**Appendix 1**

**Survey Questionnaire**

1. Medical Record Number
2. Age (completed years)
3. Sex: Male 🀆 Female 🀆
4. Diagnosis:

* Food allergy 🀆
* Insect/venom allergy 🀆
* Drug allergy 🀆
* Idiopathic anaphylaxis 🀆
* Exercise-induced anaphylaxis 🀆

1. The number of adrenaline auto-injector(s) prescribed (ideally 2 per year/ However if the home one has been used and the school one not, then will prescribe one): ……………….
2. Parental awareness of the indication of adrenaline auto-injector prescribed:

* I will use it if my child ONLY develops a mild rash/lips/ eye swelling ……. 🀆
* I will use it if my child develops a rash PLUS any of the following: cough, breathing difficulty or tightness in the throat …………………………………….🀆
* I am not sure when to use it …………………………………..……….🀆

7. I am happy and satisfied with the training I have received on how to use the adrenaline auto-injector

|  |  |  |
| --- | --- | --- |
| 1 | Strongly disagree | 🀆 |
| 2 | Disagree | 🀆 |
| 3 | Not sure | 🀆 |
| 4 | Agree | 🀆 |
| 5 | Strongly agree | 🀆 |

8. Have you used an adrenaline auto-injector before? Yes 🀆 No 🀆

9. I feel competent to use the adrenaline auto-injector in case my child needs it?

|  |  |  |
| --- | --- | --- |
| 1 | Strongly disagree | 🀆 |
| 2 | Disagree | 🀆 |
| 3 | Not sure | 🀆 |
| 4 | Agree | 🀆 |
| 5 | Strongly agree | 🀆 |

10. I feel comfortable and not scared to use the adrenaline auto-injector in my child

|  |  |  |
| --- | --- | --- |
| 1 | Strongly disagree | 🀆 |
| 2 | Disagree | 🀆 |
| 3 | Not sure | 🀆 |
| 4 | Agree | 🀆 |
| 5 | Strongly agree | 🀆 |