

Brief Report

A Survey of Parents' Firearm Access in Chicago and Implications for Pediatrician Counseling

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Background

Firearm injury is the leading cause of death among children living across the US, but the intent and the prevalence of firearm deaths vary geographically, as does firearm ownership and access to guns. To better understand geographic differences related to the presence of firearms in the home and access to firearms outside the home, we aimed to gather local data from families across Chicago that could then be used to tailor pediatrician counseling on one of the most serious health issues that youth face.

Methods

We surveyed parents and caregivers of youth who reside in each of Chicago's 77 community areas as part of the Voices of Child Health in Chicago Parent Panel Survey. Two questions about access to firearms in the home and community setting were included in a survey that was disseminated in two waves from November 2020-February 2021 and May-July 2022 via web or phone. Descriptive statistics and chi-squared tests were conducted for data analysis.

Results

Over 250 parents answered both survey questions regarding firearm access. Nearly 1 in 5 parents (18.4%), and almost 80% (21/27) of male parents, reported access to firearms either in the home, in the community, or both. Living in a higher income household was associated with more access to firearms as compared to living in a lower income household ($p=0.03$).

Conclusion

Local data on firearm access from across the large urban city of Chicago suggest that firearms are present in many households and accessible outside of the home by parents and caregivers of children, which suggests that these youth may also have the same access. This data, in conjunction with data on types of firearm deaths—homicide, suicide, and unintentional death—among youth living in Chicago can be used by pediatricians to help guide the content of their health promotion counseling in the clinical setting. Preventing youth firearm deaths is a complex health issue that requires a multilevel (individual, community, policy) and multisector (clinical, public health, criminal justice) approach. Collecting and applying local data on firearm access is one step toward improving discussions with families and youth about firearm safety and preventing firearm violence among youth.

Advocacy Focus and Impact on Health

How this work impacts health: Firearm injury is the leading cause of death for US youth. By understanding access to firearms in their homes and communities, and applying a public health approach to violence prevention, deaths can be reduced and prevented.

How this paper addresses advocacy/action: There is not a magic bullet to decrease youth firearm deaths. A systematic approach is required that includes a scaffolding of interventions such as firearm safety policies, community violence intervention programs, and physician counseling. Pediatricians routinely provide advice to families on a range of health conditions but do so with limited time and understanding of local firearm access. We advocate for the collection and use of local data regarding firearm access to help pediatricians prioritize firearm safety recommendations and improve outcomes for youth.

What this work adds to the field: Through a local survey of parents, we ascertained that in Chicago it is common for parents of children under age 18 years to have firearms in their homes and be able to access firearms outside of their homes. These data, in combination with publicly available medical examiner data, which shows that homicides are the leading cause of firearm death for Chicago youth, emphasize that secure firearm storage counseling is necessary for all families but not sufficient in Chicago to address firearm injury and prevent youth firearm deaths.

Next steps/needed action(s): Chicago-based pediatricians need to partner with a range of people and programs to help prevent deaths from firearm violence in Chicago communities. Pediatricians in other cities and states can apply a similar approach to learn about and apply local data to help tailor their health promotion counseling.

INTRODUCTION

Firearm-injury is the leading cause of death among children living in the US (Centers for Disease Control and Prevention, n.d.; Lee, Douglas, and Hemenway 2022). In 2023 in the US, among individuals aged 0-19 years old, 66% of firearm deaths were attributable to homicide, 28% to suicide, and 3% to unintentional injury (Centers for Disease Control and Prevention, n.d.). However, firearm deaths are

not evenly distributed across the country. The southern US states experience the highest rates of youth firearm deaths while the northeastern US states have the lowest rates (Centers for Disease Control and Prevention, n.d.). Firearm ownership varies regionally as well. Further, adults living in rural areas report the highest level of firearm ownership (47%) compared to suburban (30%) or urban residents (20%) (“Pew Research Center Report,” n.d.).

According to the Cook County Medical Examiner Case Archive, in 2024 in the urban setting of Chicago, 92 youth between ages 0-19 years died from firearm-related injury; over 90% (N=85) were homicide victims and 5% (N=5) were suicide victims. Two firearm deaths were reported to be due to unintentional injury. Among those 92 deaths, 80 youth (nearly 86%) were between the ages of 15-19 years (“Cook County Medical Examiner Case Archive,” n.d.). Likely as a result, nearly 80% of Chicago parents rate firearm-related violence as a major concern for child and adolescent health (Keese et al. 2025).

One strategy to prevent firearm-related injuries and deaths among children and adolescents is to limit access to firearms in their homes and communities. The American Academy of Pediatrics (AAP) recommends that the safest home for a child is one without firearms, but if a parent decides to keep a firearm in the home, they should be stored locked and unloaded, with ammunition locked up separately (Lee et al. 2022). In December 2022, the AAP reaffirmed the importance for pediatricians to provide anticipatory guidance on safer firearm storage as one component of a multifaceted approach to prevent firearm injury and violence (Lee et al. 2022).

During well childcare visits, pediatricians can mitigate the risk of firearm-involved suicide and unintentional injury among their patients by counseling parents on secure firearm storage practices (Lee et al. 2022). While available evidence for the protective effect of secure storage to protect a child from homicide is less robust (Grossman, Mueller, Riedy, et al. 2005), physicians also can provide patient families with information about resources and support services within their communities focused on violence prevention.

Because the prevalence of firearm ownership in the US varies geographically (“Pew Research Center Report,” n.d.), having a better understanding of local firearm access may help pediatricians tailor their counseling practices regarding secure gun storage. Previous research has shown that there is a connection between the mode by which youth access firearms and the type of firearm injury inflicted. For firearm-involved suicide (Johnson et al. 2010) and unintentional death (Wilson et al. 2023), access is most commonly via firearms owned by parents and stored in the home, whereas for firearm-related homicides in the community setting, where the firearm was accessed and the owner of the firearm are often undetermined.

In this study, we aimed to characterize parent and caregiver access to firearms, both inside and outside the home, across Chicago neighborhoods. Our goal was to gather locally relevant data that can be used to inform anticipatory guidance during well childcare visits and support broader

Table 1. Parent Reported Access to Firearms in Chicago: Survey Responses about Access to Firearms Inside and Outside of The Home

Firearm Access Survey Questions	Total (n, %) (N=259 [100.0])
Wave 2	
Are there any guns in your home? ^a	
Yes	36 (14.0)
No	217 (86.0)
Wave 5	
Can you access a gun that isn't usually kept in your home?	
Yes	14 (5.7)
No	245 (94.3)

^aSix parents did not answer this question

efforts to reduce firearm-related injuries and deaths among youth.

METHODS

Data were collected as a part of the Voices of Child Health in Chicago (VOCHIC) Parent Panel Survey, a panel survey administered tri-annually by the National Opinion Research Center (NORC) at the University of Chicago in English and Spanish via web and phone to parents from all 77 neighborhoods in Chicago. Parent respondents were recruited through one of three methods: the VOCHIC probability-based Parent Panel, NORC's probability-based AmeriSpeak panel, and established online nonprobability survey panels. Parents were eligible to participate if they had at least one child <18 years old living in the same household. Parents indicated their preferred method for completing surveys (online or phone) during their initial survey with the panel. Parents were compensated from \$5 to \$15, based on whether they were first-time (\$15) or continuing (\$5) participants. Additional details about the survey methods are provided in the **Supplementary Materials**.

Surveys were conducted from November 2020-February 2021 (Wave 2) and May-July 2022 (Wave 5). The two survey administrations each contained one question about access to firearms: *Are there any guns in your home?* with select-all-that-apply response options listing various ownership purposes or none, condensed for this analysis to a binary Yes/No response, (Wave 2); and *Can you access a gun that isn't usually kept in your home?* with response options of Yes/No (Wave 5). The overall sample for Wave 2 was 1,492 parents and for Wave 5 was 1,068 parents. Participants included in the present study (n = 259) were parents who responded to both survey waves, enabling linkage of participant responses across time points.

Parents self-reported race and ethnicity and other demographic information including age, education, income, and city region. City region was determined based on the six-region classification system used by the Chicago Department

of Public Health for planning and reporting purposes; the North Central region was divided into two separate regions (North and Central) to help balance out subgroup size for a total of seven city regions. All proportions and analyses were population-weighted. Differences between responses to both questions across demographic characteristics were computed using the χ^2 test between categories. A p-value of <0.05 was considered significant. The study was approved by the Institutional Review Boards of Ann & Robert H. Lurie Children's Hospital of Chicago and NORC at the University of Chicago.

RESULTS

This cross-sectional survey revealed that nearly 1 in 5 parents (18.4%) of a child aged 0-18 years living in the same household have access to a firearm, either inside or outside the home or both ([Table 1](#)). Fewer than five parents reported having access to firearms both inside and outside of their homes.

[Table 2](#) displays the demographic characteristics of the survey participants by firearm access. Reported firearm access differed significantly by household income, with lower-income households reporting less access compared to higher-income households (p = 0.03). No other participant characteristics differed significantly with respect to reported firearm access. Notably, nearly 80% (21/27) of male parents reported having access to firearms.

DISCUSSION

The findings from this study offer a rare snapshot of firearm access in a major urban city. We found that access to firearms in Chicago, either inside or outside the home, as reported by parents and caregivers of children aged 0-18 years living in the same household was nearly 1 in 5 households (18.4%). This number is similar to the 20% of adults living in an urban setting who stated that they were firearm owners, according to a recent Pew Research Center study ("Pew Research Center Report," n.d.). However, reported

Table 2. Parent Reported Access to Firearms in Chicago: Demographics of Parents with Any Reported Firearm Access Compared to Parents with No Reported Firearm Access Inside or Outside of the Home

Characteristics ^a	Parents and Caregivers, unweighted No. (weighted %)			p-value ^d
	Total (N=259 [100.0])	Has firearm access (N=47 [18.4]) ^b	Does not have firearm access (N=212 [81.6]) ^c	
Parent Gender				0.36
Female	225 (58.8)	40 (9.1)	185 (49.7)	
Male	27 (41.2)	21 (31.5)	6 (9.7)	
Parent Age (years)				0.84
18-35	87 (45.6)	19 (8.1)	68 (37.5)	
36+	166 (54.4)	27 (10.6)	139 (43.8)	
Parent Race and Ethnicity				0.47
Hispanic	80 (40.6)	11 (4.8)	69 (35.8)	
Non-Hispanic Black	40 (17.8)	6 (4.7)	34 (13.1)	
Non-Hispanic White	94 (31.3)	73 (23.6)	21 (7.7)	
Non-Hispanic Other ^e	39 (10.3)	8 (1.6)	31 (8.7)	
Parent Education				n/a
High School or Below	31 (33.4)	4 (5.3)	27 (28.1)	
Some College or Technical School	53 (24.0)	13 (6.0)	40 (18.0)	
College Graduate or Above	167 (42.5)	29 (7.5)	138 (35.0)	
Other	2 (0.2)	0 (0.0)	2 (0.2)	
Household Income by Federal Poverty Level (%FPL)				.03*
Less than 100% FPL	42 (25.8)	4 (0.9)	38 (24.9)	
100 to 399% FPL	102 (37.8)	22 (10.7)	80 (27.1)	
400% or greater FPL	109 (36.4)	20 (7.2)	89 (29.2)	
City Region^f				n/a
Central	3 (3.6)	0 (0.0)	3 (3.6)	
Far South	23 (5.7)	7 (2.4)	16 (3.3)	
North	33 (15.0)	7 (2.1)	26 (12.9)	
Northwest	71 (30.5)	11 (5.4)	60 (25.9)	
South	20 (10.1)	4 (1.6)	16 (8.5)	
Southwest	62 (22.3)	12 (3.7)	50 (18.6)	
West	41 (12.9)	5 (3.5)	36 (9.4)	

^aAll participant demographic data was self-reported.^bDefined as any parent that responded “Yes” to either having access to guns inside the home or to having access to a gun not usually kept inside the home.^cDefined as any parent that responded “No” to both having access to guns inside the home and having access to a gun not usually kept inside the home.^dFor values listed as n/a, no p-value is given for the chi-square test because there were cells with 0 respondents.^eThe non-Hispanic Other category includes those who self-identified as Chinese, Filipino, Japanese, Korean, Vietnamese, Asian Indian, Samoan, Guamanian or Chamorro, Native Hawaiian, Other Pacific Islander, American Indian or Alaska Native, and some other race.^fRegions are based on the six-region classification system used by the Chicago Department of Public Health for planning and reporting purposes; in addition, we further divided the North Central region into two separate regions (North and Central) to help balance out subgroup size for a total of seven city regions.

access to firearms in our study was lower than what was identified in a national survey in which 40.4% of adults with children reported that they lived in a household with firearms (Miller and Azrael 2022). Our findings for firearm access in this population were also lower than a national study that asked adolescents about access to firearms inside the home (Swahn, Hammig, and Ikeda 2002). Further, Salhi et al. found that although about 70% of parents reported that their adolescent child could not access a firearm kept

within their home, more than one-third of their adolescent children contradicted this assertion (Salhi, Azrael, and Miller 2021). Our study only collected data from parents and caregivers; youth were not surveyed and may have access to firearms that their parents have no knowledge about.

One potential explanation for the difference between our findings and data from previous national reports is that firearms are more prevalent in rural areas, which makes the

total average higher than what was found in this survey of an urban area (“Pew Research Center Report,” n.d.). In addition, since assessing for 1) firearm ownership or 2) firearm access inside and outside the home may be measuring two very different conditions, it may not be surprising that there are disparate results. Our findings also showed that households with higher socioeconomic status reported significantly greater firearm access than those with lower socioeconomic status. This contrasts with previous research that found associations between household level poverty and firearm injury (Barrett et al. 2022; Roberts et al. 2023). However, data on firearm ownership or access was not available in these studies; future studies should further explore these different conditions.

While our study collected some important baseline data about firearm access, it had several limitations that should be noted. First, our findings may not be generalizable to other populations; however, this simple approach to gather local data can be used to inform more tailored counseling approaches about firearm safety and can be applied to survey a range of populations in various settings. Second, in any survey that collects and analyzes self-reported behaviors, there is a possibility of social-desirability bias. Parents may not report having access to a firearm as it may be perceived as a socially undesirable response, resulting in underreporting. Third, nearly 80% of the male parents/caregivers we surveyed reported access to firearms compared to less than 20% of female parent/caregivers. If there had been more male respondents, perhaps the overall reported access to firearms would have been higher. Fourth, parents may not have understood the survey questions in the manner the survey creator intended, which could have skewed the results in either direction depending on how parental understanding differed from creator intention. This could be mitigated in future work by pilot testing the questions in cognitive interviews to ensure respondents answers are aligned with the intention of the survey questions. Lastly, our survey did not include questions about how firearms are stored in the home or outside of the home. Future surveys should investigate how firearms are secured and if parents are aware of secure storage practices, which can then be used to further tailor counseling and engagement efforts.

NEXT STEPS: DEVELOPING AND ADVOCATING FOR MULTILEVEL FIREARM INJURY PREVENTION STRATEGIES

Decreasing youth firearm injuries and deaths is a complex endeavor that includes understanding firearm access by parents, caregivers, and youth. At the same time, there are other upstream factors that contribute to firearm injury, as well as effective scientific methods and strategies that can be used to inform tailored interventions to address these factors. An example of the successful implementation of a public health strategy is the progress made in preventing motor vehicle crash deaths. There has been a dramatic decrease in motor vehicle crash deaths over the last 60 years as a result of applying a public health approach, including use of the Haddon Matrix—a systematic approach to injury

prevention that categorizes the phases (pre-event, event, post-event) and factors (host, agent, and physical and social environments) that contribute to an injury (Haddon 1972). The matrix works by applying a type of grid framework, in which the 3 phases are situated on the Y axis and the 4 factors are placed on the X axis for a total of 12 cells, and then utilizing different combinations of the phase-factor pairings to establish a multi-level prevention strategy. For example, the practice changes that contributed to a decrease in motor vehicle deaths included blood alcohol concentration laws (pre-event, host), airbags (event, agent), distance from a trauma center (post-event, physical environment), and societal support for rehabilitation services (post-event, social environment).

In their paper, “The Updated Haddon Matrix for Pediatric Firearm Injuries,” Lee et al. provided a refresh to the Haddon Matrix so that it could be applied to reduce youth firearm injury (Lee, Laraque-Arena, and Fleegler 2024). For example, in the pre-event/host cell of the matrix, secure storage counseling provided to parents by pediatricians during well childcare visits represents one component of a multi-pronged firearm injury prevention strategy. When considering the agent (firearm) in the pre-event row, secure storage of firearms can be included as another tactic. Physical and social environmental factors in the pre-event phase can include changes to the built environment such as increasing access to green spaces or decreasing poverty since both have been linked to decreases in firearm violence (Lee et al. 2022). By developing approaches for each phase-factor pairing, a robust strategy to reduce youth firearm injury and death can be developed. However, to implement the identified strategies, multi-sector collaboration will be required and much of that work will require advocacy at individual, community, and policy levels (Lee et al. 2022).

At the individual level, in their clinical role to reduce youth firearm injury and death, pediatricians can counsel parents on the health risks of firearm ownership and access and the necessity of secure storage. Based on our findings for firearm access in the home, we advocate for providing secure firearm storage counseling at all pediatric visits. However, counseling about secure storage alone may not be sufficient for all youth and families cared for by Chicago pediatricians. In Chicago, it is critical not only to talk to parents about secure storage but to talk to parents and teens about measures to mitigate the risk of community violence, the overwhelming cause of firearm death among Chicago youth (“Cook County Medical Examiner Case Archive,” n.d.).

However, previous studies have demonstrated that the amount of health advice a pediatrician is recommended to provide during a well childcare visit is unrealistic (Belamarich et al. 2006). Perhaps by understanding local data around firearm access and applying the findings of studies like ours, pediatricians can help focus their health promotion discussions to not only be more efficient but more effective. Gathering and evaluating data on firearm access confirmed that firearm safety counseling should also include discussions about firearm access—if a youth cannot

access a firearm, they are less likely to hurt themselves or others with a firearm.

At the community level, for example, pediatricians can partner with and support community-based programs that promote access to healthy foods, green space, affordable housing and poverty-reduction programs, and youth development programs (Lee et al. 2022). To reduce the majority of firearm deaths (homicide) that Chicago youth experience, pediatricians also need to forge partnerships with community-led programs and people that provide street outreach and violence interruption and work to address the causes of firearm violence. At the policy level, pediatricians can work with their local AAP chapter to promote firearm legislation such as child access prevention laws that have been shown to decrease firearm injuries (Azad, Monuteaux, Rees, et al. 2020). Using this study as a model, pediatricians across the US might choose to collect their own local data and apply the Haddon Matrix to better understand how they can best counsel and support their patient families.

Firearm injury, the leading cause of death for children in the US, is a complex health issue. As trusted champions for child health, pediatricians have a unique role to play that should include providing personalized counseling to families about how to keep their children safe from firearm injury. Local data on firearm access can help pediatricians tailor their health messages so that they can have the greatest impact.

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AUTHOR CONTRIBUTIONS

All authors made substantial contributions to the conception and design of the work; the acquisition, analysis, and interpretation of data; drafted and reviewed the work for important intellectual content; provided final approval of the manuscript to be published; and agreed to be accountable for all aspects of the work.

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ROLE OF FUNDER/SPONSOR

The anonymous family foundation had no role in the design and conduct of the study. KS is a member of the Patrick M. Magoon Institute for Healthy Communities.

ABBREVIATIONS

AAP: American Academy of Pediatrics; VOCHIC: Voices of Child Health in Chicago; NORC: National Opinion Research Center

CONFLICT OF INTEREST DISCLOSURES (INCLUDES FINANCIAL DISCLOSURES)

The authors have no conflicts of interest relevant to this article to disclose.

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SUPPLEMENTARY MATERIALS

A Survey of Parents' Firearm Access in Chicago and Implications for Pediatrician Counseling

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