Study number: ☐☐☐☐☐

HEIGHT, WEIGHT AND HEAD CIRCUMFERENCE

A1 ID Number ____________________________

A2 Name ____________________________

A3 Date of Birth dd/mm/yy ☐☐/☐☐/☐☐

A4 Hospital Number ____________________________

A5 Today's date ☐☐/☐☐/☐☐

Place for Cleft identification sticker if available

B1 Height ☐☐☐.☐cm

B2 Weight ☐☐☐.☐kg

B3 Head circumferences ☐☐.☐cm

B4 Additional information: such as excessive clothing, did not remove shoes or thick hair.

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Thank you for filling this in – please state your

C1 Name: ____

C2 Designation: ____

C3 Email: ____

C4 Contact number: ____

C5 Any additional information that you think would be helpful is most welcome.

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