Supplement Material 1. Questionnaires for adverse events following COVID-19 vaccination among children and adolescents with underlying diseases

1. Parent's phone number (Please write only numbers, no '-') ( )

2. Where do you currently live?

3. What is your relationship with your children?

3. The child's date of birth:

4. Gender

5. Body weight at birth

6. Was your baby born prematurely?

7. Has your child ever been admitted to a neonatal intensive care unit?

8. Has your child received all routine immunizations required before age 6?

Current body measurements

9. Height cm

10. Body weight kg

Please provide the information about parents

11. Father's age ( ) years old

12. Mother's age ( ) years old

13. Father's final education status

14. Mother's final education status

It’s a question about medical history.

15. Has the child been diagnosed with or is being treated for a developmental problem?

15-1. Specific diagnosis, if any ( )

16. Does your child currently have a medical condition for which he or she receives regular medical care?

16-1. Please check all conditions that apply to your child, if any.

1. Chronic kidney disease

2. End-stage kidney disease or on renal replacement therapy (peritoneal dialysis or hemodialysis)

3. Organ transplant (kidney or liver transplant)

4. Glomerulonephritis (nephrotic syndrome, focal segmental glomerulosclerosis, IgA nephropathy, Henoch-Schonlein purpura, membranous glomerulopathy, membranoproliferative glomerulonephritis, etc.)

5. Autoimmune diseases (systemic lupus erythematosus, juvenile idiopathic arthritis, vasculitis, Sjogren's syndrome, etc.)

6. Inherited kidney disease (such as Alport syndrome, Bartter syndrome, Dent disease, nephrotic diabetes insipidus, hypophosphatemic rickets, etc.)

7. Chronic lung disease

8. Chronic heart disease

9. Chronic liver disease

10. Neuro-muscular diseases

11. Diabetes

12. Obesity

13. Pediatric cancer

14. Other ( )

17. Is your child currently taking or injecting any prescription medications?

17-1. Please check all types of medications, if any.

1. Immunosuppressants
2. Antibiotics
3. Chemotherapy drugs
4. Pain relievers, anti-inflammatories, fever reducers
5. Other ( )

18. Has your child ever had an adverse reaction to a vaccination other than a COVID-19 vaccination before?

18-1. Please list all the immunizations your child received at that time

Following questionnaires are about COVID-19 vaccination history and adverse event.

Week 1 survey after 1st dose

Date of the first dose: year month day

Questions about symptoms on the day of the first dose.

19. Did your child have a fever after the vaccination?

none - almost none - some - very much - don't know

20. Did your child have any pain at the injection site?

none - almost none - some - very much - don't know

21. Was there any swelling or redness at the injection site?

none - almost none - some - very much - don't know

22. Did your child have any symptoms of vomiting or nausea?

none - almost none - some - very much - don't know

23. Did your child have any pain, such as headaches, joint pain, or muscle pain?

none - almost none - some - very much - don't know

24. Did your child feel tired?

none - almost none - some - very much - don't know

25. Did your child have an allergic reaction (e.g., hives, rash, swelling of hands or face)?

none - almost none - some - very much - don't know

26. If your child had any other symptoms, please specify.

27. Did your child visit a doctor for this adverse event? 1. yes 2. no 3. don't know

27-1. Was the child hospitalized for this adverse event? 1. yes 2. no 3. don't know

27-1-1. How long was your child hospitalized? ( ) day