

JOINT STATE GOVERNMENT COMMISSION

General Assembly of the Commonwealth of Pennsylvania

YOUTH VACCINATIONS IN PENNSYLVANIA: REPORT OF THE WORK GROUP ON YOUTH VACCINATIONS OF THE ADVISORY COMMITTEE ON PUBLIC HEALTH LAW

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REPORT

*Youth Vaccinations in Pennsylvania:
Report of the Work Group on Youth Vaccinations
of the Advisory Committee on Public Health Law*

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The Joint State Government Commission was created in 1937 as the primary and central non-partisan, bicameral research and policy development agency for the General Assembly of Pennsylvania.¹

A fourteen-member Executive Committee comprised of the leadership of both the House of Representatives and the Senate oversees the Commission. The seven Executive Committee members from the House of Representatives are the Speaker, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. The seven Executive Committee members from the Senate are the President Pro Tempore, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. By statute, the Executive Committee selects a chairman of the Commission from among the members of the General Assembly. Historically, the Executive Committee has also selected a Vice-Chair or Treasurer, or both, for the Commission.

The studies conducted by the Commission are authorized by statute or by a simple or joint resolution. In general, the Commission has the power to conduct investigations, study issues, and gather information as directed by the General Assembly. The Commission provides in-depth research on a variety of topics, crafts recommendations to improve public policy and statutory law, and works closely with legislators and their staff.

A Commission study may involve the appointment of a legislative task force, composed of a specified number of legislators from the House of Representatives or the Senate, or both, as set forth in the enabling statute or resolution. In addition to following the progress of a particular study, the principal role of a task force is to determine whether to authorize the publication of any report resulting from the study and the introduction of any proposed legislation contained in the report. However, task force authorization does not necessarily reflect endorsement of all the findings and recommendations contained in a report.

Some studies involve an appointed advisory committee of professionals or interested parties from across the Commonwealth with expertise in a particular topic; others are managed exclusively by Commission staff with the informal involvement of representatives of those entities that can provide insight and information regarding the particular topic. When a study involves an advisory committee, the Commission seeks consensus among the members.² Although an advisory committee member may represent a particular department, agency, association, or group, such representation does not necessarily reflect the endorsement of the department, agency, association, or group of all the findings and recommendations contained in a study report.

¹ Act of July 1, 1937 (P.L.2460, No.459) (46 P.S. § 65), amended by the act of June 26, 1939 (P.L.1084, No.380); the act of March 8, 1943 (P.L.13, No.4); the act of May 15, 1956 (1955 P.L.1605, No.535); the act of December 8, 1959 (P.L.1740, No.646); and the act of November 20, 1969 (P.L.301, No.128).

² Consensus does not necessarily reflect unanimity among the advisory committee members on each individual policy or legislative recommendation. However, it does, at a minimum, reflect the views of a substantial majority of the advisory committee, gained after lengthy review and discussion.

Over the years, nearly one thousand individuals from across the Commonwealth have served as members of the Commission's numerous advisory committees or have assisted the Commission with its studies. Members of advisory committees bring a wide range of knowledge and experience to deliberations involving a particular study. Individuals from countless backgrounds have contributed to the work of the Commission, such as attorneys, judges, professors and other educators, state and local officials, physicians and other health care professionals, business and community leaders, service providers, administrators and other professionals, law enforcement personnel, and concerned citizens. In addition, members of advisory committees donate their time to serve the public good; they are not compensated for their service as members. Consequently, the Commonwealth of Pennsylvania receives the financial benefit of such volunteerism, along with the expertise in developing statutory language and public policy recommendations to improve the law in Pennsylvania.

The Commission periodically reports its findings and recommendations, along with any proposed legislation, to the General Assembly. Certain studies have specific timelines for the publication of a report, as in the case of a discrete or timely topic; other studies, given their complex or considerable nature, are ongoing and involve the publication of periodic reports. Completion of a study, or a particular aspect of an ongoing study, generally results in the publication of a report setting forth background material, policy recommendations, and proposed legislation. However, the release of a report by the Commission does not necessarily reflect the endorsement by the members of the Executive Committee, or the Chair or Vice-Chair of the Commission, of all the findings, recommendations, or conclusions contained in the report. A report containing proposed legislation may also contain official comments, which may be used in determining the intent of the General Assembly.³

Since its inception, the Commission has published more than 350 reports on a sweeping range of topics, including administrative law and procedure; agriculture; athletics and sports; banks and banking; commerce and trade; the commercial code; crimes and offenses; decedents, estates, and fiduciaries; detectives and private police; domestic relations; education; elections; eminent domain; environmental resources; escheats; fish; forests, waters, and state parks; game; health and safety; historical sites and museums; insolvency and assignments; insurance; the judiciary and judicial procedure; labor; law and justice; the legislature; liquor; mechanics' liens; mental health; military affairs; mines and mining; municipalities; prisons and parole; procurement; state-licensed professions and occupations; public utilities; public welfare; real and personal property; state government; taxation and fiscal affairs; transportation; vehicles; and workers' compensation.

Following the completion of a report, subsequent action on the part of the Commission may be required, and, as necessary, the Commission will draft legislation and statutory amendments, update research, track legislation through the legislative process, attend hearings, and answer questions from legislators, legislative staff, interest groups, and constituents.

³ 1 Pa.C.S. § 1939 ("The comments or report of the commission . . . which drafted a statute may be consulted in the construction or application of the original provisions of the statute if such comments or report were published or otherwise generally available prior to the consideration of the statute by the General Assembly").

Work Group on Youth Vaccinations

Senate Resolution No. 27 of 2015

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Senate Resolution No. 27 of 2015 directed the Commission to study the issue of youth vaccinations and immunizations to determine whether or not amendments to the Commonwealth's public health laws were necessary. The objectives of the resolution were met by a Work Group comprised of members of the Advisory Committee on Public Health Law (Senate Resolution No. 194 of 2007).

The Work Group concluded that vaccination rates in Pennsylvania are below target vaccination rates, and therefore pose serious health risks to the residents of the Commonwealth. The Work Group reached consensus on a number of recommendations aimed at mitigating these risks.

I am pleased to present the *Report of the Work Group on Youth Vaccinations of the Advisory Committee on Public Health Law*.

The report is also available at <http://jsg.legis.state.pa.us/>.

Respectfully submitted,

Glenn J. Pasewicz
Executive Director

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INTRODUCTION

Senate Resolution No. 194 of 2007 directed the Joint State Government Commission (JSGC) to establish a legislative task force with an advisory committee of experts to review, update, and codify Pennsylvania's public health laws.⁴ Over the years, JSGC has worked with the advisory committee and legislative task force to produce several reports on Pennsylvania's public health laws, including several recommending codification and various updates.⁵

Senate Resolution No. 27 of 2015 directed JSGC's existing Advisory Committee on Public Health Law to study the issue of youth vaccinations and immunizations to determine whether any amendments should be made to the Commonwealth's public health laws.⁶ To that end, JSGC staff invited any member of the Advisory Committee on Public Health Law to participate in a Work Group focused on the topic of youth vaccinations. The Work Group met numerous times over the course of a year, discussing various aspects of the topic. Although participation was limited to the existing Advisory Committee on Public Health Law members, JSGC received comments and materials from several outside parties.

Ultimately, the Work Group concluded that vaccination rates are below target vaccination rates and pose serious health risks to the children and adults in the Commonwealth as a result. The Work Group came to consensus on a number of recommendations aimed at addressing that problem. This report contains the recommendations and appropriate background information.

⁴ 2007 S.R. 194.

⁵ See "Public Health Law in Pennsylvania: Disease Control Measures," Nov. 2013, http://jsg.legis.state.pa.us/publications.cfm?JSPU_PUBLN_ID=318, and "Public Health Law in Pennsylvania," Jan. 2013, http://jsg.legis.state.pa.us/publications.cfm?JSPU_PUBLN_ID=288.

⁶ 2015 S.R. 27.

SUMMARY OF RECOMMENDATIONS

In general, the Work Group's recommendations focus on regulatory and policy issues rather than on statutory changes. The recommendations fall into three categories: recommendations aimed at improving the information available regarding vaccination rates; recommendations aimed at educating the public regarding the importance and availability of vaccines, and ensuring adequate access to vaccines; and recommendations aimed at enforcement of vaccination requirements. Below are summaries of the Work Group's recommendations. The remainder of this report provides detailed information supporting the recommendations.

- **Information**

- The Work Group recommends that individual student compliance (either full vaccination or formal exemption) be reported at the conclusion of the provisional admission period so that accurate rates of immunization are available.
- The Work Group recommends that reporting to the Pennsylvania Statewide Immunization Information System (PA-SIIS) be made mandatory for all vaccine providers.
- The Work Group recommends that efforts be made to ensure school medical staff have access to the Pennsylvania Statewide Immunization Information System (PA-SIIS).
- The Work Group recommends that more information be gathered regarding parents' and guardians' reasons for not vaccinating their children.

- **Education and Access**

- The Work Group recommends that an updated and more complete list of required vaccinations that follows the Advisory Committee on Immunization Practices (ACIP) recommendations be implemented in Pennsylvania for all individuals subject to vaccination requirements.
- The Work Group recommends that programs designed to provide educational materials regarding the safety, availability, and importance of the annual influenza vaccine to parents and guardians of children, to students, and to school staff, be implemented or continued.

- The Work Group recommends that school-located influenza vaccination programs and other programs designed to make annual influenza vaccination more accessible be implemented or continued.
- The Work Group recommends that the Department of Education, the Department of Health, and the Department of Human Services, in collaboration with practitioners and insurers, implement or continue educational programs designed to inform parents and guardians of the resources available to ensure financial barriers do not prevent youth from receiving vaccinations.

- **Enforcement**

- The Work Group recommends that the Department of Health and the Department of Education consider implementing a system for making school district vaccination rates easily accessible to the public in order to encourage compliance with, and enforcement of, the vaccination requirements, as well as to encourage public awareness of the importance of vaccination compliance.
- The Work Group recommends that the Department of Health and the Department of Education provide clear procedures and criteria for documenting and certifying the allowable exemptions from vaccination.
- The Work Group recommends that enforcement procedures for vaccination compliance be defined by regulations developed in collaboration by the Department of Health and the Department of Education.
- The Work Group recommends a much shorter provisional admission period, which should expire prior to federal reporting deadlines, for children who do not meet the vaccination requirements at the beginning of the school year.

BACKGROUND INFORMATION

Definition of “Youth” and the Target Population

Senate Resolution No. 27 of 2015 directs JSGC’s Advisory Committee on Public Health Law to study the issue of youth vaccinations and immunizations, but does not define the term “youth.” Merriam-Webster defines youth as “the time of life when one is young; especially the period between childhood and maturity.”⁷ Traditionally, this is understood to be from birth to the age of 18 years. In the context of youth vaccinations, it is logical to interpret “youth” to mean the children for which the Commonwealth has the authority to mandate vaccination, i.e. children in daycare, children in kindergarten through twelfth grade (K-12), and those under the age of 18 who are entering post-secondary educational programs.

These groups of children are currently required to receive various vaccinations in order to attend daycare, K-12, and post-secondary educational programs by a number of different statutes and regulations. The different statutes and regulations will be discussed throughout this report, and have been reproduced for reference in Appendix A.

Introduction to Immunization and Vaccination

All living things are subject to infection by disease-causing agents.⁸ As organisms become more complex, their systems to defend against infection become more sophisticated.⁹ Multicellular animals, such as humans, have dedicated cells or tissues to deal with the threat of infection, and collectively, these protections are known as the immune system.¹⁰

A person may become immune to a specific disease in several ways.¹¹ For some illnesses, such as chickenpox, having the disease typically leads to lifelong immunity to that disease.¹² In 429 B.C.E., the Greek historian Thucydides observed that those who survived the smallpox epidemic in Athens did not become re-infected with the disease.¹³ In approximately 400 B.C.E., Hippocrates described diseases such as mumps and diphtheria.¹⁴

⁷ Merriam-Webster, definition of “youth,” <http://www.merriam-webster.com/dictionary/youth>.

⁸ Coll. of Physicians of Phila., “The Human Immune System and Infectious Disease,” Jan. 20, 2016, <http://www.historyofvaccines.org/content/articles/human-immune-system-and-infectious-disease>.

⁹ *Id.*

¹⁰ *Id.*

¹¹ Coll. of Physicians of Phila., “Passive Immunization,” Jan. 20, 2016, <http://www.historyofvaccines.org/content/articles/passive-immunization>.

¹² *Id.*

¹³ Nat’l Health Serv., “The History of Vaccination,” Apr. 4, 2014, <http://www.nhs.uk/conditions/vaccinations/pages/the-history-of-vaccination.aspx>.

¹⁴ Immunization Action Coal., “Vaccine Timeline,” <http://www.immunize.org/timeline/>.

Immunization is another way for an organism to become immune to a disease. Immunization is defined as “a procedure for creating resistance to a pathogen.”¹⁵ By the 1100s, the variolation technique was developed in Turkey, Africa, China, and Europe.¹⁶ Variolation was an immunization technique that involved the transfer of matter from a smallpox sore into a cut in the skin of an uninfected person.¹⁷ The variolated person would generally experience a local reaction or mild form of the disease, but would then be immune to the disease; however, variolation carried the risk of severe infection or death.¹⁸

In 1721, variolation was introduced to Great Britain.¹⁹ In 1798, Edward Jenner published a report of his development of the smallpox vaccine, which he achieved by variolating an eight-year-old boy with cowpox pustule liquid recovered from the hand of a milkmaid, and then later testing the boy’s immunity by variolating him with smallpox material.²⁰

The term “vaccine” is derived from the Latin word for cow, “vacca,” and was coined by Jenner’s friend and fellow physician, Richard Dunning.²¹ Vaccination is the introduction into an organism of a material designed to provoke an immune response that will provide protection from a related disease agent.²²

In the 220 years following Jenner’s experiment, the science of vaccination continued to advance, leading to the introduction of numerous vaccines. Vaccine research continues today, and scientists are working to develop vaccines against human immunodeficiency virus (HIV), Ebola, malaria, enterovirus, staphylococcus, human hookworm, Alzheimer’s disease, cancer, and other diseases and conditions.²³

¹⁵ Coll. of Physicians of Phila., “Glossary,” 2016, <http://www.historyofvaccines.org/glossary/all>.

¹⁶ *Supra* note 14.

¹⁷ *Supra* note 15.

¹⁸ *Id.*

¹⁹ *Supra* note 14.

²⁰ *Id.*

²¹ Coll. of Physicians of Phila., “The History of Vaccines: Timelines,” 2016, <http://www.historyofvaccines.org/content/timelines/all> at 5/17/1803.

²² Coll. of Physicians of Phila., “Glossary,” 2016, <http://www.historyofvaccines.org/glossary/all>.

²³ *See* Coll. of Physicians of Phila., “The Development of HIV Vaccines,” Jan. 20, 2016, <http://www.historyofvaccines.org/content/articles/development-hiv-vaccines>; Coll. of Physicians of Phila., “Ebola Virus Disease and Ebola Vaccines,” Jan. 4, 2016, <http://www.historyofvaccines.org/content/articles/ebola-virus-disease-and-ebola-vaccines>; Coll. of Physicians of Phila., “Malaria and Malaria Vaccine Candidates,” Jan. 20, 2016, <http://www.historyofvaccines.org/content/articles/malaria-and-malaria-vaccine-candidates>; *and* Coll. of Physicians of Phila., “Cancer Vaccines and Immunotherapy,” Jan. 4, 2016, <http://www.historyofvaccines.org/content/articles/cancer-vaccines-and-immunotherapy>.

Vaccine-Preventable Diseases

The following disease descriptions correspond to common, vaccine-preventable diseases. They are provided to illustrate the dangers posed by the various diseases.

Diphtheria

Diphtheria is a respiratory infection caused by the bacterium *Corynebacterium diphtheriae*.²⁴ Diphtheria is usually spread through coughing or sneezing, but a person can also be infected by coming in contact with an object that has bacteria on it.²⁵ The bacteria attach to the lining of the respiratory system and produce a toxin that destroys healthy tissue, resulting in weakness, sore throat, fever, and swollen glands.²⁶ Within a few days, the dead tissue forms a gray coating around the throat and nose that leads to difficulty breathing and swallowing.²⁷ The toxin may also enter the bloodstream, causing damage to the heart, kidneys, and nervous system.²⁸

Complications from diphtheria can include a blocked airway, heart damage, nerve damage, paralysis, and lung infection.²⁹ Diphtheria can be fatal; without treatment, as many as 50 percent of patients with diphtheria die from the disease, and with treatment, 10 percent of patients with diphtheria die.³⁰

Flu

Seasonal influenza, or the flu, is a respiratory illness that affects the nose, throat, and lungs.³¹ The flu is highly contagious and is spread through coughing and sneezing.³² While the severity of the flu can differ from year to year, it can be dangerous to children, the elderly, or other people with weakened immune systems.³³ Common symptoms include fever, coughing, running nose, sore throat, body aches, and fatigue.³⁴ In children, the flu can also cause vomiting and diarrhea.³⁵ Complications of the flu can include pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions.³⁶ Between 1976 and 2006, the estimated number of flu-related deaths in the United States ranges from 3,000 to 49,000 deaths per year.³⁷

²⁴ CDC, "Diphtheria - Causes and Transmission," Jan. 15, 2016, <http://www.cdc.gov/diphtheria/about/causes-transmission.html>.

²⁵ *Id.*

²⁶ CDC, "Diphtheria - Symptoms," Jan. 15, 2016, <http://www.cdc.gov/diphtheria/about/symptoms.html>.

²⁷ *Id.*

²⁸ *Id.*

²⁹ CDC, "Diphtheria - Complications," Jan. 15, 2016, <http://www.cdc.gov/diphtheria/about/complications.html>.

³⁰ *Id.*

³¹ CDC, "Key Facts about Influenza (Flu) & Flu Vaccine," Aug. 7, 2015, <http://www.cdc.gov/flu/keyfacts.htm>.

³² *Id.*

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.*

Hepatitis

Hepatitis is liver inflammation that can be caused by many things, including viral infection by a family of viruses also known as Hepatitis.³⁸ Each type is designated with a letter, and the most common types are A, B, and C.³⁹ Although each form of the virus can cause similar symptoms, they are transmitted differently.⁴⁰ Symptoms of acute Hepatitis include:

- Fever;
- Fatigue;
- Loss of appetite;
- Nausea;
- Vomiting;
- Abdominal pain;
- Dark urine;
- Clay-colored bowel movements;
- Joint pain; and
- Jaundice.⁴¹

Hepatitis A is usually spread by eating or drinking food or water that has come in contact with the fecal matter of someone infected with Hepatitis A and is closely linked with poor sanitation.⁴² Hepatitis A occurs only as an acute or newly-occurring infection.⁴³ Unlike other forms of the virus, Hepatitis A is not usually fatal and is not linked to any chronic symptoms.⁴⁴

Hepatitis B is transmitted through contact with body fluids.⁴⁵ This can happen through sexual contact, sharing drug-injection equipment, sharing razors or toothbrushes, or at birth.⁴⁶ The effects of Hepatitis B can be acute or chronic.⁴⁷ Chronic Hepatitis B can lead to serious health issues, like cirrhosis or liver cancer.⁴⁸ Symptoms of chronic Hepatitis B can vary from person to person, but most individuals with chronic Hepatitis B remain symptom free for as long as 20 to 30 years.⁴⁹ While there are vaccines available to prevent Hepatitis A and B, there is no vaccine for Hepatitis C.⁵⁰

³⁸ CDC, “Viral Hepatitis - Hepatitis A Information: Hepatitis A Questions and Answers for the Public,” Dec. 22, 2015, <http://www.cdc.gov/hepatitis/hav/afaq.htm>.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ CDC, “Viral Hepatitis - Hepatitis B Information: Hepatitis B FAQs for the Public,” Oct. 23, 2015, <http://www.cdc.gov/hepatitis/hbv/bfaq.htm>.

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Supra* note 38.

Hib

Hib, or *Haemophilus influenzae* type b, is a bacterium that can cause harmful infections and is especially dangerous to young children.⁵¹ Hib bacteria are often spread through coughing or sneezing, usually by someone not exhibiting symptoms.⁵² Symptoms of Hib infection vary and depend on the part of the body that is affected.⁵³ The most common severe Hib infections are lung infections, bloodstream infections, and infections of the brain and spinal cord.⁵⁴

Hib infections of the bloodstream can result in the loss of limbs.⁵⁵ Hib infections of the brain and spinal cord can result in brain damage or hearing loss.⁵⁶ Many Hib infections can result in death.⁵⁷

HPV

Human papillomavirus (HPV) is a group of viruses that cause various types of cancer and warts.⁵⁸ HPV is the most common sexually transmitted infection.⁵⁹ Many people with HPV never develop any symptoms and the virus often goes away without treatment.⁶⁰

Types of cancer HPV can cause include cervical, vaginal, and vulvar cancers in women, penile cancer in men, and anal cancer and some forms of throat cancer in women and men.⁶¹ HPV-related cancers may go unnoticed and can be difficult to treat once advanced enough to diagnose.⁶² HPV can also cause genital warts, small bumps that develop near the genitals.⁶³

Measles

Measles can cause a high fever, cough, runny nose, and red, watery eyes.⁶⁴ A few days after the symptoms first appear, small white spots may develop in the mouth.⁶⁵ Around five days after symptoms begin, a rash spreads across the body, starting as red spots on the head and

⁵¹ CDC, “*Haemophilus Influenzae* Type b (Hib) VIS,” April 2, 2015, <http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hib.html>.

⁵² CDC, “*Haemophilus influenzae* Disease (Including Hib) - Causes and Transmission,” April 2, 2014, <http://www.cdc.gov/hi-disease/about/causes-transmission.html>.

⁵³ CDC, “*Haemophilus influenzae* Disease (Including Hib) - Symptoms,” April 2, 2014, <http://www.cdc.gov/hi-disease/about/symptoms.html>.

⁵⁴ *Id.*

⁵⁵ CDC, “*Haemophilus influenzae* Disease (Including Hib) - Complications,” April 2, 2014, <http://www.cdc.gov/hi-disease/about/complications.html>.

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ CDC, “What is HPV?,” Sept. 30, 2015, <http://www.cdc.gov/hpv/parents/whatishpv.html>.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ CDC, “The Link Between HPV and Cancer,” Sept. 30, 2015, <http://www.cdc.gov/hpv/parents/cancer.html>.

⁶² *Id.*

⁶³ *Id.*

⁶⁴ CDC, “Measles – Signs and Symptoms,” Feb. 17, 2015, <http://www.cdc.gov/measles/about/signs-symptoms.html>.

⁶⁵ *Id.*

spreading downwards across the body.⁶⁶ When the rash worsens, a person's fever may spike to more than 104° Fahrenheit.⁶⁷ Usually, the fever subsides and the rash fades after a few days.⁶⁸ Complications can include ear infection, diarrhea, pneumonia, brain damage, and death.⁶⁹

Meningococcal Disease

Meningococcal disease is caused by the bacterium *Neisseria meningitidis*, which resides in the nose and throat of approximately one out of 10 people, and occurs when the bacteria invade other parts of the body.⁷⁰ The bacteria are spread from person to person by exchanging respiratory and throat secretions during close or extended contact.⁷¹ A common meningococcal infection is meningitis, an infection of the protective membranes covering the brain and spinal cord by *Neisseria meningitidis* bacteria.⁷² Symptoms include fever, headache, stiff neck, nausea, vomiting, sensitivity to light, and confusion.⁷³ Meningococcal meningitis is very serious, and death can occur within hours.⁷⁴ Alternatively, permanent disabilities, including hearing loss and brain damage, can occur.⁷⁵

Another common meningococcal infection is meningococcal septicemia, an infection of the bloodstream by *Neisseria meningitidis* bacteria, which damage the walls of blood vessels and cause bleeding in the skin and organs.⁷⁶ Symptoms include fatigue, vomiting, cold hands and feet, chills, muscle aches, joint pain, chest pain, abdominal pain, rapid breathing, diarrhea, and a dark purple rash.⁷⁷ Meningococcal septicemia is very serious, and death can occur within hours.⁷⁸ Alternatively, permanent disabilities, including loss of toes, fingers, or limbs, or severe scarring as a result of skin grafts can occur.⁷⁹

Mumps

Mumps is characterized by puffy cheeks and a swollen jaw, which are caused by swollen salivary glands.⁸⁰ The mumps virus is transmitted by saliva or mucus, and can be spread by coughing, sneezing, talking, sharing items such as cups or utensils, and touching objects with

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ CDC, "Complications of Measles," Feb. 17, 2015, <http://www.cdc.gov/measles/about/complications.html>.

⁷⁰ CDC, "Meningococcal Disease - Causes & Transmission," June 11, 2015, <http://www.cdc.gov/meningococcal/about/causes-transmission.html>.

⁷¹ *Id.*

⁷² CDC, "Meningococcal Disease - Signs & Symptoms," April 1, 2014, <http://www.cdc.gov/meningococcal/about/symptoms.html>.

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ CDC, "Signs and Symptoms of Mumps," May 29, 2015, <http://www.cdc.gov/mumps/about/signs-symptoms.html>.

unwashed hands.⁸¹ Symptoms do not develop until two to three weeks after infection.⁸² In addition to swollen salivary glands, common symptoms of mumps include fever, headache, muscle aches, tiredness, and loss of appetite.⁸³ Most people with mumps recover completely in a few weeks.⁸⁴ Mumps can cause complications including: inflammation of the testicles, which can lead to infertility; inflammation of the brain; inflammation of the tissue covering the brain and spinal cord; inflammation of the ovaries or breasts; or deafness.⁸⁵

Pertussis

Pertussis, or whooping cough, is a highly contagious respiratory illness that is dangerous to children.⁸⁶ The disease occurs when the bacterium *Bordetella pertussis* attaches to microscopic hair-like structures called cilia in the upper respiratory system.⁸⁷ The bacteria release toxins that damage the cilia and cause swelling in the airway.⁸⁸ Pertussis is transmitted by coughing or sneezing, or prolonged contact with someone with the disease.⁸⁹ Many babies who contract pertussis are infected by relatives who are unaware they are carrying the bacteria.⁹⁰

Pertussis begins with symptoms similar to those of the common cold, such as fever or a mild cough.⁹¹ After the disease progresses, more traditional symptoms of pertussis appear, such as distinctive “whooping” coughing fits, which can cause vomiting and exhaustion.⁹² Recovery from pertussis is slow, and symptoms can last over 10 weeks.⁹³

Pertussis can cause serious complications in babies and young children, and among babies younger than one year old who get pertussis, about 50 percent require hospitalization.⁹⁴ Of the babies who are hospitalized:

- One out of four get pneumonia;
- One out of 100 will have convulsions;
- Three out of five will have apnea (slowed or stopped breathing);
- One out of 300 will have encephalopathy (disease of the brain); and
- One out of 100 will die.⁹⁵

⁸¹ CDC, “Transmission of Mumps,” May 29, 2015, <http://www.cdc.gov/mumps/about/transmission.html>.

⁸² *Supra* note 80.

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ CDC “Complications of Mumps,” May 29, 2015, <http://www.cdc.gov/mumps/about/complications.html>.

⁸⁶ CDC, “Pertussis - Causes and Transmission,” Sept. 8, 2015, <http://www.cdc.gov/pertussis/about/causes-transmission.html>.

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ CDC, “Pertussis - Signs and Symptoms,” Sept. 8, 2015, <http://www.cdc.gov/pertussis/about/signs-symptoms.html>.

⁹² *Id.*

⁹³ *Id.*

⁹⁴ CDC, “Pertussis - Complications,” Sept. 8, 2015, <http://www.cdc.gov/pertussis/about/complications.html>.

⁹⁵ *Id.*

Complications in teens and adults are often less serious and are caused by the cough itself, including passing out or breaking a rib during violent coughing fits.⁹⁶

Pneumococcal Disease

The bacterium *Streptococcus pneumoniae* can cause many different types of infections, including pneumonia, ear infections, sinus infections, meningitis, and bloodstream infections.⁹⁷ Children under two years of age, children in group child care, children with certain illnesses, children with certain medical conditions, and children of some races are at increased risk of pneumococcal disease.⁹⁸ The pneumococcal bacterium is spread by direct contact with respiratory secretions, although many people have the bacteria in their respiratory system without being ill.⁹⁹

Symptoms of pneumococcal disease depend on the type of infection.¹⁰⁰ Complications also depend on the type of infection, but can include blocked airways, collapsed lungs, hearing loss, brain damage, or death.¹⁰¹

Polio

Poliomyelitis, or simply polio, is an infectious disease that attacks the brain and spinal cord, causing paralysis.¹⁰² The poliovirus resides in the throat and intestines of its hosts and can be spread through contact with infected stool, saliva, or mucus.¹⁰³ A person can spread the virus before symptoms appear, and for about one or two weeks after they appear.¹⁰⁴ The virus can live in infected stool for many weeks, and can contaminate food or water in unsanitary conditions.¹⁰⁵

Most people infected with poliovirus will not have visible symptoms.¹⁰⁶ About one in four people infected with poliovirus will develop flu-like symptoms that last two to five days and then resolve on their own.¹⁰⁷ A small proportion of people infected with poliovirus will develop more serious symptoms, such as paresthesia (feeling of pins and needles in the legs), meningitis, and

⁹⁶ *Id.*

⁹⁷ CDC, "Pneumococcal Disease - Types of Infection," June 10, 2015, <http://www.cdc.gov/pneumococcal/about/infection-types.html>.

⁹⁸ CDC, "Pneumococcal Disease - Risk Factors and Transmission," June 10, 2015, <http://www.cdc.gov/pneumococcal/about/risk-transmission.html>.

⁹⁹ *Id.*

¹⁰⁰ CDC, "Pneumococcal Disease - Symptoms and Complications," June 10, 2015, <http://www.cdc.gov/pneumococcal/about/symptoms-complications.html>.

¹⁰¹ *Id.*

¹⁰² CDC, "What is Polio," Oct. 15, 2015, <http://www.cdc.gov/polio/about/index.htm>.

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

paralysis.¹⁰⁸ The paralysis can lead to permanent disability or death.¹⁰⁹ Even children who seem to fully recover can develop muscle pain, weakness, or paralysis 15 to 40 years later.¹¹⁰

Rubella

Rubella, also known as German measles or three-day measles, is an illness that can cause fever, sore throat, rash, headache, and red, itchy eyes.¹¹¹ The illness is caused by a virus and transmitted by coughing and sneezing.¹¹² When children contract rubella, symptoms include fever and a rash that spreads outwards from the face.¹¹³ These symptoms usually abate after two to three days.¹¹⁴ Older children and adults can experience cold-like symptoms and swollen glands prior to the appearance of the rash.¹¹⁵ Aching joints may occur, especially in young women.¹¹⁶ Approximately half of the people infected with rubella develop symptoms.¹¹⁷ However, if acquired by a pregnant woman, rubella can cause birth defects such as deafness, cataracts, heart defects, intellectual disability, liver damage, and spleen damage.¹¹⁸

Rotavirus

Rotavirus is a contagious illness that causes inflammation in the intestines and stomach.¹¹⁹ While the virus is most common in infants and young children, older children and adults can be infected as well.¹²⁰ Symptoms usually appear two days after exposure and include severe diarrhea, vomiting, fever, and abdominal pain.¹²¹ Vomiting and diarrhea can last from three to eight days, and can lead to dehydration, which may require hospitalization for treatment.¹²²

Tetanus

Tetanus, also known as lockjaw, is caused by the bacterium *Clostridium tetani*.¹²³ The bacteria are everywhere in the environment, and enter the body through broken skin, often through

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ CDC, "About Rubella," Dec. 17, 2014 <http://www.cdc.gov/rubella/about/index.html>.

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ CDC, "Rotavirus - Symptoms," May 12, 2014 <http://www.cdc.gov/rotavirus/about/symptoms.html>.

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.*

¹²³ CDC, "Tetanus - Causes and Transmission," Jan. 9, 2013, <http://www.cdc.gov/tetanus/about/causes-transmission.html>.

injuries caused by contaminated objects.¹²⁴ Symptoms may appear between one day and several months after infection.¹²⁵ The most common symptom is spasms of the jaw muscles, but other symptoms include headache, jaw cramping, muscle spasms, muscle stiffness, difficulty swallowing, seizures, fever and sweating, and high blood pressure and rapid heart rate.¹²⁶ Complications include involuntary muscular contraction of the vocal cords, broken bones, hospital-acquired infections, pulmonary embolism, pneumonia, and difficulty breathing, possibly leading to death.¹²⁷ Between 10 and 20 percent of cases are fatal.

Varicella

Varicella-zoster virus causes chickenpox, characterized by a rash, itching, tiredness, and fever.¹²⁸ The virus is spread by touching or breathing in virus particles released by chickenpox blisters and possibly by infected respiratory droplets.¹²⁹ It takes from 10 to 21 days after infection to develop the rash, and a person is contagious from immediately before the rash develops until the rash scabs.¹³⁰ The illness usually lasts from five to 10 days.¹³¹ Rare but serious complications include dehydration, pneumonia, bleeding problems, encephalitis, skin infections, bloodstream infections, toxic shock syndrome, bone infections, and joint infections.¹³² Chickenpox can require hospitalization and can cause death.¹³³

Vaccine Development and Regulation

Vaccine development, licensure, and monitoring are coordinated efforts involving numerous federal, state, and local agencies and private entities. The Food and Drug Administration (FDA) must license a vaccine before it can be used in the United States.¹³⁴ FDA regulations for the development of vaccines aim to ensure safety, purity, potency, and effectiveness.¹³⁵ Before a vaccine is licensed, highly trained FDA scientists and physicians evaluate the results of studies on safety and effectiveness.¹³⁶ FDA also inspects the vaccine

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ CDC, "Tetanus - Symptoms and Complications," Jan. 9, 2013, <http://www.cdc.gov/tetanus/about/symptoms-complications.html>.

¹²⁷ *Id.*

¹²⁸ CDC, "Chickenpox (Varicella) - Overview," Mar. 23, 2016, <http://www.cdc.gov/chickenpox/about/overview.html>.

¹²⁹ *Id.*

¹³⁰ CDC, "Chickenpox (Varicella) - Transmission," Mar. 23, 2016, <http://www.cdc.gov/chickenpox/about/transmission.html>.

¹³¹ CDC, "Chickenpox (Varicella) - Signs and Symptoms," Nov. 16, 2011, <http://www.cdc.gov/chickenpox/about/symptoms.html>.

¹³² CDC, "Chickenpox (Varicella) - Complications," Nov. 16, 2011, <http://www.cdc.gov/chickenpox/about/complications.html>

¹³³ *Id.*

¹³⁴ CDC, "Ensuring the Safety of Vaccines in the United States," Feb. 2013, <http://www.cdc.gov/vaccines/hcp/patient-ed/conversations/downloads/vacsafe-ensuring-bw-office.pdf>.

¹³⁵ *Id.*

¹³⁶ *Id.*

manufacturing facilities to ensure they comply with current Good Manufacturing Practice regulations.¹³⁷

Vaccine development begins in the laboratory.¹³⁸ If laboratory tests show that a vaccine has potential utility, it is usually tested in animals.¹³⁹ If a vaccine is safe in animals and studies suggest that it will be safe in humans, clinical trials with human volunteers are conducted.¹⁴⁰ Vaccines that are being developed for children are first tested on adults.¹⁴¹ FDA sets guidelines for the clinical trials to ensure the safety of the volunteers.¹⁴² The results of the clinical trials are part of FDA's evaluation of each vaccine.¹⁴³

In addition to evaluating the results of the clinical trials, FDA scientists and medical professionals also evaluate a wide range of information including the vaccine's physical, chemical, and biological properties, as well as how it is manufactured, to ensure that it can be made consistently safe, pure, and potent.¹⁴⁴ The clinical trials and all other data must show that the vaccine's benefits outweigh the potential risks for people for whom the vaccine will be recommended.¹⁴⁵

After vaccines are licensed for use in humans, they are monitored closely as people begin using them to watch for adverse events.¹⁴⁶ Monitoring is essential for two reasons: first, even large clinical trials may not be big enough to reveal infrequent or rare side effects; and second, vaccine trials may not include groups who might have different types of side effects or who might have a higher risk of side effects than the volunteers who got the vaccine during clinical trials.¹⁴⁷ If a link is found between a possible side effect and a vaccine, public health officials weigh the benefits of the vaccine against its risks to determine if recommendations for using the vaccine should change.¹⁴⁸

Post-licensure monitoring begins with the Vaccine Adverse Event Reporting System (VAERS), a national system used by scientists at FDA and the Centers for Disease Control and Prevention (CDC) to collect reports of adverse events that happen after vaccination.¹⁴⁹ Health care professionals, vaccine manufacturers, vaccine recipients, and parents or family members of people who have received a vaccine are encouraged to submit reports to VAERS if they experience or observe any adverse events after vaccination.¹⁵⁰ While approximately 30,000 VAERS reports are

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

filed each year, 85 to 90 percent of the reports describe mild reactions such as fever, arm soreness, and crying or mild irritability.¹⁵¹

Scientists continually monitor VAERS reports to identify adverse events that need to be studied further.¹⁵² Reports of adverse events that are unexpected, appear to happen more often than expected, or have unusual patterns are followed up with specific studies.¹⁵³ Experience has shown that VAERS is an excellent tool for detecting potential adverse events; however, VAERS data alone usually cannot prove that a certain vaccine causes a certain side effect.¹⁵⁴ Adverse events reported to VAERS may or may not be caused by vaccines, and in fact, there are reports in VAERS of common conditions that may occur by chance alone.¹⁵⁵

Scientists use CDC's Vaccine Safety Datalink (VSD) to conduct studies that help determine if possible side effects identified using VAERS are actually related to vaccination.¹⁵⁶ VSD is a network of nine managed care organizations across the United States with a combined population of more than 9.8 million people.¹⁵⁷ Scientists can use VSD in two ways: first, scientists can look back in medical records to see if a particular adverse event is more common among people who have received a particular vaccine; and second, instead of looking back, scientists can use Rapid Cycle Analysis to continuously review information coming into VSD to see if the rate of certain health conditions is higher among vaccinated people.¹⁵⁸

Very rarely, vaccines can cause adverse reactions or even injuries. To address this issue, the National Childhood Vaccine Injury Act of 1986¹⁵⁹ created the National Vaccine Injury Compensation Program (VICP).¹⁶⁰ The VICP was created to ensure an adequate supply of vaccines, to stabilize vaccine costs, and to establish and maintain an accessible and efficient forum for individuals found to be injured by covered vaccines.¹⁶¹ The VICP is a no-fault alternative to the traditional tort system for resolving vaccine injury claims that provides compensation to people found to be injured by covered vaccines.¹⁶² The US Court of Federal Claims decides who will be paid.¹⁶³

¹⁵¹ CDC, "Vaccine Adverse Event Reporting System (VAERS)," Aug. 28, 2015, <http://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vaers/index.html>.

¹⁵² *Supra* note 134.

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ P.L. 99-660.

¹⁶⁰ Health Res. & Servs. Admin., "National Vaccine Injury Compensation Program," <http://www.hrsa.gov/vaccinecompensation/index.html>.

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ *Id.*

The Vaccine Injury Compensation Trust Fund (Trust Fund) provides funding for the VICP to compensate vaccine-related injury or death claims for covered vaccines.¹⁶⁴ The Trust Fund is funded by a \$0.75 excise tax on each dose of a covered vaccine.¹⁶⁵ The Department of Treasury collects the excise taxes and manages the Trust Fund's investments.¹⁶⁶ As of January 2016, the balance of the Trust Fund was approximately \$3.6 billion.¹⁶⁷

In the majority of cases, vaccines cause no side effects; however, side effects can occur, as with any medication, although most are mild.¹⁶⁸ Very rarely, people experience more serious side effects, such as allergic reactions.¹⁶⁹ In those instances, the VICP allows individuals to file a petition for compensation.¹⁷⁰ However, being awarded compensation for a petition does not necessarily mean that the vaccine caused the alleged injury; in fact, over 80 percent of all compensation awarded by the VICP comes as result of a negotiated settlement between the parties in which the Department of Health and Human Services has not concluded, based upon review of the evidence, that the vaccine caused the alleged injury.¹⁷¹

According to the CDC, from 2006 to 2014 over 2.5 billion doses of covered vaccines were distributed in the United States.¹⁷² For petitions filed in that time period, 3,373 petitions were adjudicated by the court, and of those 2,129 were compensated; so, for every 1 million doses of vaccine that were distributed, one individual was compensated.¹⁷³ Since 1988, over 16,729 petitions have been filed with the VICP.¹⁷⁴ Over that 27-year period, 14,397 petitions have been adjudicated, with 4,482 of those determined to be compensable, while 9,915 were dismissed.¹⁷⁵ Total compensation paid over the life of the program is approximately \$3.3 billion.¹⁷⁶

Vaccine Effectiveness

Vaccination protects children from serious illness and complications of vaccine-preventable diseases, which can include amputation or paralysis of limbs, hearing loss, convulsions, brain damage, or even death.¹⁷⁷ Organizations including the American Academy of

¹⁶⁴ *Id.*

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ Dep't of Treasury, "Vaccine Injury Compensation Reports," January 2016, <ftp://ftp.publicdebt.treas.gov/dfi/tfmb/dfivi0116.pdf>.

¹⁶⁸ Health Res. & Servs. Admin., "Data & Statistics," Feb. 3, 2016,

<http://www.hrsa.gov/vaccinecompensation/vicpmonthlyreport02032016.pdf>.

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Id.*

¹⁷⁴ *Id.*

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ Immunization Action Coal., "Top Ten Reasons to Protect Your Child by Vaccinating," Nov. 2014, <http://www.immunize.org/catg.d/p4016.pdf>.

Pediatrics, the American Academy of Family Physicians, and the CDC all strongly support protecting children with recommended vaccinations.¹⁷⁸

CDC statistics demonstrate dramatic declines in vaccine-preventable diseases when compared with the pre-vaccine era, as demonstrated in Table 1.¹⁷⁹ CDC estimates that among the 78.6 million children born between 1994 and 2013, routine childhood vaccination will prevent 322,089,000 illnesses, 21,055,000 hospitalizations, and 731,700 deaths from vaccine-preventable diseases over the course of their lifetimes, resulting in a savings of \$295 billion in direct costs and \$1.38 trillion in societal costs.¹⁸⁰

Disease	Pre-Vaccine Era Estimated Annual Morbidity	Most Recent Reports or Estimates of U.S. Cases	Percent Decrease
Diphtheria	21,053	1	>99%
<i>Haemophilus influenzae</i> type b (Hib) (invasive, <5 years of age)	20,000	40	>99
Hepatitis A	117,333	3,473	98
Hepatitis B (acute)	66,232	19,764	70
Measles	530,217	667	>99
Meningococcal disease	2,886	433	85
Mumps	162,344	1,223	>99
Pertussis	200,752	32,971	84
Pneumococcal diseases (invasive, <5 years of age)	16,069	1,900	88
Polio	16,316	0	100
Rotavirus (hospitalizations, <3 years of age)	62,500	12,500	80
Rubella	47,745	6	>99
Congenital Rubella Syndrome	152	1	99
Smallpox	29,005	0	100
Tetanus	580	25	96
Varicella	4,085,120	151,149	96
Source: Immunization Action Coal., "Vaccines Work!," Jan. 2016, http://www.immunize.org/catg.d/p4037.pdf , <i>citations omitted.</i>			

¹⁷⁸ *Id.*

¹⁷⁹ Immunization Action Coal., "Vaccines Work!," Jan. 2016, <http://www.immunize.org/catg.d/p4037.pdf>.

¹⁸⁰ CDC, "Benefits from Immunization During the Vaccines for Children Program Era - United States, 1994-2013," *MMWR*, Apr. 25, 2014, 63(16), pp. 352-55, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6316a4.htm>.

Recently, researchers announced that the vaccine designed to combat the sexually transmitted virus that causes cervical cancer, introduced just a decade ago, has already reduced the virus's prevalence in teenage girls by almost two-thirds.¹⁸¹ The virus, HPV, has been linked to numerous types of cancer, and recommendations have expanded from the original target population of teenage girls to include girls and boys from 11 to 26 years old.¹⁸²

The immediate benefit of vaccination is individual immunity.¹⁸³ The secondary benefit of vaccination is herd immunity.¹⁸⁴ Herd immunity is the protection offered to everyone in a community when vaccination rates are high.¹⁸⁵ When enough people are immunized against a given disease, it is difficult for that disease to gain a foothold in the community.¹⁸⁶ Herd immunity offers some protection to those who are unable to receive vaccinations, such as newborns and people with weakened immune systems (i.e. transplant recipients, people with cancer, etc.),¹⁸⁷ by reducing the likelihood of an outbreak in their community that could expose them to the disease.¹⁸⁸ Herd immunity also protects vaccinated individuals who may not have become fully immune to a disease against which they were vaccinated.¹⁸⁹ When community vaccination rates drop below the threshold required for herd immunity to exist, widespread disease outbreaks can occur.¹⁹⁰

Outbreaks of preventable diseases also occur when many parents decide not to vaccinate their children.¹⁹¹ Examples of this scenario are numerous, and not limited to the United States. In 1974, Japan had a successful pertussis vaccination program, with nearly 80 percent of Japanese children vaccinated.¹⁹² That year, there were only 393 cases of pertussis reported in the entire country, and there were no deaths from pertussis.¹⁹³ However, rumors began to spread that pertussis vaccination was no longer needed and that the vaccine was not safe, and by 1976, only 10 percent of infants were being vaccinated.¹⁹⁴ In 1979, Japan suffered a major pertussis epidemic, with more than 13,000 cases reported and 41 deaths.¹⁹⁵ In 1981, the Japanese government began vaccinating again and the number of pertussis cases dropped.¹⁹⁶

¹⁸¹ Jan Hoffman, "HPV Sharply Reduced in Teenage Girls Following Vaccine, Study Says," *NY Times*, Feb. 22, 2016, <http://www.nytimes.com/2016/02/22/health/vaccine-has-sharply-reduced-hpv-in-teenage-girls-study-says.html>.

¹⁸² CDC, "Use of 9-Valent Human Papillomavirus (HPV) Vaccine: Updated HPV Vaccination Recommendations of the Advisory Committee on Immunization Practices," *MMWR*, Mar. 27, 2015, 64(11), pp. 300-04, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6411a3.htm>.

¹⁸³ Coll. of Physicians of Phila., "Why Vaccinate?," July 31, 2014, <http://www.historyofvaccines.org/content/articles/why-vaccinate>.

¹⁸⁴ *Id.*

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

¹⁸⁷ *Supra* note 177.

¹⁸⁸ *Supra* note 183.

¹⁸⁹ *Id.*

¹⁹⁰ *Id.*

¹⁹¹ *Supra* note 177.

¹⁹² CDC, "Why Immunize?," Sept. 23, 2014, <http://www.cdc.gov/vaccines/vac-gen/why.htm>.

¹⁹³ *Id.*

¹⁹⁴ *Id.*

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

Vaccine-preventable diseases, such as measles, mumps, and pertussis, are still a threat, and they continue to infect children, resulting in hospitalizations and deaths every year.¹⁹⁷ Although vaccination has led to a dramatic decline in the number of cases of several infectious diseases, some of these diseases are quite common in other countries and are brought to the United States by international travelers, so if children are not vaccinated, they could easily get one of these diseases from a traveler or while traveling themselves.¹⁹⁸

The Law of Mandatory Vaccination

The federal government generally has the authority “to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession.”¹⁹⁹ Although this language seems to grant broad authority to prevent the spread of disease, perhaps including mandatory vaccination programs, in fact only regulations relating to quarantine and isolation are specifically authorized.²⁰⁰ As a result, the federal government has been relatively uninvolved in mandatory vaccination jurisprudence.

States, on the other hand, are vested with the authority to mandate vaccination, as was made explicit by the US Supreme Court in 1905 in the landmark case of *Jacobson v. Massachusetts*.²⁰¹ In that case, the City of Cambridge, Massachusetts, in response to a growing occurrence of smallpox and pursuant to state law, issued a decree that all inhabitants must be vaccinated by a particular date, with only narrow exceptions for those whose medical conditions precluded vaccination.²⁰² Jacobson refused to comply and was therefore fined five dollars and prosecuted under the authority of the statute.²⁰³

At trial, Jacobson made a three-pronged argument: first, he argued that the law invaded his liberty by subjecting him to a fine or imprisonment; second, he argued that the law was unreasonable, arbitrary, and oppressive, and thus hostile to his inherent right to care for his body and health as he saw fit; and third, he argued that the vaccination of a person against his will is an assault on that person.²⁰⁴ The Supreme Court disagreed with all of Jacobson's arguments and held that the authority of the state to enact legislation to protect the public health rested well within the state's police powers, powers that it did not surrender when it joined the Union.²⁰⁵

¹⁹⁷ *Supra* note 177.

¹⁹⁸ *Id.*

¹⁹⁹ 42 U.S.C. § 264(a) (2006).

²⁰⁰ 42 U.S.C. §§ 264(b)-(d).

²⁰¹ 197 U.S. 11 (1905).

²⁰² *Id.* at 12-13.

²⁰³ *Id.* at 13.

²⁰⁴ *Id.* at 26.

²⁰⁵ *Id.* at 24-25.

According to the Court, the good and welfare of the state were the basis of this police power.²⁰⁶ Furthermore, the Court held that the liberties secured by the Constitution were not absolute rights completely without restraint.²⁰⁷ Rather, everyone is subject to multiple restraints in order to serve the common good.²⁰⁸ Without such restraints, the Court argued society could not exist, and would surely face “disorder and anarchy.”²⁰⁹ Ultimately, the Court upheld the statute.²¹⁰ This case has stood for 104 years and is still valid today.

Mandatory vaccination of youth is generally based on two additional court cases: *Zucht v. King*²¹¹ and *Prince v. Massachusetts*.²¹² In *Zucht*, the US Supreme Court rejected a due process Fourteenth Amendment challenge to city ordinances that precluded children from attending school because of a failure to present a certificate of vaccination.²¹³ The Court held that “these ordinances confer not arbitrary power, but only that broad discretion required for the protection of the public health.”²¹⁴

In *Prince*, the US Supreme Court held that:

[N]either rights of religion nor rights of parenthood are beyond limitation. Acting to guard the general interest in youth’s well being, the state as *parens patriae* may restrict the parent’s control by requiring school attendance, regulating or prohibiting the child’s labor, and in many other ways. Its authority is not nullified merely because the parent grounds his claim to control the child’s course of conduct on religion or conscience. Thus, he cannot claim freedom from compulsory vaccination for the child more than for himself on religious grounds. The right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death.²¹⁵

Every state has enacted statutes and regulations mandating specific vaccinations for youth.²¹⁶ These laws often apply not only to children attending public schools, but also to those attending private schools, home school programs, and day care facilities.²¹⁷

²⁰⁶ *Id.* at 27.

²⁰⁷ *Id.* at 26.

²⁰⁸ *Id.*

²⁰⁹ *Id.*

²¹⁰ *Id.* at 39.

²¹¹ 260 U.S. 174 (1922).

²¹² 321 U.S. 158 (1944).

²¹³ 260 U.S. at 177.

²¹⁴ *Id.*

²¹⁵ 321 U.S. at 166-67 (footnotes omitted).

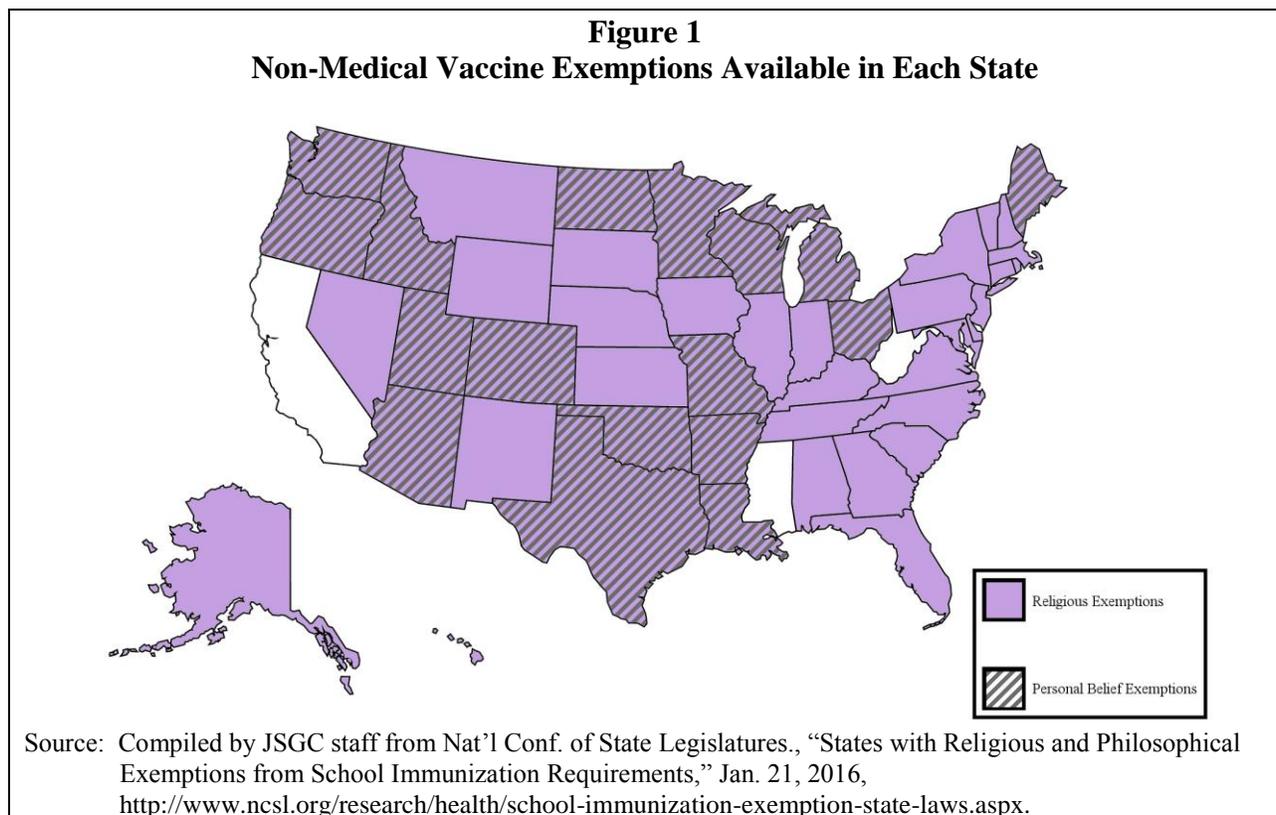
²¹⁶ CDC, “State Vaccination Requirements,” Jan. 29, 2016, <http://www.cdc.gov/vaccines/imz-managers/laws/state-reqs.html>.

²¹⁷ *Id.*

Exemptions

While all states exercise their power to require vaccines for school-aged children, all states also provide exemptions. Every state provides a medical exemption when vaccination may be detrimental to the health of the child.²¹⁸ Many states also offer exemptions for religious and/or philosophical reasons.²¹⁹

State laws and regulations also establish mechanisms for enforcement of youth vaccination requirements and exemptions.²²⁰ Many states exclude children with exemptions from vaccination requirements from school during outbreaks.²²¹ Some states do not recognize exemptions during outbreaks.²²² Some states specify that parents must submit affidavits or notarized documents in order to satisfy the exemption requirements.²²³ Several states require that the religious or philosophical exemption process include an educational component that discusses the benefits of vaccination and the risks of not being vaccinated.²²⁴ The map in Figure 1 displays the availability of non-medical exemptions in each state.



²¹⁸ *Id.*

²¹⁹ *Id.*

²²⁰ *Id.*

²²¹ CDC, "State School Immunization Requirements and Vaccine Exemption Laws," Mar. 27, 2015, <http://www.cdc.gov/phlp/docs/school-vaccinations.pdf>.

²²² *Id.*

²²³ *Id.*

²²⁴ *Id.*

WORK GROUP FINDINGS AND RECOMMENDATIONS

Vaccination Rates

As a preliminary matter, the Work Group reviewed Pennsylvania’s vaccination rates to determine whether the rates met target vaccination rates. Based on the available data, the Work Group concluded that vaccination rates are below target vaccination rates and pose serious health risks to the children and adults in the Commonwealth as a result.

Target Vaccination Rates

Healthy People is a federal program that provides science-based, 10-year national objectives for improving the health of all Americans.²²⁵ For 30 years, Healthy People has established benchmarks and monitored progress in order to encourage collaborations across communities and sectors, to empower individuals toward making informed health decisions, and to measure the impact of prevention activities.²²⁶

Healthy People 2020 continues this tradition with the launch on December 2, 2010 of its 10-year agenda for improving the nation’s health, and is the result of a multiyear process that reflects input from a diverse group of individuals and organizations.²²⁷ There are more than 1,200 objectives in Healthy People 2020.²²⁸ “Immunization and Infectious Diseases” is one of these topics.²²⁹ According to the topic overview, the “Healthy People 2020 goals for immunization and infectious diseases are rooted in evidence-based clinical and community activities and services for the prevention and treatment of infectious diseases.”²³⁰

Among the Healthy People 2020 immunization objectives are target vaccination rates for children in kindergarten and children aged 13 to 15.²³¹ Table 2 summarizes the childhood vaccination targets from Healthy People 2020.

²²⁵ Dep’t of Health and Human Servs., “About Health People,” Mar. 1, 2016, <https://www.healthypeople.gov/2020/About-Healthy-People>.

²²⁶ *Id.*

²²⁷ *Id.*

²²⁸ Dep’t of Health and Human Servs., “Objective Development and Selection Process,” Mar. 1, 2016, <https://www.healthypeople.gov/2020/about/history-development/Objective-Development-and-Selection-Process>.

²²⁹ Dep’t of Health and Human Servs., “Immunization and Infectious Diseases: Overview,” Mar. 1, 2016, <https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases>.

²³⁰ *Id.*

²³¹ See Dep’t of Health and Human Servs., “Immunization and Infectious Diseases: Objectives - IID-10, IID-11,” Mar. 1, 2016, <https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases/objectives>.

Table 2		
Healthy People 2020 Target Vaccination Rates		
Vaccination	Kindergarten	13 - 15 Years Old
≥ 4 doses of diphtheria, tetanus, & acellular pertussis (DTaP)	95%	-
≥ 2 doses of measles, mumps, & rubella (MMR)	95	-
≥ 3 doses of Polio vaccine	95	-
≥ 3 doses of hepatitis B vaccine	95	-
≥ 2 doses of varicella vaccine	95	90%
≥ 1 dose of tetanus, diphtheria, & acellular pertussis (Tdap) booster vaccine	-	80
≥ 1 dose of Meningococcal vaccine	-	80
≥ 3 doses of HPV vaccine	-	80
Source: Compiled by JSGC staff from Dep't of Health and Human Servs., "Immunization and Infectious Diseases: Objectives - IID-10, IID-11," Mar. 1, 2016, https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases/objectives .		

Pennsylvania's Vaccination Rates

In Pennsylvania, it is “the duty of all school directors, superintendents, principals, or other persons in charge of any public, private, parochial, or other school including kindergarten, to ascertain that every child, prior to admission to school for the first time has been immunized....”²³² Public, private, parochial, or nonpublic schools, including vocational schools, intermediate units, special education programs, home education programs, and cyber and charter schools must report immunization data to the Department of Health by October 15 of each year.²³³ The reports must include the following information:

- The month, day, and year of the report;
- The number of students attending school in each grade-level, or in an ungraded school in each age group, as indicated on the reporting form;
- The number of doses of each individual antigen given in each grade-level, or in an ungraded school, in each age group, as indicated on the reporting form;

²³² Act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, at § 1303(a) (24 P.S. § 13-1303a(a))

²³³ 28 Pa. Code § 23.86(a).

- The number of students attending school who were classed as medical exemptions in each grade-level, or in an ungraded school, in each age group, as indicated on the reporting form;
- The number of students attending school who were classed as religious exemptions in each grade level, or in an ungraded school, in each age group, as indicated on the reporting form;
- The number of students provisionally admitted in each grade level or, in an ungraded school, in any age group as indicated on the reporting form;
- The number of students in each grade level who were denied admission because of the student's inability to qualify for provisional admission or, in an ungraded school, in each age group as indicated on the reporting form; and
- Other information as required by the Department of Health.²³⁴

Following the collection of school immunization data, the Department of Health submits a report to the CDC each year. Unlike states that use an audit sample, Pennsylvania requires all schools to self-report immunization data, providing a larger data pool for analysis.²³⁵ The Department of Health also uses the data to prepare the Pennsylvania School Immunization Law Report (SILR), which is available to the public via the Department of Health's website.²³⁶ The SILRs are available back to the 2007-08 school year and include antigen-specific data, as well as the following information, by county and for the entire Commonwealth:

- Total number of students enrolled in kindergarten and seventh grade;
- Number of students with medical exemptions;
- Number of students with religious exemptions;
- Number of students with philosophical exemptions;
- Number of students provisionally admitted; and
- Number of students denied admission.²³⁷

The maps in Figures 2 through 8 show antigen-specific vaccination rates at the county level for the 2014-15 school year, with shades of blue used for vaccines required to attend kindergarten and shades of green used for vaccines required to attend seventh grade.

²³⁴ 28 Pa. Code § 23.86(e).

²³⁵ Pa. Dep't of Health, "School Immunization Rate,"

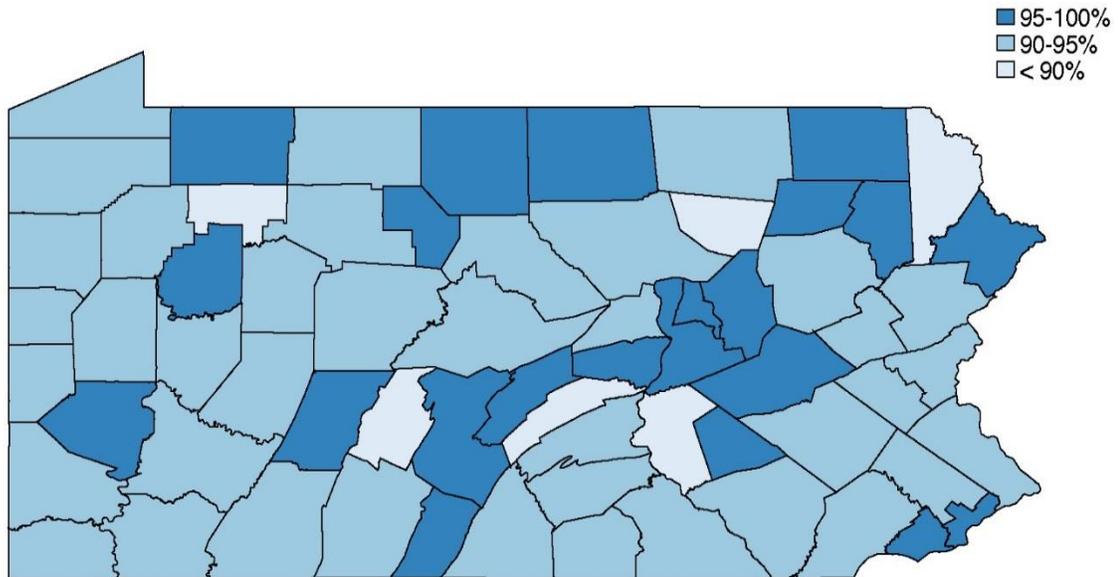
http://www.health.pa.gov/My%20Health/Immunizations/schoolimmunizationrates/Pages/default.aspx#.VtXKU_krK

Uk.

²³⁶ *Id.*

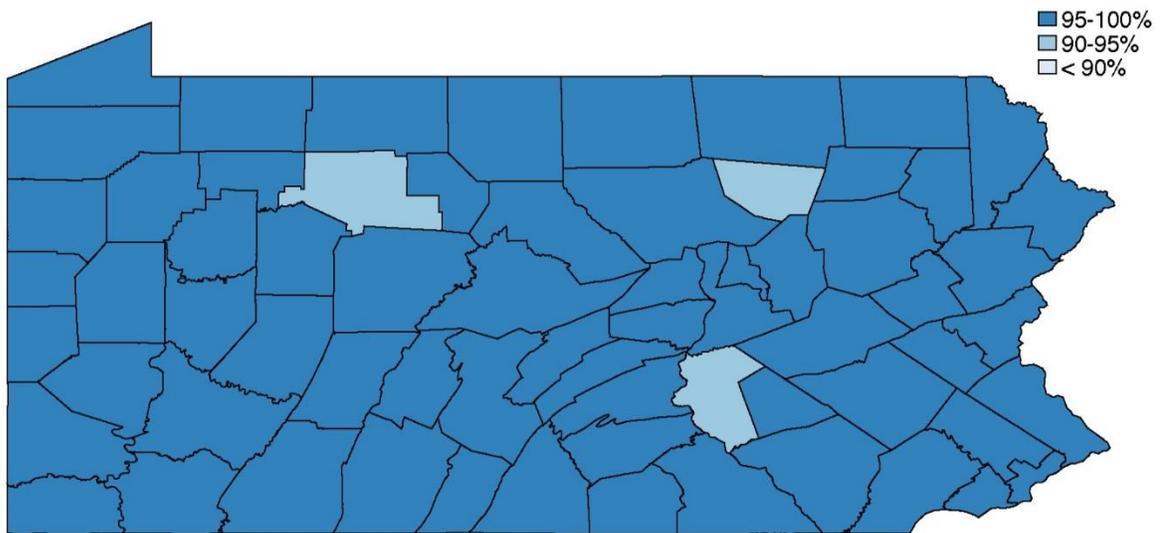
²³⁷ *Id.*

Figure 2
Diphtheria & Tetanus (DT) Vaccination Rates (4 doses), 2014-2015



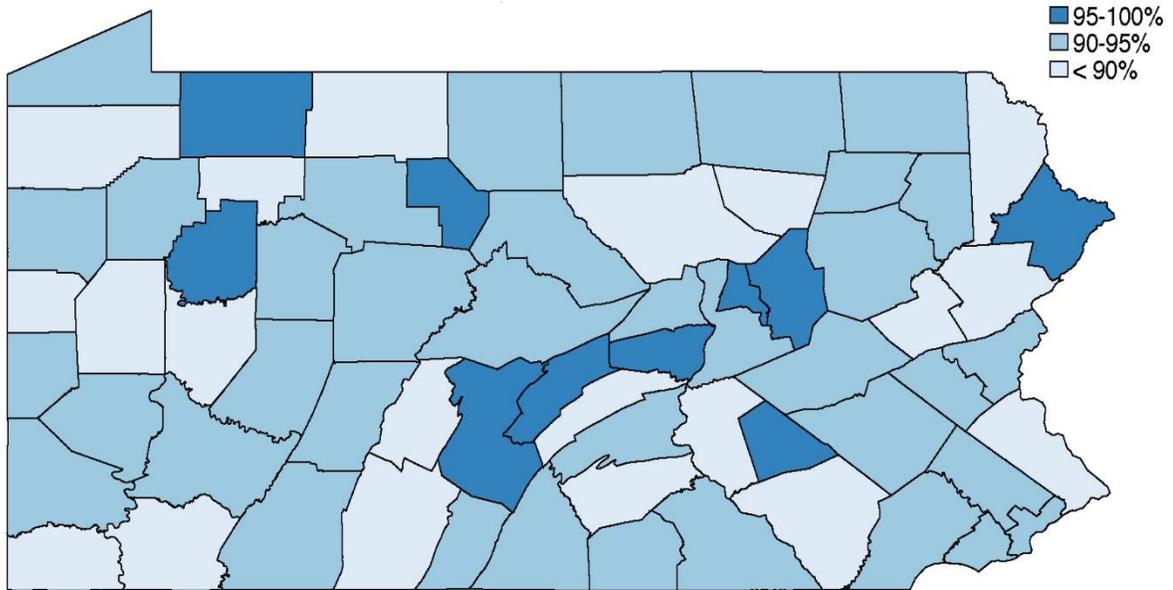
Source: Compiled by Margaret Anne Robertson, MPH Candidate, Dep't of Health Policy and Mgmt., Ctr. for Pub. Health Practice, Univ. of Pittsburgh Graduate Sch. of Pub. Health, Oct. 2015, for JSGC, from SILR for 2014-15, not currently available on Pa. Dep't of Health website.

Figure 3
Polio Vaccination Rates (3 doses), 2014-2015



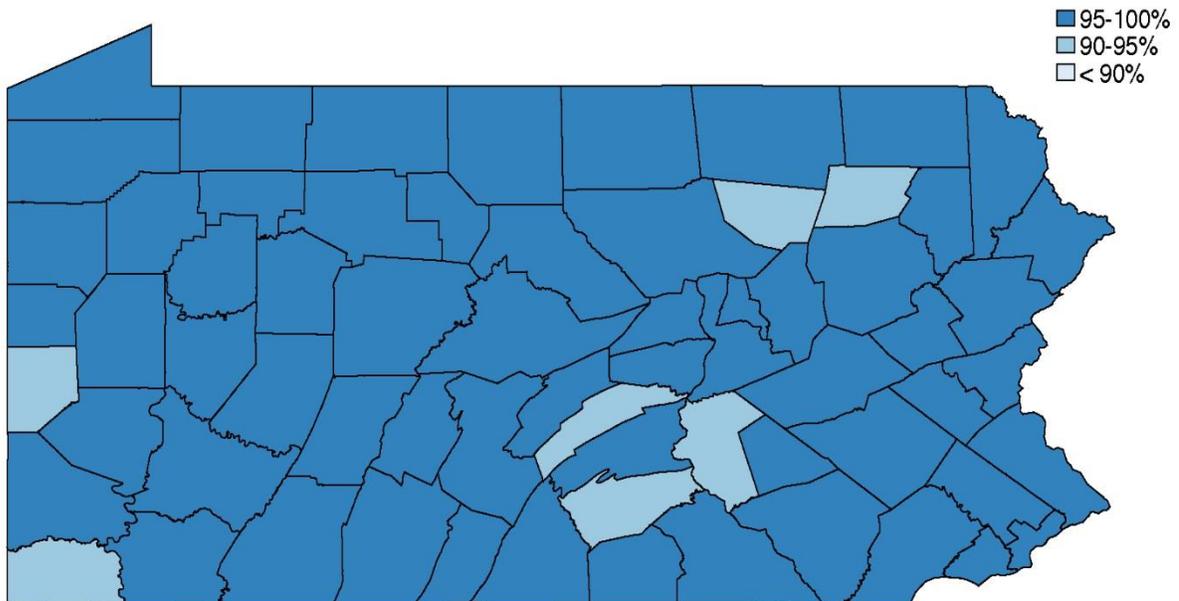
Source: Compiled by Margaret Anne Robertson, MPH Candidate, Dep't of Health Policy and Mgmt., Ctr. for Pub. Health Practice, Univ. of Pittsburgh Graduate Sch. of Pub. Health, Oct. 2015, for JSGC, from SILR for 2014-15, not currently available on Pa. Dep't of Health website.

Figure 4
Measles, Mumps, & Rubella (MMR) Vaccination Rates (2 doses), 2014-2015



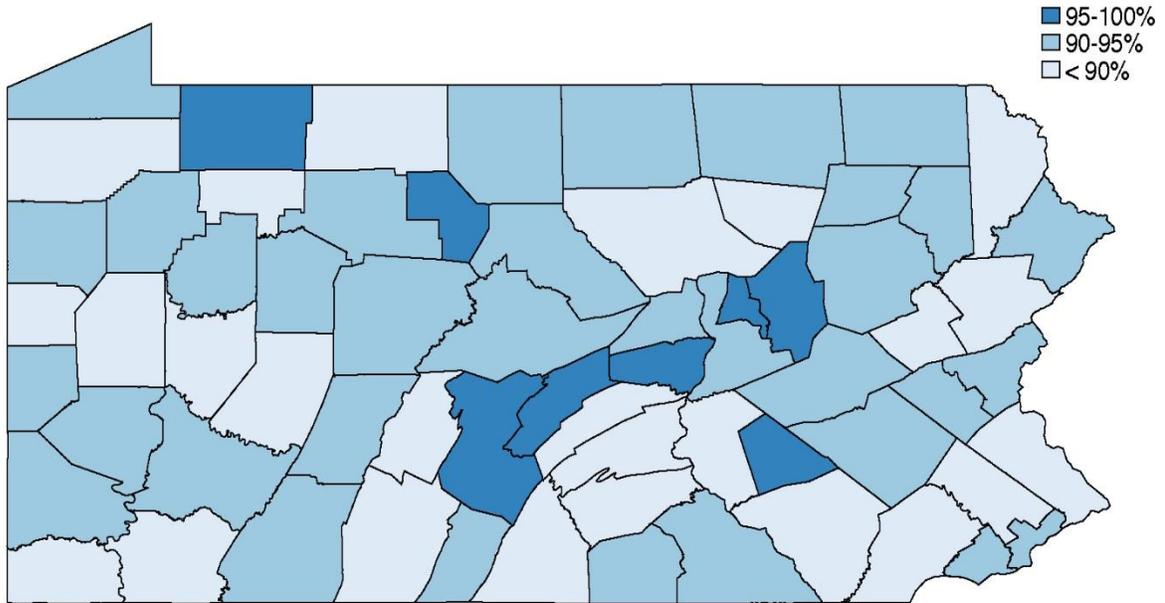
Source: Compiled by Margaret Anne Robertson, MPH Candidate, Dep't of Health Policy and Mgmt., Ctr. for Pub. Health Practice, Univ. of Pittsburgh Graduate Sch. of Pub. Health, Oct. 2015, for JSGC, from SILR for 2014-15, not currently available on Pa. Dep't of Health website.

Figure 5
Hepatitis B Vaccination Rates (3 doses), 2014-2015



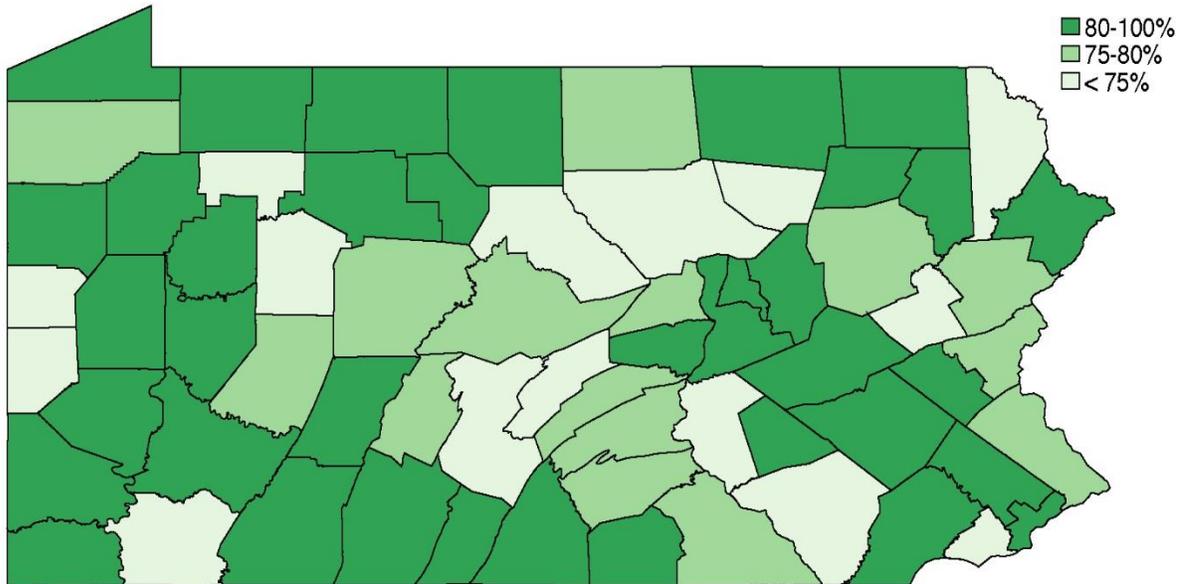
Source: Compiled by Margaret Anne Robertson, MPH Candidate, Dep't of Health Policy and Mgmt., Ctr. for Pub. Health Practice, Univ. of Pittsburgh Graduate Sch. of Pub. Health, Oct. 2015, for JSGC, from SILR for 2014-15, not currently available on Pa. Dep't of Health website.

Figure 6
Varicella Vaccination Rates (2 doses), 2014-2015



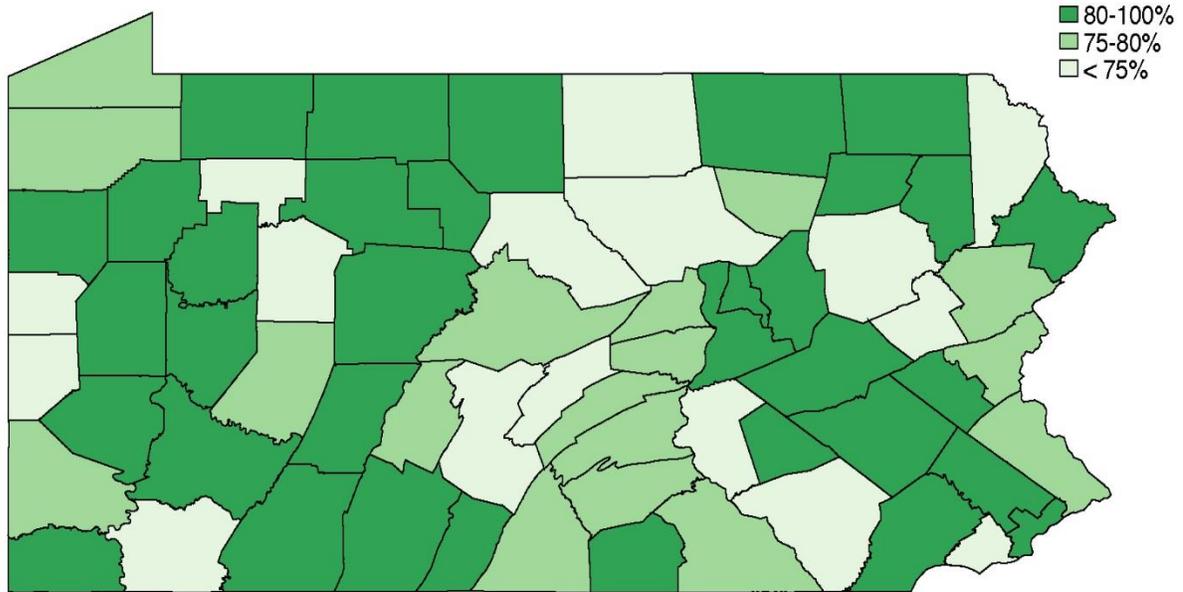
Source: Compiled by Margaret Anne Robertson, MPH Candidate, Dep't of Health Policy and Mgmt., Ctr. for Pub. Health Practice, Univ. of Pittsburgh Graduate Sch. of Pub. Health, Oct. 2015, for JSGC, from SILR for 2014-15, not currently available on Pa. Dep't of Health website.

Figure 7
Tetanus, Diphtheria, & acellular Pertussis (Tdap) Vaccination Rates (1 dose), 2014-2015



Source: Compiled by Margaret Anne Robertson, MPH Candidate, Dep't of Health Policy and Mgmt., Ctr. for Pub. Health Practice, Univ. of Pittsburgh Graduate Sch. of Pub. Health, Oct. 2015, for JSGC, from SILR for 2014-15, not currently available on Pa. Dep't of Health website.

Figure 8
Meningococcal Conjugate Vaccine (MCV) Vaccination Rates (1 dose), 2014-2015



Source: Compiled by Margaret Anne Robertson, MPH Candidate, Dep't of Health Policy and Mgmt., Ctr. for Pub. Health Practice, Univ. of Pittsburgh Graduate Sch. of Pub. Health, Oct. 2015, for JSGC, from SILR for 2014-15, not currently available on Pa. Dep't of Health website.

Tables 3 and 4 provide antigen-specific vaccination rates in the Commonwealth between the 2007-08 and 2014-15 school years for kindergarten and seventh grade students.

Table 3
Statewide Historical Vaccination Rates for Children in Kindergarten

Vaccination	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
DT ≥ 3 doses	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DT ≥ 4 doses	83.39	90.57	90.84	92.33	91.08	90.70	89.10	93.87
Polio ≥ 3 doses	87.31	94.66	94.39	95.92	95.54	94.84	94.05	97.03
MMR ≥ 2 doses	81.26	87.40	86.94	87.82	86.96	87.01	86.05	91.72
HepB ≥ 3 doses	87.87	94.43	93.52	94.91	94.39	94.06	93.00	96.21
Varicella had disease	0.00	0.00	1.74	1.03	1.88	1.84	1.15	1.04
Varicella 1 dose	61.96	46.48	35.93	36.18	0.00	0.00	0.00	0.00
Varicella 2 doses	37.91	67.24	77.68	82.49	85.14	85.70	84.76	90.96
Tdap 1 dose	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Td 1 dose	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MCV 1 dose	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Medical exemption	0.37	0.34	1.19	0.38	0.41	0.42	0.34	0.32
Religious exemption	1.01	1.14	1.95	1.27	1.41	1.54	0.75	0.80
Philosophical exemption	0.00	0.00	0.00	0.00	0.00	0.00	0.94	0.96
Admitted Provisionally	13.35	13.60	14.22	13.25	15.33	15.04	15.15	9.66
Number denied admission	236	325	86	157	204	173	179	59

Source: Compiled by JSGC staff from SILR for 2007-08 through 2014-15, available at http://www.health.pa.gov/My%20Health/Immunizations/schoolimmunizationrates/Pages/default.aspx#.VtXKU_krKUK.

Table 4
Statewide Historical Vaccination Rates for Children in 7th Grade

Vaccination	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
DT ≥ 3 doses	92.65%	92.84%	96.25%	92.66%	0.00%	0.00%	0.00%	0.00%
DT ≥ 4 doses	0.00	0.00	0.00	0.00	96.07	96.16	95.05	97.12
Polio ≥ 3 doses	95.17	95.25	97.69	94.25	97.65	97.18	96.21	97.56
MMR ≥ 2 doses	96.28	96.96	97.55	93.89	96.98	96.89	95.98	97.13
HepB ≥ 3 doses	96.17	96.32	97.32	93.89	97.12	96.59	95.91	97.20
Varicella had disease	0.00	0.00	10.61	7.54	6.12	5.38	4.43	3.33
Varicella 1 dose	82.02	74.07	46.04	38.11	0.00	0.00	0.00	0.00
Varicella 2 doses	7.65	30.58	51.33	61.73	77.53	90.93	92.03	94.68
Tdap 1 dose	28.26	39.80	53.29	59.09	73.92	81.75	77.75	81.91
Td 1 dose	23.98	20.58	14.35	14.00	13.16	11.22	11.46	10.81
MCV 1 dose	10.76	31.44	50.17	57.10	73.25	81.15	76.95	81.23
Medical exemption	0.50	0.41	0.49	0.46	0.57	0.76	0.61	0.54
Religious exemption	1.20	1.30	1.51	1.55	1.82	2.41	1.20	1.06
Philosophical exemption	0.00	0.00	0.00	0.00	0.00	0.00	1.27	1.63
Admitted provisionally	2.25	3.72	2.24	2.07	23.85	16.17	19.94	16.92
Number denied admission	35	238	36	102	385	140	447	80

Source: Compiled by JSGC staff from SILR for 2007-08 through 2014-15, available at http://www.health.pa.gov/My%20Health/Immunizations/schoolimmunizationrates/Pages/default.aspx#.VtXKU_krKUK.

When comparing the state vaccination rates to the Healthy People 2020 targets, it is clear that Pennsylvania is not meeting the target vaccination rates. Unfortunately, the vaccination rates at the county level, although highly variable, are generally even farther off from the target vaccination rates. Using MMR as an example, only 10 out of 67 counties reported vaccination rates of 95 percent or higher among kindergarten students in 2014-15.²³⁸ The trend is similar for most of the required vaccines for both kindergarten and seventh grade, and in all years that the data has been collected.

The Work Group found that available data do not explain why some children are not compliant with the vaccination requirements. Therefore, the Work Group recommends that more qualitative data be collected by schools, health care providers, and others to determine why some children are not being vaccinated.

In addition, the Work Group recommends that the Department of Health and the Department of Education consider implementing a system for making school district vaccination rates easily accessible to the public in order to encourage compliance with, and enforcement of, the vaccination requirements, as well as to encourage public awareness of the importance of vaccination compliance. The reports could provide vaccination rates, or could provide a simple yes or no response to the question “Are the vaccination rates in this district at or above the target level?”.

Required Vaccines

In Pennsylvania, several statutes and regulations provide for youth vaccination requirements. These provisions are reproduced in Appendix A. Generally, Pennsylvania requires all children in public, private, and parochial schools, child care and pre-kindergarten programs located in schools, kindergartens, special education classes, home education programs, and vocational classes, to be vaccinated against a list of specified diseases.²³⁹ Table 5 contains the list of vaccinations currently required for children in kindergarten and seventh grade, which are the reporting deadlines used in Pennsylvania.

²³⁸ Compiled by JSGC staff from SILR for 2014-15, not currently available on Pa. Dep’t of Health website.

²³⁹ Act of Mar. 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, §§ 1303, 1327.1 (24 P.S. §§ 13-1303a, 13-1327.1); 22 Pa. Code §§ 11.11, 11.20, & 51.13; 28 Pa. Code §§ 23.81-87 & 405.49.

Table 5	
Pennsylvania Required Vaccines	
Kindergarten	Diphtheria
	Hepatitis B
	Measles
	Mumps
	Poliomyelitis
	Rubella
	Tetanus
	Varicella
7th Grade	Meningococcal conjugate vaccine (MCV)
	Tdap
Source: 28 Pa. Code § 23.83.	

Pennsylvania requires all children in child care group settings to be vaccinated according to age-appropriate Advisory Committee on Immunization Practices (ACIP) recommended schedules instead of providing a list of vaccines in the regulations.²⁴⁰ Pennsylvania requires all university and college students residing in a dormitory or housing unit to be vaccinated against meningococcal disease.²⁴¹

ACIP is a group of medical and public health experts that develop recommendations on the use of vaccines in the United States.²⁴² ACIP was established under Section 222 of the Public Health Service Act.²⁴³ Each year, ACIP publishes immunization schedules for various populations, including for people from birth to 18 years old.²⁴⁴ Table 6 contains the 2016 list of the vaccines recommended for children by kindergarten (four to six years) and seventh grade (11 to 12 years).

²⁴⁰ 28 Pa. Code § 27.77(b) & (c).

²⁴¹ Act of June 28, 2002 (P.L.492, No.83), known as the College and University Student Vaccination Act, § 3(a) (35 P.S. § 633.3(a)).

²⁴² CDC, "About ACIP," June 13, 2014, <http://www.cdc.gov/vaccines/acip/about.html>.

²⁴³ 42 U.S.C. § 217a.

²⁴⁴ CDC, "Birth-18 Years & 'Catch-up' Immunization Schedules," Feb. 18, 2016, <http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html>.

Table 6	
2016 ACIP Recommended Vaccines	
Kindergarten	DTaP
	Hib
	Hepatitis A
	Hepatitis B
	Inactivated poliovirus
	Influenza - annual
	MMR
	Pneumococcal conjugate
	Rotavirus
	Varicella
	7th Grade
Influenza - annual	
MCV	
Tdap	
Source: CDC, "Recommended Immunization Schedule for Persons Aged 0 Through 18 Years - United States, 2016," Feb. 1, 2016, http://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html .	

By comparing Pennsylvania’s required vaccines with the ACIP recommended vaccines, it is clear that the ACIP recommendations include more vaccines, reflecting the most comprehensive and up-to-date medical knowledge and providing better protection from vaccine-preventable diseases. The Work Group recommends that an updated and more complete list of required vaccinations in keeping with the ACIP recommendations be implemented in Pennsylvania for all individuals subject to vaccination requirements.

Influenza

One vaccine of note that is not required in Pennsylvania is annual influenza. Influenza possesses the capability to infect a large number of people rapidly, affecting 10 to 20 percent of the US population every year.²⁴⁵ Mortality rates due to influenza have been estimated to exceed 36,000 each year, and the annual economic impact of influenza has been estimated to be between \$11 and \$18 billion.²⁴⁶ Influenza is more dangerous than the common cold for children.²⁴⁷ Each year, many children get sick with influenza, and some of those children die.²⁴⁸

²⁴⁵ Sara S. Plaspohl, Dr.PH, CHES, et al., "Impact of School Flu Vaccine Program on Student Absences," *J. of School Nursing*, 2014, 30(1), p. 75, DOI: 10.1177/1059840513487750, (citations omitted).

²⁴⁶ *Id.*

²⁴⁷ CDC, "Children, the Flu, and the Flu Vaccine," Aug. 21, 2015, <http://www.cdc.gov/flu/protect/children.htm>.

²⁴⁸ *Id.*

Furthermore, influenza causes school absenteeism.²⁴⁹ Research indicates that school absenteeism correlates with lower standardized test scores, and missing even a few days of school can affect student academic performance, shape attitudes about school, and affect school dropout rates.²⁵⁰

School-located influenza vaccination (SLIV) programs provide a valuable primary prevention measure via the administration of influenza vaccine by public health department and school nurses to students within the school setting.²⁵¹ SLIV programs can:

- Help lessen the proliferation of influenza;
- Provide access to vaccination to large numbers of children;
- Be more cost effective compared to vaccinating children in physician offices and clinics;
- Reduce the indirect costs of vaccination for parents by decreasing the need for their time and work absence to have their child immunized;
- Minimize the time lost by a student from school due to illness;
- Lower the amount of time parents spend caring for sick children;
- Help reduce the workload burden of primary care providers; and
- Increase the overall vaccination rates among school children.²⁵²

The Department of Health has undertaken efforts to fight influenza with programs such as its “Stopping the Flu Starts with YOU” campaign, which urges Pennsylvanians to protect themselves and their loved ones against influenza by being vaccinated and taking other preventive measures, and its reduced or no-cost influenza vaccine clinics.²⁵³

Education and outreach programs, such as those undertaken by the Department of Health, are not the exclusive responsibility of government. Practitioners and insurers can and should be involved in the efforts to raise annual influenza vaccination rates.

The Work Group discussed the addition of annual influenza vaccination to Pennsylvania’s required vaccines and ultimately determined that enforcement of an annual vaccine requirement would be impracticable, especially given the current structure of the reporting and enforcement mechanisms.²⁵⁴ However, the Work Group recommends that programs designed to provide educational materials regarding the safety, availability, and importance of the annual influenza vaccine to parents and guardians of children, to students, and to school staff, be implemented or continued. The Work Group also recommends that SLIV programs and other programs designed to make annual influenza vaccination more accessible be implemented or continued.

²⁴⁹ *Supra* note 245.

²⁵⁰ *Id.*

²⁵¹ *Id.* at 76.

²⁵² *Id.*

²⁵³ *See* Pa. Dep’t of Health, “Influenza (flu),”

<http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/IL/Pages/Influenza.aspx/#.VuAhRvkrKUK>

²⁵⁴ Many schools report vaccination rates on paper, as opposed to electronically. Furthermore, the collection and verification of vaccination data for students is time-consuming, and requiring annual influenza vaccination reporting would exceed the availability of resources.

Pennsylvania's Vaccine Exemptions

Pennsylvania provides for medical and religious exemptions by statute for children in schools governed by the Public School Code of 1949.²⁵⁵ The statute provides that a medical exemption is available “in the case of any child deemed to have a medical contraindication which may contraindicate immunization and so certified by a physician.”²⁵⁶ The statute goes on to provide that “[s]uch certificates may be accepted in lieu of a certificate of immunization.”²⁵⁷ The statute provides that a religious exemption is available “in the case of any child whose parent or guardian objects in writing to such immunization on religious grounds.”²⁵⁸ No more is provided regarding the requirements or procedures for exemptions.

Pennsylvania similarly provides for a medical exemption “if a physician or the physician’s designee provides a written statement that immunization may be detrimental to the health of the child” for children in schools and programs governed by the regulations promulgated by the Department of Education and the Department of Health.²⁵⁹ The regulations also provide for a religious exemption “if the parent, guardian or emancipated child objects in writing to the immunization on religious grounds or on the basis of a strong moral or ethical conviction similar to a religious belief.”²⁶⁰ Again, no more is provided regarding the requirements or procedures for the exemptions.

Pennsylvania provides the same exemptions available to school-aged children under the regulations for children in child care settings under the authority of the Department of Human Services.²⁶¹ Pennsylvania provides for a medical exemption and an exemption “for religious or other reasons” to university and college students residing in dormitories and housing units.²⁶²

The regulation implementing the statutory religious exemption provides that the grounds for receiving a religious exemption can include “a strong moral or ethical conviction similar to a religious belief.”²⁶³ However, neither this language nor any other provision of Pennsylvania law currently recognizes an exemption based solely on personal belief.

Based on the foregoing, the Work Group recommends that the Department of Health and the Department of Education provide clear procedures and criteria for documenting and certifying the allowable exemptions. However, exemption rates do not appear to account for the low vaccination rates. As addressed further in this report, Pennsylvania’s vaccination rates fall below target vaccination rates by as many as 10 percentage points for some vaccines, yet exemption rates

²⁵⁵ Act of Mar. 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, § 1303(c) & (d) (24 P.S. §§ 13-1303a(c) & (d)).

²⁵⁶ *Id.* at § 1303(c).

²⁵⁷ *Id.*

²⁵⁸ *Id.* at § 1303(d).

²⁵⁹ 28 Pa. Code § 23.84.

²⁶⁰ *Id.*

²⁶¹ *Id.* at § 27.77(d).

²⁶² Act of June 28, 2002 (P.L.492, No.83), known as the College and University Student Vaccination Act, § 3(b) (35 P.S. § 633.3(b)).

²⁶³ 28 Pa. Code § 23.84.

are below three percent, total, in each year data is available.²⁶⁴ Therefore, the Work Group does not recommend that the exemptions be changed.

Provisional Admission and Vaccination Requirement Enforcement

Currently, students who do not meet the vaccination requirements are not permitted to attend school, although students who have not received all doses of the required vaccines but have received at least one dose of the multiple-dose vaccines are provisionally admitted and may attend school for up to eight months.²⁶⁵ The regulations promulgated by the Department of Education provide that:

Provisional admission or continued attendance shall be conditioned upon the parent or guardian's submission to the superintendent of a plan for the student's completion of the required immunization doses. The plan shall be reviewed by the school district at least every 60 calendar days. If, after 8 months, the child has not received all doses of the required immunizations, the child thereafter may not be further admitted to or be permitted to attend the public schools until all doses have been received.²⁶⁶

The eight-month provisional period allows a student to attend school most of the academic school year without meeting the vaccination requirements. However, the schools are required to report student vaccination rates before the provisional admission period has ended. Therefore, because of this long provisional admission period, there is a window of time during which children may eventually become compliant with the vaccination requirements, may utilize one of the exemptions, or may never become fully compliant, but are considered non-compliant. These non-compliant children are reported as either provisionally admitted or denied admission. Furthermore, these non-compliant children can cause the spread of infectious disease to other unvaccinated students, their families, their social contacts, and their communities.

School administrators, school districts, the Department of Education, and the Department of Health currently share the responsibility for monitoring and enforcing vaccination requirements in schools. However, the Work Group was unable to find precise specification of those processes in statutes or regulations. Therefore, the Work Group recommends that enforcement procedures for vaccination compliance be defined by regulations developed in collaboration by the Department of Health and the Department of Education.

The Work Group also recommends a much shorter provisional admission period, which should expire prior to federal reporting deadlines, for children who do not meet the vaccination requirements at the beginning of the school year. Additionally, the Work Group recommends that individual student compliance (either full vaccination or formal exemption) be reported at the

²⁶⁴ See Statewide Historical Vaccination Rates for Children in Kindergarten *and* Statewide Historical Vaccination Rates for Children in 7th Grade, *supra*.

²⁶⁵ See Act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, at § 1303 (24 P.S. § 13-1303a); 22 Pa. Code §§ 11.20, 51.13, & 405.49; 28 Pa. Code §§ 23.81-87 & 27.77.

²⁶⁶ 22 Pa. Code § 11.20(b). See also 22 Pa. Code § 51.13(b).

conclusion of the provisional admission period so that accurate rates of immunization are available.

Vaccination Reporting

Immunization information systems (IIS) are confidential, population-based, computerized databases that record all immunization doses administered by participating providers to persons residing within a given area.²⁶⁷ In the clinical setting, IIS can provide consolidated immunization histories for use by vaccination providers in determining appropriate vaccinations for their patients.²⁶⁸ At the population level, IIS can provide aggregate data on vaccinations for use in surveillance and program operations, and in guiding public health action with the goals of improving vaccination rates and reducing vaccine-preventable disease.²⁶⁹ There is strong evidence that IIS have been effective in increasing vaccination rates and reducing vaccine-preventable diseases.²⁷⁰

The CDC, the National Vaccination Advisory Committee, and immunization program administrators developed minimum functional standards for the operation of IIS in 1997.²⁷¹ In 2012, the CDC and stakeholders updated the IIS Functional Standards for implementation during the period 2013-2017.²⁷² IIS now operate in all but one state, and most IIS serve all children, adolescents, and adults in the jurisdictions where they exist.²⁷³ The maps in Figure 9 and Figure 10 summarize the status of IIS around the country.

²⁶⁷ CDC, “About Immunization Information Systems,” May 15, 2012, <http://www.cdc.gov/vaccines/programs/iis/about.html>.

²⁶⁸ *Id.*

²⁶⁹ *Id.*

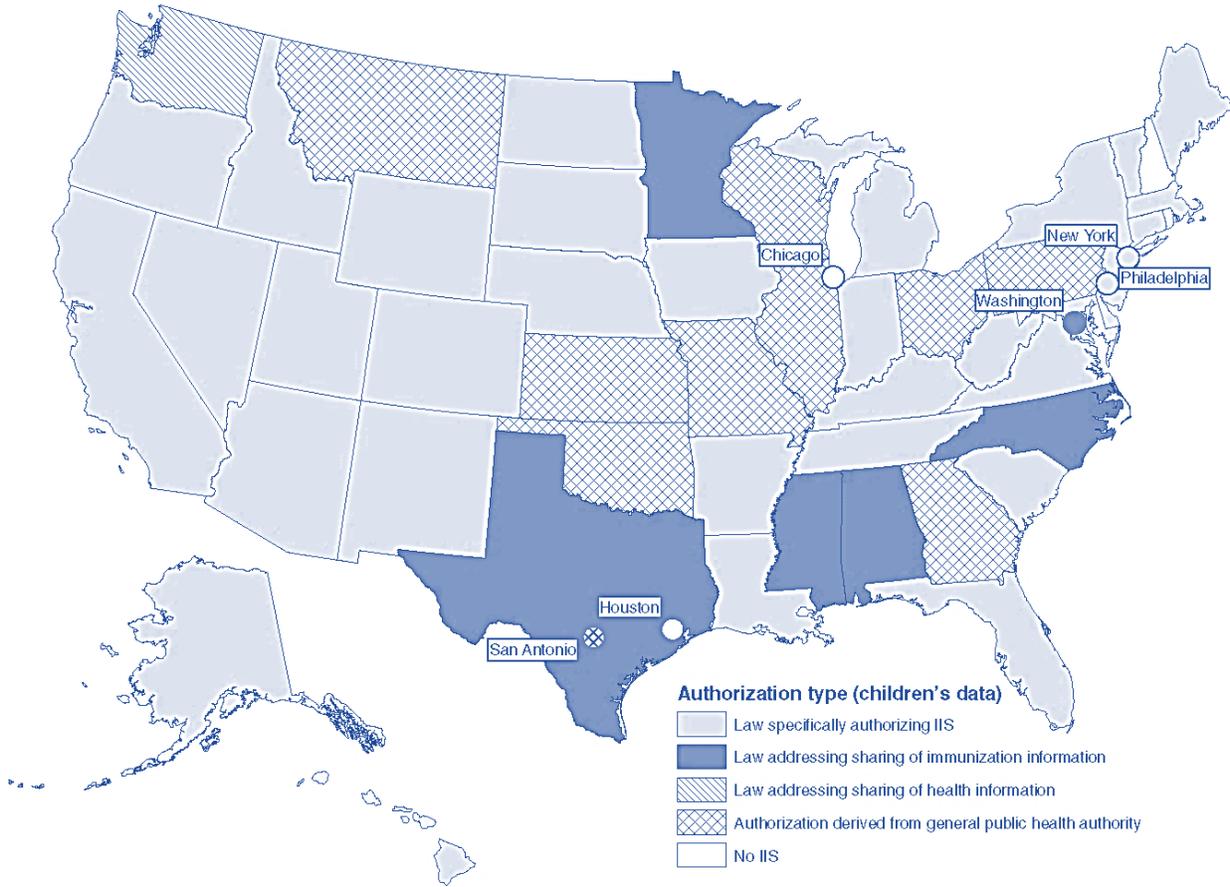
²⁷⁰ Community Preventive Servs. Task Force, “Increasing Appropriate Vaccination: Immunization Information Systems,” July 17, 2014, <http://www.thecommunityguide.org/vaccines/imminfosystems.html>.

²⁷¹ *Id.*

²⁷² *Id.*

²⁷³ *Id.*

Figure 9
Legal Basis for IIS Operation



Source: Daniel W. Martin, MSPH, et al., "Immunization Information Systems: A Decade of Progress in Law and Policy," *J. Pub. Health Mgmt. Practice*, 2015, 21(3), p. 299.

The Department of Health offers school medical staff view-only access to PA-SIIS in order to view the immunization histories of enrolled students within their respective schools.²⁷⁹ In order to obtain view-only access to PA-SIIS, each school medical staff member must review a confidentiality policy and then complete a PA-SIIS user agreement.²⁸⁰ After completion of the registration process, the school medical staff member is given login credentials to access PA-SIIS.²⁸¹

Having access to PA-SIIS can help schools enforce vaccination requirements and improve the data available regarding vaccination rates. However, the Work Group was unable to determine how many school medical staff currently use PA-SIIS or what the barriers to their use may be. Potential barriers include lack of required technology and lack of school medical staff. Therefore, the Work Group recommends that efforts be made to ensure school medical staff are available and have access to the system.

Vaccination Reporting and Electronic Health Records

One of the stated goals of the American Reinvestment & Recovery Act (ARRA), enacted in February 2009, was to increase the “meaningful” use of electronic health records (EHR).²⁸² The Centers for Medicare and Medicaid Services (CMS) established an incentive program using ARRA funds to encourage adoption and use of EHR.²⁸³ The incentives will be released in three stages over several years.²⁸⁴ The immunization-specific criteria for meaningful use have been finalized for the first stage and are under development for the remaining stages.²⁸⁵

One criterion available to qualify for the stage one incentive is to test, and if successful, establish a connection between the EHR and IIS in a jurisdiction. In Pennsylvania, the eHealth Partnership Authority is working to establish a network to enable electronic health information exchange.²⁸⁶ This network is referred to as the Public Health Gateway and will provide a secure, single point of entry for critical public health data, including immunization data. Privacy concerns regarding the type of data exchanged between EHR and IIS systems, as well as who will have access to that data, are being addressed by state and federal organizations as the EHR and IIS systems are implemented in Pennsylvania and nationwide.

²⁷⁹ Pa. Dep’t of Health, “School Nurses,”

http://www.health.pa.gov/MyRecords/Registries/PA%20SIIS/Pages/556459.aspx#.VtmWk_krKUK.

²⁸⁰ *Id.*

²⁸¹ *Id.*

²⁸² CDC, “Meaningful Use and Immunization Information Systems,” Sept. 5, 2012,

<http://www.cdc.gov/vaccines/programs/iis/meaningful-use/index.html>.

²⁸³ *Id.*

²⁸⁴ *Id.*

²⁸⁵ *Id.*

²⁸⁶ The Pennsylvania eHealth Partnership Authority was created by the Act of July 5, 2012 (P.L.1042, No.121) (35 P.S. § 510.101 *et seq.*).

Mandating reporting to PA-SIIS would ensure a larger data pool for analysis and a more complete picture of vaccination rates. Mandating reporting to PA-SIIS would also support the efforts of the eHealth Partnership Authority and offer an opportunity to qualify for federal incentives related to meaningful use of EHR. Therefore, the Work Group recommends that reporting to PA-SIIS be made mandatory for all vaccine providers. It is worth noting that making reporting easier might encourage voluntary participation. Barriers to participation, such as financial costs and technological capabilities, are certainly important considerations as well.

Vaccine Funding

Approximately 59.3 percent of children in Pennsylvania are covered by private insurance, 30.3 percent by public insurance, 5.3 percent by a combination of public and private insurance, and 5.4 percent are uninsured.²⁸⁷ Table 7 provides the number and percentage of children in each category of coverage.

Table 7		
Children’s Health Care Coverage		
Coverage Source	Number	Percent
Private insurance	1,599,200	59.0%
Public insurance	820,000	30.3
Private and public insurance	142,400	5.3
No insurance	147,300	5.4

Source: Compiled by JSGC staff from Pa. P’ships for Children, “State of Children’s Health Care in Pennsylvania: Fall 2015,” Aug. 20, 2015, http://www.papartnerships.org/publication_files/2015-state-of-childrens-health-care---ppc.pdf.

Private insurance plans are required to cover recommended vaccines, and while vaccine coverage may be subject to copayment and coinsurance provisions of health insurance policies to the same extent as other medical services covered by the policies, vaccine coverage is exempt from deductible or dollar limit provisions in health insurance policies.²⁸⁸

²⁸⁷ Pa. P’ships for Children, “State of Children’s Health Care in Pennsylvania: Fall 2015,” Aug. 20, 2015, http://www.papartnerships.org/publication_files/2015-state-of-childrens-health-care---ppc.pdf.

²⁸⁸ Act of May 21, 1992 (P.L.239, No.35), known as the Childhood Immunization Insurance Act (40 P.S. § 3501 *et seq.*); 31 Pa. Code §§ 89.801-809.

Medicaid

Under Medicaid, a public insurance program known as Medical Assistance in Pennsylvania, states are required to provide early periodic screening, diagnosis, and treatment (EPSDT) services that provide preventive screening and treatment for children.²⁸⁹ These screenings include, but are not limited to, immunizations.²⁹⁰

Under the administration of former Governor Corbett, the Healthy Pennsylvania plan was developed as an alternative to Medicaid expansion under the Patient Protection and Affordable Care Act (ACA).²⁹¹ CMS approved the state plan amendments for two of the three benefit plans on December 17, 2014.²⁹² On January 1, 2015, the Department of Human Services began providing coverage under the approved benefit plans, and also continued to provide low risk adults the then-current Medicaid state plan benefit, which the Department of Human Services designated as the “Interim Healthy” benefit plan, while awaiting approval from CMS for the third benefit plan.²⁹³

Following his inauguration in January 2015, Governor Tom Wolf announced his intent to transition from the Healthy Pennsylvania plan to a traditional Medicaid expansion.²⁹⁴ As part of this transition, the Department of Human Services consolidated the three benefit plans into one.²⁹⁵ This benefit plan provides coverage for all adults, and is similar to the Interim Healthy benefit plan with certain modifications that the Commonwealth made to comply with the Essential Health Benefits requirements established under the ACA for the ACA Newly Eligible Adult Group and federal parity requirements for behavioral health services.²⁹⁶

The adult benefit plan also provides coverage of EPSDT services for those ACA Newly Eligible Adult Group members under 21 years of age, in compliance with federal Medicaid requirements.²⁹⁷ According to the interim benefit plan, the children’s benefit plan included all medically necessary services without limitation.²⁹⁸ The benefit package effective April 27, 2015 also included all medically necessary services without limitation for children.²⁹⁹

On September 1, 2015, the Department of Human Services announced that the two-phased transition to HealthChoices, a streamlined, traditional Medicaid expansion plan, was complete.³⁰⁰

²⁸⁹ Health Res. & Servs. Admin., “Partnerships with State Medicaid and Children’s Health Insurance Program (CHIP),” <http://mchb.hrsa.gov/programs/collaboration/index.html>.

²⁹⁰ *Id.*

²⁹¹ 45 Pa. Bull. 1576 (Mar. 28, 2015), *citing* the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148).

²⁹² *Id.*

²⁹³ *Id.*

²⁹⁴ *Id.*

²⁹⁵ *Id.*

²⁹⁶ *Id.*

²⁹⁷ *Id.*

²⁹⁸ Pa. Dep’t of Human Servs., “Interim Benefit Plan,” Feb. 3, 2015, http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_144044.pdf.

²⁹⁹ Pa. Dep’t of Human Servs., “Adult Benefit Package,” Apr. 27, 2015, http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_172248.pdf.

³⁰⁰ Pa. Dep’t of Human Servs., “Pennsylvania’s Medicaid Expansion Transition Complete,” Sept. 1, 2015, http://www.media.pa.gov/Pages/DPW_details.aspx?newsid=173.

Under HealthChoices, providers cannot deny services if an individual is unable to pay her copay, and copay responsibility is not tied to Federal Poverty Level.³⁰¹

CHIP

On December 2, 1992, former Governor Casey signed into law the Children's Health Care Act,³⁰² which created the Children's Health Insurance Program (CHIP), a unique public health insurance program designed to provide insurance coverage to children whose families earned too much to qualify for Medicaid, but who could not afford to purchase private insurance.³⁰³ Pennsylvania's CHIP program was used as the model for the federal government's SCHIP program, which was enacted on August 5, 1997 by former President Clinton.³⁰⁴

On December 20, 2015, Governor Wolf signed Act 84, which extended CHIP through 2017 and moved its administration from the Pennsylvania Insurance Department to the Department of Human Services.³⁰⁵

Most families receive CHIP coverage absolutely free, although some get the same benefits at a low cost.³⁰⁶ Whether CHIP is free or low-cost depends on the number of members in the household and total household income.³⁰⁷ CHIP is available to immigrant children who have lawfully entered the United States and have received legal immigrant or qualified alien status.³⁰⁸ CHIP provides quality, comprehensive health insurance coverage including immunizations.³⁰⁹

Vaccines for Children

The Vaccines for Children (VFC) program is a federally funded program that provides ACIP-recommended vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay.³¹⁰ Funding for the VFC program is approved by the Office of

³⁰¹ Pa. Dep't of Human Servs., "Copayments," Mar. 2015,

http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_169443.pdf.

³⁰² Act of December 2, 1992 (P.L.741, No.113) (62 P.S. § 5001.101 *et seq.*). This act was amended by the Act of June 17, 1998 (P.L.464, No.68), which moved CHIP into the Act of May 17, 1921 (P.L.682, No.284) (40 P.S. § 341 *et seq.*), known as the Insurance Company Law of 1921, at Article XXIII. Article XXIII was amended by the Act of November 2, 2006 (P.L.1314, No. 136), the Act of March 22, 2010 (P.L.147, No.14), and the Act of October 16, 2013 (P.L.634, No.74) before it was repealed and replaced by Article XXIII-A by the Act of December 20, 2015 (P.L.461, No.84).

³⁰³ Pa.'s Children's Health Ins. Program, "A Brief History of CHIP," <http://www.chipcoverspakids.com/about-chip/a-brief-history-of-chip/>.

³⁰⁴ *Id.*

³⁰⁵ Pa.'s Children's Health Ins. Program, "CHIP Transition to DHS," <http://www.chipcoverspakids.com/about-chip/chip-transition-to-dhs/>.

³⁰⁶ Pa.'s Children's Health Ins. Program, "Is There a Cost?," <http://www.chipcoverspakids.com/is-there-a-cost/>.

³⁰⁷ *Id.*

³⁰⁸ Pa.'s Children's Health Ins. Program, "Information for Immigrants," <http://www.chipcoverspakids.com/eligibility-and-requirements/information-for-immigrants/>.

³⁰⁹ Pa.'s Children's Health Ins. Program, "Eligibility & Benefits," <http://www.chipcoverspakids.com/eligibility-and-requirements/>.

³¹⁰ CDC, "About VFC," Feb. 18, 2016, <http://www.cdc.gov/vaccines/programs/vfc/about/index.html>.

Management and Budget and allocated through CMS to the CDC, which buys vaccines at a discount and distributes them to state health departments and certain local and territorial public health agencies, which in turn distribute them at no charge to participating providers.³¹¹

A child is eligible for the VFC program if she is younger than 19 years of age and is any of the following:

- *Medicaid eligible*: a child who is eligible for the Medicaid program (for the purposes of the VFC program, the terms “Medicaid-eligible” and “Medicaid-enrolled” are equivalent and refer to children who have health insurance covered by a state Medicaid program);
- *Uninsured*: a child who has no health insurance coverage;
- *American Indian or Alaska Native*: as defined by the Indian Health Care Improvement Act (25 U.S.C. § 1603); or
- *Underinsured*: a child who has health insurance, but the coverage does not include vaccines or a child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only); underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or under an approved deputization agreement.³¹²

Although VFC vaccines are free of cost to recipients, participating providers still have the right to charge a fee for an office visit.³¹³ If a child is covered by Medicaid, for example, Medicaid pays for the office visit, but if the child is not covered by a health insurance policy, the child’s parent or guardian may be responsible for making appropriate payment arrangements with the participating provider for office visit charges.³¹⁴

Participating providers also have the right to charge an administrative fee for giving a child a shot; however, they are required by law to administer the vaccine even if a child cannot afford to pay the administrative fee.³¹⁵ This means that the administrative fee, unlike the office visit fee, must be eliminated if the child is unable to pay.³¹⁶

Section 317

The Section 317 Program, administered by CDC, was enacted in 1962 through the Vaccine Assistance Act, which added Section 317 to the Public Health Service Act,³¹⁷ and authorizes the federal purchase of vaccines to vaccinate children, adolescents, and adults.³¹⁸ Following recent

³¹¹ *Id.*

³¹² CDC, “VFC Eligibility Criteria,” Dec. 17, 2014, <http://www.cdc.gov/vaccines/programs/vfc/providers/eligibility.html>.

³¹³ CDC, “VFC Answers to Parents’ Questions,” Dec. 17, 2014, <http://www.cdc.gov/vaccines/programs/vfc/providers/questions/qa-parents.html>.

³¹⁴ *Id.*

³¹⁵ *Id.*

³¹⁶ *Id.*

³¹⁷ Title XXI of the Public Health Service Act (P.L. 99-660) (§2105) (42 U.S.C. § 300aa-5).

³¹⁸ CDC, “Questions Answered on Vaccines Purchased with 317 Funds,” Feb. 17, 2016, <http://www.cdc.gov/vaccines/imz-managers/guides-pubs/qa-317-funds.html>.

policy changes, Section 317 vaccines are not available to children, adolescents, and adults who have public or private insurance that covers vaccination.³¹⁹ However, Section 317 vaccines can be used to vaccinate:

- Newborns receiving the birth dose of hepatitis B prior to hospital discharge that are covered under bundled delivery or global delivery package (no routine services can be individually billed) that does not include hepatitis B vaccine;
- Fully-insured infants of hepatitis-B-infected women and the household or sexual contacts of hepatitis-B-infected individuals;
- Uninsured or underinsured adults; or
- Fully-insured individuals seeking vaccines during public health response activities including:
 - Outbreak response,
 - Post-exposure prophylaxis,
 - Disaster relief efforts,
 - Mass vaccination campaigns or exercises for public health preparedness, or
 - Individuals in correctional facilities and jails.³²⁰

Title V

Medicaid, CHIP, and Title V of the Social Security Act³²¹ serve many low-income women and children, including children with special health care needs.³²² Medicaid and CHIP provide free or low-cost health insurance to eligible participants.³²³ Title V provides federal block grant funds to states, where they are used to support comprehensive services to women and children with limited access to health care services.³²⁴ Title V complements Medicaid and CHIP by providing gap-filling services to enrollees, assisting in the identification of potentially eligible beneficiaries, and creating an infrastructure in communities to ensure that the capacity exists to support the delivery of quality health care services for women and children.³²⁵

Successful coordination of Title V with Medicaid and CHIP programs assists in maximizing federal, state, and local funds to meet the health care needs of low-income women and children.³²⁶ Federal statutes and regulations require coordination.³²⁷

³¹⁹ *Id.*

³²⁰ *Id.*

³²¹ 42 U.S.C. Subch. V.

³²² Health Res. & Servs. Admin., “Partnerships with State Medicaid and Children’s Health Insurance Program (CHIP),” <http://mchb.hrsa.gov/programs/collaboration/index.html>.

³²³ *Id.*

³²⁴ *Id.*

³²⁵ *Id.*

³²⁶ *Id.*

³²⁷ *Id.*

Effect of Funding on Vaccination Rates

Based on regression analysis comparing county-level insurance coverage rates and vaccination rates, the Work Group found no significant relationship between counties' uninsured population rates and youth vaccination rates.³²⁸ Therefore, based on the current information, the Work Group determined that financial reasons were likely not the basis for low vaccination rates in Pennsylvania. The Work Group noted, though, that continued support for the state and federal programs is essential to prevent financial barriers to vaccination from developing.

However, the Work Group was not able to determine whether parents and guardians of children in Pennsylvania know about the resources available to ensure that every child can receive the recommended vaccines; therefore, the Work Group recommends more information be gathered regarding parents' and guardians' reasons for not vaccinating their children. The Work Group also recommends that the Department of Education, the Department of Health, and the Department of Human Services implement or continue educational programs designed to inform parents and guardians of the resources available to ensure financial barriers do not prevent youth from receiving vaccinations.

As with annual influenza prevention, education and outreach programs are not the exclusive responsibility of government. Practitioners and insurers can and should be involved in the efforts to raise Pennsylvania's vaccination rates. Collaboration could also help address practical access issues, such as geographic barriers, that may be preventing children from receiving the recommended vaccines.

The Anti-Vaccination Movement

Vaccination is often considered one of the most important achievements of public health in the twentieth century, yet opposition to vaccination has existed as long as vaccination itself, and even to its precursor, variolation.³²⁹ Toward the end of the nineteenth century, smallpox outbreaks led to vaccine campaigns.³³⁰ The Anti Vaccination Society of America was founded in 1879 following a visit to the United States by a leading British anti-vaccinationist.³³¹ Two other leagues, the New England Anti Compulsory Vaccination League and the Anti-Vaccination League of New York City followed in 1882 and 1885, respectively.³³² American anti-vaccinationists fought to repeal vaccination laws in several states, including California, Illinois, and Wisconsin.³³³

³²⁸ Margaret Anne Robertson, MPH Candidate, Dep't of Health Policy and Mgmt., Ctr. for Pub. Health Practice, Univ. of Pittsburgh Graduate Sch. of Pub. Health, "Mandated Youth Vaccinations in Pennsylvania: An Analysis of Potential Financial Barriers," Oct. 2015, prepared for JSGC.

³²⁹ Coll. of Physicians of Phila., "History of Anti-Vaccination Movements," Jan. 25, 2016, <http://www.historyofvaccines.org/content/articles/history-anti-vaccination-movements>.

³³⁰ *Id.*

³³¹ *Id.*

³³² *Id.*

³³³ *Id.*

Following a smallpox outbreak in Cambridge, Massachusetts in 1902, the city's board of health mandated all residents to be vaccinated against smallpox.³³⁴ Henning Jacobson refused vaccination because the law violated his right to care for his own body.³³⁵ In response, the city filed criminal charges against him, and after losing his court battle locally, Jacobson appealed to the US Supreme Court.³³⁶ The US Supreme Court ruled in the state's favor, making clear that states have the authority to mandate vaccination.³³⁷

In the years following the *Jacobson* decision, anti-vaccinationists have attacked specific vaccines (such as DTP and MMR) and vaccination mandates generally.³³⁸ Their attacks have been based on sanitary, religious, scientific, and political objections.³³⁹ The anti-vaccination movement has had some very prominent members, especially in recent years, including television and movie stars, and has perhaps been facilitated by the internet and social media.

One major target of anti-vaccinationists was thimerosal, a mercury-containing compound used as a preservative in vaccines.³⁴⁰ The primary claim made by anti-vaccinationists was that thimerosal caused Autism Spectrum Disorder.³⁴¹ This claim has been studied and disproven.³⁴² Scientists have found no link between vaccines or vaccine ingredients, including thimerosal, and Autism Spectrum Disorder.³⁴³ As a precautionary measure, thimerosal has nevertheless been eliminated from all vaccines except for some annual influenza vaccine formulations.³⁴⁴

Another common claim made by anti-vaccinationists is the assertion that a child's immune system can be "overloaded" if the child receives multiple vaccines at once.³⁴⁵ However, children are given vaccines at a young age because this is when they are at the highest risk of getting sick or dying from vaccine-preventable diseases.³⁴⁶ Giving children several vaccines during the same office visit ensures that they are given protection as quickly as possible and reduces the number of office visits, saving time and money and reducing trauma.³⁴⁷ Administration of multiple vaccines has been thoroughly studied and has been found to be safe.³⁴⁸ Furthermore, each new vaccine is tested with the vaccines already recommended for a particular population to ensure no adverse interactions occur.³⁴⁹

³³⁴ *Id.*

³³⁵ *Id.*

³³⁶ *Id.*

³³⁷ *Id.*

³³⁸ *Id.*

³³⁹ *Id.*

³⁴⁰ *Id.*

³⁴¹ *Id.*

³⁴² CDC, "Vaccines Do Not Cause Autism," Nov. 23, 2015, <http://www.cdc.gov/vaccinesafety/concerns/autism.html>.

³⁴³ *Id.*

³⁴⁴ CDC, "Frequently Asked Questions about Thimerosal," Aug. 28, 2015, <http://www.cdc.gov/vaccinesafety/concerns/thimerosal/faqs.html>.

³⁴⁵ Coll. of Physicians of Phila., "Misconceptions About Vaccines," July 31, 2014, <http://www.historyofvaccines.org/content/articles/misconceptions-about-vaccines>.

³⁴⁶ CDC, "Multiple Vaccines and the Immune System," Oct. 27, 2015, <http://www.cdc.gov/vaccinesafety/concerns/multiple-vaccines-immunity.html>.

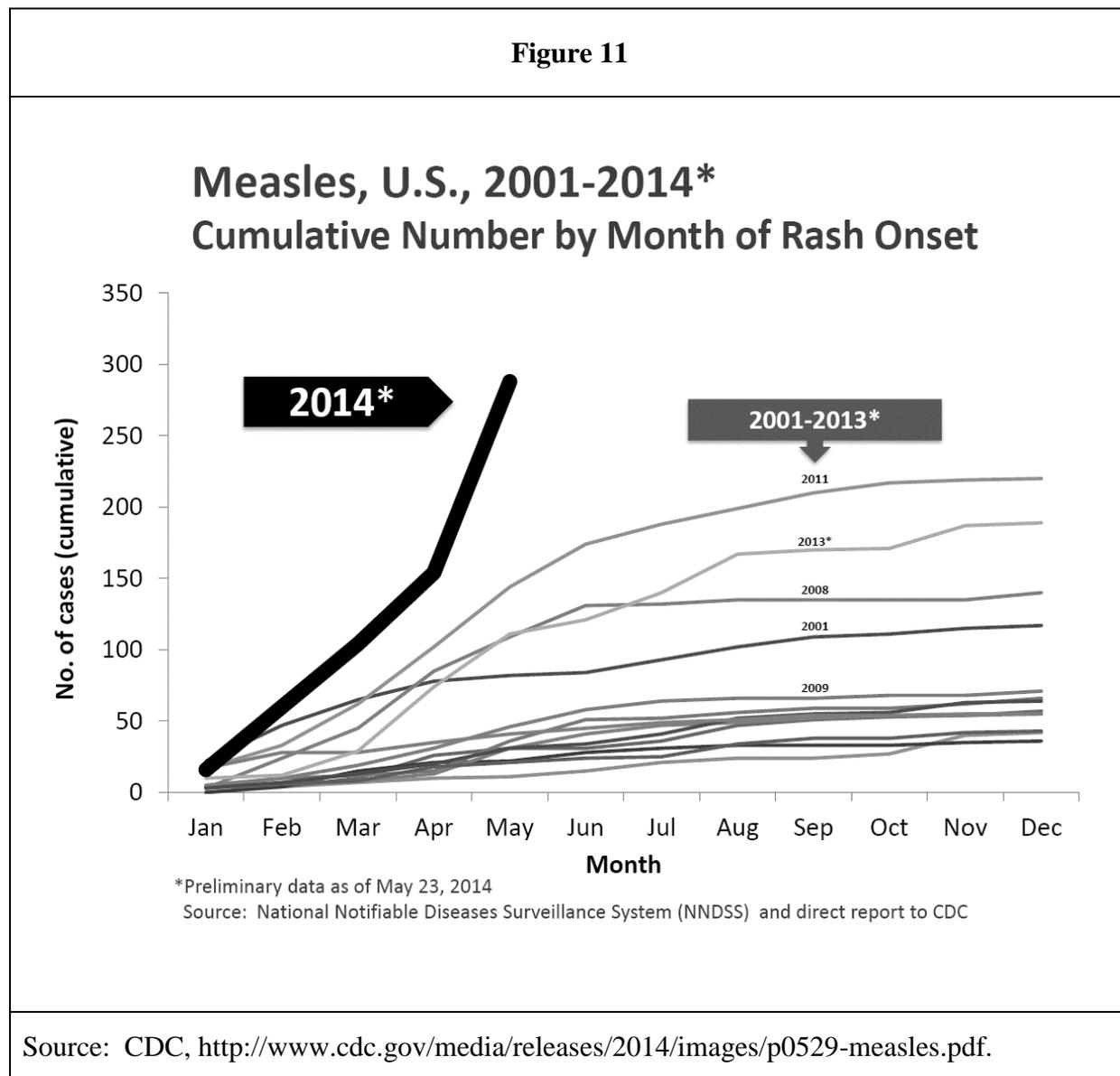
³⁴⁷ *Id.*

³⁴⁸ *Id.*

³⁴⁹ *Id.*

As a result of anti-vaccination movements, some previously eliminated or controlled vaccine-preventable diseases have reemerged. In 2000, the United States achieved elimination (defined as interruption of year-round endemic transmission) of measles, although importations of measles into the United States continued to occur.³⁵⁰ However, in early 2014, measles cases in the United States reached a 20-year high.³⁵¹ Ninety percent of those cases were in people who were not vaccinated or whose vaccination status was unknown.³⁵²

Figure 11



³⁵⁰ CDC, “Measles - United States, 2011,” *Morbidity and Mortality Weekly Report*, 61(15), Apr. 20, 2012, pp. 253-57, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6115a1.htm>.

³⁵¹ CDC, “Measles Cases in the United States Reach 20-year High,” May 29, 2014, <http://www.cdc.gov/media/releases/2014/p0529-measles.html>.

³⁵² *Id.*

In 2015, a six-year-old boy in Spain became the first person to contract diphtheria in that country since 1987.³⁵³ To treat the boy, anti-toxin had to be rushed in from Russia and France because it had not been prescribed in Spain for nearly 30 years.³⁵⁴ Following their son's diagnosis, the boy's parents allowed their younger daughter to be vaccinated.³⁵⁵ The parents reported feeling "tricked" by anti-vaccination groups they had admired.³⁵⁶

Because of the measles outbreak at Disneyland in January 2015, or because health campaigns have become more persuasive, or perhaps because schools are becoming stricter about enforcing vaccination requirements, California's vaccination rates in the fall of 2015 increased in 49 of 58 counties.³⁵⁷ For the 2015-16 school year, 92.9 percent of kindergartners met the vaccination requirements, which is an increase of 2.5 percentage points from the previous term.³⁵⁸

Researchers have tried to determine why people choose not to vaccinate. One study used the "Four C's" to describe the factors affecting the decision-making process.³⁵⁹ The four C's are complacency, convenience, confidence, and calculation.³⁶⁰ According to the authors:

- "*Complacency* 'exists where perceived risks of vaccine preventable diseases are low and vaccination is not deemed a necessary preventive action'";
- "*Convenience* is an issue when 'physical availability, affordability and willingness-to-pay, geographical accessibility, ability to understand (language and health literacy) and appeal of immunization service affect uptake'";
- "[*C*]onfidence 'is defined as trust in (i) the effectiveness and safety of vaccines, (ii) the system that delivers them, including the reliability and competence of the health services and health professionals, and (iii) the motivations of policy-makers who decide on the need of vaccines'"; and
- *Calculation* is the process in which parents "engage in an extensive information search for pros and cons of vaccination."³⁶¹

³⁵³ Jessica Mouzo Quintás, "Parents of Diphtheria-Stricken Boy Feel 'Tricked' by Anti-Vaccination Groups," *El País*, June 5, 2015, http://elpais.com/elpais/2015/06/05/inenglish/1433512717_575817.html.

³⁵⁴ *Id.*

³⁵⁵ *Id.*

³⁵⁶ *Id.*

³⁵⁷ Lisa Aliferis, "Childhood Vaccination Rates Climb in California," *NPR*, Jan. 21, 2016, <http://www.npr.org/sections/health-shots/2016/01/21/461395411/childhood-vaccination-rates-climb-in-california>.

³⁵⁸ *Id.*

³⁵⁹ Cornelia Betsch, Robert Böhm, & Gretchen B. Chapman, "Using Behavioral Insights to Increase Vaccination Policy Effectiveness," *Policy Insights from the Behavioral and Brain Sciences*, 2015, Vol. 2, No. 1, DOI: 10.1177/2372732215600716, pp. 61-73.

³⁶⁰ *Id.* at 64.

³⁶¹ *Id.* at 64.

Another recent study focusing on California found that philosophical exemptions are more common in areas with populations with a higher percentage of Caucasian residents and higher income.³⁶² Other studies have also shown that vaccine exemptions tend to cluster geographically, making some communities at greater risk for outbreaks.³⁶³

However, the Work Group did not have similar data available for review. The Work Group carefully reviewed data and materials throughout the course of this study, but on many occasions, the Work Group could only conclude that more information was needed, but was simply not available. The general trend of the recommendations in this report is that more data, both anecdotal and scientific, needs to be collected to answer the questions the Work Group and the Senate Resolution asked. The recommended improvements in data collection, verification, and reporting will likely help inform future policy decisions aimed at raising Pennsylvania's youth vaccination rates.

Recently Proposed Regulations

In November 2015, Secretary of Health Dr. Karen Murphy and Secretary of Education Pedro Rivera announced their intentions to change Pennsylvania's school immunization requirements.³⁶⁴ According to documents released by the departments answering frequently asked questions about the proposed regulations, the proposed regulations would:

- Add new defined terms to the regulations;
- Clarify existing vaccine requirements;
- Add a requirement for a meningococcal dose prior to entry into the twelfth grade;
- Change the method of providing evidence of immunity for measles, mumps, and rubella from accepting a statement of history by a parent or guardian to requiring a history of measles and rubella immunity proved by laboratory testing by a laboratory with the appropriate certification and a written statement of a history of mumps disease from a physician, nurse practitioner or physician's assistant;
- Change the method of providing evidence of immunity for varicella (chickenpox) from accepting a statement of a history of chickenpox disease from a parent or guardian to requiring a written statement of a history of chickenpox disease from a physician, nurse practitioner, or physician's assistant;
- Replace the eight month provisional admission period with the following:
 - Requiring exclusion from school attendance of a child who lacks a single dose of a single dose vaccine and/or the first dose of a multiple-dose vaccine;

³⁶² Y. Tony Yang, ScD, LLM, MPH, et al., "Sociodemographic Predictors of Vaccination Exemptions on the Basis of Personal Belief in California," *Am. J. Public Health*, Jan. 2016, Vol. 106, No. 1, DOI: 10.2105/AJPH.2015.302926, pp. 172-177.

³⁶³ CDC, "State Vaccination Requirements," Jan. 29, 2016, <http://www.cdc.gov/vaccines/imz-managers/laws/state-reqs.html>.

³⁶⁴ Pa. Dep't of Health & Pa. Dep't of Ed., "Departments of Health and Education Propose Changes to Pennsylvania's School Immunization Requirements," Nov. 5, 2015, <http://www.media.pa.gov/Pages/Health-Details.aspx?newsid=257>.

- Allowing a child that needs the next or final dose of a multiple-dose vaccine five school days to obtain the next or final dose in the series before being excluded from school attendance; or
- Allowing a child needing more than one dose of a multiple-dose vaccine series beyond the five days to attend school provisionally upon the submission of a medical certificate outlining the dates for additional vaccination.
- Requiring school administrators to review the medical certificate and the child's compliance at least every 30 days.
- Allowing school administrators to exclude a child who does not comply with the dates in the submitted medical certificate.
- Exempt from exclusion a child who is homeless;
- Exempt from exclusion for 30 days a child who is transferring from a school or country outside the Commonwealth and cannot provide records;
- Provide limited waiver of vaccine requirements in the event of a disaster impacting the ability of children transferring into a school to provide records, or a nationally recognized vaccine shortage;
- Change reporting times for schools to report kindergarten and seventh grade immunizations to allow schools more time to gather information and report; and
- Require schools to report electronically to obtain more accurate reporting.³⁶⁵

It is clear from the available information that many of the proposed changes align with the recommendations of the Work Group. These proposed regulations indicate an acknowledgement by the departments of many of the problems identified by the Work Group. The attempt to create solutions is promising.³⁶⁶

The proposed recommendations also indicate that the departments are working together to address the very serious problem of low vaccination rates in Pennsylvania. While the Department of Education is best suited to enforce the vaccination requirements in the schools, the Department of Health has the expertise to determine who should be vaccinated, against what they should be vaccinated, and when they should be vaccinated. Therefore, a coordinated approach is crucial to success.

³⁶⁵ Pa. Dep't of Health & Pa. Dep't of Ed., "Frequently Asked Questions: Proposed Revisions to School Immunization Regulations in Pennsylvania," Nov. 5, 2015, http://www.health.pa.gov/Your-Department-of-Health/Documents/FAQs_Proposed%20Changes%20to%20School%20Immunization%20Regs%20final.pdf.

³⁶⁶ The proposed regulations were published in the Pennsylvania Bulletin on April 9, 2016. The public comment period will close on May 9, 2016.

Other Issues for Future Consideration

The Work Group was tasked with studying youth vaccination in Pennsylvania. Based on its interpretation of the Senate Resolution, the available data, and the limited timeframe of the study, the Work Group focused on children in kindergarten through twelfth grade. However, the Work Group recognized that certain groups, such as school workers and health care workers, come into contact with the children addressed in this report but are not currently required to follow similar vaccination policies, potentially exposing children to vaccine-preventable diseases.

In addition, the Work Group identified numerous other issues over the course of the study that need to be addressed. Some of these issues include:

- Vaccination rates of children in child care settings, students in colleges and universities, and adults in hospitals, nursing facilities, long-term care facilities, and other settings;
- Authority to administer vaccines;
- Availability of vaccines to documented and undocumented immigrants, homeless people, other medically underserved populations, and medically underserved areas; and
- Medical consent for vaccines, especially for minors.

Because of the limitations of this study, the Work Group did not address these issues, but does intend to address them in the future as part of the ongoing Senate Resolution No. 194 project.

APPENDIX A

Public School Code of 1949 § 1303	57
College and University Student Vaccination Act	59
22 PA Code §§ 11.20, 51.13, 405.49	61
28 PA Code §§ 23.81-87, 27.77	65

PUBLIC SCHOOL CODE OF 1949
Act of Mar. 10, 1949, P.L. 30, No. 14 Cl. 24

AN ACT

Relating to the public school system, including certain provisions applicable as well to private and parochial schools; amending, revising, consolidating and changing the laws relating thereto.

ARTICLE XIII. PUPILS AND ATTENDANCE.

(a) Attendance.

Section 1303. Immunization Required; Penalty.—

(a) It shall be the duty of all school directors, superintendents, principals, or other persons in charge of any public, private, parochial, or other school including kindergarten, to ascertain that every child, prior to admission to school for the first time has been immunized, as the Secretary of Health may direct, against such diseases as shall appear on a list to be made and from time to time reviewed by the Advisory Health Board. All certificates of immunization shall be issued in accordance with the rules and regulations promulgated by the Secretary of Health with the sanction and advice of the Advisory Health Board.

(b) Any person who shall fail, neglect, or refuse to comply with, or who shall violate, any of the provisions or requirements of this section, except as hereinafter provided, shall, for every such offense, upon summary conviction thereof, be sentenced to pay a fine of not less than five dollars (\$5) nor more than one hundred dollars (\$100), and in default thereof, to undergo an imprisonment in the jail of the proper county for a period not exceeding sixty (60) days. All such fines shall be paid into the treasury of the school district.

(c) The provisions of this section shall not apply in the case of any child deemed to have a medical contraindication which may contraindicate immunization and so certified by a physician. Such certificates may be accepted in lieu of a certificate of immunization.

(d) The provisions of this section shall not apply in the case of any child whose parent or guardian objects in writing to such immunization on religious grounds.

(1303 added Apr. 11, 1974, P.L.258, No.67)

COLLEGE AND UNIVERSITY STUDENT VACCINATION ACT
Act of Jun. 28, 2002, P.L. 492, No. 83 Cl. 24

AN ACT

Providing for vaccination against meningococcal disease for students at institutions of higher education.

General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short title.

This act shall be known and may be cited as the College and University Student Vaccination Act.

Section 2. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Branch campus." A branch campus is a unit of an institution of higher education which is distinguished by all of the following characteristics:

(1) An academic degree-granting program or organized parts thereof offered on a continuing basis.

(2) Location separately identifiable from the main campus of the parent institution and providing the services normally associated with the campus.

(3) Legal authority for governance, administration and general operation derived from the charter or enabling legislation of the parent institution or of the State System of Higher Education.

"Community colleges." Institutions now or hereafter created pursuant to Article XIX-A of the act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, or the act of August 24, 1963 (P.L.1132, No.484), known as the Community College Act of 1963.

"Dormitory or housing unit." A building owned by an institution of higher education which is used as a residence by students of the institution.

"Independent institution of higher education." An institution of higher education which is operated not for profit, located in and incorporated or chartered by the Commonwealth, entitled to confer degrees and apply to itself the designation "college" or "university" as provided for by standards and qualifications prescribed by the State Board of Education under 24 Pa.C.S. Ch. 65 (relating to private colleges, universities and seminaries).

"Institution of higher education." An independent institution of higher education, a community college, a State-owned institution or a State-related institution, any of which is approved by the Department of Education.

"State-owned institutions." Those institutions which are part of the State System of Higher Education pursuant to Article XX-A of the act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949.

"State-related institutions." The Pennsylvania State University, the University of Pittsburgh, Temple University and Lincoln University and their branch campuses.

Section 3. Vaccination requirement.

(a) General rule.--Except as provided in subsection (b), an institution of higher education shall prohibit a student from residing in a dormitory or housing unit unless the student has received a one-time vaccination against meningococcal disease. If the student is a minor, the vaccination may only be administered with the consent of the student's parent or guardian.

(b) Exception.--An institution of higher education shall permit a student to reside in a dormitory or housing unit without being vaccinated for religious or other reasons against meningococcal disease if the institution provides detailed information on the risks associated with meningococcal disease and the availability and the effectiveness of any vaccine to:

(1) The student, if the student is 18 years of age or older and the student signs a written waiver stating that the student has received and reviewed the information provided and has chosen not to be vaccinated for religious or other reasons against meningococcal disease.

(2) The student's parent or guardian, if the student is a minor and the student's parent or guardian signs a written waiver stating that the parent or guardian has received and reviewed the information provided and has chosen not to have the student vaccinated for religious or other reasons against meningococcal disease.

(c) Construction.--Nothing in this section shall be construed to require an institution of higher education to provide or pay for vaccinations against meningococcal disease. An institution is only responsible for the dissemination of information and documentation of vaccination or collection of waiver forms.

Section 4. Effective date.

This act shall take effect in 60 days.

THE PENNSYLVANIA CODE

TITLE 22. EDUCATION

PART I. STATE BOARD OF EDUCATION

SUBPART A. MISCELLANEOUS PROVISIONS

CHAPTER 11. STUDENT ATTENDANCE

ADMISSION TO PUBLIC SCHOOLS

§ 11.20. Nonimmunized children.

(a) A child may not be admitted to or permitted to attend a public, private, nonpublic, special education or vocational school in a district unless the immunization, exemption or provisional admission requirements of the Department of Health, at 28 Pa. Code Chapter 23, Subchapter C (relating to immunization), have been met or the child has received from the chief school administrator of the public, private, nonpublic, special education or vocational school a medical or religious exemption from immunization under 28 Pa. Code § 23.84 (relating to exemption from immunization).

(b) A child who has not received all doses of the required immunizations or who has not been exempted from immunization, but who has received at least one dose of each of the required immunizations, may be provisionally admitted and attend public school for a period of up to 8 months. Provisional admission or continued attendance shall be conditioned upon the parent or guardian's submission to the superintendent of a plan for the student's completion of the required immunization doses. The plan shall be reviewed by the school district at least every 60 calendar days. If, after 8 months, the child has not received all doses of the required immunizations, the child thereafter may not be further admitted to or be permitted to attend the public schools until all doses have been received.

(c) A child who has been admitted to school or permitted attendance in violation of this section may not be counted toward receipt of Commonwealth reimbursement for the period of the admission or attendance.

Authority

The provisions of this § 11.20 issued under section 1317(a) of The Administrative Code of 1929 (71 P. S. § 367(a) (Repealed)); and sections 1327, 1330, 1372 and 1511 of the Public School Code of 1949 (24 P. S. § § 13-1327, 13-1330, 13-1372 and 15-1511); amended under section 2603-B of the Public School Code of 1949 (24 P. S. § 26-2603-B).

Source

The provisions of this § 11.20 adopted December 19, 1986, effective December 20, 1986, 16 Pa.B. 4874; amended October 22, 2004, effective October 23, 2004, 34 Pa.B. 5798. Immediately preceding text appears at serial pages (279552) and (244457).

THE PENNSYLVANIA CODE

TITLE 22. EDUCATION

PART II. STATE BOARD OF PRIVATE ACADEMIC SCHOOLS

CHAPTER 51. GENERAL PROVISIONS

HEALTH AND SAFETY

§ 51.13. Immunization.

(a) No child in grades K through 12 may be admitted to or permitted to attend a private school unless the child has received immunizations required by 28 Pa. Code Chapter 23 Subchapter C (relating to immunization) or has received from the director a medical or religious exemption from immunization under 28 Pa. Code § 23.84 (relating to exemption from immunization).

(b) A child who has not received all doses of the required immunizations or who has not been exempted from immunization, but who has received at least one dose of each of the required immunizations, may be provisionally admitted and attend private school for a period of up to 8 months. Provisional admission or continued attendance shall be conditional upon the parent's or guardian's submission to the director of a plan for the pupil's completion of the required immunization doses. The plan shall be reviewed by the school at least every 60 calendar days. If after 8 months, the child has not received all doses of the required immunizations, the child thereafter may not be further admitted to or be permitted to attend the private school until all doses have been received.

Authority

The provisions of this § 51.13 amended under the Private Academic Schools Act (24 P. S. § § 6701—6721).

Source

The provisions of this § 51.13 adopted June 11, 1968, effective June 26, 1969; amended October 22, 1976, effective October 23, 1976, 6 Pa.B. 2665; amended August 19, 1988, effective August 20, 1988, 18 Pa.B. 3687. Immediately preceding text appears at serial page (30535).

THE PENNSYLVANIA CODE

TITLE 22. EDUCATION

PART XVI. STANDARDS

CHAPTER 405. PA PRE-K COUNTS

PROGRAM AND CLASSROOM REQUIREMENTS

§ 405.49. Immunizations.

Approved providers shall meet the immunization requirements that pertain to their provider type; for school districts and licensed nursery schools see 28 Pa. Code § § 23.81—23.87 (relating to immunization); for child care centers and group child care homes see 28 Pa. Code § 27.77 (relating to immunization requirements for children in child care group settings); and for Head Start agencies see 45 CFR 1304.20 (relating to child health and development services), the Federal Head Start Performance Standards.

THE PENNSYLVANIA CODE
TITLE 28. HEALTH AND SAFETY
PART III. PREVENTION OF DISEASES
CHAPTER 23. SCHOOL HEALTH
SUBCHAPTER C. IMMUNIZATION

Sec.

- 23.81. Purpose and scope.
- 23.82. Definitions.
- 23.83. Immunization requirements.
- 23.84. Exemption from immunization.
- 23.85. Responsibilities of schools and school administrators.
- 23.86. School reporting.
- 23.87. Responsibilities of the Department.

Authority

The provisions of this Subchapter C issued under the Disease Prevention and Control Law of 1955 (35 P. S. § § 521.1—521.21); act of April 11, 1974 (P. L. 257, No. 66) (71 P. S. § 541(c.1)); and section 1303a of the Public School Code of 1949 (24 P. S. § 13-1303a); amended under section 1303a of the Public School Code of 1949 (24 P. S. § 13-1303a); section 16(a)(6) and (7) of the Disease Prevention and Control Law of 1955 (35 P. S. § 521.16(a)(6) and (7)); section 2111(c.1) of The Administrative Code of 1929 (71 P. S. § 541(c.1)); and Hepatitis B Prevention Act (35 P. S. § § 630.1—630.3), unless otherwise noted.

Source

The provisions of this Subchapter C adopted August 2, 1974, effective August 3, 1974, 4 Pa.B. 1626, unless otherwise noted.

Cross References

This subchapter cited in 22 Pa. Code § 11.20 (relating to nonimmunized children); and 22 Pa. Code § 51.13 (relating to immunization).

§ 23.81. Purpose and scope.

This subchapter has been promulgated to insure that school children are immunized against diseases which spread easily in schools and interrupt school life and learning for individuals and groups. This subchapter affects public, private and parochial schools, including kindergartens, special education classes, home education programs and vocational classes in this Commonwealth.

Source

The provisions of this § 23.81 amended through September 17, 1982, effective August 1, 1983, 12 Pa.B. 3288; amended August 22, 1997, effective August 23, 1997, 27 Pa.B. 4317. Immediately preceding text appears at serial page (164331).

Cross References

This section cited in 22 Pa. Code § 405.49 (relating to immunizations); and 28 Pa. Code § 27.77 (relating to immunization requirements for children in child care group settings).

§ 23.82. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

Ascertain—To determine whether or not a child is immunized as defined in this subchapter.

Attendance at school—

(i) The attendance at a grade, or special classes, kindergarten through 12th grade, including public, private, parochial, vocational, intermediate unit and home education students and students of cyber and charter schools.

(ii) The term does not cover the attendance of children at a childcare group setting, defined in § 27.1 (relating to definitions), located in a public, private, or vocational school, or in an intermediate unit.

Certificate of immunization—The official form furnished by the Department. The certificate is filled out by the parent or health care provider and signed by the health care provider, public health official or school nurse or a designee. The certificate is given to the school as proof of immunization. The school maintains the certificate as the official school immunization record or stores the details of the record in a computer data base.

Department—The Department of Health of the Commonwealth.

Immunization—The requisite number of dosages of the specific antigens at the recommended time intervals under this subchapter.

Record of immunization—A written document showing the date of immunization—that is, baby book, Health Passport, family Bible, other states' official immunization documents, International Health Certificate, immigration records, physician record, school health records and other similar documents or history.

Secretary—The Secretary of the Department.

Authority

The provisions of this § 23.82 amended under section 1303 of the Public School Code of 1949 (24 P. S. § 13-1303); section 16(b) of the Disease Prevention and Control Law of 1955 (35 P. S. § 521.16(b)); and section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)).

Source

The provisions of this § 23.82 amended through September 17, 1982, effective August 1, 1983, 12 Pa.B. 3288; amended August 22, 1997, effective August 23, 1997, 27 Pa.B. 4317; amended May 28, 2010, effective August 1, 2011, 40 Pa.B. 2747. Immediately preceding text appears at serial page (315784).

Cross References

This section cited in 22 Pa. Code § 405.49 (relating to immunizations); and 28 Pa. Code § 27.77 (relating to immunization requirements for children in child care group settings).

§ 23.83. Immunization requirements.

(a) Duties of a school director, superintendent, principal or other person in charge of a public, private, parochial or nonpublic school. Each school director, superintendent, principal, or other person in charge of a public, private, parochial or nonpublic school in this Commonwealth, including vocational schools, intermediate units, and special education and home education programs, cyber and charter schools, shall ascertain that a child has been immunized in accordance with the requirements in subsections (b), (c) and (e) prior to admission to school for the first time, under section 1303 of the Public School Code of 1949 (24 P. S. § 13-1303a) regarding immunization required; penalty.

(b) Required for attendance. The following immunizations are required as a condition of attendance at school in this Commonwealth:

(1) Diphtheria. Four or more properly-spaced doses of diphtheria toxoid, which may be administered as a single antigen vaccine or in a combination form. The fourth dose shall be administered on or after the 4th birthday.

(2) Tetanus. Four or more properly-spaced doses of tetanus toxoid, which may be administered as a single antigen vaccine or in a combination form. The fourth dose shall be administered on or after the 4th birthday.

(3) Poliomyelitis. Three or more properly spaced doses of either oral polio vaccine or enhanced activated polio vaccine, which may be administered as a single antigen vaccine, or in a combination form. If a child received any doses of inactivated polio vaccine administered prior to 1988, a fourth dose of inactivated polio vaccine is required.

(4) Measles (rubeola). Two properly-spaced doses of live attenuated measles vaccine, the first dose administered at 12 months of age or older, or a history of measles immunity proved by laboratory testing by a laboratory with the appropriate certification. Each dose of measles vaccine may be administered as a single antigen vaccine or in a combination form.

(5) German measles (rubella). One dose of live attenuated rubella vaccine, administered at 12 months of age or older or a history of rubella immunity proved by laboratory testing by a laboratory with the appropriate certification. Rubella vaccine may be administered as a single antigen vaccine or in a combination form.

(6) Mumps. Two properly-spaced doses of live attenuated mumps vaccine, administered at 12 months of age or older or a physician diagnosis of mumps disease indicated by a written record signed by the physician or the physician's designee. Mumps vaccine may be administered as a single antigen vaccine or in a combination form.

(7) Hepatitis B. Three properly-spaced doses of hepatitis B vaccine, unless a child receives a vaccine as approved by the Food and Drug Administration for a two-dose regimen, or a history of hepatitis B immunity proved by laboratory testing. Hepatitis B vaccine may be administered as single antigen vaccine or in a combination form.

(8) Chickenpox (varicella). One of the following:

(i) Varicella vaccine. Two properly-spaced doses of varicella vaccine, the first dose administered at 12 months of age or older. Varicella vaccine may be administered as a single antigen vaccine or in a combination form.

(ii) Evidence of immunity. Evidence of immunity may be shown by one of the following:

(A) Laboratory evidence of immunity or laboratory confirmation of disease.

(B) A written statement of a history of chickenpox disease from a parent, guardian or physician.

(c) Required for entry into 7th grade. In addition to the immunizations listed in subsection (b), the following immunizations are required at any public, private, parochial or nonpublic school in this Commonwealth, including vocational schools, intermediate unit, special education and home education programs, and cyber and charter schools as a condition of entry for students entering the 7th grade; or, in an ungraded class, for students in the school year that the student is 12 years of age:

(1) Tetanus and diphtheria toxoid and acellular pertussis vaccine (TdaP). One dose if at least 5 years have elapsed since the last dose of a vaccine containing tetanus and diphtheria as required in subsection (b). TdaP may be administered as a single antigen vaccine or in a combination form.

(2) Meningococcal Conjugate Vaccine (MCV). One dose of Meningococcal Conjugate Vaccine. MCV may be administered as a single antigen vaccine or in a combination form.

(d) Child care group setting. Attendance at a child care group setting located in a public, private or vocational school, or in an intermediate unit is conditional upon the child's satisfaction of the immunization requirements in § 27.77 (relating to immunization requirements for children in child care group settings).

(e) Prekindergarten programs, Early Intervention programs' early childhood special education classrooms and private academic preschools. Attendance at a prekindergarten program operated by a school district, an early intervention program operated by a contractor or subcontractor including intermediate units, school districts and private vendors, or at private academic preschools is conditional upon the child's satisfaction of the immunization requirements in § 27.77.

(f) Grace period. A vaccine dose administered within the 4-day period prior to the minimum age for the vaccination or prior to the end of the minimum interval between doses shall be considered to be a valid dose of the vaccine for purposes of this chapter. A dose administered greater than 4 days prior to minimum age or interval for a dose is invalid for purposes of this regulation and shall be repeated.

Authority

The provisions of this § 23.83 amended under section 1303 of the Public School Code of 1949 (24 P. S. § 13-1303); section 16(b) of the Disease Prevention and Control Law of 1955 (35 P. S. § 521.16(b)); and section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)).

Source

The provisions of this § 23.83 amended through September 17, 1982, effective August 1, 1983, 12 Pa.B. 3288; amended August 22, 1997, effective August 23, 1997, 27 Pa.B. 4317; amended September 28, 2001, effective September 29, 2001, 31 Pa.B. 5525; amended May 28, 2010, effective August 1, 2011, 40 Pa.B. 2747. Immediately preceding text appears at serial pages (315784) and (287119) to (287120).

Cross References

This section cited in 22 Pa. Code § 405.49 (relating to immunizations); 28 Pa. Code § 23.85 (relating to responsibilities of schools and school administrators); and 28 Pa. Code § 27.77 (relating to immunization requirements for children in child care group settings).

§ 23.84. Exemption from immunization.

(a) Medical exemption. Children need not be immunized if a physician or the physician's designee provides a written statement that immunization may be detrimental to the health of the child. When the physician determines that immunization is no longer detrimental to the health of the child, the child shall be immunized according to this subchapter.

(b) Religious exemption. Children need not be immunized if the parent, guardian or emancipated child objects in writing to the immunization on religious grounds or on the basis of a strong moral or ethical conviction similar to a religious belief.

Source

The provisions of this § 23.84 amended through September 17, 1982, effective August 1, 1983, 12 Pa.B. 3288; amended August 22, 1997, effective August 23, 1997, 27 Pa.B. 4317. Immediately preceding text appears at serial pages (164332) to (164333) and (129145).

Cross References

This section cited in 22 Pa. Code § 11.20 (relating to nonimmunized children); 22 Pa. Code § 51.13 (relating to immunization); 22 Pa. Code § 405.49 (relating to immunizations); 28 Pa. Code § 23.85 (relating to responsibilities of schools and school administrators); and 28 Pa. Code § 27.77 (relating to immunization requirements for children in child care group settings).

§ 23.85. Responsibilities of schools and school administrators.

(a) The administrator in charge of a school shall appoint a knowledgeable person to perform the following:

(1) Inform the parent, guardian or emancipated child at registration or prior to registration, if possible, of the requirements of this subchapter.

(2) Ascertain the immunization status of a child prior to admission to school or continued attendance at school.

(i) The parent, guardian or emancipated child shall be asked for a completed certificate of immunization.

(ii) In the absence of a certificate of immunization, the parent, guardian or emancipated child shall be asked for a record or history of immunization which indicates the month, day and year that immunizations were given. This information shall be recorded on the certificate of immunization and signed by the school official or the official's designee, or the details of the record shall be stored in a computer database.

(b) If the knowledgeable person designated by the school administrator is unable to ascertain whether a child has received the immunizations required under § 23.83 (relating to immunization requirements) or under subsection (e) or is exempt under § 23.84 (relating to exemption for immunization), the school administrator may admit the child to school or allow the child's continued attendance at school only according to the requirements of subsections (d) and (e).

(c) The parent or guardian of a child or the emancipated child who has not received the immunizations required under § 23.83 shall be informed of the specific immunizations required and advised to go to the child's usual source of care or nearest public clinic to obtain the required immunizations.

(d) A child not previously admitted to or not allowed to continue attendance at school because the child has not had the required immunizations shall be admitted to or permitted to continue attendance at school only upon presentation to the school administrator or school administrator's

designee of a completed certificate of immunization or immunization record, upon submission of information sufficient for an exemption under § 23.84, or upon compliance with subsection (e).

(e) Provisional admittance to school.

(1) Multiple dose vaccine series. If a child has not received all the antigens for a multiple dose vaccine series described in § 23.83, the child may be provisionally admitted to school only if evidence of the administration of at least one dose of each antigen described in § 23.83 for multiple dose vaccine series is given to the school administrator or the administrator's designee and the parent or guardian's plan for completion of the required immunizations is made part of the child's health record.

(2) Single dose vaccines. If a child has not received a vaccine for which only a single dose is required, the child may be provisionally admitted to school if the parent or guardian's plan for obtaining the required immunization is made a part of the child's health record.

(3) Completion of required immunizations. The plan for completion of the required immunizations shall be reviewed every 60 days by the school administrator or the school administrator's designee. Subsequent immunizations shall be entered on the certificate of immunization or entered in the school's computer database. Immunization requirements described in § 23.83 shall be completed within 8 months of the date of provisional admission to school. If the requirements are not met, the school administrator may not admit the child to school or permit continued attendance after that 8 month provisional period.

(f) A school shall maintain on file a certificate of immunization for a child enrolled. An alternative to maintaining a certificate on file is to transfer the immunization information from the certificate to a computer database. The certificate of immunization or a facsimile thereof generated by computer shall be returned to the parent, guardian or emancipated child or the school shall transfer the certificate of immunization (or facsimile) with the child's record to the new school when a child withdraws, transfers, is promoted, graduates or otherwise leaves the school.

Authority

The provisions of this § 23.85 amended under section 1303 of the Public School Code of 1949 (24 P. S. § 13-1303); section 16(b) of the Disease Prevention and Control Law of 1955 (35 P. S. § 521.16(b)); and section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)).

Source

The provisions of this § 23.85 amended through September 17, 1982, effective August 1, 1983, 12 Pa.B. 3288; amended August 22, 1997, effective August 23, 1997, 27 Pa.B. 4317; amended May 28, 2010, effective August 1, 2011, 40 Pa.B. 2747. Immediately preceding text appears at serial pages (287121) to (287122).

Cross References

This section cited in 22 Pa. Code § 405.49 (relating to immunizations); and 28 Pa. Code § 27.77 (relating to immunization requirements for children in child care group settings).

§ 23.86. School reporting.

(a) A public, private, parochial or nonpublic school in this Commonwealth, including vocational schools, intermediate units, special education and home education programs and cyber and charter schools, shall report immunization data to the Department by October 15 of each year, using forms provided by the Department.

(b) The school administrator or the administrator's designee shall forward the reports to the Department as indicated on the reporting form provided by the Department.

(c) Duplicate reports shall be submitted to the county health department if the school is located in a county with a full-time health department.

(d) The school administrator or the administrator's designee shall ensure that the school's identification information, including the name of the school, school district, county and school address, is correct, and shall make any necessary corrections, prior to submitting the report.

(e) Content of the reports must include the following information:

(1) The month, day and year of the report.

(2) The number of students attending school in each grade-level, or in an ungraded school in each age group, as indicated on the reporting form.

(3) The number of doses of each individual antigen given in each grade-level, or in an ungraded school, in each age group, as indicated on the reporting form.

(4) The number of students attending school who were classed as medical exemptions in each grade-level, or in an ungraded school, in each age group, as indicated on the reporting form.

(5) The number of students attending school who were classed as religious exemptions in each grade level, or in an ungraded school, in each age group, as indicated on the reporting form.

(6) The number of students provisionally admitted in each grade level or, in an ungraded school, in any age group as indicated on the reporting form.

(7) The number of students in each grade level who were denied admission because of the student's inability to qualify for provisional admission or, in an ungraded school, in each age group as indicated on the reporting form.

(8) Other information as required by the Department.

Authority

The provisions of this § 23.86 amended under section 1303 of the Public School Code of 1949 (24 P. S. § 13-1303); section 16(b) of the Disease Prevention and Control Law of 1955 (35 P. S. § 521.16(b)); and section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)).

Source

The provisions of this § 23.86 amended through September 17, 1982, effective August 1, 1983, 12 Pa.B. 3288; amended January 23, 1987, effective January 24, 1987, 17 Pa.B. 375; amended August 22, 1997, effective August 23, 1997, 27 Pa.B. 4317; amended May 28, 2010, effective August 1, 2011, 40 Pa.B. 2747. Immediately preceding text appears at serial pages (287122) to (287123).

Cross References

This section cited in 22 Pa. Code § 405.49 (relating to immunizations); and 28 Pa. Code § 27.77 (relating to immunization requirements for children in child care group settings).

§ 23.87. Responsibilities of the Department.

(a) The Department will provide the certificates of immunization to schools.

(b) The Department will monitor school districts for compliance with this subchapter and shall have access to school immunization records whether the records are maintained as certificates or whether the records are contained in a school's computer database.

(c) Questions concerning this subchapter should be addressed to the Immunization Program, Bureau of Communicable Diseases, 625 Forester St., Room 1026, Harrisburg, Pennsylvania 17120, (717) 787-5681.

Source

The provisions of this § 23.87 amended through September 17, 1982, effective August 1, 1983, 12 Pa.B. 3288; amended August 22, 1997, effective August 23, 1997, 27 Pa.B. 4317. Immediately preceding text appears at serial page (116439).

Cross References

This section cited in 22 Pa. Code § 405.49 (relating to immunizations); and 28 Pa. Code § 27.77 (relating to immunization requirements for children in child care group settings).

THE PENNSYLVANIA CODE

TITLE 28. HEALTH AND SAFETY

PART III. PREVENTION OF DISEASES

CHAPTER 27. COMMUNICABLE AND NONCOMMUNICABLE DISEASES

SUBCHAPTER C. QUARANTINE AND ISOLATION

**COMMUNICABLE DISEASES IN CHILDREN AND STAFF ATTENDING SCHOOLS
AND CHILD CARE GROUP SETTINGS**

§ 27.77. Immunization requirements for children in child care group settings.

(a) Caregiver responsibilities.

(1) Except as exempted in subsection (d), effective March 27, 2002, the caregiver at a child care group setting may not accept or retain a child 2 months of age or older at the setting, for more than 60 days, unless the caregiver has received a written objection to a child being vaccinated on religious grounds from a parent or guardian, or one of the following:

(i) For all children not exempt under subsection (d)(1)(ii), an initial written verification from a physician, the Department or a local health department of the dates (month, day and year) the child was administered any vaccines recommended by ACIP. The verification must also specify any vaccination not given due to medical condition of the child and state whether the condition is temporary or permanent. The verification must show compliance with the vaccination requirements in subsection (b).

(ii) For all children for whom vaccinations remain outstanding following the caregiver's receipt of the initial written verification, subsequent written verifications from a physician, the Department or a local health department as additional vaccinations become due. These verifications shall be prepared in the same manner as set forth in subparagraph (i), but need not repeat information contained in a previously submitted verification. The verifications must demonstrate continuing compliance with the vaccination requirements in subsection (b).

(2) If the caregiver receives a written verification under paragraph (1) explaining that timely vaccination did not occur due to a temporary medical condition, the caregiver shall exclude the child from the child care group setting after an additional 30 days unless the caregiver receives, within that 30-day period, written verification from a physician, the Department or a local health department that the child was vaccinated or that the temporary medical condition still exists. If the caregiver receives a written verification that vaccination has not occurred because the temporary condition persists, the caregiver shall require the presentation of a new verification at 30-day intervals. If a verification is not received as required, the caregiver shall exclude the child from the child care group setting and not readmit the child until the caregiver receives a verification that meets the requirements of this section.

(3) The caregiver shall retain the written verification or objection referenced in paragraphs (1) and (2) for 60 days following the termination of the child's attendance.

(4) The caregiver shall ensure that a certificate of immunization is completed and signed for each child enrolled in the child care group setting. The certificates shall be updated by the caregiver to include the information provided to the caregiver under subsection (a) when that additional information is received. The immunization status of each enrolled child shall be summarized and reported on an annual basis to the Department at the time prescribed by the Department and on the form provided by the Department.

(b) Vaccination requirements. Each child enrolled in a child care group setting shall be immunized in accordance with ACIP standards in effect on January 1, 1999, governing the issuance of ACIP recommendations for the immunization of children.

(1) The standards are as follows:

(i) The immunization practice is supported by both published and unpublished scientific literature as a means to address the morbidity and mortality of the disease.

(ii) The labeling and packaging inserts for the immunizing agent are considered.

(iii) The immunizing agent is safe and effective.

(iv) The schedule for use of the immunizing agent is administratively feasible.

(2) The Department will deem an ACIP recommendation pertaining to the immunization of children to satisfy the standards in this subsection unless ACIP alters its standards for recommending immunizations for children by eliminating a standard set forth in this subsection and the recommendation is issued under those changed standards.

(c) Notice. The Department will place a notice in the Pennsylvania Bulletin listing publications containing ACIP recommendations issued under the standards in subsection (b). The Department published the initial notice at 32 Pa.B. 539 (January 26, 2002), contemporaneously with the adoption of amendments to this chapter. The Department will update that list in a notice which it will publish in the Pennsylvania Bulletin within 30 days after ACIP issues a recommendation which satisfies the criteria of this section.

(d) Exemptions.

(1) This section does not apply to the following:

(i) Children attending kindergarten, elementary school or higher school who are 5 years of age or older. These caregivers shall comply with § § 23.81—23.87 (relating to immunization).

(ii) A caregiver who does not serve as a caregiver for at least 40 hours during at least 1 month.

(2) The requirement imposed by subsection (a), to not accept a child into a child care group setting without receiving an initial written verification or objection specified in subsection (a), does not apply during a month the caregiver does not serve as a caregiver for at least 40 hours.

(e) Exclusion when disease is present. Whenever one of the diseases in § 27.76 (relating to exclusion and readmission of children, and staff having contact with children, in child care group settings) has been identified within a child care group setting, the Department or a local health department may order the exclusion from the child care group setting or any other child care group setting which is determined to be at high-risk of transmission of that disease, of an individual susceptible to that disease in accordance with public health standards as determined by the Department.

Authority

The provisions of this § 27.77 amended under section 1303 of the Public School Code of 1949 (24 P. S. § 13-1303); section 16(b) of the Disease Prevention and Control Law of 1955 (35 P. S. § 521.16(b)); and section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)).

Source

The provisions of this § 27.77 adopted January 25, 2002, effective January 26, 2002, 32 Pa.B. 491; amended May 28, 2010, effective August 1, 2011, 40 Pa.B. 2747. Immediately preceding text appears at serial pages (287157) to (287158) and (334685).

Cross References

This section cited in 22 Pa. Code § 405.49 (relating to immunizations); 28 Pa. Code § 23.83 (relating to immunization requirements); 55 Pa. Code § 3270.131 (relating to health information); 55 Pa. Code § 3280.131 (relating to health information); and 55 Pa. Code § 3290.131 (relating to health information).

APPENDIX B

Senate Resolution No. 27 of 2015	79
Senate Resolution No 194 of 2007	81

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE RESOLUTION

No. 27 Session of 2015

INTRODUCED BY KITCHEN, FARNESE, VANCE, YUDICHAK, GREENLEAF,
BREWSTER, HAYWOOD AND RAFFERTY, FEBRUARY 20, 2015

SENATOR VANCE, PUBLIC HEALTH AND WELFARE, AS AMENDED,
FEBRUARY 25, 2015

A RESOLUTION

1 Directing the Advisory Committee on Public Health Law of the
2 Joint State Government Commission to study the issue of youth
3 vaccinations and immunizations to determine whether any
4 amendments should be made to the Commonwealth's public health
5 law.

6 WHEREAS, Senate Resolution 194 of the 2007 session, adopted
7 January 16, 2008, directed the Joint State Government Commission
8 to establish a legislative task force and advisory committee to
9 review, update and codify the Commonwealth's public health law;
10 and

11 WHEREAS, The advisory committee has published reports
12 concerning public health laws generally and the topic of disease
13 control measures; and

14 WHEREAS, The advisory committee formed subcommittees
15 concerning behavioral health and addiction services, data,
16 disease control measures, disease prevention and health
17 promotion and the public health system; and

18 WHEREAS, The advisory committee is continuing to review the
19 foregoing topics and other topics such as food and drug laws,

1 the safety of medical supplies and laboratories, occupational
2 health, environmental health, consumer product safety, animal
3 safety, safe and sanitary housing and the safety of public
4 accommodations; therefore be it

5 RESOLVED, That the Senate direct the Advisory Committee on
6 Public Health Law of the Joint State Government Commission to
7 study the issue of youth vaccinations and immunizations to
8 determine whether any amendments should be made to the
9 Commonwealth's public health law; and be it further

10 RESOLVED, That the Advisory Committee on Public Health Law of
11 the Joint State Government Commission report its recommendations
12 to the Senate within ~~18~~ 12 months of the adoption of this <--
13 resolution.

1 Public Health Law Bench Book for judges, showing the need to
2 substantially upgrade Pennsylvania's public health law; and

3 WHEREAS, Increased global travel and emerging biological
4 threats have the potential for creating serious Statewide public
5 health concerns; and

6 WHEREAS, Pennsylvania's public health law, including
7 statutes, regulations and case law, should be reviewed so the
8 law may be updated and codified to address modern public health
9 issues; and

10 WHEREAS, The emergency management services provisions of 35
11 Pa.C.S. (relating to health and safety) are the only provisions
12 of the title that have been codified; and

13 WHEREAS, Codification is the process of revising and
14 restating statutes into a concise code of law that is clear,
15 consistent and organized; and

16 WHEREAS, The public health law provisions of 35 Pa.C.S.
17 should be codified so that they are consolidated with the
18 emergency management services provisions of the title; therefore
19 be it

20 RESOLVED, That the Senate direct the Joint State Government
21 Commission to establish a legislative task force with an
22 advisory committee of experts to review, update and codify
23 Pennsylvania's public health law; and be it further

24 RESOLVED, That a legislative task force be created consisting
25 of two members appointed by the President pro tempore of the
26 Senate and two members appointed by the Minority Leader of the
27 Senate; and be it further

28 RESOLVED, That the task force create an advisory committee
29 composed of experts on public health law; and be it further

30 RESOLVED, That the task force and advisory committee report

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1 to the Senate with recommended legislation.

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