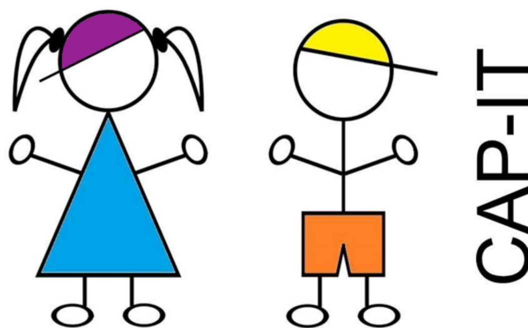
CAP-IT Symptom Diary for Parents/Guardians



To be completed by CAP-IT team:

CAP-IT Trial ID: ______________________

Day of study entry (day 1):

Day of week ______________

Date (dd/mm/yyyy) _ _/_ _/_ _ _ _

Time of first dose:

_ _ : _ _ am/pm *(delete as appropriate e.g. 08:30 am/~~pm~~)*

Important information:

Please **do not** give your child more than 14 doses of study medication.

Please keep all bottles of study medication (even if empty) in a safe place and return them to the study nurse when you visit at week 4.

CAP-IT Symptom Diary Contents

Week	Day	Contents	Follow-up schedule
Week 1	Days 1-7	• Symptoms and side effects • Your child's wellbeing • CAP-IT trial medication • Other medicines	**Telephone call (day 4)** Date: __ __/__ __/__ __ __ __ Time: _ _ : _ _ am/pm
	Day 7	• Daily activities and childcare • Other help	
Week 2	Days 8-14	• Symptoms and side effects • Your child's wellbeing	**Telephone call (day 8)** Date: __ __/__ __/__ __ __ __ Time: _ _ : _ _ am/pm
	Day 14	• Other medicines • Daily activities and childcare • Other help	
Week 3	Day 15		**Telephone call (day 15)** Date: __ __/__ __/__ __ __ __ Time: _ _ : _ _ am/pm
Week 4	Day 22		**Telephone call (day 22)** Date: __ __/__ __/__ __ __ __ Time: _ _ : _ _ am/pm
	Day 29		**Final clinic visit (day 29)** Date: __ __/__ __/__ __ __ __ Time: _ _ : _ _ am/pm

Please bring this Symptom Diary with you to
your week 4 visit. Thank you!

CAP-IT Symptom Diary Instructions

- Please complete the diary every day for a total of 13 days.
- Day 1 is the day your child enters the CAP-IT study, your diary begins on day 2.
- If any doses of study medication are missed, please record this on days 2-8:
  - ⇒ If your child's first dose of study medication was in the morning, treatment will be completed in the evening of day 7.
  - ⇒ If your child's first dose of study medication was in the evening, treatment will be completed in the morning of day 8.
- The diary should be completed in the evening based on how your child has been in the last 24 hours, but if you forget, please fill it in as soon as possible.
- Your research nurse will contact you by phone on days 4, 8, 15 and 22. You will be asked about the symptom diary at these calls so please make sure you have it with you during the call.
- When you visit the research nurse on day 29, please make sure that you have completed all the questions and bring your symptom diary with you to the visit.
- You will be given a booklet with examples of how to complete the questionnaire, please refer to this if you are unsure on any of the questions.
- Your research nurse will also be able to help if you have any problems with the diary.

CAP-IT Symptom Diary Day 2

Date of completion (dd / mm / yyyy) __ __ / __ __ / __ __ __ __

Time of completion (e.g. 8:30 ~~am~~/pm): __:__ am/pm (delete as appropriate)

A. Symptoms and side effects

Have a look at the table below with symptoms of pneumonia and possible side effects of amoxicillin treatment.

Please indicate how much of a problem each has been for your child today, if at all.

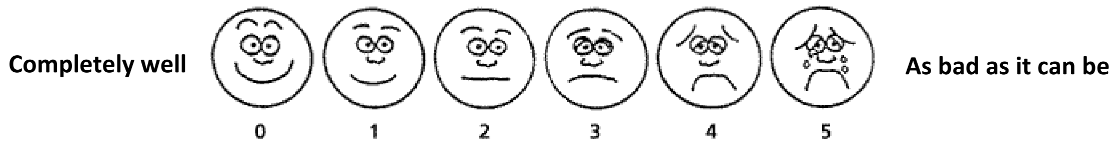
Tick ONE box per symptom listed to indicate its severity.

CAP Symptoms **Tick ONE box for each symptom**	**Not present**	**Slight / little**	**Moderate**	**Bad**	**Severe / very bad**
Fever (hot to touch, compared to normal, or had a temperature recording of more than 38°C on a thermometer)					
Cough					
Wet cough (phlegm)					
Breathing faster (shortness of breath)					
Wheeze					
Sleep disturbed by cough					
Vomiting (including after cough)					
Eating/drinking less					
Interference with normal activity					
Skin rash					
Oral thrush					
Diarrhoea					

B. Your child's wellbeing - please tell us how unwell your child has been today

Please circle the face that indicates how unwell you consider your child to have been over the past 24 hours.

Completely well



As bad as it can be

C. Your child's CAP-IT trial medication

Were any doses missed today? Yes ☐ No ☐ If 'Yes' which dose? AM ☐ PM ☐ AM & PM ☐

If any doses were missed, please confirm why:

Child had problems taking trial medication Yes ☐ No ☐

Forgot Yes ☐ No ☐

Problem with side effects Yes ☐ No ☐

Other Yes ☐ No ☐ If 'other' specify:____

D. Other medicines

Has your child taken any medication other than trial medication? Yes ☐ No ☐

If 'Yes' please complete the following questions:

Has your child taken any anti-fever medication today (e.g. calpol)? Yes ☐ No ☐

Has your child taken any anti-cough medication today? Yes ☐ No ☐

Has your child been started on antibiotics today other than those dispensed at the start of CAP-IT? Yes ☐ No ☐

CAP-IT Symptom Diary Day 3

Date of completion (dd / mm / yyyy) __ __ / __ __ / __ __ __ __

Time of completion (e.g. 8:30 ~~am~~/pm): __:__ am/pm (delete as appropriate)

A. Symptoms and side effects

Have a look at the table below with symptoms of pneumonia and possible side effects of amoxicillin treatment.

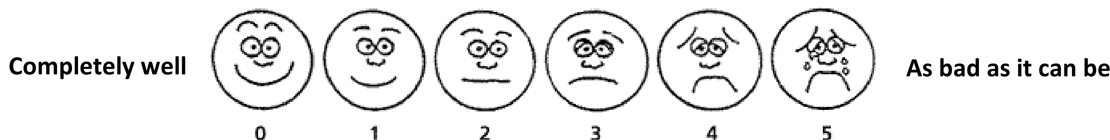
Please indicate how much of a problem each has been for your child today, if at all.

Tick ONE box per symptom listed to indicate its severity.

CAP Symptoms **Tick ONE box for each symptom**	**Not present**	**Slight / little**	**Moderate**	**Bad**	**Severe / very bad**
Fever (hot to touch, compared to normal, or had a temperature recording of more than 38°C on a thermometer)					
Cough					
Wet cough (phlegm)					
Breathing faster (shortness of breath)					
Wheeze					
Sleep disturbed by cough					
Vomiting (including after cough)					
Eating/drinking less					
Interference with normal activity					
Skin rash					
Oral thrush					
Diarrhoea					

B. Your child's wellbeing - please tell us how unwell your child has been today

Please circle the face that indicates how unwell you consider your child to have been over the past 24 hours.

Completely well  **As bad as it can be**

C. Your child's CAP-IT trial medication

Were any doses missed today? Yes ☐ No ☐ If 'Yes' which dose? AM ☐ PM ☐ AM & PM ☐

If any doses were missed, please confirm why:

Child had problems taking trial medication Yes ☐ No ☐

Forgot Yes ☐ No ☐

Problem with side effects Yes ☐ No ☐

Other Yes ☐ No ☐ If 'other' specify:____

D. Other medicines

Has your child taken any medication other than trial medication? Yes ☐ No ☐

If 'Yes' please complete the following questions:

Has your child taken any anti-fever medication today (e.g. calpol)? Yes ☐ No ☐

Has your child taken any anti-cough medication today? Yes ☐ No ☐

Has your child been started on antibiotics today other than those dispensed at the start of CAP-IT? Yes ☐ No ☐

CAP-IT Symptom Diary Day 4

Date of completion (dd / mm / yyyy) __ __ / __ __ / __ __ __ __

Time of completion (e.g. 8:30 ~~am~~/pm): __:__ am/pm (delete as appropriate)

A. Symptoms and side effects

Have a look at the table below with symptoms of pneumonia and possible side effects of amoxicillin treatment.

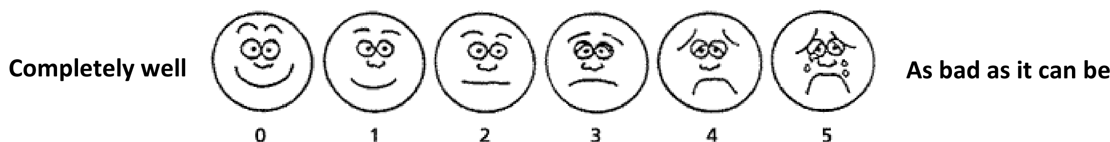
Please indicate how much of a problem each has been for your child today, if at all.

Tick ONE box per symptom listed to indicate its severity.

CAP Symptoms **Tick ONE box for each symptom**	**Not present**	**Slight / little**	**Moderate**	**Bad**	**Severe / very bad**
Fever (hot to touch, compared to normal, or had a temperature recording of more than 38°C on a thermometer)					
Cough					
Wet cough (phlegm)					
Breathing faster (shortness of breath)					
Wheeze					
Sleep disturbed by cough					
Vomiting (including after cough)					
Eating/drinking less					
Interference with normal activity					
Skin rash					
Oral thrush					
Diarrhoea					

B. Your child's wellbeing - please tell us how unwell your child has been today

Please circle the face that indicates how unwell you consider your child to have been over the past 24 hours.



C. Your child's CAP-IT trial medication

Were any doses missed today? Yes ☐ No ☐ If 'Yes' which dose? AM ☐ PM ☐ AM & PM ☐

If any doses were missed, please confirm why:

Child had problems taking trial medication Yes ☐ No ☐

Forgot Yes ☐ No ☐

Problem with side effects Yes ☐ No ☐

Other Yes ☐ No ☐ If 'other' specify:____

D. Other medicines

Has your child taken any medication other than trial medication? Yes ☐ No ☐

If 'Yes' please complete the following questions:

Has your child taken any anti-fever medication today (e.g. calpol)? Yes ☐ No ☐

Has your child taken any anti-cough medication today? Yes ☐ No ☐

Has your child been started on antibiotics today other than those dispensed at the start of CAP-IT? Yes ☐ No ☐

CAP-IT Symptom Diary Day 5

Date of completion (dd / mm / yyyy) __ __ / __ __ / __ __ __ __

Time of completion (e.g. 8:30 ~~am~~/pm): __:__ am/pm (delete as appropriate)

A. Symptoms and side effects

Have a look at the table below with symptoms of pneumonia and possible side effects of amoxicillin treatment.

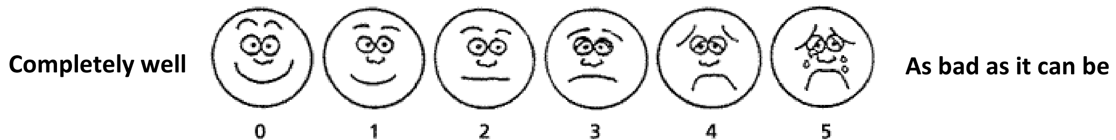
Please indicate how much of a problem each has been for your child today, if at all.

Tick ONE box per symptom listed to indicate its severity.

CAP Symptoms **Tick ONE box for each symptom**	**Not present**	**Slight / little**	**Moderate**	**Bad**	**Severe / very bad**
Fever (hot to touch, compared to normal, or had a temperature recording of more than 38°C on a thermometer)					
Cough					
Wet cough (phlegm)					
Breathing faster (shortness of breath)					
Wheeze					
Sleep disturbed by cough					
Vomiting (including after cough)					
Eating/drinking less					
Interference with normal activity					
Skin rash					
Oral thrush					
Diarrhoea					

B. Your child's wellbeing - please tell us how unwell your child has been today

Please circle the face that indicates how unwell you consider your child to have been over the past 24 hours.

Completely well  **As bad as it can be**

C. Your child's CAP-IT trial medication

Were any doses missed today? Yes ☐ No ☐ If 'Yes' which dose? AM ☐ PM ☐ AM & PM ☐

If any doses were missed, please confirm why:

Child had problems taking trial medication Yes ☐ No ☐

Forgot Yes ☐ No ☐

Problem with side effects Yes ☐ No ☐

Other Yes ☐ No ☐ If 'other' specify:____

D. Other medicines

Has your child taken any medication other than trial medication? Yes ☐ No ☐

If 'Yes' please complete the following questions:

Has your child taken any anti-fever medication today (e.g. calpol)? Yes ☐ No ☐

Has your child taken any anti-cough medication today? Yes ☐ No ☐

Has your child been started on antibiotics today other than those dispensed at the start of CAP-IT? Yes ☐ No ☐

CAP-IT Symptom Diary Day 6

Date of completion (dd / mm / yyyy) __ __ / __ __ / __ __ __ __

Time of completion (e.g. 8:30 ~~am~~/pm): __:__ am/pm (delete as appropriate)

A. Symptoms and side effects

Have a look at the table below with symptoms of pneumonia and possible side effects of amoxicillin treatment.

Please indicate how much of a problem each has been for your child today, if at all.

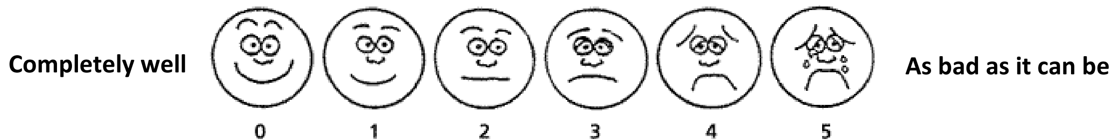
Tick ONE box per symptom listed to indicate its severity.

CAP Symptoms **Tick ONE box for each symptom**	**Not present**	**Slight / little**	**Moderate**	**Bad**	**Severe / very bad**
Fever (hot to touch, compared to normal, or had a temperature recording of more than 38°C on a thermometer)					
Cough					
Wet cough (phlegm)					
Breathing faster (shortness of breath)					
Wheeze					
Sleep disturbed by cough					
Vomiting (including after cough)					
Eating/drinking less					
Interference with normal activity					
Skin rash					
Oral thrush					
Diarrhoea					

B. Your child's wellbeing - please tell us how unwell your child has been today

Please circle the face that indicates how unwell you consider your child to have been over the past 24 hours.

Completely well



As bad as it can be

C. Your child's CAP-IT trial medication

Were any doses missed today? Yes ☐ No ☐ If 'Yes' which dose? AM ☐ PM ☐ AM & PM ☐

If any doses were missed, please confirm why:

Child had problems taking trial medication Yes ☐ No ☐

Forgot Yes ☐ No ☐

Problem with side effects Yes ☐ No ☐

Other Yes ☐ No ☐ If 'other' specify:____

D. Other medicines

Has your child taken any medication other than trial medication? Yes ☐ No ☐

If 'Yes' please complete the following questions:

Has your child taken any anti-fever medication today (e.g. calpol)? Yes ☐ No ☐

Has your child taken any anti-cough medication today? Yes ☐ No ☐

Has your child been started on antibiotics today other than those dispensed at the start of CAP-IT? Yes ☐ No ☐

CAP-IT Symptom Diary Day 7

Date of completion (dd / mm / yyyy) __ __ / __ __ / __ __ __ __

Time of completion (e.g. 8:30 ~~am~~/pm): __:__ am/pm (delete as appropriate)

A. Symptoms and side effects

Have a look at the table below with symptoms of pneumonia and possible side effects of amoxicillin treatment.

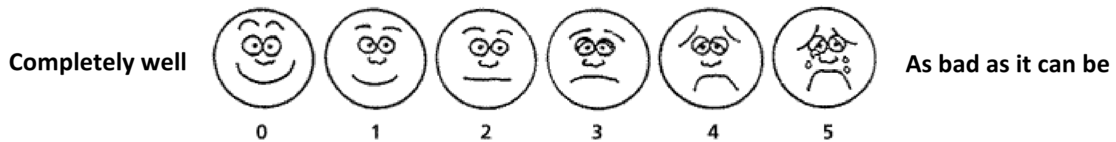
Please indicate how much of a problem each has been for your child today, if at all.

Tick ONE box per symptom listed to indicate its severity.

CAP Symptoms **Tick ONE box for each symptom**	**Not present**	**Slight / little**	**Moderate**	**Bad**	**Severe / very bad**
Fever (hot to touch, compared to normal, or had a temperature recording of more than 38°C on a thermometer)					
Cough					
Wet cough (phlegm)					
Breathing faster (shortness of breath)					
Wheeze					
Sleep disturbed by cough					
Vomiting (including after cough)					
Eating/drinking less					
Interference with normal activity					
Skin rash					
Oral thrush					
Diarrhoea					

B. Your child's wellbeing - please tell us how unwell your child has been today

Please circle the face that indicates how unwell you consider your child to have been over the past 24 hours.

Completely well  **As bad as it can be**

C. Your child's CAP-IT trial medication

Were any doses missed today? Yes ☐ No ☐ If 'Yes' which dose? AM ☐ PM ☐ AM & PM ☐

If any doses were missed, please confirm why:

Child had problems taking trial medication Yes ☐ No ☐

Forgot Yes ☐ No ☐

Problem with side effects Yes ☐ No ☐

Other Yes ☐ No ☐ If 'other' specify:____

D. Other medicines

Has your child taken any medication other than trial medication? Yes ☐ No ☐

If 'Yes' please complete the following questions:

Has your child taken any anti-fever medication today (e.g. calpol)? Yes ☐ No ☐

Has your child taken any anti-cough medication today? Yes ☐ No ☐

Has your child been started on antibiotics today other than those dispensed at the start of CAP-IT? Yes ☐ No ☐

Please remember to complete the additional Day 7 questions on the next 2 pages (Sections E, F and G).

CAP-IT Symptom Diary Day 7

E. Non-trial antibiotics

Has your child received any antibiotic treatment, other than that given as part of the CAP-IT Trial, over the **last 7 or today**?

Yes ☐ No ☐ *If 'Yes' please give details and tick each study day they took each medicine:*

Antibiotic 1	
Amoxicillin (Amoxicillin, Amoxil) ____ ☐	Start date of antibiotic 1 d d / m m / y y y y
Amoxicillin and enzyme inhibitor (Co-amoxiclav, Augmentin) ____ ☐	Ongoing? *If 'No' complete End date* Yes ☐ No ☐
Cefadroxil (Cefadroxil) ____ ☐	End date of antibiotic 1 d d / m m / y y y y
Cephalexin (Cefalexin, Ceporex, Keflex) ____ ☐	
Cefuroxime (Cefuroxime, Zinacef) ____ ☐	
Clarithromycin (Clarithromycin, Klacid) ____ ☐	
Erythromycin (Erythromycin, Erymax, Erythrocin, Erythroped) ____ ☐	
Phenoxymethylpenicillin (Phenoxymethylpenicillin = Penicillin V) ____ ☐	
Other *(please specify)*: ____ ☐	

If a second antibiotic was started please provide the details below. If not, please leave blank and move to Section F.

Antibiotic 2	
Amoxicillin (Amoxicillin, Amoxil) ____ ☐	Start date of antibiotic 2 d d / m m / y y y y
Amoxicillin and enzyme inhibitor (Co-amoxiclav, Augmentin) ____ ☐	Ongoing? *If 'No' complete End date* Yes ☐ No ☐
Cefadroxil (Cefadroxil) ____ ☐	End date of antibiotic 2 d d / m m / y y y y
Cephalexin (Cefalexin, Ceporex, Keflex) ____ ☐	
Cefuroxime (Cefuroxime, Zinacef) ____ ☐	
Clarithromycin (Clarithromycin, Klacid) ____ ☐	
Erythromycin (Erythromycin, Erymax, Erythrocin, Erythroped) ____ ☐	
Phenoxymethylpenicillin (Phenoxymethylpenicillin = Penicillin V) ____ ☐	
Other *(please specify)*: ____ ☐	

F. Daily activities and childcare

For each of the following questions, please enter the number of days in the space provided.

Please answer '0' if your answer is 'no days'.

Please circle 'not applicable' if the question does not apply to your child.

Due to your child's pneumonia or complications of this:

1. How many days in the **last 7 days** was your child unable to attend school, day care or nursery?

   __________ days / not applicable

2. If you are in paid employment, how many days in the **last 7 days** have you been unable to attend work?

   __________ days / not applicable

3. If you are not in paid employment, how many days in the **last 7 days** have you changed your usual activities (e.g. education or voluntary work)?

   __________ days / not applicable

4. On how many days in the **last 7 days** was additional outside care required for your child?

   __________ days / not applicable

CAP-IT Symptom Diary Day 7

G. Other help

Has your child used any other health services in the **last 7 days**? Yes ☐ No ☐

If 'Yes' please provide the number of times that each health service was contacted (e.g. by phone, email or text) and the number of times that each health service was visited (including GP home visits).

	Number of times contacted	**Number of times visited**
A&E / Walk-in Centres		
Out of Hours Service		
Paediatrician		
GP Practice		
Pharmacist		
NHS Direct/NHS 111		*Not applicable*
Other, if 'other' specify: ______________________		

Did your child stay at hospital overnight during the **last 7 days**? Yes ☐ No ☐

If 'Yes' please provide details below:

Number of admission	**Name of hospital**	**Reason for visit**	**Date of admission**	**Date of discharge**
1				
2				
3				

CAP-IT Symptom Diary Day 8

Date of completion (dd / mm / yyyy) __ __ / __ __ / __ __ __ __

Time of completion (e.g. 8:30 ~~am~~/pm): __:__ am/pm (delete as appropriate)

A. Symptoms and side effects

Have a look at the table below with symptoms of pneumonia and possible side effects of amoxicillin treatment.

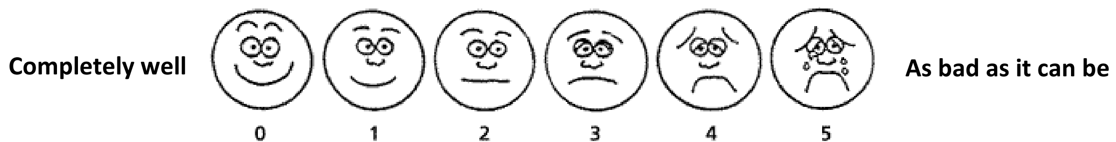
Please indicate how much of a problem each has been for your child today, if at all.

Tick ONE box per symptom listed to indicate its severity.

CAP Symptoms **Tick ONE box for each symptom**	**Not present**	**Slight / little**	**Moderate**	**Bad**	**Severe / very bad**
Fever (hot to touch, compared to normal, or had a temperature recording of more than 38°C on a thermometer)					
Cough					
Wet cough (phlegm)					
Breathing faster (shortness of breath)					
Wheeze					
Sleep disturbed by cough					
Vomiting (including after cough)					
Eating/drinking less					
Interference with normal activity					
Skin rash					
Oral thrush					
Diarrhoea					

B. Your child's wellbeing - please tell us how unwell your child has been today

Please circle the face that indicates how unwell you consider your child to have been over the past 24 hours.



C. Your child's CAP-IT trial medication (applicable if only the evening dose was given on day 1)

Was the morning dose missed today? Yes ☐ No ☐ N/A (completed trial treatment on day 7) ☐

If any doses were missed, please confirm why:

Child had problems taking trial medication Yes ☐ No ☐

Forgot Yes ☐ No ☐

Problem with side effects Yes ☐ No ☐

Other Yes ☐ No ☐ If 'other' specify:____

D. Other medicines

Has your child taken any medication other than trial medication? Yes ☐ No ☐

If 'Yes' please complete the following questions:

Has your child taken any anti-fever medication today (e.g. calpol)? Yes ☐ No ☐

Has your child taken any anti-cough medication today? Yes ☐ No ☐

Has your child been started on antibiotics today other than those dispensed at the start of CAP-IT? Yes ☐ No ☐

CAP-IT Symptom Diary Day 9

Date of completion (dd / mm / yyyy) __ __ / __ __ / __ __ __ __

Time of completion (e.g. 8:30 ~~am~~/pm): __:__ am/pm (delete as appropriate)

A. Symptoms and side effects

Have a look at the table below with symptoms of pneumonia and possible side effects of amoxicillin treatment.

Please indicate how much of a problem each has been for your child today, if at all.

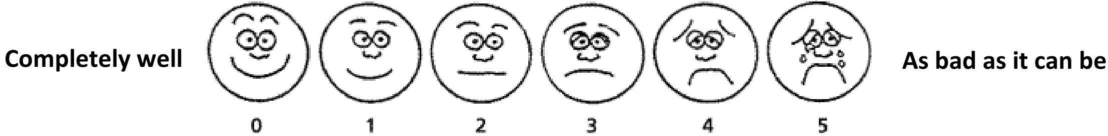
Tick ONE box per symptom listed to indicate its severity.

CAP Symptoms **Tick ONE box for each symptom**	**Not present**	**Slight / little**	**Moderate**	**Bad**	**Severe / very bad**
Fever (hot to touch, compared to normal, or had a temperature recording of more than 38°C on a thermometer)					
Cough					
Wet cough (phlegm)					
Breathing faster (shortness of breath)					
Wheeze					
Sleep disturbed by cough					
Vomiting (including after cough)					
Eating/drinking less					
Interference with normal activity					
Skin rash					
Oral thrush					
Diarrhoea					

B. Your child's wellbeing - please tell us how unwell your child has been today

Please circle the face that indicates how unwell you consider your child to have been over the past 24 hours.

Completely well



As bad as it can be

C. Other medicines

Has your child taken any medication other than trial medication? Yes ☐ No ☐

If 'Yes' please complete the following questions:

Has your child taken any anti-fever medication today (e.g. calpol)? Yes ☐ No ☐

Has your child taken any anti-cough medication today? Yes ☐ No ☐

Has your child been started on antibiotics today other than those dispensed at the start of CAP-IT? Yes ☐ No ☐

CAP-IT Symptom Diary Day 10

Date of completion (dd / mm / yyyy) __ __ / __ __ / __ __ __ __

Time of completion (e.g. 8:30 ~~am~~/pm): __:__ am/pm (delete as appropriate)

A. Symptoms and side effects

Have a look at the table below with symptoms of pneumonia and possible side effects of amoxicillin treatment.

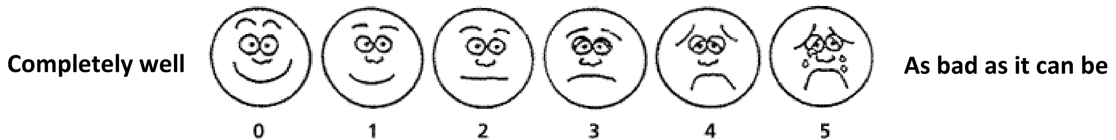
Please indicate how much of a problem each has been for your child today, if at all.

Tick ONE box per symptom listed to indicate its severity.

CAP Symptoms **Tick ONE box for each symptom**	**Not present**	**Slight / little**	**Moderate**	**Bad**	**Severe / very bad**
Fever (hot to touch, compared to normal, or had a temperature recording of more than 38°C on a thermometer)					
Cough					
Wet cough (phlegm)					
Breathing faster (shortness of breath)					
Wheeze					
Sleep disturbed by cough					
Vomiting (including after cough)					
Eating/drinking less					
Interference with normal activity					
Skin rash					
Oral thrush					
Diarrhoea					

B. Your child's wellbeing - please tell us how unwell your child has been today

Please circle the face that indicates how unwell you consider your child to have been over the past 24 hours.



C. Other medicines

Has your child taken any medication other than trial medication? Yes ☐ No ☐

If 'Yes' please complete the following questions:

Has your child taken any anti-fever medication today (e.g. calpol)? Yes ☐ No ☐

Has your child taken any anti-cough medication today? Yes ☐ No ☐

Has your child been started on antibiotics today other than those dispensed at the start of CAP-IT? Yes ☐ No ☐

CAP-IT Symptom Diary Day 11

Date of completion (dd / mm / yyyy) __ __ / __ __ / __ __ __ __

Time of completion (e.g. 8:30 ~~am~~/pm): __:__ am/pm (delete as appropriate)

A. Symptoms and side effects

Have a look at the table below with symptoms of pneumonia and possible side effects of amoxicillin treatment.

Please indicate how much of a problem each has been for your child today, if at all.

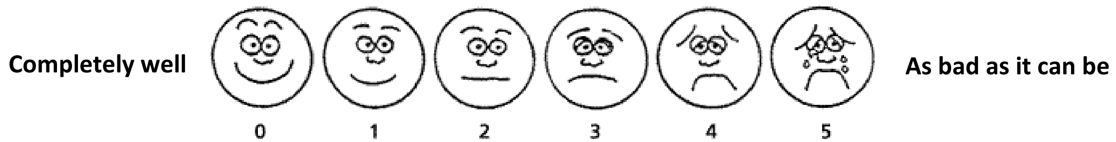
Tick ONE box per symptom listed to indicate its severity.

CAP Symptoms **Tick ONE box for each symptom**	**Not present**	**Slight / little**	**Moderate**	**Bad**	**Severe / very bad**
Fever (hot to touch, compared to normal, or had a temperature recording of more than 38°C on a thermometer)					
Cough					
Wet cough (phlegm)					
Breathing faster (shortness of breath)					
Wheeze					
Sleep disturbed by cough					
Vomiting (including after cough)					
Eating/drinking less					
Interference with normal activity					
Skin rash					
Oral thrush					
Diarrhoea					

B. Your child's wellbeing - please tell us how unwell your child has been today

Please circle the face that indicates how unwell you consider your child to have been over the past 24 hours.

Completely well



As bad as it can be

C. Other medicines

Has your child taken any medication other than trial medication? Yes ☐ No ☐

If 'Yes' please complete the following questions:

- Has your child taken any anti-fever medication today (e.g. calpol)? Yes ☐ No ☐
- Has your child taken any anti-cough medication today? Yes ☐ No ☐
- Has your child been started on antibiotics today other than those dispensed at the start of CAP-IT? Yes ☐ No ☐

CAP-IT Symptom Diary Day 12

Date of completion (dd / mm / yyyy) __ __ / __ __ / __ __ __ __

Time of completion (e.g. 8:30 ~~am~~/pm): __:__ am/pm (delete as appropriate)

A. Symptoms and side effects

Have a look at the table below with symptoms of pneumonia and possible side effects of amoxicillin treatment.

Please indicate how much of a problem each has been for your child today, if at all.

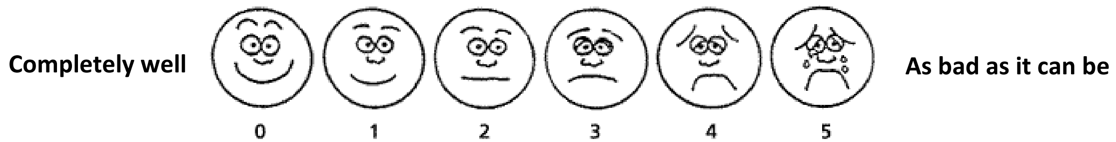
Tick ONE box per symptom listed to indicate its severity.

CAP Symptoms **Tick ONE box for each symptom**	**Not present**	**Slight / little**	**Moderate**	**Bad**	**Severe / very bad**
Fever (hot to touch, compared to normal, or had a temperature recording of more than 38°C on a thermometer)					
Cough					
Wet cough (phlegm)					
Breathing faster (shortness of breath)					
Wheeze					
Sleep disturbed by cough					
Vomiting (including after cough)					
Eating/drinking less					
Interference with normal activity					
Skin rash					
Oral thrush					
Diarrhoea					

B. Your child's wellbeing - please tell us how unwell your child has been today

Please circle the face that indicates how unwell you consider your child to have been over the past 24 hours.

Completely well



As bad as it can be

C. Other medicines

Has your child taken any medication other than trial medication? Yes ☐ No ☐

If 'Yes' please complete the following questions:

Has your child taken any anti-fever medication today (e.g. calpol)? Yes ☐ No ☐

Has your child taken any anti-cough medication today? Yes ☐ No ☐

Has your child been started on antibiotics today other than those dispensed at the start of CAP-IT? Yes ☐ No ☐

CAP-IT Symptom Diary Day 13

Date of completion (dd / mm / yyyy) __ __ / __ __ / __ __ __ __

Time of completion (e.g. 8:30 ~~am~~/pm): __:__ am/pm (delete as appropriate)

A. Symptoms and side effects

Have a look at the table below with symptoms of pneumonia and possible side effects of amoxicillin treatment.

Please indicate how much of a problem each has been for your child today, if at all.

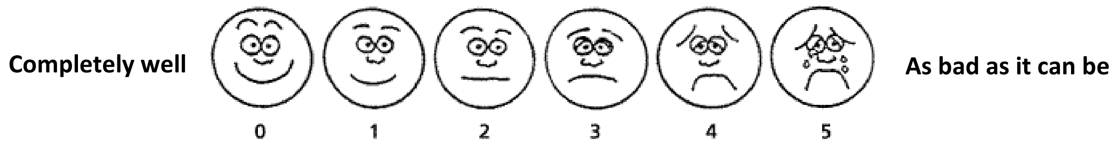
Tick ONE box per symptom listed to indicate its severity.

CAP Symptoms **Tick ONE box for each symptom**	**Not present**	**Slight / little**	**Moderate**	**Bad**	**Severe / very bad**
Fever (hot to touch, compared to normal, or had a temperature recording of more than 38°C on a thermometer)					
Cough					
Wet cough (phlegm)					
Breathing faster (shortness of breath)					
Wheeze					
Sleep disturbed by cough					
Vomiting (including after cough)					
Eating/drinking less					
Interference with normal activity					
Skin rash					
Oral thrush					
Diarrhoea					

B. Your child's wellbeing - please tell us how unwell your child has been today

Please circle the face that indicates how unwell you consider your child to have been over the past 24 hours.

Completely well



As bad as it can be

C. Other medicines

Has your child taken any medication other than trial medication? Yes ☐ No ☐

If 'Yes' please complete the following questions:

Has your child taken any anti-fever medication today (e.g. calpol)? Yes ☐ No ☐

Has your child taken any anti-cough medication today? Yes ☐ No ☐

Has your child been started on antibiotics today other than those dispensed at the start of CAP-IT? Yes ☐ No ☐

CAP-IT Symptom Diary Day 14

Date of completion (dd / mm / yyyy) __ __ / __ __ / __ __ __ __

Time of completion (e.g. 8:30 ~~am~~/pm): __:__ am/pm (delete as appropriate)

A. Symptoms and side effects

Have a look at the table below with symptoms of pneumonia and possible side effects of amoxicillin treatment.

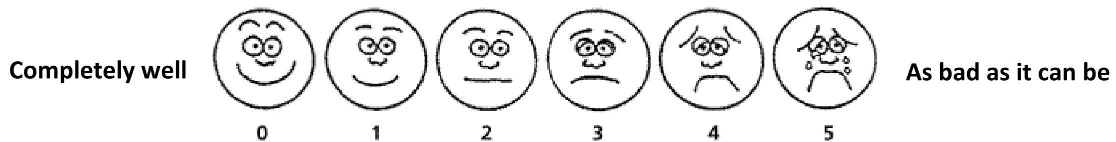
Please indicate how much of a problem each has been for your child today, if at all.

Tick ONE box per symptom listed to indicate its severity.

CAP Symptoms **Tick ONE box for each symptom**	**Not present**	**Slight / little**	**Moderate**	**Bad**	**Severe / very bad**
Fever (hot to touch, compared to normal, or had a temperature recording					
Cough					
Wet cough (phlegm)					
Breathing faster (shortness of breath)					
Wheeze					
Sleep disturbed by cough					
Vomiting (including after cough)					
Eating/drinking less					
Interference with normal activity					
Skin rash					
Oral thrush					
Diarrhoea					

B. Your child's wellbeing - please tell us how unwell your child has been today

Please circle the face that indicates how unwell you consider your child to have been over the past 24 hours.



C. Other medicines

Has your child taken any medication other than trial medication? Yes ☐ No ☐

If 'Yes' please complete the following questions:

Has your child taken any anti-fever medication today (e.g. calpol)? Yes ☐ No ☐

Has your child taken any anti-cough medication today? Yes ☐ No ☐

Has your child been started on antibiotics today other than those dispensed at the start of CAP-IT? Yes ☐ No ☐

Please remember to complete the additional Day 14 questions on the next 2 pages (Sections D, E and F).

CAP-IT Symptom Diary Day 14

D. Non-trial antibiotics

Has your child received any antibiotic treatment, other than that given as part of the CAP-IT Trial, over the **last 7 or today**?

Yes ☐ No ☐ *If 'Yes' please give details and tick each study day they took each medicine:*

Amoxicillin (Amoxicillin, Amoxil) ________ ☐	
Amoxicillin and enzyme inhibitor (Co-amoxiclav, Augmentin) ________ ☐	
Cefadroxil (Cefadroxil) ________ ☐	Start date of antibiotic 1 d d / m m / y y y y
Cephalexin (Cefalexin, Ceporex, Keflex) ________ ☐	
Cefuroxime (Cefuroxime, Zinacef) ________ ☐	Ongoing? *If 'No' complete End date* Yes ☐ No ☐
Clarithromycin (Clarithromycin, Klacid) ________ ☐	End date of antibiotic 1 d d / m m / y y y y
Erythromycin (Erythromycin, Erymax, Erythrocin, Erythroped) ________ ☐	
Phenoxymethylpenicillin (Phenoxymethylpenicillin = Penicillin V) ________ ☐	
Other *(please specify)*: ________ ☐	

If a second antibiotic was started please provide the details below. If not, please leave blank and move to Section E.

Amoxicillin (Amoxicillin, Amoxil) ________ ☐	
Amoxicillin and enzyme inhibitor (Co-amoxiclav, Augmentin) ________ ☐	
Cefadroxil (Cefadroxil) ________ ☐	Start date of antibiotic 2 d d / m m / y y y y
Cephalexin (Cefalexin, Ceporex, Keflex) ________ ☐	
Cefuroxime (Cefuroxime, Zinacef) ________ ☐	Ongoing? *If 'No' complete End date* Yes ☐ No ☐
Clarithromycin (Clarithromycin, Klacid) ________ ☐	End date of antibiotic 2 d d / m m / y y y y
Erythromycin (Erythromycin, Erymax, Erythrocin, Erythroped) ________ ☐	
Phenoxymethylpenicillin (Phenoxymethylpenicillin = Penicillin V) ________ ☐	
Other *(please specify)*: ________ ☐	

E. Daily activities and childcare

For each of the following questions, please enter the number of days in the space provided.

Please answer '0' if your answer is 'no days'.

Please circle 'not applicable' if the question does not apply to your child.

Due to your child's pneumonia or complications of this:

1. How many days in the **last 7 days** was your child unable to attend school, day care or nursery?

   __________ days / not applicable

2. If you are in paid employment, how many days in the **last 7 days** have you been unable to attend work?

   __________ days / not applicable

3. If you are not in paid employment, how many days in the **last 7 days** have you changed your usual activities (e.g. education or voluntary work)?

   __________ days / not applicable

4. On how many days in the **last 7 days** was additional outside care required for your child?

   __________ days / not applicable

F. Other help

Has your child used any other health services in the **last 7 days**? Yes ☐ No ☐

If 'Yes' please provide the number of times that each health service was contacted (e.g. by phone, email or text) and the number of times that each health service was visited (including GP home visits).

	Number of times contacted	**Number of times visited**
A&E / Walk-in Centres		
Out of Hours Service		
Paediatrician		
GP Practice		
Pharmacist		
NHS Direct/NHS 111		*Not applicable*
Other, if 'other' specify: ______________________		

Did your child stay at hospital overnight during the **last 7 days**? Yes☐ No☐

If 'Yes' please provide details below:

Number of admission	**Name of hospital**	**Reason for visit**	**Date of admission**	**Date of discharge**
1				
2				
3				

Thank you for completing the CAP-IT Symptom Diary.

Please bring this diary with you when you visit the study nurse at the end of week 4.

Date form entered onto database : dd - mm - yyyy

Initials of data enterer: ______________________