3146

Kathy Cooper

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IRRC

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From: meganburns7@aol.com
Sent: Monday, May 09, 2016 12:53 PM
To: IRRC
Subject: vaccine policy legislation IRRC #3146 & 3147

To Whom it May Concern,

As a mother who does extensive research on health related issues, I have deep concerns about some of the proposed changes to the vaccine policies for PA children, IRRC #3146 & 3147. While I have specific examples below, I ultimately believe that all parents should be able to do their own research and make decisions for both themselves and their children regarding the care that we use for our own bodies. I do not believe the government should mandate or legislate a "one size fits all" system.

The only change I support that I think make sense is the following:

Change reporting deadline from October 15 to December 31. The later reporting date will give the DOH additional time to prepare more accurate records.

The following changes that have been proposed I am in opposition to:

Decrease the provisional period for student enrollment from 240 days to 5 days.

This change is very extreme. There are NO nearby states have such short provisional periods; their average is 58 days (which is still short). 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. Give parents needed time (at least 60 days) to do what they need to do.

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.

How can the DOH insist that a highly contagious child visit a medical facility where other children, including the medically fragile, will likely be present for the sole purpose of receiving an official chicken pox diagnosis? I'm pretty certain my own doctor's office would not want us in there should we have the chicken pox. This move could increase the spread of the disease. Most families will also have the financial burden of all charges, or co-pays as well as laboratory fees. Additionally, this requirement creates an environment of distrust between the school staff and the parents as the parents' word is questioned. As someone who used to work in public education, we don't need any other issues that can lead to distrust.

Addition of Meningococcal vaccine for students entering 12th grade.

For a disease that's extremely rare, the addition of this vaccine is totally unnecessary, but also raises costs. According to the CDC, the incidence rate for meningococcal disease 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 seniors in 2014, would have cost 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. If a parent chooses the extra vaccine for their child, that's their choice. In no way should it be mandatory. Not only is it not cost effective, this vaccine has remarkable risks. If you read the package insert from vaccine manufacturers, you will find post marketing surveillance for this vaccine to have shown the following: hypersensitivity reactions such as anaphylaxis/anaphylactic reaction, wheezing, difficulty breathing, upper airway swelling, urticaria, erythema, pruritus, hypotension, Guillain-Barré syndrome, paraesthesia, vasovagal syncope, dizziness, convulsion, facial palsy, acute disseminated encephalomyelitis, transverse myelitis, and myalgia.

Inclusion of Pertussis vaccine for kindergarten admission.

Pertussis outbreaks are increasing **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 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 to 3 years after vaccination. Why would we add a vaccine that is currently being scrutinized by the medical community as an ADDED requirement.

Both the meningitis and Tdap vaccines carry the risk of death or injury. This was acknowledged by the U. S. Congress in 1986 when it passed the National Childhood Vaccine Injury Act. Since 198, more than 3.2 billion dollars has been awarded to children and adults injured by vaccines or to families whose loved ones died from a vaccine reaction. And that's only what has been paid! Two our of three who apply are denied compensation. A lack of research on genetic, biological and environmental factors means that those who have individual susceptibility to vaccine reactions are unknown at the time of vaccination. There is no recent research in vaccine safety as well as emerging research that vaccines don't actually prevent infection or transmission of diseases. Pediatricians and doctors and nurses will even tell you this when you being vaccinated. **Physicians rights and parental rights regarding medical and religious exemptions for vaccines should be protected!** In addition, vaccine manufacturers are given full protection from accountability and liability to market vaccines that are injuring Americans and causing death. Vaccine exemptions in vaccine policies and laws is the only way for Americans to fully protect themselves and their children from vaccine risks.

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 and TDaP. Evidence of Immunity is different for some of the vaccines and the proposed regulations are unclear.

All antigens should be listed individually. This will simplify the amendment process should these combinations change in the future. It will also 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. Each disease should individually list what can be given as evidence of immunity.

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There is no requirement for standardized language in communications regarding vaccine requirements.

As someone who worked in public education for many years, it was frustrating to have so much differing language from one district to another on any issue. As with everything else, 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.

Annex A lists enhanced "activated" polio vaccine.

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

Herd Immunity claims are given without clarification or verification.

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 rates, rendering this theory unreliable for massive vaccination requirements. There is plenty of information out there as to why this theory is so wrong.

Thank for your time on this matter.

Sincerely,

Megan Burns