3146

Kathy Cooper

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From: Leigh Shane <leighg12000@yahoo.com>
Sent: Thursday, May 05, 2016 2:28 PM
To: cfindley@pa.gov; ra-stateboardofed@pa.gov; IRRC
Subject: IRRC #3146 & 3147

Dear Ms. Findley and Ms. Molchanow,

I am writing to you in reference to IRRC #3146 & 3147, regarding the proposed changes by the DOH and DOE to Pennsylvania school immunization requirements. I have outlined my position on the proposed changes below:

#1 – **Change reporting deadline from October 15 to December 31**:

I support this change, which will allow the DOH additional time to prepare more accurate records.

#2 – **Decrease the provisional period for student enrollment from 240 days to 5 days**:

I oppose this change as it is extreme to say the least. NO nearby states have such short provisional periods; their average is fifty-eight days. Five days is not enough time to schedule appointments or for students who may be sick to recover before getting vaccinated. Parents will face stress and unnecessary expense as they make appointments and submit paperwork. A sixty day provisional period will give parents and sick children time to meet the requirements without undue stress given the later reporting date, a sixty day provisional period will not interfere with school data collection and analysis.

#3 – **Proof of natural immunity for chicken pox through having contracted the disease must now be provided by a doctor, physician's assistant or nurse practitioner**:

I oppose this change. Requiring an ill, highly contagious child to visit a medical facility where there are other children, possibly those who are medically fragile, just to receive an "official" chicken pox diagnosis, seems highly irresponsible of the DOH. This move could actually increase the spread of the disease. Most families will also need to incur the financial burden of all charges and co-pays as well as any lab fees. This is especially the case for parents of children who have already had chicken pox and must now obtain titers results, a fee that many insurance companies will not cover, to prove immunity. It also creates an environment of distrust between the school staff and the parents, as the parents' word is questioned.

#4 – **Addition of Meningococcal vaccine for students entering 12th grade**:

I oppose this change. Addition of this vaccine is not only unnecessary but would also significantly raise costs and increase risks that far outweigh the benefit. The disease is extremely rare; incidence for meningococcal disease, according to the CDC, is 0.3-0.5/100,000. According to the PA Department of Health EDDIE database, in 2014, there were only 16 new cases of meningitis. Vaccinating the estimated 147,040 senior classmen and women in 2014 would have cost the parents and taxpayers over $16,000,000. The CDC states that all serogroups of the disease are on the decline, including serogroup B, which is not even included in the vaccine.

Earlier during this legislative session, a bill was introduced to mandate this vaccine for all students entering 12th grade. The legislature did not see the necessity of such a mandate and thus chose not to act. The Department of Health is seeking to circumvent the legislative process in enforcing mandates that are not supported by lawmakers. This vaccine is already available to anyone who wants it.

According to vaccine manufacturer package inserts, post marketing surveillance for the meningitis vaccine has shown the following: hypersensitivity reactions such as anaphylaxis/anaphylactic reaction, wheezing, difficulty breathing, upper airway swelling, urticaria, erythema, pruritus, hypotension, Guillain-Barre syndrome, paresthesia, vasovagal syncope, dizziness, convulsion, facial palsy, acute disseminated encephalomyelitis, transverse myelitis and myalgia.

#5 – **Inclusion of pertussis vaccine for kindergarten admission:**

I oppose this change. There are currently outbreaks of pertussis among fully vaccinated populations. The CDC and top doctors are verifying the lack of efficacy and the early waning of any immunity provided by this vaccine. In February 2016 The American Academy of Pediatrics published that TDaP provided only moderate defense against the illness (pertussis) during the first year after vaccination but not much longer. Immunity waned during the second year and little protection remained 2-3 years following vaccination. It seems poorly thought out to add a vaccine that is currently under scrutiny from the medical community, to the requirements.

Meningitis and TDaP vaccines are pharmaceutical products that carry a risk of injury or death, a fact that was acknowledged by the U.S. Congress in 1986 when it passed that National Childhood Vaccine Injury Act. Since 1988 the federal vaccine injury compensation program was awarded more than $3.2 billion to children and adults injured by vaccines or to families whose loved ones died from vaccine reactions, although two out of three who apply are denied compensation. The Institute of Medicine in a series of reports on vaccine safety spanning 25 years has acknowledged there is individual susceptibility to vaccine reactions for genetic, biological and environmental reactions that have not been fully defined by science, and doctors often cannot predict ahead of time who will be harmed. Long standing gaps in vaccine safety research and emerging evidence that certain vaccines do not prevent infection or transmission of disease, urgently require legal protection of parental rights and physicians' rights regarding medical and religious exemptions to vaccination for minor children.

Vaccine manufacturers for meningitis vaccines have no civil liability. The 1986 law partially shielded drug companies selling vaccines in the U.S. from civil liability and in 2011, the US Supreme Court completely shielded the vaccine manufacturers from liability for FDA licensed and CDC recommended vaccines. There is no product liability or accountability for pharmaceutical companies marketing federally recommended and state mandated vaccines that injure Americans and cause their deaths, which makes flexible medical and non-medical vaccine exemptions in vaccine policies and laws.

#6 – **The DOH proposes to edit the current regulations by eliminating separate listings for measles, mumps, rubella, tetanus, diphtheria and pertussis vaccines that are currently most commonly consumed as combination shots. Instead, they will only be listed in the regulations in their combination forms – MMR & TDaP. Evidence of Immunity is different for some of the vaccines and the proposed regulations are unclear.**

I oppose this change. All antigens should be listed individually. This will simplify the amendment process should the combinations change in the future and will ensure accuracy in data collection and publication. Some of these vaccines are still available singularly and so listing each antigen individually is best and should not be changed.

#7 – **There is no requirement for standardized language in communications regarding vaccine requirements**:

Change Requested – Currently, each school district creates its own language in communicating with parents regarding vaccine requirements, provisional periods, and reporting. I request that the regulations be amended to require all schools to use uniform language provided by the DOH which will include the text of 28 PA CODE CH. 23 stating the accepted exemptions for PA students.

#8 – **Annex A lists enhanced "activated" polio vaccine**:

Change Requested – This is incorrect and should be changed to enhanced "inactivated" polio vaccine.

#9 – **Herd Immunity claims are given without clarification or verification**:

Change Requested – The Department of Health bases their reasoning for increasing vaccination mandates on the theory of herd immunity which was first developed when studying individuals who had the wild diseases, not those who had been vaccinated. Disease outbreaks continue to occur in populations that have reached 100% vaccination rate, rendering this theory unreliable for massive vaccination requirements.

Kindest Regards,
Leigh Shane