Dear Parent or Guardian,

You are invited to participate in a brief survey for the Prevention of Adverse Vaccine Effects (PAVE) study. This study is being conducted by the Kaiser Permanente Center for Health Research and is sponsored by the National Vaccine Program Office.

This consent statement describes the study to help you decide if you want to participate or if you want your child to participate. In this consent statement, we use the word "you" to mean either yourself or your child.

This survey asks about vaccinations your child may have experienced at a recent visit at Kaiser Permanente. This survey will take approximately 5-10 minutes to complete. As a thank you, we will send you a $10.00 gift card to Starbucks after you complete this survey.

There are no foreseeable risks for your taking part in this study. You may or may not directly benefit from participating in this research study but the information you provide may help improve medical and dental care for children in the future.

Kaiser Permanente is committed to protecting your personal health information. State and federal laws also require Kaiser Permanente to maintain the privacy and security of your information in this study. Every reasonable effort will be made to keep your records confidential, such as storing your private information in a secure location where only authorized persons will have access to it. To protect your confidentiality and whenever possible, we will use an assigned number instead of your name. Any study data that presented or published in the future will not personally identify you or your child.

If you have questions about your rights as a research subject, or have questions about research-related injuries, or want to contact the Institutional Review Board (IRB), call the Director of Research Compliance at 503-335-6725.

If you have any questions about this study in general, contact the Principal Investigator: Allison Naleway, PhD, Kaiser Permanente Center for Health Research, 3800 N. Interstate Ave, Portland, OR, 97227. Telephone: 503-335-6352.

You do not have to participate in this research study, and, if you do, you can quit at any time. If you decide not to be in this study, it will not affect your regular medical care or your health benefits.

By completing the following survey, you are agreeing to participate in the study.
Would you like to continue to the survey?

- Yes
- No
According to our records, your child recently received one or more vaccinations at a Kaiser Permanente facility. Please tell us about your child's experience while receiving their vaccination(s). Please complete the following questions to the best of your ability.

If you are not the parent or guardian who attended this visit with your child, please ask the other parent or guardian to complete the form if possible.

If your child saw their provider by herself or himself, you may ask your child to help you answer the questions.

Did you attend the recent visit during which your child received one or more vaccinations?

- Yes
- No, but I will ask the parent/guardian who attended the visit or my child to help me answer these questions
- No, but I will complete this survey to the best of my ability anyway
Please answer the following questions about how your child felt during or following her/his vaccination(s).

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
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| Did your child experience pain during or following her/his recent vaccination(s)? | Yes, my child experienced pain  
No, my child did not experience pain  
Very mild  
Mild  
Moderate  
Severe  
Very severe |
| Please describe the intensity of the pain your child felt:                |                                                                         |
|                                                                         |                                                                         |
| Did your child feel light-headed or dizzy during or after the vaccination(s)? | Yes, my child did feel light-headed or dizzy.  
No, my child did not feel light-headed or dizzy. |
| Did your child faint, 'black out', or lose consciousness during or after the vaccination(s)? | Yes, my child fainted, 'blacked out', or lost consciousness.  
No, my child did not faint, 'black out', or lose consciousness. |
| Has your child experienced any of these symptoms during or after previous vaccinations: pain, lightheadedness, dizziness, fainting, "blacking out", or loss of consciousness? | Yes  
No |
| If yes, which symptoms has your child experienced during or after past vaccinations? (PLEASE CHECK ALL THAT APPLY) | Pain  
Light-headedness or dizziness  
Fainting, 'blacking out', or loss of consciousness |
| During your visit, did your medical assistant, nurse, or doctor talk to you about possible pain, dizziness, or fainting related to vaccination? | Yes  
No |
| If yes, which symptoms did your medical provider talk to you about? (PLEASE CHECK ALL THAT APPLY) | Pain  
Light-headedness or dizziness  
Fainting, "blacking out" or loss of consciousness |
| After your child's vaccination(s), did your medical assistant/nurse/doctor ask your child to sit and rest for a few minutes? | Yes  
No |
We would now like to hear more about your experience during your most recent vaccination visit.

Was your child offered a "comfort menu" during their vaccination visit?
- Yes
- No

Who offered the comfort menu to your child?
- Medical assistant
- Nurse
- Doctor
- Other

If "Other", please describe:
__________________________________

When was the comfort menu offered to your child?
- At the beginning of the visit
- Right before vaccination(s)
- Other

If "Other", please describe:
__________________________________

Did your child select one or more comfort items from the menu?
- Yes
- No

Which comfort item(s) did your child select? (PLEASE CHECK ALL THAT APPLY)
- Water or juice
- Snack
- Warm blanket
- Squeeze ball
- Earbuds
- Pinwheel
- Shotblocker (plastic disk used during vaccination)
- Cold pack
- Self care information sheet (tips for post-vaccination)
- Other

If "Other", please describe:
__________________________________

Do you feel that the comfort item improved the vaccination experience, as compared to earlier vaccination visits?
- Yes, the item was very helpful
- Yes, the item was somewhat helpful
- Neither helpful or unhelpful
- No, the item was not helpful
Now we would like to ask a few questions about YOU. Please note that the remaining questions are about YOU (the parent or guardian) and NOT your child.

What is your sex?
- Male
- Female

What is your age?
__________________________________ (Years)

Are you of Hispanic, Latino, or Spanish origin?
- Yes
- No

Which category best describes your race?
- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Pacific Islander
- Other

If "Other", please specify:
__________________________________

What is the highest level of schooling you have completed? If you are currently enrolled in school, mark the previous grade or highest degree received.
- Less than 12 years of education
- High school graduate or equivalent
- Some college credit, no degree
- Associate's degree
- Bachelor's degree
- Master's degree
- Doctorate degree

What is your total household income?
- Less than $20,000
- $20,000 to $39,999
- $40,000 to $59,999
- $60,000 to $79,999
- $80,000 to $99,999
- $100,000 to $149,999
- $150,000 or more