> , 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 |
| p. <u>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.</u> | Yes No Unsure | Yes No Unsure | Yes No Unsure |
| j. Was [Child's name] in a [smoke cloud/dust/fog] while he/she was there? | Yes No Unsure | Yes No Unsure | Yes No Unsure |

A3. Did [Child's name] evacuate from the highlighted area on the map?

Yes

No →

Participant ID:

A4. At approximately what time did he/she evacuate?

____:____ AM PM
Hour Min

A5. How did he/she evacuate?

- Ambulance
- Privately-owned vehicle
- Bus
- Other (Please specify): _____

A6. 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 →

A7. Was [Child's name] decontaminated, meaning their clothing was removed or their body was washed?

- Yes
- No →

A8. 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): _____

A9. 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.

A10. At approximately what time was [Child's name] decontaminated?

____:____ AM PM
Hour Min

Participant ID:

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.

B1. Within 24 hours of the incident, did [Child's name] have any symptoms of an illness?

Yes

No → Go to next module

B2. 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.

| | i. Did [Child's name] experience [Symptom] within 24- hours of the incident? <u>If yes, go to ii. If no, repeat i for next symptom.</u> | | ii. Was [Child's name] experiencing [Symptom] before the incident? <u>If yes, go to iii. If no, go to iv.</u> | | iii. Was [Child's name]'s [Symptom] worse after the incident? <u>Continue to iv (if listed); otherwise, repeat i for next symptom.</u> | | iv. Is [Child's name] still experiencing [Symptom]? <u>Repeat i for next symptom.</u> | |
|--|---|----|---|----|--|----|---|----|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 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 (<u>Gasoline or other, specify</u>) | | | | | | | | |
| Headache | | | | | | | | |
| 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 | | | | | | | | |

Participant ID:

| | i. Did [Child's name] experience [Symptom] within 24- hours of the incident? <u>If yes, go to ii. If no, repeat i for next symptom.</u> | ii. Was [Child's name] experiencing [Symptom] before the incident? <u>If yes, go to iii. If no, go to iv.</u> | iii. Was [Child's name]'s [Symptom] worse after the incident? <u>Continue to iv (if listed); otherwise; repeat i for next symptom.</u> | iv. Is [Child's name] still experiencing [Symptom]? <u>Repeat i for next symptom.</u> |
|--|---|---|--|---|
| 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 | | | | |

Participant ID:

| | i. Did [Child's name] experience [Symptom] within 24- hours of the incident? <u>If yes, go to ii. If no, repeat i for next symptom.</u> | ii. Was [Child's name] experiencing [Symptom] before the incident? <u>If yes, go to iii. If no, go to iv.</u> | iii. Was [Child's name]'s [Symptom] worse after the incident? <u>Continue to iv (if listed); otherwise; repeat i for next symptom.</u> | iv. Is [Child's name] still experiencing [Symptom]? <u>Repeat i for next symptom.</u> |
|---|---|---|--|---|
| Diffuse muscle aches and pains | | | | |
| Hallucinations | | | | |
| Urinary incontinence or dribbling pee | | | | |
| Inability to urinate or pee | | | | |
| Any other symptoms? <u>If yes, What was it? Record below.</u> | | | | |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

Participant ID:

Child Survey Module C: Fire/Explosion

C3. Was [Child's name] injured as a result of the fire or explosion?

Yes

No →

C4. 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.

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

Participant ID:

Child Survey Module D: Medical care

D1. Did [Child's name] receive medical care or evaluation because of the incident?

- Yes → Go to Question D3
- No

D2. 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.

D3. Was [Child's name] provided with care by an EMT or paramedic?

- Yes
- No → Go to Question D5

D4. On what date was he/she provided care by an EMT or paramedic?

____/____/____
MM DD YYYY

D5. Was [Child's name] provided with care at a hospital?

- Yes
- No → Go to Question D15

D6. 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

D7. What is the name of the hospital(s)?

Participant ID:

D8. 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): _____

D9. 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)

D10. How many nights was he/she hospitalized, including any nights in an intensive care unit (ICU)?

_____ Nights

D11. Was he/she placed in an Intensive Care Unit or ICU?

- Yes
- No → Go to Question D15

D12. How many nights was he/she in the ICU?

_____ Nights

D13. Was he/she on a ventilator?

- Yes
- No → Go to Question D15

D14. How many nights was he/she on a ventilator?

_____ Nights

Participant ID:

D15. 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](#)

D16. Read i-iv to the respondent and record information in the table below.

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

D17. Was [Child's name] prescribed any new medicines when he/she was examined after the incident?

Yes

No → [Go to Question D19](#)

D18. 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?

D19. 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).

- a. Were you given instructions to seek medical care for [Child's name]?..... Yes No Unsure
- b. [Child's name] experienced health problems or symptoms within 24 hours of the incident?..... Yes No Unsure
- c. You were worried about possible health problems for [Child's name] associated with the incident? Yes No Unsure

Participant ID:

D20. 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

Participant ID:

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.

F1. 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 | |
|---|--|
| m. Allergies? | Yes (Please specify) _____ No Unsure |
| n. Asthma? | Yes No Unsure |
| o. Diabetes? | Yes No Unsure |
| p. High blood pressure? | Yes No Unsure |
| g. Physical disability that hinders mobility? | Yes (Please specify) _____ No Unsure |
| h. Psychological condition such as depression? | Yes (Please specify) _____ No Unsure |
| i. Cancer? | Yes (Please specify) _____ No Unsure |
| m. Neurological conditions such as cerebral palsy? | Yes No Unsure |
| n. Developmental conditions such as ADHD/ADD or autism? | Yes No Unsure |
| l. Any other medical conditions? | Yes (Please specify) _____ No Unsure |

F2. 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 →
- Don't Know →

Participant ID:

F3. What medicines was [Child's name] taking? If respondent does not know the name of the medication, ask: What was the medicine for?

Participant ID:

Child Survey Module L: Demographic Information

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

L1. Do you consider [Child's name] to be Hispanic or Latino?

- Yes
- No

L2. 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

L4. If necessary, ask. Otherwise, check appropriate box. Is [Child's name] male or female?

- Male
- Female

L5. What is [Child's name]'s date of birth?

____/____/____
MM DD YYYY

Participant ID:

Child Survey Module M: Supplemental Questions

M2. [Insert event specific questions requested by the local health department here].

Participant ID:

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.

Pet ID: _____

SECTION III: ACE PET SURVEY

Now I am going to ask you about each of your pets or assistance animals and their experience with the incident. From now on, I will refer to both pets and assistance animals as pets.

If more than 1 pet, read: I will ask you about Pet 1 first, then Pet 2, etc. You can decide which pet you want to tell me about first.

Pet # _____

1. What type of animal is your pet?

- Dog
- Cat
- Bird

- Fish →
- Other (Please specify): _____

2. What is your pet's name? _____

3. What is your pet's breed or type? _____

If pet is dog or cat, continue with Question 4. If fish, go to Question 7. If bird or other, go to Question 6.

4. What is your pet's hair length? Read all choices to the respondent and check appropriate box.

- Short
- Medium
- Long
- Hairless

If pet is cat, go to Question 6.

5. How much does your dog weigh? Would you say...Read all choices except "Don't Know" to respondent and check appropriate box.

- Less than 20 pounds,
- Between 20-50 pounds
- More than 50 pounds
- Don't Know

6. How old is your pet? If older than 12 months, report in years. Check the appropriate box.

_____ Months Years

Pet ID:

7. Where was your pet located at the time of the incident?

- At the respondent's home →
- In a vehicle →
- Someplace else →
- Don't Know →

8. On [Day of incident], how long was your pet in a vehicle in the area highlighted on the map? Report in minutes or hours. Check the appropriate box.

_____ Minutes Hours

9. What is the address where the pet was located at the time of the incident? If don't know, ask: Do you know what street or intersection it was on or near? Probe for as much location information as possible.

If pet was in a vehicle while in the area highlighted on the map, go to Question 11.

10. How long was your pet inside for the [Fill hour] hours after the incident? Would you say... Read all choices except "Don't Know" to the respondent and check appropriate box.

- 91–100% of the time,
- 51–90% of the time,
- 11–50% of the time, or
- 0–10% of the time?
- Don't know

11. In the 24-hour period following the incident, did your pet... Read all choices to the respondent and circle appropriate response.

- | | | | |
|------------------------------------|-----|----|------------|
| a. Get injured? | Yes | No | Don't Know |
| b. Become ill? | Yes | No | Don't Know |
| c. Go missing? | Yes | No | Don't Know |
| d. Die? | Yes | No | Don't Know |
| e. <u>If missing and not dead:</u> | | | |
| Was your pet found? | Yes | No | Don't Know |

12. If respondent answered "yes" to any part of 11, read: Please tell me what happened to your pet. Otherwise, go to question 13.

Pet ID:

13. Was your pet examined by a veterinarian as a result of the incident?

Yes

No → [Go to Question 16](#)

Don't Know → [Go to Question 16](#)

14. What is the name of the veterinarian who examined the pet, or the name of the veterinarian's practice?

If respondent is under age 18, go to Question 16.

15. To improve future responses, we try to study all exposures, including animal exposures, as thoroughly as possible. Are you willing to let us get a copy of your pet's veterinary records for the medical treatment your pet received because of the incident?

Yes

No

16. Did you evacuate your pet?

Yes

No → [Go to Question 18](#)

17. Where did you take your pet?

Either ask about next pet or, if all pets have been discussed, do the following based on respondent's answer to Question 15:

- If "yes" to 15, review the veterinary records release form with the respondent, collect their signature, and then go to the "Closing Statement" in the General Survey module.
- If "no" to 15 or the question was skipped because the respondent was aged 13-17, go to the "Closing Statement" in the General Survey Module.

18. Why didn't you evacuate your pet?

Either ask about next pet or, if all pets have been discussed, do the following based on respondent's answer to Question 15:

- If "yes" to 15, review the veterinary records release form with the respondent, collect their signature, and then go to the "Closing Statement" in the General Survey module.
- If "no" to 15 or the question was skipped because the respondent was aged 13-17, go to the "Closing Statement" in the General Survey Module.