

Date Kit provided to participant: _ _ / _ _ / _ 2_ 0_ _ _	Date Samples picked up _ _ / _ _ / _ 2_ 0_ _ _
KIT ID	
Assignment ID:	Site ID:
Participant ID:	Visit type: <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
Data Collector ID:	<input type="checkbox"/> 6 Month

National Children’s Study DAY 2: ADULT SALIVA DATA COLLECTION FORM

****Please collect your saliva sample on the 2 days following our visit to your home on _____. Please write down the exact time that you collected each saliva sample in the spaces below.**

Day 2 Saliva Samples

**What is the date you collected the Day 2 saliva samples? ____/____/____
Month Day Year**

Tube #	When to take sample	Time collected	For Office Use Only
Wake	As soon as you wake up	____:____ a. ____ am b. ____ pm (Answer questions 1 & 2)	Sample collected <input type="checkbox"/> Yes <input type="checkbox"/> No

Please answer the following question after you have collected the Wake saliva sample:

1. Did you spend any time dozing in bed within 2 hours before the time that you woke up and collected the first saliva sample (Wake saliva sample) this morning?

Yes No

2. If yes, estimate of time spent dozing before collecting the Wake saliva sample.

_____ minutes

Tube #	When to take sample	Time collected	For Office Use Only
+30	30 minutes after waking up	____:____ a. ____ am b. ____ pm (check am or pm)	Sample collected <input type="checkbox"/> Yes <input type="checkbox"/> No

Tube #	When to take sample	Time collected	For Office Use Only
Bedtime	Before brushing your teeth and at least 1 hour after eating for the last time today	____:____ a. __ am b. __ pm (Answer questions 3, 4 & 5)	Sample collected <input type="checkbox"/> Yes <input type="checkbox"/> No

Please answer the following questions after you have collected the Bedtime saliva sample:

3. During the past 2 hours have you done any of the following:

- a. Consumed a caffeinated beverage (coffee, tea, soda)? Yes No
- b. Smoked? Yes No
- c. Consumed alcohol? Yes No

4. During the past 2 hours has your physical activity been (circle the correct answer):

- Light? (standing, walking light, light house work)
- Moderate? (yard work, brisk walking)
- Intense? (jogging, exercise classes)

5. Please write down the name of any prescription or over the counter medications that you have taken today. Please be specific. For example, if you took Robitussin DM[®], write Robitussin DM[®] not Robitussin[®].

Please feel free to call if you have any questions:
[X at phone #]