**Health Care Provider Record Verification Form**

Date (MM/DD/YY) \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_

Please indicate whether you treated and/or diagnosed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_with the following

*Child’s Name*

conditions. If yes, please enter the date(s) of treatment and/or diagnosis.

|  |  |  |
| --- | --- | --- |
| Condition Date Treated and/or Diagnosed | Yes | No |
|  | ❑ | ❑ |
|  | ❑ | ❑ |
|  | ❑ | ❑ |
|  | ❑ | ❑ |
|  | ❑ | ❑ |
|  | ❑ | ❑ |
|  | ❑ | ❑ |
|  | ❑ | ❑ |
|  | ❑ | ❑ |
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|  | ❑ | ❑ |

Please sign and date below:

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature Date*

*Completed forms should be returned to NORC by fax (xxx)-xxx-xxxx or mail: 55 E. Monroe Street, Suite 30, Chicago, IL 60603.*

Thank you for your participation in this important study!