

National Children's Study

Adult Hair Data Collection Form

Part A: Administrative	
<p>Date: <input type="text"/> / <input type="text"/> / <input type="text"/>2__0__<input type="text"/></p> <p>Time collection started: <input type="text"/>: <input type="text"/>: <input type="text"/> <input type="checkbox"/> 1 am <input type="checkbox"/> 2 pm</p> <p>Time collection stopped: <input type="text"/>: <input type="text"/>: <input type="text"/> <input type="checkbox"/> 1 am <input type="checkbox"/> 2 pm</p> <p>Assignment ID: <input type="text"/></p> <p>Participant ID: <input type="text"/></p> <p>Data Collector ID: <input type="text"/></p> <p>Site ID: <input type="text"/></p> <p>Visit location: <input type="checkbox"/> 1 Home <input type="checkbox"/> 2 Clinic/Office</p> <p>Participant's age <input type="text"/> years</p>	<p>Section Status (Select one) Complete <input type="checkbox"/> 1 Partial Complete <input type="checkbox"/> 2 Not Done <input type="checkbox"/> 3</p> <p>Reason for Not Done/Partial (Select one)</p> <p>SP Refusal <input type="checkbox"/> 1 SP III/Emergency <input type="checkbox"/> 3 No Time <input type="checkbox"/> 4 Safety Exclusion <input type="checkbox"/> 10 Quantity Not Sufficient <input type="checkbox"/> 14 Defective Collection Kit <input type="checkbox"/> 15 Language Issue, Spanish <input type="checkbox"/> 17 Language Issue, Non-Spanish <input type="checkbox"/> 18 Cognitive Disability <input type="checkbox"/> 20 No Time (no appt. set for next data collection) <input type="checkbox"/> 25 Other Specify _____ <input type="checkbox"/> 96</p> <p>Visit type</p> <p><input type="checkbox"/> P1 <input type="checkbox"/> T1 Mom <input type="checkbox"/> T1 Prior <input type="checkbox"/> T1 Dad <input type="checkbox"/> T3 First <input type="checkbox"/> T3 Prior</p>
Part B: Hair Collection Questions	
<p>1) Do you have a hair weave or use a wig?</p> <p style="text-align: right;"> <input type="checkbox"/> 1 Yes (Go to Part C) <input type="checkbox"/> 2 No <input type="checkbox"/> 97 Refuse <input type="checkbox"/> 98 Don't Know </p>	
<p>2) Has your hair been treated with a hair dye or hair color within the last 3 months?</p> <p style="text-align: right;"> <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 97 Refuse <input type="checkbox"/> 98 Don't Know </p>	
<p>3) Has your hair been given a permanent or treated with a hair straightener within the last 3 months?</p> <p style="text-align: right;"> <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 97 Refuse <input type="checkbox"/> 98 Don't Know </p>	

Public reporting burden for this collection of information is estimated to average 6 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-xxxx*). Do not return the completed form to this address.

4) Have you used shampoo or conditioner on your hair in the last 24 hours?
 1 Yes 2 No (Go to Q 6)
 97 Refuse (Go to Q 6) 98 Don't Know (Go to Q 6)

5) Have you used any of the following dandruff shampoos or conditioners in the last 24 hours?
 1 Head and Shoulders
 2 Denorex
 3 Dermarest
 4 Selsun Blue
 96 Other, Specify _____
 97 Refused
 98 Don't Know

6) Have you used other hair care products?
 1 Yes, Specify _____ 2 No
 97 Refused 98 Don't Know

Part C: Hair Collection

Kit ID: (Affix Pre-printed Hair Kit ID Label Here)

HRC-0001	<p>Collection Status (Select one)</p> <p>Collected <input type="checkbox"/> 1 Not Collected <input type="checkbox"/> 2</p> <p>Reason for Not Collected (Select one)</p> <p>Participant Ill/Emergency <input type="checkbox"/> 1 Defective Collection Kit <input type="checkbox"/> 2 Communication Problem <input type="checkbox"/> 3 No Time <input type="checkbox"/> 4 Quantity Not Sufficient <input type="checkbox"/> 5 Hair Weave/ Wig <input type="checkbox"/> 6 Other (Specify) _____ <input type="checkbox"/> 96 Refused <input type="checkbox"/> 97</p>
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Location of hair collection

Back of neck 1
 Multiple sites 2

Hair Comment: _____

Initials QC
