The 12-Month Baby Questionnaire asks about the health, growth and development of your baby, since completion of the 8-Month Questionnaire. If you had a set of twins, triplets or quadruplets, a separate questionnaire is included for each baby, with the baby's name printed on your questionnaire booklet cover.

This questionnaire should take about 15-20 minutes to complete. Please try to answer each question. For check boxes with one option, please place an 'X' in the box that best fits your answer. For check boxes with more than one option, please place an 'X' in all the boxes that best fit your answer. If none of the options apply, please leave the question blank.

Please note that the final questions on this questionnaire refer to information we suggested you record in the Child Health Journal that we previously provided you. Prior to completing each of the questionnaires about your baby (both now and in the future), it will be helpful if you have filled out the Child Health Journal first.

**Upstate KIDS: The New York State Infant Development Screening Program**

If you have any questions or concerns, please call our toll-free number: 1-888-870-0247
Questions 1-11 ask about how your baby is being fed

Infant Feeding

1. Are you currently breastfeeding your child? (Select one answer using an ‘X’)

☐ Yes → (Please mark the box below that best describes your current breastfeeding practices):

☐ I am exclusively breastfeeding (not giving any formula or food) GO TO QUESTION 5

☐ I am partially breastfeeding (supplementing with formula or food)

☐ No → (Please mark the box below that best describes why and when you stopped breastfeeding your baby.):

☐ I never tried breastfeeding

☐ I tried breastfeeding but stopped due to one of the following issues; please also specify the date you stopped. Please provide as much of the date as you remember

Date you stopped

mm / dd / yyyy

Why did you stop?

☐ Baby celebrated his/her 1st birthday

☐ Baby had difficulty latching on or sucking properly

☐ Pain in my breast(s)

☐ Infection in the breast(s)

☐ Insufficient milk supply

☐ Returned to work

☐ Other; please specify below

2. If you are giving your baby formula or milk, please check all types you are using.
(Mark all that apply using an ‘X’)

☐ Follow-on or stage 2 formula with calcium and iron

☐ Mead Johnson (Enfamil®, Enfamil LIPIL®, IproSobee®, Nutramigen®)

☐ Ross (Similac®, Similac Advance®, Isomil®, Alimentum®)

☐ Nestle Carnation (Good Start®, Alsoy®, Follow-up®)

☐ Store brands (for example, Wal-Mart, Target)

☐ Other formula type

☐ Cow’s milk

☐ Goat’s milk

☐ Hypo-allergenic

☐ Soy milk or soy formula

☐ Unpasterurized milk

3. If you are feeding your child food other than formula or milk, please check all types below:
(Mark all that apply using an ‘X’)

☐ Rice cereal

☐ Wheat cereal

☐ Pureed fruits or vegetables

☐ Solid fruits or vegetables

☐ Meats (such as chicken, beef)

☐ Egg

☐ Fish

☐ Finger food (cheerios, crackers)

☐ Cheese, other dairy food
4. What is the source of water that is usually used to prepare your baby's formula? (Select one answer using an 'X')

[ ] Does not apply: only use already prepared formula (ready-to-serve)
[ ] Does not apply: don't use formula
[ ] Bottled water
[ ] Tap water from a private well
[ ] Tap water from the public water system
[ ] Filtered tap water (Brita or home faucet filter)

5. What type of baby bottle do you use to feed your baby? (Select one answer using an 'X')

[ ] Do not use bottles
[ ] Glass bottles
[ ] Disposable plastic liners and bottles
[ ] Nondisposable re-usable plastic
[ ] Both disposable and nondisposable (re-usable) plastic bottles and disposable liners

6. Bisphenol-A (BPA) is something found in many plastic products. Its effect on child health is not known at this time. Does your child use any BPA-free plastic items (such as plastic bottles, cups, bowls)?

[ ] No
[ ] Yes

If yes, which items are BPA-free (Mark all that apply using an 'X')

[ ] Nondisposable bottles
[ ] Disposable bottles
[ ] Disposable plastic liners
[ ] Breastmilk storage bags
[ ] Sippy cups
[ ] Bowls/dishes
[ ] Spoons
[ ] Teething ring/toys

7. Are you giving your baby water to drink? (Select one answer using an 'X')

[ ] No
[ ] Yes

What is the usual source of drinking water for your baby? (Select one answer using an 'X')

[ ] Bottled water
[ ] Tap water from a private well
[ ] Tap water from the public water system
[ ] Filtered tap water (Brita or home faucet filter)

8. Have you introduced juice into your baby's diet? (Select one answer using an 'X')

[ ] No
[ ] Yes

If yes, write in your baby's age (in months) when you first gave juice

9. How would you describe your baby's appetite on a typical day? (Select one answer using an 'X')

[ ] Very good (eats all meals without fuss)
[ ] Good (eats most meals without fuss)
[ ] Medium (eats half meals without fuss/half meals with fuss)
[ ] Poor (eats most meals with fuss)
[ ] Very poor (eats all meals with fuss)
10. Have you sought any medical advice or treatment for your child for eating conditions, since your child was 8 months of age? (Mark all that apply using an 'X')

- [ ] No
- [ ] Yes; Specify the issues you discussed (Mark all that apply using an 'X')

11. Does your baby currently get multivitamin drops? (Select one answer using an 'X')

- [ ] No
- [ ] Yes; Specify type of vitamin normally given (Select one answer using an 'X')
  - [ ] Multivitamins only
  - [ ] Multivitamins plus iron
  - [ ] Multivitamins plus fluoride
  - [ ] Multivitamins plus fluoride and iron

How many days a week on average does your baby get multivitamin drops, and how old was your baby (in weeks) when you started the drops?

<table>
<thead>
<tr>
<th>TIMES PER WEEK</th>
<th>AGE IN WEEKS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Is your baby currently seeing a physician because of a specific medical concern? (Mark all that apply using an 'X')

- [ ] No
- [ ] Yes; (Mark all that apply using an 'X')

- [ ] For birth defect
- [ ] Because of early delivery (Preterm birth)
- [ ] For slow growth following birth
- [ ] For being a multiple (twins, triplets, quadruplets)
- [ ] For a medical condition; specify:

13. Since your child was 8 months of age, has your baby been admitted to the hospital, even for a few hours?

- [ ] No
- [ ] Yes; (Select one answer using an 'X')

- [ ] For illness; specify:

- [ ] For day surgery (outpatient) specify:

- [ ] For surgery that required admission for more than 1 day, specify:
14. Since your child was 8 months of age, has your baby used a medical device in the home?

- [ ] No
- [ ] Yes, (Select one answer using an 'X')
  - [ ] Apnea or respiratory (breathing) monitor
  - [ ] Combined heart rate and respiratory monitor
  - [ ] Ventilator
  - [ ] Dialysis equipment
  - [ ] Catheter
  - [ ] Other, please specify

15. Since your child was 8 months of age, has your baby been prescribed an antibiotic?

- [ ] No
- [ ] Yes, if yes, specify how many times

16. Since your child was 8 months of age, has your baby had an ear infection diagnosed by a doctor?

- [ ] No
- [ ] Yes, if yes, specify the total number of infections and how each of them were treated

17. Since 8 months, have you been told by a doctor or health practitioner that your baby is allergic to any food, medication or other things?

- [ ] No
- [ ] Yes, if yes, what is the specific allergies?
  (Mark all that apply using an 'X')
  - [ ] Food
  - [ ] Nuts
  - [ ] Cow's milk
  - [ ] Wheat
  - [ ] Soy
  - [ ] Peanuts
  - [ ] Dairy
  - [ ] Gluten
  - [ ] Eggs
  - [ ] Fish
  - [ ] Shellfish
  - [ ] Medicines
  - [ ] Dust
  - [ ] Animals
  - [ ] Pollen
  - [ ] Ragweed
  - [ ] Don't know

18. Since 8 months, has your baby ever had frequent sneezing and/or prolonged blocked or runny nose for several months when he/she did not have a cold or the flu?

- [ ] No
- [ ] Yes

19. Since 8 months, not including diaper rash or a rash around the scalp, has your child ever had a recurrent (coming and going) dry and itchy red rash for at least 3 months?

- [ ] No
- [ ] Yes

20. Since 8 months, did a doctor or health care practitioner ever tell you that your baby had infantile eczema or atopic dermatitis (dry, itchy inflammation of the skin, redness and swelling)?

- [ ] No
- [ ] Yes, if yes, specify location on body
  (Mark all that apply using an 'X')
  - [ ] Palms of hands
  - [ ] Chest
  - [ ] Arms
  - [ ] Abdomen
  - [ ] Soles of feet
  - [ ] Back
  - [ ] Legs
  - [ ] Buttocks
21. Since your child was 8 months of age, has your child had any wheezing attacks? (By wheezing, we mean breathing that sounds like a high-pitched whistling or a squeaking sound coming from the baby's chest not throat)?
   - No
   - Yes
   → If yes; how many wheezing attacks has your child experienced since age 8 months (Write in number)

22. Since 8 months, which type of diapers have you typically used? (Select one answer using an 'X')
   - Cloth diapers
   - Disposable diapers
   - No diapers (Diaper-free)

23. Since 8 months, have you used any products to prevent diaper rash or irritation in the diaper area?
   - No
   - Yes
   → If yes; mark the products you used (Mark all that apply using an 'X')
     - Gels
     - Powders
     - Lotions

Questions 24-32 ask about childcare

24. Does your child attend daycare, or is s/he watched by a care provider, at least once per week? (A care provider is someone other than the child's parents/guardians who watches the child.)
   - No, → GO TO QUESTION 33
   - Yes

25. If yes, what was your child's primary type of daycare since 8 months of age? (Select one answer using an 'X')
   - A private home-based daycare
   - A group daycare facility
   - My home with a nanny or sitter (not live-in)
   - My home with a live-in nanny
   - My home with a family member
   - A family member's home
   - Other; please specify ________________________________

26. Are there other types of child care settings that you use at least once per week?
   - No, → GO TO QUESTION 28
   - Yes

27. If yes, what are the other types of child care settings you use most often? (Mark all that apply using an 'X')
   - A private home based daycare
   - A group daycare facility
   - My home with a nanny or sitter (not live in)
   - My home with a live-in nanny
   - My home with a family member
   - A family member's home
   - Other

28. If you indicated above that your child is watched by a family member on a regular basis, which family member is the care provider used most often? (Do not include occasional sitting.) (Select one answer using an 'X')
   - Baby's Grandmother
   - Baby's older sibling
   - Baby's Grandfather
   - Baby's cousin
   - Baby's Aunt
   - Baby's Uncle
   - Other; please specify ________________________________

29. On average, how many total hours per week does your child attend child care or get watched by a care provider?

30. How old was your child (in months) when he/she began daycare or being watched by a care provider on a regular basis?

31. About how many children are usually cared for together, at the same time in the same group, at the daycare setting used most often for your child?

32. About how many adults usually care for your child at the same time at the daycare setting most often used?
NOTE: Most children will not participate in many of these activities until later in life. We do recognize that many children grow, develop and explore at their own pace.

### Questions about your child’s activities

33. For the list of activities below, please check the appropriate box to indicate which activity or activities your child has participated in since he or she was 8 months old. For each activity that your child does or has done, please also tell us on average how many hours or minutes per day your child has usually spent doing the activity. (Mark all that apply using an "X")

<table>
<thead>
<tr>
<th>Activity</th>
<th>Hours per day or</th>
<th>Minutes per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watching television shows</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watching movies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Playing computer games</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listening to pre-recorded music</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listening to others singing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Singing (by him/herself or with others)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listening to stories that an adult reads to your child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listening to stories that are on tape or CD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scribbling, drawing, or painting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Playing card games or board games</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Playing with other children of the same age or younger</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Playing with other children who are older than your child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Playing outdoors</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
34. Which of the following best describes your child's current hair color? (Select one answer using an 'X')
- Brown
- Auburn
- Black
- Red
- Blonde

35. Which of the following best describes your child's current eye color? (Select one answer using an 'X')
- Blue
- Dark Brown
- Green
- Hazel or Amber
- Grey
- Red

36. Which of the following best describes your child's skin tone? (Select one answer using an 'X')
- Very/light very likely to sunburn and has freckles
- Light/usually sunburns with few, if any, freckles
- Light/intermediate or "average" Caucasian-as likely to sunburn as to tan
- Olive/often tans
- Medium/naturally brown skin
- Dark/naturally black-brown skin

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**Vaccinations**

37. Has your child ever been vaccinated?
- No  →  GO TO QUESTION 38
- Yes  →  GO TO QUESTION 39

38. If your child has never been vaccinated, please indicate why.
- Medical Reasons
- Religious Reasons
- Personal Reasons

---

**Questions 39 thru 43 are based on information you may have collected in the Upstate KIDS Child Health journal provided to you in your initial survey packet.**

*Like this one (but in color)*
<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose</th>
<th>Recommended Age Range</th>
<th>Received</th>
<th>Date of Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td>3</td>
<td>6-18 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria, Tetanus, Acellular Pertussis (DTaP)</td>
<td>3</td>
<td>6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenza type b (Hib, flu)</td>
<td>3</td>
<td>6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>12-15 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus</td>
<td>3</td>
<td>6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>12-15 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal (PCV)</td>
<td>3</td>
<td>6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated poliovirus (IPV, polio)</td>
<td>3</td>
<td>6-18 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps Rubella</td>
<td>1</td>
<td>12-15 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>1</td>
<td>12-15 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>1</td>
<td>12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined vaccine (PediariX®)</td>
<td>3</td>
<td>6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combines DTaP, Hepatitis B, IPV (polio)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus (Tdap)</td>
<td>1</td>
<td>As needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other combined vaccine</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please specify the vaccine name.

TIP: If you have begun completing the Upstate KIDS Child Health Journal recently provided to you, this information would be listed on pages 1-7 of the Journal.

39. Please use your baby's journal (page 1-7) to answer the following question about any vaccinations your baby has received. If you cannot remember or did not record vaccination dates, please provide as much of the date as you can remember. If your baby received a combined vaccine, such as PediariX® or Comvax®, you do not also have to mark that the individual vaccines were received.
40. Please complete the chart regarding which developmental milestones your baby has reached. Feel free to consult your baby's journal (pages 8 and 9) to answer this question.

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Definition</th>
<th>Achieved since 8 months of age</th>
<th>Date of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting without support</td>
<td>Infant can sit up straight with head erect for at least 10 seconds without using arms or hands to balance body or support the position.</td>
<td>☐</td>
<td>/ dd / yyyy</td>
</tr>
<tr>
<td>Hands-and-knees crawling</td>
<td>Infant alternately moves forward or backward on hands and knees. The stomach does not touch the supporting surface, and there are at least three movements in a row.</td>
<td>☐</td>
<td>/ dd / yyyy</td>
</tr>
<tr>
<td>Standing with assistance</td>
<td>Child can stand in upright position on both feet, holding onto a stable object (like, furniture), for at least 10 seconds without leaning on it.</td>
<td>☐</td>
<td>/ dd / yyyy</td>
</tr>
<tr>
<td>Walking with assistance</td>
<td>Child can take at least five steps sideways or forward while in an upright position and holding on to a stable object (like furniture).</td>
<td>☐</td>
<td>/ dd / yyyy</td>
</tr>
<tr>
<td>Standing alone</td>
<td>Child can stand in an upright position on both feet (not on the toes) for at least 10 seconds with no contact with a person or object.</td>
<td>☐</td>
<td>/ dd / yyyy</td>
</tr>
<tr>
<td>Walking alone</td>
<td>Child can take at least five steps independently in an upright position with no contact with a person or object.</td>
<td>☐</td>
<td>/ dd / yyyy</td>
</tr>
</tbody>
</table>
41. Please complete the chart below about which teeth, if any, your baby has. The figure below illustrates the location of various types of teeth and is identical to page 10 of your baby’s journal. Feel free to review the journal in completing this chart. (Fill in box and write in dates for each tooth.)

**teeth eruption dates**

**American Dental Association Primary Teeth Eruption Chart**

<table>
<thead>
<tr>
<th>Upper Teeth</th>
<th>Lower Teeth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erupt</td>
<td>Erupt</td>
</tr>
<tr>
<td>Central Incisor</td>
<td>8-12 Months</td>
</tr>
<tr>
<td>Lateral Incisor</td>
<td>9-13 Months</td>
</tr>
<tr>
<td>Canine (Cuspid)</td>
<td>14-16 Months</td>
</tr>
<tr>
<td>First Molar</td>
<td>16-22 Months</td>
</tr>
<tr>
<td>Second Molar</td>
<td>17-25 Months</td>
</tr>
<tr>
<td>Central Incisor</td>
<td>23-31 Months</td>
</tr>
<tr>
<td>Lateral Incisor</td>
<td>10-16 Months</td>
</tr>
<tr>
<td>Canine (Cuspid)</td>
<td>8-10 Months</td>
</tr>
<tr>
<td>First Molar</td>
<td>25-33 Months</td>
</tr>
<tr>
<td>Second Molar</td>
<td>23-31 Months</td>
</tr>
</tbody>
</table>

**Upper teeth eruption dates**
Please record the date that you first noticed the tooth

<table>
<thead>
<tr>
<th>Tooth</th>
<th>Date 1</th>
<th>Date 2</th>
<th>Date 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Central Incisor</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Left Central Incisor</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Right Lateral Incisor</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Left Lateral Incisor</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Right Canine (Cuspid)</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Left Canine (Cuspid)</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Right First Molar</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Left First Molar</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Right Second Molar</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Left Second Molar</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

**Lower teeth eruption dates**
Please record the date that you first noticed the tooth

<table>
<thead>
<tr>
<th>Tooth</th>
<th>Date 1</th>
<th>Date 2</th>
<th>Date 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Central Incisor</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Left Central Incisor</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Right Lateral Incisor</td>
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</tr>
<tr>
<td>Left Lateral Incisor</td>
<td>/</td>
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<td>/</td>
</tr>
<tr>
<td>Right Canine (Cuspid)</td>
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<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Left Canine (Cuspid)</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Right First Molar</td>
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<td>/</td>
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<tr>
<td>Left First Molar</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Right Second Molar</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Left Second Molar</td>
<td>/</td>
<td>/</td>
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</tr>
</tbody>
</table>
42. Please fill in the chart below about your baby's growth and well-baby check-ups since your child was 8 months of age. For each visit, please include your baby's age (in months or weeks) and the actual date of the check-up. If you cannot remember the complete date, please provide as much of the date as you can remember. Feel free to consult your baby's journal (pages 14-28) to answer this question.

**BABY'S GROWTH**

<table>
<thead>
<tr>
<th>Age at Visit (months)</th>
<th>Date of Visit (mm/dd/yyyy)</th>
<th>Length (inches or centimeters)</th>
<th>Weight (pounds or grams)</th>
<th>Head Circumference (inches or centimeters)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>in or cm</td>
<td>lbs oz or grams</td>
<td>in cm</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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</table>

"Upstate KIDS: The New York State Infant Development Screening Program"
### SICK VISITS

43. Please fill in the chart below about your child’s sick visits. For each visit, please include the actual date of the check-up, the health concern, and the treatment. If you cannot remember the complete date, please provide as much of the date as you can remember. This information is in the Sick Visits section of your baby’s journal.

*Please enter the number of your response(s), if other, please specify.*

<table>
<thead>
<tr>
<th>Date of Visit - mm/dd/yyyy</th>
<th>Health Concern</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/15/2008</td>
<td>1-Ear Infection, 4-Diarrhea</td>
<td>1-Antibiotic, 4-Topical Drops</td>
</tr>
<tr>
<td></td>
<td>2-Cold, 5-Rash</td>
<td>2-Tylenol, 5-Ointment</td>
</tr>
<tr>
<td></td>
<td>3-Vomiting, 6-Pink Eye</td>
<td>3-Pedialyte, 6-Other</td>
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<td>7-Other</td>
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</tr>
</tbody>
</table>

#### THANK YOU FOR YOUR PARTICIPATION IN

**Upstate KIDS**: The New York State Infant Development Screening Program

Please mail this form out to us soon! If you misplaced the postage-paid envelope that was mailed with this questionnaire, please call us and we will mail you another return envelope.

1-888-870-0247 (Toll-free)

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Upstate KIDS Program Office
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