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**Supplementary Figure S1:** Diary card for residents and staff to record side effects and their severity after each dose of the vaccine

**Men B vaccination – side effect data collection form**

Name of vaccine recipient:

Staff or Resident:

Date of birth:

Date vaccine dose 2 received:

Injection site: Left arm ☐ Right arm ☐

Please complete all the rows in the table below, using the following **GRADE** for symptoms:

- 1: No disruption to normal daily activities
- 2: Enough to reduce or affect normal daily activity to some degree
- 3: Reduced or affected normal daily activity considerably for at least 24 hours

	Occurred	Did not occur	Unable to assess	Grade if present (1, 2 or 3)	Start date	End date
Pain at the site of injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Swelling at the site of injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Itching at the site of injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Feeling hot/fever-ish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Confirmed fever >38 °C. Please state temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Tiredness (more than normal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Headache (more than normal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Loss of appetite (more than normal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Muscle aches and pains (more than normal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Bone/joint aches and pains (more than normal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Itching all over body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			