

OMB#: 0925:xxxx
Expiration Date: xx/xxx

National Children's Study

Child Hair Data Collection Form

Part A: Administrative	
Date: _ _ / _ _ / _ 2_ 0_ _ _	Site ID: _ _ _ _ _
Assignment ID: _ _ _ _ _ _ _ _ _	Participant's age _ _ months
Participant ID: _ _ _ _ _ _ _ _ _	Visit type <input type="checkbox"/> 12 Months <input type="checkbox"/> 36 Months <input type="checkbox"/> 60 Months
Data Collector ID: _ _ _ _ _ _ _ _	
Part B: Hair Collection Questions	
1) Does _____ (child's name) have a hair weave or use a wig? <div style="text-align: right;"> <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No (Go to Q 3) <input type="checkbox"/> 97 Refuse (Go to Q 3) <input type="checkbox"/> 98 Don't Know (Go to Q 3) </div>	
2) Is _____ (child's name) able to provide a hair sample today? <div style="text-align: right;"> <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No (END) <input type="checkbox"/> 97 Refuse (END) <input type="checkbox"/> 98 Don't Know (END) </div>	
3) Has _____ (child's name) hair been treated with a hair dye or hair color within the last 3 months? <div 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 </div>	
4) Has _____ (child's name) hair been given a permanent or treated with a hair straightener within the last 3 months? <div 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 </div>	
5) Has _____ (child's name) used shampoo or conditioner on his/her hair in the last 24 hours? <div style="text-align: right;"> <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No (Go to Q 7) <input type="checkbox"/> 97 Refuse (Go to Q 7) <input type="checkbox"/> 98 Don't Know (Go to Q 7) </div>	

<input type="checkbox"/>	1	Head and Shoulders	
<input type="checkbox"/>	2	Denorex	
<input type="checkbox"/>	3	Dermarest	
<input type="checkbox"/>	4	Selsun Blue	
<input type="checkbox"/>	96	Other, Specify _____	
<input type="checkbox"/>	97	Refused	
<input type="checkbox"/>	98	Don't Know	

☐ 1 Yes, Specify _____ ☐ 2 No

☐ 97 Refused ☐ 98 Don't Know

Kit ID: | | | | | | | | | | | |

Collected	<input type="checkbox"/>	1
Not Collected	<input type="checkbox"/>	2

Physical Limitations	<input type="checkbox"/> 1
Participant Ill/Emergency	<input type="checkbox"/> 2
Defective Collection Kit	<input type="checkbox"/> 3
Communication Problem	<input type="checkbox"/> 4
No Time	<input type="checkbox"/> 5
Quantity not sufficient	<input type="checkbox"/> 6
Other Specify _____	<input type="checkbox"/> 96
Refused	<input type="checkbox"/> 97
Don't know	<input type="checkbox"/> 98

Back of neck	<input type="checkbox"/> 1
Multiple sites	<input type="checkbox"/> 2