



# National Survey of Children's Health

*A study by the U.S. Department of Health and Human Services to better understand the health issues faced by children in the United States today.*



The U.S. Census Bureau is required by law to protect your information and is not permitted to publicly release your responses in a way that could identify you or your household. The U.S. Census Bureau is conducting the National Survey of Children's Health on the behalf of the Department of Health and Human Services (HHS) under Title 13, United States Code, Section 8(b), which allows the Census Bureau to conduct surveys on behalf of other agencies. Title 42 U.S.C. Section 701(a)(2) allows HHS to collect information for the purpose of understanding the health and well-being of children in the United States. Federal law protects your privacy and keeps your answers confidential under 13 U.S.C. Section 9. Per the Federal Cybersecurity Enhancement Act of 2015, your data are protected from cybersecurity risks through screening of the systems that transmit your data.

Any information you provide will be shared for the work-related purposes identified above and as permitted under the Privacy Act of 1974 (5 U.S.C. Section 552a) and SORN COMMERCE/CENSUS-3, Demographic Survey Collection (Census Bureau Sampling Frame).

Participation in this survey is voluntary and there are no penalties for refusing to answer questions. However, your cooperation in obtaining this much needed information is extremely important in order to ensure complete and accurate results.

**NSCH-S1**

(06/07/2017) Draft 1



## Start Here

Thank you for helping us learn about the health and well-being of America's children.

If your household has children 0 - 17 years old, please have an adult who is familiar with their health and health care answer all of the questions that apply.

If your household does not have any children, please answer question **1** below AND return the questionnaire.

If you need help or have questions about completing this form, please call 1-800-845-8241.  
The telephone call is free.

For Telephone Device for the Deaf (TDD) assistance, please call: 1-800-582-8330.  
The telephone call is free.

Si necesita ayuda o tiene preguntas sobre cómo completar este formulario, llame al 1-800-845-8241.  
La llamada es gratuita.

Para recibir ayuda relacionada con el Dispositivo Telefónico para Personas Sordas (TDD), llame al 1-800-582-8330.  
La llamada es gratuita.

## In Your Home

**1** Are there any children 0-17 years old who usually live or stay at this address?

☐ Yes

☐ No – *STOP HERE* after marking “No” and return this survey to us in the enclosed envelope. It is important that we receive a response from every household selected for this study.

**2** How many children 0-17 years old usually live or stay at this address?

 

Number of children living or staying at this address

**3** What is the primary language spoken in the household?

☐ English

☐ Spanish

☐ Other Language, specify:

**→** Answer the remaining questions for each of the children 0-17 years old who usually live or stay at this address.

Start with the **YOUNGEST CHILD**, who we call “Child 1” and continue with the next youngest until you have answered the questions for all children who usually live or stay at this address.



# CHILD 1

(Youngest)

**1** First name, initials, or nickname of the youngest child

→ **NOTE:** Answer **BOTH** question **2** about Hispanic origin and question **3** about race. For this survey, Hispanic origins are not races.

**2** Is this child of Hispanic, Latino, or Spanish origin?

- ☐ No, not of Hispanic, Latino, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino, or Spanish origin

**3** What is this child's race? Mark (X) one or more boxes.

- |   |   |
|---|---|
| <input type="checkbox"/> White                            | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian        |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Guamanian or Chamorro  |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Some other race        |
| <input type="checkbox"/> Korean                           |   |

**4** How old is this child? If the child is less than one month old, round age in months to 1.

<input type="text"/>	<input type="text"/>	Years	OR	<input type="text"/>	<input type="text"/>	Months
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**5** What is this child's sex?

- ☐ Male ☐ Female

**6** If this child is YOUNGER THAN 4 YEARS OLD, please SKIP to question **7**.

How well does this child speak English?

- ☐ Very well
- ☐ Well
- ☐ Not well
- ☐ Not at all

**7** Does this child CURRENTLY need or use medicine prescribed by a doctor, other than vitamins?

- ☐ Yes ☐ No

↳ If yes, is this child's need for prescription medicine because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

**8** Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?

- ☐ Yes ☐ No

↳ If yes, is this child's need for medical care, mental health, or educational services because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

**9** Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

- ☐ Yes ☐ No

↳ If yes, is this child's limitation in abilities because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

**10** Does this child need or get special therapy, such as physical, occupational, or speech therapy?

- ☐ Yes ☐ No

↳ If yes, is this because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

**11** Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?

- ☐ Yes ☐ No

↳ If yes, has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?

- ☐ Yes ☐ No



**CHILD 2***(Next youngest)*

- 1** First name, initials, or nickname of the next youngest child

→ **NOTE:** Answer BOTH question **2** about Hispanic origin and question **3** about race. For this survey, Hispanic origins are not races.

- 2** Is this child of Hispanic, Latino, or Spanish origin?

- ☐ No, not of Hispanic, Latino, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino, or Spanish origin

- 3** What is this child's race? Mark (X) one or more boxes.

- |   |   |
|---|---|
| <input type="checkbox"/> White                            | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian        |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Guamanian or Chamorro  |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Some other race        |
| <input type="checkbox"/> Korean                           |   |

- 4** How old is this child? If the child is less than one month old, round age in months to 1.

<input type="text"/>	<input type="text"/>	Years	OR	<input type="text"/>	<input type="text"/>	Months
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- 5** What is this child's sex?

- ☐ Male ☐ Female

- 6** If this child is YOUNGER THAN 4 YEARS OLD, please SKIP to question **7**.

How well does this child speak English?

- ☐ Very well
- ☐ Well
- ☐ Not well
- ☐ Not at all

- 7** Does this child CURRENTLY need or use medicine prescribed by a doctor, other than vitamins?

- ☐ Yes ☐ No

↳ If yes, is this child's need for prescription medicine because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

- 8** Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?

- ☐ Yes ☐ No

↳ If yes, is this child's need for medical care, mental health, or educational services because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

- 9** Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

- ☐ Yes ☐ No

↳ If yes, is this child's limitation in abilities because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

- 10** Does this child need or get special therapy, such as physical, occupational, or speech therapy?

- ☐ Yes ☐ No

↳ If yes, is this because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

- 11** Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?

- ☐ Yes ☐ No

↳ If yes, has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?

- ☐ Yes ☐ No



**CHILD 3***(Next youngest)*

- 1** First name, initials, or nickname of the next youngest child

→ **NOTE:** Answer BOTH question **2** about Hispanic origin and question **3** about race. For this survey, Hispanic origins are not races.

- 2** Is this child of Hispanic, Latino, or Spanish origin?

- ☐ No, not of Hispanic, Latino, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino, or Spanish origin

- 3** What is this child's race? Mark (X) one or more boxes.

- |   |   |
|---|---|
| <input type="checkbox"/> White                            | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian        |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Guamanian or Chamorro  |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Some other race        |
| <input type="checkbox"/> Korean                           |   |

- 4** How old is this child? If the child is less than one month old, round age in months to 1.

<input type="text"/>	<input type="text"/>	Years	OR	<input type="text"/>	<input type="text"/>	Months
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- 5** What is this child's sex?

- ☐ Male ☐ Female

- 6** If this child is YOUNGER THAN 4 YEARS OLD, please SKIP to question **7**.

How well does this child speak English?

- ☐ Very well
- ☐ Well
- ☐ Not well
- ☐ Not at all

- 7** Does this child CURRENTLY need or use medicine prescribed by a doctor, other than vitamins?

- ☐ Yes ☐ No

↳ If yes, is this child's need for prescription medicine because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

- 8** Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?

- ☐ Yes ☐ No

↳ If yes, is this child's need for medical care, mental health, or educational services because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

- 9** Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

- ☐ Yes ☐ No

↳ If yes, is this child's limitation in abilities because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

- 10** Does this child need or get special therapy, such as physical, occupational, or speech therapy?

- ☐ Yes ☐ No

↳ If yes, is this because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

- 11** Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?

- ☐ Yes ☐ No

↳ If yes, has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?

- ☐ Yes ☐ No



**CHILD 4***(Next youngest)*

- 1** First name, initials, or nickname of the next youngest child

→ **NOTE:** Answer BOTH question **2** about Hispanic origin and question **3** about race. For this survey, Hispanic origins are not races.

- 2** Is this child of Hispanic, Latino, or Spanish origin?

- ☐ No, not of Hispanic, Latino, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino, or Spanish origin

- 3** What is this child's race? Mark (X) one or more boxes.

- |   |   |
|---|---|
| <input type="checkbox"/> White                            | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian        |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Guamanian or Chamorro  |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Some other race        |
| <input type="checkbox"/> Korean                           |   |

- 4** How old is this child? If the child is less than one month old, round age in months to 1.

<input type="text"/>	<input type="text"/>	Years	OR	<input type="text"/>	<input type="text"/>	Months
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- 5** What is this child's sex?

- ☐ Male ☐ Female

- 6** If this child is YOUNGER THAN 4 YEARS OLD, please SKIP to question **7**.

How well does this child speak English?

- ☐ Very well
- ☐ Well
- ☐ Not well
- ☐ Not at all

- 7** Does this child CURRENTLY need or use medicine prescribed by a doctor, other than vitamins?

- ☐ Yes ☐ No

↳ If yes, is this child's need for prescription medicine because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

- 8** Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?

- ☐ Yes ☐ No

↳ If yes, is this child's need for medical care, mental health, or educational services because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

- 9** Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

- ☐ Yes ☐ No

↳ If yes, is this child's limitation in abilities because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

- 10** Does this child need or get special therapy, such as physical, occupational, or speech therapy?

- ☐ Yes ☐ No

↳ If yes, is this because of ANY medical, behavioral, or other health condition?

- ☐ Yes ☐ No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

- ☐ Yes ☐ No

- 11** Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?

- ☐ Yes ☐ No

↳ If yes, has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?

- ☐ Yes ☐ No







If there are more than four children 0-17 years old who usually live or stay at this address, list the first name, initials, or nickname for each child as well as their age and sex.

Do not repeat information for children already included for Child 1 through Child 4.

### Child 5

(Next youngest) ►

First name, initials, or nickname

Age

Years

OR

Months

Sex

☐

Male

☐

Female

### Child 6

(Next youngest) ►

First name, initials, or nickname

Age

Years

OR

Months

Sex

☐

Male

☐

Female

### Child 7

(Next youngest) ►

First name, initials, or nickname

Age

Years

OR

Months

Sex

☐

Male

☐

Female

### Child 8

(Next youngest) ►

First name, initials, or nickname

Age

Years

OR

Months

Sex

☐

Male

☐

Female

### Child 9

(Next youngest) ►

First name, initials, or nickname

Age

Years

OR

Months

Sex

☐

Male

☐

Female

### Child 10

(Next youngest) ►

First name, initials, or nickname

Age

Years

OR

Months

Sex

☐

Male

☐

Female



# Mailing Instructions

## Thank you for your participation.

On behalf of the U.S. Department of Health and Human Services, we would like to thank you for the time and effort you have spent sharing information about your household and the children of this household.

Your answers are important to us and will help researchers, policymakers and family advocates to better understand the health and health care needs of children in our diverse population.



### Make sure you have:

- Listed all first names, initials, or nicknames of children 0-17 years old in the household
- Answered all questions for each child reported



### Place the completed questionnaire in the postage-paid return envelope. If the envelope has been misplaced, please mail the questionnaire to:

U.S. Census Bureau  
ATTN: DCB 60-A  
1201 E. 10th Street  
Jeffersonville, IN 47132-0001

You may also call **1-800-845-8241** to request a replacement envelope.

