| HOBBS, Charlotte, PI

Parasite Surveillance Project | UMMC IRB #2016-0111

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**Subject ID:**

**Date:**

Month

Day

Year

OMB Control No. 0920-\*\*\*\*

                                                                                                                                    Exp. Date \*\*/\*\*/2019

**Has your child had diagnosis of developmental delay?** Y - N- Not sure

If yes, what was the diagnosis? (please circle all that apply)

Autism - ADHD - Cerebral Palsy - prefer not to answer

If other, please specify

**Has your child had a history or diagnosis of asthma/reactive airways disease?** Y - N - Not sure

If yes, what was the diagnosis? If treated, when? (MM/DD/YYYY)

If treated, where was your child treated? (Clinic/Facility)

If treated, how was your child treated? (Name of Drug)

**Has your child had a history of anemia or low blood count?** Y - N - Not sure

If yes, what was the diagnosis?

**Has your child ever been treated for an intestinal parasite?** Y - N- not sure

If yes, do you know which one? (please circle all that apply)

Hookworm - Roundworm - Whipworm - Pinworm - not sure

If treated, when? (MM/DD/YYYY)

If treated, where was your child treated? (Clinic/Facility)

If treated, what drug? (Name of Drug)

**Has your child traveled outside the U.S. in the past 5 years?** Y - N (please circle one)

'

Ifso, to where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_(yr/mo)

**Has your child had a history of skin rash?** Y - N - not sure

If yes, what was the diagnosis? If treated, when? (MM/DD/YYYY)

If treated, where was your child treated? (Clinic/Facility)

If treated, how was your child treated? (Name of Drug)

**Has your child come in contact with the following animals in the past 3 years?**

Cats - Dogs - Pigs - Other - None

If other, please specify

**Has your child played/worked outside where his/her bare hands or bare feet were in contact with soil in the past 3 years?**

Never - Sometimes (less than a month) - Often (at least monthly) - All the Time - not Sure

**Does your child live outside the city limits?** Y or N

**Does your child visit friends or relatives that live outside any city limits?** Y or N

**If so, how often?** Daily - Weekly - Monthly - Yearly

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**Has your child had a history of abnormal lead levels?** Y - N - not sure

**Has your child had loose stools for more than 1 month at a time over the past 3 years?**

If yes, what was the diagnosis? Y - N - not sure

If treated, when? (MM/DD/YYYY)

If treated, where was your child treated? (Clinic/Facility)

If treated, how was your child treated? (Name of Drug)

The public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to - CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333 ATTN: PRA (0920-\*\*\*\*)

**COMMENTS**

**What type of toilet is in the home where your child lives?**

Flushable toilet - Outdoor toilet - Other - prefer not to answer

If other, please specify

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**Form Completed By:**

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