2a. STUDENT SURVEY FORM

Ref no: *form No __/ date _____* Name of Enumerator: _____ Contact # _____

Survey Start Time:_____ Survey End Time:_____ School ID: _____ Parent ID:_____

Student Demographic Information

Student's ID:_____ Student's Name: _____ Age: _____ Gender:M/F/Other_____ Class: _____

Section(If applicable):_____ Fathers/Guardian Name: _____ Father Education: _____ Father occupation: _____

Mother education: _____ Mother occupation: _____ Home address; H#_____ Street#_____ Block#_____

Town Name:_____ Contact #:_____

1.Living Conditions

S.N.	Information/Observation	Response
1.	Total number of household members	*Give number:* _____
2.	Please specify each: *(give number)*	a. Brothers (#): _____ b. Sisters (#): _____ c. Parents (#): _____ d. Grand-parents (#): _____ e. Other (#): _____
3.	# of rooms in the house	*Give number:* _____
4.	# of toilets in the house	*Give number:* _____
6.	Is clean drinking water available at your house? ***(tick only one option)***	1.Yes 2.No
7.	What is the source of clean drinking water supply at your home? ***(tick only one option)***	a. Tap water b. From filtration plant c. Water Dispenser d. Other (*Please specify*): _____
8	# of hand washing facilities at house	*Give number:* _____

2.Nutritional Assessment

S.N.	Information/Observation	Response
1.	Did you have breakfast today? ***(tick only one option)***	1.Yes 2.No
2.	*Yes or No, ask i*s it a daily routine? ***(tick only one option)***	1.Yes 2.No

3.COVID -19 Section

3.1.Personal Health

S.N.	Information/Observation	Response
1.	Are you afraid of Corona virus? ***(tick only one option)***	1.Yes 2.No
2.	Did you have fever during last 15 days? ***(tick only one option)***	1.Yes 2.No
3.	Did you have cough during last 15 days? ***(tick only one option)***	1.Yes 2.No
4.	Did you have body aches during last 15 days? ***(tick only one option)***	1.Yes 2.No
5.	Did you have flu during last 15 days? ***(tick only one option)***	1.Yes 2.No
6.	Did you have loss of smell during last 15 days? ***(tick only one option)***	1.Yes 2.No
7.	Did you have loss of taste during last 15 days? ***(tick only one option)***	1.Yes 2.No
8.	Have you been tested for COVID-19? ***(tick only one option)***	1.Yes 2.No
9.	If yes, what was the result? ***(tick only one option)***	1.Positive 2.Negative 3. Result Awaited
10.	What SOPs do you follow for Covid-19 prevention? ***(tick only one option for each category)***	a.Wear Mask: 1.Yes 2.No b.Wash hands frequently: 1.Yes 2.No c.Maintain distance: 1.Yes 2.No d.Sneeze or cough in sleeve: 1.Yes 2.No e.Sneeze of cough in tissue paper and then dispose it off: 1.Yes 2.No

2a. STUDENT SURVEY FORM

11.	How frequently do you wash your hands? ***(tick as many as applicable)***	a. Before eating b. After using the toilet c. After games d. After coming back from school e. After entering your home e. With morning washing of face f. Any other time (*please specify):* _____
12.	How do you wash your hands? ***(tick only one option)***	a.Soap b. Liquid Soap c. others (*please specify*): _____
13.	Do you frequently feel tired? ***(tick only one option)***	1.Yes 2.No
14.	Do you often not want to talk to people around? ***(tick only one option)***	1.Yes 2.No
15.	Do you experience frequent headaches? ***(tick only one option)***	1.Yes 2.No
16.	What do you do for these complaints? ***(tick as many as applicable)***	a.Don't do any thing b. Take medicine c.Tell your parents/siblings d. Seek medical adivce e. Other:_____
17	Wash hands with soap and water frequently?	1.Yes 2.No
18	Do you sneeze or cough in Elbow?	1.Yes 2.No
19	Are you fully vaccinated against COVID 19? (for 18+ only)	1.Yes 2.No
20	Do you avoid sharing (Stationary items, masks, food, water etc) at school?	1.Yes 2.No

3.2.Family

S.N.	Information/Observation	Response
1.	Did any of your family members experience the symptoms of Fever, Cough, body aches, Flu, loss of smell, loss of taste in last 15 days? ***(tick only one option)***	1.Yes 2.No
2.	If yes, how many:	*Give number:* _____
3	If yes, did they self-isolate? ***(tick only one option)***	1.Yes 2.No
4.	Did anyone in your family get tested for Covid-19? ***(tick only one option)***	1.Yes 2.No
5.	If yes, what was the result? ***(tick only one option)***	1.Positive 2.Negative 3. Result Awaited

3.3.Going to School

S.N.	Information/Observation	Response
1..	Do you wear mask while coming to school? ***(tick only one option)***	1.Yes 2.No
2.	How do you come to school daily? ***(tick only one option)***	1.Walk 2. Personal conveyance 3.Rickshaw 4. School Bus 5.Other (*please specify*): _____
3.	If you take a school bus, in your observation, is the bus disinfected? ***(tick only one option)***	1.Yes 2.No
4.	Do you wear a mask while on bus? ***(tick only one option)***	1.Yes 2.No
5.	Does the bus operate at: ***(tick only one option)***	a.100% capacity b. 50% capacity c. Other (*please specify*):_____
6.	If you take bus regularly, do you find it disinfected regularly?	1.Yes 2.No

3.4.Inside School

S.N.	Information/Observation	Response
1.	Is your temperature taken at the time of entering school premise? ***(tick only one option)***	1.Yes 2.No
2.	Are you required to sanitize your hands at the time of entering school premise? ***(tick only one option)***	1.Yes 2.No
3..	When do you take off mask in school? ***(tick as many as applicable)***	a.During class b. While eating c.While drinking d. While sweating e.Others (*please specify*): _____
4.	Is there a focal person/teacher appointed for COVID in your school? ***(tick only one option)***	1.Yes 2.No
5.	If yes who?	*Given Designation:* _____
6.	Have you received any training on COVID SOPs at School? ***(tick only one option)***	1.Yes 2.No

2a. STUDENT SURVEY FORM

7.	If yes, when were you trained?	*a.Give date:*_____ *b.Give duration:* _____	
8.	Are you satisfied with school cleanliness? ***(tick only one option)***	1.Yes	2.No
9.	Are you required to help in school cleaning chores? ***(tick only one option)***	1.Yes	2.No
10.	If yes, which chores ***(tick as many as apply)***	a.Classroom Cleaning: c. Playground cleaning	b. Toilet cleaning: d. Other (*please specify*): _____
11.	Would you like to be a part of a school vigilance committee to learn more about corona virus and to take actions at home and at school? ***(tick only one option)***	1.Yes	2.No
12.	Do you wear mask while going back home from school? ***(tick only one option)***	1.Yes	2.No
13.	Do you know about any vigilance committee working in school for COVID SOPs? (Multiple Choice)	1. School 2. Student 3. Parent 4. None of above	

3.5.Academic Information

S.N.	Information/Observation	Response	
1.	Have you been taking online classes? ***(tick only one option)***	1.Yes	2.No
2.	If no why? ***(tick as many as apply)***	1.Lack of Computer/Smartphone 3.Other (please specify): _____	2. Lack of adequate internet access
3.	If yes, which software you use for online classes/learning ***(tick only one option for each category)***	a.Zoom: 1.Yes b.Google: 1.Yes c.WhatsApp 1.Yes d.Other (*please specify):* 1.Yes	 2.No 2.No 2.No 2.No
4.	Which did you find easier: online classes or in school? ***(tick only one option)***	1.Online easy	2. In school easy:
5.	Have you ever attended Tele-school classes? ***(tick only one option)***	1.Yes	2.No
6.	If yes, which subjects did you like more?	*Please state:* _____	
7.	Do you take tuitions? ***(tick only one option)***	1.Yes	2.No
8.	If yes, how many other students are there with you?	*Give number* _____	
9.	What COVID SOPs are followed during your tuition classes ***(tick as many as applicable)***	1.Maintain distance while seating 3. Disinfection 5. Others (*Please specify*): _____ 6. Masjid	2. Wearing masks 4. Sanitizer use

3.6.Technological Skills

1.	Do you know how to use a computer/laptop? ***(tick only one option)***	1.Yes	2.No
2.	Which phone do you have? ***(tick only one option)***	1.Simple cell Phone	2. Smart Phone/Android Phone:
3.	Do you know how to operate a smartphone? ***(tick only one option)***	1.Yes	2.No
4.	Do you use internet on: ***(tick only one option)***	1.Computer/Laptop:	2.Phone:
5.	Do you use WhatsApp? ***(tick only one option)***	1.Yes	2.No
6.	Do you use SMS service? ***(tick only one option)***	1.Yes	2.No
7.	Do you know how to use Zoom? ***(tick only one option)***	1.Yes	2.No

3.7.Sports/Gym

1.	Do you play any sports? ***(tick as many as apply)***	1.Indoor 3.Gym	2.Outdoor 4. None
2.	Do you wear a mask while playing sports ***(tick only one option)***	1.Yes	2.No
3.	Do you sanitize your hands before and after playing sports? ***(tick only one option)***	1.Before	2.After

4.Are you satisfied with your school's SOPs in preventing Covid-19 infection?

_____

_____

5.Please list any challenges that you are facing in preventing yourself from Covid-19 infection:

2a. STUDENT SURVEY FORM

_____

_____

6.Any other social or emotional challenges that you would like to share:

_____

_____

7.Any suggestions or advice:

_____

_____