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

Study Coordinator completes this additional form at the Infant Enrollment Visit combined with 6 Months old, or 6, 12, 18, 24, 30, 36, 42, and 48 Months Old study visits to record vaccinations and physical exam information.

A. VISIT INFORMATION

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

2. Visit (*check one*):

☐ 94	Infant Enrollment combined with 6 Months old	☐ 6	6 Months old	☐ 18	18 Months old	☐ 30	30 Months old	☐ 42	42 Months old
		☐ 12	12 Months old	☐ 24	24 Months old	☐ 36	36 Months old	☐ 48	48 Months old

B. INFANT IMMUNIZATION HISTORY

1. Has the infant had any vaccinations since the last visit? (*Do NOT complete if this is a Infant Enrollment combined with 6 Months old visit. Skip to Section C.*) Y N

If YES, which vaccinations since the last visit:

	Vaccination	If YES, date vaccination given:
☐ 1	Hepatitis B (HepB) vaccine	1) __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
☐ 1	Rotavirus vaccine	1) __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
☐ 1	DTaP/DTP vaccine	1) __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
☐ 1	*Haemophilus influenzae* type b (Hib) vaccine	1) __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
☐ 1	Inactive polio (IPV) vaccine	1) __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
☐ 1	Live oral polio (OPV) vaccine	1) __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
☐ 1	Pneumococcal (PCV) vaccine	1) __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
☐ 1	Influenza (LAIV) vaccine (live attenuated)	1) __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
☐ 1	Influenza (TIV) vaccine (trivalent inactivated)	1) __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
☐ 1	Measles, Mumps, Rubella (MMR, MMRV) vaccine	1) __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
☐ 1	Varicella (chicken pox) vaccine	1) __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

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: __ __/__ __ __/ __ __ __ __

B. INFANT IMMUNIZATION HISTORY (CONTINUED)

If YES, which vaccinations since the last visit:

	Vaccination	If YES, date vaccination given:
☐ 1	Vaccinia (small pox) vaccine	1) __ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
☐ 1	Tetanus and diphtheria toxoids (Td)	1) __ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
☐ 1	Meningococcal meningitis vaccine	1) __ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
☐ 1	Hepatitis A vaccine	1) __ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
☐ 1	Other	
	a. Other 1: _____	1) __ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
	b. Other 2: _____	1) __ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)

C. INFANT PHYSICAL EXAM

1. Heart rate: __ __ __ beats per minute
2. Respiratory rate: __ __ breaths per minute
3. Weight: __ __ . __ kg or __ __ . __ lbs
4. Length: __ __ . __ cm or __ __ . __ in
5. Head circumference: __ __ . __ cm or __ __ . __ in
6. Temperature: __ __ . __ °C or __ __ __ . __ °F
7. Are the following system(s) normal by history or exam?

System	Normal?	1) If NO, describe abnormality:
a. HEENT	Y N	
b. Neck	Y N	
c. Thyroid	Y N	
d. Lungs	Y N	
e. Chest	Y N	

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: __ __/__ __ __/ __ __ __ __

C. INFANT PHYSICAL EXAM (CONTINUED)

7. Are the following system(s) normal by history or exam?

System	Normal?	1) If NO, describe abnormality:
f. Heart	Y N	
g. Cardiovascular	Y N	
h. Abdomen	Y N	
i. Liver	Y N	
j. Spleen	Y N	
k. Musculoskeletal	Y N	
l. Neurologic	Y N	
m. Urological/Renal	Y N	
n. Skin (including jaundice)	Y N	
o. Nails	Y N	
p. Lymph nodes	Y N	
q. Other:	Y N	

r. Describe any other pertinent findings: _____

s. Physical exam conducted by: (*please print clearly*) _____ NAME

t. Date physical exam completed: __ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR

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

Date form completed: __ __ / ___ ___ ___ / __ __ __ __ DAY MONTH YEAR

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).*