

Swine Flu (Novel Influenza A H1N1) Vaccine Study

Memory Aid Card

Your child's next visit is scheduled for:

___/___/_____ at ___:___ hours

Child's first name: _____

Child's Number: _____

WHY DO I NEED TO COMPLETE THIS MEMORY CARD?

Dear Parent/Legal Guardian

Thank you very much for completing the diary card for the 7 days after your child was vaccinated. Please remember to return the diary card in the pre-paid envelope.

We would be grateful if you could fill in this memory card from 8 days after the vaccine until we see you at the next visit. We would like to know if any of the **symptoms that your child may have had after vaccination continued beyond day 7**. We would also like you to record any change in your child's health **that has led to your child being seen by a doctor or going to the Emergency Department (A&E)**.

If your child needs hospitalisation for any reason or if you are concerned about your child's health, please contact the study team immediately



Our contact details are:
01865 857080 (Office hours)

24 hours advice number:
07703134238

Vaccine reactions continuing after day 7

Injection site reactions •tenderness •swelling •Redness	Start date(s) of reaction dd/mm	Stop date(s) of reaction dd/mm	Date(s) of doctor / Emergency Department visit (A&E)?	Medication(s) to treat the reaction
				<input type="checkbox"/> No <input type="checkbox"/> Yes, specify:

General reactions •fever ($\geq 38^{\circ}\text{C}$) •changing in feeding/ eating •reduced activity/ irritability/ generally unwell •vomiting or diarrhoea •For children <5 years: persistent crying •For children >5 years: muscle pain or joint pain	Start date(s) of reaction dd/mm	Stop date(s) of reaction dd/mm	Date(s) of doctor / Emergency Department visit (A&E)?	Medication(s) to treat the reaction
				<input type="checkbox"/> No <input type="checkbox"/> Yes, specify:

SYMPTOMS/ILLNESSES requiring a visit to a doctor or emergency department (A&E)

Symptom / Illness	Start date (s) of reaction dd/mm	Stop date(s) of reaction dd/mm	Date(s) of doctor / Emergency Department visit (A&E)?	Medication(s) to treat the illness/ symptom
				<input type="checkbox"/> No <input type="checkbox"/> Yes, specify:

Reminder: Please bring this card with you to the next visit