

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):

<input type="checkbox"/> 94 Infant Enrollment combined with 6 Months old	<input type="checkbox"/> 6 6 Months old	<input type="checkbox"/> 18 18 Months old	<input type="checkbox"/> 30 30 Months old	<input type="checkbox"/> 42 42 Months old
	<input type="checkbox"/> 12 12 Months old	<input type="checkbox"/> 24 24 Months old	<input type="checkbox"/> 36 36 Months old	<input type="checkbox"/> 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:
<input type="checkbox"/> 1 Hepatitis B (HepB) vaccine	1) _____ / _____ / _____ <small>DAY MONTH YEAR</small>
<input type="checkbox"/> 1 Rotavirus vaccine	1) _____ / _____ / _____ <small>DAY MONTH YEAR</small>
<input type="checkbox"/> 1 DTaP/DTP vaccine	1) _____ / _____ / _____ <small>DAY MONTH YEAR</small>
<input type="checkbox"/> 1 <i>Haemophilus influenzae</i> type b (Hib) vaccine	1) _____ / _____ / _____ <small>DAY MONTH YEAR</small>
<input type="checkbox"/> 1 Inactive polio (IPV) vaccine	1) _____ / _____ / _____ <small>DAY MONTH YEAR</small>
<input type="checkbox"/> 1 Live oral polio (OPV) vaccine	1) _____ / _____ / _____ <small>DAY MONTH YEAR</small>
<input type="checkbox"/> 1 Pneumococcal (PCV) vaccine	1) _____ / _____ / _____ <small>DAY MONTH YEAR</small>
<input type="checkbox"/> 1 Influenza (LAIV) vaccine (live attenuated)	1) _____ / _____ / _____ <small>DAY MONTH YEAR</small>
<input type="checkbox"/> 1 Influenza (TIV) vaccine (trivalent inactivated)	1) _____ / _____ / _____ <small>DAY MONTH YEAR</small>
<input type="checkbox"/> 1 Measles, Mumps, Rubella (MMR, MMRV) vaccine	1) _____ / _____ / _____ <small>DAY MONTH YEAR</small>
<input type="checkbox"/> 1 Varicella (chicken pox) vaccine	1) _____ / _____ / _____ <small>DAY MONTH YEAR</small>

*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	_____

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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: (<i>please print clearly</i>)			_____ 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

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