CHILDREN OVER 5 YEARS OF AGE DIARY

Study No:				
First name:				
Date of Vaccination: _	//	Time of vaccination:		
			RIGHT / LEFT	ARM
		INST	RUCTIONS	
Please note that Day 0 is	the day of vaccin	ation, Day 1 is the next day and so o	on. At about the sar	me time each evening, please fill in the chart overleaf
HOW AND WHEN TO ME				
Take the temperature u	nder the arm (axi	llary)		
	Day 0 Day 1 - 7	•	that evening (6 - 8	3 pm)

Look at the vaccination site and measure the maximum width of any redness or swelling using the ruler and fill in the chart accordingly

GENERAL SYMPTOMS Please circle the appropriate number. If you child has symptoms then please evaluate the severity (mild, moderate or severe) of the symptom(s). Please complete each day.	(Da	ny 0 ny of cine)	Da	ny 1	Da	y 2	Da	y 3	Da	y 4	Da	y 5	Da	y 6	Da	y 7	If symptom was ongoing at day 7, please record the date this symptom resolved below
Has your child been generally unwell? O None Mild – transient with no limitation on normal activity		1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	
Mind – transfert with in limitation of informal activity Moderate – some limitation in daily activity Severe – unable to perform normal daily activity	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	
Has your child had a headache? O None 1 Mild – transient with no limitation on normal activity		1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	
Moderate – some limitation in daily activity Severe – unable to perform normal daily activity	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	
Has your child felt nauseous or vomited? 0 None 1 Mild - 1-2 episodes without interfering with routine	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	
Moderate Several episodes and cannot keep any food down Severe: Frequent episodes and taking nothing by mouth	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	
Has your child had <u>diarrhoea</u> ? 0 None 1 Mild – More loose stools than usual	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	
Moderate – Frequent runny stools without much solid material Severe – Multiple liquid stools without much solid material	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	
Has your child been eating less than usual/had a loss of appetite? 0 None 1 Mild – Eating less than normal for 1-2 meals	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	
2 Moderate Missed 1-2 meals completely 3 Severe Refused most or all meals	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	
Has your child had muscle pain? O None 1 Mild – transient with no limitation on normal activity 2 Moderate – some limitation in daily activity 3 Severe – unable to perform normal daily activity	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	
	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	
Has your child had joint pain? 0 None	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	
Mild – transient with no limitation on normal activity Moderate – some limitation in daily activity Severe – unable to perform normal daily activity	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	

VACCINE SITE SYMPTOMS: Please score any pain or tend injection site and measure an redness at the injection site.			0 (Day accine)	Di	ay 1	Da	y 2	Da	ау 3	Da	ny 4	Dâ	ay 5	Da	ау 6	Da	ay 7	If symptom was ongoing at day 7, please record the date this symptom resolved below
Has there been pain at the injection site? 0 None		0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	
Mild – transient with no limitation on r Moderate – some limitation in daily ac Severe – unable to perform normal dail	tivity	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	
Maximum swelling (mm)																		
Maximum redness (mm)																		
TEMPERATURE Day	Day 0 Evening	Day 1 Ev	ening/		ay 2 ening		Day 3	3 Evenin	g	Day 4 E	Evening		Day 5 Evening			ay 6 rening		Day 7 Evening
Axillary (under arm) temperature**	°C		°C		°C			°C			°C			°C		°(:	°C
Any medication for <u>pain or temperature</u> used?	YES / NO	YES / I	YES / NO YES / NO) YES		ES / NO		YES / NO		YES / N		S / NO		YES / NO		YES / NO	
If medication used please specify name																		

**TEMPERATURE (UNDER ARM): For an accurate temperature place the tip of the thermometer against the skin under the armpit and hold your child with his or her arm by their side closed for approximately 1 minute until the rapid beeps confirming that the temperature measurement is complete (see instruction leaflet enclosed with the thermometer for further information). On days 1 to 7, please measure your child's temperature at approximately the same time on each day.

If your child feels warm at any other time of day please record the date and time below:									
°C//::	°C//::								

If you need to see a doctor before the 2nd study visit, please take this diary with you and tell the doctor about the study.

If your child is unwell at all, if you need to call a doctor or your child is seen by a doctor or is given any medicine then please write the details below:

Date	Problem	Action taken (please circle answer)		Medicine given					
Start date:/		Did you telephone a GP? Was your child seen by a GP? Seen by GP at Taken to hospital? Admitted to hospital	Yes No Yes No Home/Surgery Yes No Yes No	Name: Start date: End date: Dosage:	(1 st medicine)	(2 nd medicine)			
Start date:// Stop date://		Did you telephone a GP? Was your child seen by a GP? Seen by GP at Taken to hospital? Admitted to hospital	Yes No Yes No Home/Surgery Yes No Yes No	Name: Start date: End date: Dosage:	(1 st medicine)	(2 nd medicine)			
Start date:/		Did you telephone a GP? Was your child seen by a GP? Seen by GP at Taken to hospital? Admitted to hospital	Yes No Yes No Home/Surgery Yes No Yes No	Name: Start date: End date: Dosage:	(1 st medicine)	(2 nd medicine)			
Start date:// Stop date://		Did you telephone a GP? Was your child seen by a GP? Seen by GP at Taken to hospital? Admitted to hospital	Yes No Yes No Home/Surgery Yes No Yes No	Name: Start date: End date: Dosage:	(1 st medicine)	(2 nd medicine)			
Start date:// Stop date://		Did you telephone a GP? Was your child seen by a GP? Seen by GP at Taken to hospital? Admitted to hospital	Yes No Yes No Home/Surgery Yes No Yes No	Name: Start date: End date: Dosage:	(1 st medicine)	(2 nd medicine)			

If you, your doctor or anyone else needs advice regarding the study, he/she should contact:

H1N1 Study Team Oxford Vaccine Group

Centre for Clinical Vaccinology and Tropical Medicine Churchill Hospital Old Road, Headington Oxford OX3 7LJ

Tel: 01865 857420

Email: ovg@paediatrics.ox.ac.uk

24 hour emergency telephone number: 07699 785400

Thank you for taking the time to fill in this diary.

We would be grateful if you would bring it with you to your next visit.