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Kathy Cooper

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IRRC

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From: Ryan Rufe <rufes@verizon.net>
Sent: Monday, May 09, 2016 11:09 PM
To: IRRC
Subject: re changes to PA vaccine schedule

I agree with the comments listed below. I oppose changes to the PA vaccine schedule.

#1 - Decreasing the provisional period for student enrollment from 240 days to 5 days.
Our Comment: While we do support shortening the provisional period in an effort to correct reporting failures and ascertain accurate data, we find this change to be extreme. This very short provisional period does not allow enough time for students who may be sick to wait until they are healthy to catch up with their vaccines. It will cause parents stress and unnecessary expense as they will have to file extensions and take their sick child to the doctor for a waiver. It will substantially increase paperwork as numerous waivers are filed requiring individual follow ups. We believe that a 60 day provisional period will meet the need of ensuring timely filing without causing undue stress on parents or endangering sick children by leading parents to seek out vaccines under duress. There are NO surrounding states with such short provisional periods. Given the later reporting date, a 60 day provisional period would not interfere with data collection and analysis.

#2 - Change reporting deadline from October 15 to December 31.
Our Comment: The later reporting date will give the DOH additional time to prepare more accurate records. We fully support this change.

#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.
Our Comment: This is objectionable for several reasons. First of all, it is irresponsible of the DOH to force a child with a highly contagious disease to visit a medical facility where other children, including those who are medically fragile, will likely be present and thus at high risk to contract the disease. Not all families have existing relationships with the list of specified medical workers, and this provision could force a family to enter into a new contractual relationship with unknown medical staff. Most families will also have the financial burden of all charges, or co-pays as well as laboratory fees. Lastly, we feel that this 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.
Our Comment: We feel that the addition of this vaccine is not only unnecessary but would significantly raise costs and risks that far outweigh any possible benefit. The disease is extremely rare. The incidence rate for meningococcal disease, according to the CDC, is 0.3-0.5/100,000 http://www.cdc.gov/vaccines/pubs/surv-manual/chpt08-mening.html. According to the CDC Pink Book, the meningococcal bacteria become invasive only rarely. "In a small proportion (less

than 1%) of colonized persons, the organism penetrates the mucosal cells and enters the bloodstream." (See reference below.)The CDC states that all serogroups of the disease are on the decline. Serogroup B, not included in the vaccine, declined along with the serogroups included in the vaccine "for reasons that are not known." Also, "The communicability of *N. meningitidis* is generally limited. In studies of households in which a case of meningococcal disease has occurred, only 3%-4% of households had secondary cases." Furthermore, "In the United States, meningococcal outbreaks account for less than 2% of reported cases (98% of cases are sporadic)." Therefore, transmission in the school setting is very unlikely.

Currently, 7th grade is the last reporting point for student vaccinations. Adding this vaccine to 12th graders will create a third reporting burden, consuming more staff hours and requiring more paperwork associated with the provisional timeline, filing of waivers, and individual follow-ups. Earlier this session, a bill was introduced to mandate this vaccine for students entering 12th grade. The legislature did not see the necessity of such a mandate and thus chose not to act. We see this insertion as an attempt to circumvent the legislative process in enforcing mandates that are not supported by lawmakers.

#5 - Inclusion of Pertussis vaccine for kindergarten admission.

Our Comment: We are currently seeing 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. It seems hasty to add a vaccine that is currently under scrutiny from the medical community to the requirements.

#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 and TDaP.

Our Comment: We feel that all antigens should be listed individually. This will simplify the amendment process should these combinations change in the future. We also want to 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.

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

Our Comment: Currently, each school district creates it's own language in communicating with parents regarding vaccine requirements, provisional periods, and reporting. We 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.

Sincerely,

Nicole Rufe

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