APPENDIX ONE HNZ00087067

Day 3 2024 Survey

Question	Response Options	Notes
Please confirm the vaccine(s) that you or your dependent received 3 days ago	a) COVID-19 and flu vaccines at the same time b) Only flu vaccine c) Only COVID-19 vaccine d) Other vaccine (end survey) e) Was not vaccinated or don't recall	
Who received the vaccine?	a) Myself b) My dependent/whānau member	
Where did you/they go to receive your/their vaccination?	a) Community vaccination centre b) General practice c) Pharmacy d) Mobile vaccination unit e) Hospital or emergency room f) Other	Use with vaccination experience question to identify issues
Were you/they pregnant/Hapū at the time of vaccination?	a) Yes b) No	
Did you experience any side effects after vaccination?	a) Yes b) No (skip to vaccination experience) c) Can't remember	Allows skip logic
Did you/they experience any of the following after vaccination? (select all that apply)	a) Anaphylaxis b) Syncope (fainting) c) Seizure/convulsion d) I don't know/unsure e) None of the above	Understand profile of early onset symptoms
How long after vaccination did the selected reaction occur?	a) 0–5 minutes b) 6–10 minutes c) 11–15 minutes d) 16–20 minutes e) 21+ minutes	One set for each: Anaphylaxis, Syncope, Seizure
Did seizure/convulsions occur with:	a) Syncope (fainting) b) Fever c) Other d) I don't know	Helps determine if it was a "true" seizure
Injection site reaction (pain, redness, swelling, itching)	a) Yes b) No	
Injection site reaction severity	Minor, Mild, Moderate, Serious, Severe (Dropdown scale)	For pain, duration, impact on daily life
Fever (≥38°C)	a) Yes b) No	
Fever severity	Minor, Mild, Moderate, Serious, Severe (Dropdown scale)	

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Question	Response Options	Notes
Swelling of glands (lymph nodes)	a) Yes b) No	
Where did you experience swelling?	a) Same arm b) Opposite arm c) Other	
Swelling severity	Minor, Mild, Moderate, Serious, Severe	
Chills, shivering, or cold sweats	a) Yes b) No	
Chills severity	Minor, Mild, Moderate, Serious, Severe	
Headaches	a) Yes b) No	
Headache severity	Minor, Mild, Moderate, Serious, Severe	
Rash (not at injection site)	a) Yes b) No	
Rash severity	Minor, Mild, Moderate, Serious, Severe	
Aches and pains	a) Yes b) No	
Aches and pains severity	Minor, Mild, Moderate, Serious, Severe	
Stomach symptoms (nausea, vomiting, diarrhoea, abdominal pain, loss of appetite)	a) Yes b) No	
Stomach symptoms severity	Minor, Mild, Moderate, Serious, Severe	
Fatigue or tiredness	a) Yes b) No	
Fatigue severity	Minor, Mild, Moderate, Serious, Severe	
Chest symptoms (pain, heaviness, tightness, palpitations)	a) Yes b) No	
Chest symptoms severity	Minor, Mild, Moderate, Serious, Severe	
Difficulty breathing	a) Yes b) No	
Difficulty breathing severity	Minor, Mild, Moderate, Serious, Severe	
Dizziness or lightheaded	a) Yes b) No	

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Dizziness severity	Minor, Mild, Moderate, Serious, Severe	
Any other symptoms not listed?	a) Yes [describe, 150 character limit] b) No	Capture rare/unexpected symptoms
Did symptoms cause you/them to miss work/study/daily activities?	a) Yes b) No	
How many days were missed?	a) Less than 1 b) 1 day c) 2 days d) 3 or more days	
Did you/they seek medical advice or care?	a) Yes b) No	
What type of care did you/they seek?	a) Phone (e.g., Healthline) b) GP clinic c) Emergency department d) Māori Health Provider e) Rongoā clinic f) Whānau Ora navigator g) Pharmacy h) Other	Select all that apply
How would you/they rate the overall experience at the vaccination site?	a) Very poor b) Poor c) Average d) Good e) Excellent	Consider staff helpfulness, cleanliness, consent process, etc.
Do you/they have any comments about the vaccine experience?	a) Yes [describe, 500 character limit] b) No	

Day 42 2024 Survey

Question	Response Options	Notes
1. Since the day 3 survey, have you or your dependent sought medical help/advice related to your vaccination? Choose all that apply	a) Phone advice from a helpline (e.g., Healthline) b) Care from a GP clinic (including the clinic nurse, a doctor, or a phone call) c) Visit to a hospital emergency department e) Rongoā clinic f) Whānau Ora navigator g) Māori Health Provider h) Pharmacy i) Other j) Did not seek any medical advice	

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Question	Response Options	Notes
2. Since the day 3 survey, have you/they been diagnosed with any medical conditions that a medical professional has attributed to your/their vaccination? If yes, please answer ONLY with the name of the condition(s).	a) No, you/they have not been diagnosed with a medical condition attributed to vaccination b) Yes, you/they have been diagnosed with a condition attributed to vaccination – [Name condition]	Character limit – 150
2a. (If Yes) Have you/they had a Centre for Adverse Reactions Monitoring (CARM) report submitted for your/their diagnosis?	a) Yes b) No c) No – I did not know about reporting d) Unsure	
2b. (If Yes) Has an ACC claim been made for your/their diagnosis?	a) Yes b) No c) No – I did not know about making an ACC claim d) Unsure	

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