Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4/22/16 Group Recommendation

***Individual Survey*** If you do not currently use caffeine but you have in the past, answer questions 2-4 based on your past experience.

None High

1. How would you rate your caffeine intake? 0 1 2 3 4 5
2. Do you find caffeine greatly affects your sleep? 0 1 2 3 4 5
3. To what extent does caffeine affects your mood? 0 1 2 3 4 5
4. To what extent does it increase affect you physiologically? 0 1 2 3 4 5

(heart rate, jitteriness, acidic stomach pains)

***Source:* (From day 2)** Cite your reputable source. Write the recommendation.

***Justification:*** Combine all team member sources, surveys, recommendations and personal data graphs. Discuss and make a team recommendation (see below). Write down the group’s reasoning: your justification for the recommendation. Explain in writing what data you used and why you used it.

Your recommendation **must** address:

1. Which group is targeted: adult, teens or child
2. Amount of the caffeine intake or quantity of caffeine intake
3. Time of the day
4. When should we stop caffeine intake that the caffeine in blood stream is low enough for adult/teens/child to go to bed

***Group Recommendation:*** Write your group recommendation down in the box below. (45 words max)