Center for Autism and Developmental Disabilities Research and Epidemiology
CADDRE

Attachment 17.a.

Form Approved
OMB No. 0920-XXXX
Exp. Date: XX/XX/XXXX

Study to Explore Early Development

Interviewer_______________

Study ID#_____________
Date of Completion ___________
Time of Completion___________

Blood Draw Information Form

1. Please tell me all vaccinations, medications, vitamins, and supplements, both prescription and over the counter, <*child first name*> has taken in the last month.
[Interviewer: Check box for MOST RECENT time frame when medication was last taken.]

If no medications, vitamins, or supplements given in last month, check here: ____

Type of substance	Last 7 days	Last month
1)_________________________	☐	☐
2) _________________________	☐	☐
3)_________________________	☐	☐
4) _________________________	☐	☐
5) _________________________	☐	☐
6) _________________________	☐	☐
7) _________________________	☐	☐
8) _________________________	☐	☐

2. List any cold, flu, fever, or other illness < *child first name*> has had in the last 2 weeks.
[Interviewer: Check box for MOST RECENT time frame when illness occurred.]

If no illness in last 2 weeks, check here: _______

Illness	Last 2 days	Last 2 weeks
1) _________________________	☐	☐
2) _________________________	☐	☐
3) _________________________	☐	☐
4) _________________________	☐	☐

Public reporting burden of this collection of information is estimated to average 10 minutes, 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 CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0010).

3. Have you or anyone else smoked cigarettes, cigars, or pipes anywhere inside your child's home in the past week?

- ☐ No
- ☐ Yes, person giving blood smoked
- ☐ Yes, someone else in home smoked