WORKSHOP EVALUATION - VAPING

1. Your name (optional - you can also use a nickname) _____

2. Do you identify as (please tick) **male** ☐ **female** ☐ **other** ☐

3. Your organisation/ group _____ **4. Your age** _____

5. Do you vape?

Never ☐ Occasionally ☐ Frequently ☐

6. How would you rate your knowledge of the effects of vaping before the session (1= very poor, 10= excellent)

1 2 3 4 5 6 7 8 9 10

7. How would you rate your knowledge of the effects of vaping after the session (1= very poor, 10= excellent)

1 2 3 4 5 6 7 8 9 10

8. How confident did you feel in resisting peer pressure around vaping before the session? (1= not at all confident, 10= very confident)

1 2 3 4 5 6 7 8 9 10

9. How likely were you to vape before the session?

1	2	3	4	5
very likely	somewhat likely	neither likely or unlikely	somewhat unlikely	very unlikely

10. How likely were you to vape after the session?

1	2	3	4	5
very likely	somewhat likely	neither likely or unlikely	somewhat unlikely	very unlikely

11. What did you find most helpful about the session? (Please specify)

12. What did you think could have been improved about the session? (Please specify)