Control 13–36 months questionnaire

Keeping Children Safe From Accidents

keeping Children SAFE AT HOME

Please complete this questionnaire for your child born on

Is your child □ Male □ Female

Please tell us the date you completed this questionnaire

Your answers really are important to us. Thank you for taking the time to help us with this study.
### Part 1. About your child's development, health and behaviour

All children develop at their own rate so we would like to ask you what your child can do. There are no right or wrong answers.

1.1 Please tell us whether your child does each thing often, has only done it once or twice or has not started to do it yet.

<table>
<thead>
<tr>
<th>Action</th>
<th>Often</th>
<th>Once or twice</th>
<th>Not yet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crawling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shuffling along the floor on his/her bottom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.2 At the moment, how likely do you think it is that your child could:

(If your child is too young to be able to do some of these things, put a tick in the "not likely" box)

<table>
<thead>
<tr>
<th>Action</th>
<th>Very likely</th>
<th>Quite likely</th>
<th>Not likely</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach, or climb on to a worktop</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reach, or climb on to something to reach a cupboard at adult eye level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open cupboards, drawers or medicine cabinets with locks or safety catches on them</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open a fridge with a lock or safety catch on it</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open a container with a child resistant cap</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open a lockable medicine box</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Get medicines out of blister packs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Touch things that you have told him/her not to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open a stair gate or safety gate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reach, or climb on to something to reach a pan on the cooker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reach, or climb on to something to reach a hot water tap</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reach to pull a table cloth hanging over the side of a table</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Turn a hot water tap on by him/herself</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climb into the bath by him/herself</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climb onto furniture e.g. sofa, chair, bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climb out of a cot</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roll off a bed or high surface</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climb up to a top bunk bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.3 Does your child have any long-term conditions (e.g. problems with hearing, eye sight, development, fits etc) that have been diagnosed by a health professional?

Long-term means anything that your child has had for at least 3 months or is expected to continue for at least the next 3 months.

- [ ] Yes
- [ ] No

If YES, please tell us what conditions your child has:

__________________________________________________________________________

1.4 How was your child's health IN THE LAST 24 HOURS? Please put an "x" on the line below to indicate how good or how bad your child's health was:

<table>
<thead>
<tr>
<th>Worst possible health</th>
<th>Perfect health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.5 If your child is aged 2 years or over, do any of the following problems last for 6 months or more?

PLEASE COMPLETE 1.5 IF YOUR CHILD IS AGED 2 YEARS OR OVER

FOR CHILDREN AGED UNDER 2 YEARS – please go to Q.17

1.5 Below is a list of things that might be a problem for your child. Please tell us how much of a problem each one has been for your child during the LAST TWO WEEKS by circling:

- 0 if it is never a problem
- 1 if it is almost never a problem
- 2 if it is sometimes a problem
- 3 if it is often a problem
- 4 if it is almost always a problem

There are no right or wrong answers.

In the LAST TWO WEEKS, how much of a problem has your child had with:

<table>
<thead>
<tr>
<th>Physical Functioning (problems with...)</th>
<th>Never</th>
<th>Almost Never</th>
<th>Some Times</th>
<th>Often</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Walking</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Running</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Participating in active play or exercise</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Lifting something heavy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Fetching</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Helping to pick up hit or her toys</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Having hurts or aches</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Low energy level</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
### Programme Grants for Applied Research

**Vol. 5 No. 14**

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#### Table: Behavioral Checklist for Children with Autism Spectrum Disorder (ASC)

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My child looks at pictures, drawings, or objects when there is no one around.</td>
<td>☐</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>2. My child does not like to be left alone.</td>
<td>☐</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>3. My child has trouble understanding what others are thinking.</td>
<td>☐</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>4. My child has trouble understanding the causes of things around them.</td>
<td>☐</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>5. My child does not like to share toys or other things with other children.</td>
<td>☐</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>6. My child has trouble understanding the meanings of words.</td>
<td>☐</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
</tbody>
</table>

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#### Diagram: Behavioral Observation Form

- **Social Functioning Problems:**
  - Never
  - Almost Always
  - Often
  - Some Times
  - Rarely

- **Emotional and Behavioral Problems:**
  - Never
  - Almost Always
  - Often
  - Some Times
  - Rarely

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#### Checklist:

1. **If you answered yes to Item 1, 2, 3, 4, 5, or 6, please indicate the degree to which the problem is a problem for your child.**

2. **If you answered yes to Item 7, 8, 9, or 10, please indicate the degree to which the problem is a problem for your child.**
1.8 Please tell us how often your child did each of the things described below during the LAST TWO WEEKS by ticking one of the boxes. You may not be able to answer some of the questions because you may not have seen your child in that situation, e.g. if the question is about going down a slide and your child did not do this in the last 2 weeks, then tick the "Not Applicable" box.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Very rarely</th>
<th>Less than half the time</th>
<th>Almost half the time</th>
<th>Always</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>While bathing, how often did your child sit quietly?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>While bathing, how often did your child splash, kick or try to jump?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>While participating in daily activities, how often did your child move quickly from one place to another?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>While participating in daily activities, how often did your child seem full of energy, even in the evening?</td>
<td></td>
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</tr>
<tr>
<td>During sleep how often did your child toss about in the bed?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>During sleep how often did your child sleep in one position only?</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>When playing outdoors with other children, how often did your child seem to be one of the most active children?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When playing outdoors with other children, how often did your child sit quietly and watch?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When being dressed or undressed, how often did your child squirm and try to get away?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When being dressed or undressed, how often did your child stay still?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When playing indoors, how often did your child run through the house?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When playing indoors, how often did your child climb over furniture?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**While playing outdoors, how often did your child:**

- Like rough and rowdy games?
- Enjoy playing boisterous games like chase?
- Enjoy vigorously jumping on the bed or seat?e?
- Not like rough or rowdy games?
- Enjoy activities such as being spun etc?
### Part 2. About your home

Every home has things that may not seem very safe for children. We want to find out which things really are safe or not. Please answer the questions below as honestly as possible.

**Please think about THE LAST 24 HOURS:**

2.1 Please tell us where your medicines and cleaning products were IN THE LAST 24 HOURS.

<table>
<thead>
<tr>
<th>Did you have this in your home? (Please tick one box)</th>
<th>IF YES At what level was it? (Please tick all that apply)</th>
<th>IF YES Where was it? (Please tick all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>At adult eye level or above</td>
</tr>
</tbody>
</table>

- Painkillers e.g. Calpol
- Iron or vitamins
- Cough mixture
- Antidepressants or sleeping tablets
- Any other medicines in the kitchen
- Any other medicines in the bathroom
- Any other medicines anywhere else in the house
- Bleach
- Dishwasher products
- Oven cleaner
- Toilet cleaner
- White spirit turpentine
- Rat or ant killer
- Garden chemicals e.g. weed killer
- Any other household products

Still thinking about THE LAST 24 HOURS:

2.2 Did all your medicines have child resistant caps or blister packs? □ Yes □ No

2.3 Had any medicines been put in a container different from the one they came in? □ Yes □ No

2.4 Were all medicines kept in a locked medicine box? □ Yes □ No

2.5 Were any medicines kept in the fridge? □ Yes □ No

If YES, was the fridge closed with a lock or safety catch? □ Yes □ No

2.6 Did all your cleaning products have child resistant caps? □ Yes □ No

2.7 Had any cleaning products been put in a container different from the one they came in? □ Yes □ No

2.8 Did you use a safety gate to stop your child/children getting in to the kitchen? □ Yes □ No

2.9 Was there anything your child could climb on to reach work tops, shelves, cupboards etc., in any of your rooms? □ Yes □ No

2.10 Did you use protective corner covers on any of your furniture? □ Yes □ No

2.11 Did your child use a baby walker? □ Yes □ No

2.12 Did your child use a stationary play centre (like a baby walker without wheels)? □ Yes □ No
Still thinking about THE LAST 24 HOURS:

2.13 Did your child use a playpen? □ Yes □ No

2.14 Did your child use a travel cot instead of a playpen? □ Yes □ No

2.15 Did you have a kettle with a curvy flex or a cordless kettle? □ Yes □ No

2.16. Where was your kettle? (Please - one box)
□ At the front of the worktop or table □ Between the front and back of the worktop or table
□ At the back of the worktop or table □ On the front ring of the cooker
□ On the back ring of the cooker □ Other (please describe)

2.17 How hot was your hot tap water? (Please - one box)
□ Very hot - you couldn’t have a bath without adding a lot of cold water
□ Hot - you would need to add some cold water to the bath
□ Warm enough - you don’t need to add any cold water to the bath
□ Not very warm - not warm enough to have a bath in

2.18 Do you know the temperature of your hot tap water? (Please - one box)
□ Lower than 54°C □ 54°C or higher □ Don’t know

2.19 Were all carpets or rugs in your home firmly fixed to the floor? □ Yes □ No

2.20 Do you have any stairs in your home? □ Yes □ No (if no, go to question 2.29)

2.21 Did you use any stair gates or safety gates in your home? □ Yes □ No

If YES, where did you use them? (Please - all that apply)
□ Bottom of stairs □ Top of stairs
□ Other (please tell us where)

Still thinking about THE LAST 24 HOURS:

2.22 Were any of your stair gates on the stairs left open? □ Yes □ No

2.23 Which of the following describe how your stairs look? (Please - all that apply)
□ Carpeted □ Exposed wood □ Exposed metal or concrete
□ Linoleum covered □ Don’t know □ Other (please describe)

2.24 Please put a tick in the box that best describes your agreement with each of the following:

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The stairs are too steep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The stairs are too narrow</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The stairs are poorly lit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The stairs are in need of repair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The stair covering is in need of repair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The stairs are safe to use</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.25 Are there any handrails on the wall next to your stairs? (Please - one box)
□ Yes on all stairs □ Yes on some stairs □ No

2.26 Is there a banister/railing at the side of your stairs to stop people from falling through? (Please - one box)
□ Yes on all stairs □ Yes on some stairs □ No

If YES, how wide are the biggest gaps between the railings? (Please write in number of inches)

2.27 Do any of your stairs have a landing part way up? □ Yes □ No

2.28 Are any of your stairs spiral or winding stair cases? □ Yes □ No
Thinking about the LAST WEEK:

2.29 How often did these things happen in the LAST WEEK? If you did not have the things the question is asking about e.g. high chair, tick the "does not apply" box. For questions that ask about older children, if you do not have older children, tick the "does not apply" box.

<table>
<thead>
<tr>
<th>Question</th>
<th>Every day</th>
<th>Most days</th>
<th>Some days</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your child was held, even for a moment, by someone holding a hot drink?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your child was held, even for a moment, by someone using the cooker?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hot drinks were passed over your child’s head?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hot drinks were left within the reach of your child e.g. coffee table, work top, other low surface?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hot drinks or hot liquids were put on a table with a table cloth?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>The front rings of the cooker were used?</td>
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<tr>
<td>Pan handles were turned towards the back of the cooker whilst cooking?</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Your child was left in the bathroom, without an adult, whilst the bath was running, even for a moment e.g. to collect clothes, nappies or answer the phone?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your child was left in the bath without an adult, even for a moment e.g. to collect clothes, nappies or answer the phone?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A bath was run for your child by an older child?</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>An older child looked after your child in the bath?</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>The bath was run using cold water first?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The temperature of your child’s bath water was checked using a thermometer or other gadget?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The temperature of your child’s bath water was checked using a hand or elbow?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There were things on your floors that could be tripped over?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your child was left on a raised surface e.g. table, sofa, adult bed, even for a moment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your child’s nappy was changed on a raised surface e.g. bed, changing table, work top?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your child was put in a car seat or bouncing seat on a raised surface e.g. table, work top, even for a moment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There were wires or cables trailing across the floor?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your child climbed onto or played on furniture e.g. bed, chair, sofa?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please tick one box on each line.
Part 3. About the worries of family life

3.1 The statements below describe things that often happen in families with young children. These things sometimes make life difficult. Please read each statement and tick how often it happens to you and then tick how much of a "hassle" you feel it has been for you in the PAST 6 MONTHS. Please answer these questions thinking about all of your children.

<table>
<thead>
<tr>
<th>How often it happens</th>
<th>Hassle (low to high)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Fairly</td>
<td>Not quite as much</td>
</tr>
<tr>
<td>Often</td>
<td>Occasionally</td>
</tr>
<tr>
<td>Continually</td>
<td>Very often</td>
</tr>
</tbody>
</table>

3.2 Please read each statement and tick the box next to each one which comes closest to how you have been feeling in the PAST WEEK. Don't take too long over your replies: your first reaction is probably better than thinking about it for too long.

I feel tense or "wound up":
- I feel as if I am slowed down:
- Most of the time
- Nearly all of the time
- A lot of the time
- Very often

Time to time, occasionally:
- Sometimes
- Not at all

I still enjoy the things I usually enjoy:
- I get a sort of frightened feeling like "butterflies in the stomach":
- Definitely as much
- Not at all
- Not quite so much
- Occasionally
- Only a little
- Quite often
- Not at all
- Very often

I feel restless as if I have to be on the move:
- As much as I always could
- Very much indeed
- Not quite as much now
- Quite a lot
- Definitely not as much now
- Not very much
- Not at all
- Not at all

Worrying thoughts go through my mind:
- I look forward with enjoyment to:
- A great deal of the time
- As much as I ever did
- A lot of the time
- Rather less than I used to
- From time to time but not too often
- Definitely less than I used to
- Only occasionally
- Hardly at all
I feel cheerful: I get sudden feelings of panic:
Not at all Very often indeed
Not often Quite often
Sometimes Not very often
Most of the time Not at all
I can sit at ease and feel relaxed: I can enjoy a good book or radio or TV programmes:
Definitely Often
Usually Sometimes
Not often Not often
Not at all Very seldom

4. About your family
4.1 How many children, including step-children, (under 5) do you have living with you? 
(please give number)
4.2 How many children, including step-children, (aged 5-16) do you have living with you? 
(please give number)
4.3 The total number of adults and children living in our home is: 
(please give number)
4.4 I am the child(ren)'s (please tick one box)
  □ Mother
  □ Father
  □ Grandparent
  □ Other (please say what)
4.5 How many brothers and sisters (including step-brothers/sisters) do your child have? 
  □ elder brothers and sisters
  □ younger brothers and sisters
4.6 Does your child live? (please tick one box)
  □ In one house only
  □ In a residential home
    □ Part time in one house and part time in another house (please answer the remaining 
    questions about the house where they spend most of their time)
4.7 How many adults, over the age of 16, live in the house with your child? (please tick one box)
  □ One parent
  □ Both parents
  □ One parent and other adults
    □ Both parents and other adults
    □ Other (please describe)
4.8 How many adults living in the house with your child work in a paid job? (please tick one box)
  □ None
  □ One
  □ Two
  □ More than two
4.9 What kind of house does your child live in? (please tick one box)
  □ Rented house
  □ House owned by, or being bought by family
  □ Other (please say what)
4.10 My family usually has the use of a car
  □ Yes
  □ No
4.11 My family receives one or more state benefits as well as child benefit
  □ Yes
  □ No
4.12 The postcode where my child lives is:
4.13 When my first child was born my age was:
4.14 I am (please tick one box)
4.15 The total number of rooms in our home is: __________________ (Please give number) (do not count bathrooms or toilets or rooms that can only be used for storage such as cupboards)

4.16 Who else looks after your child? (Please tick all that apply)

- Day Nursery
- Preschool
- Playgroup
- School
- Childminder
- Family/Grandparents
- Friends
- N/A

- Other (Please say who) ________________________________

4.17 In a typical week how many hours is your child cared for by somebody else away from the family home? (please include all those ticks in 4.16)

- __________ hours (please give number)

4.18 Is there anything else you would like to tell us about the things that you do at home to keep your children safe?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Thank you very much for filling in this questionnaire. Your answers are very important in helping us stop children’s accidents.

Please send this back to us in the FREEPOST ENVELOPE

We will need your name and address so that we can send you your gift voucher

Please fill in the pink form and send it back with your questionnaire