

Supplementary File 1

8. Assessment of things like how fast your child was breathing, how fast his or her heart was beating, or whether he or she had a fever.
9. Results from x-rays, blood tests, or other tests, showing how well your child's lungs were working or what might be causing their illness.
10. The doctor's assessment of how your child was doing.

Sometimes when children are sick, they need to take medicine or be treated in other ways. How concerned would you be if: (Image 5)

11. Your child needed to be given extra oxygen through a mask or through his or her nose.
12. Your child needed to take medicine to feel better.
13. Your child had a minor but common side effect from the treatment or medicine. Some common side effects are vomiting, rash, and diarrhea.
14. Your child had a major side effect from the treatment or medicine that was bad enough to make him or her stop taking it. Some such reactions are your child becoming very agitated or irritable, or having a serious allergic reaction.

Other Concerns

Sometimes when children are sick, they are not themselves. How concerned would you be about the following things if your child was sick? (Image 6)

15. How bad your child's symptoms were. Symptoms are signs of your child's sickness. Common symptoms are things like coughing, wheezing, fever, sore throat, headache, and struggling to breathe.
16. How long it took for your child to feel better.
17. If your child got sick again with the same illness, after feeling better.

Sometimes when children are sick, parents or caregivers need to pay for extra things. How concerned would you be about: (Image 7)

18. How much your child's treatment cost, including costs for things related to treating their illness like medications, supplies, or doctor or nurse visits.
19. Other costs that came up while your child was sick, for example, child care, parking, or lost income for missing work.

Sometimes when children are sick, parents or caregivers can't follow their regular schedule or do regular activities. How concerned would you be about: (Image 8)

20. Your child not eating or drinking well because they felt sick.
21. You or your child not getting as much sleep as you normally do.
22. Your child being away from school or daycare.
23. The illness affecting the activities your child, you, or your family would normally do on a day-to-day basis.
24. Having to take time off of work.
25. Arranging child care either for your child who was sick, or arranging child care for your other children so that you could look after your sick child or take him or her to appointments.

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It can sometimes be scary when our children are sick. (Image 9)

26. How concerned would you be if your child had mild complications such as a cough or a rash?
27. How concerned would you be if your child had severe complications? This could mean something like your child being connected to a ventilator to help his or her breathing.

28. Please tell us any other things that are important to you when your child is sick with an illness that affects their breathing that have not been included in this list.

Please tell us a little bit more about your family.

29. What is your gender?

- Male
 Female
 NR

30. What is your relationship to the child(ren) in your family? Check all that apply.

- Parent
 Step-parent
 Grandparent
 Other, specify: _____
 NR

31. How many children live in your home? ____ (__ NR)

32. What illness or illnesses that affect breathing has your child or children ever had? Please check all that apply.

- Bronchiolitis
 Croup
 Strep throat (pharyngitis) or tonsillitis
 Sinus infection (sinusitis)
 Wheezing
 Flu (influenza)
 Pneumonia
 Acute asthma
 Other, specify: _____
 I don't remember the name of the illness
 NR

33a. If you checked more than one illness above, which one did your child have **most recently**?
(drop down menu – same list as above) (__ NR)

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****The following three questions will appear to correspond to conditions above****

33b. How old was your child when they had this illness? (*drop down menu - <1/1/.../10/11 months/1/2/...18 years/can't remember*) (__ NR)

33b. When did this illness occur? MM/YYYY (__ NR)

33c. Was your child admitted to the hospital, to stay overnight or longer?

Yes
 No
(__ NR)

33d. Does your child have any health concerns?

Yes, details: _____
 No
(__ NR)

33. What year were you born in? 19____ (__ NR)

34. What is the highest level of schooling you have completed?

Grades 1-9
 Grades 10-11/Some high school
 High school graduate
 Some college/university
 College/university graduate
 Post-graduate education or degree
(__ NR)

35. What is your marital status?

Never married (single)
 Married/Common-law
 Separated, divorced, or widowed
 Other, specify: _____
(__ NR)

36. What is your household income (US dollars) per year? (<http://www.xe.com/currencyconverter/>)

Less than \$30,000 per year
 \$30,000-49,999
 \$50,000-69,999
 \$70,000-89,999
 Over \$90,000
(__ NR)

37. What was your place of birth (town/city, country)? _____ (__ NR)

38. Where do you live now (town/city, country)? _____ (__ NR)

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39. How did you hear about this survey?

- Facebook
- Twitter
- Internet search (for example, Google)
- Consumer or patient group (for example, Cochrane Consumer Network)
- From a friend
- From a health care professional (for example, a doctor or nurse)
- Research network (for example, TREKK [Translating Emergency Knowledge for Kids])
- Other, specify: _____
- NR

Thank you for taking the time to fill out this survey!

If you would like to be entered into a draw for an iPad mini, a Kobo Touch, or a Nike+ FuelBand, click [here](#) to provide us with your email address. Your email address will not be linked to the responses you have provided.