

## BRIGHT trial questionnaires and case report forms: Internal pilot phase

This document contains the questionnaires and case report forms used within the BRIGHT trial internal pilot phase (see Table 1 for an overview). Please note that the page numbers within this document are not continuous and instead apply to each individual questionnaire or case report form enclosed.

Table 1: BRIGHT trial internal pilot phase questionnaires and case report forms

Time point	Follow up number	Type	Document footer name
Baseline	Baseline	Pupil dental assessment	BRIGHT Young Person Dental Assessment Baseline V3.1 20171101
		Pupil questionnaire	BRIGHT Questionnaire Part 1 Baseline V3.1 20171020
			BRIGHT Questionnaire Part 2 Baseline V3.1 20171020
		Parent/carer questionnaire	BRIGHT Parent Resource Use Questionnaire Baseline V3.1 20171026
CBS (time constraints dependent)	FU1	Pupil questionnaire	BRIGHT YP Questionnaire FU1_CBS V1.0 20171215
Between CBS and 12 weeks (time constraints dependent)	FU2	Pupil questionnaire	BRIGHT YP Questionnaire FU2 V1.0 20180305
6 months	FU3	Pupil questionnaire	BRIGHT YP Questionnaire Pilot FU3 V2.0 20180717
1 year	FU4	Pupil questionnaire	BRIGHT YP Questionnaire Pilot FU4 V2.0 20180717
		Parent/carer questionnaire	BRIGHT Parent Resource Use Questionnaire V4.1 20180912
2 years	FU5	Pupil dental assessment	BRIGHT Young Person Dental Assessment FU5 Pilot V4.0 20180724
		Pupil questionnaire	BRIGHT YP Questionnaire Pilot FU5 V2.0 20180717
		Parent/carer questionnaire	BRIGHT Parent Resource Use Questionnaire FU5 Pilot V4.1 20180912
2.5 years	FU6	Pupil dental assessment	BRIGHT Young Person Dental Assessment FU6 Pilot V5.0 20191204
		Pupil questionnaire	BRIGHT YP Questionnaire Pilot FU6 V2.0 20180717
		Parent/carer questionnaire	BRIGHT Parent Resource Use Questionnaire FU6 Pilot V4.1 20180912

CBS = Classroom-based session; YP = young person (pupil)



## Young Person Dental Assessment: Baseline

<b>School ID:</b> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<b>Participant ID:</b> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
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To be completed by the dental assessor:	
Date of completion:	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>day</span> <span>month</span> <span>year</span> </div>
Name of Dental Nurse:	
Name of Dental Assessor:	
Signature of person completing form:	

Reason for dental assessment non-completion <i>(Please cross one box only)</i>
<input type="checkbox"/> Absent <input style="margin-left: 100px;" type="checkbox"/> No longer at school <input style="margin-left: 100px;" type="checkbox"/> Declined dental assessment

**Please carefully read the accompanying Completion Instructions, and complete this assessment questionnaire alongside these.**



## Plaque Scores

Upper arch	Buccal surface score	Palatal surface score
17	<input type="text"/>	<input type="text"/>
16	<input type="text"/>	<input type="text"/>
15	<input type="text"/>	<input type="text"/>
14	<input type="text"/>	<input type="text"/>
13	<input type="text"/>	<input type="text"/>
12	<input type="text"/>	<input type="text"/>
11	<input type="text"/>	<input type="text"/>
21	<input type="text"/>	<input type="text"/>
22	<input type="text"/>	<input type="text"/>
23	<input type="text"/>	<input type="text"/>
24	<input type="text"/>	<input type="text"/>
25	<input type="text"/>	<input type="text"/>
26	<input type="text"/>	<input type="text"/>
27	<input type="text"/>	<input type="text"/>

Lower arch	Buccal surface score	Lingual surface score
37	<input type="text"/>	<input type="text"/>
36	<input type="text"/>	<input type="text"/>
35	<input type="text"/>	<input type="text"/>
34	<input type="text"/>	<input type="text"/>
33	<input type="text"/>	<input type="text"/>
32	<input type="text"/>	<input type="text"/>
31	<input type="text"/>	<input type="text"/>
41	<input type="text"/>	<input type="text"/>
42	<input type="text"/>	<input type="text"/>
43	<input type="text"/>	<input type="text"/>
44	<input type="text"/>	<input type="text"/>
45	<input type="text"/>	<input type="text"/>
46	<input type="text"/>	<input type="text"/>
47	<input type="text"/>	<input type="text"/>

## Bleeding Scores

Tooth	Buccal (1, 0, X)	Palatal/lingual (1, 0, X)
16	<input type="text"/>	<input type="text"/>
12	<input type="text"/>	<input type="text"/>
11	<input type="text"/>	<input type="text"/>
26	<input type="text"/>	<input type="text"/>
36	<input type="text"/>	<input type="text"/>
32	<input type="text"/>	<input type="text"/>
31	<input type="text"/>	<input type="text"/>
46	<input type="text"/>	<input type="text"/>



Did you become unblinded to the child's randomisation group (intervention or control) during the examination?

 Yes No

## Important Information

**In the event of a serious pathology, safeguarding issue or adverse event being suspected, please immediately contact the Chief Investigator: Professor Nicola P T Inness, Tel: 01382 381631/07890290888, Email: n.p.innes@dundee.ac.uk.**

**If Nicola is unavailable, please contact the Co-Principal Investigator: Dr Zoe Marshman, Tel: 0114 2159398/07703179151, Email: z.marshman@sheffield.ac.uk.**

Please give details of the suspected serious pathology, safeguarding issue, or adverse event below.

Which of the Chief Investigator or Co-Principal Investigator did you contact?

Date you contacted the Chief Investigator/Co-Principal Investigator:

  
*day*

/

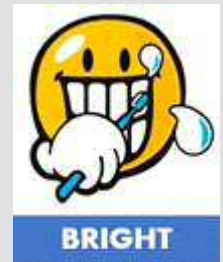
  
*month*

/

  
*year*

Initials of person who reported the above to the Chief Investigator/Co-Principal Investigator:

# Questionnaire about You and Your Teeth: Baseline Part 1



School ID:  Participant ID:

Please fill in TODAY's date:  /  /   
*day month year*

If you have a new mobile number, please text your old mobile number and new mobile number to the BRIGHT text messaging service: 07537 416 903



## Instructions

Thanks for taking part in our study. We would like you to:

- ☺ Answer all the questions in this booklet
- ☺ Remember that there are no right or wrong answers, we just want to know what you think and what matters to you
- ☺ Hand this booklet back to your teacher
- ☺ You will be asked to complete another short questionnaire again over the next few days

The first set of questions ask about **toothbrushing**. For each question, read all the options and choose which one is most like you.

Then put a cross in the box next to it  like this. Only cross **ONE** box for each question.

Example

I normally brush my teeth twice a day so I would put a cross in this box...

How often do you usually brush your teeth?

- More than three times a day
- Three times a day
- Twice a day
- Once a day
- Less than once a day
- Never

Now think about and answer the questions below.

1. How much of a problem are your teeth for you?
  - Not at all
  - A bit
  - A lot
  
2. How satisfied are you with the appearance of your teeth?
  - Very satisfied
  - Satisfied
  - Neither satisfied nor dissatisfied
  - Dissatisfied
  - Very dissatisfied
  
3. How often do you usually brush your teeth?
  - More than three times a day
  - Three times a day
  - Twice a day
  - Once a day
  - Less than once a day
  - Never
  
4. I know how to brush my teeth properly
  - Not at all true
  - Not true
  - True
  - Definitely true
  
5. If I brush my teeth twice every day then my teeth will look clean when talking to friends
  - Not at all true
  - Not true
  - True
  - Definitely true
  
6. If I brush my teeth twice every day then my teeth will be healthy
  - Not at all true
  - Not true
  - True
  - Definitely true
  
7. If I brush my teeth twice every day then my teeth will feel good
  - Not at all true
  - Not true
  - True
  - Definitely true

8. If I don't brush my teeth twice every day, I risk getting tooth decay

- Not at all true
- Not true
- True
- Definitely true

9. If I don't brush my teeth twice every day, I risk my teeth looking dirty

- Not at all true
- Not true
- True
- Definitely true

10. If I don't brush my teeth twice every day, I might have bad breath

- Not at all true
- Not true
- True
- Definitely true

11. How often do you want to brush your teeth?

- More than three times a day
- Three times a day
- Twice a day
- Once a day
- Less than once a day
- Never

12. I have a plan of how I will make myself brush when I find myself not brushing properly

- Not at all true
- Not true
- True
- Definitely true

13. I know where and when I will brush my teeth in the **morning**

- Not at all true
- Not true
- True
- Definitely true

14. I know where and when I will brush my teeth in the **evening**

- Not at all true
- Not true
- True
- Definitely true

These questions ask about **your teeth**. For each question, read all the choices and decide which one is most like you.

15. How much do your teeth hurt you?

- Not at all
- A bit
- A lot

16. Do your teeth make it hard to eat some foods?

- Not at all
- A bit
- A lot

17. Do you have to eat on one side of your mouth because of your teeth?

- Not at all
- A bit
- A lot

18. Do you get food stuck in your teeth?

- Not at all
- A bit
- A lot

19. How much do you get kept awake by your teeth?

- Not at all
- A bit
- A lot

20. How much do your teeth annoy you?

- Not at all
- A bit
- A lot

21. How much do your teeth hurt when you brush them?

- Not at all
- A bit
- A lot

22. Do you have to eat more carefully because of your teeth?

- Not at all
- A bit
- A lot

23. Do you have to eat more slowly because of your teeth?

- Not at all
- A bit
- A lot

24. Do you feel cross because of your teeth?

- Not at all
- A bit
- A lot

25. How much have you cried because of your teeth?

- Not at all
- A bit
- A lot

26. Do your teeth make it hard to do your schoolwork/homework?

- Not at all
- A bit
- A lot

**Thanks very much for your time**



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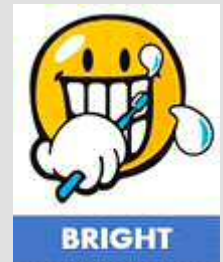
School ID:  Participant ID:

**School staff, please complete:**

Reason for questionnaire non-completion	Please cross one box only
Absent	<input type="checkbox"/>
No longer at the school	<input type="checkbox"/>
Declined to complete this questionnaire	<input type="checkbox"/>

Date this section was completed:  /  /   
*day month year*

# Questionnaire about You and Your Teeth: Baseline Part 2



School ID:  Participant ID:

Please fill in TODAY's date:  /  /   
*day month year*

If you have a new mobile number, please text your old mobile number and new mobile number to the BRIGHT text messaging service: 07537 416 903



## Instructions

Thanks for taking part in our study. You recently completed a questionnaire for us and we would like you to complete this questionnaire for us as well:

- ☺ Remember to answer all the questions in this booklet
- ☺ There are no right or wrong answers, we just want to know what you think
- ☺ Hand this booklet back to your teacher

The first set of questions ask about **how you are today**. For each question, read all the options and choose which one is most like you.

Then put a cross in the box next to it  like this. Only cross **ONE** box for each question.

Example

I normally brush my teeth twice a day so I would put a cross in this box...

How often do you usually brush your teeth?

- More than three times a day
- Three times a day
- Twice a day
- Once a day
- Less than once a day
- Never

These questions ask about how you are **TODAY**. For each question, read all the choices and decide which one is most like you **TODAY**.

1. Worried

- I don't feel worried today
- I feel a little bit worried today
- I feel a bit worried today
- I feel quite worried today
- I feel very worried today

2. Sad

- I don't feel sad today
- I feel a little bit sad today
- I feel a bit sad today
- I feel quite sad today
- I feel very sad today

3. Pain

- I don't have any pain today
- I have a little bit of pain today
- I have a bit of pain today
- I have quite a lot of pain today
- I have a lot of pain today

4. Tired

- I don't feel tired today
- I feel a little bit tired today
- I feel a bit tired today
- I feel quite tired today
- I feel very tired today

5. Annoyed

- I don't feel annoyed today
- I feel a little bit annoyed today
- I feel a bit annoyed today
- I feel quite annoyed today
- I feel very annoyed today

6. School work/ Homework (such as reading, writing, doing lessons)

- I have no problems with my schoolwork/homework today
- I have a few problems with my schoolwork/homework today
- I have some problems with my schoolwork/homework today
- I have many problems with my schoolwork/homework today
- I can't do my schoolwork/homework today

7. Sleep

- Last night I had no problems sleeping
- Last night I had a few problems sleeping
- Last night I had some problems sleeping
- Last night I had many problems sleeping
- Last night I couldn't sleep at all

8. Daily routine (things like eating, having a bath/shower, getting dressed)

- I have no problems with my daily routine today
- I have a few problems with my daily routine today
- I have some problems with my daily routine today
- I have many problems with my daily routine today
- I can't do my daily routine today

9. Able to join in activities (things like playing out with your friends, doing sports, joining in things)

- I can join in with any activities today
- I can join in with most activities today
- I can join in with some activities today
- I can join in with a few activities today
- I can join in with no activities today

Last set of questions – remember please only cross one answer.

10. Do you have your own toothbrush?

- Yes, I have my own toothbrush
- No, I share one
- No, I do not have a toothbrush

11. Do you have toothpaste you can use?

- There is always toothpaste I can use
- There is sometimes toothpaste I can use
- There is no toothpaste I can use

12. Do you usually go to the dentist?

- For a check up
- Only when I have trouble with my teeth
- I have never been to the dentist

13. How many times do you usually eat:

**Put a cross in one box on each row**

	<b>Four or more times a day</b>	<b>Three times a day</b>	<b>Two times a day</b>	<b>Once a day</b>	<b>Less than once a day</b>	<b>Never</b>
Fruit (fresh, tinned, dried or frozen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cakes or biscuits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweets (candy or chocolate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. How many times do you usually drink:

**Put a cross in one box on each row**

	<b>Four or more times a day</b>	<b>Three times a day</b>	<b>Two times a day</b>	<b>Once a day</b>	<b>Less than once a day</b>	<b>Never</b>
Diet coke or other non-sugar drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coke, other soft drinks or squash that contain sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy (sport) drinks (e.g. Powerade, Lucozade)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water (tap or bottled)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit juices and smoothies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Have you received helpful information about how to keep your teeth and mouth healthy from any of these places?

**Put a cross in one box on each row**

	<b>Yes</b>	<b>No</b>
Adverts	<input type="checkbox"/>	<input type="checkbox"/>
TV programmes	<input type="checkbox"/>	<input type="checkbox"/>
Radio	<input type="checkbox"/>	<input type="checkbox"/>
Newspapers or magazines	<input type="checkbox"/>	<input type="checkbox"/>
Social media (e.g. Facebook, Twitter)	<input type="checkbox"/>	<input type="checkbox"/>
A lesson in school	<input type="checkbox"/>	<input type="checkbox"/>
Friends in your year group	<input type="checkbox"/>	<input type="checkbox"/>
Friends in another year group	<input type="checkbox"/>	<input type="checkbox"/>
Dentists	<input type="checkbox"/>	<input type="checkbox"/>
Text messages	<input type="checkbox"/>	<input type="checkbox"/>

16. Over the last year have you regularly used any of the following products to look after your teeth or mouth?

**Put a cross in one box on each row**

	<b>Yes</b>	<b>No</b>
Toothbrush (non-electric)	<input type="checkbox"/>	<input type="checkbox"/>
Electric/battery operated toothbrush	<input type="checkbox"/>	<input type="checkbox"/>
Toothpaste	<input type="checkbox"/>	<input type="checkbox"/>
Mouthwash	<input type="checkbox"/>	<input type="checkbox"/>
Dental floss	<input type="checkbox"/>	<input type="checkbox"/>
Sugar free or dental chewing gum	<input type="checkbox"/>	<input type="checkbox"/>
Other (write below)	<input type="checkbox"/>	<input type="checkbox"/>

17. What is your gender?

- Female (girl)
- Male (boy)
- Rather not say

**Thank you very much for answering all these questions**



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School ID:  Participant ID:

**School staff, please complete:**

Reason for questionnaire non-completion	Please cross one box only
Absent	<input type="checkbox"/>
No longer at the school	<input type="checkbox"/>
Declined to complete this questionnaire	<input type="checkbox"/>

Date this section was completed:  /  /   
*day month year*



Blwrdd Iechyd Prifysgol  
Caerdydd a'r Fro  
Cardiff and Vale  
University Health Board



UNIVERSITY OF LEEDS

**BRIGHT**

# Parent/Carer Resource Use Questionnaire: Baseline

School ID:

Participant ID:

Date questionnaire sent:   /   /

*day                      month                      year*



Dear Parent/Carer,

Please could you answer the following questions which ask about your child's dental visits in the last 12 months?

For any options that apply to your child, please put a cross in the box next to it like this.

**Please fill in TODAY's date:**   /   /      
day month year

1. Not including any school dental clinics, has your child attended any dental appointments in the last 12 months? *(Please cross one box)*

Yes  How many times?

Which dental practice did your child last attend? **[Scotland only]**

No  *(Go straight to Question 5)*

2. For each appointment in the last 12 months, please tell us the following:

	Appointment 1	Appointment 2	Appointment 3	Appointment 4
What happened at the appointment?  <i>(cross all that apply)</i>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <input style="width: 100%; height: 20px;" type="text"/>

3. For each appointment in the last 12 months, please tell us the following:

	Appointment 1	Appointment 2	Appointment 3	Appointment 4
Where did you go for the appointment?  <i>(cross one only)</i>	<input type="checkbox"/> Family dentist <input type="checkbox"/> Emergency dentist <input type="checkbox"/> Hospital dentist <input type="checkbox"/> Doctor <input type="checkbox"/> Other (please specify): <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Family dentist <input type="checkbox"/> Emergency dentist <input type="checkbox"/> Hospital dentist <input type="checkbox"/> Doctor <input type="checkbox"/> Other (please specify): <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Family dentist <input type="checkbox"/> Emergency dentist <input type="checkbox"/> Hospital dentist <input type="checkbox"/> Doctor <input type="checkbox"/> Other (please specify): <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Family dentist <input type="checkbox"/> Emergency dentist <input type="checkbox"/> Hospital dentist <input type="checkbox"/> Doctor <input type="checkbox"/> Other (please specify): <input style="width: 100%; height: 20px;" type="text"/>
Did your child have a general anaesthetic (sent to sleep at a hospital for dental treatment)?	<input type="checkbox"/> Yes          <input type="checkbox"/> No	<input type="checkbox"/> Yes          <input type="checkbox"/> No	<input type="checkbox"/> Yes          <input type="checkbox"/> No	<input type="checkbox"/> Yes          <input type="checkbox"/> No

4. For each appointment in the last 12 months, please tell us the following:

	Appointment 1	Appointment 2	Appointment 3	Appointment 4
How many minutes did the appointment take (including travel time)?	<input type="text"/> <input type="text"/> <input type="text"/> minutes	<input type="text"/> <input type="text"/> <input type="text"/> minutes	<input type="text"/> <input type="text"/> <input type="text"/> minutes	<input type="text"/> <input type="text"/> <input type="text"/> minutes
How many miles did you have to travel to the appointment?	<input type="text"/> <input type="text"/> <input type="text"/> miles	<input type="text"/> <input type="text"/> <input type="text"/> miles	<input type="text"/> <input type="text"/> <input type="text"/> miles	<input type="text"/> <input type="text"/> <input type="text"/> miles
How did you travel to the appointment? <i>(cross all that apply)</i>	<input type="checkbox"/> Car <input type="checkbox"/> By foot <input type="checkbox"/> Taxi <input type="checkbox"/> Bus <input type="checkbox"/> Train <input type="checkbox"/> Other <i>(please specify):</i> <input type="text"/>	<input type="checkbox"/> Car <input type="checkbox"/> By foot <input type="checkbox"/> Taxi <input type="checkbox"/> Bus <input type="checkbox"/> Train <input type="checkbox"/> Other <i>(please specify):</i> <input type="text"/>	<input type="checkbox"/> Car <input type="checkbox"/> By foot <input type="checkbox"/> Taxi <input type="checkbox"/> Bus <input type="checkbox"/> Train <input type="checkbox"/> Other <i>(please specify):</i> <input type="text"/>	<input type="checkbox"/> Car <input type="checkbox"/> By foot <input type="checkbox"/> Taxi <input type="checkbox"/> Bus <input type="checkbox"/> Train <input type="checkbox"/> Other <i>(please specify):</i> <input type="text"/>
Did you have to take time off paid work?	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
If yes, how many hours?	<input type="text"/> <input type="text"/> . <input type="text"/> hours	<input type="text"/> <input type="text"/> . <input type="text"/> hours	<input type="text"/> <input type="text"/> . <input type="text"/> hours	<input type="text"/> <input type="text"/> . <input type="text"/> hours

5. In the past 12 months, has your child taken any prescribed (by a doctor or dentist) medicines for tooth related problems?

Yes **What was the medicine?** **How many times in the last 12 months?**

Pain relief (e.g. Calpol, Ibuprofen)

Antibiotics

Other

No

6. In the past 12 months, have you treated your child yourself (without going to the dentist/doctor) for tooth related problems?

Yes

Did you give painkillers?

Did you give something else?

*(please specify):*

No

7. Approximately how many days has your child had off school in the last 12 months due to dental problems and/or dental visits? If none, please write '0'

.  days

8. In the past 12 months, did you or another carer need to take time off paid work or find yourself unable to undertake normal daily activities because of your child's dental problems? (This is in addition to the hours you may have listed in question 4 above for dental appointments)

Yes  How many hours?  .

No

9. In the last 12 months have you had any extra child care costs (for your other children) as a result of your child's dental problems?

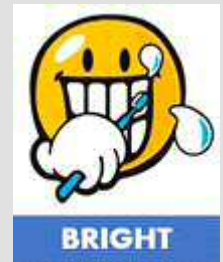
Yes  How much was this cost? £  .

No

10. What is the occupation (job/work) of the child's main parent(s) or carer(s)?

**Thank you very much**

# Questionnaire about You and Your Teeth: Follow up 1 - Classroom-based Session



School ID:  Participant ID:

Please fill in TODAY's date:  /  /   
*day month year*

If you have a new mobile number, please text your old mobile number and new mobile number to the BRIGHT text messaging service: 07537 416 903



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## Instructions

Thanks for taking part in our study. We would like you to:

- ☺ Answer all the questions in this booklet
- ☺ Remember that there are no right or wrong answers, we just want to know what you think and what matters to you
- ☺ Hand this booklet back to your teacher

These questions ask about teeth and **toothbrushing**. For each question, read all the options and choose which one is most like you.

Then put a cross in the box next to it  like this. Only cross **ONE** box for each question.

Example

My teeth are a bit of a problem so I would put a cross in this box...

How much of a problem are your teeth for you?

Not at all

A bit

A lot

Now think about and answer the questions below.

1. How much of a problem are your teeth for you?
  - Not at all
  - A bit
  - A lot
  
2. How satisfied are you with the appearance of your teeth?
  - Very satisfied
  - Satisfied
  - Neither satisfied nor dissatisfied
  - Dissatisfied
  - Very dissatisfied
  
3. How often do you usually brush your teeth?
  - More than three times a day
  - Three times a day
  - Twice a day
  - Once a day
  - Less than once a day
  - Never
  
4. I know how to brush my teeth properly
  - Not at all true
  - Not true
  - True
  - Definitely true
  
5. If I brush my teeth twice every day then my teeth will look clean when talking to friends
  - Not at all true
  - Not true
  - True
  - Definitely true
  
6. If I brush my teeth twice every day then my teeth will be healthy
  - Not at all true
  - Not true
  - True
  - Definitely true
  
7. If I brush my teeth twice every day then my teeth will feel good
  - Not at all true
  - Not true
  - True
  - Definitely true

8. If I don't brush my teeth twice every day, I risk getting tooth decay

- Not at all true
- Not true
- True
- Definitely true

9. If I don't brush my teeth twice every day, I risk my teeth looking dirty

- Not at all true
- Not true
- True
- Definitely true

10. If I don't brush my teeth twice every day, I might have bad breath

- Not at all true
- Not true
- True
- Definitely true

11. How often do you want to brush your teeth?

- More than three times a day
- Three times a day
- Twice a day
- Once a day
- Less than once a day
- Never

12. I have a plan of how I will make myself brush when I find myself not brushing properly

- Not at all true
- Not true
- True
- Definitely true

13. I know where and when I will brush my teeth in the **morning**

- Not at all true
- Not true
- True
- Definitely true

14. I know where and when I will brush my teeth in the **evening**

- Not at all true
- Not true
- True
- Definitely true

**Thanks very much for your time**



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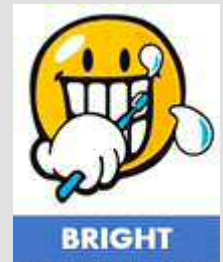
School ID:  Participant ID:

**School staff, please complete:**

Reason for questionnaire non-completion	Please cross one box only
Absent	<input type="checkbox"/>
No longer at the school	<input type="checkbox"/>
Declined to complete this questionnaire	<input type="checkbox"/>

Date this section was completed:  /  /   
*day month year*

# Questionnaire about You and Your Teeth: Follow up 2



School ID:  Participant ID:

Please fill in TODAY's date:  /  /   
*day month year*

If you have a new mobile number and have ever received text messages about toothbrushing, and want to continue receiving them, please text your old mobile number and new mobile number to the BRIGHT text messaging service: 07537 416 903



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## Instructions

Thanks for taking part in our study. We would like you to:

- ☺ Answer all the questions in this booklet
- ☺ Remember that there are no right or wrong answers, we just want to know what you think and what matters to you
- ☺ Please hand this booklet back to your teacher

The first set of questions ask about **toothbrushing**. For each question, read all the options and choose which one is most like you.

Then put a cross in the box next to it  like this. Only cross **ONE** box for each question.

Example

My teeth are a bit of a problem so I would put a cross in this box...

How much of a problem are your teeth for you?

Not at all

A bit

A lot

Now think about and answer the questions below.

1. How much of a problem are your teeth for you?
  - Not at all
  - A bit
  - A lot
  
2. How satisfied are you with the appearance of your teeth?
  - Very satisfied
  - Satisfied
  - Neither satisfied nor dissatisfied
  - Dissatisfied
  - Very dissatisfied
  
3. How often do you usually brush your teeth?
  - More than three times a day
  - Three times a day
  - Twice a day
  - Once a day
  - Less than once a day
  - Never
  
4. I know how to brush my teeth properly
  - Not at all true
  - Not true
  - True
  - Definitely true
  
5. If I brush my teeth twice every day then my teeth will look clean when talking to friends
  - Not at all true
  - Not true
  - True
  - Definitely true
  
6. If I brush my teeth twice every day then my teeth will be healthy
  - Not at all true
  - Not true
  - True
  - Definitely true
  
7. If I brush my teeth twice every day then my teeth will feel good
  - Not at all true
  - Not true
  - True
  - Definitely true

8. If I don't brush my teeth twice every day, I risk getting tooth decay

- Not at all true
- Not true
- True
- Definitely true

9. If I don't brush my teeth twice every day, I risk my teeth looking dirty

- Not at all true
- Not true
- True
- Definitely true

10. If I don't brush my teeth twice every day, I might have bad breath

- Not at all true
- Not true
- True
- Definitely true

11. How often do you want to brush your teeth?

- More than three times a day
- Three times a day
- Twice a day
- Once a day
- Less than once a day
- Never

12. I have a plan of how I will make myself brush when I find myself not brushing properly

- Not at all true
- Not true
- True
- Definitely true

13. I know where and when I will brush my teeth in the **morning**

- Not at all true
- Not true
- True
- Definitely true

14. I know where and when I will brush my teeth in the **evening**

- Not at all true
- Not true
- True
- Definitely true

15. Have you received helpful information about how to keep your teeth and mouth healthy from any of these places?

**Put a cross in one box on each row**

	<b>Yes</b>	<b>No</b>
Adverts	<input type="checkbox"/>	<input type="checkbox"/>
TV programmes	<input type="checkbox"/>	<input type="checkbox"/>
Radio	<input type="checkbox"/>	<input type="checkbox"/>
Newspapers or magazines	<input type="checkbox"/>	<input type="checkbox"/>
Social media (e.g. Facebook, Twitter)	<input type="checkbox"/>	<input type="checkbox"/>
A lesson in school	<input type="checkbox"/>	<input type="checkbox"/>
Friends in your year group	<input type="checkbox"/>	<input type="checkbox"/>
Friends in another year group	<input type="checkbox"/>	<input type="checkbox"/>
Dentists	<input type="checkbox"/>	<input type="checkbox"/>
Text messages	<input type="checkbox"/>	<input type="checkbox"/>

**Thanks very much for your time**



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School ID:

Participant ID:

**School staff, please complete:**

Reason for questionnaire non-completion	Please cross one box only
Absent	<input type="checkbox"/>
No longer at the school	<input type="checkbox"/>
Declined to complete this questionnaire	<input type="checkbox"/>

Date this section was completed:

/

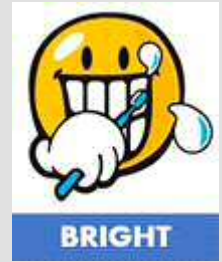
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*day*

*month*

*year*

# Questionnaire about You and Your Teeth: Follow up 3 - Pilot



School ID:

Participant ID:

Please fill in TODAY's date:

  
*day*/  
  
*month*/  
  
*year*

If you have a new mobile number and have ever received text messages about toothbrushing, and want to continue receiving them, please text your old mobile number and new mobile number to the BRIGHT text messaging service: 07537 416 903.

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## Instructions

Thanks for taking part in our study. We would like you to:

- ☺ Answer all the questions in this booklet
- ☺ Remember that there are no right or wrong answers, we just want to know what you think and what matters to you
- ☺ Please hand this booklet back to your teacher

The first set of questions ask about your teeth and **toothbrushing**. For each question, read all the options and choose which one is most like you.

Then put a cross in the box next to it  like this. Only cross **ONE** box for each question.

### Example question

Here's one we've done, to show you:

How much of a problem are your teeth for you?

Not at all

A bit

A lot

My teeth are a bit of a problem so I would put a cross in this box...

Now think about and answer the questions below.

1. How do you feel about the way your teeth look?
  - I feel very happy
  - I feel a bit happy
  - I don't feel happy or unhappy
  - I feel a bit unhappy
  - I feel very unhappy
  
2. How often do you usually brush your teeth?
  - More than three times a day
  - Three times a day
  - Twice a day
  - Once a day
  - Less than once a day
  - Never
  
3. I know how to brush my teeth properly
  - Not at all true
  - Not true
  - True
  - Definitely true
  
4. If I brush my teeth twice every day then my teeth will look clean when talking to friends
  - Not at all true
  - Not true
  - True
  - Definitely true
  
5. If I brush my teeth twice every day then my teeth will be healthy
  - Not at all true
  - Not true
  - True
  - Definitely true
  
6. If I brush my teeth twice every day then my teeth will feel good
  - Not at all true
  - Not true
  - True
  - Definitely true
  
7. If I don't brush my teeth twice every day, I risk getting tooth decay
  - Not at all true
  - Not true
  - True
  - Definitely true

8. If I don't brush my teeth twice every day, I risk my teeth looking dirty

- Not at all true
- Not true
- True
- Definitely true

9. If I don't brush my teeth twice every day, I might have bad breath

- Not at all true
- Not true
- True
- Definitely true

10. How often do you want to brush your teeth?

- More than three times a day
- Three times a day
- Twice a day
- Once a day
- Less than once a day
- Never

11. I have a plan of how I will make myself brush when I find myself not brushing properly

- Not at all true
- Not true
- True
- Definitely true

12. I know where and when I will brush my teeth in the **morning**

- Not at all true
- Not true
- True
- Definitely true

13. I know where and when I will brush my teeth in the **evening**

- Not at all true
- Not true
- True
- Definitely true

14. Do you have your own toothbrush?

- Yes, I have my own toothbrush
- No, I share one
- No, I do not have a toothbrush

15. Do you have toothpaste you can use?

- There is always toothpaste I can use
- There is sometimes toothpaste I can use
- There is no toothpaste I can use

16. Since the time that BRIGHT dental checks were first done in your school, have you received helpful information about how to keep your teeth and mouth healthy from any of these places?

**Put a cross in one box on each row**

	<b>Yes</b>	<b>No</b>
Adverts	<input type="checkbox"/>	<input type="checkbox"/>
TV programmes	<input type="checkbox"/>	<input type="checkbox"/>
Radio	<input type="checkbox"/>	<input type="checkbox"/>
Newspapers or magazines	<input type="checkbox"/>	<input type="checkbox"/>
Social media (e.g. Facebook, Twitter)	<input type="checkbox"/>	<input type="checkbox"/>
A lesson in school	<input type="checkbox"/>	<input type="checkbox"/>
Friends in your year group	<input type="checkbox"/>	<input type="checkbox"/>
Friends in another year group	<input type="checkbox"/>	<input type="checkbox"/>
Dentists	<input type="checkbox"/>	<input type="checkbox"/>
Text messages	<input type="checkbox"/>	<input type="checkbox"/>

**Thanks very much for your time**



**Page Intentionally Blank**

School ID:

Participant ID:

**School staff, please complete:**

Reason for questionnaire non-completion	Please cross one box only
Absent	<input type="checkbox"/>
No longer at the school	<input type="checkbox"/>
Declined to complete this questionnaire	<input type="checkbox"/>

Date this section was completed:

*day*

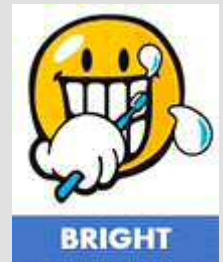
/

*month*

/

*year*

# Questionnaire about You and Your Teeth: Follow up 4 – Pilot Trial



School ID:  Participant ID:

Please fill in TODAY's date:  /  /   
*day month year*

If you have a new mobile number and have ever received text messages about toothbrushing, and want to continue receiving them, please text your old mobile number and new mobile number to the BRIGHT text messaging service: 07537 416 903.

## Instructions

Thanks for taking part in our study. You recently completed a questionnaire for us and we would like you to complete this questionnaire for us as well:

- ☺ Answer all the questions in this booklet
- ☺ Remember that there are no right or wrong answers, we just want to know what you think and what matters to you
- ☺ Please hand this booklet back to your teacher

The first set of questions ask about **your teeth and toothbrushing**. For each question, read all the options and choose which one is most like you.

Then put a cross in the box next to it  like this. Only cross **ONE** box for each question.

### Example question

Here's one we've done, to show you:

How much of a problem are your teeth for you?

Not at all

A bit

A lot

My teeth are a bit of a problem so I would put a cross in this box...

Now think about and answer the questions below.

1. How much of a problem are your teeth for you?
  - Not at all
  - A bit
  - A lot
  
2. How do you feel about the way your teeth look?
  - I feel very happy
  - I feel a bit happy
  - I don't feel happy or unhappy
  - I feel a bit unhappy
  - I feel very unhappy
  
3. How often do you usually brush your teeth?
  - More than three times a day
  - Three times a day
  - Twice a day
  - Once a day
  - Less than once a day
  - Never
  
4. I know how to brush my teeth properly
  - Not at all true
  - Not true
  - True
  - Definitely true
  
5. If I brush my teeth twice every day then my teeth will look clean when talking to friends
  - Not at all true
  - Not true
  - True
  - Definitely true
  
6. If I brush my teeth twice every day then my teeth will be healthy
  - Not at all true
  - Not true
  - True
  - Definitely true
  
7. If I brush my teeth twice every day then my teeth will feel good
  - Not at all true
  - Not true
  - True
  - Definitely true

8. If I don't brush my teeth twice every day, I risk getting tooth decay

- Not at all true
- Not true
- True
- Definitely true

9. If I don't brush my teeth twice every day, I risk my teeth looking dirty

- Not at all true
- Not true
- True
- Definitely true

10. If I don't brush my teeth twice every day, I might have bad breath

- Not at all true
- Not true
- True
- Definitely true

11. How often do you want to brush your teeth?

- More than three times a day
- Three times a day
- Twice a day
- Once a day
- Less than once a day
- Never

12. I have a plan of how I will make myself brush when I find myself not brushing properly

- Not at all true
- Not true
- True
- Definitely true

13. I know where and when I will brush my teeth in the **morning**

- Not at all true
- Not true
- True
- Definitely true

14. I know where and when I will brush my teeth in the **evening**

- Not at all true
- Not true
- True
- Definitely true

**You're half way through - thank you for taking part in BRIGHT!**



These questions ask about you and **your teeth**. For each question, read all the choices and decide which one is most like you.

15. How much do your teeth hurt you?

- Not at all
- A bit
- A lot

16. Do your teeth make it hard to eat some foods?

- Not at all
- A bit
- A lot

17. Do you have to eat on one side of your mouth because of your teeth?

- Not at all
- A bit
- A lot

18. Do you get food stuck in your teeth?

- Not at all
- A bit
- A lot

19. How much do you get kept awake by your teeth?

- Not at all
- A bit
- A lot

20. How much do your teeth annoy you?

- Not at all
- A bit
- A lot

21. How much do your teeth hurt when you brush them?

- Not at all
- A bit
- A lot

22. Do you have to eat more carefully because of your teeth?

- Not at all
- A bit
- A lot

23. Do you have to eat more slowly because of your teeth?

- Not at all
- A bit
- A lot

24. Do you feel cross because of your teeth?

- Not at all
- A bit
- A lot

25. How much have you cried because of your teeth?

- Not at all
- A bit
- A lot

26. Do your teeth make it hard to do your schoolwork?

- Not at all
- A bit
- A lot

These questions ask about how you are **TODAY**. For each question, read all the choices and decide which one is most like you **TODAY**.

27. Worried

- I don't feel worried today
- I feel a little bit worried today
- I feel a bit worried today
- I feel quite worried today
- I feel very worried today

28. Sad

- I don't feel sad today
- I feel a little bit sad today
- I feel a bit sad today
- I feel quite sad today
- I feel very sad today

29. Pain

- I don't have any pain today
- I have a little bit of pain today
- I have a bit of pain today
- I have quite a lot of pain today
- I have a lot of pain today

30. Tired

- I don't feel tired today
- I feel a little bit tired today
- I feel a bit tired today
- I feel quite tired today
- I feel very tired today

31. Annoyed

- I don't feel annoyed today
- I feel a little bit annoyed today
- I feel a bit annoyed today
- I feel quite annoyed today
- I feel very annoyed today

32. School work/ Homework (such as reading, writing, doing lessons)

- I have no problems with my schoolwork/homework today
- I have a few problems with my schoolwork/homework today
- I have some problems with my schoolwork/homework today
- I have many problems with my schoolwork/homework today
- I can't do my schoolwork/homework today

33. Sleep

- Last night I had no problems sleeping
- Last night I had a few problems sleeping
- Last night I had some problems sleeping
- Last night I had many problems sleeping
- Last night I couldn't sleep at all

34. Daily routine (things like eating, having a bath/shower, getting dressed)

- I have no problems with my daily routine today
- I have a few problems with my daily routine today
- I have some problems with my daily routine today
- I have many problems with my daily routine today
- I can't do my daily routine today

35. Able to join in activities (things like playing out with your friends, doing sports, joining in things)

- I can join in with any activities today
- I can join in with most activities today
- I can join in with some activities today
- I can join in with a few activities today
- I can join in with no activities today

**Thank you very much for answering all these questions**



School ID:  Participant ID:

**School staff, please complete:**

Reason for questionnaire non-completion	Please cross one box only
Absent	<input type="checkbox"/>
No longer at the school	<input type="checkbox"/>
Declined to complete this questionnaire	<input type="checkbox"/>

Date this section was completed:  /  /   
*day month year*



# Parent/Carer Resource Use Questionnaire: Follow Up 4 - Pilot Trial

Dear Parent/Carer,

Please could you answer the following questions which ask about your child's dental visits in the last 12 months?

For any options that apply to your child, please put a cross in the box next to it like this.

Please fill in TODAY's date:

/  /   
day month year

1. Not including any school dental clinics, has your child attended any dental appointments in the last 12 months? *(Please cross one box)*

Yes  How many times?

Which dental practice did your child last attend? **[Scotland only]**

No  *(Go straight to Question 4)*

2. For each appointment in the last 12 months, please tell us the following:

	Appointment 1	Appointment 2	Appointment 3	Appointment 4
What happened at the appointment? <i>(cross all that apply)</i>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <input type="text"/>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <input type="text"/>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <input type="text"/>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <input type="text"/>
Did your child have a general anaesthetic (sent to sleep at a hospital for dental treatment)?	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No

3. For the most recent appointment, please tell us the following:

How many minutes did the appointment take (including travel time)?  minutes

How many miles did you have to travel to the appointment?  miles

How did you travel there?  Car  By foot  Taxi  Bus  Train

Did you have to take time off paid work?  Yes  No

If 'Yes', how many hours did you have to take off work?  .  hours

4. In the past 12 months, has your child taken any **prescribed** (by a doctor or dentist) medicines for tooth related problems?

Yes **What was the medicine?**

**How many times in the last 12 months?**

Pain killers (e.g. Calpol, Ibuprofen)

--	--	--

Antibiotics

--	--	--

Other (*please specify*)

--

--	--	--

No

5. In the past 12 months, have you treated your child yourself (without going to the dentist/doctor) for tooth related problems?

Yes **How did you treat them?**

**How many times in the last 12 months?**

Pain killers (e.g. Calpol, Ibuprofen)

--	--	--

Antibiotics

--	--	--

Other (*please specify*)

--

--	--	--

No

6. Approximately how many days has your child had off school in the last 12 months due to dental problems and/or dental visits? If none, please write '0'

		.		days
--	--	---	--	------

7. In the past 12 months, did you or another carer need to take time off paid work or find yourself unable to undertake normal daily activities because of your child's dental problems? (This is in addition to the hours you may have listed in question 3 for dental appointments)

Yes  How many hours? 

		.	
--	--	---	--

No

8. What is the occupation (job/work) of the child's main parent(s) or carer(s)?

--

**Thank you very much**

*For office use only*

School ID:

Participant ID:

Date questionnaire sent:  /  /   
*day month year*



# Young Person Dental Assessment: Follow Up 5 – Pilot Trial

<b>School ID:</b> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<b>Participant ID:</b> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
---	--

**To be completed by the dental assessor:**

Date of completion:	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <small style="display: flex; justify-content: space-around; width: 100%;"> <span>day</span> <span>month</span> <span>year</span> </small>
Name of Dental Nurse:	
Name of Dental Assessor:	
Signature of person completing form:	

<b>Reason for dental assessment non-completion</b> <i>(Please cross one box only)</i>		
<input type="checkbox"/> <b>Absent</b>	<input type="checkbox"/> <b>No longer at school</b>	<input type="checkbox"/> <b>Declined dental assessment</b>

**Please carefully read the accompanying Completion Instructions,  
and complete this assessment questionnaire alongside these.**



## Plaque Scores

Upper arch	Buccal surface score	Palatal surface score
17	<input type="text"/>	<input type="text"/>
16	<input type="text"/>	<input type="text"/>
15	<input type="text"/>	<input type="text"/>
14	<input type="text"/>	<input type="text"/>
13	<input type="text"/>	<input type="text"/>
12	<input type="text"/>	<input type="text"/>
11	<input type="text"/>	<input type="text"/>
21	<input type="text"/>	<input type="text"/>
22	<input type="text"/>	<input type="text"/>
23	<input type="text"/>	<input type="text"/>
24	<input type="text"/>	<input type="text"/>
25	<input type="text"/>	<input type="text"/>
26	<input type="text"/>	<input type="text"/>
27	<input type="text"/>	<input type="text"/>

Lower arch	Buccal surface score	Lingual surface score
37	<input type="text"/>	<input type="text"/>
36	<input type="text"/>	<input type="text"/>
35	<input type="text"/>	<input type="text"/>
34	<input type="text"/>	<input type="text"/>
33	<input type="text"/>	<input type="text"/>
32	<input type="text"/>	<input type="text"/>
31	<input type="text"/>	<input type="text"/>
41	<input type="text"/>	<input type="text"/>
42	<input type="text"/>	<input type="text"/>
43	<input type="text"/>	<input type="text"/>
44	<input type="text"/>	<input type="text"/>
45	<input type="text"/>	<input type="text"/>
46	<input type="text"/>	<input type="text"/>
47	<input type="text"/>	<input type="text"/>

## Bleeding Scores

Tooth	Buccal (1, 0, X)	Palatal/lingual (1, 0, X)
16	<input type="text"/>	<input type="text"/>
12	<input type="text"/>	<input type="text"/>
11	<input type="text"/>	<input type="text"/>
26	<input type="text"/>	<input type="text"/>
36	<input type="text"/>	<input type="text"/>
32	<input type="text"/>	<input type="text"/>
31	<input type="text"/>	<input type="text"/>
46	<input type="text"/>	<input type="text"/>

# ICDAS Recording Sheet

4145250911

Please circle the tooth being scored (primary or permanent).

Surface	Upper Right								Upper Left																							
	18		17		16		15		14		13		12		11		21		22		23		24		25		26		27		28	
M																																
O																																
D																																
B																																
L																																

Surface	Lower Right								Lower Left																							
	48		47		46		45		44		43		42		41		71		72		73		74		75		36		37		38	
M																																
O																																
D																																
B																																
L																																

Did you become unblinded to the child's randomisation group (intervention or control) during the examination?

Yes

No

## Important Information

**In the event of a serious pathology, safeguarding issue or adverse event being suspected, please immediately contact the Chief Investigator: Professor Nicola P T Inness, Tel: 01382 381631/07890290888, Email: n.p.innes@dundee.ac.uk.**

**If Nicola is unavailable, please contact the Co-Principal Investigator: Dr Zoe Marshman, Tel: 0114 2159398/07703179151, Email: z.marshman@sheffield.ac.uk.**

Please give details of the suspected serious pathology, safeguarding issue, or adverse event below.

Which of the Chief Investigator or Co-Principal Investigator did you contact?

Date you contacted the Chief Investigator/Co-Principal Investigator:

/

/

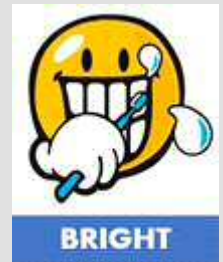
*day*

*month*

*year*

Initials of person who reported the above to the Chief Investigator/Co-Principal Investigator:

# Questionnaire about You and Your Teeth: Follow up 5 – Pilot Trial



School ID:  Participant ID:

Please fill in TODAY's date:  /  /   
*day month year*

If you have a new mobile number and have ever received text messages about toothbrushing, and want to continue receiving them, please text your old mobile number and new mobile number to the BRIGHT text messaging service: 07537 416 903.

## Instructions

Thanks for taking part in our study. You recently completed a questionnaire for us and we would like you to complete this questionnaire for us as well:

- ☺ Answer all the questions in this booklet
- ☺ Remember that there are no right or wrong answers, we just want to know what you think and what matters to you
- ☺ Please hand this booklet back to the local research team member

The first set of questions ask about **your teeth and toothbrushing**. For each question, read all the options and choose which one is most like you.

Then put a cross in the box next to it  like this. Only cross **ONE** box for each question.

### Example question

Here's one we've done, to show you:

How much of a problem are your teeth for you?

Not at all

A bit

A lot

My teeth are a bit of a problem so I would put a cross in this box...

Now think about and answer the questions below.

1. How much of a problem are your teeth for you?
  - Not at all
  - A bit
  - A lot
  
2. How do you feel about the way your teeth look?
  - I feel very happy
  - I feel a bit happy
  - I don't feel happy or unhappy
  - I feel a bit unhappy
  - I feel very unhappy
  
3. How often do you usually brush your teeth?
  - More than three times a day
  - Three times a day
  - Twice a day
  - Once a day
  - Less than once a day
  - Never
  
4. I know how to brush my teeth properly
  - Not at all true
  - Not true
  - True
  - Definitely true
  
5. If I brush my teeth twice every day then my teeth will look clean when talking to friends
  - Not at all true
  - Not true
  - True
  - Definitely true
  
6. If I brush my teeth twice every day then my teeth will be healthy
  - Not at all true
  - Not true
  - True
  - Definitely true
  
7. If I brush my teeth twice every day then my teeth will feel good
  - Not at all true
  - Not true
  - True
  - Definitely true

8. If I don't brush my teeth twice every day, I risk getting tooth decay

- Not at all true
- Not true
- True
- Definitely true

9. If I don't brush my teeth twice every day, I risk my teeth looking dirty

- Not at all true
- Not true
- True
- Definitely true

10. If I don't brush my teeth twice every day, I might have bad breath

- Not at all true
- Not true
- True
- Definitely true

11. How often do you want to brush your teeth?

- More than three times a day
- Three times a day
- Twice a day
- Once a day
- Less than once a day
- Never

12. I have a plan of how I will make myself brush when I find myself not brushing properly

- Not at all true
- Not true
- True
- Definitely true

13. I know where and when I will brush my teeth in the **morning**

- Not at all true
- Not true
- True
- Definitely true

14. I know where and when I will brush my teeth in the **evening**

- Not at all true
- Not true
- True
- Definitely true

**You're half way through - thank you for taking part in BRIGHT!**



These questions ask about you and **your teeth**. For each question, read all the choices and decide which one is most like you.

15. How much do your teeth hurt you?

- Not at all
- A bit
- A lot

16. Do your teeth make it hard to eat some foods?

- Not at all
- A bit
- A lot

17. Do you have to eat on one side of your mouth because of your teeth?

- Not at all
- A bit
- A lot

18. Do you get food stuck in your teeth?

- Not at all
- A bit
- A lot

19. How much do you get kept awake by your teeth?

- Not at all
- A bit
- A lot

20. How much do your teeth annoy you?

- Not at all
- A bit
- A lot

21. How much do your teeth hurt when you brush them?

- Not at all
- A bit
- A lot

22. Do you have to eat more carefully because of your teeth?

- Not at all
- A bit
- A lot

23. Do you have to eat more slowly because of your teeth?

- Not at all
- A bit
- A lot

24. Do you feel cross because of your teeth?

- Not at all
- A bit
- A lot

25. How much have you cried because of your teeth?

- Not at all
- A bit
- A lot

26. Do your teeth make it hard to do your schoolwork?

- Not at all
- A bit
- A lot

These questions ask about how you are **TODAY**. For each question, read all the choices and decide which one is most like you **TODAY**.

27. Worried

- I don't feel worried today
- I feel a little bit worried today
- I feel a bit worried today
- I feel quite worried today
- I feel very worried today

28. Sad

- I don't feel sad today
- I feel a little bit sad today
- I feel a bit sad today
- I feel quite sad today
- I feel very sad today

29. Pain

- I don't have any pain today
- I have a little bit of pain today
- I have a bit of pain today
- I have quite a lot of pain today
- I have a lot of pain today

30. Tired

- I don't feel tired today
- I feel a little bit tired today
- I feel a bit tired today
- I feel quite tired today
- I feel very tired today

31. Annoyed

- I don't feel annoyed today
- I feel a little bit annoyed today
- I feel a bit annoyed today
- I feel quite annoyed today
- I feel very annoyed today

32. School work/ Homework (such as reading, writing, doing lessons)

- I have no problems with my schoolwork/homework today
- I have a few problems with my schoolwork/homework today
- I have some problems with my schoolwork/homework today
- I have many problems with my schoolwork/homework today
- I can't do my schoolwork/homework today

33. Sleep

- Last night I had no problems sleeping
- Last night I had a few problems sleeping
- Last night I had some problems sleeping
- Last night I had many problems sleeping
- Last night I couldn't sleep at all

34. Daily routine (things like eating, having a bath/shower, getting dressed)

- I have no problems with my daily routine today
- I have a few problems with my daily routine today
- I have some problems with my daily routine today
- I have many problems with my daily routine today
- I can't do my daily routine today

35. Able to join in activities (things like playing out with your friends, doing sports, joining in things)

- I can join in with any activities today
- I can join in with most activities today
- I can join in with some activities today
- I can join in with a few activities today
- I can join in with no activities today

**Thank you very much for answering all these questions**



School ID:  Participant ID:

**Local Research Team member, please complete:**

Reason for questionnaire non-completion	Please cross one box only
Absent	<input type="checkbox"/>
No longer at the school	<input type="checkbox"/>
Declined to complete this questionnaire	<input type="checkbox"/>

Date this section was completed:  /  /   
*day month year*



# Parent/Carer Resource Use Questionnaire: Follow Up 5 - Pilot Trial

Dear Parent/Carer,

Please could you answer the following questions which ask about your child's dental visits in the last 12 months?

For any options that apply to your child, please put a cross in the box next to it like this.

Please fill in TODAY's date:

/   /

*day month year*

1. Not including any school dental clinics, has your child attended any dental appointments in the last 12 months? *(Please cross one box)*

Yes  How many times?

Which dental practice did your child last attend? **[Scotland only]**

No  *(Go straight to Question 4)*

2. For each appointment in the last 12 months, please tell us the following:

	Appointment 1	Appointment 2	Appointment 3	Appointment 4
What happened at the appointment? <i>(cross all that apply)</i>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <input style="width: 100%; height: 30px;" type="text"/>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <input style="width: 100%; height: 30px;" type="text"/>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <input style="width: 100%; height: 30px;" type="text"/>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <input style="width: 100%; height: 30px;" type="text"/>
Did your child have a general anaesthetic (sent to sleep at a hospital for dental treatment)?	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No

3. For the most recent appointment, please tell us the following:

How many minutes did the appointment take (including travel time)?    *minutes*

How many miles did you have to travel to the appointment?    *miles*

How did you travel there?  Car  By foot  Taxi  Bus  Train

Did you have to take time off paid work?  Yes  No

If 'Yes', how many hours did you have to take off work?   .  *hours*

4. In the past 12 months, has your child taken any **prescribed** (by a doctor or dentist) medicines for tooth related problems?

Yes **What was the medicine?**

**How many times in the last 12 months?**

Pain killers (e.g. Calpol, Ibuprofen)

--	--	--

Antibiotics

--	--	--

Other (*please specify*)

--

--	--	--

No

5. In the past 12 months, have you treated your child yourself (without going to the dentist/doctor) for tooth related problems?

Yes **How did you treat them?**

**How many times in the last 12 months?**

Pain killers (e.g. Calpol, Ibuprofen)

--	--	--

Antibiotics

--	--	--

Other (*please specify*)

--

--	--	--

No

6. Approximately how many days has your child had off school in the last 12 months due to dental problems and/or dental visits? If none, please write '0'

		.		days
--	--	---	--	------

7. In the past 12 months, did you or another carer need to take time off paid work or find yourself unable to undertake normal daily activities because of your child's dental problems? (This is in addition to the hours you may have listed in question 3 for dental appointments)

Yes  How many hours? 

		.	
--	--	---	--

No

8. What is the occupation (job/work) of the child's main parent(s) or carer(s)?

--

**Thank you very much**

*For office use only*

School ID:

Participant ID:

Date questionnaire sent:  /  /   
*day month year*



## Young Person Dental Assessment: Follow Up 6 – Pilot Trial

<b>School ID:</b> <input style="width: 40px; height: 25px;" type="text"/> <input style="width: 40px; height: 25px;" type="text"/>	<b>Participant ID:</b> <input style="width: 25px; height: 25px;" type="text"/> <input style="width: 25px; height: 25px;" type="text"/> <input style="width: 25px; height: 25px;" type="text"/> <input style="width: 25px; height: 25px;" type="text"/> <input style="width: 25px; height: 25px;" type="text"/> <input style="width: 25px; height: 25px;" type="text"/>
---	--

<b>To be completed by the dental assessor:</b>	
Date of completion:	<input style="width: 30px; height: 25px;" type="text"/> / <input style="width: 30px; height: 25px;" type="text"/> / <input style="width: 40px; height: 25px;" type="text"/> <small style="display: block; text-align: center;">day                      month                      year</small>
Name of Dental Nurse:	
Name of Dental Assessor:	
Signature of person completing form:	

<b>Reason for dental assessment non-completion</b> <i>(Please cross one box only)</i>		
<input type="checkbox"/> <b>Absent</b>	<input type="checkbox"/> <b>No longer at school</b>	<input type="checkbox"/> <b>Declined dental assessment</b>

**Please carefully read the accompanying Completion Instructions,  
and complete this assessment questionnaire alongside these.**



## Plaque Scores

Upper arch	Buccal surface score	Palatal surface score
17	<input type="text"/>	<input type="text"/>
16	<input type="text"/>	<input type="text"/>
15	<input type="text"/>	<input type="text"/>
14	<input type="text"/>	<input type="text"/>
13	<input type="text"/>	<input type="text"/>
12	<input type="text"/>	<input type="text"/>
11	<input type="text"/>	<input type="text"/>
21	<input type="text"/>	<input type="text"/>
22	<input type="text"/>	<input type="text"/>
23	<input type="text"/>	<input type="text"/>
24	<input type="text"/>	<input type="text"/>
25	<input type="text"/>	<input type="text"/>
26	<input type="text"/>	<input type="text"/>
27	<input type="text"/>	<input type="text"/>

Lower arch	Buccal surface score	Lingual surface score
37	<input type="text"/>	<input type="text"/>
36	<input type="text"/>	<input type="text"/>
35	<input type="text"/>	<input type="text"/>
34	<input type="text"/>	<input type="text"/>
33	<input type="text"/>	<input type="text"/>
32	<input type="text"/>	<input type="text"/>
31	<input type="text"/>	<input type="text"/>
41	<input type="text"/>	<input type="text"/>
42	<input type="text"/>	<input type="text"/>
43	<input type="text"/>	<input type="text"/>
44	<input type="text"/>	<input type="text"/>
45	<input type="text"/>	<input type="text"/>
46	<input type="text"/>	<input type="text"/>
47	<input type="text"/>	<input type="text"/>

## Bleeding Scores

Tooth	Buccal (1, 0, X)	Palatal/lingual (1, 0, X)
16	<input type="text"/>	<input type="text"/>
12	<input type="text"/>	<input type="text"/>
11	<input type="text"/>	<input type="text"/>
26	<input type="text"/>	<input type="text"/>
36	<input type="text"/>	<input type="text"/>
32	<input type="text"/>	<input type="text"/>
31	<input type="text"/>	<input type="text"/>
46	<input type="text"/>	<input type="text"/>



Is the young person wearing an orthodontic appliance?

	Upper arch	Lower arch
No appliance	<input type="checkbox"/>	<input type="checkbox"/>
Fixed orthodontic appliance	<input type="checkbox"/>	<input type="checkbox"/>
Removable orthodontic appliance*	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify for each arch)	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>

\*If the young person was wearing a removable orthodontic appliance, was it removed during the dental assessment?  Yes  No

Did you become unblinded to the child's randomisation group (intervention or control) during the examination?  Yes  No

### Important Information

**In the event of a serious pathology, safeguarding issue or adverse event being suspected, please immediately contact the Chief Investigator: Professor Nicola P T Innes, Tel: 01382 381631/07890290888, Email: n.p.innes@dundee.ac.uk. If Nicola is unavailable, please contact the Co-Principal Investigator: Professor Zoe Marshman, Tel: 0114 2159398/07703179151, Email: z.marshman@sheffield.ac.uk.**

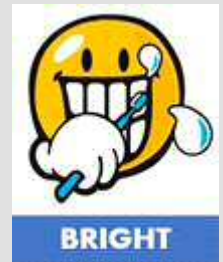
Please give details of the suspected serious pathology, safeguarding issue, or adverse event below.

Which of the Chief Investigator or Co-Principal Investigator did you contact?

Date you contacted the Chief Investigator/Co-Principal Investigator:  /  /   
*day month year*

Initials of person who reported the above to the Chief Investigator/Co-Principal Investigator:

# Questionnaire about You and Your Teeth: Follow up 6 – Pilot Trial



School ID:  Participant ID:

Please fill in TODAY's date:  /  /   
*day month year*

If you have a new mobile number and have ever received text messages about toothbrushing, and want to continue receiving them, please text your old mobile number and new mobile number to the BRIGHT text messaging service: 07537 416 903.



## Instructions

Thanks for taking part in our study. You recently completed a questionnaire for us and we would like you to complete this questionnaire for us as well:

- ☺ Answer all the questions in this booklet
- ☺ Remember that there are no right or wrong answers, we just want to know what you think and what matters to you
- ☺ Please hand this booklet back to the local research team member

The first set of questions ask about **your teeth and toothbrushing**. For each question, read all the options and choose which one is most like you.

Then put a cross in the box next to it  like this. Only cross **ONE** box for each question.

### Example question

Here's one we've done, to show you:

How much of a problem are your teeth for you?

Not at all

A bit

A lot

My teeth are a bit of a problem so I would put a cross in this box...

Now think about and answer the questions below.

1. How much of a problem are your teeth for you?
  - Not at all
  - A bit
  - A lot
  
2. How do you feel about the way your teeth look?
  - I feel very happy
  - I feel a bit happy
  - I don't feel happy or unhappy
  - I feel a bit unhappy
  - I feel very unhappy
  
3. How often do you usually brush your teeth?
  - More than three times a day
  - Three times a day
  - Twice a day
  - Once a day
  - Less than once a day
  - Never
  
4. I know how to brush my teeth properly
  - Not at all true
  - Not true
  - True
  - Definitely true
  
5. If I brush my teeth twice every day then my teeth will look clean when talking to friends
  - Not at all true
  - Not true
  - True
  - Definitely true
  
6. If I brush my teeth twice every day then my teeth will be healthy
  - Not at all true
  - Not true
  - True
  - Definitely true
  
7. If I brush my teeth twice every day then my teeth will feel good
  - Not at all true
  - Not true
  - True
  - Definitely true

8. If I don't brush my teeth twice every day, I risk getting tooth decay

- Not at all true
- Not true
- True
- Definitely true

9. If I don't brush my teeth twice every day, I risk my teeth looking dirty

- Not at all true
- Not true
- True
- Definitely true

10. If I don't brush my teeth twice every day, I might have bad breath

- Not at all true
- Not true
- True
- Definitely true

11. How often do you want to brush your teeth?

- More than three times a day
- Three times a day
- Twice a day
- Once a day
- Less than once a day
- Never

12. I have a plan of how I will make myself brush when I find myself not brushing properly

- Not at all true
- Not true
- True
- Definitely true

13. I know where and when I will brush my teeth in the **morning**

- Not at all true
- Not true
- True
- Definitely true

14. I know where and when I will brush my teeth in the **evening**

- Not at all true
- Not true
- True
- Definitely true

**You're half way through - thank you for taking part in BRIGHT!**



These questions ask about you and **your teeth**. For each question, read all the choices and decide which one is most like you.

15. How much do your teeth hurt you?

- Not at all
- A bit
- A lot

16. Do your teeth make it hard to eat some foods?

- Not at all
- A bit
- A lot

17. Do you have to eat on one side of your mouth because of your teeth?

- Not at all
- A bit
- A lot

18. Do you get food stuck in your teeth?

- Not at all
- A bit
- A lot

19. How much do you get kept awake by your teeth?

- Not at all
- A bit
- A lot

20. How much do your teeth annoy you?

- Not at all
- A bit
- A lot

21. How much do your teeth hurt when you brush them?

- Not at all
- A bit
- A lot

22. Do you have to eat more carefully because of your teeth?

- Not at all
- A bit
- A lot

23. Do you have to eat more slowly because of your teeth?

- Not at all
- A bit
- A lot

24. Do you feel cross because of your teeth?

- Not at all
- A bit
- A lot

25. How much have you cried because of your teeth?

- Not at all
- A bit
- A lot

26. Do your teeth make it hard to do your schoolwork?

- Not at all
- A bit
- A lot

These questions ask about how you are **TODAY**. For each question, read all the choices and decide which one is most like you **TODAY**.

27. Worried

- I don't feel worried today
- I feel a little bit worried today
- I feel a bit worried today
- I feel quite worried today
- I feel very worried today

28. Sad

- I don't feel sad today
- I feel a little bit sad today
- I feel a bit sad today
- I feel quite sad today
- I feel very sad today

29. Pain

- I don't have any pain today
- I have a little bit of pain today
- I have a bit of pain today
- I have quite a lot of pain today
- I have a lot of pain today

30. Tired

- I don't feel tired today
- I feel a little bit tired today
- I feel a bit tired today
- I feel quite tired today
- I feel very tired today

31. Annoyed

- I don't feel annoyed today
- I feel a little bit annoyed today
- I feel a bit annoyed today
- I feel quite annoyed today
- I feel very annoyed today

32. School work/ Homework (such as reading, writing, doing lessons)

- I have no problems with my schoolwork/homework today
- I have a few problems with my schoolwork/homework today
- I have some problems with my schoolwork/homework today
- I have many problems with my schoolwork/homework today
- I can't do my schoolwork/homework today

33. Sleep

- Last night I had no problems sleeping
- Last night I had a few problems sleeping
- Last night I had some problems sleeping
- Last night I had many problems sleeping
- Last night I couldn't sleep at all

34. Daily routine (things like eating, having a bath/shower, getting dressed)

- I have no problems with my daily routine today
- I have a few problems with my daily routine today
- I have some problems with my daily routine today
- I have many problems with my daily routine today
- I can't do my daily routine today

35. Able to join in activities (things like playing out with your friends, doing sports, joining in things)

- I can join in with any activities today
- I can join in with most activities today
- I can join in with some activities today
- I can join in with a few activities today
- I can join in with no activities today

**Thank you very much for answering all these questions**



School ID:   Participant ID:

**Local Research Team member, please complete:**

Reason for questionnaire non-completion	Please cross one box only
Absent	<input type="checkbox"/>
No longer at the school	<input type="checkbox"/>
Declined to complete this questionnaire	<input type="checkbox"/>

Date this section was completed:   /   /      
*day month year*



# Parent/Carer Resource Use Questionnaire: Follow Up 6 - Pilot Trial

Dear Parent/Carer,

Please could you answer the following questions which ask about your child's dental visits in the last 12 months?

For any options that apply to your child, please put a cross in the box next to it like this.

Please fill in TODAY's date:

/   /

*day month year*

1. Not including any school dental clinics, has your child attended any dental appointments in the last 12 months? *(Please cross one box)*

Yes  How many times?

Which dental practice did your child last attend? **[Scotland only]**

No  *(Go straight to Question 4)*

2. For each appointment in the last 12 months, please tell us the following:

	Appointment 1	Appointment 2	Appointment 3	Appointment 4
What happened at the appointment?  <i>(cross all that apply)</i>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Check-up <input type="checkbox"/> Filling <input type="checkbox"/> Extraction (tooth removed) <input type="checkbox"/> Other (please specify): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Did your child have a general anaesthetic (sent to sleep at a hospital for dental treatment)?	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No

3. For the most recent appointment, please tell us the following:

How many minutes did the appointment take (including travel time)?    *minutes*

How many miles did you have to travel to the appointment?    *miles*

How did you travel there?  Car  By foot  Taxi  Bus  Train

Did you have to take time off paid work?  Yes  No

If 'Yes', how many hours did you have to take off work?   .  *hours*

4. In the past 12 months, has your child taken any **prescribed** (by a doctor or dentist) medicines for tooth related problems?

Yes **What was the medicine?**

**How many times in the last 12 months?**

Pain killers (e.g. Calpol, Ibuprofen)

--	--	--

Antibiotics

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Other (*please specify*)

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No

5. In the past 12 months, have you treated your child yourself (without going to the dentist/doctor) for tooth related problems?

Yes **How did you treat them?**

**How many times in the last 12 months?**

Pain killers (e.g. Calpol, Ibuprofen)

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Antibiotics

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Other (*please specify*)

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No

6. Approximately how many days has your child had off school in the last 12 months due to dental problems and/or dental visits? If none, please write '0'

		.		days
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7. In the past 12 months, did you or another carer need to take time off paid work or find yourself unable to undertake normal daily activities because of your child's dental problems? (This is in addition to the hours you may have listed in question 3 for dental appointments)

Yes  How many hours? 

		.	
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No

8. What is the occupation (job/work) of the child's main parent(s) or carer(s)?

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**Thank you very much**

*For office use only*

School ID:

Participant ID:

Date questionnaire sent:  /  /   
*day month year*