

Section O. INJURY CONTROL AND CHILD SAFETY AND HEALTH									
01	Refer to household composition.	1 <input type="checkbox"/> Children under 10 in family (1) 2 <input type="checkbox"/> No children under 10 in family (03)	37						
Read to respondent: These questions are about preventing injuries to children.			38						
1a.	Have you ever heard about POISON CONTROL CENTERS?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2)							
b.	Do you have the telephone number for a Poison Control Center in your area?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	39						
2.	There is a medication called IPECAC (ip' i kak) SYRUP which is sometimes taken to cause vomiting after something poisonous is swallowed. Do you now have any Ipecac Syrup in this household?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	40						
02	Refer to household composition.	1 <input type="checkbox"/> Children under 5 in family (3) 2 <input type="checkbox"/> No children under 5 in family (03)	41						
3.	Have you heard about child safety seats, sometimes called car safety carriers, which are designed to carry children while they are riding in a car?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (03)	42						
4.	Did a doctor or other health professional EVER tell you about the importance of using car safety seats for (your) children?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	43						
03	Refer to household composition.	1 <input type="checkbox"/> Children under 18 in family (04) 2 <input type="checkbox"/> No children under 18 in family (10)	44						
04	Enter person number and name of all children under 18; THEN mark box.	<table border="1"> <tr> <td>Person Number</td> <td>5-6</td> </tr> <tr> <td>First name</td> <td></td> </tr> <tr> <td>1 <input type="checkbox"/> Under 5 (5) 2 <input type="checkbox"/> 5-17 (7)</td> <td>7</td> </tr> </table>	Person Number	5-6	First name		1 <input type="checkbox"/> Under 5 (5) 2 <input type="checkbox"/> 5-17 (7)	7	RT73 3-4
Person Number	5-6								
First name									
1 <input type="checkbox"/> Under 5 (5) 2 <input type="checkbox"/> 5-17 (7)	7								
5.	When --- was brought home from the hospital following birth, was --- buckled in a car safety seat?	5. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Not born in hospital 4 <input type="checkbox"/> Didn't ride home in "car" 9 <input type="checkbox"/> DK	8						
6a.	Does --- now have a car safety seat?	6a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (7)	9						
b.	When riding in a car, is --- buckled in a car safety seat all or most of the time, some of the time, once in awhile, or never?	b. 1 <input type="checkbox"/> All or most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in awhile 4 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK } (7) (NP)	10						
7.	When riding in a car, does --- wear a seat belt all or most of the time, some of the time, once in awhile, or never?	7. 1 <input type="checkbox"/> All or most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in awhile 4 <input type="checkbox"/> Never 5 <input type="checkbox"/> Uses child safety seat 9 <input type="checkbox"/> DK	11						
05	Refer to age.	05 1 <input type="checkbox"/> Under 5 (8) 8 <input type="checkbox"/> Other (06)	12						
Read to respondent: (These next questions are about breastfeeding.)			13						
8.	Was --- ever breastfed?	8. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (06)							
9.	How old was --- when --- COMPLETELY stopped breastfeeding?	9. 000 <input type="checkbox"/> Still breastfed <table border="1"> <tr> <td>1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</td> <td></td> </tr> </table> Age	1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years		14-16				
1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years									
06	Respondent	06 1 <input type="checkbox"/> Child's parent 8 <input type="checkbox"/> Other	17						

FORM HIS-1(SB) (1985) (4-25-85)

Section O. INJURY CONTROL AND CHILD SAFETY AND HEALTH — Continued		RT74
		3-4
		5
10. When driving or riding in a car, do you wear a seat belt all or most of the time, some of the time, once in awhile, or never?	<input type="checkbox"/> All or most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Once in awhile <input type="checkbox"/> Never <input type="checkbox"/> Don't ride in car	
<i>Read to respondent:</i> The next questions are about this home.		6-7
11a. How many smoke detectors are installed in this home?	<input type="checkbox"/> Only 1 (11c) _____ Number (11b) <input type="checkbox"/> None } (12) <input type="checkbox"/> DK }	
b. How many of them are now working?	_____ Number (11d) <input type="checkbox"/> None (11f)	8-9
c. Is it now working?	<input type="checkbox"/> Yes <input type="checkbox"/> No } (11f) <input type="checkbox"/> DK }	10
d. How do you know [it is/they are] working?	<input type="checkbox"/> Tested it/them <input type="checkbox"/> It/they went off because of smoke <input type="checkbox"/> It/they went off while cooking <input type="checkbox"/> Changed the batteries <input type="checkbox"/> The light is on <input type="checkbox"/> Beeps when battery is low <input type="checkbox"/> Other (Specify) _____	11 12 13 14 15 16 17
e. Any other way?	<input type="checkbox"/> Yes (Reask 11d and e) <input type="checkbox"/> No	
f. [Is it/Are any of the smoke detectors] next to a sleeping area?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	18
12a. Do you know about what the hot water temperature is in this home?	<input type="checkbox"/> Yes <input type="checkbox"/> No (13)	19
b. About what temperature is the hot water?	_____ Temperature OR <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> Medium	20-22 23
c. How did you estimate the hot water temperature?	<input type="checkbox"/> The setting on hot water heater <input type="checkbox"/> Tested with thermometer <input type="checkbox"/> Guessed <input type="checkbox"/> Other (Specify) _____	24
13. In the past 12 months, have you (or has anyone in your household) used a thermometer to test the temperature of the hot water here?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	25
14. ABOVE what temperature will hot water cause scald injuries?	_____ Temperature <input type="checkbox"/> DK	26-28
FOOTNOTES		

FORM HD-100 (100) (100) (4-25-50)