the runny ear study

Your Child's 3-Month Quality of Life Questionnaire

(for parent to complete)

Child's participant ID number:
(study team to write in)

Study entry date (Day 1):
(study team to write in)

D D / M M / Y Y Y Y

INSTRUCTIONS

- Please complete this questionnaire using black ink only.
- Instructions are given for the questions.
- **If you have chosen to complete the questionnaire on-line via the app (this is smartphone-friendly):** If you have not received an email or text or have any problems completing the online questionnaire, please contact us on [redacted] or [redacted] / or study email address: [redacted]. **Please refer to the REST web app user guide (in the patient pack at recruitment) for instructions on how to use the app**.

If you have any questions about filling in the questionnaire, please contact us:

Sue Harris, Research Nurse
Email: [redacted]
Tel: [redacted] / [redacted] (work mobile)

Kate Rowley, Trial Co-ordinator
Email: [redacted]
Tel: [redacted] / [redacted] (work mobile)

Annie Sadoo, Trial Research Administrator
Email: [redacted]
Tel: [redacted]

Kathryn Curtis, Trial Manager
Email: [redacted]
Tel: [redacted] / [redacted] (work mobile)

Thank you for your co-operation in helping us with this research.

Instructions: Please help us understand the impact of ear infections or fluid on your child's quality of life by ticking one box for each question below.

Thank you

Physical suffering: Ear pain, ear discomfort, ruptured ear drum, high fever, or poor balance. How much of a problem for your child during the past 4 weeks?

- ☐ Not present/no problem
- ☐ Hardly a problem at all
- ☐ Somewhat of a problem
- ☐ Moderate problem
- ☐ Quite a bit of a problem
- ☐ Very much of a problem
- ☐ Extreme problem

Hearing loss: Difficulty hearing, questions must be repeated, frequently says "What?", or television is excessively loud. How much of a problem for your child during the past 4 weeks?

- ☐ Not present/no problem
- ☐ Hardly a problem at all
- ☐ Somewhat of a problem
- ☐ Moderate problem
- ☐ Quite a bit of a problem
- ☐ Very much of a problem
- ☐ Extreme problem

Speech impairment: Delayed speech, poor pronunciation, difficult to understand, or unable to repeat words clearly. How much of a problem for your child during the past 4 weeks?

- ☐ Not present/no problem
- ☐ Hardly a problem at all
- ☐ Somewhat of a problem
- ☐ Moderate problem
- ☐ Quite a bit of a problem
- ☐ Very much of a problem
- ☐ Extreme problem

Emotional distress: Irritable, frustrated, sad, restless, or poor appetite. How much of a problem for your child during the past 4 weeks because of ear infections or fluid?

- ☐ Not present/no problem
- ☐ Hardly a problem at all
- ☐ Somewhat of a problem
- ☐ Moderate problem
- ☐ Quite a bit of a problem
- ☐ Very much of a problem
- ☐ Extreme problem

Activity limitations: Playing, sleeping, doing things with friends/family, attending school or day care. How limited have your child's activities been during the past 4 weeks because of ear infections or fluid?

- ☐ Not limited at all
- ☐ Hardly limited at all
- ☐ Very slightly limited
- ☐ Slightly limited
- ☐ Moderately limited
- ☐ Very limited
- ☐ Severely limited

Caregiver concerns: How often have you, as a caregiver, been worried, concerned, or inconvenienced because of your child's ear infections or fluid over the past 4 weeks?

- ☐ None of the time
- ☐ Hardly any time at all
- ☐ A small part of the time
- ☐ Some of the time
- ☐ A good part of the time
- ☐ Most of the time
- ☐ All of the time

RETURN OF CHILD'S STOOL SAMPLE (COLLECT AT 3 MONTHS AFTER STUDY ENTRY)

- Once you have collected the stool sample (please follow the instruction sheet provided), please post the sample in the return addressed envelope provided in the kit as soon as possible.

QUESTIONNAIRE RETURN

- Please post the questionnaire back to us in the pre-paid envelope provided. We would be grateful if you could do this as soon as possible after completing the questionnaire.
- If you have lost the envelope, you can send it back to the following FREEPOST address:

FREEPOST RTZH-TUTT-KXSB
The REST Study
University of Bristol
Department of Social Medicine
Canynge Hall
39 Whatley Road
BRISTOL
BS8 2PS

THANK YOU!
For making a valuable contribution to health research. If you can obtain a stool sample from your child, we will send you a £5 voucher when we receive the sample.

IRAS ID: 229293

The Runny Ear Study is funded by the National Institute for Health Research's HTA Programme HTA 16/85/01

REST study: measuring treatment contamination and adherence SOP

Rationale

We intend to collect data on treatment contamination in order to confirm receipt of the active intervention by study participants. We will also be collecting data on adherence of trial medication in order to confirm study participants have correctly followed the advice given to them by their GP when randomised to the trial.

We intend to ask these questions on Day 1-14 of the participant follow up. Allocation to drops will be confirmed by way of questions asking if the child has received antibiotic ear drops in the Symptom Recovery Questionnaire.

1) Contamination

Questions asked to parents during follow up:

a) If your child was prescribed a medicine to take by mouth, were you told to "wait and see" before cashing in the prescription? **(NB: THIS IS OFFICE USE ONLY – ENTER ON FOLLOW-UP TRACKER. DO NOT ENTER ON TRANSFoRm DATABASE)**

Yes 1 No 2 Not applicable 7

b) If your child was prescribed an antibiotic ear drop were you told to "wait and see" before cashing in the prescription? **(NB: THIS IS OFFICE USE ONLY – ENTER ON FOLLOW-UP TRACKER. DO NOT ENTER ON TRANSFoRm DATABASE)**

Yes 1 No 2 Not applicable 7

b) Were you given an advice sheet relevant to the antibiotic medicine your child was prescribed? **(NB: THIS IS FOR OFFICE USE ONLY – ENTER ON FOLLOW-UP TRACKER. NOT FOR ENTERING ONTO TRANSFoRm DATABASE)**

Yes 1 No 2 Not applicable 7

2) Adherence

Parents are asked to complete a Symptom Recovery Questionnaire where they will record the number of doses of medication their child has received each day for 14 days post-recruitment.

Suggested by MM.

Immediate:

Since this is a tds dosing I suggest two out of three doses for three days for the tablets and the first dose as you imply may not be on the day of randomisation but should be within say 24 hours of the index consultation.

Delayed

A prescription was issued at the time of the consultation and the patient ticks a box to say they were allocated to a delayed approach (need to check if we have this anywhere)

Drops

To be consistent the drops should have similar rules to the oral meds

the runny ear study

CHILD ASSENT FORM
(Age 6-16 Years)

Please circle the answer you agree with:

1.	Has a doctor or nurse explained this study to you?	Yes	/	No
2.	Did you understand?	Yes	/	No
3.	Have you asked all the questions that you want?	Yes	/	No
4.	Did you understand the answers?	Yes	/	No
5.	It's okay to say no, at any time. Do you understand this?	Yes	/	No
6.	Do you want to take part?	Yes	/	No

Please write your name here if you want to take part.

Your name: ________________________________ **Date:** ____________________

Name of clinician taking assent: ________________________________ **Date:** ____________________

Signature of clinician taking assent: ________________________________

Person taking assent to write Participant ID here:

Paperwork management instructions: Complete one copy.
- Send to Bristol Trial Centre via secure fax ( ) or encrypted email **TODAY.**
- Photocopy and give copy to parent (put it in the shopping bag provided in the Participant Pack).
- Scan into child's medical record and store in the REST Site File (these will be collected at the end of the study).

IRAS ID: 229293

The Runny Ear Study is funded by the National Institute for Health Research's HTA Programme HTA 16/85/01

the runny ear study

Your Child's Symptom and Recovery Questionnaire

(OFFICE USE ONLY)

Child's participant ID number:
(recruiting clinician to write in)

Study entry date (Day 1):
(recruiting clinician to write in)

D D / M M / Y Y Y Y

FOLLOW-UP PHONE CALLS:

Day 1 due: **# attempts:** **Completed:** **By:**
Comments:

Data entered: Y/N **Date:**

Day 3 due: **# attempts:** **Completed:** **By:**
Comments:

Data entered: Y/N **Date:**

Day 7 due: **# attempts:** **Completed:** **By:**
Comments:

Data entered: Y/N **Date:**

Day 10 due: **# attempts:** **Completed:** **By:**
Comments:

Data entered: Y/N **Date:**

Day 14 due: **# attempts:** **Completed:** **By:**
Comments:

Data entered: Y/N **Date:**

Parent SRQ return date:
Voucher sent date:

6 Week Call due:

INSTRUCTIONS

- Please complete this questionnaire using black ink only.
- Instructions are given for each set of questions.
- **Day 1:** please answer these questions on the same day your child entered the study. We want to try to help so we will aim to telephone you within the first two days and answer any questions you may have.
- **Days 2-14:** please answer these questions every evening until Day 14 **even if all your child's symptoms are completely better**.
    - We'll also telephone you ***2 or 3*** times over the next two weeks, at a time convenient for you, to collect your information and offer help if needed.
- **Days 7 and 14 Weekly Questions:** please answer these questions **even if all your child's symptoms are completely better**.
    - We will telephone you on Days 7 and 14 to ask some further questions.
    - **If your child's ear problem has not got better by Day 14**, we'll ask if you are willing to answer some questions (by telephone call only) 6 weeks after the study entry date.
    - If the ear problem has stopped by Day 14, you will be asked to return the completed paper questionnaire in the pre-paid return envelope provided.
- **If you have chosen to complete the questionnaire on-line via the app (this is smartphone-friendly):** If you have not received an email or text within **24 hours** after entering the study or have any problems completing the online questionnaire, please contact us on or / or study email address: . **Please refer to the REST web app user guide (enclosed) for instructions on how to use the app**.

Thank you for your co-operation in helping us with this research.

If you have any questions about filling in the questionnaire, please contact us:

Sue Harris, Research Nurse
Email:
Tel: / (work mobile)

Kate Rowley, Trial Co-ordinator
Email:
Tel: / (work mobile)

Annie Sadoo, Trial Research Administrator
Email:
Tel:

Kathryn Curtis, Trial Manager
Email:
Tel: / (work mobile)

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

Please enter today's date: D D / M M / Y Y Y Y

DAY 1 (DAY OF STUDY ENTRY) QUESTIONS ONLY

A. ABOUT YOUR CHILD

Please answer these questions about your child.

1. Has your child ever had insertion of ventilation tubes (grommets)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.2 below**

   i) **If yes,** how many times? ☐☐

2. Has your child ever had any relevant surgical procedures/ ENT surgeries? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.3 below**

   i) **If yes,** which of the following procedures/operations? (tick **all** that apply)

		Yes
a)	Adenoidectomy (with or without tonsillectomy)	☐ 1
b)	Tonsillectomy	☐ 1
c)	Surgical removal of (persistent) grommets	☐ 1
d)	Other surgical procedure, please tick box and describe:	☐ 1

   ………

3. Has your child ever suffered from allergic-type conditions, e.g. asthma, hay fever or eczema? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

4.a) What is the name of the antibiotic medicine your child was prescribed today? Please write name:

   ………

b) If your child was prescribed a medicine to take by mouth, were you told to "wait and see" before cashing in the prescription? **(NB: THIS IS OFFICE USE ONLY – ENTER ON FOLLOW-UP TRACKER. DO NOT ENTER ON TRANSFoRm DATABASE)**

   Yes ☐ 1 No ☐ 2 Not applicable ☐ 7

c) Were you given an advice sheet relevant to the antibiotic medicine your child was prescribed? **(NB: THIS IS FOR OFFICE USE ONLY – ENTER ON FOLLOW-UP TRACKER. NOT FOR ENTERING ONTO TRANSFoRm DATABASE)**

   Yes ☐ 1 No ☐ 2 Not applicable ☐ 7

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

4. Please describe your child's ethnic group (tick **one** box only):

a) White: British ☐ 1 Irish ☐ 2 Any other White background ☐ 3

b) Black or Black British: African ☐ 1 Caribbean ☐ 2 Any other Black background ☐ 3

c) Mixed or Mixed British: White/Black Caribbean ☐ 1 White/Black African ☐ 2 White/Asian ☐ 3 Any other Mixed background ☐ 4

d) Asian or Asian British: Indian ☐ 1 Pakistani ☐ 2 Bangladeshi ☐ 3 Chinese ☐ 4 Any other Asian background ☐ 5

e) Other Ethnic Group: Arab ☐ 1 Any other ethnic group (please describe): ☐ 2

....

f) Prefer not to answer: ☐ 1

5. Does anybody living in the child's home smoke? (tick **one** box only)

Yes ☐ 1 No ☐ 2 → **If no, go to Section B below**

i) If yes, does anyone smoke **in the house**? (tick **one** box only)

Yes ☐ 1 No ☐ 2

B. ABOUT YOU (PARENT/GUARDIAN)
Please answer these questions about yourself.

1. Would you describe your educational qualifications as: (tick **one** box only)

Left school before age 16 years ☐ 1 Usual school exams for 15-16 ☐ 2 Usual school exams for 17-18 ☐ 3

Further qualifications but not university degree ☐ 4 University degree ☐ 5 Not applicable ☐ 6

2. Are you: (tick **one** box only)

Child's mother ☐ 1 Child's father ☐ 2 Other, please specify: ☐ 3

....

...Now go to Day 1 Daily Questions on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

Please enter today's date: D D / M M / Y Y Y Y

DAY 1 (DAY OF STUDY ENTRY) - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 1 (the day your child entered the study) looking back over the last 24 hours. We will ask the same questions every day until Day 14 so we can track your child's recovery from their ear problem – please answer them even if all your child's symptoms are completely better.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 and 2, go to Day 2 on page 7**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**").

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu. 6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

7. Has your child had any ear discharge **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1   No ☐ 2 ⟶ **If no, go to Qu.8 below**

   i) **If yes,** from which ear? (tick **one** box only)

   Right ear ☐ 1   Left ear ☐ 2   Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions – tick **one** box only to score each symptom as an **average for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 2 on the next page ⟶

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 2

Please enter today's date: D D / M M / Y Y Y Y

DAY 2 - DAILY QUESTIONS

Please answer all the following questions in the evening of Day 2 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 and 2, go to Day 3 on page 9**

a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

☐☐ → **If "00", go to Qu.3 below**

b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 2

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1   No ☐ 2 → **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1   Left ear ☐ 2   Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

...Now go to Day 3 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 3

Please enter today's date: D D / M M / Y Y Y Y

DAY 3 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 3 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 4 on page 11**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ________

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ________

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 3

7. Has your child had any ear discharge? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

   i) **If yes,** from which ear? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
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f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 4 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 4

Please enter today's date: D D / M M / Y Y Y Y

DAY 4 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 4 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 5 on page 13**

a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

☐☐ → **If "00", go to Qu.3 below**

b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ______

6. Did your child take any other medicine for their ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ______

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 4

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 5 on the next page ⟶

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 5

Please enter today's date: D D / M M / Y Y Y Y

DAY 5 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 5 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 6 on page 15**

a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 5

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 6 on the next page

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 6

Please enter today's date: D D / M M / Y Y Y Y

DAY 6 - DAILY QUESTIONS

Please answer all the following questions in the evening of Day 6 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 7 on page 17**

a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

☐☐ → **If "00", go to Qu.3 below**

b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 6

7. Has your child had any ear discharge? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Qu.8 below**

   i) **If yes,** from which ear? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 7 on the next page ⟶

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7

Please enter today's date: D D / M M / Y Y Y Y

DAY 7 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 7 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to End of Week 1 Questions on page 19**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to End of Week 1 Questions on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7 – End of Week 1 Questions

Please enter today's date: D D / M M / Y Y Y Y

Please complete the following questions at the end of the week on Day 7.

A. NEW OR WORSENING SYMPTOMS

1.a) Did your child experience, on one or more days **in the last week** any **new** symptom, or **worsening** of a pre-existing symptom (or symptoms) other than the ones you have already scored?

Yes ☐ 1 No ☐ 2 → **If no, go to Section B below.**

b) **If yes,** please tell us what it was and if it was mild, moderate or severe when at its worst:

	Mild	Moderate	Severe
i)	☐ 1	☐ 2	☐ 3
ii)	☐ 1	☐ 2	☐ 3
iii)	☐ 1	☐ 2	☐ 3
iv)	☐ 1	☐ 2	☐ 3
v)	☐ 1	☐ 2	☐ 3
vi)	☐ 1	☐ 2	☐ 3
vii)	☐ 1	☐ 2	☐ 3
viii)	☐ 1	☐ 2	☐ 3

B. HEALTH SERVICES

Please tell us about any other health services your child has used **in the last 7days** because of their ear problem. If you have used NHS services for other health problems <u>not</u> to do with your child's ear problem, you **<u>do not</u>** need to tell us about them.

1. Has your child had to see a GP again **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.2 below**

   i) **If yes,** how many times? ☐☐

2. Have you had a GP telephone appointment for your child **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.3 below**

   i) **If yes,** how many calls? ☐☐

3. Has your child seen a GP practice nurse **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.4 on the next page**

   i) **If yes,** how many times? ☐☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7 – End of Week 1 Questions

4. Have you used the NHS telephone service 111 **in the last 7 days** because of your child's ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Qu.5 below**

   i) **If yes,** how many times? ☐☐

5. Has your child attended an A&E department **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

6. Has your child attended a hospital outpatient department **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Qu.7 below**

   i) **If yes,** how many times? ☐☐

7. Has your child stayed overnight in hospital **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Qu.8 below**

   i) **If yes,** how many nights? ☐☐

8. Did your child receive any additional treatment **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Section C on the next page**

   i) **If yes,** please tell us what treatment they received:

a)
b)
c)

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7 – End of Week 1 Questions

C. PRESCRIPTION MEDICINES

Please tell us about **ALL** medicines and remedies a doctor/nurse has prescribed **in the last 7 days** to treat your child's ear problem. If any medicines/remedies have been prescribed for **other** health problems **not** to do with your child's ear problem, you **do not** need to tell us about them.

1. Has your child been prescribed any medicines or remedies by a doctor/nurse for their ear problem in **the last 7 days**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Day 8 on the next page**

   i) **If yes,** please tell us which medicine or remedy was prescribed (tick all that apply):

	Yes	No
a) Paracetamol, e.g. Calpol®	☐	☐
b) Ibuprofen, e.g. Nurofen®	☐	☐
c) Other pain-killing remedy, please tick box and write name:	☐	☐
d) Other medicine for ear problem, e.g. new antibiotic, please tick box and write name:	☐	☐

…Now go to Day 8 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 8

Please enter today's date: D D / M M / Y Y Y Y

DAY 8 - DAILY QUESTIONS

Please answer all the following questions in the evening of Day 8 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1   No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1   No ☐ 2 → **If no to Questions 1 & 2, go to Day 9 on page 24**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1   Left ear ☐ 2   Both ears ☐ 3   Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1   Yes, for high temperature ☐ 2   Yes, for both ☐ 3   No ☐ 4

   i) **If yes,** how many times? ☐☐   **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1   Yes, for high temperature ☐ 2   Yes, for both ☐ 3   No ☐ 4

   i) **If yes,** how many times? ☐☐   **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1   No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1   No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 8

7. Has your child had any ear discharge? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

   i) **If yes,** from which ear? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 9 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 9

Please enter today's date: D D / M M / Y Y Y Y

DAY 9 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 9 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 10 on page 26**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 9

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 10 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 10

Please enter today's date: D D / M M / Y Y Y Y

DAY 10 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 10 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 11 on page 28**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 10

7. Has your child had any ear discharge? (tick **one** box only)

   Yes ☐ 1   No ☐ 2 → **If no, go to Qu.8 below**

   i) **If yes,** from which ear? (tick **one** box only)

   Right ear ☐ 1   Left ear ☐ 2   Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 11 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 11

Please enter today's date: D D / M M / Y Y Y Y

DAY 11 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 11 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 12 on page 30**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 11

7. Has your child had any ear discharge? (tick **one** box only)

   Yes ☐ 1   No ☐ 2 → **If no, go to Qu.8 below**

   i) **If yes,** from which ear? (tick **one** box only)

   Right ear ☐ 1   Left ear ☐ 2   Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer <u>**all**</u> the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 12 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 12

Please enter today's date: D D / M M / Y Y Y Y

DAY 12 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 12 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1   No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1   No ☐ 2 → **If no to Questions 1 & 2, go to Day 13 on page 32**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1   Left ear ☐ 2   Both ears ☐ 3   Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1   Yes, for high temperature ☐ 2   Yes, for both ☐ 3   No ☐ 4

   i) **If yes,** how many times? ☐☐   **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1   Yes, for high temperature ☐ 2   Yes, for both ☐ 3   No ☐ 4

   i) **If yes,** how many times? ☐☐   **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1   No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1   No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 12

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	1 = Very little problem	2 = Slight problem	3 = Moderately bad	4 = Bad	5 = Very bad	6 = Extremely bad
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 13 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 13

Please enter today's date: D D / M M / Y Y Y Y

DAY 13 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 13 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 14 on page 34**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 13

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 14 on the next page ⟶

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14

Please enter today's date: D D / M M / Y Y Y Y

DAY 14 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 14 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to End of Week 2 Questions on page 36**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14

7. Has your child had any ear discharge? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

   i) **If yes,** from which ear? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to End of Week 2 Questions on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14 – End of Week 2 Questions

Please enter today's date: D D / M M / Y Y Y Y

Please complete the following questions at the end of the week on Day 14.

A. NEW OR WORSENING SYMPTOMS

1.a) Did your child experience, on one or more days **in the last week** any **new** symptom, or **worsening** of a pre-existing symptom (or symptoms) other than the ones you have already scored?

Yes ☐ 1 No ☐ 2 → **If no, go to Section B below**

b) **If yes,** please tell us what it was and if it was mild, moderate or severe when at its worst:

	Mild	Moderate	Severe
i)	☐ 1	☐ 2	☐ 3
ii)	☐ 1	☐ 2	☐ 3
iii)	☐ 1	☐ 2	☐ 3
iv)	☐ 1	☐ 2	☐ 3
v)	☐ 1	☐ 2	☐ 3
vi)	☐ 1	☐ 2	☐ 3
vii)	☐ 1	☐ 2	☐ 3
viii)	☐ 1	☐ 2	☐ 3

B. HEALTH SERVICES

Please tell us about any other health services your child has used **in the last 7days** because of their ear problem. If you have used NHS services for other health problems **not** to do with your child's ear problem, you **do not** need to tell us about them.

1. Has your child had to see a GP again **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.2 below**

   i) **If yes,** how many times? ☐☐

2. Have you had a GP telephone appointment for your child **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.3 below**

   i) **If yes,** how many calls? ☐☐

3. Has your child seen a GP practice nurse **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.4 on the next page**

   i) **If yes,** how many times? ☐☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14 – End of Week 2 Questions

4. Have you used the NHS telephone service 111 **in the last 7 days** because of your child's ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.5 below**

   i) **If yes,** how many times? ☐☐

5. Has your child attended an A&E department **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

6. Has your child attended a hospital outpatient department **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 below**

   i) **If yes,** how many times? ☐☐

7. Has your child stayed overnight in hospital **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu. 8 below**

   i) **If yes,** how many nights? ☐☐

8. Did your child receive any additional treatment **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Section C on the next page**

   i) **If yes,** please t please tell us what treatment they recived?

a)
b)
c)

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14 – End of Week 2 Questions

C. PRESCRIPTION MEDICINES

Please tell us about **ALL** medicines and remedies a doctor/nurse has prescribed **in the last 7 days** to treat your child's ear problem. If any medicines/remedies have been prescribed for **other** health problems **not** to do with your child's ear problem, you **do not** need to tell us about them.

1. Has your child been prescribed any medicines or remedies by a doctor/nurse for their ear problem in **the last 7 days**? (tick **one** box only)

Yes ☐ 1 No ☐ 2 → **If no, go to Section D below**

i) **If yes,** please tell us which medicine or remedy was prescribed (tick **all** that apply):

	Yes	No
a) Paracetamol, e.g. Calpol®	☐	☐
b) Ibuprofen, e.g. Nurofen®	☐	☐
c) Other pain-killing remedy, please tick box and write name:	☐	☐
d) Other medicine for ear problem, e.g. new antibiotic, please tick box and write name:	☐	☐

D. PARENT'S SATISFACTION WITH TREATMENT

1. Overall, how satisfied were you with the treatment your child received for their ear problem? (tick **one** box only)

1 = Extremely satisfied	**2 = Satisfied**	**3 = Neither satisfied or dissatisfied**	**4 = Not satisfied**	**5 = Extremely dissatisfied**
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

If your child has not recovered by Day 14 and still has ear-related symptoms and taking antibiotics or pain-killing medicines, we would like to call you again in 6 weeks' time to ask about your child's recovery. There are no further questions to complete in this booklet.

You have now completed the questionnaire. Thank you!

END OF QUESTIONNAIRE INSTRUCTIONS

RETURN OF CHILD'S STOOL SAMPLE (COLLECT ON DAY 14)

- Once you have collected the stool sample on Day 14 (please follow the instruction sheet provided), please post the sample in the return addressed envelope provided in the kit as soon as possible.

DIARY RETURN

- Please post the questionnaire back to us in the pre-paid envelope provided. We would be grateful if you could do this as soon as possible after completing the questionnaire **but not before the final follow-up phone call** from the study team.
- If you have lost the envelope, you can send it back to the following FREEPOST address:

FREEPOST RTZH-TUTT-KXSB
The REST Study
University of Bristol
Department of Social Medicine
Canynge Hall
39 Whatley Road
BRISTOL
BS8 2PS

THANK YOU!
For making a valuable contribution to health research. We will send you a £10 High Street Voucher by post as a token of our thanks for the valuable time you have given to help us with this research. If you can obtain a stool sample from your child, we will send you a further £5 voucher when we receive the sample.

University of BRISTOL | UNIVERSITY OF Southampton | Bristol Randomised Trials Collaboration | REST the runny ear study | Funded by NHS National Institute for Health Research

IRAS ID: 229293
The Runny Ear Study is funded by the National Institute for Health Research's HTA Programme HTA 16/85/01

the runny ear study

Your Child's Symptom and Recovery Questionnaire
(for parent to complete)

Child's participant ID number:
(recruiting clinician to write in)

Study entry date (Day 1):
(recruiting clinician to write in)

D D / M M / Y Y Y Y

INSTRUCTIONS

- Please complete this questionnaire using black ink only.
- Instructions are given for each set of questions.
- **Day 1:** please answer these questions on the same day your child entered the study. We want to try to help so we will aim to telephone you within the first two days and answer any questions you may have.
- **Days 2-14:** please answer these questions every evening until Day 14 **even if all your child's symptoms are completely better**.
  - We'll also telephone you ***2 or 3*** times over the next two weeks, at a time convenient for you, to collect your information and offer help if needed.
- **Days 7 and 14 Weekly Questions:** please answer these questions **even if all your child's symptoms are completely better**.
  - We will telephone you on Days 7 and 14 to ask some further questions.
  - **If your child's ear problem has not got better by Day 14**, we'll ask if you are willing to answer some questions (by telephone call only) 6 weeks after the study entry date.
  - If the ear problem has stopped by Day 14, you will be asked to return the completed paper questionnaire in the pre-paid return envelope provided.
- **If you have chosen to complete the questionnaire on-line via the app (this is smartphone-friendly):** If you have not received an email or text within **24 hours** after entering the study or have any problems completing the online questionnaire, please contact us on [redacted] or [redacted] / or study email address: [redacted]. **Please refer to the REST web app user guide (enclosed) for instructions on how to use the app**.

If you have any questions about filling in the questionnaire, please contact us:

Sue Harris, Research Nurse
Email: [redacted]
Tel: [redacted] / [redacted] (work mobile)

Kate Rowley, Trial Co-ordinator
Email: [redacted]
Tel: [redacted] / [redacted] (work mobile)

Annie Sadoo, Trial Research Administrator
Email: [redacted]
Tel: [redacted]

Kathryn Curtis, Trial Manager
Email: [redacted]
Tel: [redacted] / [redacted] (work mobile)

Thank you for your co-operation in helping us with this research.

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

Please enter today's date: D D / M M / Y Y Y Y

DAY 1 (DAY OF STUDY ENTRY) QUESTIONS ONLY

A. ABOUT YOUR CHILD
Please answer these questions about your child.

1. Has your child ever had insertion of ventilation tubes (grommets)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.2 below**

   i) **If yes,** how many times? ☐☐

2. Has your child ever had any relevant surgical procedures/ ENT surgeries? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.3 below**

   i) **If yes,** which of the following procedures/operations? (tick **all** that apply)

		Yes
a)	Adenoidectomy (with or without tonsillectomy)	☐ 1
b)	Tonsillectomy	☐ 1
c)	Surgical removal of (persistent) grommets	☐ 1
d)	Other surgical procedure, please tick box and describe:	☐ 1

   ……

3. Has your child ever suffered from allergic-type conditions, e.g. asthma, hay fever or eczema? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

4. What is the name of the antibiotic medicine your child was prescribed today? Please write name:

   ……

5. Please describe your child's ethnic group (tick **one** box only):

a)	White:	British ☐ 1	Irish ☐ 2	Any other White background ☐ 3
b)	Black or Black British:	African ☐ 1	Caribbean ☐ 2	Any other Black background ☐ 3
c)	Mixed or Mixed British:	White/Black Caribbean ☐ 1	White/Black African ☐ 2	White/Asian ☐ 3
		Any other Mixed background ☐ 4		
d)	Asian or Asian British:	Indian ☐ 1	Pakistani ☐ 2	Bangladeshi ☐ 3
		Chinese ☐ 4	Any other Asian background ☐ 5	
e)	Other Ethnic Group:	Arab ☐ 1	Any other ethnic group (please describe): ☐ 2 ……………………………………	
f)	Prefer not to answer:	☐ 1		

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

6. Does anybody living in the child's home smoke? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Section B below**

   i) If yes, does anyone smoke **in the house**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

B. ABOUT YOU (PARENT/GUARDIAN)

Please answer these questions about yourself.

1. Would you describe your educational qualifications as: (tick **one** box only)

   Left school before age 16 years ☐ 1
   Usual school exams for 15-16 ☐ 2
   Usual school exams for 17-18 ☐ 3
   Further qualifications but not university degree ☐ 4
   University degree ☐ 5
   Not applicable ☐ 6

2. Are you: (tick **one** box only)

   Child's mother ☐ 1
   Child's father ☐ 2
   Other, please specify: ☐ 3

   ……………………………………………………

…Now go to Day 1 Daily Questions on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

Please enter today's date: D D / M M / Y Y Y Y

DAY 1 (DAY OF STUDY ENTRY) - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 1 (the day your child entered the study) looking back over the last 24 hours. We will ask the same questions every day until Day 14 so we can track your child's recovery from their ear problem – please answer them even if all your child's symptoms are completely better.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 and 2, go to Day 2 on page 8**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**").

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu. 6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

7. Has your child had any ear discharge **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1   No ☐ 2 ⟶ **If no, go to Qu.8 below**

   i) **If yes,** from which ear? (tick **one** box only)

   Right ear ☐ 1   Left ear ☐ 2   Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions – tick **one** box only to score each symptom as an **average for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 2 on the next page ⟶

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 2

Please enter today's date: D D / M M / Y Y Y Y

DAY 2 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 2 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 and 2, go to Day 3 on page 10**

a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 2

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 3 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 3

Please enter today's date: D D / M M / Y Y Y Y

DAY 3 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 3 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 4 on page 12**

a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

☐☐ → **If "00", go to Qu.3 below**

b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 3

7. Has your child had any ear discharge? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

   i) **If yes,** from which ear? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 4 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 4

Please enter today's date: D D / M M / Y Y Y Y

DAY 4 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 4 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 5 on page 14**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for their ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 4

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1   No ☐ 2 → **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1   Left ear ☐ 2   Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 5 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 5

Please enter today's date: D D / M M / Y Y Y Y

DAY 5 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 5 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 6 on page 16**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 5

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 6 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 6

Please enter today's date: D D / M M / Y Y Y Y

DAY 6 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 6 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 7 on page 18**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 6

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 7 on the next page ⟶

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7

Please enter today's date: D D / M M / Y Y Y Y

DAY 7 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 7 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to End of Week 1 Questions on page 20**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD’S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to End of Week 1 Questions on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7 – End of Week 1 Questions

Please enter today's date: D D / M M / Y Y Y Y

Please complete the following questions at the end of the week on Day 7.

A. NEW OR WORSENING SYMPTOMS

1.a) Did your child experience, on one or more days **in the last week** any **new** symptom, or **worsening** of a pre-existing symptom (or symptoms) other than the ones you have already scored?

Yes ☐ 1 No ☐ 2 → **If no, go to Section B below.**

b) **If yes,** please tell us what it was and if it was mild, moderate or severe when at its worst:

	Mild	Moderate	Severe
i)	☐ 1	☐ 2	☐ 3
ii)	☐ 1	☐ 2	☐ 3
iii)	☐ 1	☐ 2	☐ 3
iv)	☐ 1	☐ 2	☐ 3
v)	☐ 1	☐ 2	☐ 3
vi)	☐ 1	☐ 2	☐ 3
vii)	☐ 1	☐ 2	☐ 3
viii)	☐ 1	☐ 2	☐ 3

B. HEALTH SERVICES

Please tell us about any other health services your child has used **in the last 7days** because of their ear problem. If you have used NHS services for other health problems <u>**not**</u> to do with your child's ear problem, you <u>**do not**</u> need to tell us about them.

1. Has your child had to see a GP again **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.2 below**

   i) **If yes,** how many times? ☐☐

2. Have you had a GP telephone appointment for your child **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.3 below**

   i) **If yes,** how many calls? ☐☐

3. Has your child seen a GP practice nurse **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.4 on the next page**

   i) **If yes,** how many times? ☐☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7 – End of Week 1 Questions

4. Have you used the NHS telephone service 111 **in the last 7 days** because of your child's ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.5 below**

   i) **If yes,** how many times? ☐☐

5. Has your child attended an A&E department **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

6. Has your child attended a hospital outpatient department **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 below**

   i) **If yes,** how many times? ☐☐

7. Has your child stayed overnight in hospital **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

   i) **If yes,** how many nights? ☐☐

8. Did your child receive any additional treatment **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Section C on the next page**

   i) **If yes,** please tell us what treatment they received:

a)
b)
c)

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7 – End of Week 1 Questions

C. PRESCRIPTION MEDICINES

Please tell us about **ALL** medicines and remedies a doctor/nurse has prescribed **in the last 7 days** to treat your child's ear problem. If any medicines/remedies have been prescribed for **other** health problems **not** to do with your child's ear problem, you **do not** need to tell us about them.

1. Has your child been prescribed any medicines or remedies by a doctor/nurse for their ear problem in **the last 7 days**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Day 8 on the next page**

   i) **If yes,** please tell us which medicine or remedy was prescribed (tick all that apply):

	Yes	No
a) Paracetamol, e.g. Calpol®	☐	☐
b) Ibuprofen, e.g. Nurofen®	☐	☐
c) Other pain-killing remedy, please tick box and write name:	☐	☐
d) Other medicine for ear problem, e.g. new antibiotic, please tick box and write name:	☐	☐

…Now go to Day 8 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 8

Please enter today's date: D D / M M / Y Y Y Y

DAY 8 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 8 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 9 on page 25**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 8

7. Has your child had any ear discharge? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

   i) **If yes,** from which ear? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	1 = Very little problem	2 = Slight problem	3 = Moderately bad	4 = Bad	5 = Very bad	6 = Extremely bad
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 9 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 9

Please enter today's date: D D / M M / Y Y Y Y

DAY 9 - DAILY QUESTIONS

Please answer all the following questions in the evening of Day 9 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 10 on page 27**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 9

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 10 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 10

Please enter today's date: D D / M M / Y Y Y Y

DAY 10 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 10 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 11 on page 29**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ______

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ______

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 10

7. Has your child had any ear discharge? (tick **one** box only)

   Yes ☐ 1   No ☐ 2 ⟶ **If no, go to Qu.8 below**

   i) **If yes,** from which ear? (tick **one** box only)

   Right ear ☐ 1   Left ear ☐ 2   Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 11 on the next page ⟶

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 11

Please enter today's date: D D / M M / Y Y Y Y

DAY 11 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 11 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 12 on page 31**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 11

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 12 on the next page ⟶

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 12

Please enter today's date: D D / M M / Y Y Y Y

DAY 12 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 12 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 13 on page 33**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 12

7. Has your child had any ear discharge? (tick **one** box only)

   Yes ☐ 1   No ☐ 2 → **If no, go to Qu.8 below**

   i) **If yes,** from which ear? (tick **one** box only)

   Right ear ☐ 1   Left ear ☐ 2   Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 13 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 13

Please enter today's date: D D / M M / Y Y Y Y

DAY 13 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 13 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to Day 14 on page 35**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ☐

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 13

7. Has your child had any ear discharge? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

   i) **If yes,** from which ear? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to Day 14 on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14

Please enter today's date: D D / M M / Y Y Y Y

DAY 14 - DAILY QUESTIONS
Please answer all the following questions in the evening of Day 14 looking back over the last 24 hours.

1. Has your child had any ear infection-related symptoms **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2

2. Has your child been given an antibiotic **in the last 24 hours** (ear drops or by mouth)? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no to Questions 1 & 2, go to End of Week 2 Questions on page 37**

   a) **If yes,** how many times? Write the number in the boxes (if none, please write "**00**")

   ☐☐ → **If "00", go to Qu.3 below**

   b) If ear drops were used, which ear(s) did you treat? (tick **one** box only)

   Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3 Drops not prescribed ☐ 4

3. Did your child take any paracetamol, e.g. Calpol®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.4**

4. Did your child take any ibuprofen, e.g. Nurofen®, **in the last 24 hours**? (tick **one** box only)

   Yes, for pain ☐ 1 Yes, for high temperature ☐ 2 Yes, for both ☐ 3 No ☐ 4

   i) **If yes,** how many times? ☐☐ **If no, go to Qu.5**

5. Did your child take any other pain-killing remedy today? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

   ii) **If yes,** please write the name of the remedy: ____________

6. Did your child take any other medicine for the ear infection **in the last 24 hours**? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.7 on the next page**

   i) **If yes,** please write the name of the medicine: ____________

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14

7. Has your child had any ear discharge? (tick **one** box only)

Yes ☐ 1 No ☐ 2 → **If no, go to Qu.8 below**

i) **If yes,** from which ear? (tick **one** box only)

Right ear ☐ 1 Left ear ☐ 2 Both ears ☐ 3

8. Has your child had any of the following symptoms **over the last 24 hours**? Please answer **all** the questions - tick **one** box only to score each symptom as an average **for the last 24 hours**.

	0 = Normal/no problem	**1 = Very little problem**	**2 = Slight problem**	**3 = Moderately bad**	**4 = Bad**	**5 = Very bad**	**6 = Extremely bad**
a) Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) High temperature (fever)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Ear discharge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d) Being unwell	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e) Disturbed sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f) Episodes of distress/crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g) Eating or drinking less than normal	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h) Interference with normal activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

…Now go to End of Week 2 Questions on the next page →

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14 – End of Week 2 Questions

Please enter today's date: D D / M M / Y Y Y Y

Please complete the following questions at the end of the week on Day 14.

A. NEW OR WORSENING SYMPTOMS

1.a) Did your child experience, on one or more days **in the last week** any **new** symptom, or **worsening** of a pre-existing symptom (or symptoms) other than the ones you have already scored?

Yes ☐ 1 No ☐ 2 → **If no, go to Section B below**

b) **If yes,** please tell us what it was and if it was mild, moderate or severe when at its worst:

	Mild	Moderate	Severe
i)	☐ 1	☐ 2	☐ 3
ii)	☐ 1	☐ 2	☐ 3
iii)	☐ 1	☐ 2	☐ 3
iv)	☐ 1	☐ 2	☐ 3
v)	☐ 1	☐ 2	☐ 3
vi)	☐ 1	☐ 2	☐ 3
vii)	☐ 1	☐ 2	☐ 3
viii)	☐ 1	☐ 2	☐ 3

B. HEALTH SERVICES

Please tell us about any other health services your child has used **in the last 7days** because of their ear problem. If you have used NHS services for other health problems **not** to do with your child's ear problem, you **do not** need to tell us about them.

1. Has your child had to see a GP again **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.2 below**

   i) **If yes,** how many times? ☐☐

2. Have you had a GP telephone appointment for your child **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.3 below**

   i) **If yes,** how many calls? ☐☐

3. Has your child seen a GP practice nurse **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 → **If no, go to Qu.4 on the next page**

   i) **If yes,** how many times? ☐☐

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14 – End of Week 2 Questions

4. Have you used the NHS telephone service 111 **in the last 7 days** because of your child's ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Qu.5 below**

   i) **If yes,** how many times? ☐☐

5. Has your child attended an A&E department **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Qu.6 below**

   i) **If yes,** how many times? ☐☐

6. Has your child attended a hospital outpatient department **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Qu.7 below**

   i) **If yes,** how many times? ☐☐

7. Has your child stayed overnight in hospital **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Qu. 8 below**

   i) **If yes,** how many nights? ☐☐

8. Did your child receive any additional treatment **in the last 7 days** because of their ear problem? (tick **one** box only)

   Yes ☐ 1 No ☐ 2 ⟶ **If no, go to Section C on the next page**

   i) **If yes,** please t please tell us what treatment they recived?

a)
b)
c)

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14 – End of Week 2 Questions

C. PRESCRIPTION MEDICINES

Please tell us about **ALL** medicines and remedies a doctor/nurse has prescribed **in the last 7 days** to treat your child's ear problem. If any medicines/remedies have been prescribed for **other** health problems **not** to do with your child's ear problem, you **do not** need to tell us about them.

1. Has your child been prescribed any medicines or remedies by a doctor/nurse for their ear problem in **the last 7 days**? (tick **one** box only)

Yes ☐ 1 No ☐ 2 → **If no, go to Section D below**

i) **If yes,** please tell us which medicine or remedy was prescribed (tick **all** that apply):

	Yes	**No**
a) Paracetamol, e.g. Calpol®	☐	☐
b) Ibuprofen, e.g. Nurofen®	☐	☐
c) Other pain-killing remedy, please tick box and write name:	☐	☐
d) Other medicine for ear problem, e.g. new antibiotic, please tick box and write name:	☐	☐

D. PARENT'S SATISFACTION WITH TREATMENT

1. Overall, how satisfied were you with the treatment your child received for their ear problem? (tick **one** box only)

1 = Extremely satisfied	**2 = Satisfied**	**3 = Neither satisfied or dissatisfied**	**4 = Not satisfied**	**5 = Extremely dissatisfied**
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

If your child has not recovered by Day 14 and still has ear-related symptoms and taking antibiotics or pain-killing medicines, we would like to call you again in 6 weeks' time to ask about your child's recovery. There are no further questions to complete in this booklet.

You have now completed the questionnaire. Thank you!

END OF QUESTIONNAIRE INSTRUCTIONS

RETURN OF CHILD'S STOOL SAMPLE (COLLECT ON DAY 14)

- Once you have collected the stool sample on Day 14 (please follow the instruction sheet provided), please post the sample in the return addressed envelope provided in the kit as soon as possible.

QUESTIONNAIRE RETURN

- Please post the questionnaire back to us in the pre-paid envelope provided. We would be grateful if you could do this as soon as possible after completing the questionnaire **but not before the final follow-up phone call** from the study team.
- If you have lost the envelope, you can send it back to the following FREEPOST address:

FREEPOST RTZH-TUTT-KXSB
The REST Study
University of Bristol
Department of Social Medicine
Canynge Hall
39 Whatley Road
BRISTOL
BS8 2PS

THANK YOU!
For making a valuable contribution to health research. We will send you a £10 High Street Voucher by post as a token of our thanks for the valuable time you have given to help us with this research. If you can obtain a stool sample from your child, we will send you a further £5 voucher when we receive the sample.

University of BRISTOL · UNIVERSITY OF Southampton · Bristol Randomised Trials Collaboration · REST the runny ear study · Funded by NHS National Institute for Health Research

IRAS ID: 229293

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