

BASELINE CRF

Participant ID: SO  ---



### Stand Out in Class - Baseline Case Report Form

Date of visit:  
(DD/MM/YYYY)   /   /

Class: \_\_\_\_\_ Teacher's initials: \_\_\_\_\_

Assent given (please tick): Yes  No

Date of assent:  
(DD/MM/YYYY)   /   /

If no, please state reason (please tick):

Absent	<input type="checkbox"/>
Left school	<input type="checkbox"/>
School commitment/not available	<input type="checkbox"/>
Does not want to participate	<input type="checkbox"/>
Other (please specify below)	<input type="checkbox"/>

Other reason: \_\_\_\_\_

<b>CRF Section Sign-Off</b>	
CRF section completed by ( <i>insert name</i> ):	_____
Signature:	_____
Date of completion (DD/MM/YYYY)	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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**Demographic information**

Child's date of birth (DD/MM/YYYY):   /   /

Child's sex (please tick):            Male             Female

Child's ethnicity (please tick):

White British	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
White Irish	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>
Other White	<input type="checkbox"/>	Other Asian	<input type="checkbox"/>
White and Black Caribbean	<input type="checkbox"/>	Black Caribbean	<input type="checkbox"/>
White and Black African	<input type="checkbox"/>	Black African	<input type="checkbox"/>
White and Asian	<input type="checkbox"/>	Other Black	<input type="checkbox"/>
Other Mixed	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
Indian	<input type="checkbox"/>	Other Ethnic Group	<input type="checkbox"/>

Please state if Other Ethnic Group: \_\_\_\_\_

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CRF section completed by ( <i>insert name</i> ):	_____
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**Questionnaires returned/completed (please tick)**

Strength and Difficulties questionnaire (teacher reported):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Child Body Part Comfort Survey:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
My Learning:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Paediatric Quality of Life (self-reported):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
EQ-5D Y (self-reported)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Activity monitor/sleep diary:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Health-related resource use (parent reported):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Education-related resource use (teacher reported):	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**CRF Section Sign-Off**

CRF section completed by (*insert name*): \_\_\_\_\_

Signature: \_\_\_\_\_

Date of completion (DD/MM/YYYY)   /   /

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**Objective measures**

ActiGraph no:

ActiGraph placed on child's right hip (please tick)? Yes  No

If yes, please state the time the ActiGraph was fitted (please use the 24 hour clock, HH:MM):

:



If no, please tick reason below

Child does not want to wear the monitor today	<input type="checkbox"/>
Child wants their parent/guardian to place the monitor on them	<input type="checkbox"/>
Child wants to put their own monitor on in private	<input type="checkbox"/>
Absent from school	<input type="checkbox"/>
Other	<input type="checkbox"/>

Please state if other reason:

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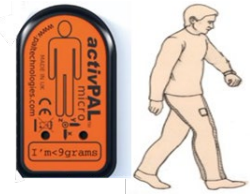
If the ActiGraph was not fitted, was it left with the teacher (please tick)? Yes  No

Date of ActiGraph issue (DD/MM/YYYY):   /   /

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activPAL no:



activPAL placed on child (please tick)?      Yes       No

If yes, please state the time the activPAL was fitted (please use the 24 hour clock, HH:MM):

:

If no, please tick reason below

Child does not want to wear the monitor today	<input type="checkbox"/>
Child wants their parent/guardian to place the monitor on them	<input type="checkbox"/>
Child wants to put their own monitor on in private	<input type="checkbox"/>
Absent from school	<input type="checkbox"/>
Other	<input type="checkbox"/>

Please state if other reason:

\_\_\_\_\_

If the activPAL was not fitted, was it left with the teacher (please tick)?      Yes       No

Date of activPAL issue (DD/MM/YYYY):       /  /

CRF Section Sign-Off	
CRF section completed by ( <i>insert name</i> ):	_____
Signature:	_____
Date of completion (DD/MM/YYYY)	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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Date of ActiGraph return (DD/MM/YYYY):   /   /

Date of activPAL return (DD/MM/YYYY):   /   /

<b>CRF Section Sign-Off</b>	
CRF section completed by ( <i>insert name</i> ):	_____
Signature:	_____
Date of completion (DD/MM/YYYY)	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

**Compliance**

At least 3 days of ActiGraph data, with over 8 hours of daily wear (please tick)?

Yes  No

At least 3 days of activPAL data, with over 8 hours of daily wear (please tick)?

Yes  No

<b>CRF Section Sign-Off</b>	
CRF section completed by ( <i>insert name</i> ):	_____
Signature:	_____
Date of completion (DD/MM/YYYY)	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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**Physiological measures**

Standing height (record to nearest 0.5cm):    .  cm

*Not completed report why:*

**Tanita scale measurements**

*Not completed report why:*

Age in years:   years

Asked participant if they have a pacemaker or other implanted medical device?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do they have a pacemaker? (if yes, do not use impedance mode, just use weight mode)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Clothes weight tare 1.0 kg

Tick if socks/tights worn

Weight:    .  kg

Body fat %:   .  %

Fat mass:    .  kg

Visceral rating:   unit less

BMI:   .  kg/m<sup>2</sup>

Attached paper print out to this page of the CRF?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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**Blood pressure (systolic/diastolic)**

**Heart rate**

To be taken after a 5 minute rest in the seated position, using the left arm level with the heart

Measure 1:    /    mm/Hg    bpm

Measure 2:    /    mm/Hg    bpm

Measure 3:    /    mm/Hg    bpm

Average of measures 2 and 3 (to be calculated in the database):

/    mm/Hg    bpm

*Not completed report why:*

**CRF Section Sign-Off**

CRF section completed by (*insert name*): \_\_\_\_\_

Signature: \_\_\_\_\_

Date of completion (DD/MM/YYYY)   /   /



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**Cognitive function**

Cognitive function test battery completed (please tick)? Yes  No

If no, please tick reason below

Child does not want to complete these measurements	<input type="checkbox"/>
Absent from school	<input type="checkbox"/>
Other	<input type="checkbox"/>

If other, please state reason: \_\_\_\_\_

**CRF Section Sign-Off**

CRF section completed by (*insert name*): \_\_\_\_\_

Signature: \_\_\_\_\_

Date of completion (DD/MM/YYYY)   /   /

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**Question for participant on thoughts of using a Sit-to-Stand desk**

1. How do you feel about possibly using desks which adjust so you can stand up in class?

2. How do you think such desks could affect your:

Body?

Concentration?

Learning?

Behaviour?

3. Do you think you would **like** or **dislike** using such desk to work standing up, why?

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**Child Body Part Comfort Survey**

Circle the face that best describes how you feel at your desk



	I feel	Good		OK		Bad
Neck						
Arm						
Back						
Wrists/ Hands						
Hips						
Legs						
Ankles/ feet						

If not completed, please state reason:

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Engagement vs Disaffection with Learning questionnaire - for information on this measure, please see:

<https://journals.sagepub.com/doi/abs/10.1177/0013164408323233?journalCode=epma>

EQ-5D-Y – for information on this measure, please see:

<https://euroqol.org/eq-5d-instruments/eq-5d-y-about/>

PEDS-QL - for information on this measure, please see:

<https://www.pedsql.org/>

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**Note for researcher:**

1. Please go back through the CRF now to check all sections are complete.
2. Were there any sections or questions that the participant could not, or found difficult to complete?

Yes  No

If Yes, which section(s)?

What was the problem?

3. Do you have any concerns about the validity of the data you have collected?

Yes  No

Please write any concerns here.

**CRF Section Sign-Off**

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Strengths and Difficulties Questionnaire – for information on this measure, please see:

<http://www.sdqinfo.com/>



## Stand Out in Class Study - Questionnaire for Parents

**In the last 3 months, what contact has your child had with any of these health services?**

	Has your child had contact with? (please circle YES or NO)		If yes, please state number of contacts your child has had
General practitioner (GP) Surgery visit	YES	NO	
General practitioner (GP) Home visit	YES	NO	
General practitioner (GP) phone call	YES	NO	
GP Nurse Surgery visit	YES	NO	
GP Nurse Home visit	YES	NO	
GP Nurse phone call	YES	NO	
Health visitor	YES	NO	
District nurse	YES	NO	
Other doctor	YES	NO	
Psychiatrist	YES	NO	
Psychologist	YES	NO	
Other counsellor/therapist	YES	NO	
Mental health nurse	YES	NO	
Accident and Emergency Visit	YES	NO	
Hospital Outpatient appointment	YES	NO	
Social worker office visit	YES	NO	
Social worker home visit	YES	NO	

**In the last 3 months has your child been admitted to hospital for overnight stays?**  
YES / NO (please circle)

**If Yes**, please list details of each admission below if applicable:

Reason for admission	Number of days



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How many days have you been unable to do your usual activities (for example, house work, leisure activities) in the last 3 months due to ill health of your child?  
\_\_\_\_\_ days

How many days have you been unable to do your usual activities (for example, house work, leisure activities) in the last 3 months due to childcare issues?  
\_\_\_\_\_ days

**Employment**

<b>What is your current employment status?</b>	<b>Please tick</b>
Employed	
Employed (on maternity/paternity leave)	
Unemployed	
Student	
Housewife/husband	
Retired	
Other, please state:	

**If employed**, how many hours per week do you work? \_\_\_\_\_ hours/week

How many days have you been absent from work over the last 3 months due to ill health of your child?  
\_\_\_\_\_ days absent

How many days have you been absent from work over the last 3 months due childcare issues?  
\_\_\_\_\_ days absent