Site Number: __ __ __ __ Screening ID: __ __ __ __ __ - __ Participant Letters: __ __ __

The Study Coordinator completes this form at all study follow-up visits except when there is an Infant Enrollment Visit combined with 3 Months old or Infant Enrollment Visit combined with 6 Months old visit.

A. VISIT INFORMATION

1. Date of visit *(e.g. 05/Sep/2006):* __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

2. Visit: *(check one)*:

☐ 3	3 Months old	☐ 12	12 Months old	☐ 21	21 Months old	☐ 36	36 Months old
☐ 6	6 Months old	☐ 15	15 Months old	☐ 24	24 Months old	☐ 42	42 Months old
☐ 9	9 Months old	☐ 18	18 Months old	☐ 30	30 Months old	☐ 48	48 Months old

3. The participant completed visit activities *(check one)*: ☐ 1 By phone ☐ 2 At clinic

4. Is the mother <u>currently</u> nursing the eligible infant? Y N

   If YES, also complete Nursing Mother Visit Form (**NPP09**).

   a. If NO, did the mother nurse the infant previous to this visit? Y N

   1) If YES, when did the mother discontinue nursing the infant? __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

B. INFANT MEDICAL HISTORY

1. Has the infant had any illnesses <u>since the last visit</u>? Y N

   If NO, skip to **Section C**.
   If YES, complete the below:

<u>Illness</u>		1) <u>If YES, number of times?</u> (*Circle number or enter # of times*)
HEENT		
a. Eye discharge/pinkeye (not blocked tear ducts)	Y N	1 2 3 4 5 __
b. Mouth sores (includes ulcers, thrush, cold sores)	Y N	1 2 3 4 5 __
c. Ear infection	Y N	1 2 3 4 5 __
Respiratory		
d. Respiration (breathing) problems	Y N	1 2 3 4 5 __
e. Cold or runny nose	Y N	1 2 3 4 5 __
f. Cough	Y N	1 2 3 4 5 __
g. Croup (e.g. barking cough)	Y N	1 2 3 4 5 __
h. Bronchitis/ Bronchiolitis	Y N	1 2 3 4 5 __

On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates. Write "" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*

Site: __ __ __ __ Screening ID: __ __ __ __ __ - __ Letters: __ __ __ Visit Date: __ __/__ __ __/ __ __ __ __

i. Pneumonia/ RSV	Y N	1 2 3 4 5 __

B. INFANT MEDICAL HISTORY (CONTINUED)

Illness		1) If YES, number of times? (*Circle number or enter # of times)*
Gastrointestinal		
j. Colic	Y N	1 2 3 4 5 __
k. Vomiting (≥ 3 times in 24 hours)	Y N	1 2 3 4 5 __
l. Diarrhea (≥ 3 times in 24 hours)	Y N	1 2 3 4 5 __
m. Gastrointestinal infection	Y N	1 2 3 4 5 __
n. Intestinal parasite	Y N	1 2 3 4 5 __
o. Yellow skin (jaundice)	Y N	1 2 3 4 5 __
p. Bloody stool	Y N	1 2 3 4 5 __
Neurologic		
q. Seizures	Y N	1 2 3 4 5 __
r. Meningitis	Y N	1 2 3 4 5 __
Infections		
s. Fever (over 100°F or 37.7°C)	Y N	1 2 3 4 5 __
t. Strep infection	Y N	1 2 3 4 5 __
u. German measles (rubella)	Y N	1 2 3 4 5 __
v. Measles	Y N	1 2 3 4 5 __
w. Chickenpox	Y N	1 2 3 4 5 __
x. Mumps	Y N	1 2 3 4 5 __
y. Rash (not diaper rash)	Y N	1 2 3 4 5 __
Hematological		
z. Excessive bleeding	Y N	1 2 3 4 5 __

Site: __ __ __ __ Screening ID: __ __ __ __ __ - __ Letters: __ __ __ Visit Date: __ __/__ __ __/ __ __ __ __

B. INFANT MEDICAL HISTORY (CONTINUED)

Illness

1) If YES, number of times?
(*Circle number or enter # of times)*

Surgery

aa. Surgery	Y N	1 2 3 4 5 __
2) If YES, specify surgery:		

Other

ab. Other 1:		1 2 3 4 5 __
ac. Other 2:		1 2 3 4 5 __
ad. Other 3:		1 2 3 4 5 __

C. INFANT RECENT EVENTS

1.	Did the infant have an immunization within the last 14 days?	Y N
2.	Has the infant had any febrile infectious illness in the last 14 days?	Y N
3.	Has the infant had any non-febrile infectious illness(es) in the last 14 days?	Y N
4.	Did the infant taken any antibiotics within the last 14 days?	Y N
5.	Has the infant taken steroids (oral or inhaled) or other immunosuppressive medications in the last 30 days?	Y N
6.	Has the infant received any immunoglobulin treatments or blood products since the last visit?	Y N

Site: __ __ __ __ Screening ID: __ __ __ __ __ - __ Letters: __ __ __ Visit Date: __ __/__ __ __/ __ __ __ __

D. INFANT MEDICATIONS

1. Has the parent(s) or legal guardian given the infant any medications since the last visit (prescription and/or non-prescription NOT including omega-3 fatty acids, DHA, vitamins, or dietary supplements)? (*Refer to NWK02 Concomitant Medication Worksheet. Use NPP20 Infant Vitamin and Dietary Supplement Form to record vitamins and dietary supplements*) Y N

If YES, fill in the following table. List all medications given since the last visit. (*Use the Medication Category Codes to complete Category Code*):

	Trade Name	1) Category Code	2) Currently taking?
a.		__ __ __	Y N
b.		__ __ __	Y N
c.		__ __ __	Y N
d.		__ __ __	Y N
e.		__ __ __	Y N

Medication Category Codes:

Use the Number Codes below to indicate the type of medication used:

001	Antibiotic	**006**	NSAID
002	Aspirin	**007**	Steroid Preparation
003	Immunization	**008**	Thyroid Medication
004	Immunosuppressive	**999**	Other
005	Non-Insulin Diabetes Medication		

Initials (first, middle, last) of person completing this form: __ __ __ (F M L)

Date form completed: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)