ARCHIE

The early use of Antibiotics in at Risk Children with InfluEnza

__ __ __ / __ __ __ __

**ARCHIE ID**

**WEEK 2 FOLLOW-UP**

**Questions for participant's parent/guardian - to be completed by healthcare professional or research assistant at week 2 telephone consultation (can be done from day 14 to day 17 inclusive).**

1. Date of study entry (day 1) | D | D | M | M | Y | Y | Y | Y |

2. Date week 2 follow-up form completed | D | D | M | M | Y | Y | Y | Y |

3. **Contacted parent/guardian?** **YES** ☐ **NO** ☐

*If **Yes,** proceed to question 4. If **NO**, go directly to question 11.*

***During the last week:***

*4.* Has the parent/guardian completed the week 2 diary?
*If **NO**, please remind them to **complete and return** week 2 study diary* **YES** ☐ **NO** ☐

5. Have you and your child had to seek medical advice because of your child's flu-like illness or complications of this (e.g. chest infection, ear infection)? **YES*** ☐ **NO** ☐
*If **YES**, please remind parent to note these occasions in their ARCHIE study diary.*

6. Has your child had to stay in hospital for one or more nights for ANY reason? **YES*** ☐ **NO** ☐
*If **YES**, please remind parent to note these occasions in their ARCHIE study diary. Site to complete a **Serious Adverse Event** form.*

7. Has your child had any of the following side-effects from his or her study medication? **YES*** ☐ **NO** ☐
*If **YES**, please tick all that apply:*

Diarrhoea ☐ Vomiting ☐ Nausea ☐ Thrush ☐

*8.* Has your child had any new unexpected symptoms or illnesses since entering the study? *If **YES**, please tick all that apply:* **YES*** ☐ **NO** ☐

*Skin rash* ☐ *Other (please specify)* ☐ _____

***If you have answered 'YES' to ANY of the above questions (5 to 8) please see guidance on back of bottom copy for further reporting requirements.***

9. Does your child still have a fever? *If **NO**, when was the last day your child was feverish?*
Date (dd/mm/yyyy): _____ Time: _____ am/pm (delete as appropriate) **YES** ☐ **NO** ☐

Temp that day if known:

**ONLY ASK Q10 AT WEEK 2 CALL IF WEEK 1 CALL NOT COMPLETED.**

10. Did your child take all 10 doses of his/her study medication? If ***NO**, number of doses taken: _____ doses* **YES** ☐ **NO** ☐

*Decision to stop study medication made by (circle as appropriate):*
*Parent or guardian / healthcare professional/child*

**N/A Week 1 Call Completed** ☐

*Reason for stopping study medication(circle as appropriate):*
*Did not tolerate study medication / other (please specify):*

11. Print Name: _____ Sign: _____ Date: _____

**Please return TOP copy to Oxford PC CTU in reply envelope provided and file BOTTOM copy in ISF**