

APPENDIX 17

CHILD ROSTER FORM

Program Name:
Center Name:
Center ID:
Center City:
Center State:
Center Phone:
Center Contact Name:



INSTRUCTIONS:

- For each sampled classroom, please provide the requested information for each **MSHS funded** child, including child name (Column A), child date of birth (Column B), child gender (Column C), and child primary language (Column D). Please include **ONLY** those children funded through **FEDERAL ACF MSHS FUNDS**.
- In column E, please include the full name of the child's Parent/Primary Caregiver.
- If any MSHS funded child has a sibling **in this classroom or another classroom selected for the study** at your center, please record the sibling's name in Column F. If there is more than one, please note this in the Notes box at the bottom of the roster. For this study, siblings are any children who live in the same household and are cared for by the **same** Parent/Primary Caregiver.
- When finished, please return this form to the Westat study team through the Huddle site, using the login credentials that were sent to you in a separate email. Please do **NOT** email this information to the study team.
- If you have questions about this form or accessing Huddle, please call us toll-free at 1-888-XXX-XXXX.

Classroom Teacher Name: _____
First _____ **Last** _____

Session (Please Circle): PM Full Day Other (specify) _____

Child Information				Parent/Primary Caregiver			Siblings				
Column A			Column B	Column C	Column D	Column E			Column F		
First Name	Middle Name	Last	Date of Birth (Month/Day/Year)	Gender M-Male F-Female	Primary Language E-English S-Spanish O-Other	First Name	Middle Name	Last	First Name	Middle Name	Last
Name						Name			Name		
1. _____			___/___/___	M F	___	_____			_____		
2. _____			___/___/___	M F	___	_____			_____		
3. _____			___/___/___	M F	___	_____			_____		
4. _____			___/___/___	M F	___	_____			_____		
5. _____			___/___/___	M F	___	_____			_____		
6. _____			___/___/___	M F	___	_____			_____		
7. _____			___/___/___	M F	___	_____			_____		

Child Information				Parent/Primary Caregiver			Siblings				
Column A			Column B	Column C	Column D	Column E			Column F		
First Name	Middle Name	Last Name	Date of Birth (Month/Day/Year)	Gender M-Male F-Female	Primary Language E-English S-Spanish O-Other	First Name	Middle Name	Last Name	First Name	Middle Name	Last Name
8. _____	_____	_____	___/___/___	M F	___	_____	_____	_____	_____	_____	_____
9. _____	_____	_____	___/___/___	M F	___	_____	_____	_____	_____	_____	_____
10. _____	_____	_____	___/___/___	M F	___	_____	_____	_____	_____	_____	_____

Paperwork Reduction Act Statement: The referenced collection of information is voluntary. 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. The OMB control number for this collection is xxxx-xxxx and it expires XX/XX/XXXX. The time required to complete this collection of information is estimated to average 15 minutes, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the collection of information. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Abt Associates, 55 Wheeler Street, Cambridge MA 02138 Attention: Linda Caswell.