OMB #: 0925-0593 Expiration Date: 07/31/2013 Infant and Child Health Care Log, Phase 2e

Infant and Child Health Care Log

(Birth to 6 years old)



CHILD'S LAST NAME:
CHILD'S FIRST NAME:
CHILD'S DATE OF BIRTH:
month day year

BRING THIS LOG TO ALL HEALTH CARE VISITS.
USE THIS LOG FOR ALL NATIONAL CHILDREN'S STUDY TELEPHONE CALLS AND VISITS.
PLEASE TELL NCS STAFF WHEN MORE FORMS ARE NEEDED.

Save all bottles and containers of medications. Bring to National Children's Study visits and have available for telephone calls:

Medicines (those prescribed by a health care provider and those bought "over-the-counter")

Public reporting for this collection of information is estimated to average 20 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 (0925-0593). Do not return the completed form to this address.

Infant and Child Health Care Log

This Infant and Child Health Care Log will help you keep track of all your child's visits to doctors or other health care providers from birth to 6 years old. We will ask you about your child's visits whenever we interview you by telephone or in person.

A Health Care Provider can be:

- Pediatrician or family medicine doctor
- Specialist (like a surgeon, heart doctor, allergy or skin doctor)
- Nurse practitioner or physician assistant
- Nurse
- Social worker/counselor
- Other

Health Care Visits can be to:

- Doctor's office, clinic or health center
- Emergency room
- Urgent care center
- Hospital (inpatient, overnight stay)
- Some other place

The log has two parts:

- 1. **Health Care Provider Log** is to record information about where your child visits the doctor or other health care provider.
- 2. **Health Care Visit Log** is to record information about all of your child's visits to doctors, other healthcare providers, or an emergency room. This includes overnight hospital stays as well as outpatient visits.

BRING this Infant and Child Health Care Log with you to all of your child's health care and National Children's Study visits. Also, have it available for all National children's Study telephone interviews.

If you forget to bring it with you to a health care visit, please fill it in as soon as possible.

Medicines (those prescribed by a health care provider and those bought "over-the-counter")

[•] Vitamins, minerals, herbs, and any other supplements

HEALTH CARE PROVIDER LOG INSTRUCTIONS

The Health Care Provider is the person who cared for your child at this visit (doctor, nurse, social worker, etc.)

Column 1. A number is listed for each health care provider (for example, 1, 2, 3, 4, etc.). This number will be referred to on the Health Care Visit Log pages.

Column 2. Attach the health care provider's business card here.

Fill in columns 3-10 only if you have not attached the health care provider's business card.

Column 3. Write in the name of the health care provider.

Column 4. Check the box for the type of provider. If it was "Other," write the type of health care provider.

Column 5. Check the box for the type of place where you saw the provider. If it was "Other place," write in the type of place where your child visited the health care provider.

Columns 6-9. Write in the address of the place including city/town, state, and ZIP code.

Column 10. Write in the telephone number of the health care provider including area code.

See the example in the first line of the log on the next page.

After you fill out the Health Care Provider Log, please fill out the Health Care Visit Log.

Inform the National Children's Study staff when more Log pages are needed.

Medicines (those prescribed by a health care provider and those bought "over-the-counter")

[•] Vitamins, minerals, herbs, and any other supplements

			CARE PRO						
		Fil	ll in ONLY if y	ou HAVE N	NOT attac	hed a busine	ess ca	rd	
1	2	3	4	5	6	7	8	9	10
Health Care Provider Number	Attach Health Care Provider Business Card	Name of Health Care Provider/Clinic/Ho spital	Type of Health Care Provider	Type of Place	Street Address	City or Town	Stat e	Zip Code	Telepho ne Number
			X Pediatrician or	X Doctor's					
0	Exan	Dr. Joe Jones	Family Physician Specialist Nurse practitioner or physician assistant Nurse Social Worker/counselor Other(specify):	office, clinic, or health center □Emergency room □ Urgent care center □ Hospital □ Other place (specify):	400 Main Street	Capitol City	MN	56087	(507) - 123 - 4567
			D Dedictorials as as						
1			☐ Pediatrician or Family Physician ☐ Specialist ☐ Nurse practitioner or physician assistant ☐ Nurse ☐ Social Worker/counselor ☐ Other (specify):	□ Doctor's office, clinic, or health center □Emergency room □ Urgent care center □ Hospital □ Other place (specify):					
2			☐ Pediatrician or Family Physician ☐ Specialist ☐ Nurse practitioner or physician assistant ☐ Nurse ☐ Social Worker/counselor ☐ Other (specify):	□ Doctor's office, clinic, or health center □Emergency room □ Urgent care center □ Hospital □ Other place (specify):					

	T	
	☐ Other (specify):	Li Onter prace
		(specify):
	☐ Pediatrician or	□ Doctor's
	Family Physician	office, clinic, or
	☐ Specialist	health center
	☐ Nurse practitioner or	□Emergency
4	physician assistant	room
4	□ Nurse	□ Urgent care
	□ Social	center
	Worker/counselor	□ Hospital
	☐ Other (specify):	□ Other place
		(specify):
	☐ Pediatrician or	□ Doctor's
	Family Physician	office, clinic, or
	☐ Specialist	health center
	☐ Nurse practitioner or	□Emergency
5	physician assistant	room
5	□ Nurse	□ Urgent care
	□ Social	center
	Worker/counselor	□ Hospital
	☐ Other (specify):	□ Other place
		(specify):

		HEALTH	CARE PRO	OVIDER I	.OG				
		Fi	II in ONLY if y	ou HAVE I	NOT attac	hed a busine	ss car	d	
1	2	3	4	5	6	7	8	9	10
Health Care Provider Number	Attach Health Care Provider Business Card	Name of Health Care Provider/Clinic/Hos pital	Type of Health Care Provider	Type of Place	Street Address	City or Town	Stat e	Zip Code	Telephon e Number
6			☐ Pediatrician or Family Physician ☐ Specialist ☐ Nurse practitioner or physician assistant ☐ Nurse ☐ Social Worker/counselor ☐ Other (specify):	□ Doctor's office, clinic, or health center □Emergency room □ Urgent care center □ Hospital □ Other place (specify):					
7			☐ Pediatrician or Family Physician ☐ Specialist ☐ Nurse practitioner or physician assistant ☐ Nurse ☐ Social Worker/counselor ☐ Other (specify): ———	□ Doctor's office, clinic, or health center □Emergency room □ Urgent care center □ Hospital □ Other place (specify):					
8			□ Pediatrician or Family Physician □ Specialist □ Nurse practitioner or physician assistant □ Nurse □ Social Worker/counselor □ Other (specify):	□ Doctor's office, clinic, or health center □Emergency room □ Urgent care center □ Hospital □ Other place (specify):					

HEALTH CARE VISIT LOG INSTRUCTIONS Office and Outpatient Visits and Overnight Hospital Stays

Each time your child goes to the doctor or any other health care provider (for example, doctor, nurse, social worker, etc.) or is hospitalized overnight, write down information about the visit on a new line in the Health Care Visit Log.

Please try to fill in columns 1-3 before the visit. If possible, ask your health care provider or the office staff to fill out columns 4-10. If that is not possible, please fill out columns 4-10 at the visit or as soon as possible.

- **Column 1.** Health care visit date (month/day/year).
- **Column 2.** Write the Health Care Provider number from Column 1 in the Health Care Provider Log.
- **Column 3.** Check (\checkmark) the reason(s) for the visit and explain if needed. Include office/outpatient visits and overnight hospital stays. For example: If your child got a well-baby check up, put a check (\checkmark) in the "check-up/well child visit" box.
- **Columns 4-6.** Write in your child's weight, and length or height at the visit. Write in the head circumference through age 2. If these measurements were not done, check ($\sqrt{}$) "Not Done." For example: If your child is 22 inches long at his visit, write in "22" inches.
- **Column 7.** If your child got an immunization/vaccination/shot during the visit, put a check (√) in the "YES" box and **Go to the** Immunization/Vaccination/Shot Log.
- **Column 8.** If your child gets any test, medication, or treatment during his/her visit, put a check $(\sqrt{})$ next to the medication/treatment and list each.
- **Column 9.** Write what the health care provider told you (the diagnosis) at the visit. Include a few key words to describe the event or diagnosis.

For example: For a check-up or well child visit, the doctor may have told you that your child is 'growing normally and is healthy' or 'has an ear infection.' Write this down in the 'Diagnosis' column.

Column 10. Check the box to show if the office staff filled out the log or if you did. After you report the visit to the NCS study staff, please write in the date you told us about that visit.

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Bring this log to all health care visits. Use this log for all National Children's Study telephone calls and visits.

Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

[•] Medicines (those prescribed by a health care provider and those bought "over-the-counter")

[•] Vitamins, minerals, herbs, and any other supplements

	LOG F	OR OUTPATIENT	HEALT	H CARE	VISITS A	AND OVE	RNIGHT HOS	PITAL STAYS	
1	2	3	4	5	6	7	8	9	10
Date of visit	Health Care Provider # from Health Care Provider Log	Reason for visit (check all that apply)	Weight	Length/ Height	Head circumferen ce (0-2 yrs.)	Immunizati on/ Vaccination / Shot	Tests/ Medications/ Treatments e.g., lab tests (blood, urine), medicines, vitamins, minerals, herbs, supplements, procedures	Diagnosis or Problem	Complet ed by Office or Self Date Reporte d to NCS
March 3, 2010	o 	V Routine well visit ☐ Sick visit ☐ Specialist doctor visit ☐ Emergency visit ☐ Immunization/ ☐ Follow-up visit ☐ Overnight hospital stay How many nights? ☐ Some other reason (explain):	10lb pounds4 oz. ounces OR	in Inches ORcm centimete rs □ Not Done/Don't Know		□ NO √ YES, If 'YES' then go to Immunizati on / Vaccination / Shot Log	Lab test (blood)	Well infant, good growth and development	√ Office □ Self Date: March 4, 2011
		□ Routine well visit □ Sick visit □ Specialist doctor visit □ Emergency visit □ Immunization/ vaccination/shot □ Follow-up visit □ Overnight hospital stay How many nights? □ Some other reason (explain):	lb poundsoz. ounces ORkg kilograms □ Not Done/Don' t Know	or centimet ers	cm centimeters OR Inches Not Done/Don't Know	□ NO □ YES, If 'YES' then go to Immunizati on / Vaccination / Shot Log			□ Office □ Self Date:
		□ Routine well visit □ Sick visit □ Specialist doctor visit □ Emergency visit □ Immunization/ vaccination/shot □ Follow-up visit	lb poundsoz. ounces ORkg kilograms	in Inches OR cmcmcentimet	cm centimeters ORin Inches	□ NO □ YES, If 'YES' then go to Immunizati on / Vaccination /			□ Office □ Self Date:

	LOG F	Overnight hospital stay How many nights? Some other reason (explain): OR OUTPATIENT	□Not Done/Don' t Know	ers □ Not Done/Don' t Know	□Not Done/Don't Know	Shot Log	RNIGHT HOS	ΡΙΤΔΙ STΔΥS	
Date of visit	2 Health Care Provider # from Health Care Provider Log	3 Reason for visit (check all that apply)	4 Weight	5 Length/ Height	6 Head circumferen ce (0-2 yrs.)	7 Immunizati on/ Vaccination / Shot	8 Tests/ Medications/ Treatments e.g., lab tests (blood, urine), medicines, vitamins, minerals, herbs, supplements, procedures	9 Diagnosis or Problem	10 Complet ed by Office or Self Date Reporte d to NCS
		□ Routine well visit □ Sick visit □ Specialist doctor visit □ Emergency visit □ Immunization/ vaccination/shot □ Follow-up visit □ Overnight hospital stay How many nights? □ Some other reason (explain):	lb poundsoz. ounces ORkg kilograms □ Not Done/Don' t Know	OR cm centimet ers Not Done/Don' t Know	cm centimeters ORin Inches □ Not Done/Don't Know	□ NO □ YES, If 'YES' then go to Immunizati on / Vaccination / Shot Log			□ Office □ Self Date:
		□ Routine well visit □ Sick visit □ Specialist doctor visit □ Emergency visit □ Immunization/ vaccination/shot □ Follow-up visit □ Overnight hospital stay How many nights? □ Some other reason (explain):	lb poundsoz. ounces ORkg kilograms □ Not Done/Don' t Know	or centimet ers Not Done/Don't Know	cm centimeters ORin Inches □ Not Done/Don't Know	□ NO □ YES, If 'YES' then go to Immunizati on / Vaccination / Shot Log			□ Office □ Self Date:

How many nights? Done/Don' Some other reason (explain): Not Done/Don' t Know Not Done/Done/Done/Done/Done/Done/Done/Done/	☐ Sick vi ☐ Specia ☐ Emerg ☐ Immur vaccin ☐ Follow ☐ Overn How m ☐ Some	list doctor visit ency visit inization/ ation/shot -up visit iight hospital stay nany nights? other reason pounds oz. ounces OR kilograms	Done/Don'	-	□ NO □ YES, If 'YES' then go to Immunizati on / Vaccination / Shot Log			□ Office □ Self Date:
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	LOG F	OR OUTPATIENT	HEALTI	H CARE	VISITS A	AND OVE	RNIGHT HOS	PITAL STAYS	
1	2	3	4	5	6	7	8	9	10
Date of visit	Health Care Provider # from Health Care Provider Log	Reason for visit (check all that apply)	Weight	Length/ Height	Head circumferen ce (0-2 yrs.)	Immunizati on/ Vaccination / Shot	Tests/ Medications/ Treatments e.g., lab tests (blood, urine), medicines, vitamins, minerals, herbs, supplements, procedures	Diagnosis or Problem	Complet ed by Office or Self Date Reporte d to NCS
		□ Routine well visit □ Sick visit □ Specialist doctor visit □ Emergency visit □ Immunization/ vaccination/shot □ Follow-up visit □ Overnight hospital stay How many nights? □ Some other reason (explain):	lb poundsoz. ounces ORkg kilograms □ Not Done/Don' t Know	or centimet ers	cm centimeters OR Inches Not Done/Don't Know	□ NO □ YES, If 'YES' then go to Immunizati on / Vaccination / Shot Log			□ Office □ Self Date:
		□ Routine well visit □ Sick visit □ Specialist doctor visit □ Emergency visit □ Immunization/ vaccination/shot	lb poundsoz. ounces ORkg	Inches in	cm centimeters ORin	□ NO □ YES, If 'YES' then go to Immunizati on /			□ Office □ Self Date:

☐ Follow-up visit ☐ Overnight hospital stay How many nights? ☐ Some other reason (explain):	kilograms Not Done/Don' t Know	cm centimet ers □ Not Done/Don' t Know	Inches □ Not Done/Don't Know	Vaccination / Shot Log		
□ Routine well visit □ Sick visit □ Specialist doctor visit □ Emergency visit □ Immunization/ vaccination/shot □ Follow-up visit □ Overnight hospital stay How many nights? □ Some other reason (explain):	lb poundsoz. ounces ORkg kilograms □ Not Done/Don' t Know	in Inches OR cm centimet ers Not Done/Don't Know	cm centimeters ORin Inches □ Not Done/Don't Know	□ NO □ YES, If 'YES' then go to Immunizati on / Vaccination / Shot Log		□ Office □ Self Date:

	LOG F	OR OUTPATIENT	HEALTI	H CARE	VISITS A	AND OVE	RNIGHT HOS	PITAL STAYS	
1 Date of visit	2 Health Care	3 Reason for visit (check all that apply)	4 Weight	5 Length/ Height	6 Head circumferen	7 Immunizati on/	8 Tests/ Medications/ Treatments	9 Diagnosis or Problem	10 Complet
	Provider # from Health Care				ce (0-2 yrs.)	Vaccination / Shot	e.g., lab tests (blood, urine), medicines, vitamins, minerals, herbs, supplements,		ed by Office or Self Date
	Provider Log						procedures		Reporte d to NCS
		☐ Routine well visit ☐ Sick visit	lb pounds	in Inches	cm centimeters	□ NO			□ Office □ Self
		☐ Specialist doctor visit☐ Emergency visit☐ Immunization/	ounces OR	OR	OR	☐ YES, If 'YES' then go to Immunizati			
		vaccination/shot Follow-up visit	kg kilograms	cm centimet	in Inches	on / Vaccination			Date:
		☐ Overnight hospital stay How many nights? ☐ Some other reason (explain):	□ Not Done/Don' t Know	ers Not Done/Don' t Know	□ Not Done/Don't Know	Shot Log			

	 □ Routine well visit □ Sick visit □ Specialist doctor visit □ Emergency visit □ Immunization/ vaccination/shot □ Follow-up visit □ Overnight hospital stay How many nights? □ Some other reason (explain): 	lb poundsoz. ounces ORkg kilograms □ Not Done/Don' t Know	or centimet ers Not Done/Don't Know	cm centimeters ORin Inches □ Not Done/Don't Know	□ NO □ YES, If 'YES' then go to Immunizati on / Vaccination / Shot Log		□ Office □ Self Date:
	□ Routine well visit □ Sick visit □ Specialist doctor visit □ Emergency visit □ Immunization/ vaccination/shot □ Follow-up visit □ Overnight hospital stay How many nights? □ Some other reason (explain):	lb pounds oz. ounces OR kg kilograms □ Not Done/Don' t Know	or centimet ers Not Done/Don't Know	cm centimeters ORin Inches □ Not Done/Don't Know	□ NO □ YES, If 'YES' then go to Immunizati on / Vaccination / Shot Log		□ Office □ Self Date:

Inform the National Children's Study staff when more pages are needed.

 $Bring\ this\ log\ to\ all\ health\ care\ visits.\ Use\ this\ log\ for\ all\ National\ Children's\ Study\ telephone\ calls\ and\ visits.$

Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:
• Medicines (those prescribed by a health care provider and those bought "over-the-counter")

[•] Vitamins, minerals, herbs, and any other supplements

IMMUNIZATION / VACCINATION / SHOT LOG INSTRUCTIONS

- > Write in the date of the immunization/vaccination/shot.
- > Put a √ in the box of each vaccine(s) given to your child. Ask your child's Health Care Provider to help you to check all of the right boxes.
- > At the bottom of the Log, write in if your child had any problems after any of the immunizations, vaccinations or shots.

CONTACT YOUR CHILD'S DOCTOR IF YOUR CHILD HAS ANY PROBLEMS AFTER AN IMMUNIZATION/ SHOT/ VACCINATION.

IMMUNIZATION / VACCINATION / SHOT LOG **Needles or injections** Nasa Βy Needle Mouth Combination vaccines Mist and Rubella (MMR) Pertussis (whooping cough) and Flu') 'Flu') /aricella (Chickenpox) Inactivated Polio (IPV) Mumps, Rubella, Diphtheria, Tetanus, 므 Pneumococcal Conjugate Varicella (MMRV) and Syncotial Viru В Meningococcal nfluenza (Seasonal Hepatitis B (Hep (Seasonal DTaP and Hib and IPV and Hep I DTaP, IPV, and Hepatitis A Rotavirus œ. Heb Mumps, a DTaP nfluenza alivizumab to Measles, **DATE OF** Measles, **IMMUNIZATIO** and N √ √ March 3, 2011 **XYZ Vaccine** ANY PROBLEMS AFTER A SHOT/IMMUNIZATION/VACCINATION? **DATE YOU FIRST NOTICED DATE OF THE DESCRIBE THE PROBLEM** Immunization / THE PROBLEM **Vaccination / Shot**

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Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

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