**Questionnaire about complaints that occur within 4 days after the MenACWY vaccination**

Last week your child received the vaccination that protects against four types of meningococcal disease (MenACWY). The questionnaire below is about complaints that may occur within 4 days after the vaccination. Filling in this list takes approximately 10 to 15 minutes.

**Notes for completing the questionnaire:**

Different types of questions are asked in the questionnaire. For questions with square boxes you can give multiple answers, in a round box only one answer is possible.

When you have answered the questions, you can click on 'send'.

**General questions**

**What is the birthdate of your child?**

**What is the sex of your child**

○ Boy

○ Girl

**What is the length of your child? …… cm**

**What is the weight of your child? ….. kg**

**Your child's state of health**

**Can you indicate whether your child regularly suffers from: (you can tick multiple answers)**

□ coughing/shortness of breath

□ vomiting and/or diarrhoea

□ Infections

□ Rash

□ Hypersensitivity/allergy

□ Other, namely

□ None of the above

**Where is the MMR vaccine administered?**

○ right upper arm

○ left upper arm

○ right upper leg

○ left upper leg

○ Other

**Where is the MenACWY vaccine administered?**

○ right upper arm

○ left upper arm

○ right upper leg

○ left upper leg

○ Other

**Does your child take medicines?**

**Please fill in the details of other medicines your child is taking, in addition to the given vaccines. Please note also medicines that can bought without a prescription at, for example, the drugstore or the supermarket.**

**…………………………………………………………………………………………………………..**

**…………………………………………………………………………………………………………..**

**On what date have your child been vaccinated? (dd.mm.jjjj)**

**…………………………………………………………………………………………………………..**

**The following questions are related to complaints after the vaccinations**

**Did your child experience side effects after the vaccination?**

○ yes

○ no

**What side effects occurred after vaccination? (You can click on multiple options. NOTE: Side effects not mentioned here can be filled in later!)**

□ Injection site reaction of the MMR arm

□ Injection site reaction of the MenACWY arm

□ Fever

□ Rash

□ Decreased appetite

□ Listlessness

□ Deviating sleeping pattern

□ Drowsiness

□ Vomiting

□ Diarrhea

□ Convulsions with or without fever

□ None of the above

**In case of an injection site reaction of the MMR arm:**

**What reaction experienced your child? (You can click on multiple options)**

□ Red

□ Warm

□ Pain

□ Thick

□ Hard drive

□ Blue

□ Itching

□ Other

**Can you indicate the size of the reaction?**

…………………… cm

**Can you indicate how long after the vaccination the reaction occurred?**

…………………….

**Has your child been treated for the reaction?**

○ Yes

○ No

**Have your child recovered from the reaction?**

○ Yes

○ No

**How stressful did you, as a parent, experience this reaction?**

○ Not stressful

○ Somewhat stressful

○ Quite stressful

○ Very stressful

**In case of an injection site reaction of the MenACWY arm:**

**What reaction experienced your child? (You can click on multiple options)**

□ Red

□ Warm

□ Pain

□ Thick

□ Hard drive

□ Blue

□ Itching

□ Other

**Can you indicate the size of the reaction?**

…………………… cm

**Can you indicate how long after the vaccination the reaction occurred?**

…………………….

**Has your child been treated for the reaction?**

○ Yes

○ No

**Have your child recovered from the reaction?**

○ Yes

○ No

**How stressful did you, as a parent, experience this reaction?**

○ Not stressful

○ Somewhat stressful

○ Quite stressful

○ Very stressful

**Fever**

**After how much time did the fever develop?**

............

**How high was the fever?**

○ ............. °C

○ Not measured

**How is the fever measured?**

○ Rectally (between the buttocks)

○ Ear thermometer

○ Different, namely .................................

**Has your child been treated for the fever?**

○ Yes

○ No

**Have your child recovered from the fever?**

○ Yes

○ No

**How stressful did you, as a parent, experience the fever?**

○ Not stressful

○ Somewhat stressful

○ Quite stressful

○ Very stressful

**Rash**

**Can you describe the rash (f.e. bumps and/or itching)?**

…………………………………………………………………………………………………………………………

**At what place of the body did the rash appeared?**

…………………………………………………………………………………………………………………………

**After how much time did the rash develop?**

............

**Has your child been treated for the rash?**

○ Yes

○ No

**Have your child recovered from the rash?**

○ Yes

○ No

**How stressful did you, as a parent, experience the rash?**

○ Not stressful

○ Somewhat stressful

○ Quite stressful

○ Very stressful

**Decreased appetite**

**After how much time did the decreased appetite occur?**

............

**Has your child been treated for the decreased appetite?**

○ Yes

○ No

**Have your child recovered from the decreased appetite?**

○ Yes

○ No

**How stressful did you, as a parent, experience the decreased appetite?**

○ Not stressful

○ Somewhat stressful

○ Quite stressful

○ Very stressful

**Listlessness**

**After how much time did the listlessness occur?**

............

**Has your child been treated for the listlessness?**

○ Yes

○ No

**Have your child recovered from the listlessness?**

○ Yes

○ No

**How stressful did you, as a parent, experience the listlessness?**

○ Not stressful

○ Somewhat stressful

○ Quite stressful

○ Very stressful

**Drowsiness**

**After how much time did the drowsiness occur?**

............

**Has your child been treated for the drowsiness?**

○ Yes

○ No

**Have your child recovered from the drowsiness?**

○ Yes

○ No

**How stressful did you, as a parent, experience the drowsiness?**

○ Not stressful

○ Somewhat stressful

○ Quite stressful

○ Very stressful

**Vomiting**

**After how much time did the vomiting occur?**

............

**Has your child been treated for the vomiting?**

○ Yes

○ No

**Have your child recovered from the vomiting?**

○ Yes

○ No

**How stressful did you, as a parent, experience the vomiting?**

○ Not stressful

○ Somewhat stressful

○ Quite stressful

○ Very stressful

**Diarrhea**

**After how much time did the diarrhea occur?**

............

**Has your child been treated for the diarrhea?**

○ Yes

○ No

**Have your child recovered from the diarrhea?**

○ Yes

○ No

**How stressful did you, as a parent, experience the diarrhea?**

○ Not stressful

○ Somewhat stressful

○ Quite stressful

○ Very stressful

**Convulsions**

**Can you describe the convulsions?**

**………………………………………………………………………………………………………..**

**Did your child have a fever just before or after the convulsion?\***

○ Yes

○ No

○ I do not know

**How high was the fever?**

○ ............. °C

○ Not measured

**How is the fever measured?**

○ Rectally (between the buttocks)

○ Ear thermometer

○ Different, namely .................................

**After how much time did the convulsion occur?**

........................................................................................................

**Has your child been treated for the convulsion?**

○ Yes

○ No

**How has the convulsion been treated?**

........................................................................................................

**Have your child recovered from the convulsions?**

○ Yes

○ No

**How long did it take for your child to recover from the convulsions?**

……………………………………………………………………………………………………

**How stressful did you, as a parent, experience the convulsions?**

○ Not stressful

○ Somewhat stressful

○ Quite stressful

○ Very stressful

**Other side effects**

**Did your child experience other side effects after the vaccinations?**

○ Yes

○ No

**Can you describe these side effects?**

**………………………………………………………………………………………………………..**

**After how much time did these side effects occur?**

........................................................................................................

**Has your child been treated for these side effects?**

○ Yes

○ No

**Have your child recovered from these side effects?**

○ Yes

○ No

**How stressful did you, as a parent, experience these side effects?**

○ Not stressful

○ Somewhat stressful

○ Quite stressful

○ Very stressful

**Medical Intervention**

**Have you sought medical help for the side effects that have occurred?**

○ Yes

○ No

**If yes, what kind of medical help has been sought related to the complaints of your child?**

□ Contact general practitioner and/or youth health care organization by phone

□ Visit general practitioner and/or youth health care organization

□ Hospital visit

□ Admission to hospital

□ Immediate life-threatening situation

□ Other, namely: **…….**

□ None of the above

**May we possibly contact you for additional information?**

○ Yes

○ No

**Use analgesics**

**Did your child take analgesics in the days after vaccinations?**

○ Yes, namely .............................

○ No

**For which complaints has your child used the analgesics?**

............................................................

**How much time after the vaccinations did you give your child analgesics?**

○ 0-6 hours after vaccinations

○ 6-24 hours after vaccinations

○ 24-48 hours after vaccinations

○ >48 hours after vaccinations

**How long has your child been on analgesics?**

○ < 1 day

○ 1-2 days

○ > 2 days

**Absence**

**Has your child been absent from childcare or other activities due to the side effects?**

○ No

○ Yes, < 1 day

○ Yes, 1-2 days

○ Yes, > 2 days

○ Not applicable

**Have you been absent from work due to your child's side effects?**

○ No

○ Yes, < 1 day

○ Yes, 1-2 days

○ Yes, > 2 days

○ Not of application

**Additional question**

**How many children does your family consist of?**

....................

***This is the end of this questionnaire. Thank you for your participation!***

Send