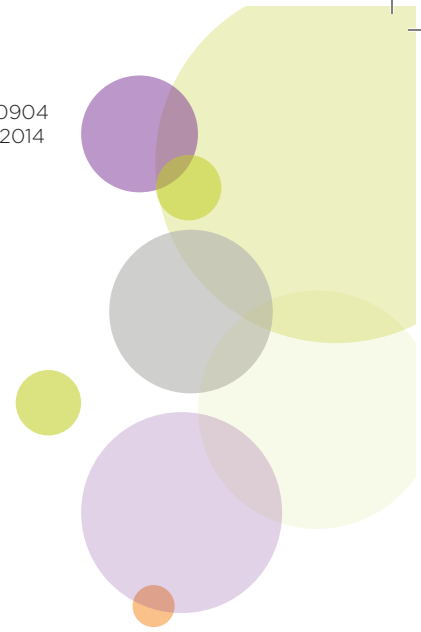


Form Approved  
OMB No. 0920-0904  
Exp. Date 11/30/2014



# Initial Participant Survey

Parent / Guardian Version

This survey is to be filled out by the Parent or legal Guardian of the child age less than 18 years old who has diabetes.

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining 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 CDC Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0904)





This survey is to be filled out by the **PARENT** or **LEGAL GUARDIAN**. We want to learn more about children and young people who have diabetes. You can help us to do that by filling out these questions. In this survey, we will use the term **CHILD** to refer to **YOUR CHILD** or the child that you are the **LEGAL GUARDIAN** for.

1. What is today's date? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

For example, if today is May 1, 2011, write in 05/01/2011

2. What is your child's sex? 1  Female 2  Male

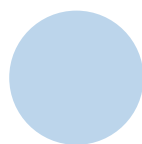
3. Has your doctor or nurse ever told you or your child that your child has diabetes?

1  **YES.** Turn the page and continue on to question 4.

2  **NO. STOP.** Please turn to **page 9** and complete this information.

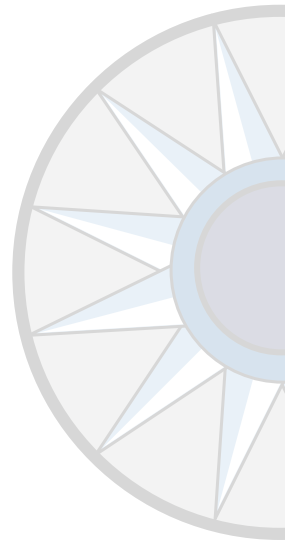
Please mail the survey to us in the stamped envelope.

**Thank You**  
for filling out these questions.



**We would like to ask you some questions about your child's birthday, when your child first got diabetes, and how you or your child takes care of his/her diabetes.**

Please answer the questions as best as you can. If you do not know the answer to a question, leave it blank.



4. What is your child's birthdate? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

5. When was your child first told by a doctor or a nurse that he/she had diabetes?  
 This means when your child was told about his/her diabetes diagnosis.  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

6. How did you first find out that your child had diabetes?  
 (Check Yes or No for each question)

Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>	My child was thirsty, had to pee a lot, or got sick very quickly.
Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>	I found out that my child had diabetes when he/she had a school physical or at a regular check-up.
Yes 1 <input type="checkbox"/>	2 No <input type="checkbox"/>	I found out that my child had diabetes when his/her blood sugar was checked at a health fair or at school.
Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>	I found out that my child had diabetes when she was pregnant and the diabetes <b>did not</b> go away after the pregnancy.
Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>	I found out that my child had diabetes when she was pregnant but the diabetes <b>went away</b> after the pregnancy.

If none of the above apply to you, please write on the lines below how you first found out your child had diabetes.

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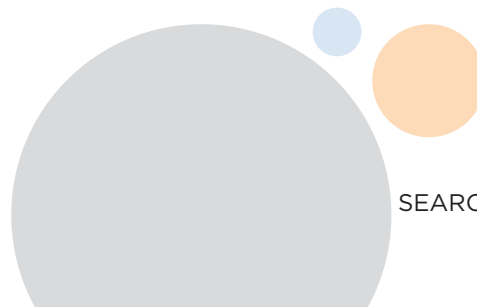
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7. What type of diabetes did the doctor or nurse tell you or your child that he/she has?  
 (please check one box)

- 1  Type 1 diabetes, IDDM, juvenile diabetes
- 2  Type 2 diabetes, NIDDM
- 3  Maturity onset diabetes of youth (MODY)
- 4  Other type of diabetes, please specify \_\_\_\_\_
- 5  Don't know







**20.** Does the child have any full or half brothers?

1  Yes   2  No   3  Don't know

(If No or Don't know, skip to question 21)

**20a.** If Yes, how many full or half brothers does your child have?

\_\_\_\_\_ brothers

**20b.** If Yes, how many full or half brothers have diabetes?

\_\_\_\_\_ brothers

**21.** Does the child have any full or half sisters?

1  Yes   2  No   3  Don't know

(If No or Don't know, skip to question 22)

**21a.** If Yes, how many full or half sisters does your child have?

\_\_\_\_\_ sisters

**21b.** If Yes, how many full or half sisters have diabetes?

\_\_\_\_\_ sisters



**Now we would like to learn a bit about your child's health insurance and health care services.**

**22.** What kind of health insurance plan does your child have **NOW**?  
(Answer Yes or No for each question).

22a. Medicaid/Medicare/State-funded/other Federally-funded	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>
22b. Private insurance, through employer	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>
22c. Private insurance, purchased on your own	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>
22d. Military	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>
22e. School-based insurance	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>
22f. Tribe/Indian Health Service	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>
22g. Any other or type unknown	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>
22h. None	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>



**23.** What kind of health insurance plan did your child have when he/she was diagnosed with diabetes?  
(Answer Yes or No for each question).

23a. Medicaid/Medicare/State-funded/other Federally-funded	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>
23b. Private insurance, through employer	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>
23c. Private insurance, purchased on your own	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>
23d. Military	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>
23e. School-based insurance	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>
23f. Tribe/Indian Health Service	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>
23g. Any other or type unknown	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>
23h. None	Yes 1 <input type="checkbox"/>	No 2 <input type="checkbox"/>

**24.** Who does your child usually go to for most of his/her care related to diabetes?  
(Please check only one response).

- 1  Pediatrician
- 2  Family practice or internal medicine physician
- 3  Pediatric endocrinologist/diabetologist (diabetes specialist)
- 4  Adult endocrinologist/diabetologist (diabetes specialist)
- 5  Another type of physician
- 6  Other health care professional (nurse, nurse practitioner, physician assistant, certified diabetes educator, or other)
- 7  Unsure





**The next few questions are related to the education and household income of your family.**

**25.** What is the highest degree or level of school that your child's mother/guardian and father/guardian have completed?

	Mother/ guardian	Father/ guardian
25a. Any education less than a high school graduate, no diploma or GED	1 <input type="checkbox"/>	1 <input type="checkbox"/>
25b. High school graduate, (high school diploma) or equivalent (for example, GED)	2 <input type="checkbox"/>	2 <input type="checkbox"/>
25c. Business/technical school, associate degree (AA, AS) or some college	3 <input type="checkbox"/>	3 <input type="checkbox"/>
25d. Bachelor degree (for example, BA, AB, BS) (4-year)	4 <input type="checkbox"/>	4 <input type="checkbox"/>
25e. Master degree (for example MA, MS, MEng, Med., MSW)	5 <input type="checkbox"/>	5 <input type="checkbox"/>
25f. Professional or doctorate degree (for example, MD, DDS, JD, PhD, EdD)	6 <input type="checkbox"/>	6 <input type="checkbox"/>
25g. Don't know	7 <input type="checkbox"/>	7 <input type="checkbox"/>

**26.** Which of these categories best describes the **total** income of all persons living in the Parent's/ Guardian's household for the past 12 months? (check only one category)

- |  |  |
|--|--|
| 1 <input type="checkbox"/> Less than \$5,000         | 6 <input type="checkbox"/> \$35,000 through \$49,999 |
| 2 <input type="checkbox"/> \$5,000 through \$11,999  | 7 <input type="checkbox"/> \$50,000 through \$74,999 |
| 3 <input type="checkbox"/> \$12,000 through \$15,999 | 8 <input type="checkbox"/> \$75,000 through \$99,999 |
| 4 <input type="checkbox"/> \$16,000 through \$24,999 | 9 <input type="checkbox"/> \$100,000 and greater     |
| 5 <input type="checkbox"/> \$25,000 through \$34,999 | 10 <input type="checkbox"/> Don't know               |

**27.** How many people are living in the Parent/Guardian's household?

**27a.** Total number of people \_\_\_\_\_

**27b.** Number of children (less than 18) \_\_\_\_\_

**27c.** Number of adults \_\_\_\_\_

Of the number of adults, how many bring income into the household? \_\_\_\_\_





C. What is the **best** address, email and phone number to send mail or call?

[Grid of 25 boxes for address input]

P.O.Box

Street

Apt#

[Grid of 25 boxes for address input]

City

[Grid of 2 boxes for city input]

[Grid of 5 boxes for city input]

State

Zip

[Grid of 25 boxes for address input]

Email address

Phone number (best) [Grid of 3 boxes] - [Grid of 7 boxes] - [Grid of 4 boxes]  
area code extension

Is this:  Home  Work  Cellular Phone  Other

Phone number (other) [Grid of 3 boxes] - [Grid of 7 boxes] - [Grid of 4 boxes]  
area code extension

Is this:  Home  Work  Cellular Phone  Other

Phone number (other) [Grid of 3 boxes] - [Grid of 7 boxes] - [Grid of 4 boxes]  
area code extension

Is this:  Home  Work  Cellular Phone  Other

What is the best time to call?  morning  afternoon  evening

May we contact you over the weekend?  Yes  No

May we contact you at work?  Yes  No

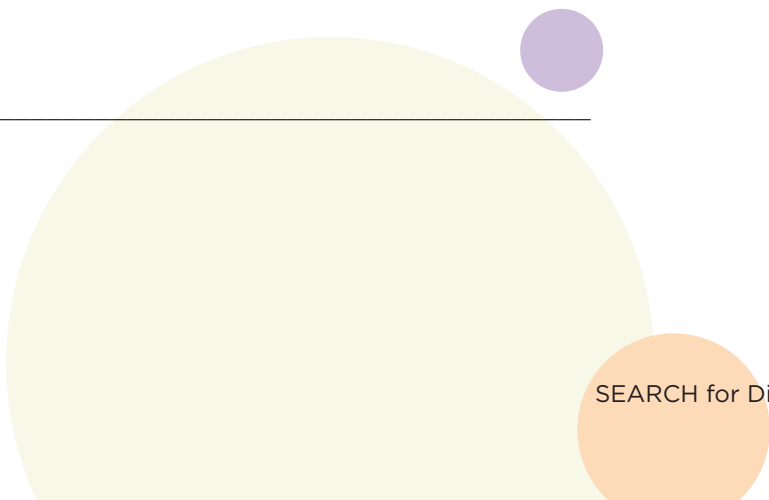
Who lives at this address? (check yes or no for each one)

- My child does 1  Yes 2  No
- Child's Father 1  Yes 2  No
- Child's Mother 1  Yes 2  No
- Child's Spouse 1  Yes 2  No
- Other 1  Yes 2  No

Does your child usually speak:

- 1  English
- 2  Spanish
- 3  Some other language

Specify: \_\_\_\_\_



## Alternate Contact Information

As a part of this study, we may be contacting you in the future. Please provide us with the names, addresses, phone numbers, and email addresses of two people who could contact you if your address or phone number changes.

### Contact #1:

First Name

Middle Name

Last Name

Relationship

P.O.Box

Street

Apt#

City

State

Zip Code

Email address

Phone number (best)

area code

extension

Phone number (other)

area code

extension

Phone number (other)

area code

extension



**Contact #2:**

First Name

Middle Name

Last Name

Relationship

P.O.Box

Street

Apt#

City

State

Zip Code

Email address

Phone number (best)

area code

extension

Phone number (other)

area code

extension

Phone number (other)

area code

extension

# Thank You

for filling out this survey.

Please mail it to us in the stamped, pre-addressed envelope. If you have lost the envelope, please send it to the address below.



## FOR STUDY USE ONLY

Patient ID Number        
Site Sub-site Sequential ID

Date Completed       Completed by     
Month Day Year

Mode of Administration  In Person  Telephone  Mailed  CATI

Date Reviewed       Reviewer Code     
Month Day Year

Date Entered       Data Entry Code     
Month Day Year

