

Introduction Survey

STUDY TITLE: Vaccination Status and Health Outcomes among Homeschool Children

Dear Parent,

This study concerns a major current health question: namely, whether vaccination is linked in any way to children's long-term health. Vaccination is one of the greatest discoveries in medicine, yet little is known about its long-term impact. The objective of this study is to evaluate the effects of vaccination by comparing vaccinated and unvaccinated children in terms of a number of major health outcomes, including asthma, autism, diabetes, and learning disability.

The study involves a partnership between Jackson State University (JSU), Jackson, MS and the National Home Education Research Institute (NHERI), Salem, OR, which has long been involved in research on homeschool education.

We are asking biological mothers of homeschool children ages 6- to 12-years-old to participate in the survey. We chose ages 6 to 12 because by age 6 children will have completed most of their vaccinations.

Study participants will remain anonymous. This study has been reviewed and approved by the Institutional Review Board of Jackson State University. Any questions or concerns about your rights as a research participant may be directed to: Office of the Vice President for Research, Dr. Felix Okojie, Jackson State University, P.O. Box 17199, Jackson, Mississippi, 39217; Tel. 601-979-2931.

INSTRUCTIONS

1. Please **TAKE YOUR TIME** with the survey, which will take about 20 minutes, if you have one child. Please note that your responses will be automatically saved each time you press the NEXT arrow. You may continue at any later time by clicking on the same LINK in your email, provided you use the same computer. Alternatively, you may bookmark the link and add it to your favorites.
2. Please **HAVE YOUR CHILDREN'S VACCINATION RECORDS ON HAND** when completing the questionnaire. If you are in any doubt about which vaccinations your child has received to date, please consult with your child's healthcare provider before completing the questionnaire.
3. We are requesting information on ALL of your children currently between the ages of 6 and 12 years. After you complete the information on the first child, a screen will pop-up allowing you to enter information on additional biological children.
4. For ease in completing the survey, we strongly advise printing the attached PDF version first before entering the data online.

CONSENT TO PARTICIPATE:

I understand the purpose of the study; that participation is completely voluntary and anonymous, and that I will not be personally identified in any way. I also understand that I may refuse to answer specific questions and withdraw my participation at any time. If I have questions about the study I can contact the study team: Brian D. Ray, PhD, President, NHERI (bray@nheri.org) or Anthony R. Mawson, MA, DrPH, Principal Investigator, School of Health Sciences, JSU (anthony.r.mawson@jsums.edu).

Please check the **CIRCLE** below to confirm that 1) you have one or more biological children currently aged 6- to 12-years-old; 2) that you understand the aims of the study, and 3) that you are willing to participate in the survey.

Check the CIRCLE here

Section 1. Data on Mother and Household

Please indicate the state in which you currently reside and your zip code.

Zip Code

Your Ethnicity/Race

Black/African
American

White

Hispanic/Latino/Spanish
origin

Native American

Asian

Other

Education Level (Please indicate your highest level of education)

Less than high school

High school graduate

Some college

College graduate

Graduate degree

Your current Age in years

Your Height in feet and inches

feet

inches

Your Weight in pounds

Total gross household income

< \$20,000

\$20,000 - 49,999

\$50,000 -100,000

> \$100,000

Religious affiliation

Buddhism

Christianity

Islam

Judaism

Other

Marital status

 Married Not married

Do you live within 1-2 miles to any of the following?

 Furniture manufacturing factory Hazardous waste site Landfill Lumber processing factory None Do not know

Do you use pesticides and/or herbicides in your yard more than once a month?

 Yes No

Do you use pesticides in your home more than once a month?

 Yes No

How often do you use organically grown vegetables/fruits?

Never

Sometimes

Almost always

Do you usually wash fruit and vegetables before eating them raw?

 Yes No

What is your attitude toward routine vaccination?

Strongly favor

Neutral

Strongly against

Question for loop

Please provide information on all of your biological children now age 6-12 years old, starting with the eldest child. If you indicate that you have more than one child age 6-12 years, the computer will automatically take you to the starting point of data entry for each consecutive child.

How many biological children do you have currently between the ages of 6 and 12 (inclusive)?

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REMINDER!

- 1) Please obtain and use your Child (or Children's) Vaccination Record(s) to complete the questionnaire.
- 2) Please provide the requested information on each child.

Section 2. Data on Child

#{Im://Field/2}

Child's current age in years

|

Child's date of birth (mm/dd/yyyy)

Child's gender

Male

Female

Child's Ethnicity/Race

Black/African American

White

Hispanic/Latino/Spanish origin

Native American

Asian

Other

Was this child born preterm (less than 37 weeks of gestation)?

Yes

No

Was this child born by Cesarean section?

Yes

No

How many months did you breastfeed this child?

|

Child's hair color

Black

Red

Blond

Brown

Child's current Weight in pounds

Child's current Height in feet and inches

feet

inches

Child's current grade level

Has this child always been homeschooled?

- Yes
- No

Child's age when homeschooling began

Total number of years child has been homeschooled

Reasons for homeschooling this child (check all that apply)

- Allows more control over child's education
- Can't get vaccination exemptions to attend regular school
- Child has a physical or mental health problem
- Concern for child's safety
- Control of moral environment
- Desire more contact with child
- Enhance family relationships
- Poor quality of local schools
- Transportation problems
- Other

Has this child seen a doctor for a routine checkup in the past 12 months?

- Yes
- No

Had this child seen a dentist in the past 12 months?

- Yes

No

Has this child had any vaccinations?

Yes

No

Has this child had any Pneumococcal vaccinations (**PCV/PPSV**)?

Yes

No

Dates of Pneumococcal vaccinations (**PCV/PPSV**)

Date of dose 1 (mm/dd/yyyy)

Date of dose 2 (mm/dd/yyyy)

Date of dose 3 (mm/dd/yyyy)

Date of dose 4 (mm/dd/yyyy)

Date of dose 5 (mm/dd/yyyy)

Has this child had any Diphtheria and tetanus toxoids and acellular pertussis (**DTaP**) vaccinations?

Yes

No

Dates of Diphtheria and tetanus toxoids and acellular pertussis (**DTaP**) vaccinations

Date of dose 1 (mm/dd/yyyy)

Date of dose 2 (mm/dd/yyyy)

Date of dose 3 (mm/dd/yyyy)

Date of dose 4 (mm/dd/yyyy)

Date of dose 5 (mm/dd/yyyy)

Has this child had any Hepatitis B (**HepB**) vaccinations?

- Yes
 No

Dates of Hepatitis B (HepB) vaccinations

Date of dose 1 (mm/dd/yyyy)

Date of dose 2 (mm/dd/yyyy)

Date of dose 3 (mm/dd/yyyy)

Has this child had Haemophilus influenzae type b (Hib) conjugate vaccine?

- Yes
 No

Dates of Haemophilus influenzae type b (Hib) conjugate vaccinations

Date of dose 1 (mm/dd/yyyy)

Date of dose 2 (mm/dd/yyyy)

Date of dose 3 (mm/dd/yyyy)

Date of dose 4 (mm/dd/yyyy)

Has this child had Inactivated poliovirus vaccine (IPV)?

- Yes
 No

Dates of Inactivated poliovirus vaccination (IPV)

Date of dose 1 (mm/dd/yyyy)

Date of dose 2 (mm/dd/yyyy)

Date of dose 3 (mm/dd/yyyy)

Date of dose 4 (mm/dd/yyyy)

Has this child had Measles, mumps and rubella (MMR) vaccine?

- Yes
 No

Dates of Measles, mumps and rubella (MMR) vaccinations

Date of dose 1 (mm/dd/yyyy) Date of dose 2 (mm/dd/yyyy)

Has this child had Varicella (VAR) vaccine?

 Yes No

Dates of Varicella (VAR) vaccinations

Date of dose 1 (mm/dd/yyyy) Date of dose 2 (mm/dd/yyyy)

Has this child had Meningococcal conjugate vaccine, quadrivalent (MCV4) vaccine?

 Yes No

Dates of Meningococcal conjugate vaccine, quadrivalent (MCV4)

Date of dose 1 (mm/dd/yyyy) Date of dose 2 (mm/dd/yyyy)

Has this child had Hepatitis A (HepA) vaccine?

 Yes No

Dates of Hepatitis A (HepA) vaccinations

Date of dose 1 (mm/dd/yyyy) Date of dose 2 (mm/dd/yyyy)

Has this child had Rotavirus (**RV**) vaccine?

- Yes
 No

Dates of Rotavirus (**RV**) vaccinations

Date of dose 1 (mm/dd/yyyy)

Date of dose 2 (mm/dd/yyyy)

Date of dose 3 (mm/dd/yyyy)

Has this child had Influenza vaccine (Flu shot)?

- Yes
 No

Number of times child has received annual **Flu shot**

Has this child had all recommended vaccinations for his/her age?

- Yes
 No

My child has not received all recommended vaccinations for his/her age because (check all that apply):

- Can't afford the cost
- Child has no health insurance
- Child reacted badly to initial or earlier vaccines
- Doctor recommended against this child receiving one or more vaccinations
- No doctor or clinic available where we live
- Older child/children had bad reactions
- Religious/philosophical reasons
- We are concerned about vaccine safety
- We got behind but plan to complete all required shots
- Other

Please indicate each and every illness or condition that your child has been diagnosed with by a licensed physician or other healthcare practitioner. Check all that apply

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergic rhinitis | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Inflammatory bowel disease |
| <input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD) | <input type="checkbox"/> Diabetes Type 1 (insulin dependent) | <input type="checkbox"/> Juvenile rheumatoid arthritis |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Diabetes Type 2 (non insulin dependent) | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Eczema (atopic dermatitis) | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Child served under Individual Disability Education Act (IDEA) | <input type="checkbox"/> Encephalopathy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Childhood Disintegrative Disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Guillian-Barré syndrome | <input type="checkbox"/> Tourette's syndrome |
| <input type="checkbox"/> Conduct disorder | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> None |

Please indicate any acute condition this child has experienced

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Measles | <input type="checkbox"/> Influenza | <input type="checkbox"/> Rotavirus |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Mumps | <input type="checkbox"/> Otitis media | <input type="checkbox"/> Rubella (German measles) |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Meningitis (viral) | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> None |
| <input type="checkbox"/> High fever in last 6 months (over 102 F) | <input type="checkbox"/> Meningitis (bacterial) | <input type="checkbox"/> Pertussis (whooping cough) | |

Number of visits by this child to hospital Emergency Department in last 12 months

Number of "sick" visits by this child to doctors or clinics in last 12 months

Number of times this child has ever spent one or more nights in the hospital

Number of days this child has spent in the hospital in the last 12 months

Does this child have fitted ear drainage tubes?

- Yes
 No

Number of courses of antibiotics child has taken in the last 12 months

Does this child currently use allergy medication?

- Yes
 No

Estimated number of times this child has been given fever medications

Child uses medication for ADHD

- Yes
 No

Child uses medication for seizures

- Yes
 No

Based on your child's illnesses (if any), previous medical treatments, hospitalizations, and use of medications, please provide a rating of his or her overall state of health (out of 10, where 1= very poor and 10=excellent)

- | | | | | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1=Very
poor | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10=Excellent |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Estimated average number of hours spent outdoors each day

Number of hours per week typically spent with non-sibling children

What was your weight when you became pregnant with this child?

Weight in pounds

While pregnant with this child did you use/have/do any of the following?
(Check all that apply)

- Accutane (for acne)
- Acetaminophen
- Alcoholic beverages
- Antacids
- Antibiotics
- Anti-depression drugs
- Anti-epileptics
- Illicit drug use
- Influenza
- Rhogam shot (if you are Rh-negative)
- Selective Serotonin Reuptake Inhibitors (SSRIs), e.g. fluoxetine
- Smoked during pregnancy
- None

While pregnant with this child, were you diagnosed with any of the following?

- HELLP syndrome
- Gestational diabetes
- Preeclampsia
- None

Were you vaccinated during this pregnancy?

- Yes
- No

The next question is the last one for this child. Next, a screen will pop-up, allowing you to enter information on

your additional biological children. If you have no additional children, you have finished the questionnaire.

Number of ultrasound scans with this child
