ARCHIE

The early use of Antibiotics in at Risk Children with InfluEnza

__ __ __ / __ __ __ __

ARCHIE ID

WEEK 1 FOLLOW-UP

Questions for participant's parent/guardian - to be completed by healthcare professional or research assistant at week 1 telephone consultation (can be done from day 7 to day 10 inclusive).

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

2. Date week 1 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 1 diary?
*If **NO**, please remind them to **complete and return** week 1 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?* **YES** ☐ **NO** ☐

Date (dd/mm/yyyy): _____ Time: _____ am/pm (delete as appropriate)

Temp that day if known: _____

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

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

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