Day 8 Survey Vacinees

1. Please indicate your child’s gender.
   □ Female  
   □ Male 

2. How old is your child? ________ years _________ months

3. Does your child have any underlying health conditions?
   □ No  
   □ Yes 

4. Has your child been vaccinated against seasonal influenza before this year?
   □ No  
   □ Yes

   If « yes » is given to question 4 the following question will appear:
   Did your child receive Flumist (vaccine in the nose) last year?
   □ No  
   □ Yes

   If « no » is given to question 4 the following question will appear:
   Was the influenza immunization your child received last week your child’s first or second influenza vaccine this year?
   □ First  
   □ Second  
   □ Don’t know

5. What influenza vaccine did you child receive last week?
   □ Flumist (vaccine in the nose)  
   □ TIV (vaccine in the arm) 
   □ Don’t know

6. In the first week (7 days) following vaccination did your child have any new symptoms severe enough to limit his/her normal daily activities?
   □□ No  
   □□ Yes

   If « yes » is given to question 6 the following questions will appear:

7. Did your child have fever higher than 38.5C?
   □□ No  
   □□ Yes

8. Did your child have feverishness, chills?
   □□ No  
   □□ Yes
9. Did your child have screaming episode/persistent crying longer than 3 hours?
   □ No
   □ Yes

10. Did your child stop eating?
    □ No
    □ Yes

11. Did your child have seizures/convulsions?
    □ No
    □ Yes

12. Did your child start wheezing?
    □ No
    □ Yes

13. Did your child have a rash or itching or tingling skin?
    □ No
    □ Yes

14. Did your child have a respiratory infection (cold, flu, sore throat)?
    □ No
    □ Yes

15. Did your child have a stomach problem (nausea and/or vomiting and/or diarrhea)?
    □ No
    □ Yes

16. Did your child have any other symptoms? Please specify:
    ______________________________________________________

17. How long did the most severe symptoms last?
    _____ hours  or  _____ days  or □ □ They are still present

18. How would you describe the severity of these symptoms?
    □ Easily tolerated
    □ Uncomfortable, but didn't prevent daily activities or require contacting a doctor or nurse
    □ Severe enough to miss school/daycare or to prevent daily activities
    □ Severe enough to contact a doctor or a nurse
    □ Severe enough to miss school/daycare or to prevent daily activities AND to contact a doctor or nurse

19. Do you think that these symptoms are related to the vaccine?
We would like to gather information that will help us improve how we conduct the surveillance survey in the future. Please take the time to answer the following questions.

20. Did you find the survey easy to access? Yes □ No □

21. Did you find the survey easy to understand? Yes □ No □
   If no what did you not understand? ________________________________
   __________________________________________________________________

22. Would you change anything in the survey? _________________________

23. Would you be willing to do a similar web-based survey next year? Yes □ No □
   If no, why? _______________________

24. Did you find the e-mail reminder helpful? Yes □ No □ Did not use

25. Do you have other comments about the web-based survey process? _______________________

26. What electronic device did you use to complete this survey?
   □ Computer (laptop/desktop)
   □ Tablet (iPad etc)
   □ Mobile phone with internet access
   □ Other: specify _______________________

27. What other kinds of electronic communication device(s) do you use?
   Please check all that apply
   □ Mobile phone (no internet access)
   □ Mobile phone (with internet access)
   □ Land line/ home phone
   □ Skype calling
   □ Computer (laptop/desktop) no internet access
   □ Computer (laptop/desktop) with internet access
   □ Tablets (iPad etc) no internet access
   □ Tablets (iPad etc) with internet access
   □ No access to electronic devices
   □ Other: specify _______________________

28. For this type of web-based survey how would you prefer to receive the invitation?
   □ Email
Active Surveillance of Adverse Events Following Immunization among Children Immunized with the Influenza Vaccine

Identification #: [_____________]

☐ Website
☐ Facebook
☐ Text message
☐ Mail
☐ Phone call
☐ Other social network site
☐ Other: specify ___________________

29. If you were to take part in this study again, how would you prefer to complete the survey?
   ☐ Online web-based survey
   ☐ Phone call (person to person)
   ☐ Phone call (automated voice response)
   ☐ Instant messaging (‘chat’)
   ☐ Other: specify ___________________

Thank you for completing this year’s surveillance survey.

If the participant answered <<yes>> to severe enough to miss school/daycare or to prevent daily activities and/or severe enough to contact a doctor or a nurse the following message will appear

Because you have answered that your child had new symptoms severe enough to miss school/daycare or prevent daily activities and/or required medical contact, a research nurse will contact you within 48 hours to collect more information about your child’s health problem.

If you are concerned about any side effects from the vaccine(s) please call public health or your regular care provider.

Additional Questions for Non-responders:

Now we would like your opinion about the self-report process.

1. Can you tell me why you did not fill in the web-based adverse event report form?
   ☐ Did not receive the email link
   ☐ Too busy
   ☐ Other: specify ___________________
2. Is there anything about the process that could be changed to make it easier for you to respond?

□ Yes □ No □

2.1. If yes, what?

________________________________________________________________________
________________________________________________________________________

*If the participant answered <<yes>> to severe enough to miss school/daycare or to prevent daily activities and/or severe enough to contact a doctor or a nurse please complete the follow up questionnaire with them on this call.*