Request for Approval under the "Generic Clearance for Citizen Science and Crowdsourcing Projects" (OMB Control Number: 2080-0083)

TITLE OF INFORMATION COLLECTION: Using Citizen Science to Improve Drinking Water Epidemiology Studies (OMB Control Number 2080-0083; EPA ICR Number 2521.22)

INSTRUMENT: Instrument script is attached below. Final online product will include mandatory OMB control number, expiration date, and burden statement.

ID#					
25000	(home	1	survey	num	ber

Self-Report Health Questionnaire &

Risk Factor Survey

Complete one per student

Date of Interview:	
Place of Interview:	
Name of Interviewee:	
Home Address:	
Interviewee's information 1. Age:	IAUPR-IRB CENTRAL OFFICE
2. Sex: 1- Male 2- Female	
Sex: 1- Male 2- Female Household information	26 -01- 18 - 26 -01- 19 APPROVED

Name Relation to the Head of the Household Age Sex Occupation/Student

	ion of the head of the household? educational degree achieved?	
□ No School	☐Elementary or Less	☐ Middle School
☐ High School	□University	☐ Post Graduate
. How long has your fan	nily lived at this location?	
a. If less than	10 years, where did you move from	? (address)
How many bedroom	s are there in the house?	
5. Do you own the hou	ise?	
 Do you own the hou Yes 		☐ No, the home is rented
	ī	No, the home is rented
☐ Yes ☐ Living with friends	ī	Living with family
☐ Yes ☐ Living with friends	1	Living with family
☐ Yes ☐ Living with friends ☐ Other (explain) Water usage	1	Living with family
☐ Yes ☐ Living with friends ☐ Other (explain) Water usage	ink from the tap without boiling the	Living with family
☐ Yes ☐ Living with friends ☐ Other (explain) Water usage 6. How often do you d	ink from the tap without boiling the	Living with family water?
☐ Yes ☐ Living with friends ☐ Other (explain) Water usage 6. How often do you d ☐ Always ☐ Sometimes 7. Do you treat the wa	rink from the tap without boiling the	Living with family water?
☐ Yes ☐ Living with friends ☐ Other (explain) Water usage 6. How often do you d ☐ Always ☐ Sometimes 7. Do you treat the wa	rink from the tap without boiling the Mo Nev ter before drinking it? Yes see explain how. by	Living with family water? st of the time er

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			ID#		
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Do you have any process.	roblems with your drinking w	rater? ☐ Yes	□ No		
	following happened?				
	tonowing inspection.				
☐ bad odor ☐ cloudy		☐ bad taste ☐ color			
other (explain)_					
9. Do you drink water	r at school?				
	rat schoolf Li fes Li No				
If yes, which?					
☐ drinking fountain	1	☐ bottled wat	ter		
☐ tap water		□ other			
10. Do you drink water	from other sources? Yes	□ No			
If yes, which?					
☐ bottled water		☐ river water	r		
☐ rain water		□ other			
Sanitation					
Sanitation					
11. Does your home ha	ave access to any of the follow	wing?			
☐ toilet discharging	into a sewage system	☐ toilet disch	arging into a septi	c tank	
☐ latrine		☐ toilet disch	arging into a river	or land	
other (explain) _				-	
12. If you have sentic t	ank, how often is emptied?				
_	and the street is employed			ICE 19	0
☐ never ☐ more than once a	NOSC .	once a year	r or less	FF 1	Е
in more than once a	i year			THRU OF -01-	-
		_		TR/	0
13. Are there problem:	s with your septic tank? Y	es 🗆 No		S M CEN	0
☐ leaks		☐ bad odor		FRO T	0_
other (explain) _				LID FRO	0
14. Do you own any of	these pets or farm animals?			IAUPR-IRB CENTRAL OFFICE VALID FROM THRU 26 -01- 18 - 26 -01- 19	A
□dogs	□cats		□pigs		
□chickens	□ducks		□cows		

Daily Report Card	Card								Study ID Number	ID Na	mber							
Participant: First Name									Date			Month		Year		_		
Last Name							1					=						
Please note any symptoms experienced during trips you made for each day of the week.	ny syn	npt	mo.	s e)	cbe	rier	Jce	o p	uring tr	rips yc	on ma	de for	each o	lay of the	week.			
										Τ.	lad	any sy	mpt	Had any symptoms?				
700						No.	Vomiting	9	Stomach	Nausea	5		Fount	Cough, nasal		We	Were you traveling?	ou 18?
Á	Diarrhea	ea	N D	Diarrhea w/ blood	e p	= "	(feeling sick)	9	ache/pain or cramping			Headache	chills	sore throat, or throat infection	No	Abroad (outside the US)	Sn	Did not travel
Monday	1 2	3+	3+ 1 2	2	3+	3+ 1 2	_	3+										
Tuesday																		
Wednesday																		
Thursday																		
Friday																		
Saturday																		
Sunday																		

If you experience diarrhea or vomiting this week, please complete questions 1 through 12 of the **Extended Daily Record**

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Commodeneise concet event		Chudu ID annachas	hou	(HOLLIE) SALVEY HALLIDEL)
comprehensive report card		study ID	nuper	
Participant:		Date	Month Ye	Year
First Name				
Last Name				
Please note if you experienced vomiting or diarrhea during the week, before completing this questionnaire.	before complet	ing this questic	onnaire.	
As a result of the symptoms listed on the daily report card	No Yes		What do you think caused the disease?	the disease?
1. Did you visit the doctor?			Please mark one box below	
2. Have you contacted a doctor in another manner?			Medicine (i.e. antibiotic, steroids)	roids)
3. Did you consult with a nurse or a doctor?			Person to person contact (transmission)	ransmission)
4. Did you call a 24-hour medical care facility (Urgent Care)?			Alcohol	
5. Did you go to the Health Services Center?			Food Poisoning	
6. Did you go to an Emergency Room?			Drinking water at the house	
7. Were you hospitalized for this condition?				
a. How many days did you spend?			Contact with water or cons	Contact with water or consumed from another location
8. Were you hospitalized during the night?			Pregnancy or Menstruation	
9. Was a stool sample taken?		L		
a. What were the results of the analysis?			Contact with Animals	
10. Did you take any medication for the symptoms?		L		
 a. □ over the counter □ with prescription 			Chemotherapy or Radiation	
b. What was the name of the medicine?				
11. Are you taking any antibiotic medications?		L		al surgery
12. Are you taking probiotic supplements or eating probiotic foods prepared by barrierial formentation like yours?	-	L	Intestinal Disorder	
	_	_	in the second se	ENTRA
13. Up you suffer from chronic disease (lasting > 6 months)?			Unknown Intection	VALID FROM THRU
14. Do these symptoms require that a family member miss work or attend school?			Other (Explain)	26 -01- 18 - 26 -01- 19
a. Total days of work missed due to				
Symptoms b. Total days of school missed due to			Unknown	APPROVED

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(home / survey number)

Consent Form

If you want to be part of the health study, please print your name and school name and then sign and date in the boxes shown below. Parents or guardians must sign on behalf of children under the age of twelve (12). If you are under 21 years of age, please sign the document and have your parent or guardian sign the document as a witness to your signature. If you (or a family member or friend) would like more information about this study, please do not hesitate to contact Graciela Ramirez Toro at 787-264-1912 ext. 7630, 7631.

I confirm that I read the information sheet on this study and I have the opportunity to ask questions. I agree to take part in the health study.

Name of Student Participant	Signature	Date	School Name
	>		
Name of Student Participant's Parent (If student is less than 21 years old)	Signature	Date	
	>		

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