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|-------------|-------------|---------|-------------|------|
| Study # 030 | Plate # 001 | F2_Date | Visit # 001 | |
| CASE_REGLOG | | | | |
| Site Center | Page No. | Day | Month | Year |

VERSION# 2
 VERSION

Directions: Complete the following information for each child younger than 5 years old who is seeking medical care at the health facility.

| Number CHILDID | Time TIME | Cluster Unit CLUSTER | AGE Age | GENDER Gender | HOSP Hospitalized? |
|--------------------------|----------------------|--|---|---|---|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> |
| | 24 hour clock | | In Months | Boy Girl | No Yes |
| <input type="checkbox"/> | | DSS | | | |
| N/A | | Qualifies for DSS? <input type="text"/> <input type="text"/> | Three or more abnormally loose or watery stools in the previous 24 hour period? | | <input type="text"/> <input type="text"/> |
| | | No Yes | | | No Yes |

LOOSE_STOOLS

| Number | Time | Cluster Unit | Age | Gender | Hospitalized? |
|--------------------------|----------------------|--|---|---|---|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> |
| | 24 hour clock | | In Months | Boy Girl | No Yes |
| <input type="checkbox"/> | | | | | |
| N/A | | Qualifies for DSS? <input type="text"/> <input type="text"/> | Three or more abnormally loose or watery stools in the previous 24 hour period? | | <input type="text"/> <input type="text"/> |
| | | No Yes | | | No Yes |

| Number | Time | Cluster Unit | Age | Gender | Hospitalized? |
|--------------------------|----------------------|--|---|---|---|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> |
| | 24 hour clock | | In Months | Boy Girl | No Yes |
| <input type="checkbox"/> | | | | | |
| N/A | | Qualifies for DSS? <input type="text"/> <input type="text"/> | Three or more abnormally loose or watery stools in the previous 24 hour period? | | <input type="text"/> <input type="text"/> |
| | | No Yes | | | No Yes |

| Number | Time | Cluster Unit | Age | Gender | Hospitalized? |
|--------------------------|----------------------|--|---|---|---|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> |
| | 24 hour clock | | In Months | Boy Girl | No Yes |
| <input type="checkbox"/> | | | | | |
| N/A | | Qualifies for DSS? <input type="text"/> <input type="text"/> | Three or more abnormally loose or watery stools in the previous 24 hour period? | | <input type="text"/> <input type="text"/> |
| | | No Yes | | | No Yes |

| Number | Time | Cluster Unit | Age | Gender | Hospitalized? |
|--------------------------|----------------------|--|---|---|---|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> |
| | 24 hour clock | | In Months | Boy Girl | No Yes |
| <input type="checkbox"/> | | | | | |
| N/A | | Qualifies for DSS? <input type="text"/> <input type="text"/> | Three or more abnormally loose or watery stools in the previous 24 hour period? | | <input type="text"/> <input type="text"/> |
| | | No Yes | | | No Yes |

| | | | | | | | |
|---------------------|----------------------|-------------------------|----------------------|-------|----------------------|----------------------|----------------------|
| Interviewer's Code: | <input type="text"/> | Quality Control's Code: | <input type="text"/> | Date: | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | INT_CODE | | QC_CODE | | Day | Month | Year |
| | | | | | | QC_DATE | |