QUESTIONS? ¿PREGUNTAS?
713-500-ALL5 (2555)

YOU WOULDN'T GIVE YOUR KID HALF A BACKPACK.

IT'S ALL FOR THEM.
GET ALL THE VACCINES.

FREE VACCINATION CLINICS ARE COMING TO CAMPUS!

¡LAS CLÍNICAS DE VACUNAS GRATUITAS VIENEN A SU ESCUELA!

BURBANK MIDDLE SCHOOL

Clinic Date / Fecha de la clínica

2/8/22

Return by / Entregue antes de

2/1/22

Cancer Prevention & Research Institute of Texas

UTHealth Houston

HISD

We know protecting your child's health is important to you. So we're inviting you to sign up for a free vaccination clinic, where your child can receive all of their recommended childhood and adolescent shots*.

Protect your child from serious illnesses and cancer, now and in the future—with Tdap, HPV, Meningococcal, Flu, as well as other vaccines they may need.

You do not need to be present at the clinic if you complete and return the forms in this packet to the school.
Questions? Need help with the forms? Call 713-500-ALL5.

This clinic will be sponsored and run by healthcare providers from Memorial Hermann Health Centers for Schools. Turn over this letter for instructions. Please send your child's most recent immunization record to school on the day of the clinic. We will stamp the record and send it home with your child.

Clinic staff will be following CDC guidelines regarding protection from COVID-19, including wearing masks and physical distancing. Students will be required to wear masks during the clinic visit only. Please send your child to school with their own mask on the day of the clinic.

We hope your child has a wonderful year!

Jacqueline Birmingham, MSN, RN, NE-BC, CNOR
Director, HISD Health and Medical Services

Please complete the following forms in order for your child to participate:

FORM A: Consent Forms (2)
1. Informed Consent for Treatment
2. Vaccine Consent

FORM B:
Immunization Registry Minor Consent Form (ImmTrac2)

FORM C:
Patient Eligibility Screening Record (Texas Vaccines for Children)

FORM D:
Screening Checklist

FORM E:
UTHealth Participation Form

REMEMBER:
PROTECTING YOUR CHILD STARTS NOW.

Just like you wouldn't give your child half an umbrella, you shouldn't send them to school with only half of their recommended vaccines. You can protect your child from serious health risks by getting them ALL of the vaccines they need. Because it's **ALL for them**.

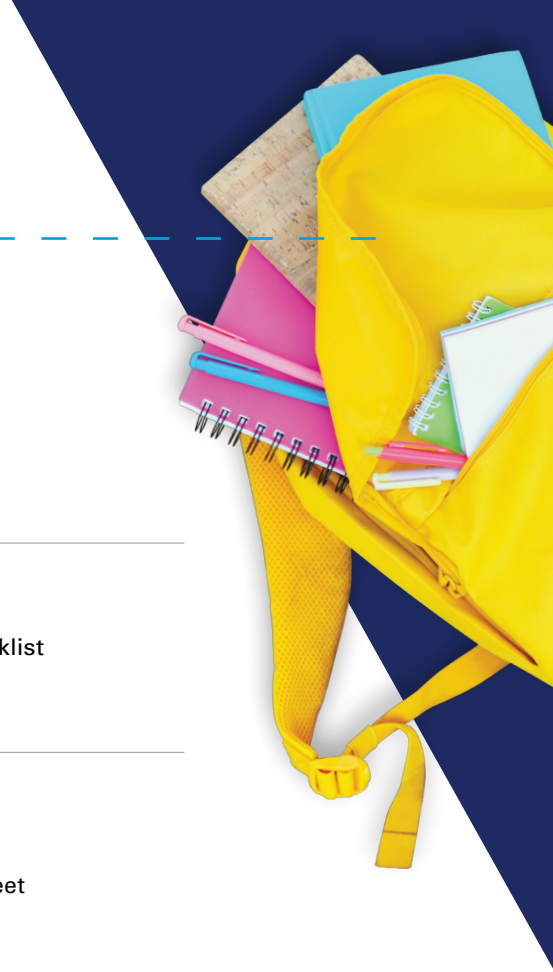
WANT TO KNOW MORE?
VISIT OUR WEBSITE OR CALL US!

AllForThemVaccines.com
713-500-ALL5 (2555)

*At this time, we are not able to provide the COVID-19 vaccine, but we can help you find out where to get it for your child.

UTHealth The University of Texas Health Science Center at Houston | Cancer Prevention & Research Institute of Texas | Baylor College of Medicine | Memorial Hermann | HISD

INSTRUCTIONS FOR YOUR CHILD TO PARTICIPATE



The table below lists what papers are in this packet.

These should be filled out in pen, signed and sent back to school.

These are for your information. You can review and keep them.

Sign and Return	Read and Keep
FORM A: Consent Forms (2) 1. Informed Consent for Treatment 2. Vaccine Consent	Welcome Letter / Checklist
FORM B: Immunization Registry Minor Consent Form (ImmTrac2)	
FORM C: Patient Eligibility Screening Record (Texas Vaccines for Children)	HPV Vaccine Fact Sheet
FORM D: Screening Checklist	
FORM E: UTHealth Participation Form	

Complete and return ALL forms in this packet to your child's school nurse one week before the vaccination clinic.

Step 1: Make sure to fill out the forms in **BLUE OR BLACK PEN** (NOT pencil).

Step 2: **Complete, sign, and date** each form at the bottom of each page.

Step 3: Make sure that you check **YES** or **NO** for every question.

All childhood and adolescent vaccines (except for COVID-19 vaccines) will be available at the clinic.

- **Please read the Vaccine Information Statements (VIS) about each vaccine here:** www.allforthemvaccines.com. If you want printed copies or do not have internet access, please call (713) 500-ALL5 (2555). You can also request printed copies of these VIS at your child's school.
- Parents are not required to be at school when vaccines are given if forms are completed and turned into the school, but parents are welcome to be present. A parent or legal guardian must be available by phone during the day of the vaccine clinic.
- **Please send your child's most recent immunization record to school on the day of the clinic.** It will be stamped and returned home with your child.

If you have any questions about the vaccinations or eligibility, please call program staff at 713-500-ALL5 (2555).

IT'S ALL FOR THEM.

PROTECT YOUR CHILD NOW AND IN THE FUTURE WITH ALL OF THEIR RECOMMENDED VACCINES.

GET ALL THE FACTS

ABOUT THE HPV VACCINE

There is no better time to get your child vaccinated against Human Papillomavirus (HPV).

The vaccine used to prevent HPV protects your child throughout their life. Like all vaccines, it's best to vaccinate children against HPV long before they will ever come into contact with the virus. It's a normal part of keeping your child healthy and protects their ability to grow up and have a family of their own one day.

Make sure your child gets the HPV vaccine along with the other recommended adolescent vaccines.

BECAUSE ALL IS BETTER THAN SOME.

ALLFORTHEMVACCINES.COM

1. Everyone needs the HPV vaccine.

- The vaccine protects both boys and girls.
- HPV is so common that almost everyone will be infected at some point in their life.
- HPV can cause cancers, genital warts and other illnesses.

2. The HPV vaccine works.

- The vaccine prevents HPV-related cancers and illnesses.
- Since doctors started giving the vaccine to their patients, there has been a huge drop in HPV infections.

3. The HPV vaccine is proven to be safe.

- The side effects are mostly mild and similar to other vaccines, such as temporary redness and soreness in the arm.
- The vaccine does not contain harmful ingredients.

4. The HPV vaccine works best when given between the ages of 11 and 12.

- Research shows that younger people respond better to the vaccine, meaning their bodies will be more prepared to prevent an HPV infection if they get the vaccine between the ages of 11 and 12.
- It's never too late to vaccinate. All children over 11 years old should be vaccinated.

5. Younger children need fewer doses for full protection.

- The HPV vaccine is given in multiple doses.
- If a child gets their first shot before they turn 15 years old, they only need two doses. After they turn 15, they need three doses.

Source: https://www.cdc.gov/hpv/parents/

UTHealth | School of Public Health
The University of Texas Health Science Center at Houston

Cancer Prevention & Research Institute of Texas

Baylor College of Medicine

A1

MEMORIAL HERMANN HEALTH CENTERS FOR SCHOOLS BURBANK CLINIC, HOUSTON, TEXAS

INFORMED CONSENT FOR TREATMENT AND OTHER PREVENTIVE HEALTH CARE SERVICES

PLEASE READ CAREFULLY AND FILL OUT THE CONSENT FORM BELOW FOR YOUR STUDENT TO BE TREATED AT THE HEALTH CENTER

Memorial Hermann Health Centers for Schools (MHHCS) or "Health Center" is concerned with the health of students at contracted schools. We provide a number of health care services, subject to the limitations of the facility.

THE FOLLOWING HEALTH CARE SERVICES ARE AVAILABLE AT THE BURBANK SCHOOL-BASED HEALTH CENTER.

1. Immunizations
2. Well Exams / Check-ups
3. Athletic and Camp Physicals
4. Health Education
5. Nutrition Education
6. Family Planning Services
7. Social Service Assistance
8. Treatment of minor illness and injury
9. Mental Health counseling
10. Exercise education and counseling
11. Detection and treatment of sexually transmitted diseases (STD)

Please indicate which of the following apply to the student:

☐ Medicaid # _____ Medicaid Plan _____ ☐ Harris Health/Gold Card

☐ CHIP ☐ Private Health Insurance ☐ No Insurance

IMPORTANT – PLEASE NOTE: The Health Center is a Medicaid Provider and will bill Medicaid for services to those students who have Medicaid coverage. **Non covered services will NOT be billed to the student or family.**

I authorize MHHCS to bill Medicaid or my Medicaid plan and receive payment directly from them for services rendered. I also authorize MHHCS to release information as required to Medicaid or my Medicaid plan, for the purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse, and/or mental health issues. A photocopy or a telefaxed copy of this authorization shall be deemed as valid as the original.

I authorize the Health Center staff to disclose to the school nurse, medical or athletic team appropriate health information about my child as deemed necessary, solely for treatment purposes, and for the continuity of my child's care. I further authorize school personnel to disclose grades, absenteeism, and disciplinary data for my child, if seen by the Licensed Clinical Social Worker or Licensed Professional Counselor.

XX _____ _____ _____ _____

Parent / Guardian Signature **Print Name** **Relationship to Student** **Date**

PLEASE NOTE:

Primary health care services are provided to students by a full time Advanced Practice Provider. In addition, counseling services are provided by a Licensed Clinical Social Worker (LCSW) or Licensed Professional Counselor (LPC). Services provided at the Health Center are optional and at no cost to the student or family.

I authorize a designated MHHCS professional healthcare provider to provide necessary and/or advisable treatment for the student.

_____ _____

Student Name Date of Birth

I give my permission for MHHCS to provide all services indicated above within the capabilities of the facility and its personnel except for

item(s) _____.

I authorize the above named facility to provide transportation and/or accompany my child from the contracted schools to the Health Center for services after receiving permission from the school nurse.

I have read and completed this consent form. I understand that school personnel may see this informed consent. I understand that any questions I may have concerning the Health Center will be answered by calling (713) 742-8151.

XX _____ _____ _____ _____

Parent / Guardian Signature **Print Name** **Relationship to Student** **Date**

Phone number where parent/guardian can be reached during school hours:

Name:_____ Phone Number:_____ Best time to call:_____

Email:_____

Second Parent/Guardian
Signature (optional):: _____ Phone Number:_____ Best time to call:_____

MEMORIAL HERMANN

Informed Consent

A2

REQUEST FOR VACCINATION(S) - CONSENT FORM

The doctor or clinic may keep this record in your medical file, or your child's medical file. They will record what vaccine(s) given, when vaccine(s) is given, name of the company that made the vaccine(s), and address where vaccine(s) given. I have received a copy and have read, or have had explained to me, the information contained in the appropriate "Vaccine Information Statement" about the disease(s) and vaccine(s) indicated below. I have had a chance to ask questions which were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) below to be given to me or to the person named below for whom I am authorized to make this request.

PLEASE PRINT ALL ENTRIES CLEARLY IN BLACK OR BLUE PEN (not pencil):

Child's Last Name: _____ Child's First Name: _____

Date of Birth: _____ Age: _____ Grade: _____Telephone: _____

Street Address: _____ City: _____State: _____ Zip Code: _____

If person receiving vaccines/testing is under 18, PRINT parent's/guardian's name:

Mother's Maiden Name: _____

Father's Name: _____

Legal Guardian's Name: _____

SEX: Please check the box that applies to the person being immunized:

□ Male

□ Female

□ Other _____

Has the person to be vaccinated ever had Guillain-Barre syndrome? (circle one) YES NO DON'T KNOW

ALLERGIES: _____

X _____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

Vaccine	1	2	3	4	5	M/C	Lot #	Site	Exp. date	VIS NDC
MCV4	/ /	/ /	/ /	/ /	/ /	SP		LA / RA LT / RT		08/06/21 49281-589-05
Hep A	/ /	/ /	/ /	/ /	/ /	GSK		LA / RA LT / RT		07/28/20 58160-825-52
Td/Tdap	/ /	/ /	/ /	/ /	/ /	SP		LA / RA LT / RT		08/06/21 08/06/21 49281-215-15 49281-400-15
Varicella	/ /	/ /	/ /	/ /	/ /	Merck		LA / RA LT / RT		08/06/21 0006-4827-00
Hib	/ /	/ /	/ /	/ /	/ /	SP		LA / RA LT / RT		08/06/21 49281-545-05
MMR	/ /	/ /	/ /	/ /	/ /	Merck		LA / RA LT / RT		08/06/21 0006-4681-00
Hep B	/ /	/ /	/ /	/ /	/ /	GSK		LA / RA LT / RT		08/15/19 0006-4093-02
IPV	/ /	/ /	/ /	/ /	/ /	SP		LA / RA LT / RT		08/06/21 49281-860-10
HPV9	/ /	/ /	/ /	/ /	/ /	Merck		LA / RA LT / RT		08/06/21 0006-4121-02
Flu: Fluzone Fluarix	/ /	/ /	/ /	/ /	/ /	Med GSK		LA / RA LT / RT		08/06/21 49281-416-50 58160-905-52
Proquad						Merck		LA/RA		08/06/21 0006-4171-01
Bexsero						GSK		LA / RA LT / RT		08/06/21 58160-976-06

SIGNATURE OF VACCINE ADMINISTRATOR: _____

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

B

(Please print clearly)

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) _____/_____/_____ *Children younger than 18 years old only.

Child's Gender: ☐ Female ☐ Male

Telephone _____-_____-_____

Child's Address _____ Apartment # _____ Email address _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian, or managing conservator:

Printed Name _____

Date _____ Signature _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2

Please enter client information in ImmTrac2 and **affirm** that consent has been granted.
DO NOT fax to ImmTrac2. **Retain this form in your client's record.**

C

Texas Vaccines for Children Program
Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five (5) years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. Child's Name: _____ (Last Name) _____ (First Name) _____ (MI)
2. Child's Date of Birth: ____ / ____ / _____
3. Parent, Guardian, or Individual of Record: _____ (Last Name) _____ (First Name) _____ (MI)
4. Primary Provider's Name: _____ (Last Name) _____ (First Name) _____ (MI)
5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC Program, at each immunization encounter or visit, enter the date and mark the appropriate eligibility category. *If Column A - F is marked, the child is eligible for the TVFC Program. If column G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	Has health insurance that covers vaccines

**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC), a Rural Health Clinic (RHC), or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC or an RHC and the state, local, or territorial immunization program in order to vaccinate underinsured children.*

*** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the TVFC Program because the provider or facility is not an FQHC or an RHC, or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-TVFC eligible children.*

**** Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC Program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.*

Medicaid:

Medicaid Number: _____

Date of Eligibility: _____

CHIP:

CHIP Number: _____

Group Number: _____

Date of Eligibility: _____

Private Insurance:

Name of Insurer: _____

Insurance Name: _____

Insurer Contact Number: _____

Policy or Subscriber Number: _____

D

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. Does the child have a parent, brother, or sister with an immune system problem?	☐	☐	☐
10. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
13. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

immunization action coalition
IAC
immunize.org

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (10/20)

The University of Texas Health Science Center at Houston (UTHealth)
School of Public Health

HSC-SPH-20-0356

INFORMED CONSENT TO TAKE PART IN RESEARCH

You are invited:
We would like to invite you to take part in a project called, "*Expanding All for Them: A school-based approach to increase HPV vaccination through public schools*", conducted by Dr. Paula Cuccaro of UTHealth. This project is a collaboration between researchers, healthcare providers, and educators at the UTHealth School of Public Health, UTHealth Cizik School of Nursing, Baylor College of Medicine, University of Texas Medical Branch at Galveston ,Texas Children's Mobile Clinic Program, Harris County Public Health, Memorial Hermann Health Centers for Schools, CHRISTUS Foundation for HealthCare, the University of North Texas Health Science Center School of Public Health and Pediatric Mobile Clinic, The University of Texas M.D. Anderson Cancer Center,, and the following school districts:

Crowley Independent School District (CISD)
Fort Worth Independent School District (FWISD)
Goose Creek Consolidated Independent School District (GCCISD)
Houston Independent School District (HISD)

You are eligible to take part in this project if you are a parent or guardian who has a child attending a participating middle, junior, or high school in the school districts listed above.

Why we are doing this project:
- To make immunizations available to students in the participating school districts at no cost.
- To increase the percentage of students who complete the HPV vaccine series.
- To help you make sure your child's school district has the most current information on your child's immunization records.

How the project works:
The *All for Them* clinic where your child is receiving vaccinations is part of this project. After your child has received their immunizations at the vaccine clinic, we would like your help in collecting the following information about your child:
- name
- date of birth
- county your child lives in
- gender
- race/ethnicity
- grade level
- vaccines given (with dosage type for HPV vaccine)
- whether they received an HPV vaccine reminder card
- whether they participated in previous years of the project

After we collect the information listed above, we will provide your child's name, date of birth, and vaccines given to the school district's nurse to update your child's school immunization records.

Total time commitment:
5 minutes (after your child receives their immunizations)

Confidentiality:
Your child will not be personally identified in any reports or publications that may result from this project. Any information provided would be kept private. Your child's name, date of birth, and vaccines given will only be collected so that the school district's nurse can update your child's school immunization records, as described above.

Project withdrawal:
Taking part in this project is voluntary. You can withdraw at any time. If you do not want to take part, this decision will not affect your child's grades or the services available to you or your child at school. The information collected will be used up to the point of your project withdrawal.

Alternatives:
The only alternative is to not take part in the project.

Benefits:
Your child is receiving free immunizations as part of this project. As an additional benefit, we will let the school district know which immunizations your child received so that you don't have to. You may not receive any other direct benefit from taking part in this project. The information you provide will help us develop better vaccination programs for adolescents.

Risks and/or discomforts:
There are no known risks to taking part in this project. The only possible risk may be breach of confidentiality.

Reimbursement/Compensation:
There is no compensation to take part in this project.

Questions: You can contact Dr. Paula Cuccaro at 713-500-9684 if you have any questions about this study.

By signing this form, I agree to provide the information listed above regarding immunizations my child received at the *All for Them* clinic and for UTHealth to provide this information to the school district nurse:

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ Date: _____

Child's Name: _____ Child's DOB: _____

Name of School District: _____

Name of Child's School: _____

Child's Grade Level: _____

If you have any questions about this project, please contact project staff at **allforthem@uth.tmc.edu**. This research project has been reviewed by the Committee for the Protection of Human Subjects (CPHS) of the University of Texas Health Science Center at Houston (HSC-SPC-20-0356). For any questions about your rights as a research participant, call CPHS at (713) 500-7943.