James

# Pontifical Academy for Life

## Note on Italian vaccine issue

**The Pontifical Academy for Life issued a document commenting on the Italian vaccine issue, in collaboration with the "Ufficio per la Pastorale della Salute" of Italian Bishops' Conference and the "Association of Italian Catholic Doctors", on July 31, 2017.**

Clarifications on the medical and scientific nature of vaccination:

The lack of vaccinations of the population indicates a serious health risk of diffusing dangerous and often lethal diseases and infections that had been eradicated in the past, such as measles, rubella, and chickenpox. As noted by the Italian National Health Institute, since 2013 there has been a progressive trend in decreasing vaccination coverage. Vaccination coverage data for measles and rubella decreased from 90.4% in 2013 to 85.3% in 2015, contrary to WHO indications that recommend 95% vaccination coverage to eliminate virus circulation.

In the past, vaccines had been prepared using cells from aborted human fetuses, however currently used cell lines are very distant from the original abortions. The vaccines being referred to, the ones most commonly used in Italy, are those against rubella, chickenpox, polio, and hepatitis A. **It should be noted that today it is no longer necessary to obtain cells from new voluntary abortions, and that the cell lines on which the vaccines are based in are derived solely from two fetuses originally aborted in the 1960's.** From the clinical point of view, it should also be reiterated that treatment with vaccines, despite the very rare side effects (the events that occur most commonly are mild and due to an immune response to the vaccine itself), is safe and effective. No correlation exists between the administration of the vaccine and the onset of Autism.

Reflections on the ethical nature of vaccines:

In 2005 the Pontifical Academy for Life published a document entitled: "Moral reflections about vaccines prepared from cells of aborted human fetuses" which, in the light of medical advances

and current conditions of vaccine preparation, could soon be revised and updated.

Especially in consideration of the fact that **the cell lines currently used are very distant from the original abortions and no longer imply that bond of moral cooperation indispensable for an ethically negative evaluation of their use.**

On the other hand, **the moral obligation to guarantee the vaccination coverage necessary for the safety of others is no less urgent, especially the safety more vulnerable subjects such as pregnant women and those affected by immunodeficiency who cannot be vaccinated against these diseases.**

As for the question of the vaccines that used or may have used cells coming from voluntarily aborted fetuses in their preparation, it must be specified that the "wrong" in the moral sense lies in the actions, not in the vaccines or the material itself.

**The technical characteristics of the production of the vaccines most commonly used in childhood lead us to exclude that there is a morally relevant cooperation between those who use these vaccines today and the practice of voluntary abortion. Hence, we believe that all clinically recommended vaccinations can be used with a clear conscience and that the use of such vaccines does not signify some sort of cooperation with voluntary abortion.** While the commitment to ensuring that every vaccine has no connection in its preparation to any material of originating from an abortion, the moral responsibility to vaccinate is reiterated in order to avoid serious health risks for children and the general population.

Rome, 31 July 2017

Pontifical Academy for Life - National Office for Health Pastoral Care (CEI) - Association of Italian Catholic Doctors

# Protect Human & Federal Privacy Rights
# Oppose SB 163

National Vaccine Information Center
Your Health. Your Family. Your Choice.
NVIC.org & NVICAdvocacy.org

## CDC Guidance - Improving School Vaccination Rates

Centers for Disease and Control (CDC) reports on kindergarten vaccination rates for 2017-18 and 2018-19 state rates could be improved to potentially 95% if schools collected missing vaccine records. In October 2018 the CDC's Director of the Center for the National Center for Immunization and Respiratory Diseases (NCIRD), Dr. Nancy Messonnier clarified the CDC's 2017-2018 report on kindergarten vaccination rates and stated on increases in exemptions:

> *"Parental choice may play some role, but CDC's data really suggests that many of these parents do want to vaccinate their children, but they may not be able to get vaccines for them. They may face hurdles like not having a health care professional near by, not having time to get their children to a doctor, and thinking that they cannot*

**FACT: Colorado is one of 44 states that could improve vaccination rates by schools enforcing existing law and collecting missing records (CDC). SB 163 will *NOT* address vaccine access issues, but schools collecting missing information may help identify vaccine access issues.**

## Why SB 163 is NOT Needed

- ⇒ **Existing laws and the administrative rule-making authority conferred to CDPHE already provides the ability to review ACIP recommendations, expand and change vaccine requirements and policy, and to provide education;**
- ⇒ **Emergency powers already exist for CDPHE and the Governor in the event of an outbreak or epidemic to address any public health crisis;**
- ⇒ **Existing law already requires CDPHE and schools to make vaccination and exemption rates available to the public;**
- ⇒ **CDC guidance and school enforcement of existing law to collect missing vaccination records demonstrate increased vaccination rates, while preserving exemption and privacy rights;**
- ⇒ **Resources would be better spent identifying barriers preventing schools from enforcing the existing law and assuring transparent reporting by public health officials relating to limitations of their data – i.e. report rates in context.**

## What CDPHE Vaccination Data Really Says

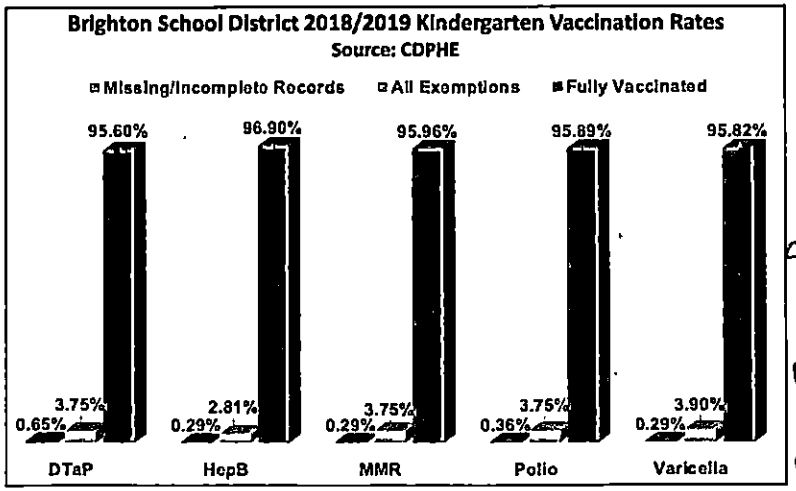
Colorado student vaccination rates improve over the K-12 timeframe;

Missing kindergarten vaccination records **OUTPACE** exemption rates, but **DOES NOT** mean children aren't vaccinated. ***It means CDPHE vaccination rates are inaccurate due to data limitations.***

CDPHE data reveals that schools following CDC guidance and existing Colorado law to collect missing records results in improved rates, fewer exemptions and more accurate data. Brighton School District (below) is a great role model for all schools;

**CDPHE data DOES NOT** indicate a public health crisis, or justify the burden, discrimination and restriction of rights and privacy that SB 163 would impose on Coloradans.

## OPPOSE SB 163

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## Correcting Misinformation

**STATEMENT** – SB 163 and Children's Hospital Colorado report $55 million spent in 2017 on hospital and emergency room visits for vaccine-preventable diseases. **MISLEADING**

**REALITY** - $42 million related to influenza, and a vaccine not required for Colorado school children. The vaccine has an overall average effectiveness rate of under 50% (CDC 2004-2018).

$10 million related to pneumococcal disease cases. CDPHE 2017 surveillance notes many cases are not preventable due to vaccine strain mismatch.

$1.5 million related to pertussis, mumps and varicella cases. CDPHE 2017 data shows a high number of pertussis and mumps cases occur in the fully vaccinated. Numbers for varicella vaccine failure were not reported by CDPHE for 2017, however, previous reports noted vaccine failure.

What are the associated costs for vaccine failure and strain mismatch?

**STATEMENT** – Colorado has the lowest kindergarten vaccine rates and needs to tighten up their vaccine exemption laws. **MISLEADING**

**REALITY** – CDPHE data shows that missing records for kindergarteners often outpace exemptions, making the "rate" inaccurate. Data also shows as schools close the gap on missing records exemptions go down and rates go up.

## Why OPPOSE SB 163?

**Democratic Checks & Balances Disrupted** - Circumvents the administrative rule and legislative process and confers authority without check to CDPHE and Board of Health to mandate forms and use of "educational" content;

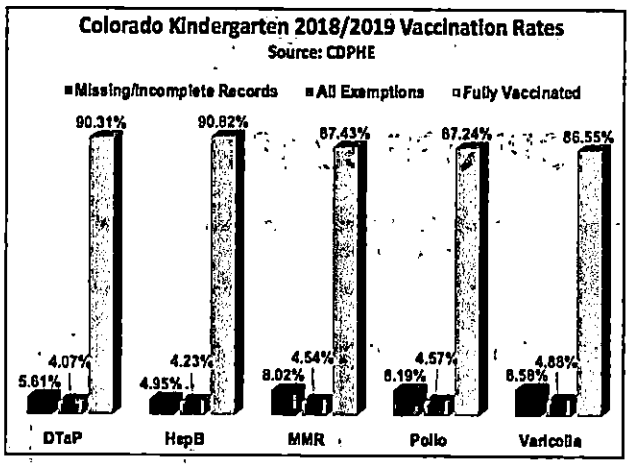
**Discriminatory** – Assumes exempting families are ignorant and require re-education and approval of their beliefs by health care providers or public health officials to obtain an exemption on the newly created form.

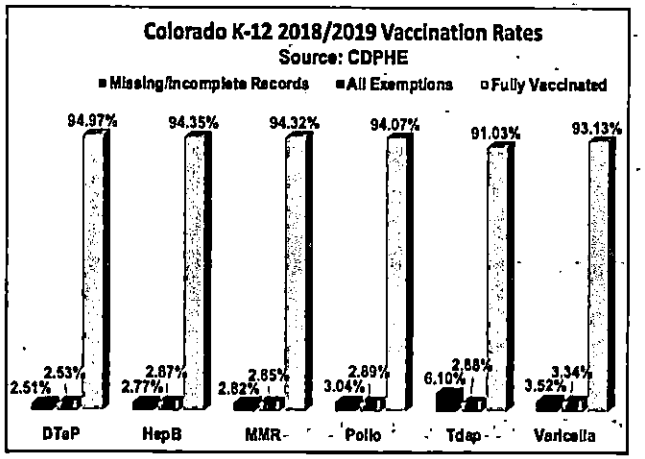
Forces student's into Colorado's vaccine tracking registry and robs students of their federal privacy rights. Students vaccinated according to Colorado requirements will retain their federal privacy rights and not have their beliefs judged or approved.

Families who are refused well-care due to vaccine choices, use holistic medicine, or who have been refused a religious or personal belief exemption by a vaccine provider will be coerced into completing CDPHE's "education" module to obtain their exemption.

Violates the informed consent ethic through coercion and sanction to convert sincerely held beliefs. Informed consent has guided the ethical practice of medicine since the Nuremberg Trials.

**Burdens Parents, Schools and Vaccine Providers** – Schools will be required to insert their vaccination and exemptions rates onto CDPHE's Certificate of Immunization for annual hard copy distribution to families, and vaccine providers will be asked sign off on a new exemption form. Families may have to see several vaccine providers before finding one who will sign their exemption forms, or spend the time to be re-educated by the state's education module.




# Protect Human & Federal Privacy Rights

# OPPOSE SB 163

## Where there is risk, there must be choice!

Vaccines are liability-free pharmaceutical products carrying the risk for injury and death. Over two decades of physician committee reports issued by the National Academies of Science Institute of Medicine reviewing the medical literature noted significant vaccine safety research deficits and the difficulty in reliably predicting vaccine injuries prior to vaccination.

Vaccine adverse events are under reported. A CDC funded study estimated that vaccine reactions, injuries, and deaths reported to the federal vaccine adverse event reporting system (VAERS) represent less than 1% of all vaccine adverse events that occur in the U.S (Lazarus 2010). There are approximately 10,000 reports that have been submitted to VAERS for Colorado.

Additionally, vaccines do not always work and outbreaks can occur in highly vaccinated populations. Last December a Texas school closed due to a pertussis outbreak in their 100% vaccinated student population.

# U.S. Department of Education

February 25, 2004

Ms. Martha Holloway
State School Nurse Consultant
Department of Education
Gordon Persons Building
P.O. Box 302101
Montgomery, Alabama 36130-2101

Dear Ms. Holloway:

This is in response to the information you provided this Office on January 23, 2004. Specifically, you faxed us a memorandum dated April 22, 2003 from Donald E. Williamson, M.D., State Health Officer, Alabama Department of Public Health (DPH), that was addressed to superintendents and head masters. In the memorandum, Dr. Williamson noted that concerns had been raised regarding the "sharing information with the [DPH] regarding immunizations." Dr. Williamson went on to state that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) applies to students' immunization records and that HIPAA permits schools to disclose these records to the DPH. He also stated:

> The U.S. Department of Health and Human Services (HHS), who promulgated the HIPAA regulations, and the Centers for Disease Control [and Prevention] (CDC) recently emphasized the public health exception to HIPAA in guidance issued on April 11, 2003. The guidance states that covered entities may disclose protected health information to public health entities, without patient authorization, for the conduct of public health surveillance, investigations, or interventions, as well as for the purpose of preventing or controlling diseases. Additionally, the HHS Office of Civil Rights guidance issued on July 6, 2001 states that covered entities may rely on the judgement (sic) of a public health entity when requesting a disclosure as to the minimum amount of information that is needed by Public Health.

When I was in Montgomery and Birmingham in January conducting training sessions on the Family Educational Rights and Privacy Act (FERPA), I received several questions concerning the applicability of FERPA to immunization and other health records maintained by schools subject to FERPA. You asked that we comment on Dr. Williamson's assertion that student immunization records are covered by HIPAA and whether or not FERPA applies. As you know, this Office administers FERPA. See 20 U.S.C. § 1232g; 34 C.F.R Part 99 (2003).

FERPA is a federal law that protects privacy interests of parents in their children's "education records," and generally prevents an educational institution from having a policy or practice of disclosing the education records of students, or personally identifiable information contained in education records, without the written consent of the parent. The term "education records" is defined as all records, files, documents and other materials which contain information directly

related to a student and are maintained by the educational agency or institution or by a person acting for such agency or institution. 20 U.S.C. § 1232g(a)(4)(A); 34 C.F.R § 99.3 "Education records."

Additionally, the records of a student that pertain to services provided to that student under the Individuals with Disabilities Education Act (IDEA) are "education records" under FERPA and are subject to the confidentiality provisions under IDEA (see 34 C.F.R §§ 300.560-300.576) and to all of the provisions of FERPA. When a student reaches the age of 18 or attends an institution of postsecondary education, the student is considered an "eligible student" under FERPA and all of the rights afforded by FERPA transfer from the parents to the student. 20 U.S.C. § 1232g(d); 34 C.F.R § 99.3 "Eligible student."

A K-12 student's health records, including immunization records, maintained by an educational agency or institution subject to FERPA, including records maintained by a school nurse, would generally be "education records" subject to FERPA because they are 1) directly related to a student; 2) maintained by an educational agency or institution, or a party acting for the agency or institution; and 3) not excluded from the definition as treatment or sole possession records, or on some other basis. 20 U.S.C. §1232g(a)(4)(a).

The HIPAA Privacy Rule at 45 C.F.R. Parts 160 and 164 provides additional guidance with respect to the treatment of student health records including immunization records. Specifically, the HIPAA Privacy Rule establishes guidelines to protect the privacy of Protected Health Information (PHI). PHI is defined as: "individually identifiable health information: (1) except as defined in paragraph 2 of this definition that is: (i) transmitted by electronic media; (ii) maintained in electronic media; or (iii) transmitted or maintained in any form or medium. (2) Protected health information excludes individually identifiable health information in:

> (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g;
> (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and
> (iii) Employment records held by a covered entity in its role as employer." See 45 C.F.R. §160.103.

Thus, education records, including individually identifiable health information contained in such records, that are subject to FERPA, are specifically exempt from the HIPAA Privacy Rule. The reason for this exemption is that Congress, through FERPA, previously addressed how education records should be protected.

Therefore, student immunization records that are maintained by an educational agency or institution subject to FERPA that directly relate to a student or students are considered to be education records under FERPA and are not subject to the HIPAA Privacy Rule. Accordingly, HIPAA neither authorizes nor permits the disclosure of these records.

Under FERPA, there are a number of several specific statutory exceptions to the general rule against nonconsensual disclosure that are set forth at 20 U.S.C. § 1232g(b)-(j) and 34 C.F.R § 99.31. However, there is no exception to FERPA's prior consent rule that would permit a school subject to FERPA to disclose health or other immunization records to a State health agency such as DPH under the circumstances described in Dr. Williamson's April 22, 2003 memorandum. A very limited exception to FERPA's prior consent rule allows educational agencies and institutions to disclose personally identifiable non-directory information to appropriate officials in connection with a health or safety emergency. Specifically, FERPA provides that education records may be disclosed without consent:

> in connection with an emergency [to] appropriate persons if the knowledge of such information is necessary to protect the health or safety of the student or other persons.

20 U.S.C. § 1232g(b)(1)(I). However, the regulations implementing this provision at 34 C.F.R §§ 99.31(a)(10) and 99.36 indicate that these conditions will be "strictly construed."

The exception to FERPA's prior written consent requirement was created with the first FERPA amendments that were signed into law on December 13, 1974. The legislative history demonstrates that Congress intended to limit application of the "health or safety" exception to exceptional circumstances, as follows:

> Finally, under certain emergency situations it may become necessary for an educational agency or institution to release personal information to protect the health or safety of the student or other students. In the case of the outbreak of an epidemic, it is unrealistic to expect an educational official to seek consent from every parent before a health warning can be issued. On the other hand, a blanket exception for "health or safety" could lead to unnecessary dissemination of personal information. Therefore, in order to assure that there are adequate safeguards on this exception, the amendments provided that the Secretary shall promulgate regulations to implement this subsection. It is expected that he will strictly limit the applicability of this exception.

Joint Statement in Explanation of Buckley/Pell Amendment, 120 Cong. Rec. S21489, Dec. 13, 1974. (These amendments were made retroactive to November 19, 1974, the date on which FERPA became effective.)

This Office has consistently interpreted this provision narrowly by limiting its application to a *specific situation* that presents *imminent danger* to students or other members of the community, or that requires an *immediate need* for information in order to avert or diffuse serious threats to the safety or health of a student or other individuals. While the exception is not limited to emergencies caused by terrorist attacks, the Department's Guidance on "Recent Amendments to [FERPA] Relating to Anti-Terrorism Activities," issued by this Office on April 12, 2002 provides a useful and relevant summary of our interpretation (emphasis added):

> [T]he health or safety exception would apply to nonconsensual disclosures to appropriate persons in the case of a smallpox, anthrax or other bioterrorism attack. This exception also would apply to nonconsensual disclosures to appropriate persons in the case of another terrorist attach such as the September 11 attack. However, *any release must be narrowly tailored considering the immediacy, magnitude, and specificity of information concerning the emergency. As the legislative history indicates, this exception is temporally limited to the period of the emergency and generally will not allow for a blanket release of personally identifiable information from a student's education records.*
>
> Under the health and safety exception, school officials may share relevant information with "appropriate parties," that is, those parties whose knowledge of the information is necessary to provide immediate protection of the health and safety of the student or other individuals. (Citations omitted.) Typically, law enforcement officials, public health officials, and trained medical personnel are the types of parties to whom information may be disclosed under this FERPA exception....
>
> The educational agency or institution has the responsibility to make the initial determination of whether a disclosure is necessary to protect the health or safety of the student or other individuals. ...

In summary, educational agencies and institutions subject to FERPA may disclose personally identifiable, non-directory information from education records under the "health or safety emergency" exception only if the agency or institution determines, on a case-by-case basis, that a *specific situation* presents *imminent danger or threat* to students or other members of the community, or requires an *immediate need* for information in order to avert or diffuse serious threats to the safety or health of a student or other individuals. Any release must be *narrowly tailored* considering the immediacy and magnitude of the emergency and must be made only to parties who can address the specific emergency in question. This exception is temporally limited to the period of the emergency and generally does not allow a blanket release of personally identifiable information from a student's education records to comply with general requirements under State law. Certainly an outbreak of diseases such as measles, rubella, mumps, and polio not only pose threat of permanent disability or death for the individual, but have historically presented themselves as epidemic in nature. Thus, disclosure of personally identifiable information from students' education records to State health officials for such reasons would generally be permitted under FERPA's health or safety emergency provisions.

In disclosing the information to a State health agency, a school should advise the agency that personally identifiable information disclosed by the school may not be redisclosed or shared with any other party outside of the appropriate officials at that agency, unless such disclosure is done with the prior written consent of parents or eligible students or is done on behalf of the school for the same purpose it was disclosed to the agency. See 34 C.F.R § 99.33. Further, FERPA

establishes a recordkeeping requirement for educational agencies and institutions in 34 C.F.R § 99.32. Briefly, this section states that an educational agency or institution (1) shall maintain a record of each request for access to and each disclosure of personally identifiable information from the education records of each student and (2) shall maintain the record with the education records of the student as long as the records are maintained. The record of disclosure must also include: (1) the parties who have requested the information from the education records, and (2) the legitimate interests the parties had in requesting or obtaining the information.

Please note, however, that FERPA does not prohibit an educational agency or institution from disclosing "non-personally identifiable information" to State health officials. Rather, FERPA specifically prohibits the disclosure of *personally identifiable information* from education records without the prior written consent of parents and students under 34 C.F.R § 99.30. The FERPA regulations at 34 C.F.R. § 99.3 define personally identifiable information to include:

> (a) the student's name;
> (b) the name of the student's parent or other family member;
> (c) the address of the student or student's family;
> (d) a personal identifier, such as the student's social security number or student number;
> (e) a list of personal characteristics that would make the student's identity easily traceable; or
> (f) other information that would make the student's identity easily traceable.

In order to make sure that information is not personally identifiable, the disclosing educational agency or institution would need to remove the name, identification number, and any other identifier that would permit the identity of an individual student to be easily determined.

Finally, nothing in FERPA prohibits school officials from obtaining parental consent in order to disclose personally identifiable information on students to State health officials. The written consent required before an educational agency or institution may disclose personally identifiable, non-directory information from education records should:

> (1) specify the records that may be disclosed;
> (2) state the purpose of the disclosure; and
> (3) identify the party or class of parties to whom the disclosure may be made.
>
> 34 C.F.R § 99.30(b); see 20 U.S.C. § 1232g(b)(2)(A).

If requested, the agency or institution must provide a parent or student with a copy of the records disclosed. 34 C.F.R § 99.30(c).

I hope that this letter adequately explains the requirements of FERPA as they relate to the disclosure of personally identifiable information to the DPH by educational agencies and institutions subject to FERPA. Should you have any further questions, please do not hesitate to contact this Office at the following address and telephone number:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202-5901
(202) 260-3887

Sincerely,

/s/

LeRoy S. Rooker
Director
Family Policy Compliance Office

National Vaccine Information Center

www.NVIC.org

# Education, Vaccine Research Deficits & Impact of Non-Medical Exemptions on State Disease Incidence

**A mixed methods study of parental vaccine decision making and parent-provider trust.** - ***A survey of Colorado parents*** between 2008 and 2011 found that parents who declined or delayed vaccines were ***"8 times more likely to report that they constantly reevaluate their vaccine decisions than parents who accepted all vaccines."*** Overall, parents trusted a "pediatrician's advice on nutrition, behavior, and the physical examination, they did not believe their pediatrician provided ***"balanced"*** information on both the benefits and risks of vaccination." *Acad Pediatr. 2013 Sep-Oct;13(5):481-8. doi: 10.1016/j.acap.2013.05.030.*

**The Association Between Intentional Delay of Vaccine Administration and Timely Childhood Vaccination Coverage** – Results showed that parents' concern about vaccine safety or efficacy is the most common reason associated with the delay of vaccine administration and consistent with other studies that show this as a main reason for delay. Parents who delay seek additional information in making their decision to delay. *Public Health Rep. 2010 Jul-Aug; 125(4): 534–541.*

**Parental Delay or Refusal of Vaccine Doses, Childhood Vaccination Coverage at 24 Months of Age, and the Health Belief Model** - Showed that parental hesitancy is concordant with other research that demonstrated that children whose parents refused all vaccines were significantly more likely to have a mother who was a college graduate and to live in a suburban household with a higher annual family income. Public Health Rep. 2011; 126(Suppl 2): 135–146.

**HHS National Vaccine Advisory Committee White Paper on the U.S. Vaccine Safety System** - In 60% of 30 vaccine injury causality assessments since 2001, the IOM "inadequate evidence to make a determination" on causality. *U.S. HHS-NVPO IOM Causality Assessments, Sept. 2011, pgs 17 & 43*

**Adverse Effects of Vaccines: Evidence and Causality** – The Institute of Medicine (IOM) reviewed the epidemiological, clinical, and biological evidence regarding 158 of the most commonly reported adverse health events associated with 8 childhood vaccines and for 85%, or 135, of these events the IOM was prevented from determining causality due to either an absence of science, or the lack of quality science. *National Research Council. Washington, DC: The National Academies Press. Aug 2012*

**The Childhood Immunization Schedule and Safety** - The IOM Committee, which examined the safety of the current federally recommended childhood vaccine schedule, found that *"evidence assessing outcomes in subpopulations of children, who may be potentially susceptible to adverse reactions to vaccines (such as children with a family history of autoimmune disease or allergies or children born prematurely), was limited and is characterized by uncertainty about the definition of populations of interest and definitions of exposures or outcomes." National Research Council. Washington, DC: The National Academies Press. Jan 2013*

***A Longitudinal Analysis of the Effect of Nonmedical Exemption (NME) Law and Vaccine Uptake on Vaccine-Targeted Disease Rates*** – Neither measure of non-medical exemption use—the restrictiveness of a state's laws or vaccine uptake rates—was associated with annual disease incidence rates for four of the diseases evaluated (Hep B, Measles, Mumps, Haemophilus influenzae type b). If ALL states increased the restrictiveness of their exemption laws annual pertussis cases would only decline by 1.14%, or 0.20 cases per 100,000 persons, resulting in 171 fewer cases nationally. Further, if states increased their pertussis vaccine uptake by 1%, the annual number of pertussis cases would only decline by 0.04%, or 0.01 cases per 100,000 persons, resulting in five fewer cases nationally. *American Journal of Public Health* February 2014;104(2): 371-377.

21525 Ridgetop Circle, Suite 100 Sterling, VA 20166 • Phone 703.938.0342 • Fax 571.313.1268

# MMR Vaccine (Measles, Mumps, and Rubella): *What You Need to Know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

## 1 Why get vaccinated?

**MMR vaccine** can prevent **measles, mumps,** and **rubella.**

- **MEASLES (M)** can cause fever, cough, runny nose, and red, watery eyes, commonly followed by a rash that covers the whole body. It can lead to seizures (often associated with fever), ear infections, diarrhea, and pneumonia. Rarely, measles can cause brain damage or death.
- **MUMPS (M)** can cause fever, headache, muscle aches, tiredness, loss of appetite, and swollen and tender salivary glands under the ears. It can lead to deafness, swelling of the brain and/or spinal cord covering, painful swelling of the testicles or ovaries, and, very rarely, death.
- **RUBELLA (R)** can cause fever, sore throat, rash, headache, and eye irritation. It can cause arthritis in up to half of teenage and adult women. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects.

Most people who are vaccinated with MMR will be protected for life. Vaccines and high rates of vaccination have made these diseases much less common in the United States.

## 2 MMR vaccine

**Children** need 2 doses of MMR vaccine, usually:

- First dose at 12 through 15 months of age
- Second dose at 4 through 6 years of age

**Infants who will be traveling outside the United States when they are between 6 and 11 months of age** should get a dose of MMR vaccine before travel. The child should still get 2 doses at the recommended ages for long-lasting protection.

**Older children, adolescents,** and **adults** also need 1 or 2 doses of MMR vaccine if they are not already immune to measles, mumps, and rubella. Your health care provider can help you determine how many doses you need.

A third dose of MMR might be recommended in certain mumps outbreak situations.

MMR vaccine may be given at the same time as other vaccines. Children 12 months through 12 years of age might receive MMR vaccine together with varicella vaccine in a single shot, known as MMRV. Your health care provider can give you more information.

## 3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of MMR or MMRV vaccine,** or has any **severe, life-threatening allergies.**
- Is **pregnant,** or thinks she might be pregnant.
- Has a **weakened immune system,** or has a **parent, brother, or sister with a history of hereditary or congenital immune system problems.**
- Has ever had a **condition that makes him or her bruise or bleed easily.**
- Has recently **had a blood transfusion or received other blood products.**
- Has **tuberculosis.**
- Has **gotten any other vaccines in the past 4 weeks.**

In some cases, your health care provider may decide to postpone MMR vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting MMR vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

## 4 Risks of a vaccine reaction

- Soreness, redness, or rash where the shot is given and rash all over the body can happen after MMR vaccine.
- Fever or swelling of the glands in the cheeks or neck sometimes occur after MMR vaccine.
- More serious reactions happen rarely. These can include seizures (often associated with fever), temporary pain and stiffness in the joints (mostly in teenage or adult women), pneumonia, swelling of the brain and/or spinal cord covering, or temporary low platelet count which can cause unusual bleeding or bruising.
- In people with serious immune system problems, this vaccine may cause an infection which may be life-threatening. People with serious immune system problems should not get MMR vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

## 5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

## 6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

## 7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's **www.cdc.gov/vaccines**

**Immune compromised and pregnant women receive vaccines and vaccination does not guarantee that a person will not get infected or transmit infections to others.**

National Vaccine Information Center
NVIC.org & NVICAdvocacy.org

### Immune Compromised Persons Are Often Vaccinated

Under guidelines published by the CDC's Advisory Committee on Immunization Practices (ACIP), almost no health condition or vaccine reaction history is considered to be an absolute contraindication to vaccination. [1] Under ACIP guidelines, more than 99 percent of people are considered to be candidates for vaccination 100 percent of the time. [2]

According to the CDC, there are only two types of vaccine reactions that are absolute contraindications to getting re-vaccinated: (1) a life threatening allergic anaphylactic reaction that occurs within minutes of vaccination; (2) development of encephalopathy, such as prolonged seizures, coma and other brain dysfunction, within seven days of receiving pertussis-containing vaccines – but only if the doctor believes the encephalopathy is "not attributable to another cause." [3]

The CDC and medical trade associations tell doctors that only pregnancy or severe immunodeficiency is a contraindication to getting live virus vaccines like MMR and varicella zoster, but inactivated vaccines are not an absolute contraindication for people with severe immunodeficiency. [4] [5] Most immune compromised individuals are vaccinated, often using an alternative schedule. [6]

### Vaccinated Persons Can Get Infected and Transmit to Others

Vaccines do not guarantee protection from being infected. For example, pertussis vaccine immunity wanes within a few years [7] and influenza vaccines have been less than 50 percent effective for more than a decade. [8] Both vaccinated and unvaccinated people can and do get infected with viral and bacterial diseases like pertussis, [9] [10] [11] measles, [12] [13] [14] [15] mumps [16] [17] and influenza [18] and may transmit to others but show few or no symptoms that are not identified or reported. A school with a 100 percent vaccination rate and zero exemptions had a pertussis outbreak in 2019. [19]

Children and teachers interact with many vaccinated and unvaccinated people outside the school setting. It is an illusion that immune compromised children will not be exposed to infections if vaccine exemptions are removed to attain a 99.99 percent vaccination rate in schools.

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# Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2020

**Always use this table in conjunction with Table 1 and the notes that follow.**

| VACCINE | INDICATION | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Pregnancy | Immunocompromised status (excluding HIV infection) | HIV infection CD4+ count[1] | | Kidney failure, end-stage renal disease, or on hemodialysis | Heart disease or chronic lung disease | CSF leaks or cochlear implants | Asplenia or persistent complement component deficiencies | Chronic liver disease | Diabetes |
| | | | <15% and total CD4 cell count of <200/mm3 | ≥15% and total CD4 cell count of ≥200/mm3 | | | | | | |
| Hepatitis B | | | | | | | | | | |
| Rotavirus | | SCID[2] | | | | | | | | |
| Diphtheria, tetanus, & acellular pertussis (DTaP) | | | | | | | | | | |
| *Haemophilus influenzae* type b | | | | | | | | | | |
| Pneumococcal conjugate | | | | | | | | | | |
| Inactivated poliovirus | | | | | | | | | | |
| Influenza (IIV) or Influenza (LAIV) | | | | | | Asthma, wheezing: 2–4yrs[3] | | | | |
| Measles, mumps, rubella | | | | | | | | | | |
| Varicella | | | | | | | | | | |
| Hepatitis A | | | | | | | | | | |
| Tetanus, diphtheria, & acellular pertussis (Tdap) | | | | | | | | | | |
| Human papillomavirus | | | | | | | | | | |
| Meningococcal ACWY | | | | | | | | | | |
| Meningococcal B | | | | | | | | | | |
| Pneumococcal polysaccharide | | | | | | | | | | |

- Vaccination according to the routine schedule recommended
- Recommended for persons with an additional risk factor for which the vaccine would be indicated
- Vaccination is recommended, and additional doses may be necessary based on medical condition. See Notes.
- Not recommended/ contraindicated—vaccine should not be administered
- Precaution—vaccine might be indicated if benefit of protection outweighs risk of adverse reaction
- Delay vaccination until after pregnancy if vaccine indicated
- No recommendation/ not applicable

1 For additional information regarding HIV laboratory parameters and use of live vaccines, see the General Best Practice Guidelines for Immunization, "Altered Immunocompetence," at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html and Table 4-1 (footnote D) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

2 Severe Combined Immunodeficiency

3 LAIV contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months.

Daily Camera

# BVSD down to just 25 students missing immunization paperwork

## Students without documentation or an exemption won't be allowed to attend school

By Amy Bounds | boundsa@dailycamera.com | Boulder Daily Camera
PUBLISHED: December 2, 2019 at 5:12 p.m. | UPDATED: December 2, 2019 at 5:13 p.m.

Boulder Valley officials said the school district only had about 25 students still missing immunization paperwork by the end of school today, down from about 5,000 when school started in August.

"On the whole parents have been very supportive," said Stephanie Faren, Boulder Valley's health services director. "A lot of them didn't realize students were missing vaccines. We're very thankful for all the families who helped us out."

Boulder Valley, for the first time, is enforcing a state law requiring families to provide documentation that their children are vaccinated or to sign off on an exemption.

The district set a deadline of the Friday before Thanksgiving for families to provide documentation of vaccination, documentation of an appointment scheduled to receive the missing vaccination or a signed exemption form.

Families with children not in compliance were notified by email, phone and text messages. The district also continued to accept documentation over the break.

Faren said 76 students, out of 30,850, were still missing documentation Monday morning.

Some brought their paperwork to school, while school staff members called parents for others, she said. Those whose parents couldn't be reached were called down to the office and asked to give their parents a call.

"We certainly don't want to keep any student out of school," she said. "For these last few kiddos, we really tried to make every option available."

Faren said measles outbreaks across the country last school year prompted the decision to start enforcing the state requirement this school year.

If there's an outbreak, health departments use school records to identify unvaccinated students who need to stay home. Along with setting a deadline for student documentation, Faren said, the district is collecting vaccination records from staff members.

Indira Gujral, communicable disease and emergency management division manager for Boulder County Public Health, said the health department is "very supportive" of the district's decision to set a deadline.

"Immunization records are vital for making informed decisions," she said in a written statement. "For example, when school outbreaks occur, it is very important for schools to have access to each child's immunization record as this information helps guide emergency response efforts, prevents absenteeism and exclusion, and reduces impacts on children and families."

Boulder County's immunization rates of school-aged children tend to be lower than the rest of the state, ranging from 89% to 93%, depending on the vaccination, according to 2018-19 school year data collected by the state health department.

The lowest rate is for the combination of the tetanus and whooping cough vaccine that's supposed to be given before students enter sixth grade.

In Colorado, parents are allowed to exempt children for medical, personal or religious reasons. For personal or religious exemptions, parents are required to provide the school with a statement every year.

Students who aren't included in the fully vaccinated numbers are those with personal, medical or religious exemptions and those with missing paperwork.

Last school year, between 3% and 7% of Boulder Valley students were missing paperwork, depending on the vaccination, according to state records. In the neighboring St. Vrain Valley School District, 3% to close to 11% of students were missing paperwork, depending on the vaccination.

Faren said the percentage of Boulder Valley students who are fully vaccinated is going up as the district contacts families ahead of the deadline. The district expects to have an exact percentage in the next few weeks.

THE COLORADO SUN

# Colorado's near-lowest vaccination rates have schools ready to enforce state law to prevent an outbreak

**Boulder Valley, Littleton and Brighton are excluding noncompliant students from school amid growing fears about Colorado's vaccination rates**

Published on Nov 4, 2019 5:05AM MST
Jennifer Brown @jenbrowncolo

Concern that Colorado is vulnerable to a major outbreak of measles, mumps or whooping cough has prompted a few school districts to try something new: follow state law.

Colorado requires that school districts exclude students from school if they do not have up-to-date immunizations or exemptions on file. But most districts do not follow that law, and the state health department has no mechanism to enforce it.

That means thousands of Colorado students are attending school despite not having the required vaccines and without medical, religious or personal exemption forms on file.

This year, though, at least two school districts "updated policy" to follow the law as written, each setting a cut-off date for when students could no longer attend school without the required paperwork.

Littleton Public Schools picked Friday as the day students still not in compliance — despite numerous phone calls, emails and letters going back to May — were excluded from school. On Thursday, school officials called the nearly 100 students left on the list. And on Friday, those still without vaccinations or exemptions were sent to the office, where parents were required to pick them up.

Boulder Valley School District, which has the highest vaccine-exemption rate in the state, set Dec. 2 as its deadline. The district started the school year with 4,900 students not in compliance and has whittled that down to about 1,100 after months of communication, including letters listing the exact vaccinations each noncompliant student was lacking.

The two districts are following the lead of the Brighton school district, called 27J Schools, which revamped its policy three years ago. The first year was an "epic disaster," recalled Haley Houtchens, a Children's Hospital Colorado nurse who works in four Brighton schools through a partnership between the hospital and the district.

Nearly 300 kids were sitting in the halls, waiting on their parents. And when parents were called at work to pick up their children, "obscenities were flying," she said.

Now in year three, the policy is working much more smoothly. Still, there were dozens of students kept out of class on Oct. 16, Brighton's deadline.

"It's always one of those days that makes the hairs on my arms stand up because it's a little contentious," Houtchens said. "It's always a little dicey."

But here is why Houtchens and six other nurses rewrote the Brighton policy and why they care so much that the district is making sure as many kids as possible are immunized. "Watch the news: Last year we had a measles outbreak in this country," she said, referring to the 372 people sickened by measles in 2018 across several states, mainly in New York and New Jersey. "This stuff is real."

Closer to home, Houtchens helped monitor a mumps outbreak last year at one of Brighton's middle schools. Two students who had not been vaccinated against the disease were kept out of school for three weeks.

Schools rely on herd immunity to protect those who cannot receive immunizations for medical reasons, she said. Last year, Houtchens was tasked with helping protect two students who could not have the mumps vaccine — one who had a kidney transplant and another who had a heart transplant.

The issue is especially concerning to school and public health officials in Colorado, which has some of the lowest vaccination rates in the nation, according to the Centers for Disease Control and Prevention.

School districts need records on every student so that in case of an outbreak, they can quickly determine who is at risk, Houtchens said.

In all three districts — Brighton, Littleton and Boulder — more parents took their children to get the required vaccines than filled out the exemption form after they were notified their children were out of compliance, school officials said. In many cases, students hadn't received vaccinations not because their parents were opposed, but because they were unaware or weren't keeping up with annual health checkups.

"That was a really pleasant surprise," Houtchens said. "I thought we would have a lot of parents who were going to say, 'Give me the stupid form.'" In Colorado, getting an exemption is as easy as writing a note on a napkin, although parents are required to ask for the exemption every year.

Boulder Valley began tightening its immunization policy three years ago, said Stephanie Faren, director of health services. The district not only had the highest number of exemptions in the state, but also one of the highest percentages of students without required documentation.

The district employed letters, emails and phone calls, but "that only went so far," said Faren, noting that Boulder "has been a well-known pocket of vaccination controversy."

This year, the district got serious, setting its Dec. 2 exclusion date — no paperwork, no school.

Already this fall, Boulder Valley has increased its vaccination rate by about 3%, or about 1,000 students. It also increased its exemption rate, going to 5% of the 31,000-student population from 3%.

While public health officials aren't necessarily happy about that increase in exemptions, Faren says it's better to have the records. "My argument is that if we have a situation going on, an outbreak, at least we know ... instead of having thousands of kids where we just had no clear information."

The policy was revamped after last year's uptick in measles cases across the country. Colorado has had a single measles case so far in 2019, a Denver adult who had traveled out of the country. The state also had two cases in 2016, according to the CDC. Measles had been declared eliminated by the CDC in 2000.

"It really provided enough of an impetus to move forward and say, 'We honor your right, if you don't want to vaccinate your child, that's fine ... and we also want you to know what that means in case of an outbreak.'"

Local public health departments have jurisdiction to enforce quarantines during an outbreak. Standard practice is to exclude any unvaccinated student or staff member from school for 21 days following the last reported measles case.

The district is now requiring all teachers and staff to provide their immunization records. "You can't have a school open if there are no teachers," Faren said.

Officials at the Colorado Department of Public Health and Environment said they were pleased that some districts are choosing to follow the law as written.

"We applaud districts that are stepping up to follow the law by ensuring kids have the right vaccination or exemption paperwork on file," said Dr. Daniel Shodell, acting chief medical officer.

The state and local health departments have increased efforts in recent years to communicate with schools, making sure they understand the law and the importance of vaccines.

Gov. Jared Polis' budget request, which was released Friday, calls for $2.5 million for the state health department to increase vaccination rates in Colorado. The request notes that Colorado's measles, mumps

and rubella vaccination rate of 87.4% last school year does not meet the 92-94% herd immunity threshold recommended by health authorities to protect against a measles outbreak.

Gov. Jared Polis speaks at a news conference in the Colorado Capitol. (Jesse Paul, The Colorado Sun)

Under state law, schools receive regular health and safety inspections during which health authorities can ask school officials to produce immunization records. But there is no penalty for not being able to produce the required documents.

Many school districts set a date when immunization records are due, but they do not exclude students from school if they don't comply. Denver Public Schools and Douglas County, for example, have no exclusion date.

State law also requires school districts to report their immunization rates to the state health department by Jan. 15 each year, but not every district complies.

Littleton started the year with about 1,000 of its 15,000 students out of compliance, said Melissa Cooper, director of student support services.

The communication those families have received since May has been relentless. Cooper herself dialed between 50 and 75 phone numbers of families in one day last week.

Many of the nearly 100 noncompliant students showed up with vaccination records Friday or didn't come to school. A few were sent home. The district still had 27 students who weren't allowed to attend Monday unless they arrived with the proper paperwork.

The goal was not to exclude anyone from class, and for the most part, parents have understood. "After you get seven emails, it can get a little annoying, but they understand they just need to provide the information that we need," Cooper said.

"What's really happening is that the policy hasn't changed. The state law hasn't changed. But our implementation of it has."

# Influenza Facts

There are over 200 viruses that cause Influenza-Like-Illness (ILI), which produce the same symptoms as influenza and transmission can be prevented or reduced in home and health care settings with hand washing, masking, and separating sick and healthy persons.[1] [2] [3] Laboratory tests are necessary to distinguish between ILI and influenza, as both last for days and rarely cause serious illness or death.[4] Influenza vaccine strains are determined annually and based on what strains are expected to circulate during the season, resulting in vaccine effectiveness than can vary considerably from season to season. The CDC reported that last year's flu vaccine provided "no significant protection" and that the overall effectiveness was 29 percent.[5] Below are additional facts:

- A 2010 systematic review by the Cochrane Collaboration stated that "At best, vaccines might be effective against only influenza A and B, which represent about 10% of all circulating viruses."[6]
- A 2018 Cochrane Collaboration systematic review on influenza vaccine in healthy adults found that influenza vaccine may have no appreciable effect on hospitalizations or working days lost and found vaccines increase the number of adverse events, including fever.[7]
- The Cochrane Collaboration 2016 review on Influenza vaccination for healthcare workers who care for people aged 60 or older living in long-term care institutions that research "did not provide reasonable evidence to support the vaccination of healthcare workers to prevent influenza in those aged 60 years or older resident in LTCIs."[8]

**CDC Adjusted vaccine effectiveness estimates for influenza seasons from 2004-2018**

| Influenza Season† | Reference | No. of Patients | Adjusted Overall Effectiveness |
|---|---|---|---|
| 2018-19 | Flannery 2020 | 3,254 | 29% |
| 2017-18 | Rolfes 2019 | 8,436 | 38% |
| 2016-17 | Flannery 2019 | 7410 | 40% |
| 2015-16 | Jackson 2017 | 6879 | 48% |
| 2014-15 | Zimmerman 2016 | 9311 | 19% |
| 2013-14 | Gaglani 2016 | 5999 | 52% |
| 2012-13 | McLean 2014 | 6452 | 49% |
| 2011-12 | Ohmit 2014 | 4771 | 47% |
| 2010-11 | Treanor 2011 | 4757 | 60% |
| 2009-10 | Griffin 2011 | 6757 | 56% |
| 2008-09 | Unpublished | 6713 | 41% |
| 2007-08 | Belongia 2011 | 1914 | 37% |
| 2006-07 | Belongia 2009 | 871 | 52% |
| 2005-06 | Belongia 2009 | 346 | 21% |
| 2004-05 | Belongia 2009 | 762 | 10% |

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Table 1: Cases, rates, and charges for Colorado children 0-19 years of age with vaccine-preventable diseases, 2017.

| Vaccine | Hospitalized Cases | Rate per 100,000 | Hospital Charges | ED Cases | Rate per 100,000 | ED Charges | Total Charges |
|---|---|---|---|---|---|---|---|
| Diphtheria | 0 | -- | -- | -- | -- | -- | -- |
| H. influenzae | 8 | 0.56 | $974,904 | -- | -- | -- | $974,904 |
| Hepatitis A | 3 | 0.21 | $215,047 | 3 | 0.21 | $33,850 | $248,897 |
| Hepatitis B | 3 | 0.21 | $92,473 | 3 | 0.21 | $49,416 | $141,889 |
| Influenza | 460 | 32.48 | $20,107,457 | 8,656 | 611.12 | $22,632,148 | $42,739,605 |
| Measles | 0 | | | 3 | 0.21 | $14,320 | $14,320 |
| Mumps | 1 | 0.07 | $15,743 | 11 | 0.78 | $24,321 | $40,064 |
| Pertussis | 12 | 0.85 | $426,771 | 58 | 4.09 | $132,862 | $559,633 |
| Pneumococcal disease | 61 | 4.31 | $9,673,258 | 6 | 0.42 | $41,057 | $9,714,315 |
| Polio | 0 | -- | -- | -- | -- | -- | -- |
| Rubella | 0 | -- | -- | 2 | 0.14 | $3,968 | $3,968 |
| Tetanus | 0 | -- | -- | 4 | 0.28 | $65,847 | $65,847 |
| Varicella | 10 | 0.71 | $812,241 | 120 | 8.47 | $185,187 | $997,428 |
| Total | 558 | 39.40 | $32,317,894 | 8,866 | 625.95 | $23,182,976 | $55,500,870 |

Most hospitalizations related to vaccine-preventable diseases occurred among infants and children under 5 (**Figure 3a**), while most ED visits occurred in children 5-19 years of age (**Figure 3b**).

**Figure 3a: VPD hospitalizations of Colorado children in 2017 by age, including influenza (N = 555)**

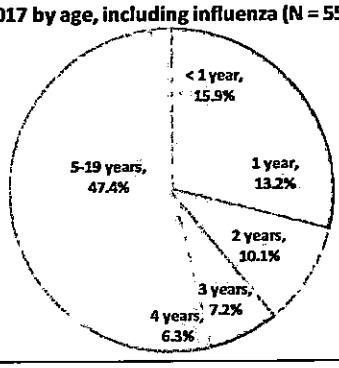
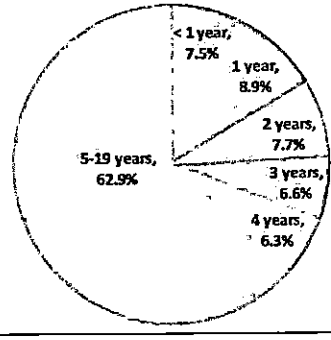



**Figure 3b: VPD emergency department visits of Colorado children in 2017 by age, including influenza (N = 8,865)**




## Mapping Colorado Immunizations: *School District Immunization Rates and Health Care Access*

*Marlee Barton, MPH, Colorado School of Public Health, University of Colorado*

Comprehensive school district immunization data provides the opportunity to examine school immunization rates and health care access indicators at a local level. This data is available thanks to 2014 legislation (Colorado HB 14-1288) that requires schools and childcares to make immunization information publically available.

The 2016-2017 school immunization data collected by the Colorado Department of Public Health and Environment (CDPHE) was combined with 2015 insurance data from the Colorado Health Institute (CHI), clinic location data from the Vaccines for Children program (VFC, which provides vaccines for children with Medicaid), CDPHE health facilities data, and school demographic data from the Colorado Department of Education.

**Indicators of High Immunization Rates**

- Prevalence of Free-or-Reduced Lunch (PR 1.25, CI 1.09-1.43)
- Prevalence of Medicaid (PR 1.29, CI 0.09-1.75)

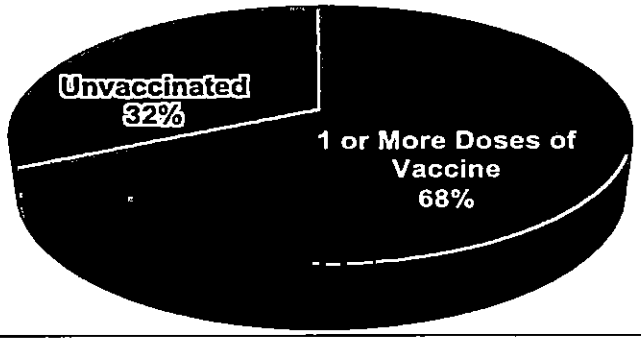
**Indicators of Low Immunization Rates**

- Prevalence of Student Mobility (PR 0.51, CI 0.33-0.80)
- Prevalence of Private Insurance (PR 0.88, CI 0.77-1.04)

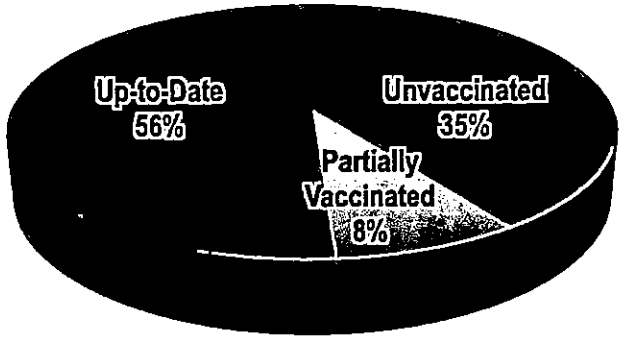
## Reported Cases In 0-19 Year Olds - Source CDPHE
## Colorado 2005-2015


| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Hib | 12 | 0 | 1 | 0 | 2 | 2 | 0 | 0 | 13 | 14 | 8 |
| Hep B | 0 | 0 | 0 | 1 | 1 | 3 | 0 | 0 | 0 | 1 | 0 |
| Measles | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Meningococcal Disease | 12 | 8 | 8 | 6 | 6 | 8 | 3 | 2 | 2 | 2 | 1 |
| Mumps | 2 | 24 | 10 | 3 | 0 | 3 | 0 | 4 | 4 | 1 | 1 |
| Pertussis | 896 | 410 | 181 | 90 | 143 | 392 | 337 | 1204 | 1152 | 931 | 621 |
| Pneumococcal | 69 | 71 | 75 | 89 | 93 | 86 | 63 | 54 | 40 | 36 | 51 |
| Tetanus | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Varicella | 0 | 1469 | 1036 | 839 | 477 | 363 | 409 | 440 | 332 | 316 | 273 |

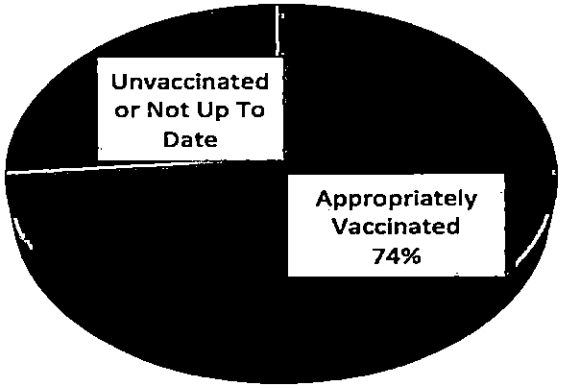
## Colorado Vaccination Known Status Varicella Cases - All Ages
## 2005-2011 Total Cases 5,769
## Source: CDPHE Surveilance Data




## 2016 Mumps Vaccination Status <1-19 Yrs
**46 Total Cases * Source CDPHE Surveillance Data**




## 2005-2011 PERTUSSIS CASES KNOWN VACCINATION STATUS - 7MO-9YRS
**SOURCE - CDPHE SURVEILLANCE DATA * TOTAL CASES 970**




## 2009-2011 PERTUSSIS CASES KNOWN VACCINATION STATUS - 10-17YRS
**SOURCE: CDPHE SURVEILLANCE DATA**
**TOTAL CASES 121**

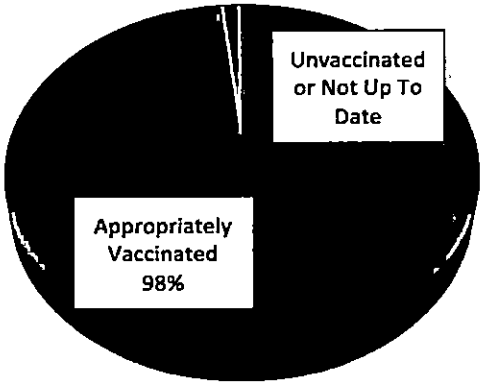


Figure 12: Reported Pertussis Cases by Age Group and Number of Vaccine Doses, Colorado, 2017

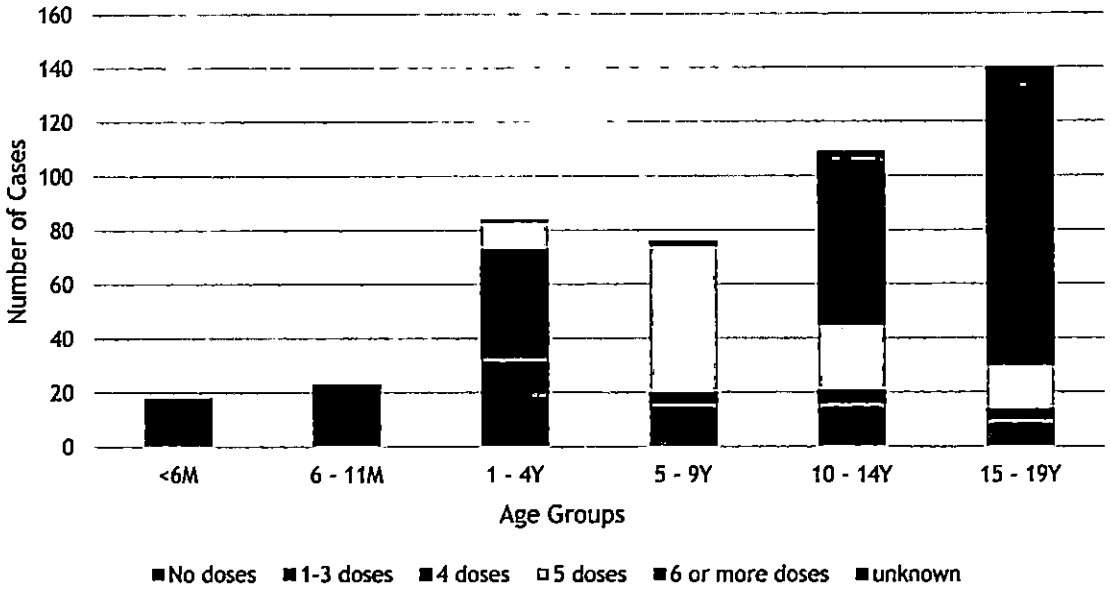
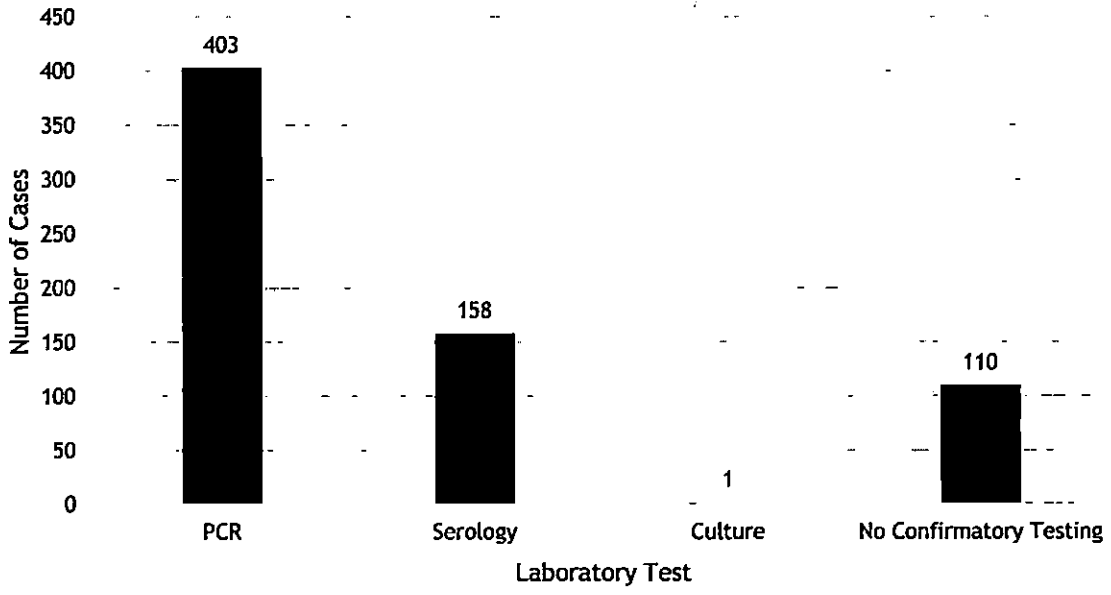



Figure 13: Reported Pertussis Cases by Laboratory Test, Colorado, 2017



Testimony: Francis Sincere, Lakewood Colorado on SB 163, Feb. 19, 2020

Before the Colorado Senate Health and Human Services Committee

**Add Legal protections for Medical Providers who Sign Exemptions**

- SINCE ALL VACCINE MAKERS AND MEDICAL PROVIDERS OF VACCINATIONS ARE HELD HARMLESS FROM LAWSUITS FOR VACCINE INJURIES AS PROVIDED IN THE **Childhood Vaccine Injury Act** (NCVIA) of **1986,**
  AND
- SINCE THE JUDGMENTS OF HIGHLY TRAINED MEDICAL PROFESSIONALS WHO KNOW THEIR PATIENTS HEALTH CONDITIONS ARE TO BE HONORED AND RESPECTED;
  AND
- SINCE MEDICAL PROFESSIONALS WHO LAWFULLY SIGNED EXEMPTIONS IN OTHER STATES WITH A SIMILAR LAW PROPOSED IN SB 163 HAVE SUFFERED LEGAL, REGULATORY AND PROFESSIONAL BOARD SANCTIONS RESULTING IN LOSS OF MD PRACTICE; *

**I PROPOSE THAT THE FOLLOWING SENTENCE BE ADDED TO SB163 SECTION II, (B) ON PAGE 9 AS FOLLOWS……" ANY PERSON AUTHORIZED PURSUANT TO TITLE 12 TO ADMINISTER IMMUNIZATIONS WITHIN HIS OR HER SCOPE OF PRACTICE WHO SIGNS CERTIFICATES OF MEDICAL OR NONMEDICAL EXEMPTIONS SHALL BE INDEMNIFIED AND HELD HARMLESS FROM ANY LEGAL, REGULATORY, PROFESSIONAL BOARD OR SOCIETY SANCTIONS.**

**ALTERNATIVELY, STRIKE OUT SECTION II (B) ALTOGETHER!**

RESPECTFULL SUBMITTED,

FRANCIS SINCERE

LAKEWOOD CO

303 886 3467

**SEE EXHIBIT ON PAGE 2**

Testimony: Francis Sincere, Lakewood Colorado on SB 163, Feb. 19, 2020
Before the Colorado Senate Health and Human Services Committee
**Add Legal protections for Medical Providers who Sign Exemptions**

(II) (A) A COMPLETE CERTIFICATE OF COMPLETION OF THE ONLINE EDUCATION MODULE IS ACQUIRED UPON COMPLETING THE ONLINE EDUCATION MODULE DESCRIBED IN SUBSECTION (2.7) OF THIS SECTION.

(B) A COMPLETE CERTIFICATE OF NONMEDICAL EXEMPTION MUST INCLUDE THE SIGNATURE OF A PERSON WHO IS AUTHORIZED PURSUANT TO TITLE 12 TO ADMINISTER IMMUNIZATIONS WITHIN HIS OR HER SCOPE OF PRACTICE TO THE STUDENT FOR WHOM THE CERTIFICATE OF NONMEDICAL EXEMPTION IS SOUGHT. NOTHING IN THIS SUBSECTION (2)(b)(II)(B) REQUIRES A PERSON AUTHORIZED PURSUANT TO TITLE 12 TO ADMINISTER



IMMUNIZATIONS WITHIN HIS OR HER SCOPE OF PRACTICE TO SIGN A CERTIFICATE OF NONMEDICAL EXEMPTION.

- **ADD…to paragraph II (B) above …" ANY PERSON AUTHORIZED PURSUANT TO TITLE 12 TO ADMINISTER IMMUNIZATIONS WITHIN HIS OR HER SCOPE OF PRACTICE WHO SIGNS CERTIFICATES OF MEDICAL OR NONMEDICAL EXEMPTIONS SHALL BE INDEMNIFIED AND HELD HARMLESS FROM ANY LEGAL, REGULATORY, PROFESSIONAL BOARD OR SOCIETY SANCTIONS.**

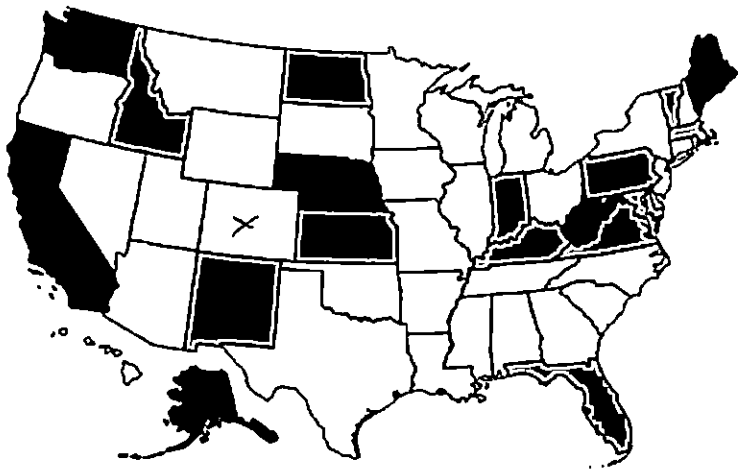
-9- SB20-163

*https://gogetfunding.com/dr-ken-stoller-and-his-medically-vaccine-exempt-patients-need-your-help-again/

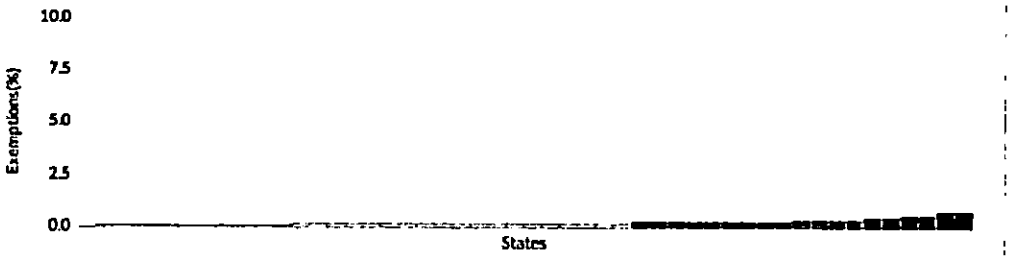
# Estimated number and percentage of children enrolled in kindergarten with an exemption from one or more vaccines by state and the United States, School Vaccination Assessment Program, 2018–19 school year

Map Selection | HHS Regions

Currently Viewing: School Assessment >> Medical Exemption >> All kindergartners >> Exemptions for 2018-19



Reported Exemptions from One or More Vaccines for Children Enrolled in Kindergarten by State




State Table or National Median

Reported Exemptions from One or More Vaccines for Children Enrolled in Kindergarten

| States | N | Survey Type | % | Footnotes |
|---|---|---|---|---|
| Arkansas | 39,257 | Census (public), voluntary response (private) | 0.0 | - |
| • California | 568,947 | Census | 0.6 | ‡,† |
| Colorado | 64,191 | Census | 0.2 | § |
| Connecticut | 38,230 | Census | 0.2 | † |
| • Delaware | 10,798 | Stratified 2-stage cluster sample | 0.3 | † |
| • District of Columbia | NA | Census | NA | - |
| • Florida | 224,641 | Census | 0.4 | † |
| Georgia | 131,275 | Census | 0.1 | † |
| Hawaii | 16,051 | Stratified 2-stage cluster sample | 0.1 | † |

Clear Filter

**Data Notes and Footnotes**

**Abbreviations:** NA: not available

**Data Notes:**

- Data for the 2010-11 school year were not verified.
- In 2009-10, data were weighted based on the population if awardee submitted reports for <95% of enrolled students. In 2011-12, all estimates of percent of children with exemptions were weighted to the number of enrolled children unless noted; number of exemptions were unweighted counts. Other years, estimates were adjusted for non-response and weighted for sampling as appropriate.

**Legend (%)**

- 0.00 - 0.08
- 0.09 - 0.26
- 0.27 - 0.44
- 0.45 - 0.64
- 0.65 - 0.80
- NA

Source: cdc.gov / Schoolvaxview

William Son

Holly Calvert

Good morning. My name is Holly Calvert and I represent 24,000 members of Parents United for Kids. I oppose SB-163. This bill is a DISCRIMINATORY attack on a small MINORITY of CHILDREN who will be tracked as if they are CRIMINALS. This adds extreme burden to low income families who have to make special arrangements from work, with daycare, transportation, and pay a doctor for visits for each child, YEARLY!

The online module would collect personally identifiable information which would be used to bully parents and children and place targets on their backs. This bill would create a new document, to be determined, to be passed out to families, that is bullying. That's turning neighbor on neighbor, child against child.

Homeschoolers would be required to submit personally identifiable information to the secondary database and sign a form that incriminates them, because the Health Department will BULLY School Districts into requiring the online form and re-education module.

On page 6, line 23 "A student is not required to comply if the student is participating in a NONPUBLIC homebased education program" Which means the law wouldn't allow you to participate in Online PUBLIC School. So, you have to pay extra money on top of the taxes you already pay for the public school you are being denied entry into. This creates extreme extra burden on low income families who can't afford to pay for private online homeschooling.

Vote No on this bill because;

- This bill creates a re-education video, what other group of people would you require, under law, to watch a re-education video?

- It creates a special class of people, the "Vaccine Protected Class", suggesting all others are lesser humans.

- It is written by Corporate Special Interests and Aims to Segregate healthy people using fear tactics

- It is unnecessary, there is no emergency, the policies we have in place work

- This bill was designed to BULLY and COERCE a minority into complying with the demands of CDPHE, or else, receive a punishment, be harassed, be pressured and bullied, be kicked out of school, be forced out of the State

- All exemptions MUST remain as they are and continue to be submitted directly to the school nurse who is tasked with protecting this private medical information under FERPA law.

- Please do not be distracted today, by the stories you will hear from Proponents of this bill who make money off of these products, who are not liable for damages, who will claim that this bill does not do what it clearly says it will do. They will claim this bill does not remove exemptions, but it attempts to, by making Exemptions almost impossible to get. Medical Doctors will not sign off on Exemptions.

- Every single person in favor of this bill, has their own medical information keep completely private and protected. The people for this bill would seek to strip away privacy protection from children while they continue to enjoy their own privacy protection.

HHS Senate committe SB20-163
Andrea Mercier
to:
Elizabeth.Burger
02/19/2020 10:54 AM
Hide Details
From: Andrea Mercier <mercier.andrea2@gmail.com>
To: Elizabeth.Burger@state.co.us
History: This message has been replied to.

Remote Testimony in opposition to Senate Bill:

My name is Andrea Mercier. I am speaking on behalf of my child who sustained harm from issues in the complexities and sometimes over reach in some of the health care models utilized by a majority. This bill requires persons who want to claim the non-medical exemption for immunization to submit either a:

- Certificate of completion of the online education module or
- Certificate of non-medical exemption signed by a medical professional

These CDPHE created forms may be written using "compelled speech" which would incriminate parents, yet they would be required to sign in order to obtain the exemption. Having to receive a certificate for religious reasons under a non-medical exemption is regulating an establishment of religion and preventing the free exercise of religion.

An individual wanting to exercise their religious or personal freedom will:

1. Be required to obtain the signature of a medical professional, effectively having the validity of their religious or personal beliefs determined by another person just because they have a medical degree
2. See a medical professional who may or may not understand their religious or personal stance and is not required to sign their non-medical exemption form when asked.
3. Have a higher financial and personal burden
4. Loose their leverage regarding religious and personal freedom going forward.

By removing the distinctions of "Religious" and "Philosophical" and placing both into one category of "non-medical Exemption," this bill effectively removes one of our three current exemptions stripping Coloradans of both religious freedom and liberty of conscience. Is Colorado prepared to violate religious freedoms and liberty of conscience? How will the higher financial burden impact working and lower class families? How will families who cannot afford a computer, printer, and internet get their certificate from the online module?

The bill creates a vaccine-protected children standard, whereby the immunization rate goal for every school is 95% of the student population to be vaccinated. The bill requires the CDPHE to amend an immunization document it currently publishes annually to include information about the vaccine-protected children standard. Every school shall use this document to publish its immunization and exemption rates compared to the new standard, and annually distribute it to the parents, legal guardians, and students of the school. In addition, schools will be provided with information to educate students about vaccines, the risks of vaccine-preventable diseases and where to receive the vaccines. Will students also be taught the risks associated with receiving vaccines?

This is a CDPHE power grab and allows rules to be made without legislative input.

The downward effects of this bill could be a rise in state Medicaid need, waiver need, and further disabled populations. We are already in a crisis and further contributing to the crisis by omission of information in the current health care model and further over reach at the government level is contributing to a separate socio economic issue that is already in a state of crisis.

Thank you, Andrea Mercier

Dir K 5

**COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH STUDENT ATTENDING COLORADO SCHOOLS**

Name _____ Date of Birth _____

Parent/Guardian _____

## COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION

| Vaccine | | Enter the month, day and year each immunization was given | | | | | |
|---|---|---|---|---|---|---|---|
| **Hep B** | Hepatitis B | | | | | | |
| **DTaP** | Diphtheria, Tetanus, Pertussis (pediatric) | | | | | | |
| **DT** | Diphtheria, Tetanus (pediatric) | | | | | | |
| **Tdap** | Tetanus, Diphtheria, Pertussis | | | | | | |
| **Td** | Tetanus, Diphtheria | | | | | | |
| **Hib** | *Haemophilus influenzae* type b | | | | | | |
| **IPV/OPV** | Polio | | | | | | |
| **PCV** | Pneumococcal Conjugate | | | | | | |
| **MMR** | Measles, Mumps, Rubella | | | | | | |
| **Varicella** | Chickenpox | | | Healthcare Provider Documentation Date _____ | | Lab Verification Date _____ | |
| Vaccines recorded below this line are recommended. Recording of dates is encouraged. | | | | | | | |
| **HPV** | Human Papillomavirus | | | | | | |
| **Rota** | Rotavirus | | | | | | |
| **MCV4/MPSV4** | Meningococcal | | | | | | |
| **Hep A** | Hepatitis A | | | | | | |
| **TIV/LAIV** | Influenza | | | | | | |
| **Other** | | | | | | | |

## THIS SECTION CAN BE COMPLETED BY CHILD CARE/SCHOOL/HEALTH CARE PROVIDER

☐ **A) Child Care Up to Date**
Up to date through 6 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **B) Child Care Up to Date**
Up to date through 18 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **C) Child Care/Pre-school/Pre-K***
Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **D) Complete for K–5th Grade**
Up to date for K–5th Grade for Colorado School Immunization Requirements — Update Signature _____ Date _____

* If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D.

## HAS MET ALL IMMUNIZATION REQUIREMENTS FOR COLORADO SCHOOLS (6TH GRADE OR HIGHER)

Signed _____ Title _____ Date _____
(Physician, nurse, or school health authority)

## STATEMENT OF EXEMPTION TO IMMUNIZATION LAW (DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)

**IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.**
**SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.**

**MEDICAL EXEMPTION:** The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.
**EXENCIÓN POR RAZONES MÉDICAS:** El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

***Medical exemption** to the following vaccine(s):*
***La exención por razones médicas** aplica a la(s) siguiente(s) vacuna(s):*

Signed (Firma) _____ Date (Fecha) _____
Physician (Médico)

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

**RELIGIOUS EXEMPTION:** Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.
**EXENCIÓN POR MOTIVOS RELIGIOSOS:** El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

***Religious exemption** to the following vaccine(s):*
***Exención por motivos religiosos** de la(s) siguiente(s) vacuna(s):*

Signed (Firma) _____ Date (Fecha) _____
Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

**PERSONAL EXEMPTION:** Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.
**EXENCIÓN POR CREENCIAS PERSONALES:** Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

***Personal exemption** to the following vaccine(s):*
***Exención por creencias personales** de la(s) siguiente(s) vacuna(s):*

Signed (Firma) _____ Date (Fecha) _____
Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

## Table 1. MINIMUM NUMBER OF DOSES REQUIRED FOR CERTIFICATE OF IMMUNIZATION

| VACCINE [a] | Level of School/Age of Student | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Child Care 2–3 mos | Child Care 4–5 mos | Child Care 6–7 mos | Child Care 8–11 mos | Child Care 12–14 mos | Child Care 15–18 mos | Child Care 19–23 mos | Pre-school 2–4 yrs | K Entry 4–6 yrs | Grades K to 5 5–10 yrs | Grades 6 to 12 11–18+yrs | College |
| Hepatitis B [l] | 1 | 2 | 3 | | | | | | 3 | 3 | 3 | |
| Pertussis/Tetanus/ Diphtheria | 1 | 2 | 3 | | see footnote b | 4 | | | 5/4 [b] | 5/4 [b c] | 5/6 [c d] | |
| *Haemophilus influenzae* type b (Hib) [i] | 1 | 2 | 2 | 3/2 | 3/2 | 3/2/1 | 3/2/1 | 3/2/1 | | | | |
| Pneumococcal Conjugate [k] | 1 | 2 | 3/2 | | 4/3/2 see footnote k | | | | | | | |
| Polio [e] | 1 | 2 | 3 | | | | | | 4/3 [f] | 4/3 [f] | 4/3 [f] | |
| Measles/Mumps/ Rubella [g] | | | | | 1 | see footnote g | | | 2 [h] | 2 [h] | 2 [h] | 2 [h i] |
| Varicella [m] | | | | | 1 | see footnote n | | | 2 [n] | 2/1 [n] | 2/1 [n] | |
| Meningococcal | | | | | | | | | | | | o |

a: Vaccine doses administered no more than 4 days before the minimum interval or age are to be counted as valid.

b: Five doses of pertussis, tetanus, and diphtheria vaccines are required at school entry in Colorado unless the 4th dose was given at 48 months of age or older (i.e., on or after the 4th birthday) in which case only 4 doses are required. There must be at least 4 weeks between dose 1 and dose 2, at least 4 weeks between dose 2 and dose 3, at least 6 months between dose 3 and dose 4 and at least 6 months between dose 4 and dose 5. The final dose must be given no sooner than 4 years of age (dose 4 may be given at 12 months of age provided there is at least 6 months between dose 3 and dose 4). If a child has received 6 doses of DTaP before the age of 4 years, no additional doses are required.

c: For students 7 years of age or older who have not had the required number of pertussis doses, no new or additional doses are required. Any student 7 years of age or older at school entry in Colorado who has not completed a primary series of 3 appropriately spaced doses of tetanus and diphtheria vaccine may be certified after the 3rd dose of tetanus and diphtheria vaccine (or tetanus, diphtheria, and pertussis vaccine if 10 or 11 years) if it is given 6 months or more after the 2nd dose.

d: The student must meet the minimum prior requirement for the 4th or 5th doses of diphtheria, tetanus, and pertussis vaccine and have 1 tetanus, diphtheria, and pertussis vaccine dose.

e: For polio, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable.

f: Four doses of polio vaccine are required at school entry in Colorado unless the 3rd dose was given at 48 months of age or older (i.e., on or after the 4th birthday) in which case only 3 doses are required. There must be at least 4 weeks between dose 1 and dose 2, at least 4 weeks between dose 2 and dose 3 and at least 6 months between dose 3 and dose 4. The final dose must be given no sooner than 4 years of age. Minimum age/interval does not apply if 4th dose of polio (3rd dose if given after 4th birthday) was administered prior to July 1, 2009.

g: For measles, mumps, and rubella, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable for the specific disease tested. The 1st dose of measles, mumps, and rubella vaccine must have been administered at 12 months of age or older (i.e., on or after the 1st birthday) to be acceptable.

h: The 2nd dose of measles vaccine or measles, mumps, and rubella vaccine must have been administered at least 28 calendar days after the 1st dose.

i: Measles, mumps, and rubella vaccine is not required for college students born before January 1, 1957.

j: The number of Hib vaccine doses required depends on the student's current age and the age when the vaccine was administered. If any dose was given at 15 months of age or older, the Hib vaccine requirement is met. For students who began the series before 12 months of age, 3 doses are required of which at least 1 dose must have been administered at 12 months of age or older (i.e., on or after the 1st birthday). If the 1st dose was given at 12 to 14 months of age, 2 doses are required. If the current age is 5 years of age or older, no new or additional doses are required.

k: The number of pneumococcal conjugate vaccine (PCV) doses required depends on the student's current age and the age when the 1st dose was administered. If the 1st dose was administered before 6 months of age, the child is required to receive 3 doses 2 months apart and an additional dose between 12–15 months of age. If started between 7–11 months of age, the child is required to receive 2 doses, two months apart and an additional dose between 12–15 months of age. For any student who received the 3rd dose on or after the first birthday, a 4th dose is not required. If the 1st dose was given at 12 to 23 months of age, 2 doses are required. If any dose was given at 24 months of age through 4 years of age, the PCV vaccine requirement is met. If the current age is 5 years or older, no new or additional doses are required.

l: For hepatitis B, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable. The second dose is to be administered at least 4 weeks after the first dose, and the third dose is to be administered at least 16 weeks after the first dose and at least 8 weeks after the second dose. The final dose is to be administered at 24 weeks of age (6 months of age) or older and is not to be administered prior to 6 months of age. Minimum age/interval does not apply to those students who had 3 doses of the vaccine administered prior to July 1, 2009.

m: For varicella, written evidence of a laboratory test showing immunity or a documented disease history from a health care provider is acceptable. The 1st dose of varicella vaccine must have been administered at 12 months of age or older (i.e., on or after the 1st birthday) to be acceptable.

n: If the second dose of varicella vaccine was administered to a child before 13 years of age, the minimum interval between dose 1 and dose 2 is three months, however, if the second dose is administered at least 28 days following the first dose, the second dose does not need to be repeated. For a child who is 13 years of age or older, the second dose of varicella vaccine must have been administered at least 28 calendar days after the 1st dose. See Table 2 for the school years/grade levels that the 1st and 2nd doses of varicella will be required.

o: Information concerning meningococcal disease and the meningococcal vaccine shall be provided to each new student or if the student is under 18 years, to the student's parent or guardian. If the student does not obtain a vaccine, a signature must be obtained from the student or if the student is under 18 years, the student's parent or guardian indicating that the information was reviewed

## Table 2. TIMETABLE FOR IMPLEMENTATION OF REQUIREMENTS FOR SELECTED IMMUNIZATIONS FOR GRADES K TO 12

Refer to Table 1 for the minimum number of doses required for a particular grade level. Table 2 shows the year of implementation for a requirement from Table 1 and is restricted to varicella vaccine dose 1 (Var1) and dose 2 (Var2) and tetanus, diphtheria, and pertussis vaccine (Tdap). Requirements and effective dates for other vaccines are listed in Table 1. In this table, after a vaccine is required for grades K to 12, it is no longer shown, but the requirements listed in Table 1 continue to apply.

| School Year | Grade Level | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | K | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 2007–08 | Var2 | Var1 | Var1 | Var1 | Var1 | Var1 | Tdap Var1 | Var1 | | | Tdap | | |
| 2008–09 | Var2 | Var2 | Var1 | Var1 | Var1 | Var1 | Tdap Var1 | Tdap Var1 | Var1 | | Tdap | Tdap | |
| 2009–10 | Var2 | Var2 | Var2 | Var1 | Var1 | Var1 | Tdap Var1 | Tdap Var1 | Tdap Var1 | Var1 | Tdap | Tdap | Tdap |
| 2010–11 | Var2 | Var2 | Var2 | Var2 | Var1 | Var1 | Tdap Var1 | Tdap Var1 | Tdap Var1 | Tdap Var1 | Tdap Var1 | Tdap | Tdap |
| 2011–12 | Var2 | Var2 | Var2 | Var2 | Var2 | Var1 | Var1 | Var1 | Var1 | Var1 | Var1 | Var1 | |
| 2012–13 (Var1 required for grades K to 12) | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var1 | Var1 | Var1 | Var1 | Var1 | Var1 | Var1 |
| 2013–14 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | | | | | | |
| 2014–15 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | | | | | |
| 2015–16 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | | | | |
| 2016–17 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | | | |
| 2017–18 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | | |
| 2018–19 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | |
| 2019–20 (Var2 required for grades K to 12) | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 |

Before I start, I have some reference documents I have compiled to follow along with my testimony.

Good afternoon!! My name is Desirae Richards, and I am comprehensive wellness broker and I am asking you to please vote no on this bill.

I have spent over 15 years studying how to keep our populations of healthy mind, body and spirit. Despite the fact we have the highest rates of vaccine uptake of any developed nation, we spend the most on healthcare and have the highest chronic illness and SIDS rates in children and adults.

1. According to this historical data, section 1f of this bill is inaccurate, giving vaccines credit for things they did not do. The vaccines did not come into use until well after water sanitation, indoor plumbing, cleaner factories, child labor laws and city and home sanitation practices. Section 1 (a) of your bill declares that vaccines save lives, there is no data to conclude that to be true.

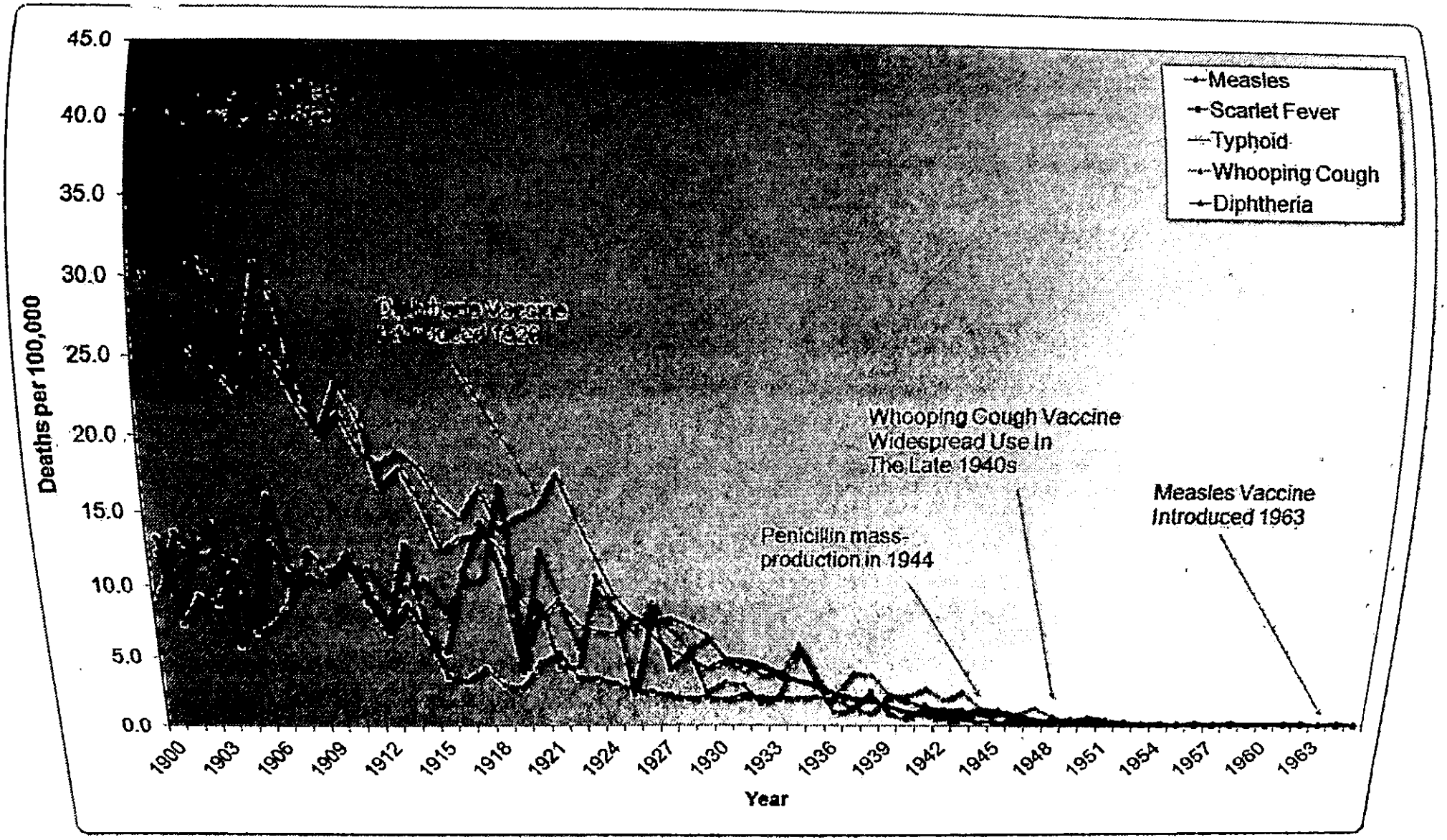
The exemptions exist because the NVIA (National Childhood Vaccine Injury Act of 1986) removed financial liability from manufacturers, doctors and medical practices for any side effects, injury, or death related to vaccines. Manufacturers continue to pay on lawsuits around the world. NVIA placed many harmful restrictions and all liability on the state, citizen consumers, insurance.

2. NVIA charged HHS and NIH with collecting bi-annual safety data from the manufacturers while creating a task force to make the vaccine program safer. In 2018, they were found out of compliance, none of these steps were taken.

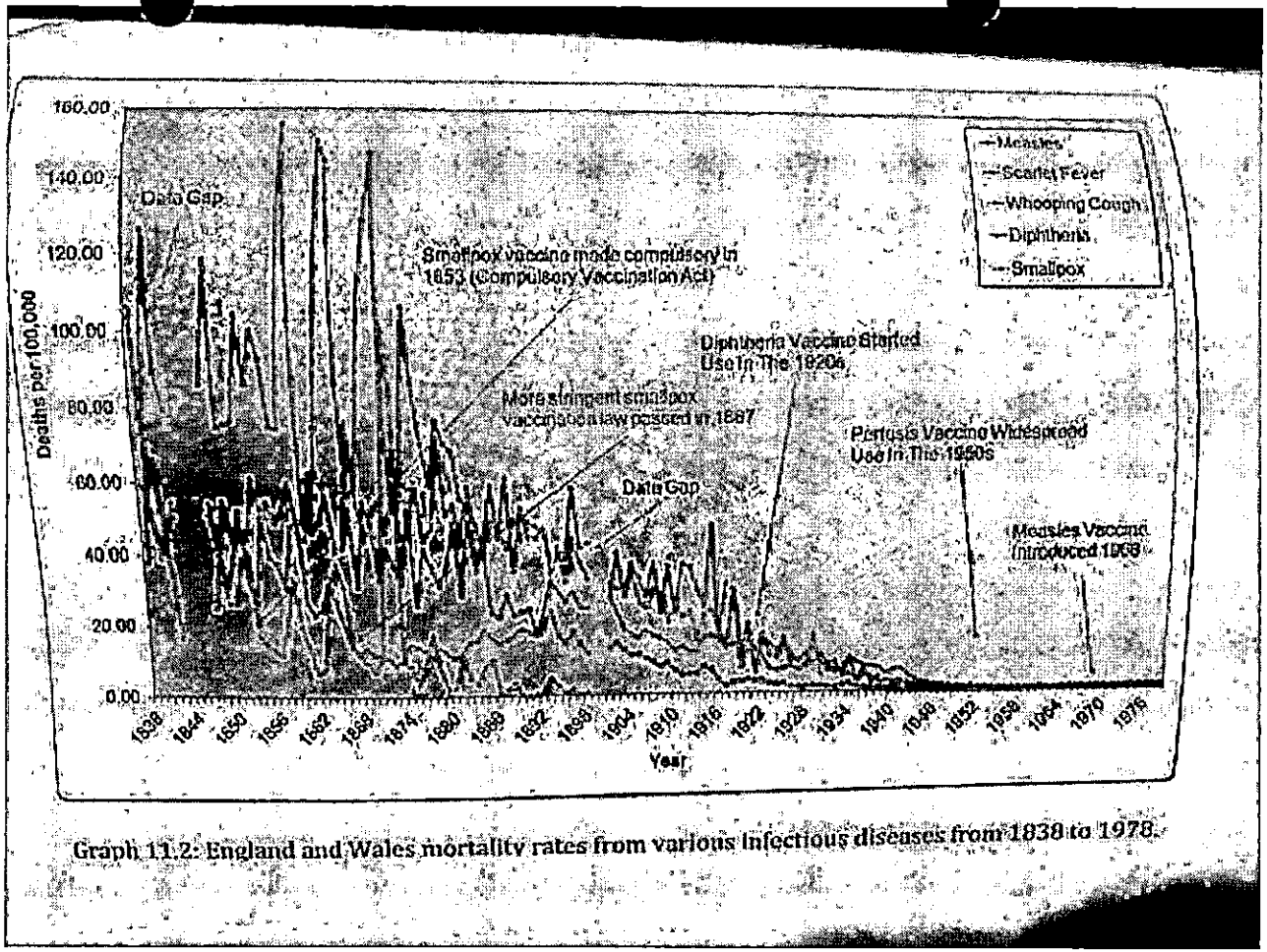
3. A study from Harvard indicating that VAERS the system to capture Vaccine Adverse Events is capturing less than 1% of injuries. NVIA has paid out over $4 billion on 1% of that 1% since its inception, so the remaining 99.9% of cost is being absorbed by the state, citizen consumers and insurance.

4. Section 1b states preventable cases cost the state $55.5 million in one year. There are very costly health issues that are exponentially higher in vaccinated children versus unvaccinated children. That CDC study is also for your review. What do these negative health consequences of the vaccine program cost the state, consumers, and insurance annually?

There are currently hundreds other mild infections that we do not vaccinate for, and do not fear. This bill only creates increased liability, and cost to the state and its citizen consumers.




Graph 14.3: United States mortality rates from various infectious diseases from 1900 to 1965.




Graph 11.2: England and Wales mortality rates from various infectious diseases from 1838 to 1978.

USDC SDNY
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ELECTRONICALLY FILED
DOC #:
DATE FILED: 07/09/2018

**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF NEW YORK**

INFORMED CONSENT ACTION NETWORK,

Plaintiff,

-against-

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

Defendant.

**STIPULATION**

18-cv-03215 (JMF)

WHEREAS, 42 U.S.C. § 300aa-27, entitled "Mandate for safer childhood vaccines," provides as follows:

> (a) General rule
>
> In the administration of this part and other pertinent laws under the jurisdiction of the Secretary [of the Department of Health and Human Services], the Secretary shall—
>
> > (1) promote the development of childhood vaccines that result in fewer and less serious adverse reactions than those vaccines on the market on December 22, 1987, and promote the refinement of such vaccines, and
> >
> > (2) make or assure improvements in, and otherwise use the authorities of the Secretary with respect to, the licensing, manufacturing, processing, testing, labeling, warning, use instructions, distribution, storage, administration, field surveillance, adverse reaction reporting, and recall of reactogenic lots or batches, of vaccines, and research on vaccines, in order to reduce the risks of adverse reactions to vaccines.
>
> . . .
>
> (c) Report
>
> Within 2 years after December 22, 1987, and periodically thereafter, the Secretary shall prepare and transmit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report describing the

> actions taken pursuant to subsection (a) of this section during the preceding 2-year period.

WHEREAS, on August 25, 2017, Informed Consent Action Network ("ICAN") submitted a Freedom of Information Act request (the "FOIA Request") to the Department of Health and Human Services ("HHS" or the "Department"), which was assigned control number 2017-01119-FOIA-OS, that sought the following records:

> **Any and all reports transmitted to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate by the Secretary of HHS pursuant to 42 U.S.C. §300aa-27(c).**

WHEREAS, on April 12, 2018, ICAN filed a Complaint for Declaratory and Injunctive Relief in the United States District Court, Southern District of New York against HHS seeking records, if any, responsive to the FOIA Request;

WHEREAS, the HHS Immediate Office of the Secretary ("IOS") maintains the official correspondence file of the Secretary of HHS, including reports to Congress by the Secretary of HHS, and therefore those files were most likely to contain records responsive to the FOIA Request;

WHEREAS, on June 27, 2018, HHS sent ICAN the following response to the FOIA Request:

> The [Department]'s searches for records did not locate any records responsive to your request. The Department of Health and Human Services (HHS) Immediate Office of the Secretary (IOS) conducted a thorough search of its document tracking systems. The Department also conducted a comprehensive review of all relevant indexes of HHS Secretarial Correspondence records maintained at Federal Records Centers that remain in the custody of HHS. These searches did not locate records responsive to your request, or indications that records responsive to your request and in the custody of HHS are located at Federal Records Centers.

WHEREAS, ICAN believes the foregoing response from HHS now resolves all claims asserted in this action;

IT IS HEREBY STIPULATED AND AGREED, by and between the parties by and through their respective counsel:

1. That the above-captioned action is voluntarily dismissed, with prejudice, pursuant to Federal Rule of Civil Procedure 41(a)(1)(A)(ii), each side to bear its own costs, attorney fees, and expenses; and

2. That this stipulation may be signed in counterparts, and that electronic (PDF) signatures may be deemed originals for all purposes.

Dated: July 6, 2018
New York, New York

KENNEDY & MODONNA LLP
*Attorney for Plaintiff*

By: _____
Robert F. Kennedy, Jr.
48 Dewitt Mills Road
Hurley, NY 12443
(845) 481-2622

Dated: July 6, 2018
New York, New York

GEOFFREY S. BERMAN
United States Attorney
*Attorney for Defendant*

By: _____
ANTHONY J. SUN
Assistant United States Attorney
86 Chambers Street, Third Floor
New York, New York 10007
(212) 637-2810
anthony.sun@usdoj.gov

SO ORDERED:

_____
HON. JESSE M. FURMAN, U.S.D.J.

Dated: New York, New York
July 6, 2018

Any pending motions are moot. All conferences are vacated. The Clerk of Court is directed to close the case.

ICAN

Informed Consent Action Network

For Immediate Release: July 13, 2018

**US District Court Judge signs order granting Plaintiff, Informed Consent Action Network (ICAN) and counsel, Robert F. Kennedy, Jr., the relief sought in a lawsuit against the US Department of Health and Human Services (HHS)**

On Monday, June 9th, the United States District Court for the Southern District of New York signed an order granting Plaintiff, the nonprofit Informed Consent Action Network (ICAN), the relief it sought against the Defendant, the United States Department of Health and Human Services, HHS. ICAN was represented by Robert F. Kennedy, Jr.

In May 2017, ICAN Founder, Del Bigtree, Robert F. Kennedy, Jr.. and a handful of other individuals concerned about vaccine safety were selected by the White House to participate in a seminal meeting with the Counselor to the Secretary of HHS, the heads of the National Institute of Health, NIH, the Center for Disease Control, CDC, and Food and the Drug Administration, FDA. Del Bigtree and Robert F. Kennedy, Jr. suspected that HHS was not fulfilling its critical vaccine safety obligations as required by Congress in The National Childhood Vaccine Injury Act of 1986.

The 1986 Act granted unprecedented, economic immunity to pharmaceutical companies for injuries caused by their products and eviscerated economic incentive for them to manufacture safe vaccine products or improve the safety of existing vaccine products. Congress therefore charged the Secretary of HHS with the explicit responsibility to assure vaccine safety.

Hence, since 1986, HHS has had the primary and virtually sole responsibility to make and assure improvements in the licensing, manufacturing, adverse reaction reporting, research, safety and efficacy testing of vaccines in order to reduce the risk of adverse vaccine reactions. In order to assure HHS meets its vaccine safety obligations, Congress required as part of the 1986 Act that the Secretary of HHS submit a biennial reports to Congress detailing the improvements in vaccine safety made by HHS in the preceding two years.

ICAN therefore filed a Freedom of Information Act, FOIA, request on August 25th, 2017 to HHS seeking copies of the biennial reports that HHS was supposed to submit to Congress, starting in 1988, detailing the improvements it made every two years to vaccine safety. HHS stonewalled ICAN for eight months refusing to provide any substantive response to this request.

ICAN
Informed Consent Action Network

ICAN was therefore forced to file a lawsuit to force HHS to either provide copies of its biennial vaccine safety reports to Congress or admit it never filed these reports. The result of the lawsuit is that HHS had to finally and shockingly admit that it never, not even once, submitted a single biennial report to Congress detailing the improvements in vaccine safety. This speaks volumes to the seriousness by which vaccine safety is treated at HHS and heightens the concern that HHS doesn't have a clue as to the actual safety profile of the now 29 doses, and growing, of vaccines given by one year of age.

In contrast, HHS takes the other portions of the 1986 Act, which require promoting vaccine uptake, very seriously, spending billions annually and generating a steady stream of reports on how to improve vaccine uptake. Regrettably, HHS has chosen to focus on its obligation to increase vaccine uptake and defend against any claim vaccines cause harm in the National Injury Vaccine Compensation Program (aka, the Vaccine Court) to such a degree that it has abandoned its vaccine safety responsibilities. If HHS is not, as confirmed in Court this week, even fulfilling the simple task of filing a biennial report on vaccine safety improvements, there is little hope that HHS is actually tackling the much harder job of actually improving vaccine safety.

For additional information or interviews please contact:
Catharine Layton, COO, ICAN
cat@icandecide.org (512) 522-8739

USDC SDNY
DOCUMENT
ELECTRONICALLY FILED
DOC #:
DATE FILED: 6/4/18

**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF NEW YORK**

INFORMED CONSENT ACTION NETWORK,

Plaintiff,

-against-

NATIONAL INSTITUTES OF HEALTH, and
HEALTH RESOURCES & SERVICES ADMINISTRATION

Defendants.

**STIPULATION**
Case 1:18-cv-02000-PAC

WHEREAS, on August 25, 2017, Informed Consent Action Network ("ICAN" or "Plaintiff") submitted a Freedom of Information Act ("FOIA") request to the National Institutes of Health ("NIH") which stated, in relevant part:

> Section 300-aa27(b) provides that "The Secretary shall establish a task force on safer childhood vaccines which shall consist of the Director of the National Institutes of Health, the Commissioner of the Food and Drug Administration, and the Director of the Centers for Disease Control." This section further provides that "The Director of the National Institutes of Health shall serve as chairman of the task force . . . [and] the task force shall prepare recommendations to the Secretary concerning implementation of the requirements of subsection (a) of this section."
>
> By this letter, please provide the following records, created after January 1, 2009, in NIH's possession to the above referenced address in electronic form on a CD or DVD:
>
> **Any and all recommendations to the Secretary of HHS pursuant to 42 U.S.C. §300aa-27(b)(3).**

WHEREAS, on March 6, 2018, ICAN filed a Complaint for Declaratory and Injunctive Relief in the United States District Court, Southern District of New York against NIH and the Health Resources & Services Administration ("HRSA", together with NIH, "Defendants");

WHEREAS, the parties hereto now desire to resolve this action;

IT IS HEREBY STIPULATED AND AGREED, by and between the parties by and through their respective counsel:

1. That after conducting a reasonable search of the files most likely to contain responsive records, neither the NIH nor HRSA were able to identify any records reflecting recommendations by the Task Force on Safer Childhood Vaccines to the Secretary of the Department of Health & Human Services pursuant to 42 U.S.C. § 300aa-27(b)(3) at any time between from January 1, 2009 and April 10, 2018, the date the searches were completed;

2. That the above-captioned action is voluntarily dismissed, with prejudice pursuant to Federal Rule of Civil Procedure 41(a)(1)(A)(ii), each side to bear its own costs, attorney fees, and expenses; and

3. That this stipulation may be signed in counterparts, and that electronic (PDF) or fax signatures may be deemed originals for all purposes.

Dated: June 1, 2018
New York, New York

SIRI & GLIMSTAD LLP
Attorney for Plaintiff

By: _____
200 Park Avenue, 17th Floor
New York, New York 10166
(212) 532-1091
aaron@sirillp.com

Dated: May 31, 2018
New York, New York

GEOFFREY S. BERMAN
United States Attorney
Attorney for Defendants

By: _____
STEPHEN CHA-KIM
Assistant United States Attorney
86 Chambers Street, Third Floor
New York, New York 10007
(212) 637-2768
stephen.cha-kim@usdoj.gov

Dwight New York
June 4, 2018

So Ordered
Paul A. Crotty
USDJ

*Grant Final Report*
**Grant ID: R18 HS 017045**

# Electronic Support for Public Health–Vaccine Adverse Event Reporting System (ESP:VAERS)

**Inclusive dates: 12/01/07 - 09/30/10**

**Principal Investigator:**
Lazarus, Ross, MBBS, MPH, MMed, GDCompSci

**Team members:**
Michael Klompas, MD, MPH

**Performing Organization:**
Harvard Pilgrim Health Care, Inc.

**Project Officer:**
Steve Bernstein

**Submitted to:**
**The Agency for Healthcare Research and Quality (AHRQ)**
**U.S. Department of Health and Human Services**
**540 Gaither Road**
**Rockville, MD 20850**
**www.ahrq.gov**

# Abstract

**Purpose:** To develop and disseminate HIT evidence and evidence-based tools to improve healthcare decision making through the use of integrated data and knowledge management.

**Scope:** To create a generalizable system to facilitate detection and clinician reporting of vaccine adverse events, in order to improve the safety of national vaccination programs.

**Methods:** Electronic medical records available from all ambulatory care encounters in a large multi-specialty practice were used. Every patient receiving a vaccine was automatically identified, and for the next 30 days, their health care diagnostic codes, laboratory tests, and medication prescriptions were evaluated for values suggestive of an adverse event.

**Results:** Restructuring at CDC and consequent delays in terms of decision making have made it challenging despite best efforts to move forward with discussions regarding the evaluation of ESP:VAERS performance in a randomized trial and comparison of ESP:VAERS performance to existing VAERS and Vaccine Safety Datalink data. However, Preliminary data were collected and analyzed and this initiative has been presented at a number of national symposia.

**Key Words:** electronic health records, vaccinations, adverse event reporting

The authors of this report are responsible for its content. Statements in the report should not be construed as endorsement by the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services of a particular drug, device, test, treatment, or other clinical service.

# Final Report

## Purpose

This research project was funded to improve the quality of vaccination programs by improving the quality of physician adverse vaccine event detection and reporting to the national Vaccine Adverse Event Reporting System (VAERS), via the following aims:

**Aim 1.** Identify required data elements, and develop systems to monitor ambulatory care electronic medical records for adverse events following vaccine administration.

**Aim 2.** Prepare, and securely submit clinician approved, electronic reports to the national Vaccine Adverse Event Reporting System (VAERS).

**Aim 3.** Comprehensively evaluate ESP:VAERS performance in a randomized trial, and in comparison to existing VAERS and Vaccine Safety Datalink data.

**Aim 4.** Distribute documentation and application software developed and refined in Aims 1 and 2 that are portable to other ambulatory care settings and to other EMR systems.

## Scope

Public and professional confidence in vaccination depends on reliable postmarketing surveillance systems to ensure that rare and unexpected adverse effects are rapidly identified. The goal of this project is to improve the quality of vaccination programs by improving the quality of physician adverse vaccine event detection and reporting to the national Vaccine Adverse Event Reporting System (VAERS). This project is serving as an extension of the Electronic Support for Public Health (ESP) project, an automated system using electronic health record (EHR) data to detect and securely report cases of certain diseases to a local public health authority. ESP provides a ready-made platform for automatically converting clinical, laboratory, prescription, and demographic data from almost any EHR system into database tables on a completely independent server, physically located and secured by the same logical and physical security as the EHR data itself. The ESP:VAERS project developed criteria and algorithms to identify important adverse events related to vaccinations in ambulatory care EHR data, and made attempts at formatting and securely sending electronic VAERS reports directly to the Centers for Disease Control and Prevention (CDC).

Patient data were available from Epic System's Certification Commission for Health Information Technology-certified EpicCare system at all ambulatory care encounters within Atrius Health, a large multispecialty group practice with over 35 facilities. Every patient receiving a vaccine was automatically identified, and for the next 30 days, their health care diagnostic codes, laboratory tests, and medication prescriptions are evaluated for values

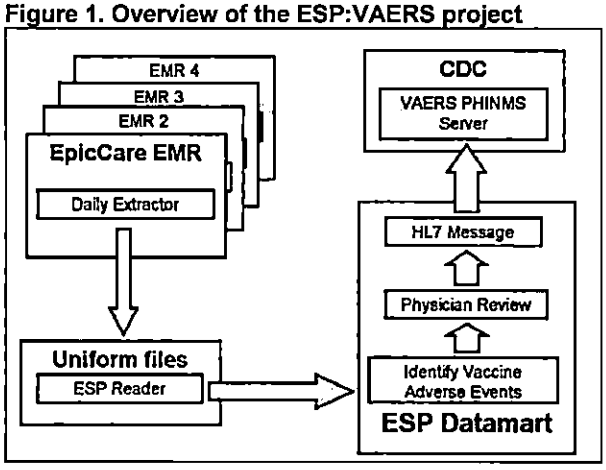
suggestive of an adverse vaccine event. When a possible adverse event was detected, it was recorded, and the appropriate clinician was to be notified electronically.

Clinicians in-basket messaging was designed to provide a preview a pre-populated report with information from the EHR about the patient, including vaccine type, lot number, and possible adverse effect, to inform their clinical judgment regarding whether they wish to send a report to VAERS. Clinicians would then have the option of adding free-text comments to pre-populated VAERS reports or to document their decision not to send a report. The CDC's Public Health Information Network Messaging System (PHIN-MS) software was installed within the facilities so that the approved reports could be securely transferred to VAERS as electronic messages in an interoperable health data exchange format using Health Level 7 (HL7).

# Methods

The goal of Aim 1: *Identify required data elements, and develop systems to monitor ambulatory care electronic medical records for adverse events following vaccine administration*, and Aim 2: *Prepare, and securely submit clinician approved, electronic reports to the national Vaccine Adverse Event Reporting System (VAERS)*, was to construct the below flow of data in order to support the first two Aims:

**Figure 1. Overview of the ESP:VAERS project**




Existing and functioning ESP components are shown on the left, and Aims 1 and 2 on the right. ESP:VAERS flags every vaccinated patient, and prospectively accumulate that patient's diagnostic codes, laboratory tests, allergy lists, vital signs, and medication prescriptions. A main component of Aim 1 was to *Develop AE criteria to assess these parameters for new or abnormal values that might be suggestive of an adverse effect.* A reporting protocol & corresponding algorithms were developed to detect potential adverse event cases using diagnostic codes, and methods were tested to identify prescriptions or abnormal laboratory values that might be suggestive of an adverse effect. These algorithms were designed to seek both expected and unexpected adverse effects.

This reporting protocol was approved by both internal & external partners. We initially prepared a draft document describing the elements, algorithms, interval of interest after vaccination, and actions for broad classes of post-vaccination events, including those to be reported immediately without delay (such as acute anaphylactic reaction following vaccination), those never to be reported (such as routine check-ups following vaccination) and those to be reported at the discretion and with additional information from the attending physician through a feedback mechanism. The draft was then widely circulated as an initial / working draft for comment by relevant staff in the CDC and among our clinical colleagues at Atrius. In addition to review by the internal CDC Brighton Collaboration liaison, this protocol has also received review & comment via the CDC's Clinical Immunization Safety Assessment (CISA) Network.

The goal of Aim 2 was the *Development of HL7 messages code for ESP:VAERS to ensure secure transmission to CDC via PHIN-MS.* The HL7 specification describing the elements for an electronic message to be submitted to Constella, the consultants engaged by CDC for this project was implemented. Synthetic and real test data was been generated and transmitted between Harvard and Constella. However, real data transmissions of non-physician approved reports to the CDC was unable to commence, as by the end of this project, the CDC had yet to respond to multiple requests to partner for this activity.

The goal of Aim 3 was to *Comprehensively evaluate ESP:VAERS performance in a randomized trial, and in comparison to existing VAERS and Vaccine Safety Datalink data.*

We had initially planned to evaluate the system by comparing adverse event findings to those in the Vaccine Safety Datalink project—a collaborative effort between CDC's Immunization Safety Office and eight large managed care organizations. Through a randomized trial, we would also test the hypothesis that the combination of secure, computer-assisted, clinician-approved, adverse event detection, and automated electronic reporting will substantially increase the number, completeness, validity, and timeliness of physician-approved case reports to VAERS compared to the existing spontaneous reporting system; however, due to restructuring at CDC and consequent delays in terms of decision making, it became impossible to move forward with discussions regarding the evaluation of ESP:VAERS performance in a randomized trial, and compare ESP:VAERS performance to existing VAERS and Vaccine Safety Datalink data. Therefore, the components under this particular Aim were not achieved.

Aim 4 *Distribution of documentation and application software developed and refined in Aims 1 and 2 that are portable to other ambulatory care settings and to other EMR systems* has been successfully completed. Functioning source code is available to share under an approved open source license. ESP:VAERS source code is available as part of the ESP source code distribution. It is licensed under the LGPL, an open source license compatible with commercial use. We have added the ESP:VAERS code, HL7 and other specifications and documentation to the existing ESP web documentation and distribution resource center http://esphealth.org, specifically, the Subversion repository available at:
http://esphealth.org/trac/ESP/wiki/ESPVAERS.

# Results

Preliminary data were collected from June 2006 through October 2009 on 715,000 patients, and 1.4 million doses (of 45 different vaccines) were given to 376,452 individuals. Of these doses, 35,570 possible reactions (2.6 percent of vaccinations) were identified. This is an average of 890 possible events, an average of 1.3 events per clinician, per month. These data were presented at the 2009 AMIA conference.

In addition, ESP:VAERS investigators participated on a panel to explore the perspective of clinicians, electronic health record (EHR) vendors, the pharmaceutical industry, and the FDA towards systems that use proactive, automated adverse event reporting.

Adverse events from drugs and vaccines are common, but underreported. Although 25% of ambulatory patients experience an adverse drug event, less than 0.3% of all adverse drug events and 1-13% of serious events are reported to the Food and Drug Administration (FDA). Likewise, fewer than 1% of vaccine adverse events are reported. Low reporting rates preclude or slow the identification of "problem" drugs and vaccines that endanger public health. New surveillance methods for drug and vaccine adverse effects are needed. Barriers to reporting include a lack of clinician awareness, uncertainty about when and what to report, as well as the burdens of reporting: reporting is not part of clinicians' usual workflow, takes time, and is duplicative. Proactive, spontaneous, automated adverse event reporting imbedded within EHRs and other information systems has the potential to speed the identification of problems with new drugs and more careful quantification of the risks of older drugs.

Unfortunately, there was never an opportunity to perform system performance assessments because the necessary CDC contacts were no longer available and the CDC consultants responsible for receiving data were no longer responsive to our multiple requests to proceed with testing and evaluation.

## Inclusion of AHRQ Priority Populations

The focus of our project was the Atrius Health (formerly HealthOne) provider & patient community. This community serves several AHRQ inclusion populations, specifically low-income and minority populations in primarily urban settings.

Atruis currently employs approximately 700 physicians to serve 500,000 patients at more than 18 office sites spread throughout the greater Metropolitan Boston area. The majority of Atruis physicians are primary care internal medicine physicians or pediatricians but the network also includes physicians from every major specialty.

The entire adult and pediatric population served by Atruis was included in our adverse event surveillance system (ESP:VAERS). Atruis serves a full spectrum of patients that reflects the broad diversity of Eastern Massachusetts. A recent analysis suggests that the population served by Atruis is 56% female, 16.6% African American, 4% Hispanic. The prevalence of type 2 diabetes in the adult population is 5.7%. About a quarter of the Atruis population is under age 18.

# List of Publications and Products

ESP:VAERS [source code available as part of the ESP source code distribution]. Licensed under the GNU Lesser General Public License (LGPL), an open source license compatible with commercial use. Freely available under an approved open source license at: http://esphealth.org.

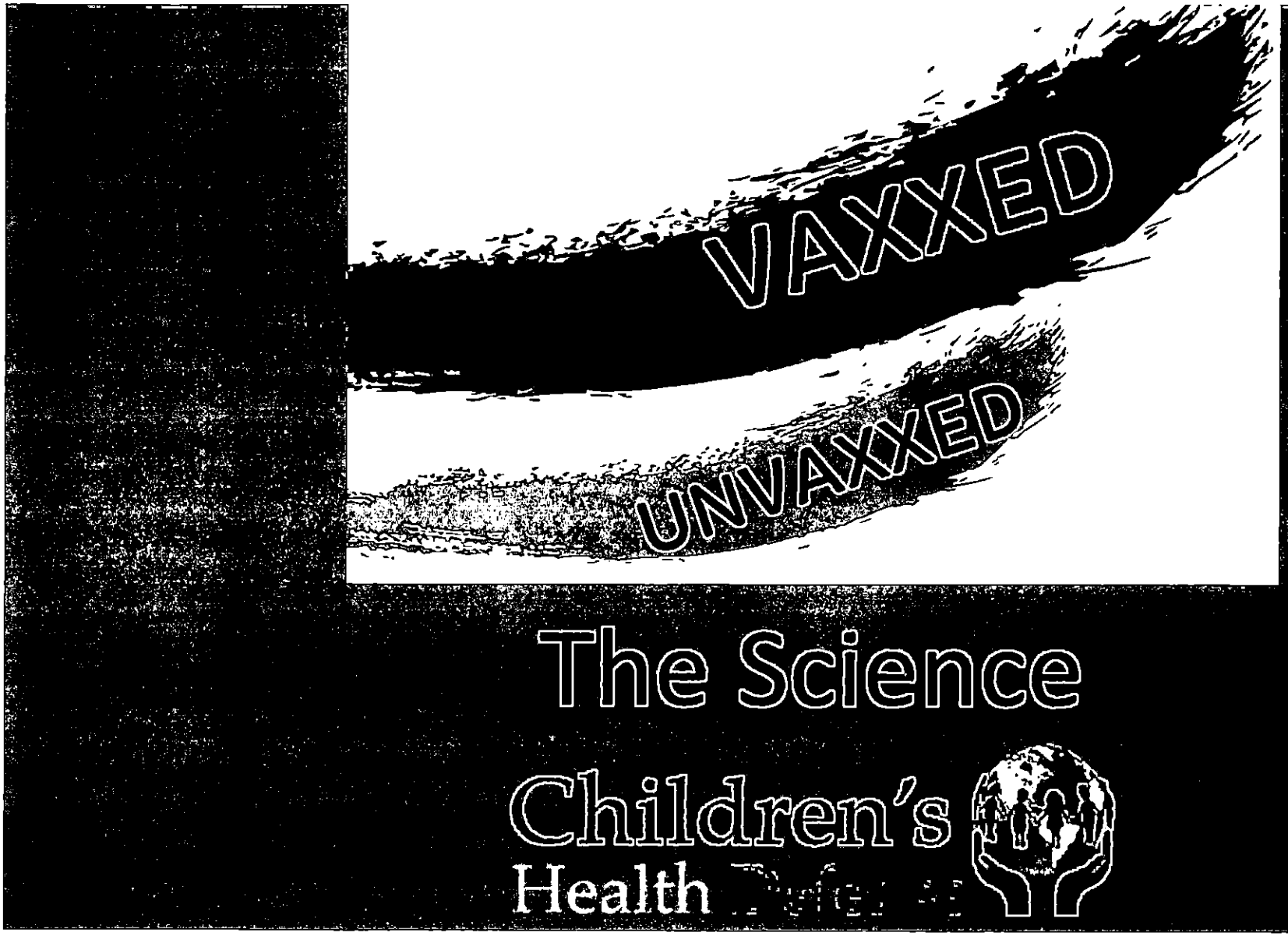
Lazarus, R, Klompas M, Hou X, Campion FX, Dunn J, Platt R. Automated Electronic Detection & Reporting of Adverse Events Following Vaccination: ESP:VAERS. The CDC Vaccine Safety Datalink (VSD) Annual Meeting. Atlanta, GA; April, 2008.

Lazarus R, Klompas M Automated vaccine adverse event detection and reporting from electronic medical records. CDC Public Health Informatics Network (PHIN) Conference August 27, 2008.

Klompas M, Lazarus R ESP:VAERS Presented at the American Medical Informatics Association Annual Symposium; 2009 November 17th.

Lazarus R, Klompas M, Kruskal B, Platt R Temporal patterns of fever following immunization in ambulatory care data identified by ESP:VAERS Presented at the American Medical Informatics Association Annual Symposium; 2009 November 14–18: San Francisco, CA.

Linder J, Klompas M, Cass B, et al. Spontaneous Electronic Adverse Event Reporting: Perspectives from Clinicians, EHR Vendors, Biopharma, and the FDA. Presented at the American Medical Informatics Association Annual Symposium; 2009 November 14–18: San Francisco, CA.


VAXXED
UNVAXXED
The Science
Children's
Health

# Generation 1: CDC's Unpublished Verstraeten Study on Hep B Showed Dramatic Increased Risk of Autism (7.6X), Sleep Disorders (5X), Speech Disorders (2.1X) and Neurodevelopmental Disorders (1.8X)

Verstraeten, Thomas M., MD, NIP, Division of Epidemiology and Surveillance, Vaccine Safety and Development Branch, Mailstop E-61, 770-639-8327.
EIS Class Year of Entry: 1999
No previous EIS Conference presentations
Mackel Award consideration: No
Number of abstracts submitted: 2, priority this abstract: 1
Strong preference for poster presentation: No

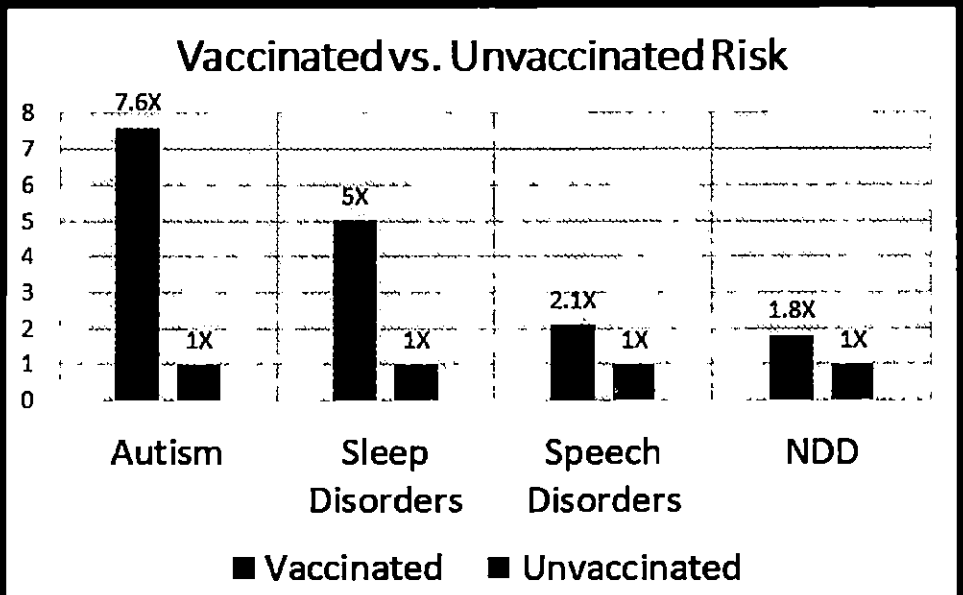
Thomas M. Verstraeten, R. Davies, D. Gu, F DeStefano

**Increased risk of developmental neurologic impairment after high exposure to thimerosal-containing vaccine in first month of life.**

**Background:** Concern has risen on the presence of the ethylmercury containing preservative thimerosal in vaccines. We assessed the risk for neurologic and renal impairment associated with past exposure to thimerosal-containing vaccine using automated data from the Vaccine Safety Datalink (VSD). VSD is a large linked database from four health maintenance organizations in Washington, Oregon and California, containing immunization, medical visit and demographic data on over 400,000 infants born between '91 and '97.

**Methods:** We categorized the cumulative ethylmercury exposure from thimerosal containing vaccines after one month of life and assessed the subsequent risk of degenerative and developmental neurologic disorders and renal disorders before the age of six. We applied proportional hazard models adjusting for HMO, year of birth, and gender, excluding premature babies.

**Results:** We identified 286 children with degenerative and 3702 with developmental neurologic disorders, and 310 with renal disorders. The relative risk (RR) of developing a neurologic development disorder was 1.8 (95% confidence intervals [CI] = 1.1-2.8) when comparing the highest exposure group at 1 month of age (cumulative dose > 25 ug) to the unexposed group. Within this group we also found an elevated risk for the following disorders: autism (RR 7.6, 95% CI = 1.8-31.5), nonorganic sleep disorders (RR 5.0, 95% CI = 1.6-15.9), and speech disorders (RR 2.1, 95% CI=1.1-4.0). For the neurologic degenerative or renal impairment. Further confirmatory studies are needed.




CDC UNPUBLISHED DATA OBTAINED BY FOIA

**"The relative risk (RR) of developing a neurologic development disorder was 1.8 (95% confidence intervals [CI] = 1.1-2.8) when comparing the highest exposure group at 1 month of age (cumulative dose > 25 ug) to the unexposed group. Within this group we also found an elevated risk for the following disorders: autism (RR 7.6, 95% CI=1.8-31.5), nonorganic sleep disorder (RR 5.0, 95% CI=1.6-15.9), and speech disorders (RR 2.1, 95% CI=1.1-4.0)."**

Health

# DTP and Tetanus Vaccinations Increase the Odds of Allergies (1.63X) in Children

PubMed

Advanced

Format: Abstract

Send to

**Effects of diphtheria-tetanus-pertussis or tetanus vaccination on allergies and allergy-related respiratory symptoms among children and adolescents in the United States.**

Author information

Abstract

BACKGROUND: Findings from animal and human studies confirm that diphtheria and tetanus toxoids and pertussis (DTP) and tetanus vaccinations induce allergic responses. Associations between childhood vaccinations and subsequent allergies have been reported recently.

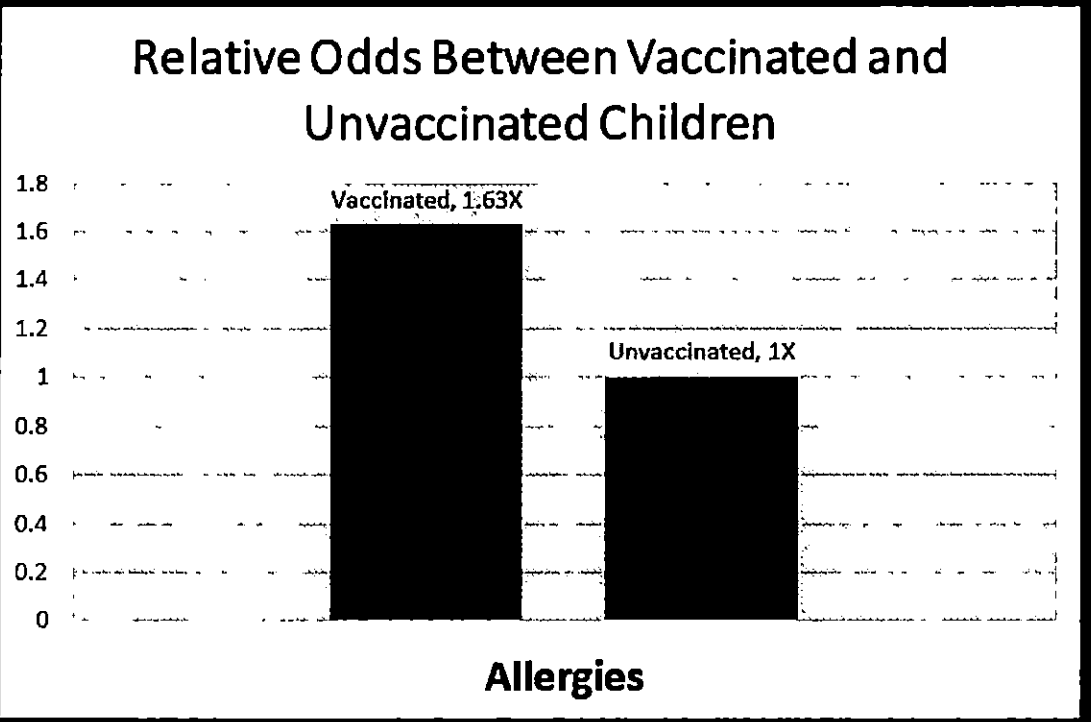
OBJECTIVE: The association of DTP or tetanus vaccination with allergies and allergy-related respiratory symptoms among children and adolescents in the United States was assessed.

METHODS: Data were used from the Third National Health and Nutrition Examination Survey on infants aged 2 months through adolescents aged 16 years. DTP or tetanus vaccination, lifetime allergy history, and allergy symptoms in the past 12 months were based on parental or guardian recall. Logistic regression modeling was performed to estimate the effects of DTP or tetanus vaccination on each allergy.

RESULTS: The odds of having a history of eczema was twice as great among vaccinated subjects than among unvaccinated subjects (adjusted odds ratio, 2.00; 95% confidence interval, 0.59 to 6.74). The odds of having had any allergy-related respiratory symptom in the past 12 months was 63% greater among vaccinated subjects than unvaccinated subjects (adjusted odds ratio, 1.63; 95% confidence interval, 1.05 to 2.54). The associations between vaccination and subsequent allergies and symptoms were greatest among children aged 5 through 10 years.

CONCLUSIONS: DTP or tetanus vaccination appears to increase the risk of allergies and related respiratory symptoms in children and adolescents. Although it is unlikely that these results are entirely because of any sources of bias, the small number of unvaccinated subjects and the study design limit our ability to make firm causal inferences about the true magnitude of effect.

**Published Feb 2000**




**"The odds of having had any allergy-related respiratory symptom in the past 12 months was 63% greater among vaccinated subjects than unvaccinated subjects. Conclusions: DTP or tetanus vaccination appears to increase the risk of allergies and related respiratory symptoms in children and adolescents."**

Health

# Hepatitis B Vaccines Increase the Odds for Special Education by 8.63X

Original Articles

## Hepatitis B triple series vaccine and developmental disability in US children aged 1–9 years

Carolyn Gallagher & Melody Goodman

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Download citation https://doi.org/10.1080/02772240701826501

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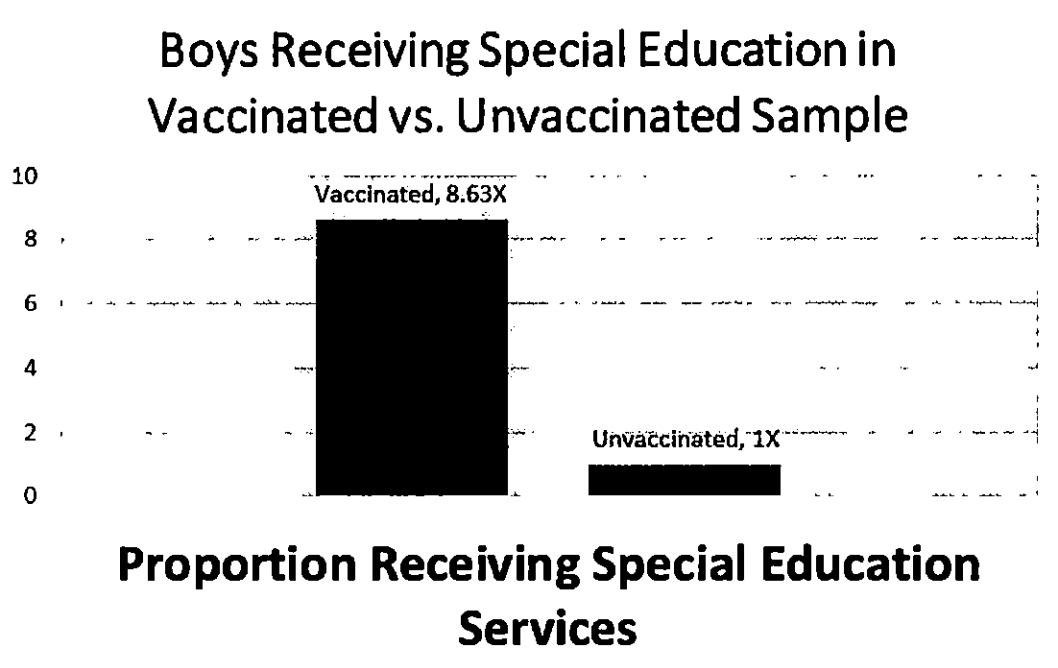
### Abstract

This study investigated the association between vaccination with the Hepatitis B triple series vaccine prior to 2000 and developmental disability in children aged 1–9 years ($n$ = 1824), proxied by parental report that their child receives early intervention or special education services (EIS). National Health and Nutrition Examination Survey 1999–2000 data were analyzed and adjusted for survey design by Taylor Linearization using SAS version 9.1 software, with SAS callable SUDAAN version 9.0.1. The odds of receiving EIS were approximately nine times as great for vaccinated boys ($n$ = 46) as for unvaccinated boys ($n$ = 7), after adjustment for confounders. This study found statistically significant evidence to suggest that boys in United States who were vaccinated with the triple series Hepatitis B vaccine, during the time period in which vaccines were manufactured with thimerosal, were more susceptible to developmental disability than were unvaccinated boys.

**Published Oct 2008**




**"The odds of receiving EIS were approximately nine times as great for vaccinated boys (n=46) as for unvaccinated boys (n=7) after adjustment for confounders."**

Health

# Hepatitis B Vaccines in Male Newborns Increased the Odds of Autism 3X

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J Toxicol Environ Health A. 2010;73(24):1665-77. doi: 10.1080/15287394.2010.519317.

**Hepatitis B vaccination of male neonates and autism diagnosis, NHIS 1997-2002.**

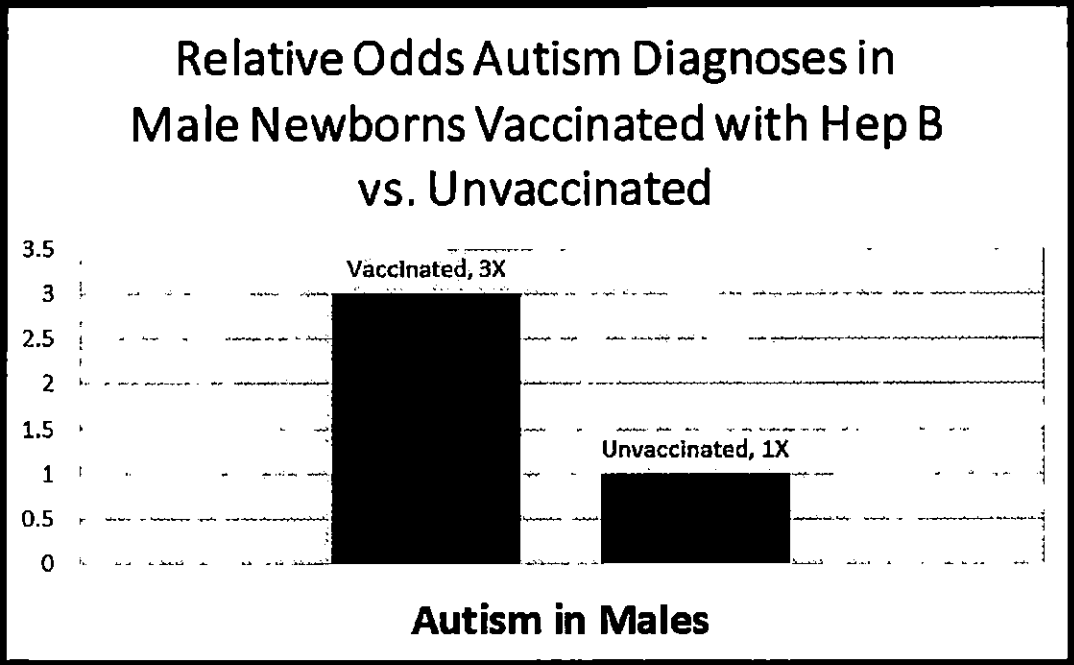
Gallagher CM[1], Goodman MS.

⊕ Author information

**Abstract**

Universal hepatitis B vaccination was recommended for U.S. newborns in 1991; however, safety findings are mixed. The association between hepatitis B vaccination of male neonates and parental report of autism diagnosis was determined. This cross-sectional study used weighted probability samples obtained from National Health Interview Survey 1997-2002 data sets. Vaccination status was determined from the vaccination record. Logistic regression was used to estimate the odds for autism diagnosis associated with neonatal hepatitis B vaccination among boys age 3-17 years, born before 1999, adjusted for race, maternal education, and two-parent household. Boys vaccinated as neonates had threefold greater odds for autism diagnosis compared to boys never vaccinated or vaccinated after the first month of life. Non-Hispanic white boys were 64% less likely to have autism diagnosis relative to nonwhite boys. Findings suggest that U.S. male neonates vaccinated with the hepatitis B vaccine prior to 1999 (from vaccination record) had a threefold higher risk for parental report of autism diagnosis compared to boys not vaccinated as neonates during that same time period. Nonwhite boys bore a greater risk.

**Published Nov 2010**




**"Boys vaccinated as neonates had threefold greater odds for autism diagnosis compared to boys never vaccinated or vaccinated after the first month of life. Non-Hispanic white boys were 64% less likely to have autism diagnosis relative to nonwhite boys. Findings suggest that U.S. male neonates vaccinated with the hepatitis B vaccine prior to 1999 (from vaccination record) had a threefold higher risk for parental report of autism diagnosis compared to boys not vaccinated as neonates during that same time period. Nonwhite boys bore a greater risk."**

Health . .

# Flu Shot Increases Rate of Non-Flu Infection 4.4X

BRIEF REPORT

## Increased Risk of Noninfluenza Respiratory Virus Infections Associated With Receipt of Inactivated Influenza Vaccine

Benjamin J. Cowling,[1] Vicky J. Fang,[1] Hiromichi Nishiura,[1,2] Kwok-Hung Chan,[1] Sophia Ng,[1] Dennis K. M. Ip,[1] Susan S. Chiu,[3] Gabriel M. Leung,[1] and J. S. Malik Peiris[3,4]

[1]School of Public Health, Li Ka Shing Faculty of Medicine, The University of Hong Kong, Pokfulam, Hong Kong SAR, China; [2]PRESTO, Japan Science and Technology Agency, Saitama; [3]Department of Microbiology, Li Ka Shing Faculty of Medicine, The University of Hong Kong, Queen Mary Hospital; [4]Department of Pediatrics and Adolescent Medicine, The University of Hong Kong, Queen Mary Hospital, and [5]Centre for Influenza Research, Li Ka Shing Faculty of Medicine, The University of Hong Kong, Pokfulam, Hong Kong SAR, China

We randomized 115 children to trivalent inactivated influenza vaccine (TIV) or placebo. Over the following 9 months, TIV recipients had an increased risk of virologically-confirmed non-influenza infections (relative risk: 4.40; 95% confidence interval: 1.31-14.8). Being protected against influenza, TIV recipients may lack temporary non-specific immunity that protected against other respiratory viruses.

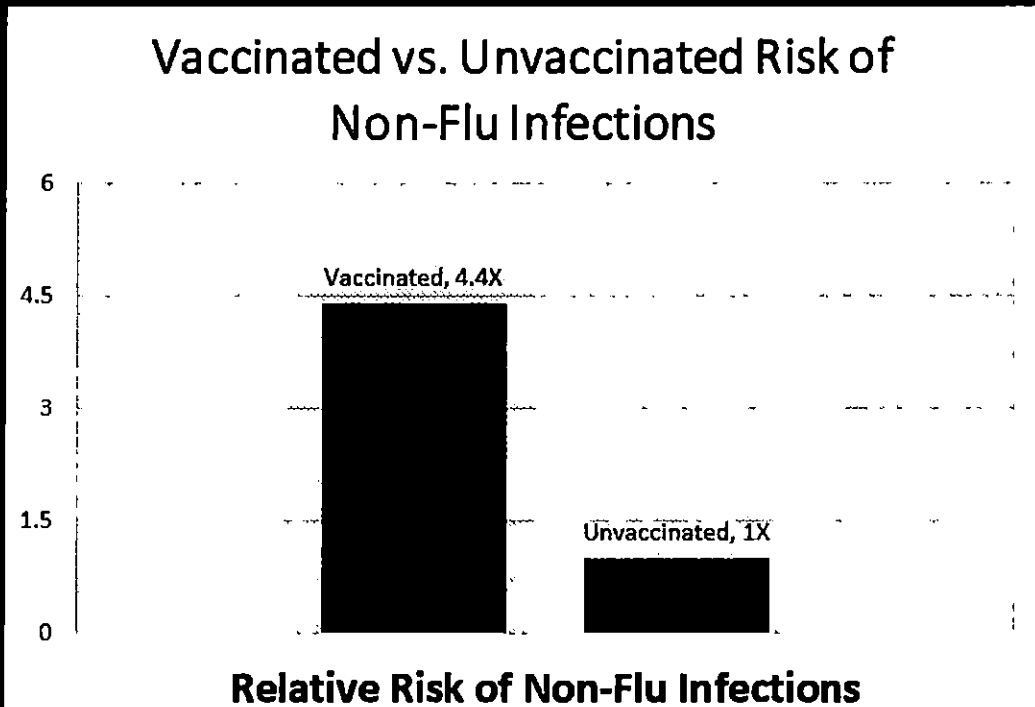
### METHODS

#### Recruitment and Follow-up of Participants

In a double-blind randomized controlled trial, we randomly allocated children aged 6–15 years to receive 2008–2009 seasonal trivalent influenza inactivated vaccine (TIV; 0.5 mL Vaxigrip, Sanofi Pasteur) or placebo [16]. Serum specimens were obtained from participants before vaccination from November through December 2008, a month after vaccination, in mid-July around April 2009, and at the end of the study from August through October 2009. Participants were followed up for illnesses through symptom diaries and telephone calls, and illness reports in any household member triggered home visits during which nasal and throat swab specimens (NTSs) were collected from all household members. We defined the follow-up period for each participant from 14 days after receipt of TIV or placebo to collection of mid-study serum samples as the winter season and from collection of mid-study samples through final serum sample obtainment as the summer season.

Proxy written informed consent was obtained for all participants from their parents or legal guardians, with additional written assent from those ≥8 years of age. The study protocol was approved by the Institutional Review Board of Hong Kong University.

**Published Mar 2012**




**"There was no statistically significant difference in the risk of confirmed seasonal influenza infection between recipients of TIV or placebo."**

**"TIV recipients had higher risk of confirmed non-influenza respiratory virus infection."**

Health

# DTP Increases Mortality in Girls 10X

Contents lists available at ScienceDirect

EBioMedicine

journal homepage: www.ebiomedicine.com

Research Paper

## The Introduction of Diphtheria-Tetanus-Pertussis and Oral Polio Vaccine Among Young Infants in an Urban African Community: A Natural Experiment

Soren Wengel Mogensen [a,1], Andreas Andersen [b,1], Amabelia Rodrigues [a], Christine S Benn [b,c], Peter Aaby [a,b,*]

ARTICLE INFO

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Diphtheria-tetanus-pertussis vaccine
DTP
Measles vaccine
Non-specific effects of vaccines
Oral polio vaccine

ABSTRACT

Background: We examined the introduction of diphtheria-tetanus-pertussis (DTP) and oral polio vaccine (OPV) in an urban community in Guinea-Bissau in the early 1980s.

Methods: The child population had been followed with 3-monthly nutritional weighing sessions since 1978. From June 1981 DTP and OPV were offered from 3 months of age at these sessions. Due to the 3-monthly intervals between sessions, the children were allocated by birthday in a 'natural experiment' to receive vaccinations early or late between 3 and 5 months of age. We included children who were < 6 months of age when vaccinations started and children born until the end of December 1983. We compared mortality between 3 and 5 months of age of DTP vaccinated and not yet DTP vaccinated children in Cox proportional hazard models.

Results: Among 3–5 month old children, having received DTP (± OPV) was associated with a mortality hazard ratio (HR) of 5.00 (95% CI 1.53–16.3) compared with not yet DTP vaccinated children. Differences in background factors did not explain the effect. The negative effect was particularly strong for children who had received DTP only and no OPV (HR = 10.0 (2.61–38.6)). All cause infant mortality after 3 months of age increased after the introduction of these vaccines (HR = 2.13 (1.07–4.19)).

Conclusion: DTP was associated with increased mortality; OPV may modify the effect of DTP.

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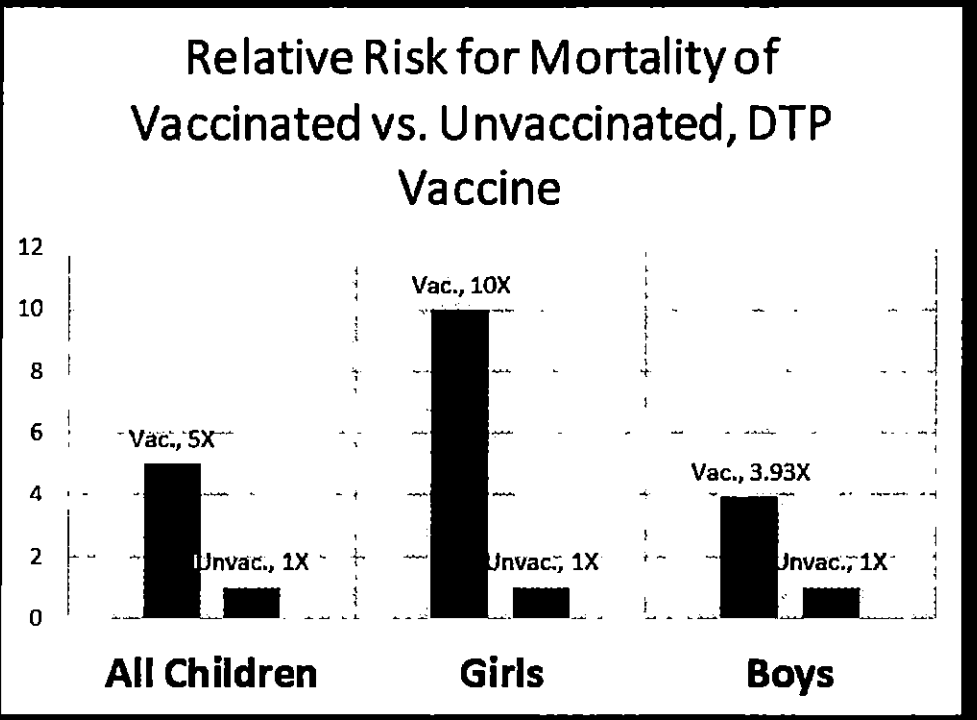
**Published Jan 2017**




**"DTP vaccinations were associated with increased infant mortality even though there was no vaccine-induced herd immunity. When unvaccinated controls were normal children who had not yet been eligible for vaccination, mortality was 5 times higher for DTP-vaccinated children."**

**"All currently available evidence suggests that DTP vaccine may kill more children from other causes than it saves from diphtheria, tetanus, or pertussis."**

**Table 3**
Mortality rate and hazard rate (HR) for children from 3 months of age until first examination without vaccination or 6 months of age. Natural experiment.

| Age group 3–5 months | Mortality rate (deaths/person-years) | | | HR (95% CI) DTP vs unvaccinated |
|---|---|---|---|---|
| All Unvaccinated (N = 651) | 4.5 (5/111.4) | DTP (±OPV) (N = 462) | 17.4 (11/63.1) | 5.00 (1.53–16.3) |
| | | DTP only (N = 101) | 35.2 (5/14.2) | 10.0 (2.61–38.6) |

**10X**

# Vaccination of Preemies Increased Odds of Neurodevelopmental Disorders 6.6X

Journal of Translational Science

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Research Article ISSN: 2059-26BX

## Preterm birth, vaccination and neurodevelopmental disorders: a cross-sectional study of 6- to 12-year-old vaccinated and unvaccinated children

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[2]Associate Professor, School of Public Health, Jackson State University, Jackson, MS 39213, USA

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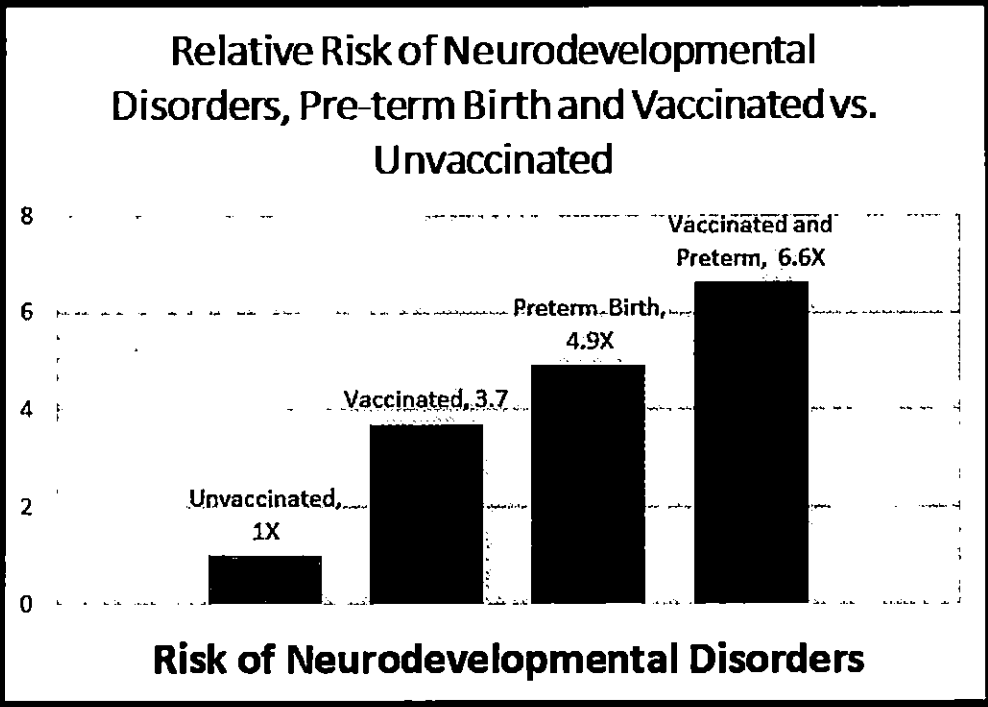
[4]President, National Home Education Research (NHERI), P.O. Box 13939, Salem, OR 97309, USA

**Abstract**

From about 0% to 27% of extremely preterm infants develop symptoms of autism spectrum disorder, but the causes are not well understood. Preterm infants receive the same doses of the recommended vaccines and on the same schedule as term infants. The possible role of vaccination in neurodevelopmental disorders (NDD) among premature infants is unknown, in part because pre-licensure clinical trials of pediatric vaccines have excluded ex-preterm infants. This paper explores the association between preterm birth, vaccination and NDD, based on a secondary analysis of data from an anonymous survey of mothers, comparing the birth history and health outcomes of vaccinated and unvaccinated homeschool children 6 to 12 years of age. A convenience sample of 666 children was obtained, of which 261 (39%) were unvaccinated, 7.5% had an NDD (defined as a learning disability, Attention Deficit Hyperactivity Disorder and/or Autism Spectrum Disorder), and 7.2% were born preterm. No association was found between preterm birth and NDD in the absence of vaccination, but vaccination was significantly associated with NDD in children born at term (OR 2.7, 95% CI: 1.2, 6.0). However, vaccination coupled with preterm birth was associated with increasing odds of NDD, ranging from 5.4 (95% CI: 2.5, 11.9) compared to vaccinated but non-preterm children, to 14.5 (95% CI: 5.4, 38.7) compared to children who were neither preterm nor vaccinated. The results of this pilot study suggest clues to the epidemiology and causation of NDD but question the safety of current vaccination practices for preterm infants. Further research is needed to validate and investigate these associations in order to optimize the impact of vaccines on children's health.

**Published April 2017**




**"Vaccination (i.e., receipt of one of more of the recommended vaccines) was significantly associated with NDD, while preterm birth without vaccination was not. Preterm birth coupled with vaccination, however, was associated with a synergistic increase in the odds of NDD, suggesting the possibility that vaccination could precipitate adverse neurodevelopmental outcomes in preterm infants. These results provide clues to the epidemiology and causation of NDD but question the safety of current vaccination programs for preterm infants."**

Health

# Vaccination Increases Risk of Allergic Rhinitis (30X), Allergy (3.1X), ADHD (4.2X), Autism (4.2X), Eczema (2.9X), Learning Disability (5.2X) and Neurodevelopmental Disorders (3.7X)

Journal of Translational Science

Research Article ISSN: 2059-268X

## Pilot comparative study on the health of vaccinated and unvaccinated 6- to 12-year-old U.S. children

Anthony R Mawson*, Brian D Ray², Azad R Bhuiyan³ and Binu Jacob⁴

¹Professor, Department of Epidemiology and Biostatistics, School of Public Health, Jackson State University, Jackson, MS 39213, USA

²President, National Home Education Research Institute, PO Box 13939, Salem, OR 97309, USA

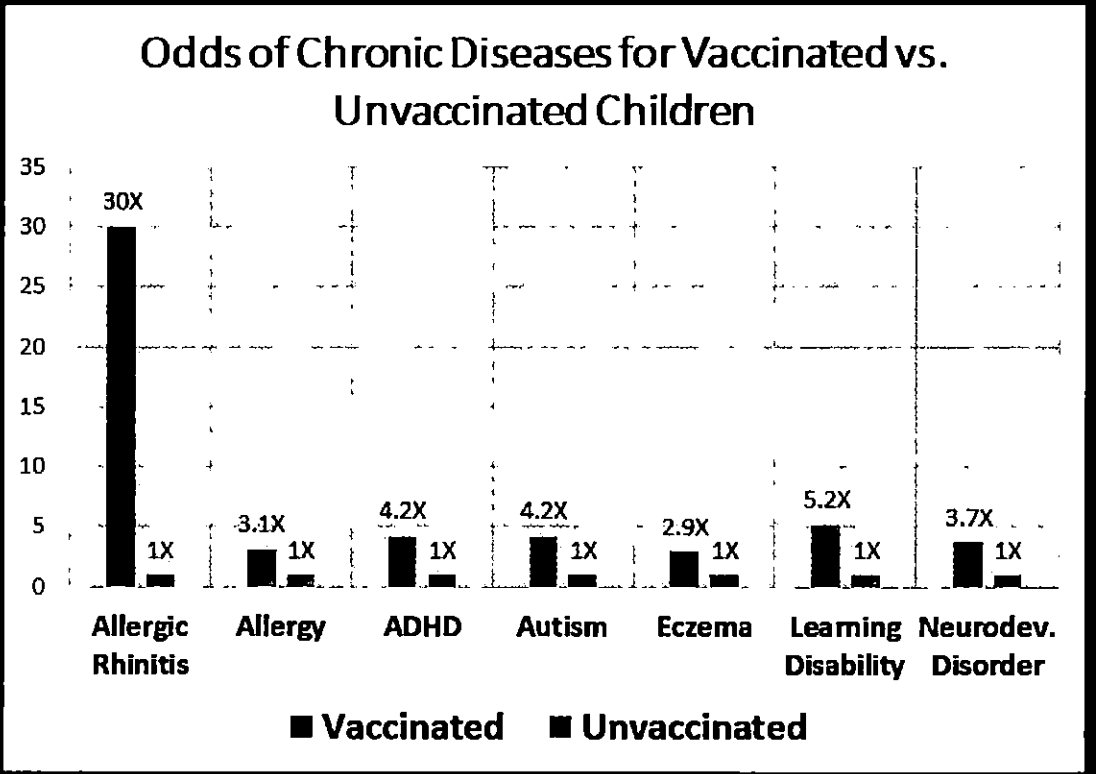
³Associate Professor, Department of Epidemiology and Biostatistics, School of Public Health, Jackson State University, Jackson, MS 39213, USA

⁴Former graduate student, Department of Epidemiology and Biostatistics School of Public Health, Jackson State University, Jackson, MS 39213, USA

**Abstract**

Vaccinations have prevented millions of infectious illnesses, hospitalizations and deaths among U.S. children, yet the long-term health outcomes of the vaccination schedule remain uncertain. Studies have been recommended by the U.S. Institute of Medicine to address this question. This study aimed 1) to compare vaccinated and unvaccinated children on a broad range of health outcomes, and 2) to determine whether an association found between vaccination and neurodevelopmental disorders (NDD), if any, remained significant after adjustment for other measured factors. A cross-sectional study of mothers of children educated at home was carried out in collaboration with homeschool organizations in four U.S. states: Florida, Louisiana, Mississippi and Oregon. Mothers were asked to complete an anonymous online questionnaire on their 6- to 12-year-old biological children with respect to pregnancy-related factors, birth history, vaccinations, physician-diagnosed illnesses, medications used, and health services. NDD, a derived diagnostic measure, was defined as having one or more of the following three closely-related diagnoses: a learning disability, Attention Deficient Hyperactivity Disorder, and Autism Spectrum Disorder. A convenience sample of 666 children was obtained, of which 261 (39%) were unvaccinated. The vaccinated were less likely than the unvaccinated to have been diagnosed with chickenpox and pertussis, but more likely to have been diagnosed with pneumonia, otitis media, allergies and NDD. After adjustment, vaccination, male gender, and preterm birth remained significantly associated with NDD. However, in a final adjusted model with interaction, vaccination but not preterm birth remained associated with NDD, while the interaction of preterm birth and vaccination was associated with a 6.6-fold increased odds of NDD (95% CI: 2.8, 15.5). In conclusion, vaccinated homeschool children were found to have a higher rate of allergies and NDD than unvaccinated homeschool children. While vaccination remained significantly associated with NDD after controlling for other factors, preterm birth coupled with vaccination was associated with an apparent synergistic increase in the odds of NDD. Further research involving larger, [illegible] unexpected findings in order to optimize the impact of vaccines on

**Published April 2017**




**"In this pilot study of vaccinated and unvaccinated homeschool children, reduced odds of chickenpox and whooping cough were found among the vaccinated, as expected, but unexpectedly increased odds were found for many other physician-diagnosed conditions."**

Health .

# Vaccination Increases Type I Diabetes 3X

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J Pediatr Endocrinol Metab. 2003 Apr-May;16(4):495-506

**Clustering of cases of type 1 diabetes mellitus occurring 2-4 years after vaccination is consistent with clustering after infections and progression to type 1 diabetes mellitus in autoantibody positive individuals.**

Classen JB[1], Classen DC

Author Information

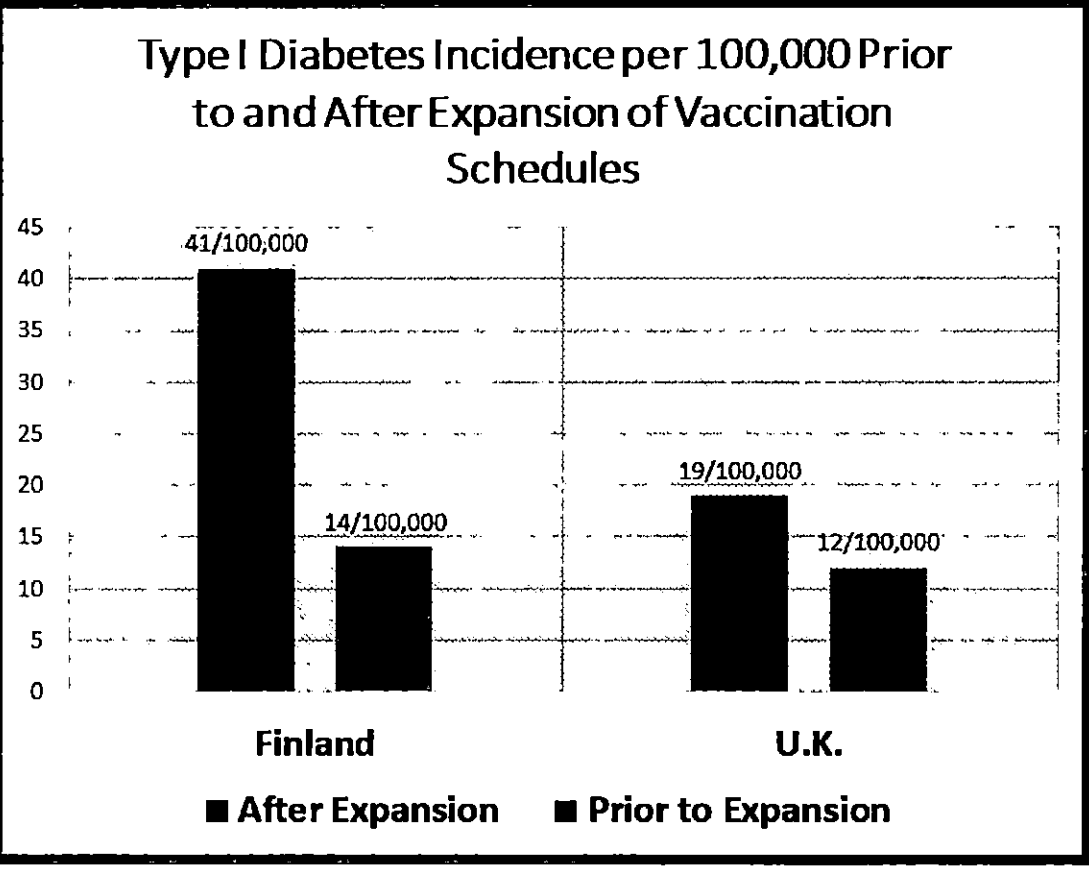
**Abstract**

OBJECTIVE: We previously analyzed data from a hemophilus vaccine trial and identified clusters of extra cases of type 1 diabetes mellitus (T1DM) caused by the vaccine that occurred between 36 and 48 months after immunization. Published reports indicate clustering of cases of T1DM occurring approximately 2-4 years after mumps infection. Others have reported a 2-4 year delay between the onset of autoantibodies and the development of T1DM. We attempted to determine whether similar clustering of cases of T1DM occurred after immunization with vaccines other than hemophilus.

METHODS: We searched MEDLINE and reviewed references from published papers to find databases on the incidence of T1DM and then searched MEDLINE to determine whether changes in immunization occurred in these regions during the times the incidence of DM was being recorded.

RESULTS: Distinct rises in the incidence of T1DM occurred 2-4 years following the introduction of the MMR and pertussis vaccines. A drop in the incidence of T1DM was detected between 3-4 years following discontinuation of pertussis and BCG vaccines.

CONCLUSION: The identification of clusters of cases of T1DM occurring in consistent temporal time periods allowed a link between the hemophilus vaccine and T1DM to be established. The current findings indicate the there are also clusters of cases of T1DM occurring 2-4 years post-immunization with the pertussis, MMR, and BCG vaccine. The data are consistent with the occurrence of clusters following mumps infection and the progression to T1DM in patients with pancreatic autoantibodies.

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**"The identification of clusters of cases of Type I diabetes occurring in consistent temporal patterns allowed a link between the hemophilus vaccine and Type I diabetes... there are also clusters of cases of Type I diabetes occurring 2-4 years post-immunization with the pertussis, MMR and BCG vaccines."**

# Polio Vaccination Increases Type I Diabetes 2.5X

*The Open Pediatric Medicine Journal*, 2008, 2, 7-10 7

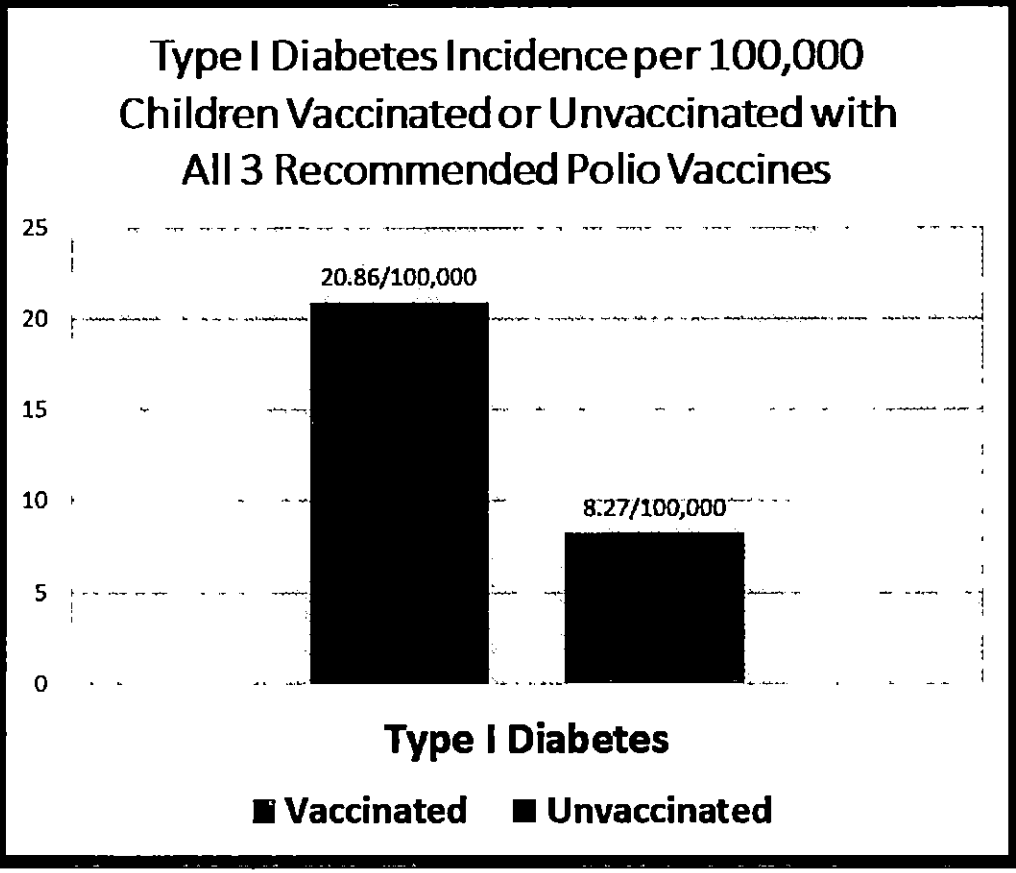
## Risk of Vaccine Induced Diabetes in Children with a Family History of Type 1 Diabetes

John Barthelow Classen*

*Classen Immunotherapies Inc., 6517 Montrose Avenue, Baltimore, MD 21212, USA*

**Abstract:** Cohort data from Denmark in all children born from January 1, 1990 to December 31, 2000 was analyzed to assess the association between immunization and type 1 diabetes in all Danish children and in a subgroup where children had a sibling with type 1 diabetes. Pediatric vaccines were associated with a statistically significant increased risk of type 1 diabetes in 12 of 21 endpoints in the general population. The rate ratios in children who received at least one dose of a specific vaccine were also elevated in the subgroup and were statistically the same as in the general population. Three doses of the hemophilus vaccine were associated with a rate ratio of 1.23 (1.02<<RR<<1.48) and an absolute risk in the general population of three cases/100,000 per year compared to 1.58 (0.60<<RR<<4.15) and an absolute risk of 2885 cases/100,000 per year in the subgroup with a sibling with type 1 diabetes. The hemophilus immunization is associated with a cumulative attributable risk of 2.3/100 (2.3%) in the subgroup.

**Keywords:** Type 1 diabetes mellitus, vaccines, hemophilus, pertussis, polio.




**"Pediatric vaccines were associated with a statistically significant increased risk of type 1 diabetes in 12 of 21 endpoints in the general population."**

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# Raw CDC Data Shows Vaccination on Time with MMR Increased Odds of Autism 3.64X

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Pediatrics. 2004 Feb;113(2):259-66.

**Age at first measles-mumps-rubella vaccination in children with autism and school-matched control subjects: a population-based study in metropolitan atlanta.**

DeStefano F[1], Bhasin TK, Thompson WW, Yeargin-Allsopp M, Boyle C

Author Information

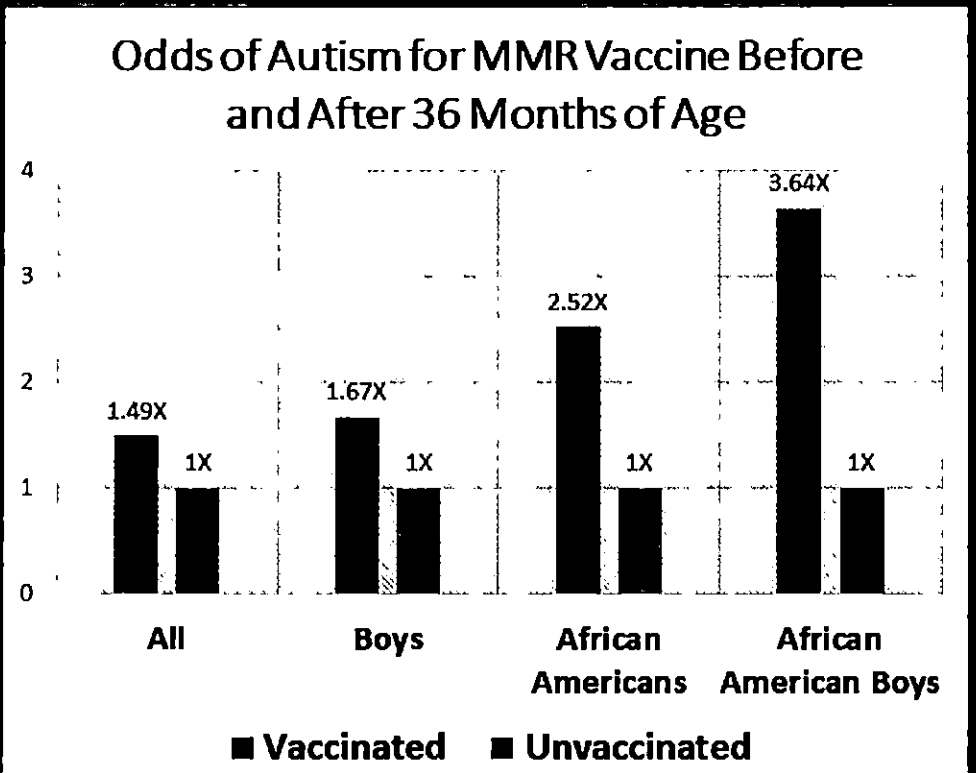

**Abstract**

**OBJECTIVE:** To compare ages at first measles-mumps-rubella (MMR) vaccination between children with autism and children who did not have autism in the total population and in selected subgroups, including children with regression in development.

**METHODS:** A case-control study was conducted in metropolitan Atlanta. Case children (N = 624) were identified from multiple sources and matched to control children (N = 1824) on age, gender, and school. Vaccination data were abstracted from immunization forms required for school entry. Records of children who were born in Georgia were linked to Georgia birth certificates for information on maternal and birth factors. Conditional logistic regression was used to estimate odds ratios (ORs).

**RESULTS:** The overall distribution of ages at MMR vaccination among children with autism was similar to that of matched control children, most case (70.5%) and control children (67.5%) were vaccinated between 12 and 17 months of age. Similar proportions of case and control children had been vaccinated before 18 or before 24 months. No significant associations for either of these age cutoffs were found for specific case subgroups, including those with evidence of developmental regression. More case (93.4%) than control children (90.6%) were vaccinated before 36 months (OR: 1.49; 95% confidence interval: 1.03-2.14 in the total sample; OR: 1.23; 95% confidence interval: 0.64-2.36 in the birth certificate sample). This association was strongest in the 3- to 5-year age group.

**CONCLUSIONS:** Similar proportions of case and control children were vaccinated by the recommended age or shortly after (ie, before 18 months) and before the age by which atypical development is usually recognized in children with autism (ie, 24 months). Vaccination before 36 months was more common among case children than control children, especially among children 3 to 5 years of age, likely reflecting immunization requirements for enrollment in early intervention programs.


CDC UNPUBLISHED DATA OBTAINED BY FOIA

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**Press Release, August 2014: "I regret that my coauthors and I omitted statistically significant information in our 2004 article published in the journal Pediatrics. The omitted data suggested that African American males who received the MMR vaccine before age 36 months were at increased risk for autism." – Dr. William Thompson, *CDC senior vaccine safety scientist***

# Thimerosal-Containing Hepatitis B Series Increases Odds of Autism 3.39X

Translational Neurodegeneration 2013 Dec 19;2(1):25. doi: 10.1186/2047-9158-2-25

**A two-phase study evaluating the relationship between Thimerosal-containing vaccine administration and the risk for an autism spectrum disorder diagnosis in the United States.**

Geier DA, Hooker BS, Kern JK, King PG, Sykes LK, Geier MR[1]

Author information

**Abstract**

BACKGROUND: Autism spectrum disorder (ASD) is defined by standardized criteria of qualitative impairments in social interaction, qualitative impairments in communication, and restricted and stereotyped patterns of behavior, interests, and activities. A significant number of children diagnosed with ASD suffer a loss of previously-acquired skills, which is suggestive of neurodegeneration or a type of progressive encephalopathy with an etiological pathogenic basis occurring after birth. To date, the etiology of ASD remains under debate, however, many studies suggest toxicity, especially from mercury (Hg), in individuals diagnosed with an ASD. The present study evaluated concerns about the toxic effects of organic-Hg exposure from Thimerosal (49.55% Hg by weight) in childhood vaccines by conducting a two-phased (hypothesis generating/hypothesis testing) study with documented exposure to varying levels of Thimerosal from vaccinations.

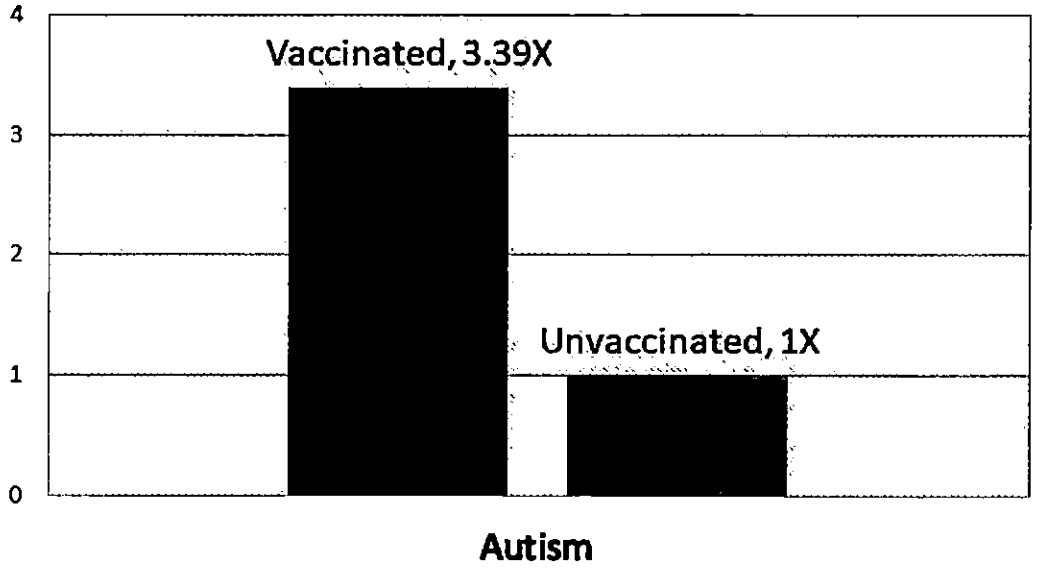
METHODS: A hypothesis generating cohort study was undertaken to evaluate the relationship between exposure to organic-Hg from a Thimerosal-containing Diphtheria-Tetanus-acellular-Pertussis (DTaP) vaccine in comparison to a Thimerosal-free DTaP vaccine administered, from 1998 through 2000, for the risk of ASD as reported in the Vaccine Adverse Event Reporting System (VAERS) database (phase I). A hypothesis testing case-control study was undertaken to evaluate the relationship between organic-Hg exposure from Thimerosal-containing hepatitis B vaccines administered at specific intervals in the first six months of life among cases diagnosed with an ASD and controls born between 1991 through 1999 in the Vaccine Safety Datalink (VSD) database (phase II).

RESULTS: In phase I, it was observed that there was a significantly increased risk ratio for the incidence of ASD reported following the Thimerosal-containing DTaP vaccine in comparison to the Thimerosal-free DTaP vaccine. In phase II, it was observed that cases diagnosed with an ASD were significantly more likely than controls to receive increased organic-Hg from Thimerosal-containing hepatitis B vaccine administered within the first, second, and sixth month of life.

CONCLUSIONS: Routine childhood vaccination is an important public health tool to reduce the morbidity and mortality associated with infectious diseases, but the present study provides new epidemiological evidence supporting an association between increasing organic-Hg exposure from Thimerosal-containing childhood vaccines and the subsequent risk of an ASD diagnosis.

PMID: 24354291 PMCID: PMC3878304 DOI: 10.1186/2047-9158-2-25

## Odds of Receiving an Autism Diagnosis from Receiving Thimerosal-Containing Hepatitis B Vaccines




Children's Health

**"It was observed that cases diagnosed with an ASD were significantly more likely than controls to receive increased organic-Hg from Thimerosal-containing hepatitis B vaccine administered within the first, second, and sixth month of life."**

# Human Papilloma Virus Vaccine Increases the Odds of Asthma 8.01X

SAGE Open Med. 2019 Jan 8;7:2050312118822650. doi: 10.1177/2050312118822650. eCollection 2019

**A cross-sectional study of the relationship between reported human papillomavirus vaccine exposure and the incidence of reported asthma in the United States.**

Geier DA[1,2], Kern JK[1,3], Geier MR[1,2]

⊕ Author Information

**Abstract**

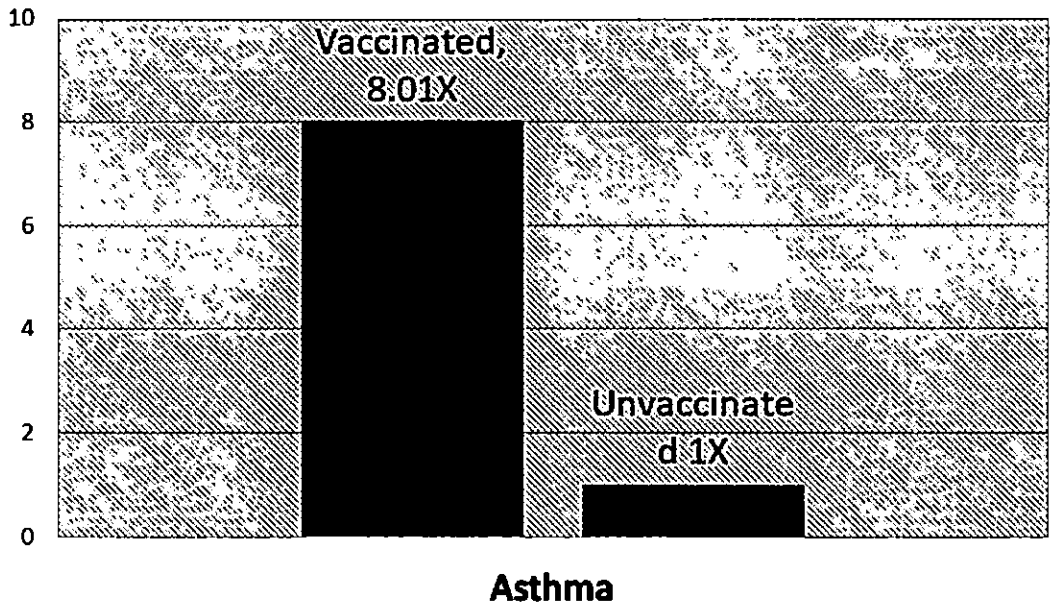
**OBJECTIVES:** Asthma is a chronic disorder that affects persons of all ages impacting the quality of their lives. This cross-sectional hypothesis-testing study evaluated the relationship between human papillomavirus vaccine and the risk of an incident asthma diagnosis in a defined temporal period post-vaccination.

**METHODS:** The 2015-2016 National Health and Nutrition Examination Survey data were examined for a group of 60,934,237 weighted persons between 9 and 26 years old in Statistical Analysis Software.

**RESULTS:** Reported incident asthma significantly clustered in the year of reported human papillomavirus vaccination. When the data were separated by gender, the effects observed remained significant for males but not females.

**CONCLUSION:** The results suggest that human papillomavirus vaccination resulted in an excess of 261,475 asthma cases with an estimated direct excess lifetime cost of such persons being US$42 billion. However, it is unclear what part of the vaccine and/or vaccine medium may have increased an individual's susceptibility to an asthma episode, whether the asthma diagnosis represented one asthma episode or if it is chronic, and how much therapeutic support was needed (if any) and for how long, which would impact cost. Despite the negative findings in this study, routine vaccination is an important public health tool, and the results observed need to be viewed in this context.

## Odds of Asthma Diagnosis After HPV Vaccine




Children's Health

**"The results suggest that human papillomavirus vaccination resulted in an excess of 261,475 asthma cases with an estimated direct excess lifetime cost of such persons being US$42 billion."**

# Thimerosal-Containing Hepatitis B Series Increases Odds of Premature Puberty 2.1X

Toxics. 2015 Nov 15;6(4). pii: E67. doi: 10.3390/toxics6040067

**Premature Puberty and Thimerosal-Containing Hepatitis B Vaccination: A Case-Control Study in the Vaccine Safety Datalink.**

Geier DA[1,2], Kern JK[3,4,5], Geier MR[6,7]

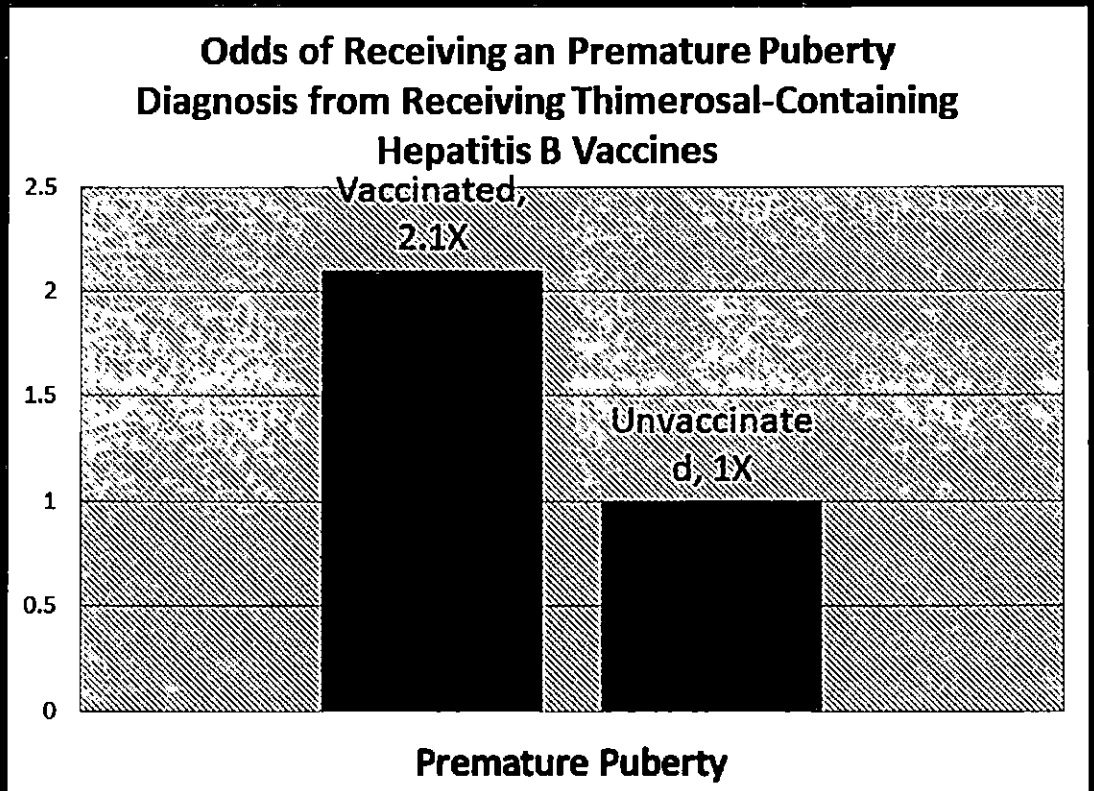
Author Information

**Abstract**

Studies suggest a relationship between exposure to endocrine disrupters, such as mercury (Hg), and premature puberty. Hg exposure from Thimerosal-containing hepatitis B vaccine, administered at specific intervals within the first six months of life, and the child's long-term risk of being diagnosed with premature puberty (ICD-9 code: 259.1), was retrospectively examined, using a hypothesis-testing, longitudinal case-control design on prospectively collected data, in the Vaccine Safety Datalink (VSD). Cases diagnosed with premature puberty were significantly more likely to have received increased exposure to Hg from hepatitis B vaccines preserved with Thimerosal given in the first month after birth (odds ratio (OR) = 1.803), first two months after birth (OR = 1.768), and first six months after birth (OR = 2.0955), compared to control subjects. When the data were separated by gender, the effects remained among females but not males. Female cases, as compared to female controls, were significantly more likely in a dose-dependent manner to have received a greater exposure to Hg from hepatitis B vaccines preserved with Thimerosal, given in the first six months after birth (OR = 1.0281 per µg Hg). The results of this study show a dose-dependent association between increasing organic Hg exposure from Thimerosal-containing hepatitis B vaccines administered within the first six months of life and the long-term risk of the child being diagnosed with premature puberty.

KEYWORDS: ethylmercury; mercury; merthiolate; premature puberty; thiomersal

PMID: 30445743 PMCID: PMC6318132 DOI: 10.3390/toxics6040067




Children's Health

**"The results of this study show a dose-dependent association between increasing organic Hg exposure from Thimerosal-containing hepatitis B vaccines administered within the first six months of life and the long-term risk of the child being diagnosed with premature puberty."**

# MMR Vaccine Increases Risk of Crohn's Disease 3.01X and Ulcerative Colitis 2.53X

Lancet. 1995 Apr 29;345(8957):1071-4.

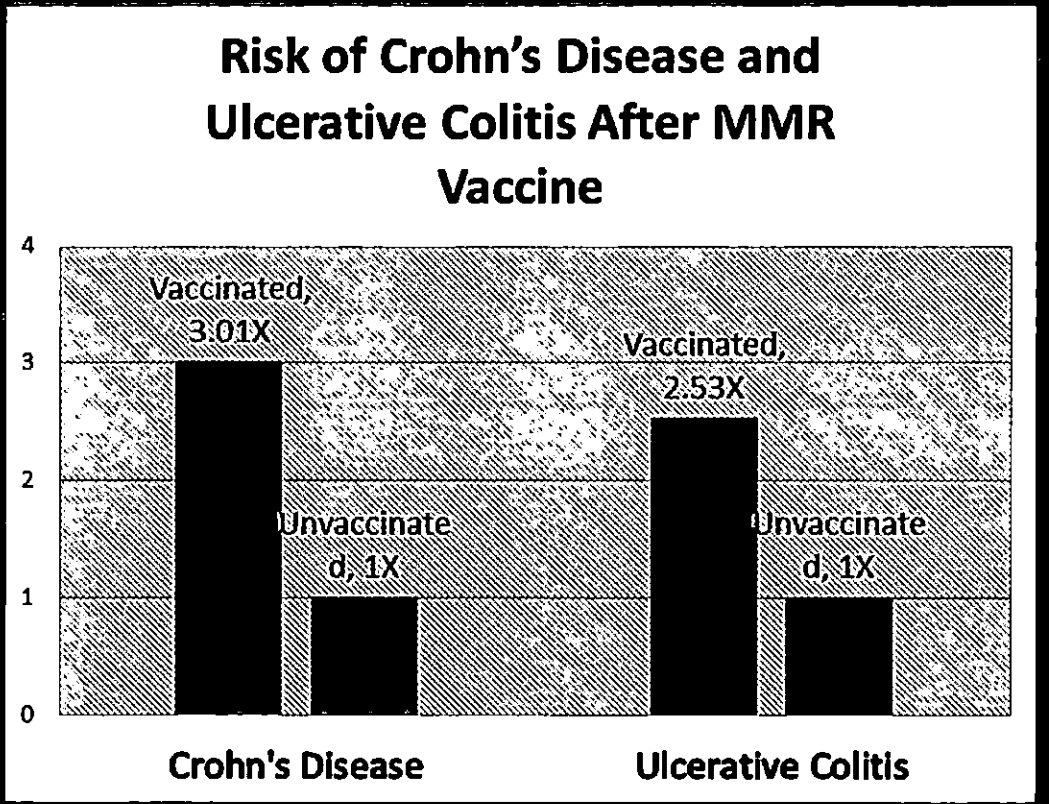
**Is measles vaccination a risk factor for inflammatory bowel disease?**

Thompson NP[1], Montgomery SM, Pounder RE, Wakefield AJ.

Author information

**Abstract**

Measles virus may persist in intestinal tissue, particularly that affected by Crohn's disease, and early exposure to measles may be a risk factor for the development of Crohn's disease. Crohn's disease and ulcerative colitis occur in the same families and may share a common aetiology. In view of the rising incidence of inflammatory bowel disease (Crohn's disease and ulcerative colitis), we examined the impact of measles vaccination upon these conditions. Prevalences of Crohn's disease, ulcerative colitis, coeliac disease, and peptic ulceration were determined in 3545 people who had received live measles vaccine in 1964 as part of a measles vaccine trial. A longitudinal birth cohort of 11,407 subjects was one unvaccinated comparison cohort, and 2541 partners of those vaccinated was another. Compared with the birth cohort, the relative risk of developing Crohn's disease in the vaccinated group was 3.01 (95% CI 1.45-6.23) and of developing ulcerative colitis was 2.53 (1.15-5.58). There was no significant difference between these two groups in coeliac disease prevalence. Increased prevalence of inflammatory bowel disease, but not coeliac disease or peptic ulceration, was found in the vaccinated cohort compared with their partners. These findings suggest that measles virus may play a part in the development not only of Crohn's disease but also of ulcerative colitis.




**"These findings suggest that measles virus may play a part in the development not only of Crohn's disease but also of ulcerative colitis."**

Children's Health

# Thimerosal Containing Hepatitis B Vaccines – When Compared to Children Vaccinated Without Thimerosal - Increased Odds of ADHD 1.98X

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National Institutes of Health

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J Trace Elem Med Biol. 2018 Mar;46:1-9. doi: 10.1016/j.jtemb.2017.11.001. Epub 2017 Nov 6

**A cross-sectional study of the relationship between infant Thimerosal-containing hepatitis B vaccine exposure and attention-deficit/hyperactivity disorder.**

Geier DA[1], Kern JK[2], Homme KG[3], Geier MR[4]

Author information

**Abstract**

Attention-deficit/hyperactivity disorder (ADHD) is characterized by a marked pattern of inattention and/or hyperactivity-impulsivity that is inconsistent with developmental level and interferes with normal functioning in at least two settings. This study evaluated the hypothesis that infant Thimerosal-containing hepatitis B vaccine (T-HepB) exposure would increase the risk of an ADHD diagnosis. This cross-sectional study examined 4393 persons between 13 and 19 years of age from the combined 1999-2004 National Health and Nutritional Examination Survey (NHANES) by analyzing demographic, immunization, socioeconomic, and health-related variables using the SAS system. Three doses of T-HepB exposure in comparison to no exposure significantly increased the risk of an ADHD diagnosis using logistic regression (adjusted odds ratio=1.980), linear regression (adjusted beta-coefficient=0.04747), Spearman's rank (Rho=0.04807), and 2×2 contingency table (rate ratio=1.8353) statistical modeling even when considering other covariates such as gender, race, and socioeconomic status. Current health status outcomes selected on an a priori basis to not be biologically plausibly linked to T-HepB exposure showed no relationship with T-HepB. The observed study results are biologically plausible and supported by numerous previous epidemiological studies, but because the NHANES data is collected on a cross-sectional basis, it is not possible to ascribe a direct cause-effect relationship between exposure to T-HepB and an ADHD diagnosis. During the decade from 1991 to 2001 that infants were routinely exposed to T-HepB in the United States (US), an estimated 1.3-2.5 million children were diagnosed with ADHD with excess lifetime costs estimated at US $350-$660 billion as a consequence of T-HepB. Although Thimerosal use in the HepB in the US has been discontinued, Thimerosal remains in the HepB in developing countries. Routine vaccination is an important public health tool to prevent infectious diseases, but every effort should be made to eliminate Thimerosal exposure.

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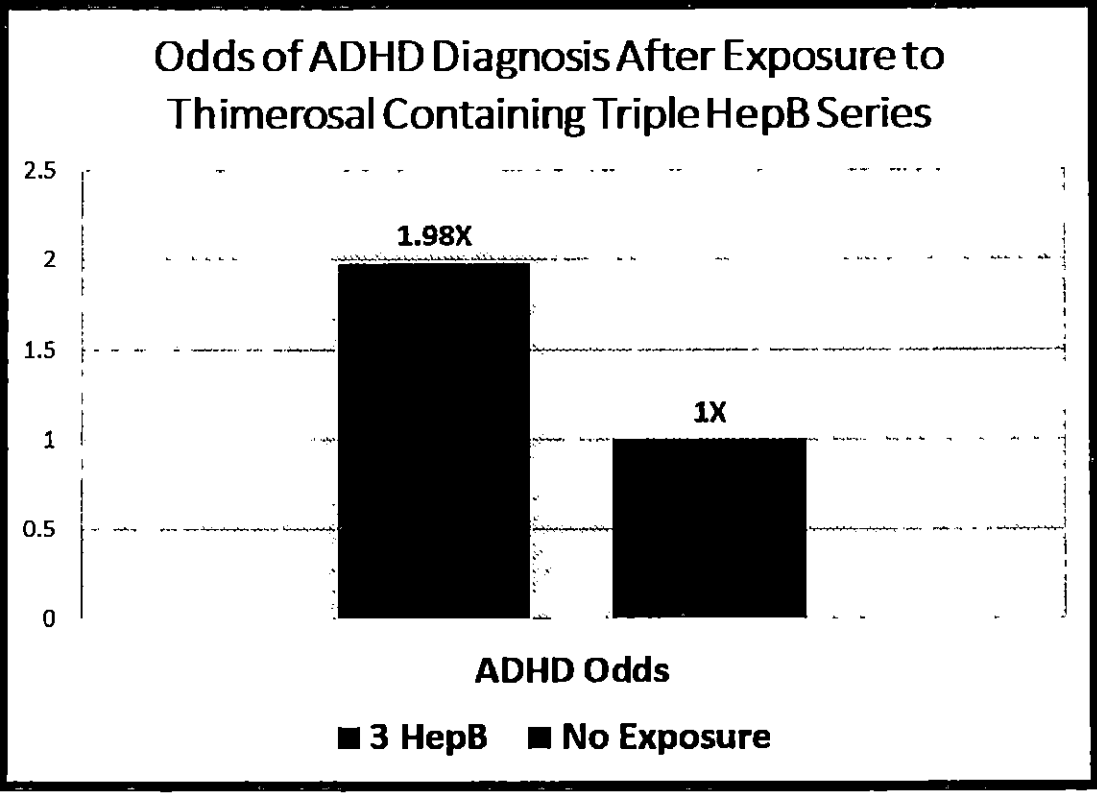



Children's [illegible]

**"During the decade from 1991 to 2001 that infants were routinely exposed to T-HepB (thimerosal containing HepB) in the United States (US), an estimated 1.3-2.5 million children were diagnosed with ADHD with excess lifetime costs estimated at US $350-$660 billion as a consequence of T-HepB."**

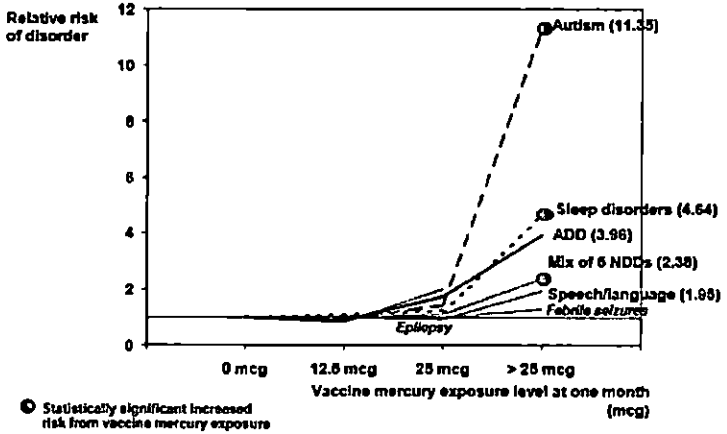
# Highest Levels of Thimerosal Exposure Increase Autism Risk 11.35X

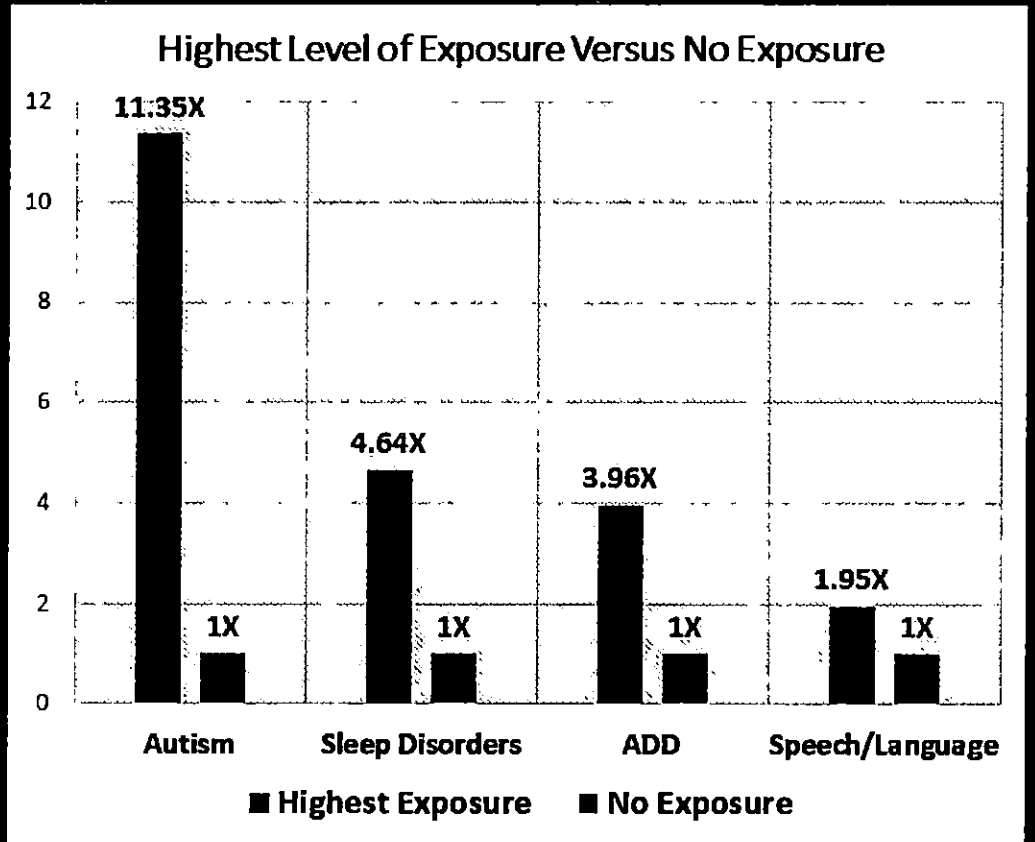
**GENERATION ZERO**

***Thomas Verstraeten's First Analyses of the Link Between Vaccine Mercury Exposure and the Risk of Diagnosis of Selected Neuro-Developmental Disorders Based on Data from the Vaccine Safety Datalink: November-December 1999***

**Safe Minds**
**September 2004**

**ONE MONTH EXPOSURE: SUMMARY ANALYSIS OF FIVE NDDs**
**Comparison to Control Diagnoses Epilepsy and Febrile Seizures**




CDC UNPUBLISHED DATA OBTAINED BY FOIA

Children's Health

**"Autism risks were the highest of all the diagnostic codes, with a relative risk at one month of 11.35 between the high and zero exposure groups."**

# Two H1N1-Containing Influenza Vaccines Prior to and During Pregnancy Increases Miscarriage Odds by 7.7X

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Vaccine. 2017 Sep 25;35(40):5314-5322. doi: 10.1016/j.vaccine.2017.08.069

**Association of spontaneous abortion with receipt of inactivated influenza vaccine containing H1N1pdm09 in 2010-11 and 2011-12.**

Donahue JG[1], Kieke BA[2], King JP[3], DeStefano F[4], Mascola MA[5], Irving SA[6], Cheetham TC[7], Glanz JM[8], Jackson LA[9], Klein NP[10], Naleway AL[11], Weintraub E[12], Belongia EA[13]

Author Information


Abstract

INTRODUCTION: Inactivated influenza vaccine is recommended in any stage of pregnancy, but evidence of safety in early pregnancy is limited, including for vaccines containing A/H1N1pdm2009 (pH1N1) antigen. We sought to determine if receipt of vaccine containing pH1N1 was associated with spontaneous abortion (SAB).

METHODS: We conducted a case-control study over two influenza seasons (2010-11, 2011-12) in the Vaccine Safety Datalink. Cases had SAB and controls had live births or stillbirths and were matched on site, date of last menstrual period, and age. Of 919 potential cases identified using diagnosis codes, 485 were eligible and confirmed by medical record review. Exposure was defined as vaccination with inactivated influenza vaccine before the SAB date; the primary exposure window was the 1-28days before the SAB.

RESULTS: The overall adjusted odds ratio (aOR) was 2.0 (95% CI, 1.1-3.6) for vaccine receipt in the 28-day exposure window; there was no association in other exposure windows. In season-specific analyses, the aOR in the 1-28days was 3.7 (95% CI 1.4-9.4) in 2010-11 and 1.4 (95% CI 0.6-3.3) in 2011-12. The association was modified by influenza vaccination in the prior season (post hoc analysis). Among women who received pH1N1-containing vaccine in the previous influenza season, the aOR in the 1-28days was 7.7 (95% CI 2.2-27.3); the aOR was 1.3 (95% CI 0.7-2.7) among women not vaccinated in the previous season. This effect modification was observed in each season.

CONCLUSION: SAB was associated with influenza vaccination in the preceding 28days. The association was significant only among women vaccinated in the previous influenza season with pH1N1-containing vaccine. This study does not and cannot establish a causal relationship between repeated influenza vaccination and SAB, but further research is warranted.



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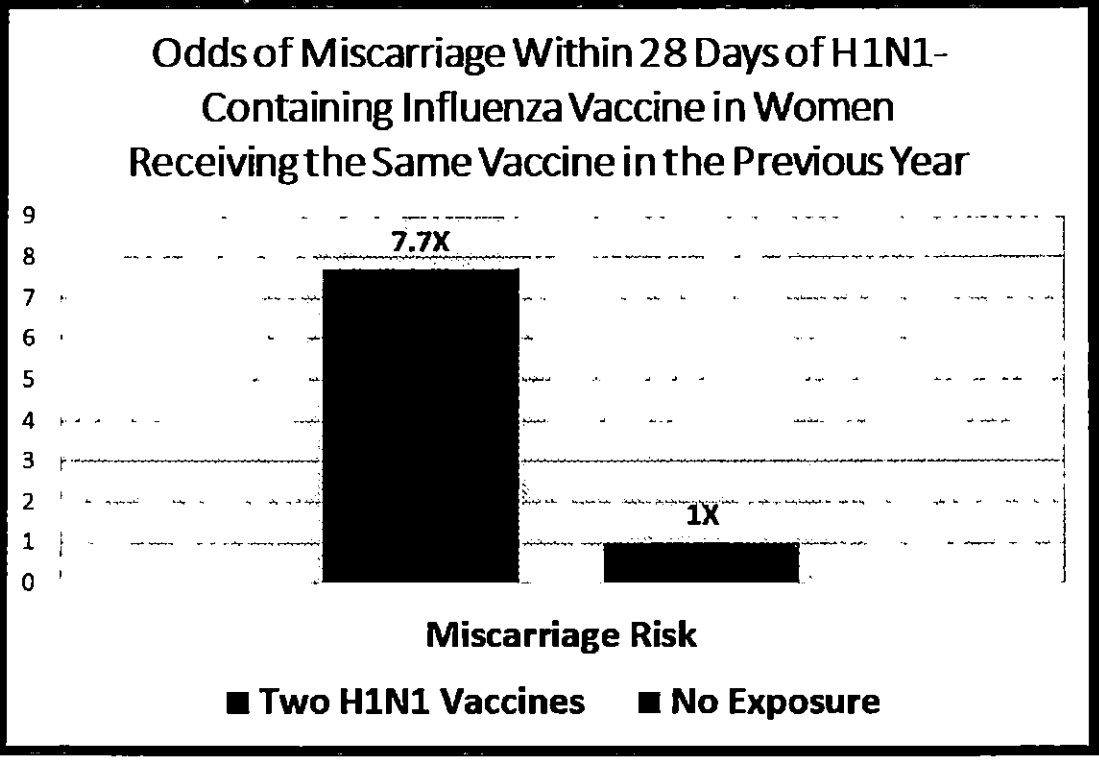


Children's Health

**"SAB (spontaneous abortion) was associated with influenza vaccination in the preceding 28 days. The association was significant only among women vaccinated in the previous influenza season with pH1N1-containing vaccine."**

# H1N1 Influenza Vaccine Increases Risks of Bell's Palsy (1.34X), Paraesthesia (1.25X) and Inflammatory Bowel Disease (1.25X) in High Risk Patients

PubMed.gov — PubMed — H1N1 Bardage 2011

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BMJ. 2011 Oct 12;343:d5956. doi: 10.1136/bmj.d5956.

**Neurological and autoimmune disorders after vaccination against pandemic influenza A (H1N1) with a monovalent adjuvanted vaccine: population based cohort study in Stockholm, Sweden.**

Bardage C[1], Persson I, Ortqvist A, Bergman U, Ludvigsson JF, Granath F.

Author information

**Abstract**

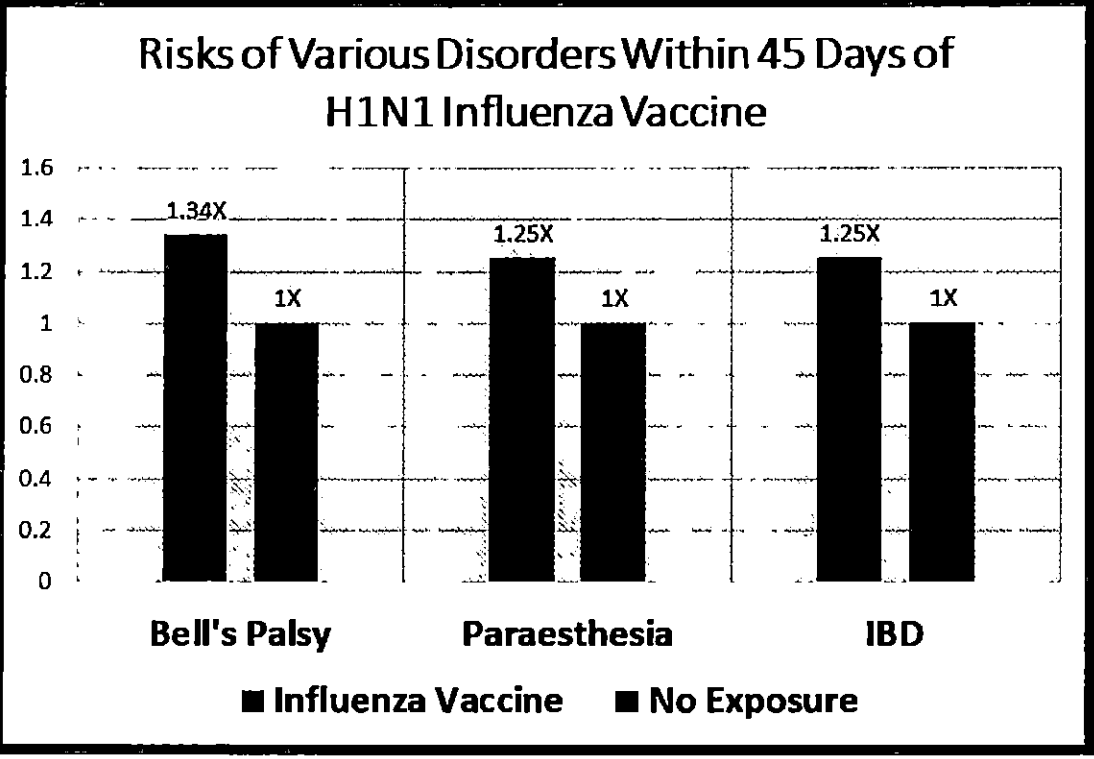
OBJECTIVE: To examine the risk of neurological and autoimmune disorders of special interest in people vaccinated against pandemic influenza A (H1N1) with Pandemrix (GlaxoSmithKline, Middlesex, UK) compared with unvaccinated people over 6-10 months

DESIGN: Retrospective cohort study linking individualised data on pandemic vaccinations to an inpatient and specialist database on healthcare utilisation in Stockholm county for follow-up during and after the pandemic period

SETTING: Stockholm county, Sweden. Population All people registered in Stockholm county on 1 October 2009 and who had lived in this region since 1 January 1998, 1,024,019 were vaccinated against H1N1 and 921,005 remained unvaccinated

MAIN OUTCOME MEASURES: Neurological and autoimmune diagnoses according to the European Medicines Agency strategy for monitoring of adverse events of special interest defined using ICD-10 codes for Guillain-Barré syndrome, Bell's palsy, multiple sclerosis, polyneuropathy, anaesthesia or hypoaesthesia, paraesthesia, narcolepsy (added), and autoimmune conditions such as rheumatoid arthritis, inflammatory bowel disease, and type 1 diabetes; and short term mortality according to vaccination status

RESULTS: Excess risks among vaccinated compared with unvaccinated people were of low magnitude for Bell's palsy (hazard ratio 1.25, 95% confidence interval 1.06 to 1.48) and paraesthesia (1.11, 1.00 to 1.23) after adjustment for age, sex, socioeconomic status, and healthcare utilisation. Risks for Guillain-Barré syndrome, multiple sclerosis, type 1 diabetes, and rheumatoid arthritis remained unchanged. The risks of paraesthesia and inflammatory bowel disease among those vaccinated in the early phase (within 45 days from 1 October 2009) of the vaccination campaign were significantly increased; the risk being increased within the first six weeks after vaccination. Those vaccinated in the early phase were at a slightly reduced risk of death than those who were unvaccinated (0.94, 0.91 to 0.98), whereas those vaccinated in the late phase had an overall reduced mortality (0.68, 0.64 to 0.71). These associations




Children's Health

**"Relative risks were significantly increased for Bell's palsy, paraesthesia, and inflammatory bowel disease after vaccination, predominantly in the early phase of the vaccination campaign.**

# HPV Vaccination Increases Odds of Memory Impairment (1.23X) and Involuntary Movement (1.53X)

PubMed.gov — US National Library of Medicine, National Institutes of Health

Published | yaju tsubaki papilloma

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Jpn J Nurs Sci. 2019 Jan 28. doi: 10.1111/jjns.12252. [Epub ahead of print]

**Safety concerns with human papilloma virus immunization in Japan: Analysis and evaluation of Nagoya City's surveillance data for adverse events.**

Yaju T[1], Tsubaki H[2].

Author information


**Abstract**

**AIM:** To assess the safety of human papilloma virus (HPV) vaccines by using data from the "Nagoya City Cervical Cancer Immunization Program Survey"

**METHODS:** Unadjusted odds ratios (OR) were calculated between HPV-vaccinated cases and un-vaccinated controls. Age-stratified analyses were performed to evaluate the interaction between age and events. Adjusted ORs were also estimated with multiple logistic regression models.

**RESULTS:** In the 15-16-year-old group, the unadjusted ORs were significantly higher for symptoms of memory impairment, dyscalculia, and involuntary movement. The age-adjusted multivariate analyses demonstrated that the vaccinated cases were less likely than the unvaccinated controls to have experienced symptoms in almost all symptoms, except for two symptoms such as involuntary movement and weakness. However, study period-adjusted multivariate analyses demonstrated that the vaccinated cases were significantly more likely than un-vaccinated controls to have experienced symptoms of memory impairment and involuntary movement.

**CONCLUSIONS:** Based on our analysis using data from the Nagoya City surveillance survey, a possible association between HPV vaccination and distinct symptoms such as cognitive impairment or movement disorders exists. A consistent causal relationship between HPV vaccination and these symptoms remains uncertain. However, given the seriousness of symptoms, we believe that a more comprehensive and large-scale study is essential to confirm the safety of HPV vaccination.



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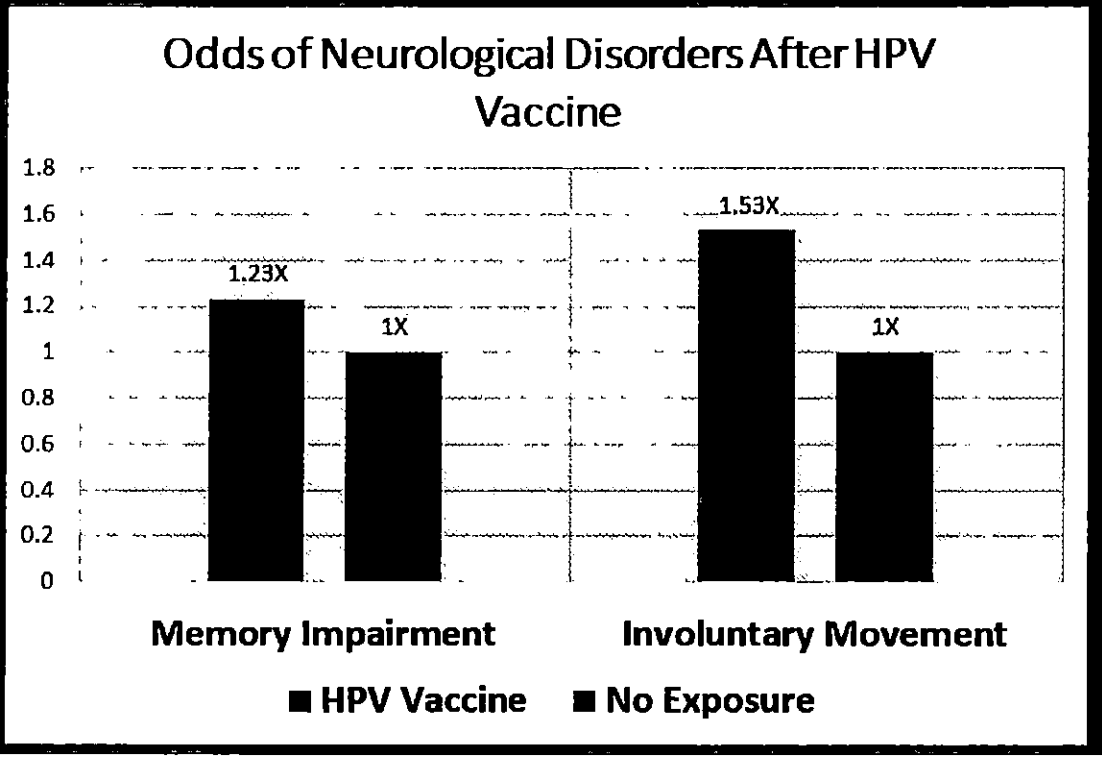
KEYWORDS: adverse events; human papilloma virus; surveillance; vaccine


Children's Health

**"Based on our analysis using data from the Nagoya City surveillance survey, a possible association between HPV vaccination and distinct symptoms such as cognitive impairment or movement disorders exists."**

# Thimerosal Containing Triple HepB Series in the First Six Months of Life Increases Odds of Emotional Disturbances by 2.37X

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**Thimerosal exposure and disturbance of emotions specific to childhood and adolescence: A case-control study in the Vaccine Safety Datalink (VSD) database.**

Author Information

Abstract

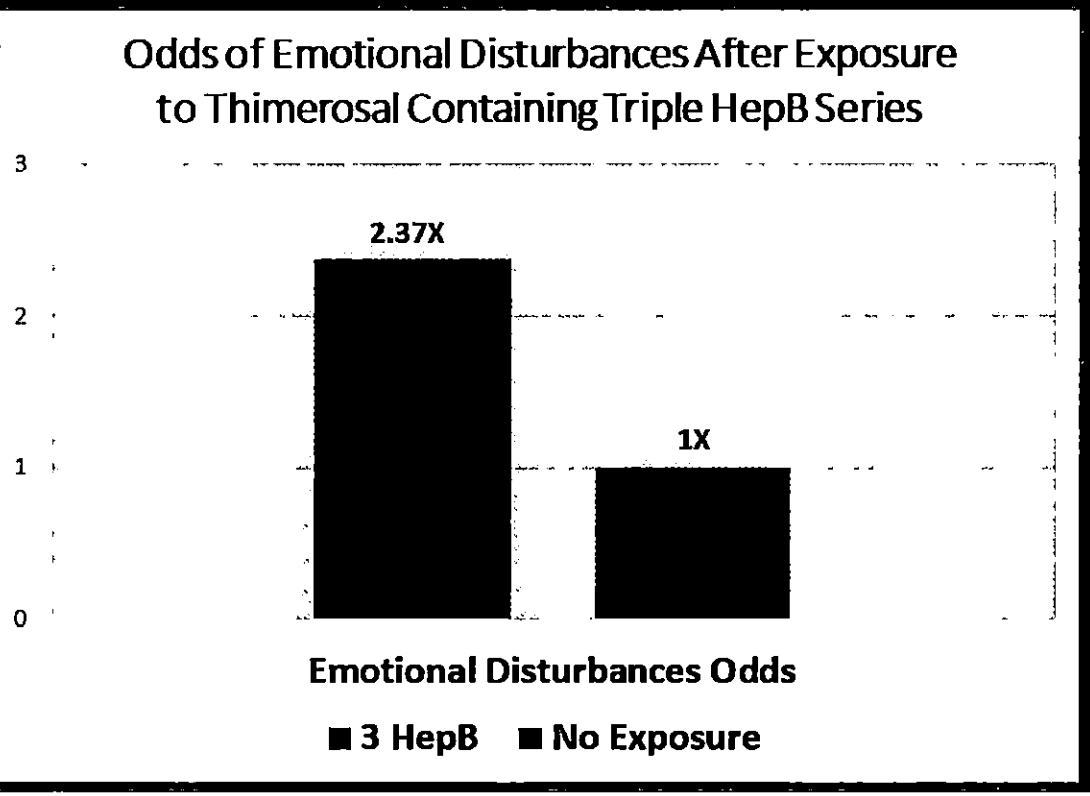
BACKGROUND: This study evaluated Thimerosal-containing childhood vaccines and the risk of a diagnosis called disturbance of emotions specific to childhood and adolescence (ED). Thimerosal is an organic-mercury (Hg)-containing compound used in some vaccines.

METHODS: A hypothesis-testing prospective, longitudinal case-control study evaluated Hg exposure from Thimerosal in hepatitis B vaccines administered at specific times within the first 6 months of life and its association with medically diagnosed ED (313.xx) (n = 517) in children born between 1991-2000 in comparison to controls (n = 27 491) in the Vaccine Safety Datalink (VSD) database.

RESULTS: Cases diagnosed with ED were significantly more likely than controls to have received increased Hg exposure within the first month of life (odds ratio (OR) = 1.3384), the first 2 months of life (OR = 1.3367) and the first 6 months of life (OR = 2.37). When the data were separated by gender, similar significant adverse effects were observed for males, but not females. On a per microgram Hg basis, cases diagnosed with ED were significantly more likely than controls to have received increased exposure within the first 6 months of life (OR = 1.025 per microgram Hg).

CONCLUSIONS: The results show a significant relationship between Hg exposure from Thimerosal-containing childhood vaccines and the subsequent risk of an ED diagnosis.

KEYWORDS: Emotional disturbances; anxiety; ethylmercury; mercury; merthiolate; shyness; social impairment; thiomersal




**"The results show a significant relationship between mercury exposure from Thimerosal-containing childhood vaccines and the subsequent risk of an emotional disturbances diagnosis."**

Children's Health

# HPV Vaccine Increases the Risk of Celiac Disease by 1.56X

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J Intern Med. 2018 Feb;283(2):154-165. doi: 10.1111/joim.12694. Epub 2017 Oct 18.

## Human papillomavirus vaccination of adult women and risk of autoimmune and neurological diseases.

Hviid A[1], Svanström H[1], Scheller NM[1], Grönhøj Q[2], Pasternak B[1,3], Arnheim-Dahlström L[2]

Author Information


**Abstract**

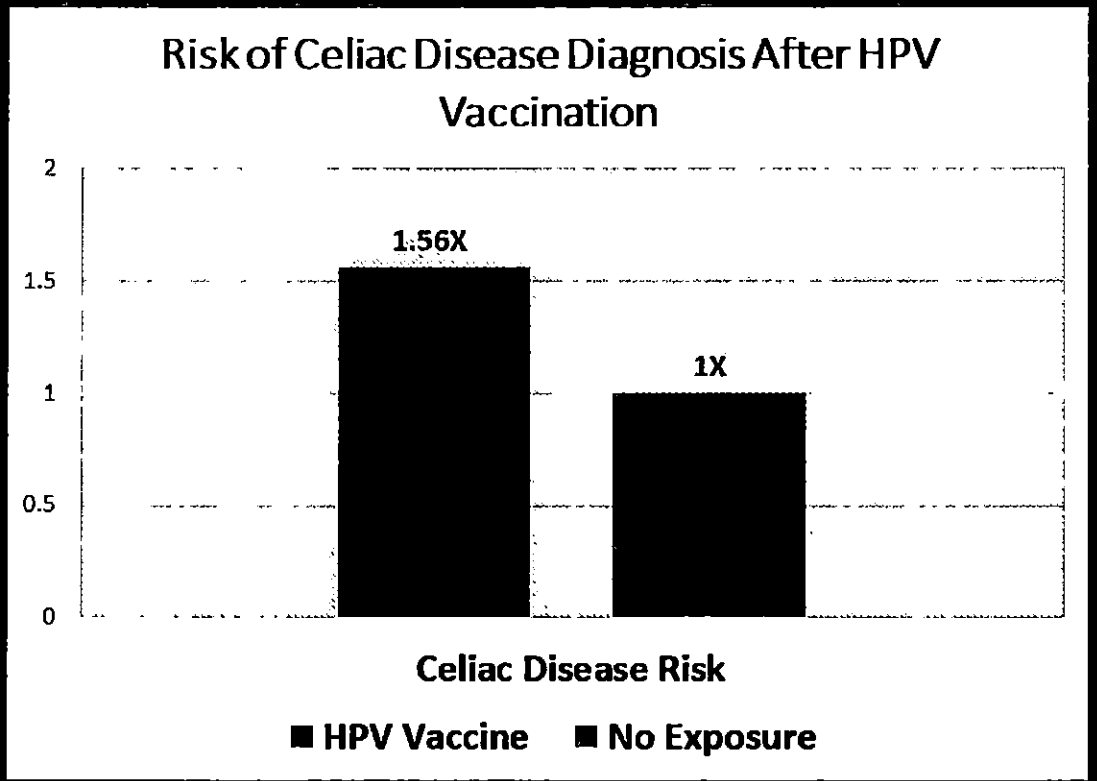
BACKGROUND: Since 2006, human papillomavirus (HPV) vaccines have been introduced in many countries worldwide. Whilst safety studies have been reassuring, focus has been on the primary target group, the young adolescent girls. However, it is also important to evaluate safety in adult women where background disease rates and safety issues could differ significantly.

OBJECTIVE: We took advantage of the unique Danish and Swedish nationwide healthcare registers to conduct a cohort study comparing incidence rate ratios (RRs) of 45 preselected serious chronic diseases in quadrivalent HPV (qHPV)-vaccinated and qHPV-unvaccinated adult women 18-44 years of age.

METHODS: We used Poisson regression to estimate RRs according to qHPV vaccination status with two-sided 95% confidence intervals (95% CIs).

RESULTS: The study cohort comprised 3 126 790 women (1 195 865 [38%] Danish and 1 930 925 [62%] Swedish) followed for 16 386 459 person-years. Vaccine uptake of at least one dose of qHPV vaccine was 8% in the cohort: 18% amongst Danish women and 2% amongst Swedish. We identified seven adverse events with statistically significant increased risks following vaccination-Hashimoto's thyroiditis, coeliac disease, localized lupus erythematosus, pemphigus vulgaris, Addison's disease, Raynaud's disease and other encephalitis, myelitis or encephalomyelitis. After taking multiple testing into account and conducting self-controlled case series analyses, coeliac disease (RR 1.56 [95% confidence interval 1.29-1.89]) was the only remaining association.

CONCLUSION: Unmasking of conditions at vaccination visits is a plausible explanation for the increased risk associated with qHPV in this study because coeliac disease is underdiagnosed in Scandinavian populations. In conclusion, our study of serious adverse event rates in qHPV-vaccinated and qHPV-unvaccinated adult women 18-44 years of age did not raise any safety issues of concern.


Children's Health

**"Relative Risks for celiac disease were increased for both the period any time after vaccination (RR 1.56, 1.29–1.89), the first 179 days (1.54, 1.16–2.03) and the more than 180 days after vaccination period (1.58, 1.22–2.05)."**

# The H1N1 and Seasonal Influenza Vaccines Both Given During Pregnancy Increase Fetal Loss by 11.4X Compared to the Seasonal Influenza Vaccine Only

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Hum Exp Toxicol. 2013 May;32(5):464-75. doi: 10.1177/0960327112455087. Epub 2012 Sep 27.

**Comparison of VAERS fetal-loss reports during three consecutive influenza seasons: was there a synergistic fetal toxicity associated with the two-vaccine 2009/2010 season?**

Goldman GS[1].

Author Information

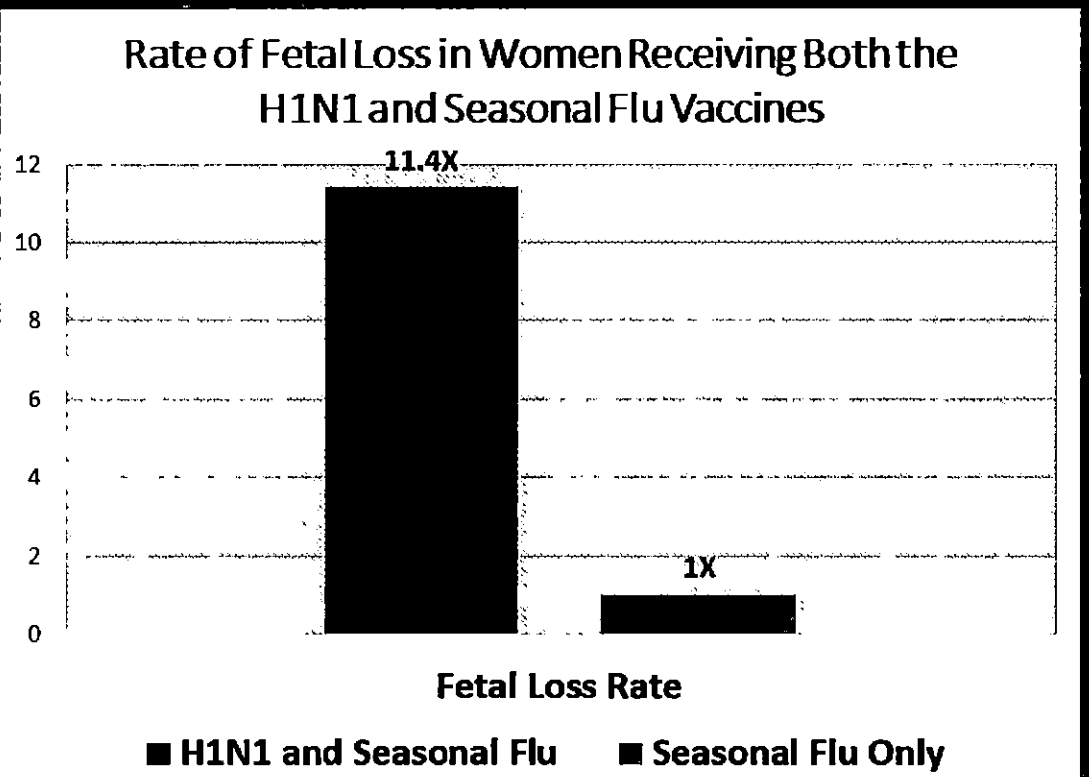
**Abstract**

The aim of this study was to compare the number of inactivated-influenza vaccine-related spontaneous abortion and stillbirth (SB) reports in the Vaccine Adverse Event Reporting System (VAERS) database during three consecutive flu seasons beginning 2008/2009 and assess the relative fetal death reports associated with the two-vaccine 2009/2010 season. The VAERS database was searched for reports of fetal demise following administration of the influenza vaccine/vaccines to pregnant women. Utilization of an independent surveillance survey and VAERS, two-source capture-recapture analysis estimated the reporting completeness in the 2009/2010 flu season. Capture-recapture demonstrated that the VAERS database captured about 13.2% of the total 1321 (95% confidence interval (CI): 815-2795) estimated reports, yielding an ascertainment-corrected rate of 590 fetal-loss reports per million pregnant women vaccinated (or 1 per 1695). The unadjusted fetal-loss report rates for the three consecutive influenza seasons beginning 2008/2009 were 6.8 (95% CI: 0.1-13.1), 77.8 (95% CI: 66.3-89.4), and 12.6 (95% CI: 7.2-18.0) cases per million pregnant women vaccinated, respectively. The observed reporting bias was too low to explain the magnitude increase in fetal-demise reporting rates in the VAERS database relative to the reported annual trends. Thus, a synergistic fetal toxicity likely resulted from the administration of both the pandemic (A-H1N1) and seasonal influenza vaccines during the 2009/2010 season.

KEYWORDS: Human toxicology; Thimerosal; immunization; influenza vaccine; spontaneous abortion; stillbirth

PMID: 23023030 PMCID: PMC3565271 DOI: 10.1177/0960327112455087

[Indexed for MEDLINE] Free PMC Article




Children's Health

**"Because of the order of magnitude increase in fetal-loss report rates, from 6.8 fetal-loss reports per million pregnant women vaccinated in the single-dose 2008/2009 season to 77.8 in the two-dose 2009/2010 season, further long-term studies are needed to assess adverse outcomes in the surviving children."**

# Swine Flu Vaccine (Pandemrix) Increases Rate of Narcolepsy in Swedish Children by 25X

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Neurology. 2013 Apr 2;80(14):1315-21. doi: 10.1212/WNL.0b013e31828ab26f. Epub 2013 Mar 13.

**Increased childhood incidence of narcolepsy in western Sweden after H1N1 influenza vaccination.**

Szakács A[1], Darin N, Hallböök T

Author information


**Abstract**

**OBJECTIVES:** To assess the incidence of narcolepsy between January 2000 and December 2010 in children in western Sweden and its relationship to the Pandemrix vaccination, and to compare the clinical and laboratory features of these children.

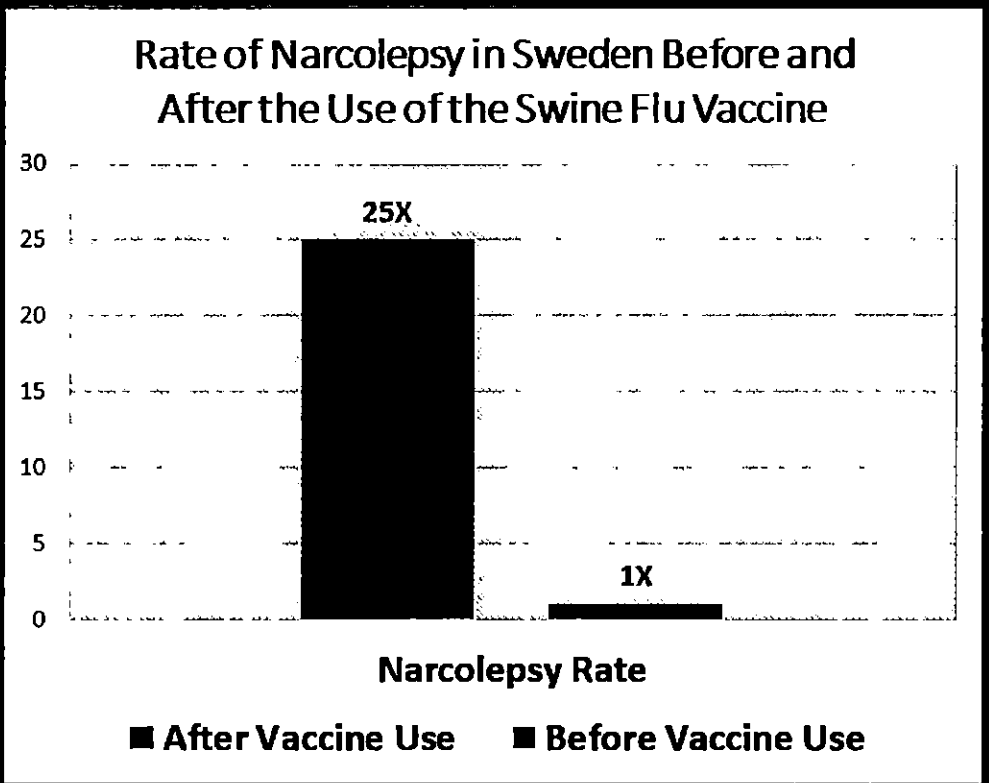
**METHODS:** The children were identified from all local and regional pediatric hospitals, child rehabilitation centers, outpatient pediatric clinics, and regional departments of neurophysiology. Data collection was performed with the aid of a standardized data collection form, from medical records and telephone interviews with patients and parents. The laboratory and investigational data were carefully scrutinized.

**RESULTS:** We identified 37 children with narcolepsy. Nine of them had onset of symptoms before the H1N1 vaccination and 28 had onset of symptoms in relationship to the vaccination. The median age at onset was 10 years. All patients in the postvaccination group were positive for human leukocyte antigen (HLA)-DQB1*0602. Nineteen patients in the postvaccination group, compared with one in the prevaccination group, had a clinical onset that could be dated within 12 weeks.

**CONCLUSION:** Pandemrix vaccination is a precipitating factor for narcolepsy, especially in combination with HLA-DQB1*0602. The incidence of narcolepsy was 25 times higher after the vaccination compared with the time period before. The children in the postvaccination group had a lower age at onset and a more sudden onset than that generally seen.


**Comment in**

Association between H1N1 vaccination and narcolepsy-cataplexy: Bu to sleep. [Neurology. 2013]




**"The incidence of narcolepsy was 25 times higher after the vaccination compared with the time period before. The children in the postvaccination group had a lower age at onset and a more sudden onset than that generally seen."**

Children's Health

# Risk of Chorioamnionitis in Pregnant Women Vaccinated with Tdap Versus Pregnant Women Not Vaccinated with Tdap

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JAMA. 2014 Nov 12;312(18):1897-904. doi: 10.1001/jama.2014.14828.

**Evaluation of the association of maternal pertussis vaccination with obstetric events and birth outcomes.**

Author information


**Abstract**

**IMPORTANCE:** In 2010, due to a pertussis outbreak and neonatal deaths, the California Department of Health recommended that the tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) be administered during pregnancy. Tdap is now recommended by the Advisory Committee on Immunization Practices for all pregnant women, preferably between 27 and 36 weeks' gestation. Limited data exist on Tdap safety during pregnancy.

**OBJECTIVE:** To evaluate whether maternal Tdap vaccination during pregnancy is associated with increased risks of adverse obstetric events or adverse birth outcomes.

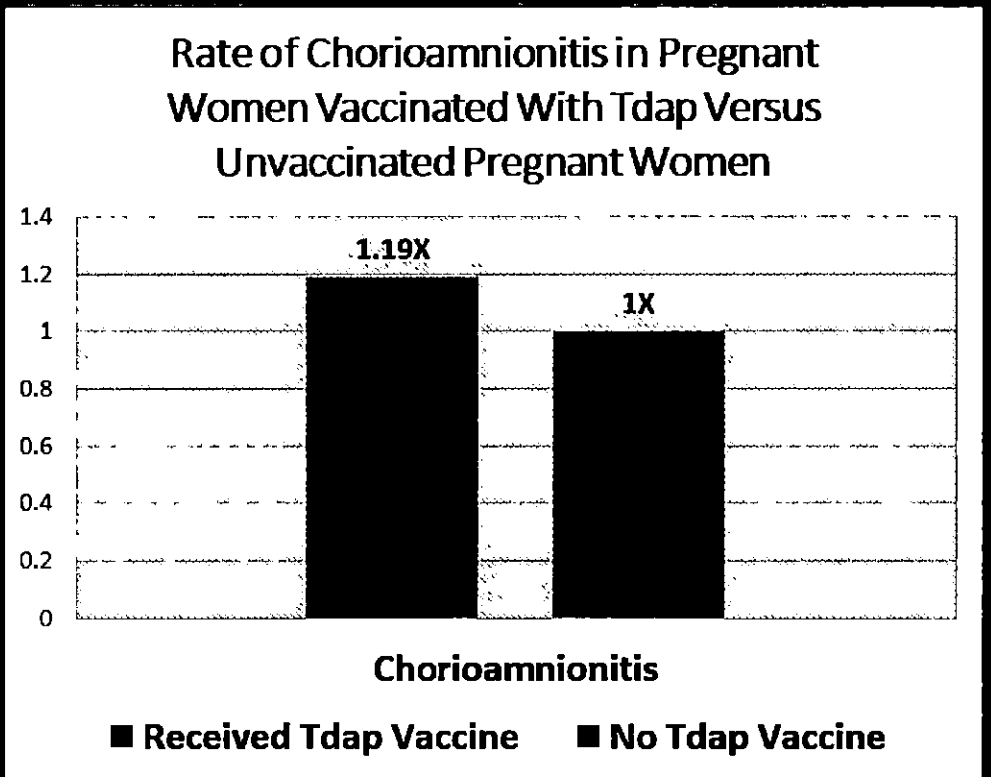
**DESIGN AND SETTING:** Retrospective, observational cohort study using administrative health care databases from 2 California Vaccine Safety Datalink sites.

**PARTICIPANTS AND EXPOSURES:** Of 123,494 women with singleton pregnancies ending in a live birth between January 1, 2010, and November 15, 2012, 26,229 (21%) received Tdap during pregnancy and 97,265 did not.

**MAIN OUTCOMES AND MEASURES:** Risks of small-for-gestational-age (SGA) births (<10th percentile), chorioamnionitis, preterm birth (<37 weeks' gestation), and hypertensive disorders of pregnancy were evaluated. Relative risk (RR) estimates were adjusted for site, receipt of another vaccine during pregnancy, and propensity to receive Tdap during pregnancy. Cox regression was used for preterm delivery, and Poisson regression for other outcomes.

**RESULTS:** Vaccination was not associated with increased risks of adverse birth outcomes: crude estimates for preterm delivery were 6.3% of vaccinated and 7.6% of unvaccinated women (adjusted RR, 1.03; 95% CI, 0.97-1.09); 8.4% of vaccinated and 8.3% of unvaccinated had an SGA birth (adjusted RR, 1.00; 95% CI, 0.96-1.05). Receipt of Tdap before 20 weeks was not associated with hypertensive disorder of pregnancy (adjusted RR, 1.09; 95% CI, 0.99-1.20); chorioamnionitis was diagnosed in 6.1% of vaccinated and 5.5% of unvaccinated women (adjusted RR, 1.19; 95% CI, 1.13-1.26).

**CONCLUSIONS AND RELEVANCE:** In this cohort of women with singleton pregnancies that ended in live birth, receipt of Tdap during pregnancy was not associated with increased risk of hypertensive disorders of pregnancy or preterm or SGA birth, although a small but statistically significant increased risk of chorioamnionitis diagnosis was observed.


**"Among women who received Tdap at anytime during pregnancy, 6.1% were diagnosed with chorioamnionitis compared with 5.5% of unexposed women. After adjusting for site, receipt of 1 or more other vaccines in pregnancy and the propensity score, the adjusted relative risk (RR) was 1.19 (95% CI, 1.13–1.26)."**

Children's Health

# First Dose of Rotavirus Vaccine (Rotarix) Increases Intussusception Odds by 5.8X

PubMed.gov — US National Library of Medicine National Institutes of Health

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N Engl J Med. 2011 Jun 16;364(24):2283-92. doi: 10.1056/NEJMoa1012952.

## Intussusception risk and health benefits of rotavirus vaccination in Mexico and Brazil.

Patel MM[1], López-Collada VR, Bulhões MM, De Oliveira LH, Bautista Márquez A, Flannery B, Esparza-Aguilar M, Montenegro Renoiner EI, Luna-Cruz ME, Sato HK, Hernández-Hernández Ldel C, Toledo-Cortina G, Carón-Rodríguez M, Chavez-Romero N, Martínez-Alcazar M, Aquinaga-Villaseñor RG, Plascencia-Hernández A, Feijoo-González F, Hernández-Pereda Rea G, Gutiérrez-Ramírez SE, Doreste-Castillo R, Tinoco-Pizano R, Mercado-Villegas B, Barbosa MR, Maluf EM, Ferreira LB, de Carvalho FM, dos Santos AR, Cesar ED, de Oliveira ME, Silva CL, de Los Angeles Cortes M, Ruiz Matus C, Tate J, Gargiullo P, Pershad JD.

⊕ Author information

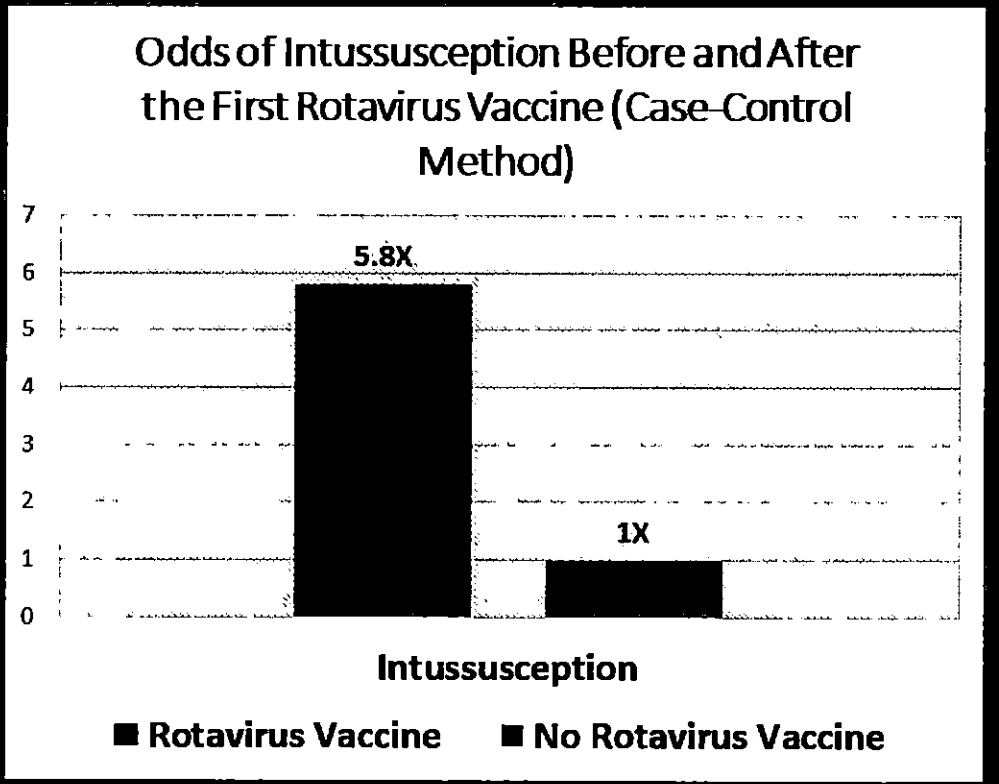
**Abstract**

**BACKGROUND:** Because postlicensure surveillance determined that a previous rotavirus vaccine, RotaShield, caused intussusception in 1 of every 10,000 recipients, we assessed the association of the new monovalent rotavirus vaccine (RV1) with intussusception after routine immunization of infants in Mexico and Brazil.

**METHODS:** We used case-series and case-control methods to assess the association between RV1 and intussusception. Infants with intussusception were identified through active surveillance at 69 hospitals (16 in Mexico and 53 in Brazil), and age-matched infants from the same neighborhood were enrolled as controls. Vaccination dates were verified by a review of vaccination cards or clinic records.

**RESULTS:** We enrolled 615 case patients (285 in Mexico and 330 in Brazil) and 2050 controls. An increased risk of intussusception 1 to 7 days after the first dose of RV1 was identified among infants in Mexico with the use of both the case-series method (incidence ratio, 5.3; 95% confidence interval [CI], 3.0 to 9.3) and the case-control method (odds ratio, 5.8; 95% CI, 2.6 to 13.0). No significant risk was found after the first dose among infants in Brazil, but an increased risk, albeit smaller than that seen after the first dose in Mexico—an increase by a factor of 1.9 to 2.6 - was seen 1 to 7 days after the second dose. A combined annual excess of 96 cases of intussusception in Mexico (approximately 1 per 51,000 infants) and in Brazil (approximately 1 per 68,000 infants) and of 5 deaths due to intussusception was attributable to RV1. However, RV1 prevented approximately 80,000 hospitalizations and 1300 deaths from diarrhea each year in these two countries.

**CONCLUSIONS:** RV1 was associated with a short-term risk of intussusception in approximately 1 of every 51,000 to 68,000 vaccinated infants. The absolute number of deaths and hospitalizations averted because of vaccination far exceeded the number of intussusception cases that may have been associated with vaccination. (Funded in part by the GAVI Alliance and the U.S. Department of Health and Human Services.).




Children's Health

**"An increased risk of intussusception 1 to 7 days after the first dose of RV1 was identified among infants in Mexico with the use of both the case-series method (incidence ratio, 5.3; 95% confidence interval [CI], 3.0 to 9.3) and the case-control method (odds ratio, 5.8; 95% CI, 2.6 to 13.0)."**

# Measles Vaccination Versus Measles Infection Increases the Odds of Atopy (Allergy) by 2.8X

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PubMed.gov — PubMed — Shaheen Lancet Aaby Measles Atopy 1996

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Lancet. 1996 Jun 29;347(9018):1792-6.

## Measles and atopy in Guinea-Bissau.

Shaheen SO[1], Aaby P, Hall AJ, Barker DJ, Heyes CB, Shiell AW, Goudiaby A.

Author Information

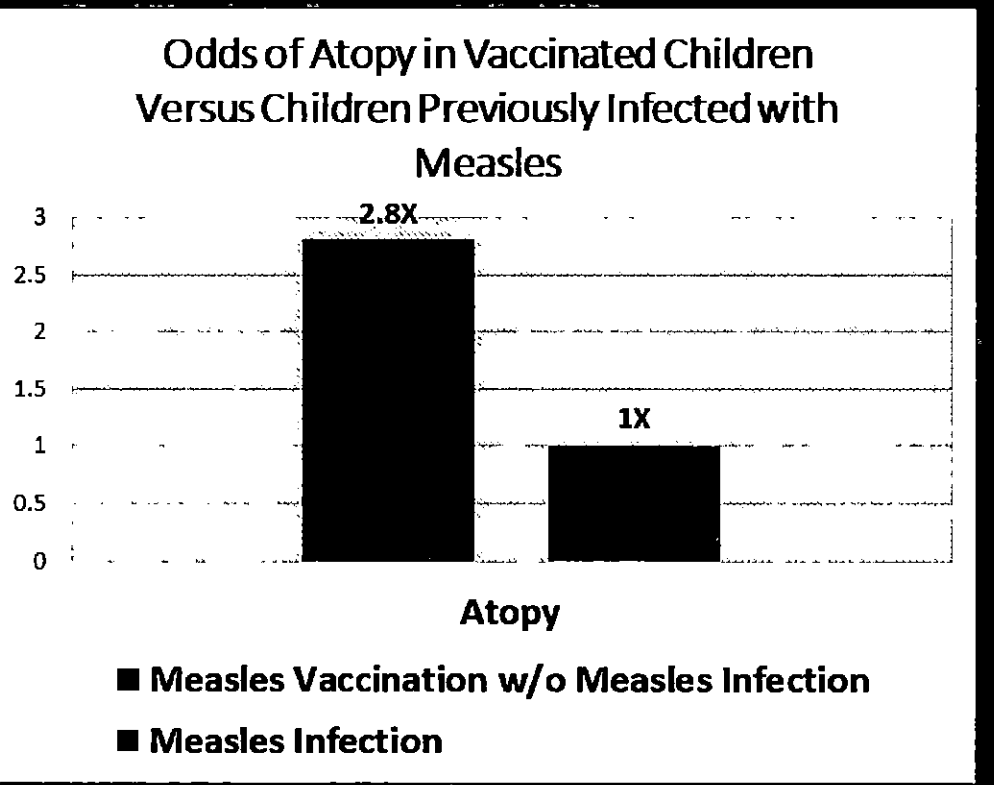

Abstract

BACKGROUND: Epidemiological studies have led to speculation that infections in early childhood may prevent atopic sensitisation but evidence to support this hypothesis is lacking. We investigated whether measles infection protects against the development of atopy in children of Guinea-Bissau, West Africa.

METHODS: We conducted a historical cohort study in Bandim, a semi-rural district of Bissau, the capital of Guinea-Bissau. 395 young adults, first surveyed in 1978-80 aged 0-6 years, were followed up in 1994. Our analyses were restricted to 262 individuals still living in Bandim for whom a measles history, documented in childhood, was judged to be reliable. We defined atopy as skin-prick test positivity (> or = 3 mm weal) to one or more of seven allergens.

FINDINGS: 17 (12.8 percent) of 133 participants who had had measles infection were atopic compared with 33 (25.6 percent) of 129 of those who had been vaccinated and not had measles (odds ratio, adjusted for potential confounding variables 0.36 [95 percent CI 0.17-0.78], p=0.01). Participants who had been breastfed for more than a year were less likely to have a positive skin test to housedust mite. After adjustment for breastfeeding and other variables, measles infection was associated with a large reduction in the risk of skin-prick test positivity to housedust mite (odds ratio for Dermatophagoides pteronyssinus 0.20 [0.05-0.81], p=0.02; D farinae 0.20 [0.06-0.71], p=0.01).

INTERPRETATION: Measles infection may prevent the development of atopy in African children.


**"17 (12.8%) of 133 participants who had had measles infection were atopic compared with 33 (25.6%) of 129 of those who had been vaccinated and not had measles"**

Children's Health

# Higher Exposure to Thimerosal from Infant Vaccines Increases the Odds of Motor Tics (2.19X) and Phonic Tics (2.44X) in Boys

PubMed.gov — US National Library of Medicine, National Institutes of Health

PubMed | thompson price 2007 thimerosal

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N Engl J Med. 2007 Sep 27;357(13):1281-92.

**Early thimerosal exposure and neuropsychological outcomes at 7 to 10 years.**

Thompson WW[1], Price C, Goodson B, Shay DK, Benson P, Hinrichsen VL, Lewis E, Eriksen E, Ray P, Marcy SM, Dunn J, Jackson LA, Lieu TA, Black S, Stewart G, Weintraub ES, Davis RL, DeStefano F; Vaccine Safety Datalink Team.

⊕ Author Information

**Abstract**

BACKGROUND: It has been hypothesized that early exposure to thimerosal, a mercury-containing preservative used in vaccines and immune globulin preparations, is associated with neuropsychological deficits in children.

METHODS: We enrolled 1047 children between the ages of 7 and 10 years and administered standardized tests assessing 42 neuropsychological outcomes. (We did not assess autism-spectrum disorders.) Exposure to mercury from thimerosal was determined from computerized immunization records, medical records, personal immunization records, and parent interviews. Information on potential confounding factors was obtained from the interviews and medical charts. We assessed the association between current neuropsychological performance and exposure to mercury during the prenatal period, the neonatal period (birth to 28 days), and the first 7 months of life.

RESULTS: Among the 42 neuropsychological outcomes, we detected only a few significant associations with exposure to mercury from thimerosal. The detected associations were small and almost equally divided between positive and negative effects. Higher prenatal mercury exposure was associated with better performance on one measure of language and poorer performance on one measure of attention and executive functioning. Increasing levels of mercury exposure from birth to 7 months were associated with better performance on one measure of fine motor coordination and on one measure of attention and executive functioning. Increasing mercury exposure from birth to 28 days was associated with poorer performance on one measure of speech articulation and better performance on one measure of fine motor coordination.

CONCLUSIONS: Our study does not support a causal association between early exposure to mercury from thimerosal-containing vaccines and immune globulins and deficits in neuropsychological functioning at the age of 7 to 10 years.

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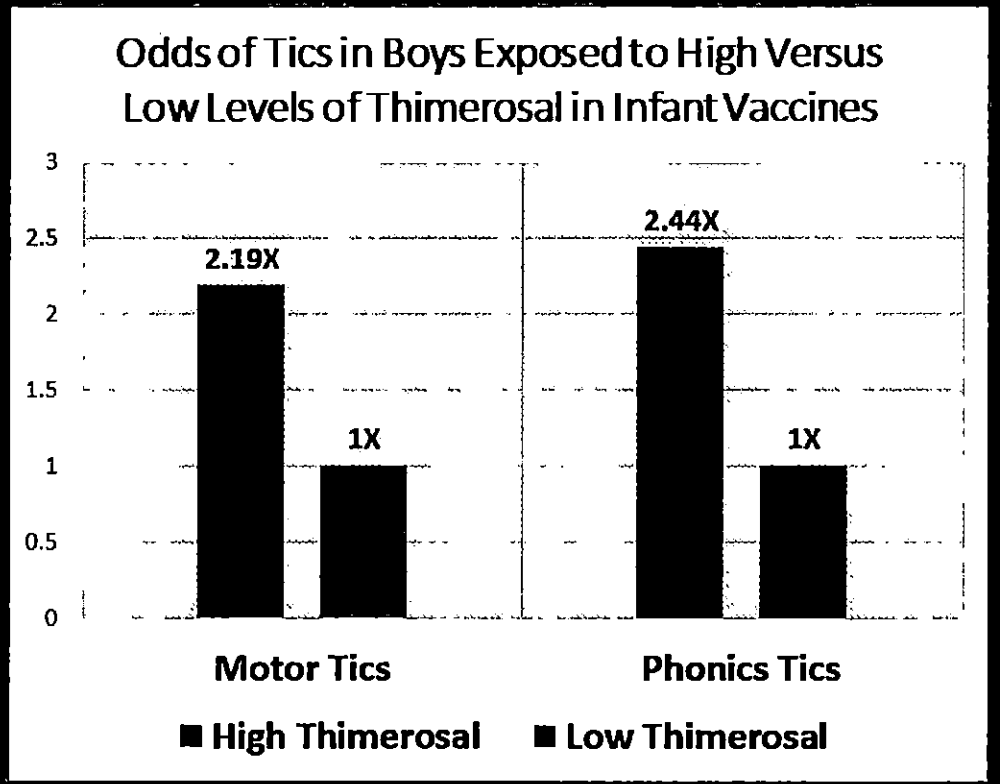


**"Among boys, higher exposure to mercury from birth to 7 months was associated with ... a higher likelihood of motor and phonic tics, as reported by the children's evaluators."**

Children's Health

# Delaying the First Three DPT Vaccine Doses Reduces Asthma Risk by 61%

PubMed.gov — PubMed — McDonald Huq 2008 pertussis asthma

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J Allergy Clin Immunol. 2008 Mar;121(3):626-31. doi: 10.1016/j.jaci.2007.11.034. Epub 2008 Jan 18.

**Delay in diphtheria, pertussis, tetanus vaccination is associated with a reduced risk of childhood asthma.**

McDonald KL[1], Huq SI, Lix LM, Bednar AS, Kozyrskyj AL.

⊕ Author information


Abstract

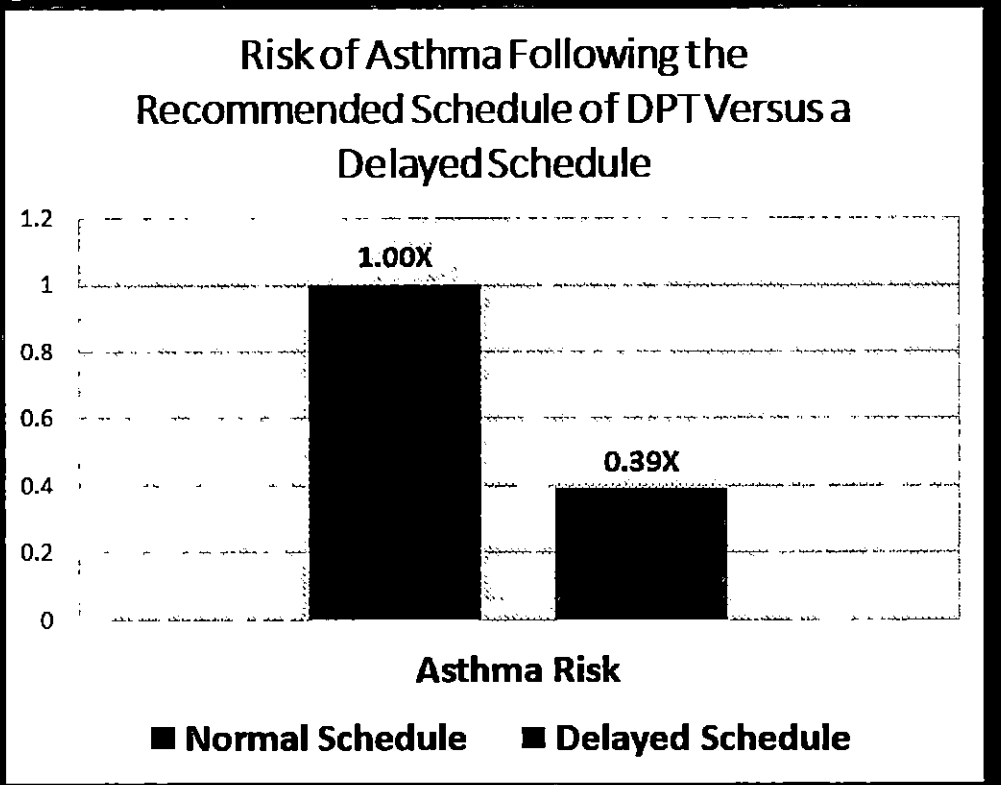
BACKGROUND: Early childhood immunizations have been viewed as promoters of asthma development by stimulating a T(H)2-type immune response or decreasing microbial pressure, which shifts the balance between T(H)1 and T(H)2 immunity.

OBJECTIVE: Differing time schedules for childhood immunizations may explain the discrepant findings of an association with asthma reported in observational studies. This research was undertaken to determine whether timing of diphtheria, pertussis, tetanus (DPT) immunization has an effect on the development of childhood asthma by age 7 years.

METHODS: This was a retrospective longitudinal study of a cohort of children born in Manitoba in 1995. The complete immunization and health care records of cohort children from birth until age 7 years were available for analysis. The adjusted odds ratio for asthma at age 7 years according to timing of DPT immunization was computed from multivariable logistic regression.

RESULTS: Among 11,531 children who received at least 4 doses of DPT, the risk of asthma was reduced to (1/2) in children whose first dose of DPT was delayed by more than 2 months. The likelihood of asthma in children with delays in all 3 doses was 0.39 (95% CI, 0.18-0.86).

CONCLUSION: We found a negative association between delay in administration of the first dose of whole-cell DPT immunization in childhood and the development of asthma; the association was greater with delays in all of the first 3 doses. The mechanism for this phenomenon requires further research.


**"Among 11,531 children who received at least 4 doses of DPT, the risk of asthma was reduced to (1/2) in children whose first dose of DPT was delayed by more than 2 months. The likelihood of asthma in children with delays in all 3 doses was 0.39 (95% CI, 0.18-0.86)."**

Children's Health

# Exposure to Higher Levels of Thimerosal in Infant Vaccines Before 13 Months of Age Increases the Rate of Premature Puberty by 6.45X

Indian J Med Res 131, April 2010, pp 500-507

## Thimerosal exposure & increasing trends of premature puberty in the vaccine safety datalink

David A. Geier[a,*], Heather A. Young[b] & Mark R. Geier[c]

[a]*The Institute of Chronic Illnesses, Inc., Silver Spring, MD,* [*]*CoMeD, Inc., Silver Spring, MD,* [b]*The George Washington University School of Public Health & Health Services, Department of Epidemiology & Biostatistics, Washington, DC &* [c]*ASD Centers, LLC, USA*

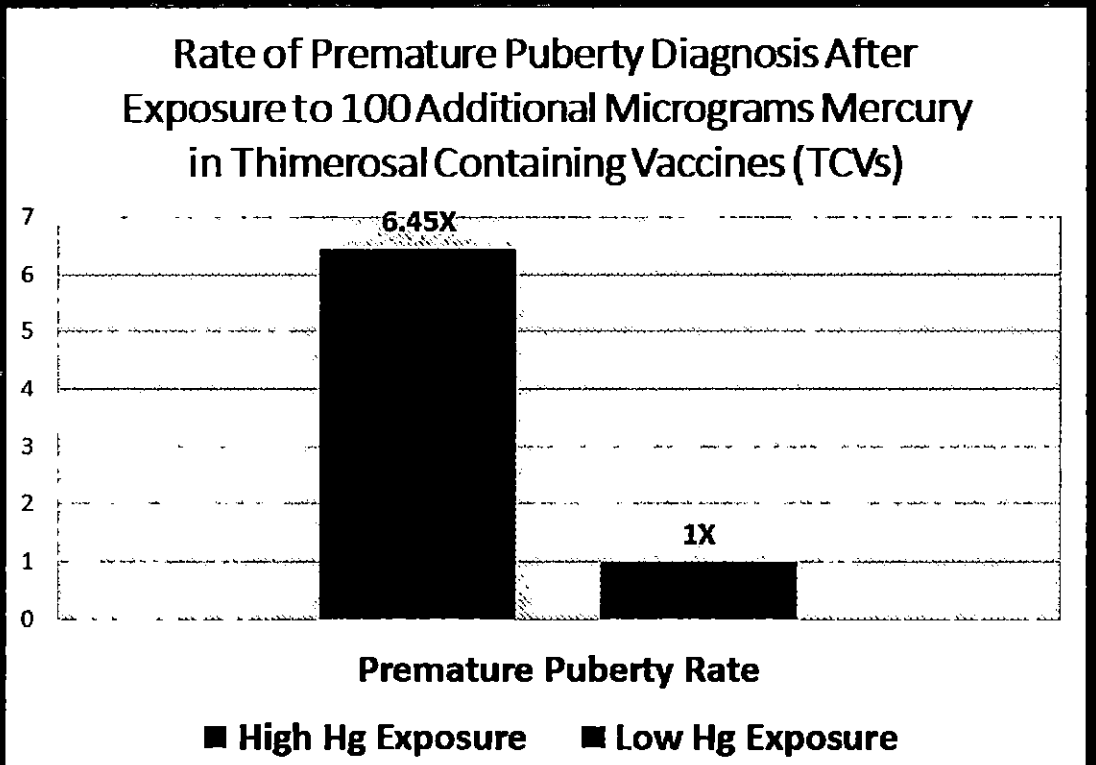
Received December 12, 2008

***Background & objectives:*** The US Agency for Toxic Substances and Disease Registry (ATSDR) reports that mercury (Hg) is a known endocrine disruptor and it adversely affects the steroid synthesis pathway in animals and humans, and may interact to enhance the risk for a child developing premature puberty. An association between premature puberty and exposure to Hg from thimerosal-containing vaccines (TCVs) was evaluated in computerized medical records within the Vaccine Safety Datalink (VSD).

***Methods:*** A total of 378,624 subjects were identified in birth cohorts from 1990-1996. The birth cohort prevalence rates of medically diagnosed International Classification of Disease, 9th revision (ICD-9) premature puberty and control outcomes were calculated. Exposures to Hg from TCVs were calculated by birth cohort for specific exposure windows from birth-7 months and birth-13 months of age. Poisson regression analysis was used to model the association between the prevalence of outcomes and Hg doses from TCVs.

***Results:*** Significantly increased ($P<0.0001$) rate ratios were observed for premature puberty for a 100 µg difference in Hg exposure from TCVs in the birth-7 months (rate ratio=5.58) and birth-13 months (rate ratio=6.45) of age exposure windows. By contrast, none of the control outcomes had significantly increased rate ratios with Hg exposure from TCVs.

***Interpretation & conclusions:*** Routine childhood vaccination should be continued to help reduce the morbidity and mortality associated with infectious diseases, but efforts should be undertaken to remove Hg from vaccines. Additional studies should be done to evaluate the relationship between Hg exposure and premature puberty.




**"Significantly increased ($P<0.0001$) rate ratios were observed for premature puberty for a 100 µg difference in Hg exposure from TCVs in the birth-7 months (rate ratio=5.58) and birth-13 months (rate ratio=6.45) of age exposure windows. By contrast, none of the control outcomes had significantly increased rate ratios with Hg exposure from TCVs."**

Children's Health

# Addition of the Hepatitis B Vaccine in 1988 Increased the Rate of Type 1 Diabetes 1.62X in Children in New Zealand

Infectious Diseases In Clinical Practice IDCP

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Classen David C.; Classen, John Barthelow

Infectious Diseases in Clinical Practice: September-October 1997 - Volume 6 - Issue 7 - ppg 449-454
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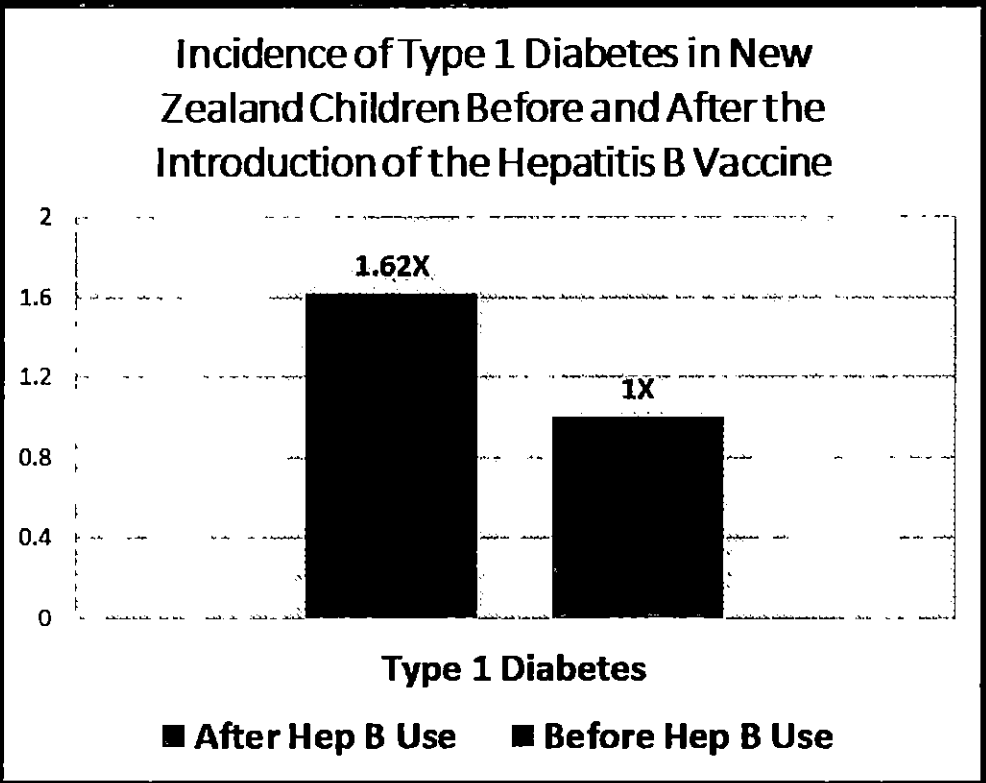
## THE TIMING OF PEDIATRIC IMMUNIZATION AND THE RISK OF INSULIN-DEPENDENT DIABETES MELLITUS

by David C. Classen and John Barthelow Classen




**"The incidence of type I diabetes in persons 0-19 years old living in Christchurch rose from 11.2 cases per 100,000 children annually in the years before the immunization program, 1982-1987, to 18.1 cases per 100,000 children annually ( $P = .0008$) in the years following the immunization, 1989-1991."**

Children's Health

# DTP Vaccination Increases Mortality by 2.45X in Girls Previously Receiving the BCG (Tuberculosis) Vaccine

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Trans R Soc Trop Med Hyg. 2016 Dec;110(10):570-581. Epub 2016 Nov 17.

**Is diphtheria-tetanus-pertussis (DTP) associated with increased female mortality? A meta-analysis testing the hypotheses of sex-differential non-specific effects of DTP vaccine.**

Aaby P[1,2], Benn H[2,3], Fisker AB[4,2,3], Rodrigues A[4], Benn CS[4,2,3]

Author information

1 Bandim Health Project, Indepth Network, Apartado 861, Bissau, Guinea-Bissau p.aaby@bandim.org
2 Research Centre for Vitamins and Vaccines (CVIVA), Bandim Health Project, Statens Serum Institut, Artillerivej 5, 2300 Copenhagen S, Denmark.
3 OPEN, Institute of Clinical Research, University of Southern Denmark/Odense University Hospital
4 Bandim Health Project, Indepth Network, Apartado 861, Bissau, Guinea-Bissau.

**Abstract**

BACKGROUND: Ten years ago, we formulated two hypotheses about whole-cell diphtheria-tetanus-pertussis (DTP) vaccination: first, when given after BCG, DTP increases mortality in girls and, second, following DTP there is an increase in the female/male mortality rate ratio (MRR). A recent review by WHO found no convincing evidence that DTP increases mortality in females.

METHODS: We used previous DTP reviews as well as the recent WHO review for assessing the hypotheses. As pre-specified we excluded studies with survival or frailty bias; if children had received BCG and DTP simultaneously; and if the children had received neonatal vitamin A.

RESULTS: In seven studies of BCG-vaccinated children, DTP vaccination was associated with a 2.54 (95% CI 1.68-3.86) increase in mortality in girls (with no increase in boys [ratio 0.96, 0.55-1.68]). In 10 studies of BCG-vaccinated children, the female-to-male mortality ratio was 2.45 (1.48-4.06) times higher after DTP than before DTP. In 15 studies of children who had received DTP after previous BCG vaccination, mortality was 1.53 (1.21-1.93) times higher in girls than boys. The findings were similar in studies conducted before and after formulation of the hypotheses.

CONCLUSIONS: The two hypotheses were confirmed in the studies that fulfilled pre-specified criteria.

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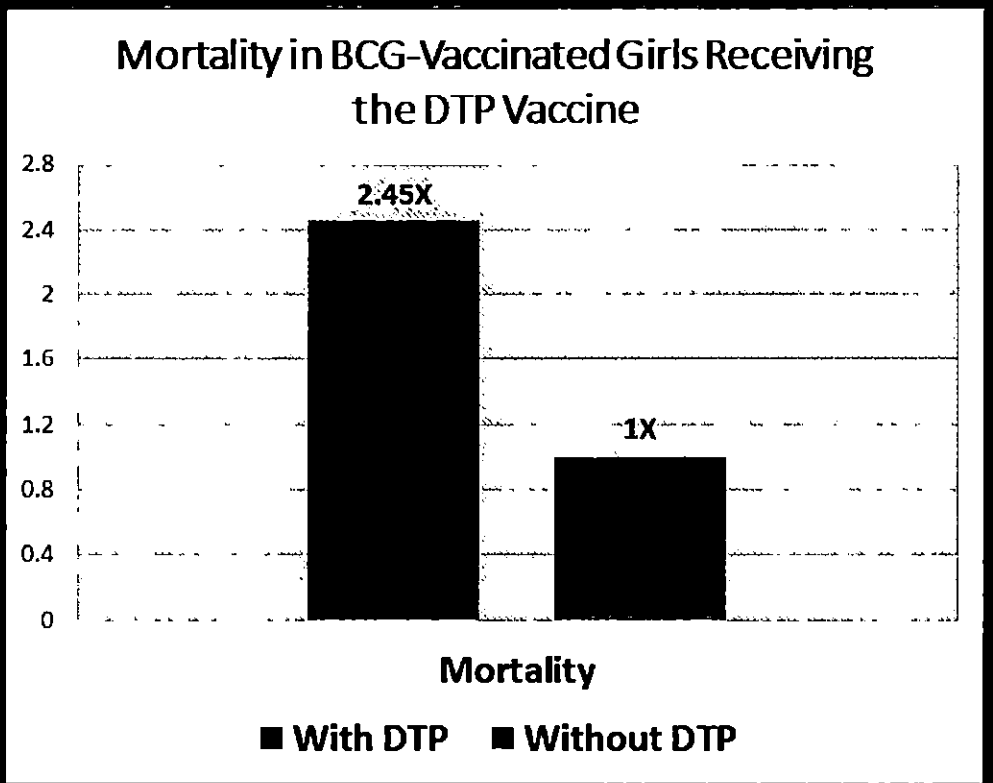


**"In seven studies of BCG-vaccinated children, DTP vaccination was associated with a 2.54 (95% CI 1.68–3.86) increase in mortality in girls (with no increase in boys [ratio 0.96, 0.55–1.68]). The ways in which the female and the male immune systems may respond differently to vaccinations in infants are only beginning to be studied."**

Children's Health

# Higher Number of Vaccine Doses Prior to One Year of Age Increases Infant Mortality by 1.83X

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Hum Exp Toxicol. 2011 Sep;30(9):1420-8. doi: 10.1177/0960327111407844. Epub 2011 May 4.

**Infant mortality rates regressed against number of vaccine doses routinely given: is there a biochemical or synergistic toxicity?**

Miller NZ[1], Goldman GS

Author information

1 Think Twice Global Vaccine Institute, USA. neilzmiller@gmail.com [corrected]

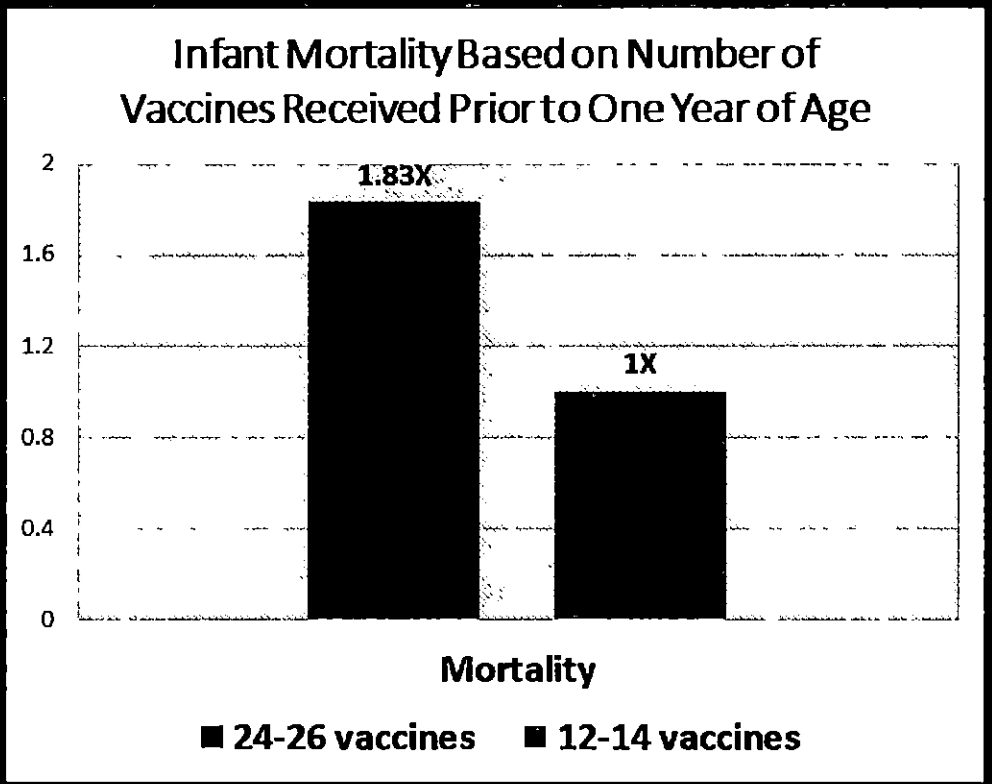
Erratum in
Hum Exp Toxicol. 2011 Sep;30(9):1429.

**Abstract**

The infant mortality rate (IMR) is one of the most important indicators of the socio-economic well-being and public health conditions of a country. The US childhood immunization schedule specifies 26 vaccine doses for infants aged less than 1 year—the most in the world—yet 33 nations have lower IMRs. Using linear regression, the immunization schedules of these 34 nations were examined and a correlation coefficient of $r = 0.70$ ($p < 0.0001$) was found between IMRs and the number of vaccine doses routinely given to infants. Nations were also grouped into five different vaccine dose ranges: 12-14, 15-17, 18-20, 21-23, and 24-26. The mean IMRs of all nations within each group were then calculated. Linear regression analysis of unweighted mean IMRs showed a high statistically significant correlation between increasing number of vaccine doses and increasing infant mortality rates, with $r = 0.992$ ($p = 0.0009$). Using the Tukey-Kramer test, statistically significant differences in mean IMRs were found between nations giving 12-14 vaccine doses and those giving 21-23, and 24-26 doses. A closer inspection of correlations between vaccine doses, biochemical or synergistic toxicity, and IMRs is essential.

PMID: 21543527 PMCID: PMC3170073 DOI: 10.1177/0960327111407844

[Indexed for MEDLINE] Free PMC Article




**"Using the Tukey-Kramer test, statistically significant differences in mean IMRs (infant mortality rates) were found between nations giving 12–14 vaccine doses and those giving 21–23, and 24–26 doses."**

Children's Health

# One Dose of the DTP Vaccine Increases Infant Mortality by 1.84X

PubMed.gov — US National Library of Medicine National Institutes of Health

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BMJ. 2000 Dec 9;321(7274):1435-8.

**Routine vaccinations and child survival: follow up study in Guinea-Bissau, West Africa.**

Kristensen I[1], Aaby P, Jensen H

Author information

1 Bandim Health Project, Apartado 861, Bissau, Guinea-Bissau

**Abstract**

**OBJECTIVE:** To examine the association between routine childhood vaccinations and survival among infants in Guinea-Bissau.

**DESIGN:** Follow up study.

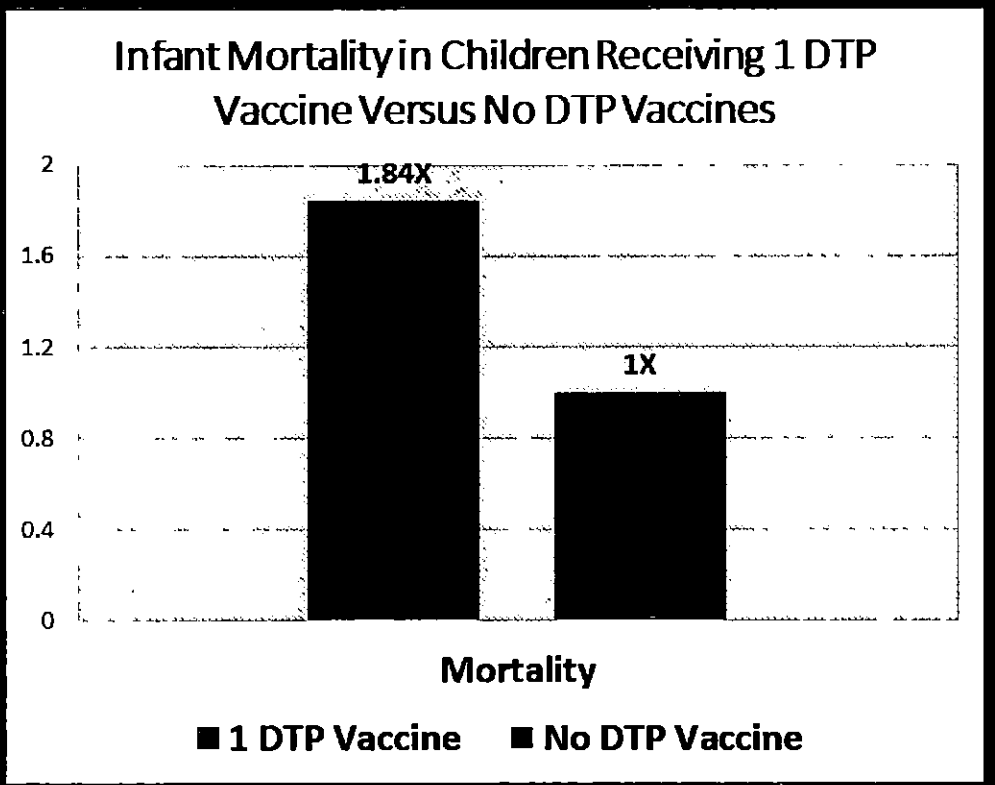
**PARTICIPANTS:** 15 351 women and their children born during 1990 and 1996.

**SETTING:** Rural Guinea-Bissau.

**MAIN OUTCOME MEASURES:** Infant mortality over six months (between age 0-6 months and 7-13 months for BCG, diphtheria, tetanus, and pertussis, and polio vaccines and between 7-13 months and 14-20 months for measles vaccine).

**RESULTS:** Mortality was lower in the group vaccinated with any vaccine compared with those not vaccinated, the mortality ratio being 0.74 (95% confidence interval 0.53 to 1.03). After cluster, age, and other vaccines were adjusted for, BCG was associated with significantly lower mortality (0.55 (0.36 to 0.85)). However, recipients of one dose of diphtheria, tetanus, and pertussis or polio vaccines had higher mortality than children who had received none of these vaccines (1.84 (1.10 to 3.10) for diphtheria, tetanus, and pertussis). Recipients of measles vaccine had a mortality ratio of 0.48 (0.27 to 0.87). When deaths from measles were excluded from the analysis the mortality ratio was 0.51 (0.28 to 0.95). Estimates were unchanged by controls for background factors.

**CONCLUSIONS:** These trends are unlikely to be explained exclusively by selection biases since different vaccines were associated with opposite tendencies. Measles and BCG vaccines may have beneficial effects in addition to protection against measles and tuberculosis.




Children's Health

**"One dose of diphtheria, tetanus, and pertussis vaccine was associated with a mortality ratio of 1.84 (1.10 to 3.10) and two to three doses with a ratio of 1.38 (0.73 to 2.61) compared with children who had received no dose of these vaccines."**

# Early DTP Vaccination in Girls Increased Infant Mortality by 5.68X

PubMed.gov — Published — Advanced

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Arch Dis Child. 2012 Aug;97(8):635-91. doi: 10.1136/archdischild-2011-300649. Epub 2012 Feb 13.

**Early diphtheria-tetanus-pertussis vaccination associated with higher female mortality and no difference in male mortality in a cohort of low birthweight children: an observational study within a randomised trial.**

Aaby P[1], Rayn H, Rodrigues A, Lisse IM, Ovesen BR, Leyoh KR, Lund N, Reinvoven J, Blenno-Sørensen S, Whittle H, Benn CS.

Author information

1 Bandim Health Project, Statens Serum Institut, Artillerivej 5, 2300 Copenhagen S, Denmark. p.aaby@bandim.org

Abstract

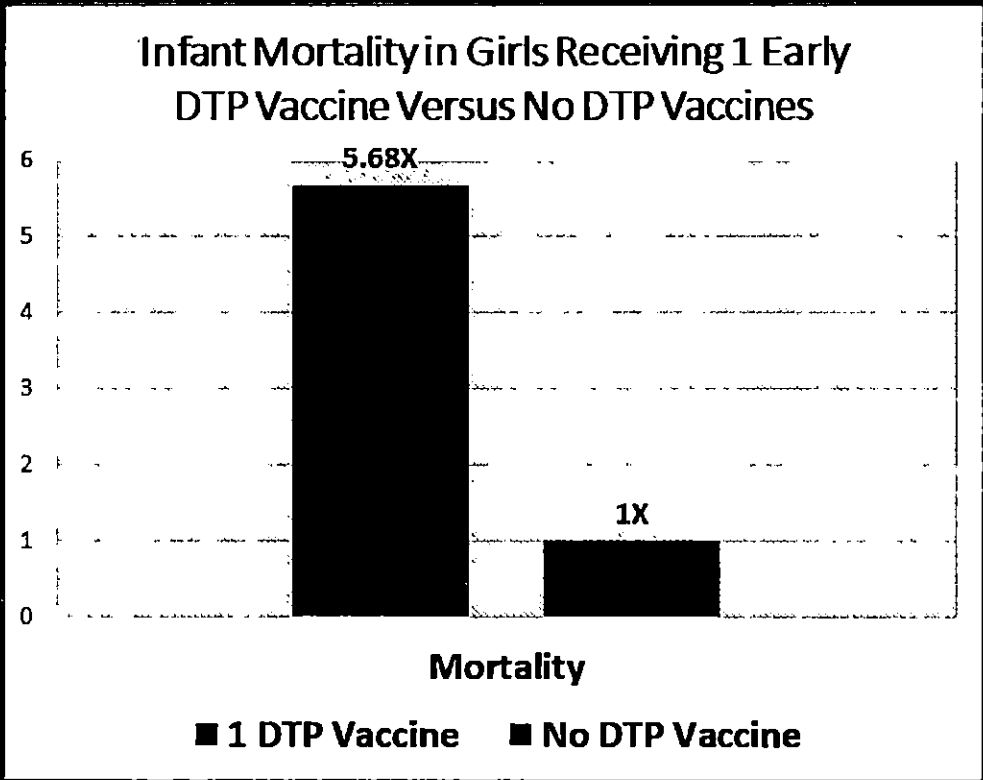
BACKGROUND: Studies from low-income countries have suggested that diphtheria-tetanus-pertussis (DTP) vaccine provided after Bacille Calmette-Guerin (BCG) vaccination may have a negative effect on female survival. The authors examined the effect of DTP in a cohort of low birthweight (LBW) infants.

METHODS: 2320 LBW newborns were visited at 2, 6 and 12 months of age to assess nutritional and vaccination status. The authors examined survival until the 6-month visit for children who were DTP vaccinated and DTP unvaccinated at the 2-month visit.

RESULTS: Two-thirds of the children had received DTP at 2 months and 50 deaths occurred between the 2-month and 6-month visits. DTP vaccinated children had a better anthropometric status for all indices than DTP unvaccinated children. Small mid-upper arm circumference (MUAC) was the strongest predictor of mortality. The death rate ratio (DRR) for DTP vaccinated versus DTP unvaccinated children differed significantly for girls (DRR 2.45; 95% CI 0.93 to 6.45) and boys (DRR 0.53; 95% CI 0.23 to 1.20) (p=0.016, homogeneity test). Adjusting for MUAC, the overall effect for DTP vaccinated children was 2.62 (95% CI 1.34 to 5.09); DRR was 5.68 (95% CI 1.83 to 17.7) for girls and 1.29 (95% CI 0.56 to 2.97) for boys (p=0.023, homogeneity test). While anthropometric indices were a strong predictor of mortality among boys, there was little or no association for girls.

CONCLUSION: Surprisingly, even though the children with the best nutritional status were vaccinated early, early DTP vaccination was associated with increased mortality for girls.

PMID: 22331531 PMCID: PMC3475457 DOI: 10.1136/archdischild-2011-300649




"Surprisingly, even though the children with the best nutritional status were vaccinated early, early DTP vaccination was associated with increased mortality."

Children's Health

# Receipt of Both the BCG and DTP Vaccines Increased Infant Mortality in Girls by 2.4X

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PubMed | moulton halsey katz

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Trop Med Int Health. 2005 Oct;10(10):947-55.

**Evaluation of non-specific effects of infant immunizations on early infant mortality in a southern Indian population.**

Moulton LH[1], Rahmathullah L, Halsey NA, Thulasiraj RD, Katz J, Tielsch JM

Author Information

1 Department of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD 21205, USA. lmoulton@jhsph.edu


Abstract

OBJECTIVE: The aim of this study was to assess the relationship between receipt of routine childhood immunizations and infant mortality before 6 months of age.

METHODS: This was an observational study of 10,274 infants, in a randomized trial of vitamin A supplementation, who received the study dose and survived to at least 1 week of age. The primary outcome was mortality before 6 months of age, analysed in Cox regression models as a function of vaccine receipt and gender.

RESULTS: Receipt of Bacille Calmette Guerin (BCG) or diphtheria, tetanus, polio (DTP) vaccine was associated with significant reductions of one-half to two-thirds of mortality hazards; among girls, those who received both BCG and DTP experienced higher mortality than those who received only one of the two vaccines (hazards ratio 2.4; 95% confidence interval 1.2-5.0).

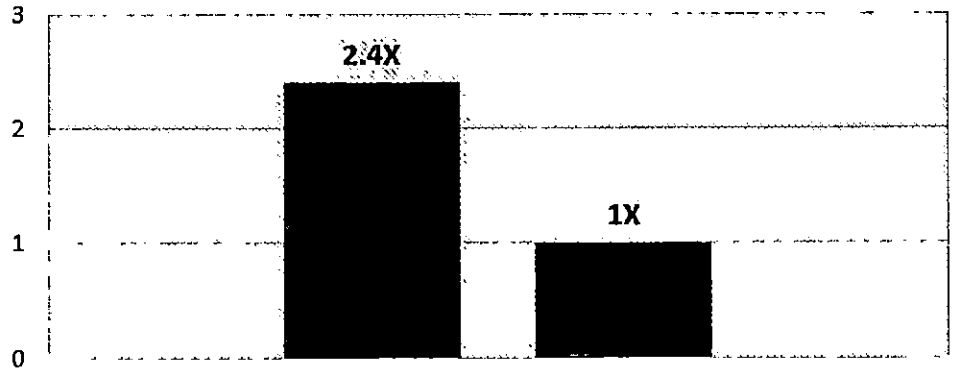
CONCLUSION: The reduced mortality rate associated with receipt of BCG or DTP may be due to both biological and selection factors; the analyses regarding the combined effect of these vaccines and gender need to be replicated in other settings.



PMID: 16185228 DOI: 10.1111/j.1365-3156.2005.01434.x

[Indexed for MEDLINE] Free full text


## Infant Mortality in Girls Receiving Both BCG and DTP Vaccines Versus One of the Vaccines Only




**"Among girls, those who received both BCG and DTP experienced higher mortality than those who received only one of the two vaccines (hazards ratio 2.4; 95% confidence interval 1.2–5.0)."**

Children's Health

# Receipt of the Second and Third Dose of the DTP Vaccine Increases Infant Mortality by 4.36X

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Int J Epidemiol. 2004 Apr;33(2):374-80.

**The introduction of diphtheria-tetanus-pertussis vaccine and child mortality in rural Guinea-Bissau: an observational study.**

Aaby P[1], Jensen H, Gomes J, Fernandes M, Lisse IM.

Author information

1 Bandim Health Project, Apartado 861, Bissau, Guinea-Bissau. pab@mail.gtelecom.gw


Abstract

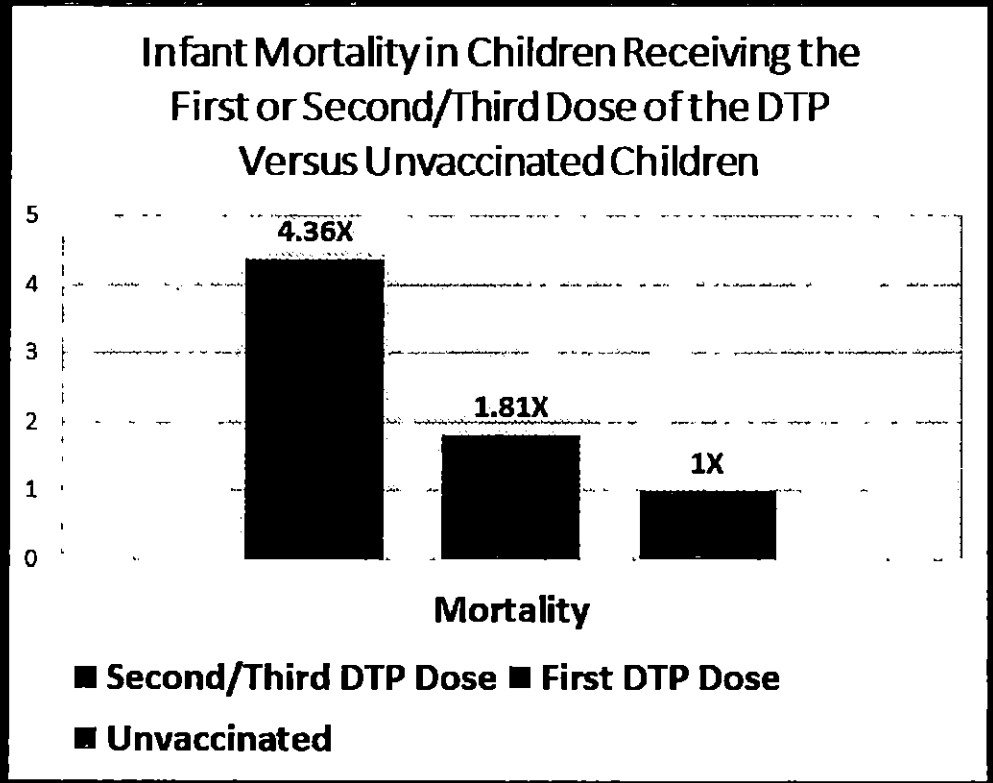
BACKGROUND: and objective Previous studies from areas with high mortality in West Africa have not found diphtheria-tetanus-pertussis (DTP) vaccine to be associated with the expected reduction in mortality, a few studies suggesting increased mortality. We therefore examined mortality when DTP was first introduced in rural areas of Guinea-Bissau in 1984-1987. Setting Twenty villages in four regions have been followed with bi-annual examinations since 1979.

SUBJECTS: In all, 1657 children aged 2-6 months. Design Children were weighed when attending the bi-annual examinations and they were vaccinated whenever vaccines were available. DTP was introduced in the beginning of 1984, oral polio vaccine later that year. We examined mortality for children aged 2-6 months who had received DTP and compared them with children who had not been vaccinated because they were absent, vaccines were not available, or they were sick.

MAIN OUTCOME MEASURE: Mortality over the next 6 months from the day of examination for vaccinated and unvaccinated children.

RESULTS: Prior to the introduction of vaccines, children who were absent at a village examination had the same mortality as children who were present. During 1984-1987, children receiving DTP at 2-6 months of age had higher mortality over the next 6 months, the mortality rate ratio (MR) being 1.92 (95% CI: 1.04, 3.52) compared with DTP-unvaccinated children, adjusting for age, sex, season, period, BCG, and region. The MR was 1.81 (95% CI: 0.95, 3.45) for the first dose of DTP and 4.36 (95% CI: 1.28, 14.9) for the second and third dose. BCG was associated with slightly lower mortality (MR = 0.63, 95% CI: 0.30, 1.33), the MR for DTP and BCG being significantly inversed. Following subsequent visits and further vaccinations with DTP and measles vaccine, there was no difference in vaccination coverage and subsequent mortality between the DTP-vaccinated group and the initially DTP-unvaccinated group (MR = 1.06, 95% CI: 0.78, 1.44).

CONCLUSIONS: In low-income countries with high mortality, DTP as the last vaccine received may be associated with slightly increased mortality. Since the pattern was inversed for BCG, the effect is unlikely to be due to higher-risk children having received vaccination. The role of DTP in high mortality areas needs to be clarified.


**"The MR (mortality rate) was 1.81 (95% CI: 0.95, 3.45) for the first dose of DTP and 4.36 (95% CI: 1.28, 14.9) for the second and third dose."**

Children's HealthCare

# Vaccination increases the risk of asthma (11.4X) and hay fever (10X) in children with no family history of those disorders

PubMed.gov
US National Library of Medicine National Institutes of Health

PubMed | Enriquez Addington vaccine

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J Allergy Clin Immunol. 2005 Apr;115(4):737-44.

**The relationship between vaccine refusal and self-report of atopic disease in children.**

Enriquez R[1], Addington W, Davis E, Freels S, Pan CL, Hargrave RC, Pendry V.

Author Information

1 Division of Allergy, Pulmonary and Critical Care Medicine, School of Medicine, T-1218 Medical Center North, 1161 21st Avenue South, Nashville, TN 37232-2650, USA. Rachel.Enriquez@vanderbilt.edu


Abstract

BACKGROUND: In the last 3 decades, there has been an unexplained increase in the prevalence of asthma and hay fever.

OBJECTIVE: We sought to determine whether there is an association between childhood vaccination and atopic diseases, and we assessed the self-reported prevalence of atopic diseases in a population that included a large number of families not vaccinating their children.

METHODS: Surveys were mailed to 2964 member households of the National Vaccine Information Center, which represents people concerned about vaccine safety, to ascertain vaccination and atopic disease status.

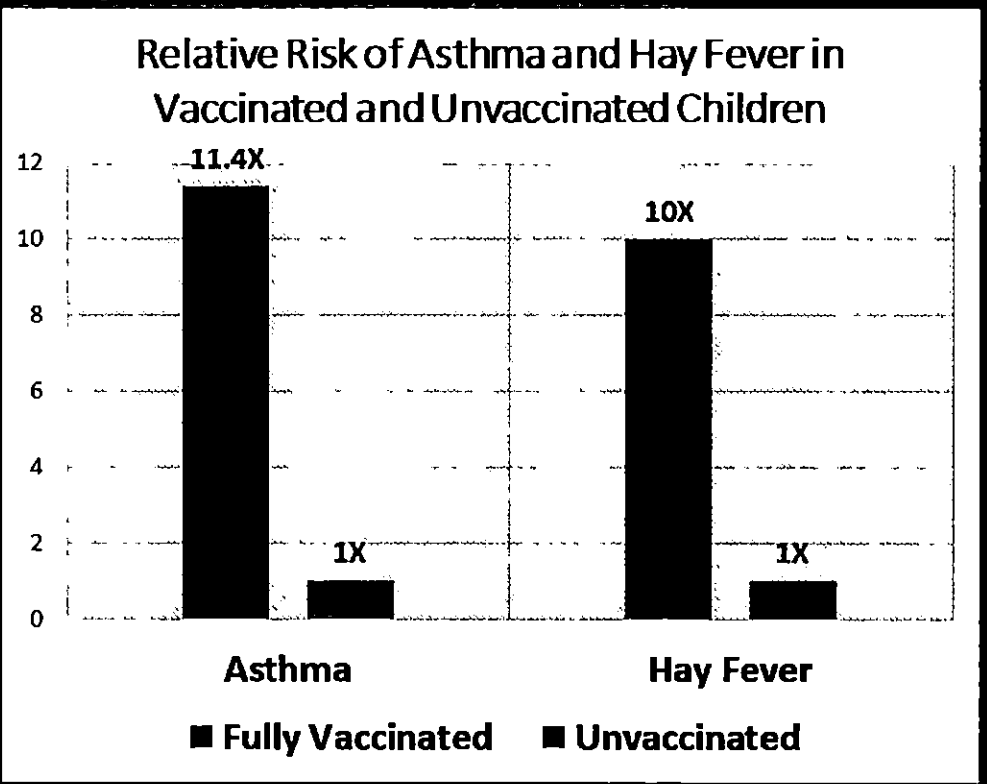
RESULTS: The data included 515 never vaccinated, 423 partially vaccinated, and 239 completely vaccinated children. In multiple regression analyses there were significant ( P < .0005) and dose-dependent negative relationships between vaccination refusal and self-reported asthma or hay fever only in children with no family history of the condition and, for asthma, in children with no exposure to antibiotics during infancy. Vaccination refusal was also significantly ( P < .005) and negatively associated with self-reported eczema and current wheeze. A sensitivity analysis indicated that substantial biases would be required to overturn the observed associations.

CONCLUSION: Parents who refuse vaccinations reported less asthma and allergies in their unvaccinated children. Although this relationship was independent of measured confounders, it could be due to differences in other unmeasured lifestyle factors or systematic bias. Further research is needed to verify these results and investigate which exposures are driving the associations between vaccination refusal and allergic disease. The known benefits of vaccination currently outweigh the unproved risk of allergic disease.



PMID: 15806092 DOI: 10.1016/j.jaci.2004.12.1128

[Indexed for MEDLINE]


**"In multiple regression analyses there were significant (P<.0005) and dose dependent negative relationships between vaccination refusal and self-reported asthma or hay fever only in children with no family history of the condition and, for asthma, in children with no exposure to antibiotics during infancy."**

Children's Health

# Vaccination with DTP simultaneously with measles vaccine or DTP after measles vaccine increased risk of death (2.59X)

PubMed.gov — PubMed — Aaby senegal 2015 vaccination — Create RSS — Create alert — Advanced

Format: Abstract — Send to

Trans R Soc Trop Med Hyg. 2015 Jan;109(1):77-84. doi: 10.1093/trstmh/tru186.

**Sex-differential and non-specific effects of routine vaccinations in a rural area with low vaccination coverage: an observational study from Senegal.**

Aaby P[1], Nielsen J[2], Benn CS[2], Trape JF[3].

Author Information

1 Institut de Recherche pour le Développement (IRD), Laboratoire de Paludologie, Epidémiologie et Zoologie africotropicales, BP 1386, Dakar, Senegal Bandim Health Project, Indepth Network, Apartado 861, Bissau, Guinea-Bissau p.aaby@bandim.org.

2 Research Center for Vitamins and Vaccines (CVIVA), Statens Serum Institut, Copenhagen, Denmark.

3 Institut de Recherche pour le Développement (IRD), Laboratoire de Paludologie, Epidémiologie et Zoologie africotropicales, BP 1386, Dakar, Senegal.

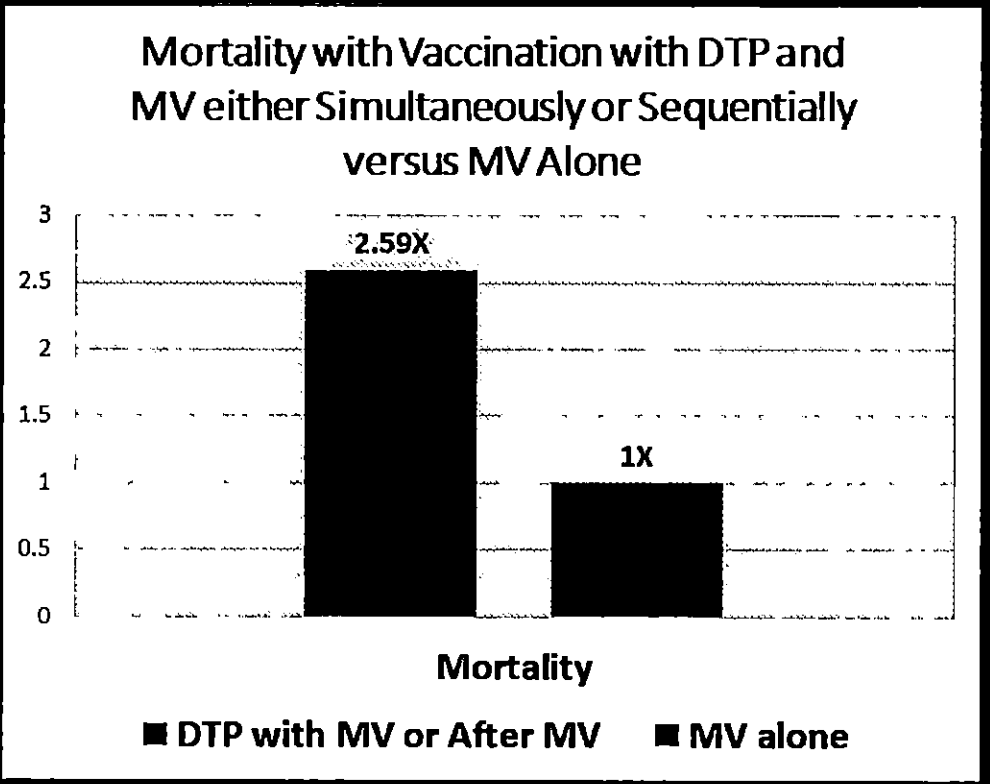
Abstract

BACKGROUND: We examined the potential sex-differential and non-specific effects of bacille Calmette-Guérin (BCG), diphtheria-tetanus-pertussis (DTP) and measles vaccine (MV) in a rural area of Senegal.

METHODS: The 4133 children born in the area between 1996 and 1999 were included in the study. Vaccinations were provided at three health centres. Vaccine information was collected through 3-monthly home visits. The survival analysis compared the effects of BCG and DTP according to the following sequence of vaccinations: BCG-first, BCG+DTP1-first, or DTP1-first. We compared DTP and MV between 9 and 24 months of age, as 9 months is the minimum age for MV.

RESULTS: At 12 months the vaccination coverage was 44%, 46% and 9%, respectively, for BCG, DTP1 and MV. Most children received BCG+DTP1-first and this combination was associated with a significantly lower mortality rate ratio (MRR) of 0.69 (0.53-0.89) compared with unvaccinated children. There was no benefit for children receiving BCG-first or DTP1-first. The female-male MRR was 0.79 (0.64-0.96) among unvaccinated children, but was significantly inversed with 1.45 (1.00-2.10) for children receiving DTP vaccination (test of homogeneity, p=0.006). Children who had received DTP simultaneously with MV or DTP after MV had significantly higher mortality (MRR=2.59 [1.32-5.07]) compared with children having MV-only as their most recent vaccination. After 9 months, the female-male MRR was 0.61 (0.31-1.19) for measles-vaccinated children but remained 1.54 (1.03-2.31) for DTP-vaccinated children who had not received MV (p=0.01).

CONCLUSIONS: The sequence of routine vaccinations is important for the overall impact on child survival and these vaccines are associated with sex-differential effects.




**"Children who had received DTP simultaneously with MV or DTP after MV had significantly higher mortality (MRR=2.59 [1.32–5.07]) compared with children having MV-only as their most recent vaccination."**

Children's Health

# Hepatitis B Vaccination Increases the Odds (3.1X) of a Multiple Sclerosis Diagnosis

PubMed.gov

Published

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Format: Abstract

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Neurology. 2004 Sep 14;63(5):838-42.

**Recombinant hepatitis B vaccine and the risk of multiple sclerosis: a prospective study.**

Hernán MA[1], Jick SS, Olek MJ, Jick H

Author information

1 Department of Epidemiology, Harvard School of Public Health, 677 Huntington Avenue, Boston, MA 02115, USA. miguel_hernan@post.harvard.edu

**Abstract**

**BACKGROUND:** A potential link between the recombinant hepatitis B vaccine and an increased risk of multiple sclerosis (MS) has been evaluated in several studies, but some of them have substantial methodologic limitations.

**METHODS:** The authors conducted a nested case-control study within the General Practice Research Database (GPRD) in the United Kingdom. The authors identified patients who had a first MS diagnosis recorded in the GPRD between January 1993 and December 2000. Cases were patients with a diagnosis of MS confirmed through examination of medical records, and with at least 3 years of continuous recording in the GPRD before their date of first symptoms (index date). Up to 10 controls per case were randomly selected, matched on age, sex, practice, and date of joining the practice. Information on receipt of immunizations was obtained from the computer records.

**RESULTS:** The analyses include 163 cases of MS and 1,604 controls. The OR of MS for vaccination within 3 years before the index date compared to no vaccination was 3.1 (95% CI 1.5, 6.3). No increased risk of MS was associated with tetanus and influenza vaccinations.

**CONCLUSIONS:** These findings are consistent with the hypothesis that immunization with the recombinant hepatitis B vaccine is associated with an increased risk of MS, and challenge the idea that the relation between hepatitis B vaccination and risk of MS is well understood.

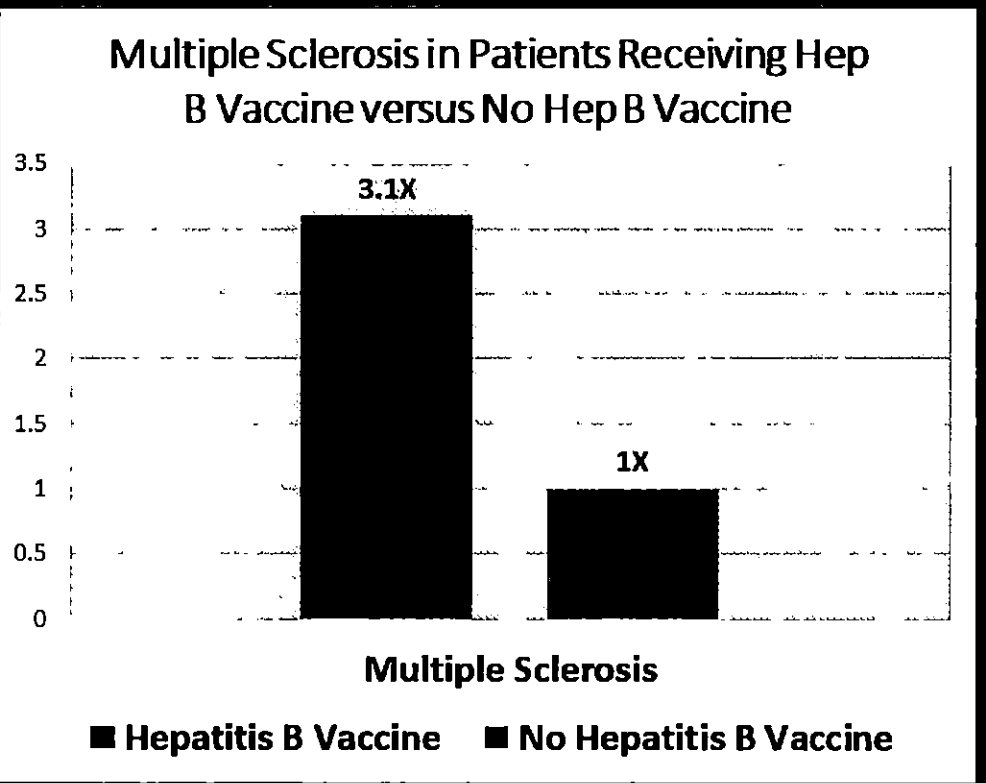
Comment in

Does the hepatitis B vaccine cause multiple sclerosis? [Neurology. 2004]

Recombinant hepatitis B vaccine and the risk of multiple sclerosis: a prospective study. [Neurology. 2005]

Recombinant hepatitis B vaccine and the risk of multiple sclerosis: a prospective study. [Neurology. 2005]

PMID: 15365133 DOI: 10.1212/01.wnl.0000138433.01870.92




**"The OR of MS for vaccination within 3 years before the index date compared to no vaccination was 3.1 (95% CI 1.5, 6.3). No increased risk of MS was associated with tetanus and influenza vaccinations."**

Children's Health

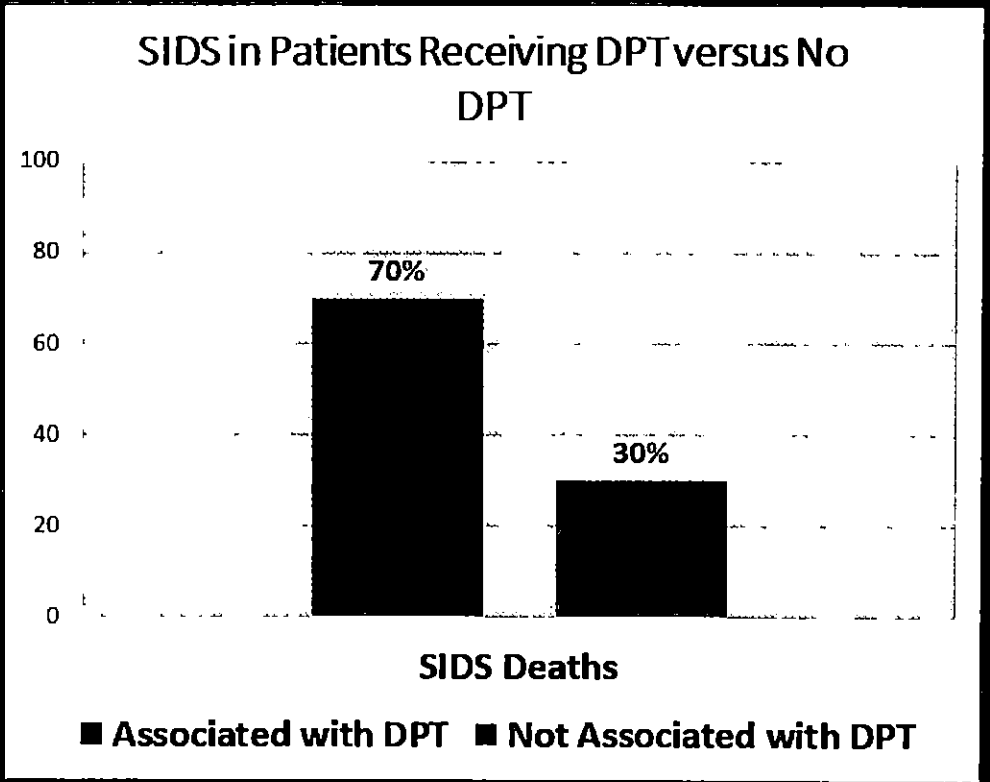
# 70% of SIDS Deaths Occur Within Three Weeks of DPT Vaccination

**Diphtheria-Pertussis-Tetanus (DPT) Immunization: A Potential Cause of the Sudden Infant Death Syndrome (SIDS)** 10.00 AM 3

WILLIAM C. TORCH, Reno, NV

A recent report of eight DPT-associated cot deaths in Tennessee, and knowledge of four sudden deaths within 3½ to 19 hours of inoculation in Nevada (in three infants and one 3-year-old child) stimulated a study on the relationship of SIDS to DPT immunization in over 200 randomly reported SIDS cases. Preliminary data on the first 70 cases studied shows that ⅔ had been immunized prior to death. DPT #1, 2, and 3 were administered on the average at age 2, 4, and 6 months, respectively. In the DPT SIDS group, 6.5% died within 12 hours of inoculation; 13% within 24 hours, 26% within 3 days, and 37%, 61%, and 70% within 1, 2, and 3 weeks, respectively. Significant SIDS clustering occurred within the first 2 to 3 weeks of DPT #1, 2, 3, or 4. The age range of the DPT group was 59 days to 3 years (mean age, 3 months); for the non-DPT group, 17 to 172 days (mean age, 2 months). SIDS frequencies peaked at age 2 months in the non-DPT group, and had a biphasic peak occurrence at 2 and 4 months in the DPT group. DPT #1 and 2 were associated with more SIDS than #3 or 4 (ratio 30:11:4:1). Males and females were equally affected. Cot death occurred maximally in the fall/winter season in the non-DPT group, but was nonseasonal in the DPT group. Death occurred most often in sleep in healthy allergy-free infants following brief periods of irritability, crying, lethargy, upper respiratory tract symptoms, and sleep disturbance. Autopsy findings in both groups were typical of SIDS, (e.g. petechiae of lung, pleura, pericardium, and thymus; vascular congestion; pulmonary edema; pneumonitis; and brain edema). In conclusion, these data show that DPT vaccination may be a generally unrecognized major cause of sudden infant and early childhood death, and that the risks of immunization may outweigh its potential benefits. A need for reevaluation and possible modification of current vaccination procedures is indicated by this study.

April 1982 NEUROLOGY (NY) 32/2) A169




**"In the DPT SIDS group, 6.5% died within 12 hours of inoculation; 13% within 24 hours, 26% within 3 days, and 37%, 61%, and 70% within 1, 2, and 3 weeks, respectively."**

Children's Health

Madeleine Larson

# MY Statement (first Draft)

One time my scidrist said "Madelyn
ine shoed HAVE pis per DOL" Ah She
OLso told me the risks & Benefits
my mom & i agreed to try it. This
is called informed consent.
this BILL tries to take away informed
Corent. jumping for our rights to talk
with our Dolters about if vaccines are
right for us. We need To know ABOUT the
risks and Benifits Before We get a shot.

You need to change this BILL or make
it go AWAY! Please vote no for me and
my Brother and sister.

7.18 Testimony

CDE COLORADO DEPARTMENT of EDUCATION

# PUBLIC SCHOOL FINANCE ACT OF 1994

## 2019-2020 FUNDING SUMMARY

Run Date: 02/10/2020

District Name Academy 20

District Number : 1040

| Description | Amount |
|---|---|
| FC1. FY20 October FTE Count (minus on-line)- enter line V5 | 24,709.0 |
| FC2. FY19 October FTE Count - enter line V13 | 24,172.5 |
| FC3. FY18 October FTE Count - enter line V14 | 23,862.0 |
| FC4. FY17 October FTE Count - enter line V15 | 23,688.5 |
| FC4.1. FY16 October FTE Count - enter line V15.1 | 23,278.0 |
| FC5. AVERAGED FUNDED PUPIL COUNT - enter the greater of line FC1 or | 24,709.0 |
| FC5.1. FY20 Full Day Kindergarten Factor | 41.9 |
| FC6. FY20 CPP Pupil Count - enter line V17 | 30.5 |
| FC6.1. FY20 Charter Institute CPP Pupil Count - enter line V20.1 | 0.0 |
| FC6.5. FY20 CHARTER INSTITUTE PUPIL COUNT - enter line V19 | 0.0 |
| FC7. FY20 FUNDED PUPIL COUNT - enter line FC5, plus FC5.1, plus line FC6, plus FC6.5, plus FC6. | 24,781.4 |
| FC7.5. FY20 ASCENT Pupil Count - enter line FC4.1 | 14.5 |
| FC7.6. FY20 CHARTER INSTITUTE ASCENT Pupil Count - enter line V20.6 | 0.0 |
| FC8. FY20 On-line Multi-District Pupil Count - enter line V4 | 817.5 |
| FC8.5. FY20 CHARTER INSTITUTE ONLINE PUPIL COUNT - enter line V20 | 0.0 |
| FC9. TOTAL FUNDED PUPIL COUNT - enter line FC7 plus line FC8 plus line FC7.5 | 25,613.4 |
| | |
| AR4. Projected K-12 free lunch count using 1-8 percent - | 2,640.2 |
| AR5. Free Lunch (grades K-12) Count - enter line V7 plus V18 (ELL Count) | 2,389.0 |
| AR6. FY20 At-Risk Pupil Count | 2,640.2 |
| | |
| TF1. Formula Funding without At-risk - enter line PP9 | $211,910,819.72 |
| TF2. Formula At-risk Funding - enter line AR19 | $2,709,226.82 |
| TF3. Formula Funding - enter line TF1 plus line TF2 | $214,620,046.54 |
| TF4. On-Line Formula Funding - enter line OL3 | $6,973,824.00 |
| TF5. Total Formula Funding (including on-line funding) - enter line TF3 plus line TF4 | $221,593,870.54 |
| TF6. Minimum Formula Funding - enter line MF3 | $221,922,483.51 |
| TF10. TABOR Formula Funding - enter line TB4 | $221,889,514.54 |
| TF11. TOTAL FORMULA FUNDING | $221,889,514.54 |
| TP2. Total Funding Beyond TABOR Formula - enter line AF6 | $32,968.97 |
| GT1. TOTAL PROGRAM FUNDING - enter line TP3 | $221,922,483.51 |
| | |
| V31. FY20 Assessed Valuation | $1,839,909,320 |
| ML6. EQUALIZED MILL LEVY (FINAL) | 0.026952 |
| GT2. PROPERTY TAX REVENUES - enter line ML6 times line V31 | $49,589,235.99 |
| GT3. SPECIFIC OWNERSHIP TAX - enter line V30 | $5,425,671.88 |
| GT4. STATE SHARE | $166,907,575.64 |
| GT6. TOTAL PROGRAM PER-PUPIL FUNDING | $8,664.31 |
| | |
| GT7. BUDGET STABILIZATION FACTOR | -$15,588,340.89 |
| GT7.1. TOTAL PROGRAM | $206,334,142.62 |
| GT7.2. PROPERTY TAXES | $49,589,235.99 |
| GT7.3. SPECIFIC OWNERSHIP TAXES | $5,425,671.88 |
| GT7.4. STATE SHARE | $151,319,234.75 |
| GT7.5. REQUIRED CATEGORICAL BUYOUT FROM TOTAL PROGRAM | $0.00 |
| GT7.6. PER PUPIL FUNDING AFTER BUDGET STABILIZATION FACTOR | $8,055.71 |
| | |
| GT8. Adjusted district In-school per pupil funding | $8,064.52 |
| GT9. District On-line per pupil funding | $7,793.23 |
| GT10. Charter School Institute Total Program Funding | $0.00 |
| GT11. DISTRICT'S ADJUSTED TOTAL PROGRAM FUNDING (GT1 plus GT10) | $206,334,142.62 |
| GT12. PROPERTY TAX REVENUES - enter line GT2 | $49,589,235.99 |
| GT13. SPECIFIC OWNERSHIP TAX - enter line GT3 | $5,425,671.88 |
| GT14. DISTRICT'S ADJUSTED STATE SHARE | $151,238,196.03 |
| | |
| RS1. RESCISSION TO DISTRICT (GT11 multiplied by rescission percentage in cell GB302) | -$81,038.72 |
| RS2. DISTRICT'S TOTAL PROGRAM FUNDING AFTER RESCISSION (GT11 plus RS1) | $206,253,103.90 |
| RS5. DISTRICT'S STATE SHARE AFTER RESCISSION | $151,238,196.03 |
| RS6. DISTRICT IN-SCHOOL PER PUPIL FUNDING AFTER RESCISSION | $8,061.36 |
| RS7. DISTRICT ON-LINE PER PUPIL FUNDING AFTER RESCISSION | $7,790.17 |

Madame Chair, Members of the Committee,

My name is Kimberly Baylor, and I represent my family. I oppose Senate Bill 163.

I homeschool my three children. Colorado's homeschool vaccine requirements are directly tied to Colorado's school immunization laws. According to Colorado law, as a homeschool parent, I am required to keep record of either my children's up to date immunization records or an exemption to present to the school district upon request. As a result, Senate Bill 163 will apply to all homeschool families, not just those using state funded homeschool programs. Even if a parent chooses to exempt a child from one vaccine, this bill will force the family to be re-educated or to obtain a signed exemption from a physician.

According the Colorado Revised Statues, "The general assembly further declares that nonpublic home-based educational programs shall be subject only to minimum state controls which are currently applicable to other forms of nonpublic education." Please follow Colorado law and provide only minimum state controls for homeschool families. This bill needs to be amended to exclude homeschool families.

Forced education is not effective. Forcing parents to watch an education module is like forcing women to watch an education video before receiving reproductive healthcare: It will not change their minds. Forced education does not adequately address the underlying causes of vaccine hesitancy and refusal. In fact, forced education will likely increase the mistrust of the vaccine program and will add a barrier to access education.

Furthermore, granting unchecked power to the CDPHE to add additional vaccines to the schedule is offering way too much power. Where is the accountability? Shouldn't Coloradoans have input through the legislative process about injected pharmaceutical products? Where does the power of the CDPHE end?

While an immunization rate of 95% at every school sounds good, this will not guarantee healthy schools. This month, at Louisiana State University, twelve students contracted mumps. All twelve students had received two MMR vaccines and were in full compliance with vaccine requirements.

A vaccine exemption should not contain compelled speech. Forcing a parent to sign words that she doesn't agree with to obtain a valid vaccine exemption is wrong and illegal.

I urge you to oppose this bill. Thank you.

1 weather alerts

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# One quarantined as LSU student mumps cases increase to 12

**Posted:** 4:39 PM, Feb 12, 2020 **Updated:** 8:32 PM, Feb 12, 2020

**By:** KATC News

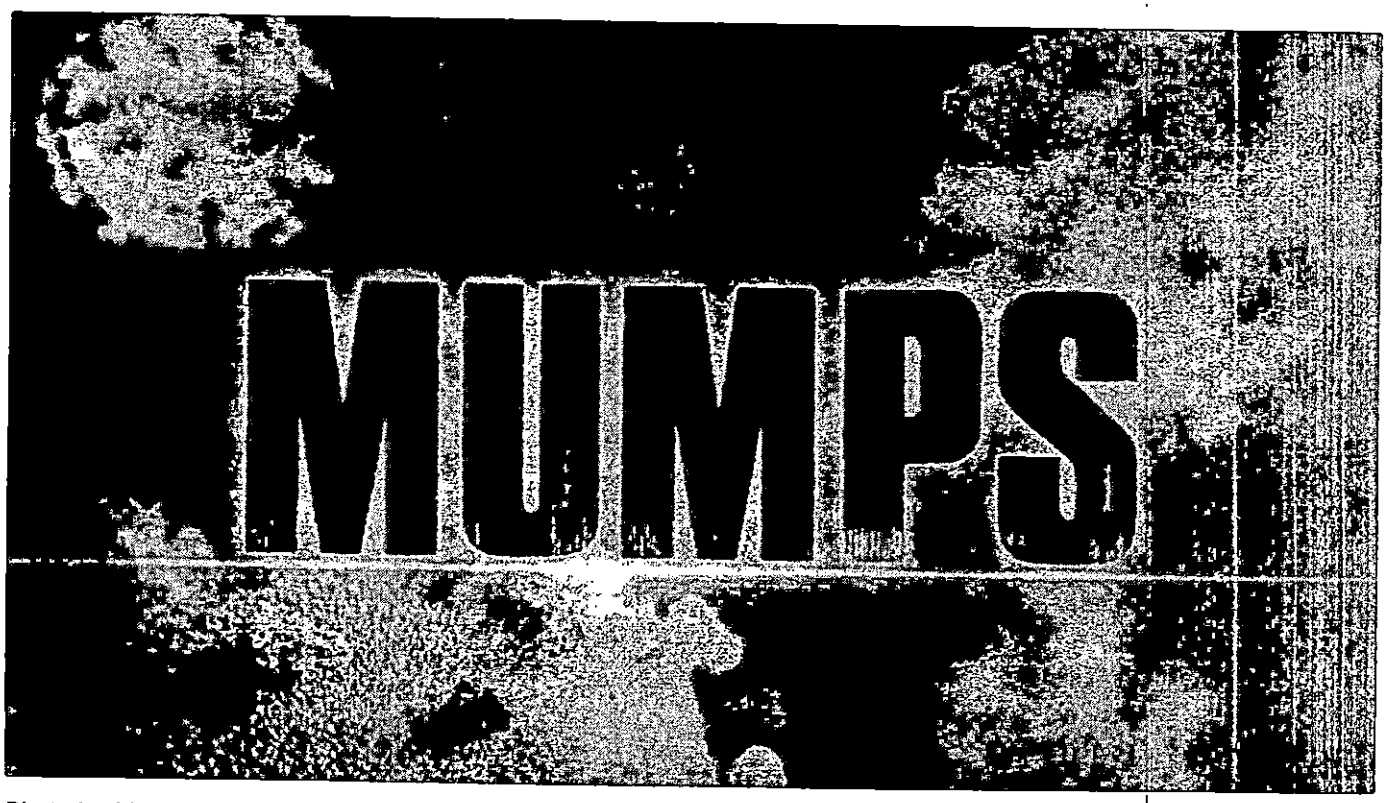


Photo by: MGN Online

The number of confirmed mumps cases at LSU has now increased to 12 as of Wednesday, multiple outlets report. One student has been quarantined.

The Reveille reports that the LSU Student Health Center confirmed those 12 cases on Wednesday. LSU Media Relations Director Ernie Ballard said 11 of the 12 students live off campus. The one student who lives on campus apparently lives alone in an apartment and will be quarantined for two weeks, reports WBRZ.

LSU first confirmed cases of mumps in students on February 4.

Last week, five students had been diagnosed; on Monday, LSU said nine students total were ill. Now, on Wednesday, that number has increased to 12.

Mumps is a contagious disease spread by contact with infectious respiratory tract secretions and saliva.

LSU is offering free doses of the MMR vaccine to any student who falls under a "high-risk" group. Those include students who have not received two doses of the MMR vaccine in their lifetime and students who have been in direct contact with someone diagnosed with mumps.

Other high-risk groups identified for this cluster of mumps are:

- Members of the LSU tennis team
- Members of all LSU fraternities and sororities
- Members of the Tiger Band

Ballard said that all 12 students with mumps had received two MMR vaccinations and "were in compliance with vaccination requirements."

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# Home School Law

## Title 22, Colorado Revised Statutes: Education Article 33: School Attendance Law of 1963 Section 104.5, as amended

Return

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**22-33-104.5. Home-based education - legislative declaration - definitions - guidelines.**

(1) The general assembly hereby declares that it is the primary right and obligation of the parent to choose the proper education and training for children under his care and supervision. It is recognized that home-based education is a legitimate alternative to classroom attendance for the instruction of children and that any regulation of nonpublic home-based educational programs should be sufficiently flexible to accommodate a variety of circumstances. The general assembly further declares that nonpublic home-based educational programs shall be subject only to minimum state controls which are currently applicable to other forms of nonpublic education.

(2) As used in this section:

(a) "Nonpublic home-based educational program" means the sequential program of instruction for the education of a child which takes place in a home, which is provided by the child's parent or by an adult relative of the child designated by the parent, and which is not under the supervision and control of a school district. This educational program is not intended to be and does not qualify as a private and nonprofit school.

(b) "Parent" includes a parent or guardian.

(c) **"Qualified person"** means an individual who is selected by the parent of a child who is participating in a nonpublic home-based educational program to evaluate such child's progress and who is a teacher licensed pursuant to article 60.5 of this title, a teacher who is employed by an independent or parochial school, a licensed psychologist, or a person with a graduate degree in education.

(3) The following guidelines shall apply to a nonpublic home-based educational program:

(a) A parent or an adult relative designated by a parent to provide instruction in a nonpublic home-based educational program shall not be subject to the requirements of the "Colorado Educator Licensing Act of 1991", article 60.5 of this title, nor to the provisions of article 61 of this title relating to teacher employment.

(b) A child who is participating in a nonpublic home-based educational program shall not be subject to compulsory school attendance as provided in this article; except that any child who is habitually truant, as defined in section 22-33-107 (3), at any time during the last six months that the child attended school before proposed enrollment in a nonpublic home-based educational program may not be enrolled in the program unless the child's parents first submit a written description of the curricula to be used in the program along with the written notification of establishment of the program required in paragraph (e) of subsection (3) to any school district within the state.

(c) A nonpublic home-based educational program shall include no less than one hundred seventy-two days of instruction, averaging four instructional contact hours per day.

(d) A nonpublic home-based educational program shall include, but need not be limited to, communication skills of reading, writing, and speaking, mathematics, history, civics, literature, science, and regular courses of instruction in the constitution of the United States as provided in section 22-1-108.

(e) Any parent establishing a nonpublic home-based educational program shall provide written notification of the establishment of said program to a school district within the state fourteen days prior to the establishment of said program and each year thereafter if the program is maintained. The parent in charge and in control of a nonpublic home-based educational program shall certify, in writing, only a statement containing the name, age, place of residence, and number of hours of attendance of each child enrolled in said program. Notwithstanding the provisions of section 22-33-104 (1), a parent who intends to establish a nonpublic home-based education program is not required to:

(I) Provide written notification of the program to a school district within the state until the parent's child is **six** years of age;

(II) Establish the program until the parent's child is **seven** years of age; or

(III) Continue the program or provide the notification after the child is **sixteen** years of age.

(f) Each child participating in a nonpublic home-based educational program shall be evaluated when such child reaches grades three, five, seven, nine, and eleven. Each child shall be given a nationally standardized achievement test* to evaluate the child's academic progress, or a **qualified person** shall evaluate the child's academic progress. The test or evaluation results, whichever is appropriate, shall be submitted to the school district that received the notification required by paragraph (e) of this subsection (3) or an independent or parochial school within the state of Colorado. If the test or evaluation results are submitted to an independent or parochial school, the name of such school shall be provided to the school district that received the notification required by paragraph (e) of this subsection (3). The purpose of such tests or evaluations shall be to evaluate the educational progress of each child. No scores for a child participating in a nonpublic home-based educational program shall be considered in measuring school performance or determining accreditation pursuant to article 11 of this title.

(g) The records of each child participating in a nonpublic home-based educational program shall be maintained on a permanent basis by the parent in charge and in control of said program. The records shall include, but need not be limited to, attendance data, test and evaluation results, and immunization records, as required by sections 25-4-901, 25-4-902, and 25-4-903, C.R.S. Such records shall be produced to the school district that received the notification required by paragraph (e) of this subsection (3) upon fourteen days' written notice if the superintendent of said school district has probable cause to believe that said program is not in compliance with the guidelines established in this subsection (3).

(4) Any child who has participated in a nonpublic home-based educational program and who subsequently enrolls in the public school system may be tested by the school district for the purpose of placing the child in the proper grade and shall then be placed at the grade level deemed most appropriate by said school district, with the consent of the child's parent or legal guardian. The school district shall accept the transcripts for credit from non-public home-based educational program for any such child; except that the school district may reject such transcripts if the school district administers testing to such child and the testing does not verify the accuracy of such transcripts.

(5) (a) (I) If test results submitted to the appropriate school district pursuant to the provisions of paragraph (f) of subsection (3) of this section show that a child participating in a nonpublic home-based educational program received a composite score on said test which was above the thirteenth percentile, such child shall continue to be exempt from the compulsory school attendance requirement of this article. If the child's composite score on said test is at or below the thirteenth percentile, the school district shall require the parents to place said child in a public or independent or parochial school until the next testing period; except that no action shall be taken until the child is given the opportunity to be retested using an alternate version of the same test or a different nationally standardized achievement test selected by the parent from a list of approved tests supplied by the state board.

(II) If evaluation results submitted to the appropriate school district pursuant to the provisions of paragraph (f) of subsection (3) of this section show that the child is making sufficient academic progress according to the child's ability, the child will continue to be exempt from the compulsory school attendance requirement of this article. If the evaluation results show that the child is not making sufficient academic progress, the school district shall require the child's parents to place the child in a public or independent or parochial school until the next testing period.

(b) If the child's test or evaluation results are submitted to an independent or parochial school, said school shall notify the school district that received the notification pursuant to paragraph (e) of subsection (3) of this section if the composite score on said test was at or below the thirteenth percentile or if the evaluation results show that the child is not making sufficient academic progress. The school district shall then require the parents to proceed in the manner specified in paragraph (a) of this subsection(5).

(6) (a) If a child is participating in a nonpublic home-based educational program but also attending a public school for a portion of the school day, the school district of the public school shall be entitled to count such child in accordance with the provisions of section 22-54-103 (10) for purposes of determining pupil enrollment under the "Public School Finance Act of 1994", article 54 of this title.

(b)(I) For purposes of this subsection (6), a child who is participating in a nonpublic home-based educational program shall have the same rights as a student enrolled in a public school of the school district in which the child resides or is enrolled and may participate on an equal basis in any extracurricular or interscholastic activity offered by a public school or offered by a private school, at the private school's discretion, as provided in section 22-32-116.5 and is subject to the same rules of any interscholastic organization or association of which the student's school of participation is a member.

(II) (A) Except as provided for in sub-subparagraph (B) of this subparagraph (II), for purposes of section 22-32-116.5, the school district of attendance for a child who is participating in a nonpublic home-based educational program shall be deemed to be the school district that received the notification pursuant to paragraph (e) of subsection (3) of this section.

(B) For purposes of section 22-32-116.5, the school district of attendance for a child who withdraws from a public or private school more than fifteen days after the start of the school year and enters a non-public home-based educational program shall be the school district or private school from which the child withdrew for the remainder of that school year. If, during the remainder of that academic year, the child chooses to participate in extracurricular or interscholastic activities at the same school and was eligible for participation prior to withdrawing from the school, the child remains eligible to participate at such school.

(c) No child participating in an extracurricular or interscholastic activity pursuant to paragraph (b) of this subsection (6) shall be considered attending the public school district where the child participates in such activity for purposes of determining pupil enrollment under paragraph (a) of this subsection (6).

(d) As used in this subsection (6), "extracurricular or interscholastic activities" shall have the same meaning as "activity" as set forth in section 22-32-116.5 (10).

(e) If any fee is collected pursuant to this subsection (6) for participation in an activity the fee shall be used to fund the particular activity for which it is charged and shall not be expended for any other purpose.

School Attendance Law
General Assembly Resolution

Assessment Law



UPDATEDSeptember 30, 2016
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COLORADO HEALTH CHOICE ALLIANCE
Protecting medical rights

# Vaccine education backfires: A survey of articles

## Effective messages in vaccine promotion: A randomized trial

https://pediatrics.aappublications.org/content/133/4/e835?sid=1f3

### Abstract

**OBJECTIVES:** To test the effectiveness of messages designed to reduce vaccine misperceptions and increase vaccination rates for measles-mumps-rubella (MMR).

**METHODS:** A Web-based nationally representative 2-wave survey experiment was conducted with 1759 parents age 18 years and older residing in the United States who have children in their household age 17 years or younger (conducted June–July 2011). Parents were randomly assigned to receive 1 of 4 interventions: (1) information explaining the lack of evidence that MMR causes autism from the Centers for Disease Control and Prevention; (2) textual information about the dangers of the diseases prevented by MMR from the Vaccine Information Statement; (3) images of children who have diseases prevented by the MMR vaccine; (4) a dramatic narrative about an infant who almost died of measles from a Centers for Disease Control and Prevention fact sheet; or to a control group.

**RESULTS:** None of the interventions increased parental intent to vaccinate a future child. Refuting claims of an MMR/autism link successfully reduced misperceptions that vaccines cause autism but nonetheless decreased intent to vaccinate among parents who had the least favorable vaccine attitudes. In addition, images of sick children increased expressed belief in a vaccine/autism link and a dramatic narrative about an infant in danger increased self-reported belief in serious vaccine side effects.

**CONCLUSIONS:** Current public health communications about vaccines may not be effective. For some parents, they may actually increase misperceptions or reduce vaccination intention. Attempts to increase concerns about communicable diseases or correct false claims about vaccines may be especially likely to be counterproductive. More study of pro-vaccine messaging is needed.

## Strategies intended to address vaccine hesitancy: Review of published reviews

https://www.sciencedirect.com/science/article/pii/S0264410X15005058

There is mixed evidence on the effectiveness of interventions involving face-to-face communication interventions, health-care provider training, community-based actions, and communication using mass media. Vaccination requirements or mandates for school admittance are viewed as effective in increasing vaccine uptake in high-income countries [2], [12], [20], [24], [31]. However, these strategies do not adequately address the underlying causes of vaccine hesitancy and refusal [24]. In addition, such policies can raise concerns about civil liberties [32] that may heighten mistrust in the vaccine program. Moreover, there are high-income countries where such policies are not in place, such as Canada, yet uptake rates are comparable. Concerns have also been raised that

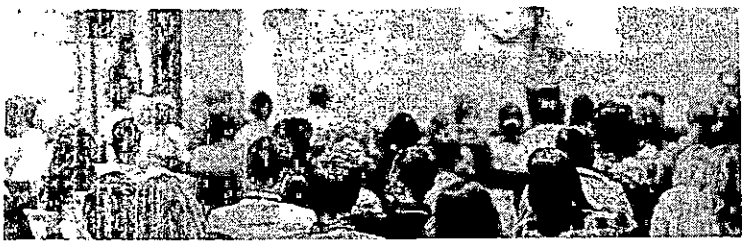
in low-income countries, mandatory vaccination for school entry may add another barrier to access to primary education. Thus, mandating vaccination as a strategy to address vaccine hesitancy must be approached with great care and caution. The impact of potential negative consequences (e.g. distrust in the immunization program, decrease in school access) may outweigh potential benefits such as the increase in vaccination coverage in some settings.

Many traditional educational tools (e.g. information pamphlets) had little or no impact on vaccine hesitancy [13], [14], [16], [17], [20], [21], [25]. Furthermore, some communication interventions could even reinforce vaccine hesitancy, as shown by a recent study by Nyhan et al. [33]. These researchers conducted a randomised controlled trial in the United States using four interventions to refute claims of a link between the measles, mumps and rubella (MMR) vaccine and autism, based on current public health communication. The study showed that none of the interventions significantly increased parental intention to vaccinate although it did reinforce the decision of those who were already intending to do so. Most importantly, these interventions decreased the intention to vaccinate among parents who had the least favourable attitudes towards vaccines [33]. This highlights the importance of carefully designed public health messages, and that messages need to be tailored for the specific target group, because messaging that too strongly advocates vaccination may be counterproductive, reinforcing the hesitancy of those already hesitant [34].

Article cited as effective in conclusion:

C. Jarrett, R. Wilson, M. O'Leary, E.Eckersberger, H.J. Larson, Strategies for addressing vaccine hesitancy – a systematic review Vaccine, 33 (34) (2015), pp. 4180-4190

Overall, our results showed that multicomponent and dialogue-based interventions were most effective. However, given the complexity of vaccine hesitancy and the limited evidence available on how it can be addressed, identified strategies should be carefully tailored according to the target population, their reasons for hesitancy, and the specific context.



# Vaccine hesitancy: In search of the risk communication comfort zone

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5346025/

## Vaccine Hesitancy: What's to be done?

Health officials have used numerous approaches to persuade parents who do not vaccinate their children to change their views and behaviours and to reinforce positive vaccine behaviour among those who already do. Attempts to frighten parents about the risks of disease or correct false claims about vaccines have been largely ineffective, and may be counterproductive 15. Sandman and Lanard16 argue that there is a fine line between warning the public that a given risk may be potentially worrisome without actually scaring people. Yet, officials often resort to scare tactics and have occasion to use dramatic and vivid imagery to frighten or shame parents into having their children vaccinated. Images of sick children may effectively provoke fear, worry, and other emotions that can be persuasive. Yet, the use of emotionally evocative images may also strengthen beliefs in a vaccine/autism link among a core group of parents, while dramatic narratives that describe the risks to infants of under-immunization can increase self-reported beliefs about serious side effects of vaccines 15.

While our study did not involve experimental testing of risk communication interventions, we did ask participating parents to reflect on messages that public health officials often use to persuade those who are vaccine hesitant, and to indicate which, if any, they feel work best at increasing vaccine uptake among this group (Table 1).

The majority of respondents believed that all of the suggested messages, with the exception of shaming, are likely to be effective in persuading parents to have their children vaccinated. Interestingly, while almost two-thirds of our parents agreed with the statement, "parents who do not have their children immunized (except in cases involving medical exemptions) are irresponsible," nearly as many (64 percent) believed that this message would be unlikely to change the immunization behaviours of other parents. The relationship between these two questions was moderate and statistically significant: parents who strongly disagree that those who do not vaccinate their children are irresponsible are more likely to dispute the efficacy of shame-based messaging to change vaccine hesitant behaviour. However, parents who do vaccinate their children also believe

that this approach is unlikely to be effective in changing behaviour.

The messages that respondents overall felt would most likely work with vaccine hesitant parents were those that emphasized the scientific evidence showing that vaccines are safe and effective (47 percent), followed by messages about the likelihood of catching a serious childhood illness without vaccine protection (40 percent) and those which vividly detail the effects of childhood diseases (37 percent). Among the small number of parents who self-identified as holding anti-vaccine beliefs, the only message that showed any hope of effectively persuading parents like them was, "provide positive encouragement and emphasize that vaccines are strongly recommended, but ultimately the decision is theirs to make" (77 percent). All other messages generated very strong negative reactions for non-vaccinating parents, indicating they would all be unlikely to ameliorate their hesitant beliefs and behaviors.

Finally, research participants were invited to suggest other possible risk communication approaches for persuading vaccine hesitant parents to change their beliefs and behaviors. We coded the 857 discrete responses to this question into numerous other categories, of which the most commonly cited recommendation (28 percent of respondents) was, "use of research to debunk vaccine myths." Among parents with strongly vaccine hesitant views, messages based on "showing compassion" and "communicating honestly about risk" were most common, although this represents a very small baseline of responses.

The results of our research illustrate a potential disconnect between what parents of young children believe will be effective in persuading parents who are vaccine hesitant with what the available experimental research already tells us: more evidence, statistics and debunking strategies are the least likely to work 15 ,17 , 18. Of concern, all of these approaches have been shown in other research to have little to no positive impact on vaccine uptake, and may be counterproductive. If it is assumed that parents who do not have their children vaccinated do so because they lack appropriate knowledge and information, or because they have been duped by anti-vaccine celebrities and activists, then perhaps it is not surprising that parents (and health professionals) would try to address that problem with more science, data and evidence.

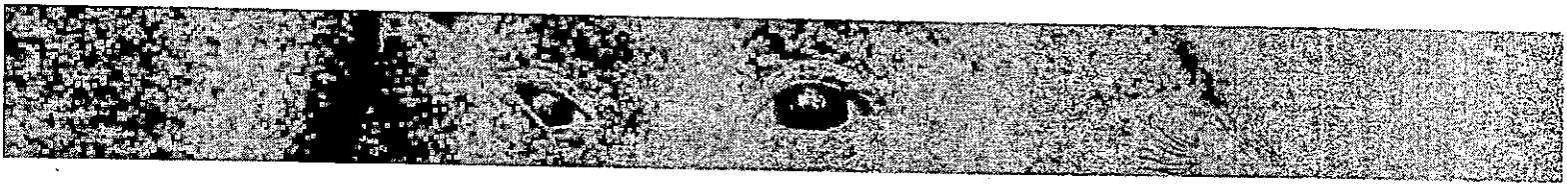
The responses about vaccine risk messaging from parents who hold more strident vaccine-hesitant views are worth considering to the extent they reflect the value and importance of expressing empathy and compassion, and providing support and positive encouragement as a means for building trust with parents over the longer term, even if in the short term that does not lead to changes in immunization behaviour. Openness, dialogue, empathy, and respect are foundational values to ethical and effective risk communication 19 , 20 , 21. And while they might not yield an immediate shift in vaccination behaviours, they may, over the longer term, be our most effective protection against the wicked problem of vaccine hesitancy.

## Parents' beliefs in misinformation about vaccines are strengthened by pro-vaccine campaigns

https://link.springer.com/article/10.1007/s10339-019-00919-w


### Abstract

The main objective of this study was to determine whether one of the most commonly employed pro-vaccination strategies based on the "myths vs. facts" format can be considered an effective tool to counter vaccines misinformation. Sixty parents were randomly presented with either a control message or a booklet confronting some common myths about vaccines with a number of facts. Beliefs in the autism/vaccines link and in vaccines side effects, along with intention to vaccinate one's child, were evaluated both immediately after the intervention and after a 7-day delay to reveal possible backfire effects. Data provided support for the existence of backfire effects associated with the use of the myths vs. facts format, with parents in this condition having stronger vaccine misconceptions over time compared with participants in the control condition. The myths vs. facts strategy proved to be ineffective. Efforts to counter vaccine misinformation should take into account the many variables that affect the parents' decision-making.

SB 20-163
Thank you, I am speaking on my family's behalf.

Discrimination and rage towards ex-vaccinating families has increased dramatically. The pro-vax community is retaliating against us, they're very hateful due to fear mongering from the media, this is why I didn't bring my children today. Last week, while watching me get my 7-year-old son into his wheelchair a woman cursed at and harassed us at the Columbine library because of a NO FORCED VACCINATION sticker, she was so angry and threatening. Now this bill wants to risk our safety by putting us in a database. ***How do you opt out?***

I will be forced to homeschool or leave Colorado with legislation like this. My husband and I refuse to be put into a PII database or to take a course on something that we have **researched for 7 years.** We've experienced firsthand what vaccine injury can do and it is life changing.

I could sit here and rattle off studies, test results and try to convince you the immunizations are not safe. We are seeing first-hand that unvaccinated children are healthier. **But are you really listening?**
This bill is the beginning of what happened in California. The United States agenda regarding immunization sickens me. Here I am having 2 minutes to pour my heart out to you begging you to **vote NO on SB 20-163** so that I can move on with raising my beautiful children. If you have questions about my son's results, I'd be happy to answer after my testimony.

I was unknowingly in the trial year of the TDap shot during my first pregnancy in 2012. My son suffered a debilitating in utero vaccine injury. I have 7 years of medical tests backing this. Several specialists at Children's have agreed. They gave me studies from a toxicologist saying that aluminum adjuvant, via vaccinations, can cause neurodevelopmental issues and neurological disorders. The Toxicologist said there is nothing they can do because nothing is known past that. I've been told by multiple neurologist that they're not allowed to comment on this matter. So how do you expect me to keep my children's medical exemptions when doctors won't even discuss the topic? My son pays the price every day for the CDC's mistake.
My son is permanently utilizing a wheelchair and suffers severe hypertonia of his entire body. This is a neurological movement disorder that has been linked to vaccines. He is 35lbs at 7 years old. His dream is to be a running back for the broncos someday. He is the biggest sports fanatic you'll ever meet.

Do any of you know **what it's like** having a child with a severe debilitating lifelong condition- caused by an injection that was claimed to protect them? Knowing that a choice you made, trusting the CDC, permanently disabled your child?
What it's like getting looks because people know your story? What it's like having to explain to a 7-year-old boy and his peers why he is different and why it is hard to keep up with his peers, why he can't yet ride a skateboard. My son is completely cognitively aware and wants to just be one of the boys. he doesn't like that I have to assist him constantly and he has to have a para assist him through every part of his day at school. he's starting to question why his language sounds different, why he's not the same height as his peers. How do I explain this to him? he is the most amazing child, touches everyone's heart that he comes in contact with. I will always keep him going and motivated an experience everything he can. then he has to see me worrying and spending time on bills like this to protect him from further damage. I also would like to know who will be held accountable for the vaccine injuries and deaths that will happen by bullying people into getting more immunizations?

I sadly feel that this is all a waste of time because I've seen repeatedly, legislators telling me that the bills will be killed before testimony even begins, this has shown me that your minds are made up and the system is flawed. It's a game of how many Democrats vs Republicans. Prove me wrong by voting NO on SB 20-163.

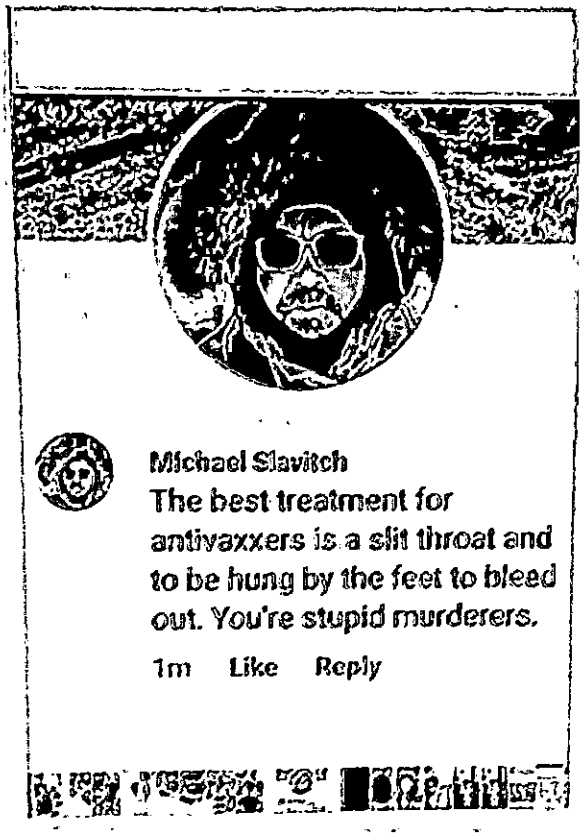
Doctors should be doing genetic, titer testing and toxicity testing on every single person before they inject them with a huge load of toxins and heavy metals. I'm seeing firsthand having a 4-year-old and 7-year-old in public school that the vaccinated children are so sick every month a new virus. However, my children thankfully have only been getting sick once or twice a year. I'm also seeing the viruses are getting stronger and I think that's because vaccinations are introducing man-made strains that are challenging the immune system. However, we use a Whole food organic diet, elderberry syrup, vitamin C, D and other supplements and my kids are allergy free and never have green mucous coming from their noses like the vaccinated children do.

WE NEED TO PRORECT THE VACCINE INJURED AS WELL AS THE GENERAL PUBLIC.
Sincerely concerned Morrison Colorado citizen,
Nicole Smythe
n.smythe@outlook.com

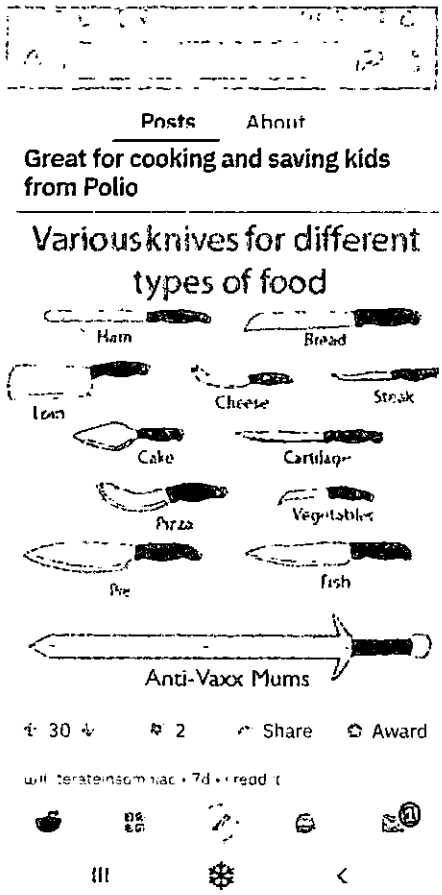
# SB20-163

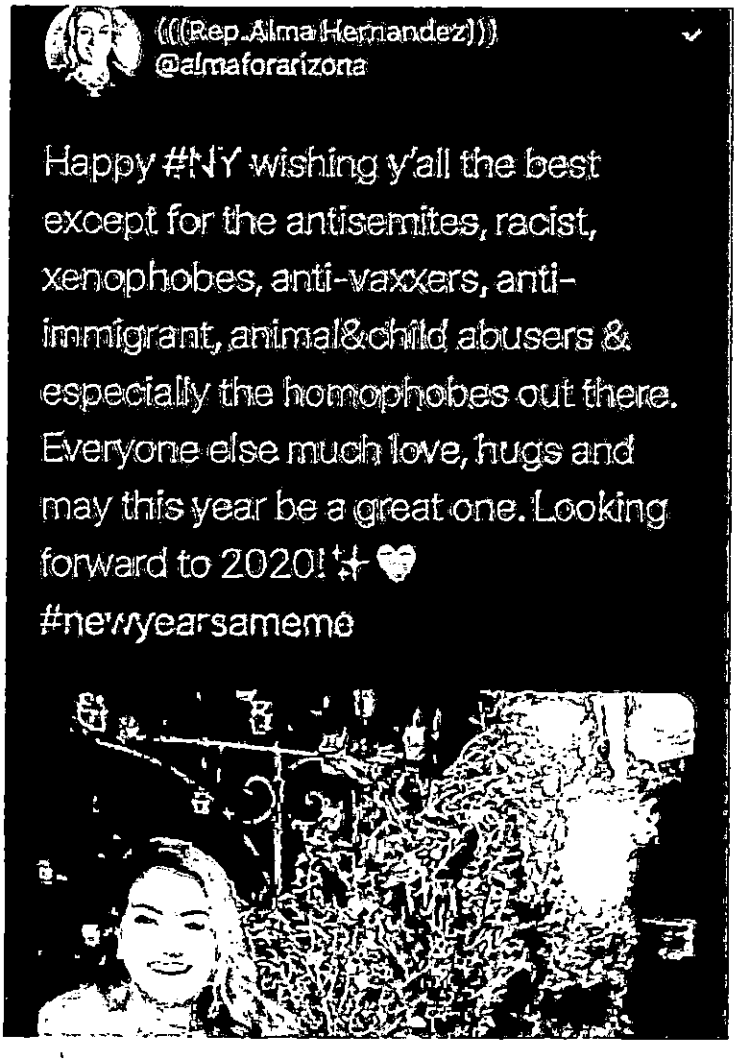
# Threat & Harass Packet


**Testimony of Heather Lahdenpera, Ft. Collins, CO**




**Thousands of mothers are begging to have their concerns about the bloated US vaccination schedule heard. Many have witnessed their children being harmed. Instead of listening - the public, media and government are silencing them at best and threatening them at worst.**




**Governmental Officials are also participating in this harassment. Representative Alma Hernandez from Arizona.**

**People call for execution**

**View 3 more replies**

**Chris Murray** Sandy Willcox so you...

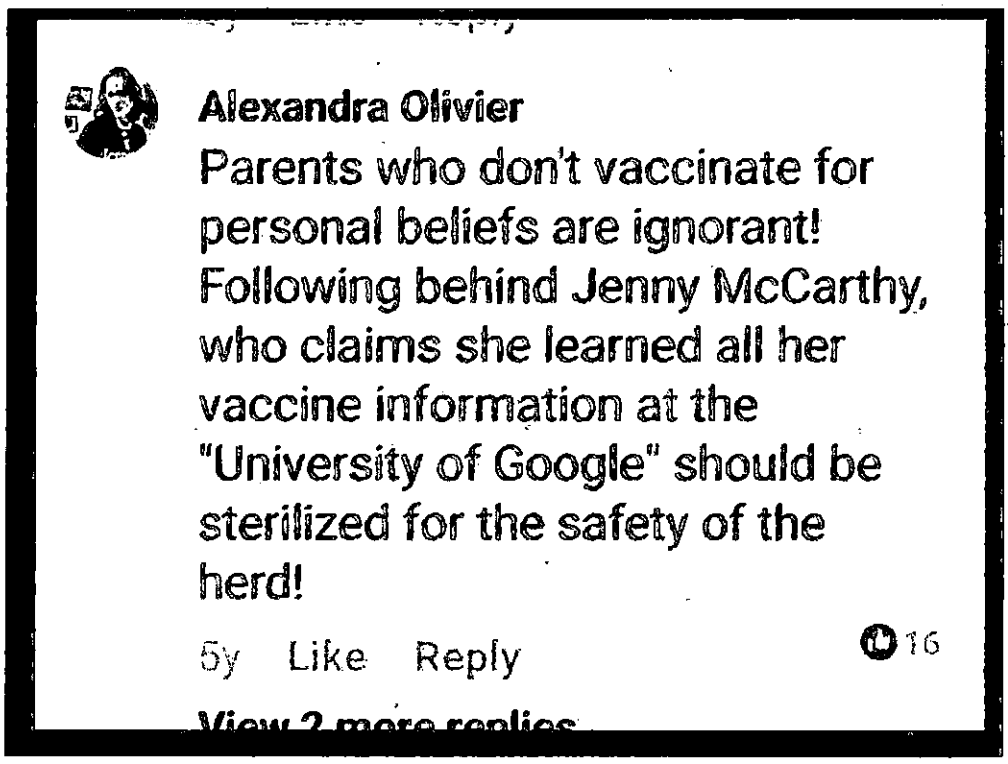
**Ron Gowins**
The government should just make vaccines mandatory for everyone, and execute anyone who refuses. For public safety.

Like Reply 5

**View 4 more replies**

**Carmella Mae Dunkin** Ron Gowins...

**People call for Sterilization**



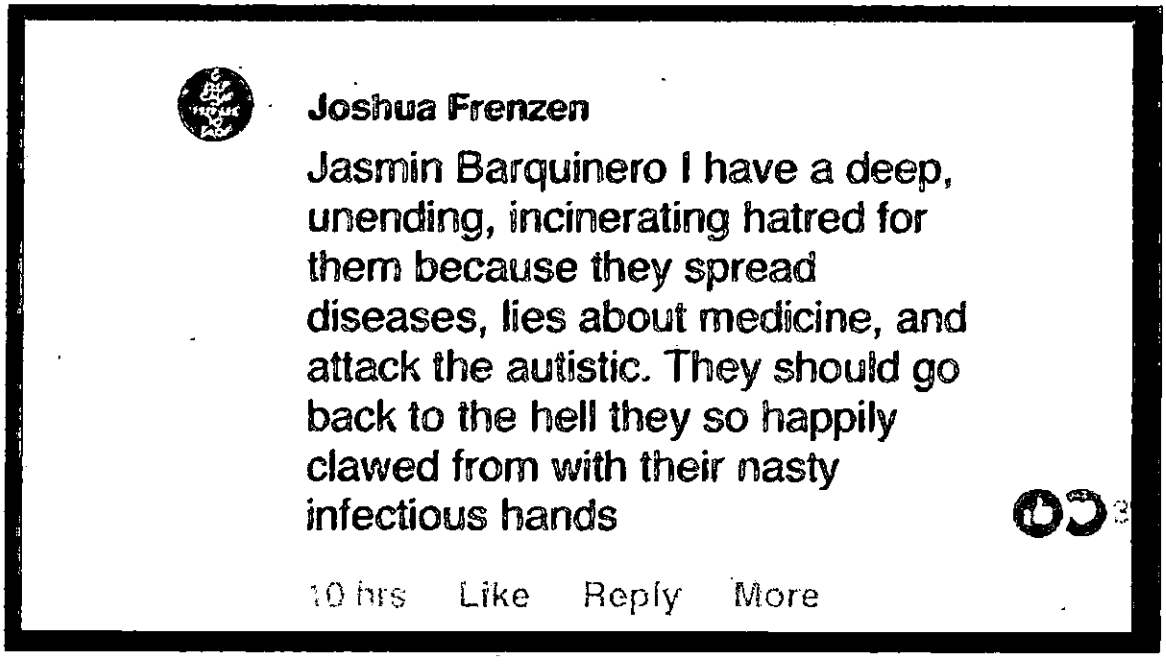
**Alexandra Olivier**

Parents who don't vaccinate for personal beliefs are ignorant! Following behind Jenny McCarthy, who claims she learned all her vaccine information at the "University of Google" should be sterilized for the safety of the herd!

5y Like Reply 16

View 2 more replies

**People damn parents to hell**



**Joshua Frenzen**

Jasmin Barquinero I have a deep, unending, incinerating hatred for them because they spread diseases, lies about medicine, and attack the autistic. They should go back to the hell they so happily clawed from with their nasty infectious hands

10 hrs Like Reply More

**and use foul threatening language**

Go fucking kill yourself you stupid worthless cunt. Your babies will die because you're so fucking dumb and against vaccines. Kill. Your. Self.

**Kimberly Bean**
VACCINATE YOUR DAMN CROTCH GOBLINS
7y Like Reply 107
View 48 more replies

I hope they take your children away

I hope you are fined and have to spend time in jail.

You people are horrible disease vectors that threaten the health and even lives of those unfortunate enough to be around you

If you don't vaccinate, you are a shit parent. You're worse than pedophiles. At least their evil is sporadic and isolated.

You lot would willingly and knowingly infect other people you don't know. All to satisfy your vanity and cement your status as a "victim".

You're not victims.

You're the shady guy on the corner offering free candy to any kids who go in his van.

**Meaghen Couvillon Haynie**
Not the average person, but the influencers, definitely. Fuck Larry Cook.
2h Like Reply

**Ben Gentry**
**Meaghen Couvillon Haynie** But in this day and age anyone can become an influencer
2h Like Reply

**Meaghen Couvillon Haynie**
I know, but there's a spectrum there.

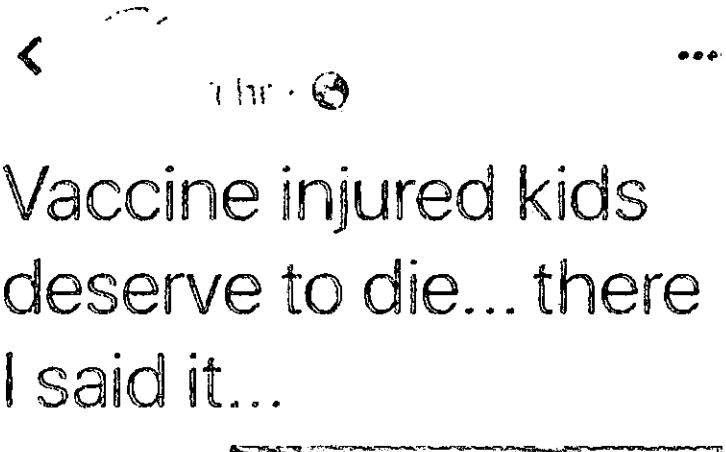
I would happily kick modern alternative mama in the cunt, tho.
1h Like Reply

**Caitlin Welch**
**Meaghen Couvillon Haynie** Add Gigi Kuntalini to that list.
1h Like Reply

**Meaghen Couvillon Haynie**
**Caitlin Welch** oh, there is a list.
1h Like Reply


**Even worse, children are being threatened and harassed**

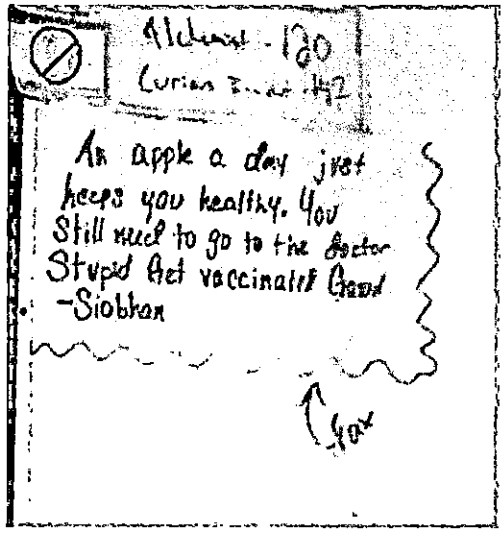
More provax poetry:




You are disgusting i Hope you die a slow and pain full death, ogg yea you are vaxx, well i Hope you kids die slow then.

[redacted] anti vax kids need to be kept out of schools! One of my daughters friends is an anti vax kid- she gave everyone influenza A in her class last month. And we all KNEW it was her because she was the only one that didn't get it! It's because they're spreading it and it's leaving their body so they don't get it. I was so mad!

16m Reply 5




**Above is a photo of a white board at a Colorado school. The teacher allowed this to be kept up in the classroom. A science teacher in this school told the students that people who did not receive the flu shot were the ones that were making the flu "bad" this year. This is nonsensical and is being taught to children even though it is patently false.**

**As you can see above here, this type of false information is not an anomaly.**

## A Colorado Nurse Posted this:

**Nurses have access to CIIS - any nurse in the state could search CIIS for children with exemptions. This nurse could post children's names, addresses, birthdates, phone numbers, parent's names, addresses, and phone numbers all over the internet.**

**These children and their parents would be in danger if any one of the thousands of people with access to CIIS decided to expose these families.**

If you're antivax and you see me making fun of antivax people, I just want to say that I am talking about you personally and I hope you're offended because you're stupid.

## Also happening in Colorado

**Doctors have access to CIIS.**

**It would only take one out of thousands of doctors in the state to share exempted children's information.**

Words witnessed in person today at Boulder Conference on World Affairs...

"All unvaccinated children should not be able to go into public or attend public school and parents of unvaccinated children should be prosecuted for murder if their children infects someone with a vaccine preventable disease."

Find him and shut him down.

COLORADO.EDU

**Charles van der Horst**

Charles Michael van der Horst, MD, FACP, FIDSA (Duke '74, Harvard '

21 34 Comments Seen by 84

**Denver Post Comment**

**Comments from editorial below, By KRISTA KAFER | Columnist for The Denver Post**
**February 7, 2020 at 8:00 a.m.**

# This man calls for SEGREGATION AND CRIMINALIZATION

**windbourne** ★ 2d

Actually, I think that school districts should require a single school for the non-medically exempt kids to go to. This way, those that are medically exempt are not threatened by these other kids.
And if a school district is too small to designate a school for non-medically exempt, then those districts need to require that the kids be home-schooled.
So, a good example, would be for Douglas County school district to designate that Plum Creek Academy handle all of the non-medical.
In fact, for most school districts, the alternative education buildings could be designated with extra money for the students.

However, by the same token, we need to require that these same families be held legally and economically responsible for any spreading of the disease.
That means first and foremost, if the kids get sick, the parents pay the medical costs, not insurance or the government.
Secondly, if they LIE or CHEAT in ANY way and put their unvaccinated kids in regular schools, and they are the vector of it spreading, than they will be held accountable for assault and if a child dies, they will be held accountable for murder in the same fashion as somebody with HiV fornicating with others and not telling them.

**More Segregation and Criminalization**

**Jai Kanta**
Pretty soon we'll be able to arrest anti-vaxxers for their misinformation. 1
3 hrs Like Reply More

**Abigail Martinez**
Anti-vaxxers should be segregated and exterminated for being bioterrorists and merely existing.

Like Reply

**Darryl Mead**
Thanks to these intellectually crippled, fact refuting, no education, anti vaxx morons.
Like Reply

**Lacie Hall Adams**
I wish all these people that want to live like a third world county would just go there and live!!! We should have our kids at risk because there are idiots that won't vaccinate!!!!!!
Like Reply

**Jai Kanta**
The only reason measles has had a resurgence in the US is because of anti-vax populations in geographical areas providing reservoirs for the disease.

Those choosing to be selfish and ignorant about the safety of vaccines should be fined and imprisoned for their crime of endangering the public.

https://journals.plos.org/plosmedicine/article?id=10.1371%2Fjournal.pmed.1002578
4

**Brandon Blank**
My thoughts on anti vax movement is anyone who doesn't vaccinate their child should immediately eject themselves into space.
2
9 mos Like Reply More

Adrian Lee If people are too foolish to willfully vaccinate their children, and mandating vaccinations is bad mmmkay, then those people should therefore be held criminally liable for their children passing any of these preventable diseases to any other child. You can't have your cake and eat it too. Living within a society comes with the responsibility of caring for that society. Antivaxxers need to look beyond their selfish little family microcosms.

Like Reply Message · 55m

Adrian Lee Just as there is nothing in the Constitution

Nick Meyer

@melissa Sure vaccination should be a choice, however access to public space or private business spaces should be dependent on being vaccinated. No vaccine, no public access. No stores, schools, restaurants, etc. No vaccination = isolation.

1mo Like Reply More

VICE News's Post

Top Fan

Drew Owen

Screw these people and their conspiracy theory pseudoscience nonsense. Get out of my country.

1d Like Reply 3

**Joshua Frenzen**

**Jasmin Barquinero** who would want to listen to antivaxers? They're terrorists. Better off not existing in the first place

10 hrs Like Reply More

**More Threats**

Join us in protesting Vaxxed 2.

Anti-vaccination film is to be shown at a council-owned venue
dailymail.co.uk

7 1 23

Amanda Davrie
@AmandaDavrie

Replying to [redacted]

Take a gun, shoot them both. Get a medal.

Hey, I think suicide would look great on you! You should try it sometime! Besides, you don't vaccinate your fucking offspring so they'll be dead before you anyway. Regulations are getting more strict. Either wisen up and vaccinate your kids, or just go kill yourself and let someone take those babies in that'll take care of them. You're not a mother. You're just some cow that got knocked up and continued to make sorry ass choices. No wonder no one came to your birthday parties when you were young, even then people knew you were mentally retarded.

[redacted]

I'm glad your baby is dead sweetie. It's just a shame you didn't lose the other one too!

[redacted] Like Reply

[redacted]

Anti-vaxxers deserve dead babies, not live ones. They shouldn't be allowed to breed because they are responsible for the deaths of millions. You deserve unhappiness in life.

[redacted] Like Reply 3

[redacted] Like Reply

John Seitz
Shannon Walton, You don't love your children, and the world is probably a better place because of those "thousands of children," who died from vaccines. It's good to thin out the weakest in the herd, from time to time.

[redacted] Like Reply

**Calls for denial of Medical Care**

**Victoria Martinez**

Don't want vaccines fine but also don't come to a PCP, hospital or clinic seeking medical attention. You are a waste of time, money and energy. A person that wants to get better , that will listen to reasonable medical advise can use the bed or appointment. Stay home. 20

11 hrs Like Reply More

**View previous replies**

Supporter

**Chilibeanie Maggie G**

Marie Shelton The whole fam needs to stay home. Pay to get groceries delivered. Homeschool. 1

10 hrs Like Reply More

Write a reply .

**View more comments...**

**Jen Lemon and 892 others**

**Mike Brenneman**

Actually I don't care. I am vaccinated, my kids are vaccinated so if you choose not to vaccinate then you shouldn't be allowed to go to the hospital IF you get sick. Since you Hippies are all for "No vaccinate my choice" then it's your choice not to accept vaccinate when you are sick. This would become population control.

3

Write a comment...

Perhaps you agree with the above comments and posts. You may believe that children that are not fully vaccinated are dangerous.

People used to say similar things about black people and gay people and transgender people and many many other people for whom there was no room for compassion or understanding or listening.

When the majority cannot relate to a minority group or does not listen to a minority group, the minority group is often harmed.

It has always been acceptable in this country to ignore women and mothers and clearly it is still alive and well here.

It is easy to accept that vaccines are safe and effective for everyone if you have not witnessed a severe reaction from a vaccine yourself or in someone you love. However, the moment you do, you will understand.

Throughout time people have been discriminated against, their experiences diminished or ignored, because their experience was not that of the majority.

Think carefully. Do not perpetrate against these mothers and their children what has been perpetrated against so many other minority groups in the past. Do not let it happen again.

One data breach of this information could harm thousands of children and their parents. Clearly the threats are out there. Data breaches are common - my entire family was a part of the Anthem breach and I was a part of the Target breach.

Would we create a state tracking data base for children with active Hep C, HIV, syphilis, gonorrhea, herpes, or chlamydia? No, because, even though these children may spread these active disease to others, we respect their medical privacy as we should. We do not expose these children to a potential data breach, to harassment by phone, email or mail or by home visits by a public health authority as these forms with their extensive PII obviously intend to do.

No one who would be adversely affected by this bill was invited to a stakeholder meeting. This bill should be thrown out as a result.

Keep exemptions in the schools. If you really want exemption rates to go down, improve access to those who don't have it and have schools follow the law and collect the missing paperwork.

Do Not let this happen again in America

## Matthew Shepard

Matthew Wayne Shepard was a gay American student at the University of Wyoming who was beaten, tortured, and left to die near Laramie on the night of October 6, 1998. He was taken by rescuers to Poudre Valley Hospital in Fort Collins, Colorado, where he died six days later from severe head injuries. Wikipedia

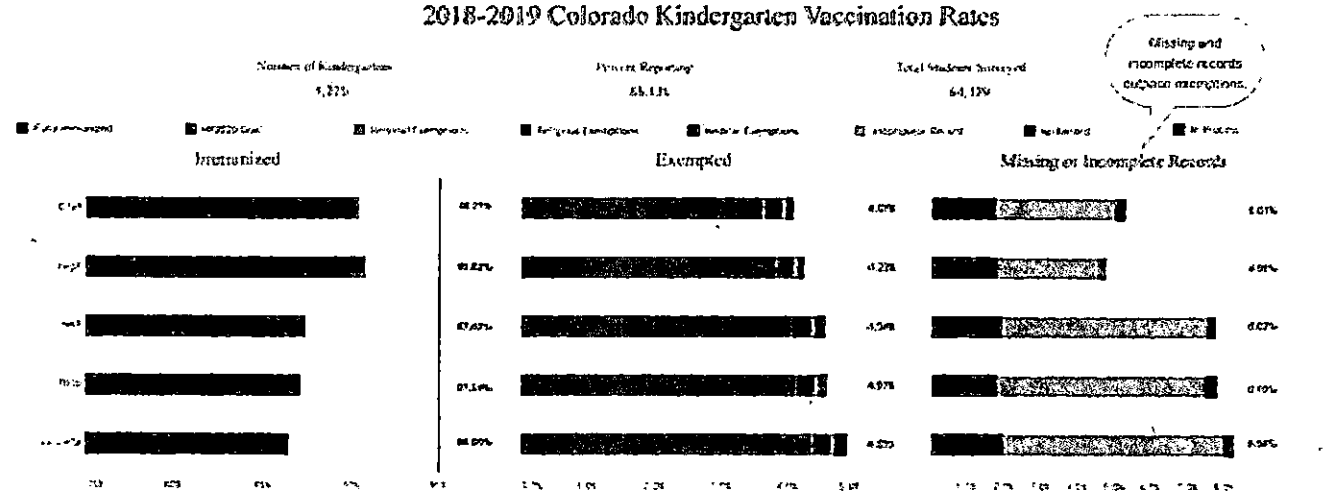

**Colorado Department of Public Health & Environment vaccine coverage data**

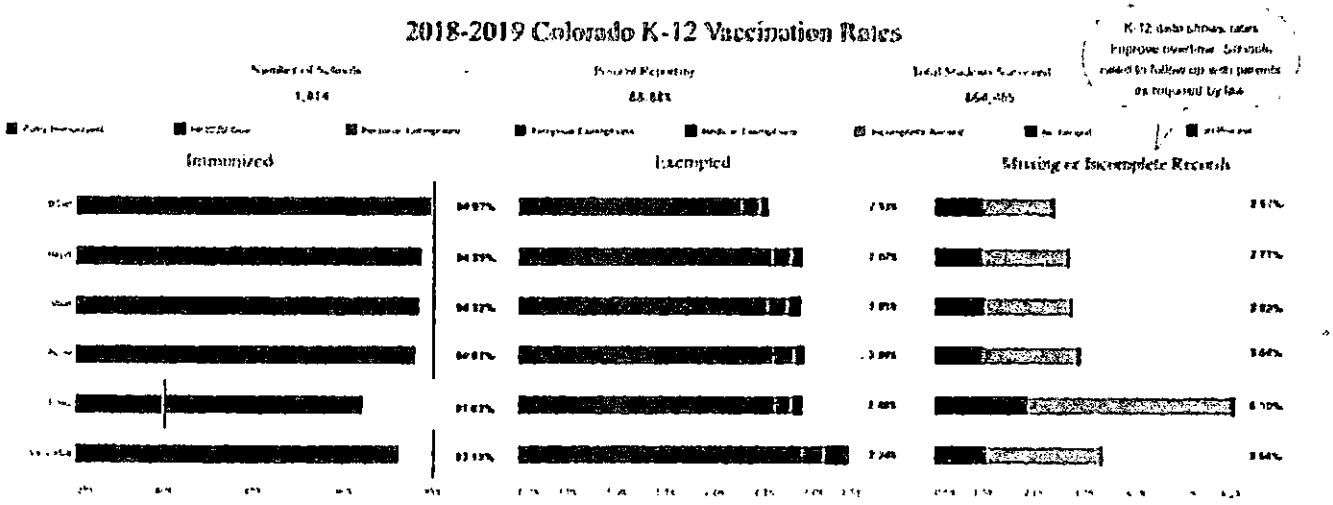
- shows high vaccine coverage rates.
- reveals that the number of students with incomplete school vaccination records often exceeds the number of students who exempt from vaccines;
- on K-12 shows that vaccination rates and complete student information improves over time; and
- ***suggests Colorado's school vaccination rates would significantly improve by following CDC recommendation to improve vaccine access and schools enforcing current Colorado statutes CRS 25-4-902 and CRS 25-4-903 requiring collection of complete vaccine records for student.***

**The Center for Disease Control (CDC) says...**

*"Parental choice may play some role, but CDC's data really suggests that many of these parents do want to vaccinate their children, but they may not be able to get vaccines for them. They may face hurdles like not having a health care professional near by, not having time to get their children to a doctor, and thinking that they cannot afford vaccines."*

*Dr. Nancy Messonnier, CDC - October 2018 ACIP Meeting on the CDC MMWR Vaccination Coverage for Selected Vaccines and Exemption Rates Among Children in Kindergarten United States, 2017–18 School Year*



# NO
# on
# SB20-163

# Protect
# ALL
# Children

# Immunization

## Non-Medical Exemption Form (Religious and Personal Belief)

Vaccines are one of the greatest public health achievements of the past century and save an estimated 3 million children's lives every year. The Colorado Department of Public Health and Environment strongly supports vaccination as one of the easiest and most effective tools in preventing diseases that can cause serious illness and even death. For nearly all children, the benefits of preventing disease with a vaccine far outweigh the risks. Declining to follow the advice of a health care provider, or public health official who has recommended vaccines may endanger an unvaccinated child's health and others who come into contact with him/her. Some vaccine-preventable diseases are common in other countries and unvaccinated children could easily get one of these diseases while traveling or from a traveler.

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending child care facilities licensed by the Colorado Department of Human Services, public, private and parochial kindergarten, elementary and secondary schools through 12th grade, and colleges or universities. Prior to kindergarten, a non-medical exemption must be filed each time a student is due for vaccines according to the schedule developed by the Advisory Committee on Immunization Practices.[1,2] From kindergarten through 12th grade, a non-medical exemption must be filed every year ~~during the student's school enrollment/registration process~~[1]. **~~Students with an exemption may be kept out of child care or school during a disease outbreak.~~**

Please complete all required fields below; incomplete forms will not be accepted. *All fields are required unless noted optional.*

| Type of Non-Medical Exemption Claimed: ☐ Personal Belief ☐ Religious |
|---|

### Student Information:

| | | |
|---|---|---|
| Last Name: | First Name: | (optional) Middle Name: |
| Gender: ☐ Female ☐ Male | Date of Birth: | |
| Street #: | Street Name: | Street Type (e.g. Ave.): |
| Unit #: | P.O. Box: | |
| City: | State: CO | Zip Code: |
| Email Address: | | County: |
| Phone Number: | | ☐ Home ☐ Cell |

### Parent/Guardian Completing This Form: ☐ Check if an emancipated student or student over 18 years old

| | | |
|---|---|---|
| Last Name: | First Name: | (optional) Middle Name: |
| Relationship to student: ☐ Mother ☐ Father ☐ Guardian | | |
| Street #: | Street Name: | Street Type (e.g. Ave.): |
| Unit #: | P.O. Box: | |
| City: | State: CO | Zip Code: |
| Email Address: | | County: |
| Phone Number: | | ☐ Home ☐ Cell |

### School/Licensed Child Care Facility Information:

| | | |
|---|---|---|
| School Name/Licensed Child Care Facility: | | |
| School District: | | ☐ Check if Not Applicable |
| Address: | | |
| City: | State: CO | Zip Code: |
| Phone Number: | | Grade of Student: |

[1] Colorado Board of Health rule 6 CCR 1009-2: http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6437&fileName=6%20CCR%201009-2.

[2] 2016 Recommended Immunizations from Birth through 6 Years Old: www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf. Based on this schedule, a non-medical exemption would be submitted at 2 months, 4 months, 6 months, 12 months and 18 months of age.

## Vaccine Preventable Disease Information

The information provided below is to ensure parents/guardians/students are informed about the risks of not vaccinating.

**Diphtheria, tetanus, pertussis (DTaP, Tdap)** - Unvaccinated children may be at increased risk of developing diphtheria, tetanus and/or pertussis if exposed to these diseases. Serious symptoms and effects of diphtheria include heart failure, paralysis, breathing problems, coma, and death. Serious symptoms and effects of tetanus include "locking" of the jaw, difficulty swallowing and breathing, seizures, painful tightening of muscles in the head and neck, and death. Serious symptoms and effects of pertussis (whooping cough) include severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures, brain damage, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/dtap.pdf and http://www.cdc.gov/vaccines/hcp/vis/vis-statements/tdap.pdf

**Haemophilus influenza type b (Hib)** - Unvaccinated children may be at increased risk of developing invasive Hib disease if exposed to this disease. Serious symptoms and effects include bacterial meningitis, pneumonia, severe swelling in the throat, permanent neurologic damage including blindness, deafness, and mental retardation, infections of the blood, joints, bones, and covering of the heart, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hib.pdf

**Hepatitis B** - Unvaccinated children may be at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects include jaundice, life-long liver problems such as liver damage, scarring, liver cancer, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf

**Inactivated poliovirus (IPV)** - Unvaccinated children may be at increased risk of developing polio if exposed to this disease. Serious symptoms and effects include paralysis of muscles that control breathing, meningitis, permanent disability, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/ipv.pdf

**Measles, mumps, rubella (MMR)** - Unvaccinated children may be at increased risk of developing measles, mumps, and/or rubella if exposed to these diseases. Serious symptoms and effects of measles include pneumonia, seizures, brain damage, and death. Serious symptoms and effects of mumps include meningitis, painful swelling of the testicles or ovaries, sterility, deafness, and death. Serious symptoms and effects of rubella include rash, arthritis, and muscle or joint pain. If a pregnant woman gets rubella, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, and mental retardation. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mmr.pdf

**Pneumococcal conjugate (PCV13) or polysaccharide (PPSV23)** - Unvaccinated children may be at increased risk of developing pneumococcal disease if exposed to this disease. Serious symptoms and effects include pneumonia, lung infections, blood infections, meningitis and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/pcv13.pdf and http://www.cdc.gov/vaccines/hcp/vis/vis-statements/ppv.pdf

**Varicella (chickenpox)** - Unvaccinated children may be at increased risk of developing varicella if exposed to this disease. Serious symptoms and effects include severe skin infections, pneumonia, brain damage, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/varicella.pdf

## Required Vaccines for School Entry - Place an "X" next to each vaccine you are declining.

| | | | |
|---|---|---|---|
| | Diphtheria, tetanus, pertussis (DTaP) | | Inactivated poliovirus (IPV) |
| | Tetanus, diptheria, pertussis (Tdap) | | Measles, mumps, rubella (MMR) |
| | Haemophilus influenza type b (Hib) | | Pneumococcal conjugate (PCV13) or polysaccharide (PPSV23) |
| | Hepatitis B | | Varicella (chickenpox) |

I am the parent/guardian of the above-named student or am the student himself/herself (emancipated or over 18 years of age) and am declining the vaccine(s) indicated above due to a religious or personal belief that is opposed to vaccines. The information I have provided on this form is complete and accurate.

- I may change my mind at any time and accept vaccination(s) for my child/myself in the future.
- I can review evidence-based vaccine information at www.colorado.gov/cdphe/immunization-education, or www.ImmunizeforGood.com for additional information on the benefits and risks of vaccines and the diseases they prevent.
- I can contact the Colorado Immunization Information System (CIIS) at www.ColoradoIIS.com or my health care provider to locate my child's/my immunization record.[3]

*I acknowledge that I have read this document in its entirety.*

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

Required to sign statements of harm above! Where are the risks???

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

[3] Under Colorado law, you have the option to exclude your child's/your information from CIIS at any time. To opt out of CIIS, go to: www.colorado.gov/cdphe/ciis-opt-out-procedures. Please be advised you will be responsible for maintaining your child's/your immunization records to ensure school compliance.

# COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____ Date of birth: _____

Parent/guardian: _____

No: address
phone
school
gender
grade
email
✓
what does
this mean?
It means harassment
by mail > email
phone > home
visits for anyone
who MPRNA from
any vaccine!

## Required vaccines

| | Immunization date(s) MM/DD/YY | | | | Titer date* MM/DD/YY |
|---|---|---|---|---|---|
| **Hep B** Hepatitis B | | | | | |
| **DTaP** Diphtheria, Tetanus, Pertussis (pediatric) | | | | | |
| **Tdap** Tetanus, Diphtheria, Pertussis | | | | | |
| **Td** Tetanus, Diphtheria | | | | | |
| **Hib** *Haemophilus influenzae* type b | | | | | |
| **IPV/OPV** Polio | | | | | |
| **PCV** Pneumococcal Conjugate | | | | | |
| **MMR** Measles, Mumps, Rubella | | | | | |
| **Measles** | | | | | |
| **Mumps** | | | | | |
| **Rubella** | | | | | |
| **Varicella** Chickenpox | | | | | |

| | | | |
|---|---|---|---|
| **Varicella** - date of disease | | **Varicella** - positive screen date | |

*A positive laboratory titer report must be provided to the school to document immunity.

*The shaded area under "titer date" indicates that a titer is not acceptable proof of immunity for this vaccine.

## Recommended vaccines

| | Immunization date(s) MM/DD/YY | | | | | | |
|---|---|---|---|---|---|---|---|
| **HPV** Human Papillomavirus | | | | | | | |
| **Rota** Rotavirus | | | | | | | |
| **MCV4/MPSV4** Meningococcal | | | | | | | |
| **Men B** Meningococcal | | | | | | | |
| **Hep A** Hepatitis A | | | | | | | |
| **Flu** Influenza | | | | | | | |
| **Other** | | | | | | | |

Health care provider signature or stamp: _____ Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

# M-M-R® II
# (MEASLES, MUMPS, and RUBELLA VIRUS VACCINE LIVE)

## DESCRIPTION

M-M-R® II (Measles, Mumps, and Rubella Virus Vaccine Live) is a live virus vaccine for vaccination against measles (rubeola), mumps, and rubella (German measles).

M-M-R II is a sterile lyophilized preparation of (1) ATTENUVAX® (Measles Virus Vaccine Live), a more attenuated line of measles virus, derived from Enders' attenuated Edmonston strain and propagated in chick embryo cell culture; (2) MUMPSVAX® (Mumps Virus Vaccine Live), the Jeryl Lynn™ (B level) strain of mumps virus propagated in chick embryo cell culture; and (3) MERUVAX® II (Rubella Virus Vaccine Live), the Wistar RA 27/3 strain of live attenuated rubella virus propagated in WI-38 human diploid lung fibroblasts.{1,2}

The growth medium for measles and mumps is Medium 199 (a buffered salt solution containing vitamins and amino acids and supplemented with fetal bovine serum) containing SPGA (sucrose, phosphate, glutamate, and recombinant human albumin) as stabilizer and neomycin.

The growth medium for rubella is Minimum Essential Medium (MEM) [a buffered salt solution containing vitamins and amino acids and supplemented with fetal bovine serum] containing recombinant human albumin and neomycin. Sorbitol and hydrolyzed gelatin stabilizer are added to the individual virus harvests.

The cells, virus pools, and fetal bovine serum are all screened for the absence of adventitious agents.

The reconstituted vaccine is for subcutaneous administration. Each 0.5 mL dose contains not less than 1,000 $TCID_{50}$ (tissue culture infectious doses) of measles virus; 12,500 $TCID_{50}$ of mumps virus; and 1,000 $TCID_{50}$ of rubella virus. Each dose of the vaccine is calculated to contain sorbitol (14.5 mg), sodium phosphate, sucrose (1.9 mg), sodium chloride, hydrolyzed gelatin (14.5 mg), recombinant human albumin (≤0.3 mg), fetal bovine serum (<1 ppm), other buffer and media ingredients and approximately 25 mcg of neomycin. The product contains no preservative.

Before reconstitution, the lyophilized vaccine is a light yellow compact crystalline plug. M-M-R II, when reconstituted as directed, is clear yellow.

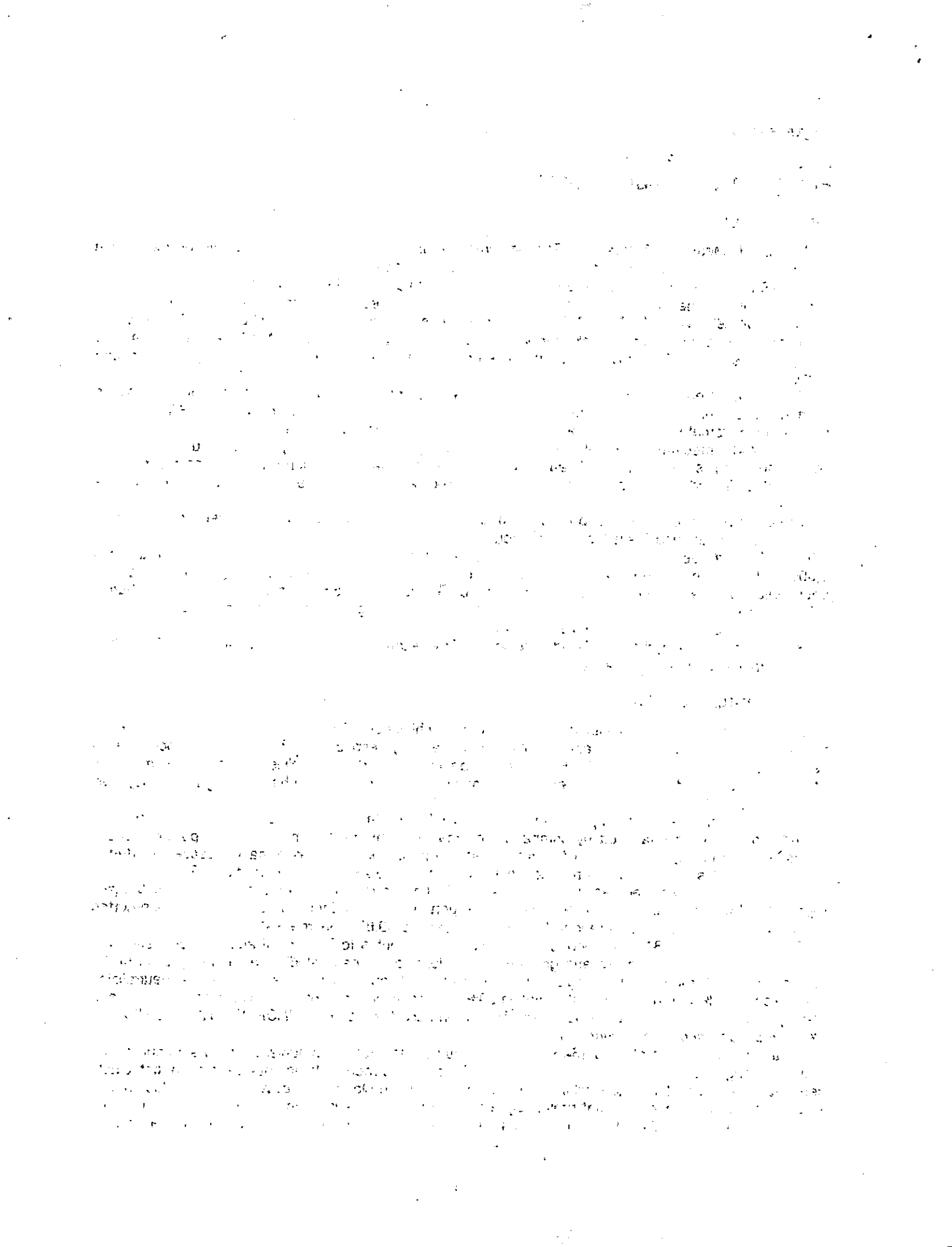
## CLINICAL PHARMACOLOGY

Measles, mumps, and rubella are three common childhood diseases, caused by measles virus, mumps virus (paramyxoviruses), and rubella virus (togavirus), respectively, that may be associated with serious complications and/or death. For example, pneumonia and encephalitis are caused by measles. Mumps is associated with aseptic meningitis, deafness and orchitis; and rubella during pregnancy may cause congenital rubella syndrome in the infants of infected mothers.

The impact of measles, mumps, and rubella vaccination on the natural history of each disease in the United States can be quantified by comparing the maximum number of measles, mumps, and rubella cases reported in a given year prior to vaccine use to the number of cases of each disease reported in 1995. For measles, 894,134 cases reported in 1941 compared to 288 cases reported in 1995 resulted in a 99.97% decrease in reported cases; for mumps, 152,209 cases reported in 1968 compared to 840 cases reported in 1995 resulted in a 99.45% decrease in reported cases; and for rubella, 57,686 cases reported in 1969 compared to 200 cases reported in 1995 resulted in a 99.65% decrease.{3}

Clinical studies of 284 triple seronegative children, 11 months to 7 years of age, demonstrated that M-M-R II is highly immunogenic and generally well tolerated. In these studies, a single injection of the vaccine induced measles hemagglutination-inhibition (HI) antibodies in 95%, mumps neutralizing antibodies in 96%, and rubella HI antibodies in 99% of susceptible persons. However, a small percentage (1-5%) of vaccinees may fail to seroconvert after the primary dose (see also INDICATIONS AND USAGE, *Recommended Vaccination Schedule*).

A study{4} of 6-month-old and 15-month-old infants born to vaccine-immunized mothers demonstrated that, following vaccination with ATTENUVAX, 74% of the 6-month-old infants developed detectable neutralizing antibody (NT) titers while 100% of the 15-month-old infants developed NT. This rate of seroconversion is higher than that previously reported for 6-month-old infants born to naturally immune mothers tested by HI assay. When the 6-month-old infants of immunized mothers were revaccinated at 15



See also PRECAUTIONS, *General.*

*Carcinogenesis, Mutagenesis, Impairment of Fertility*

M-M-R II has not been evaluated for carcinogenic or mutagenic potential, or potential to impair fertility.

*Pregnancy*

Animal reproduction studies have not been conducted with M-M-R II. It is also not known whether M-M-R II can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Therefore, the vaccine should not be administered to pregnant females; furthermore, pregnancy should be avoided for 3 months following vaccination (see INDICATIONS AND USAGE, *Non-Pregnant Adolescent and Adult Females* and CONTRAINDICATIONS).

In counseling women who are inadvertently vaccinated when pregnant or who become pregnant within 3 months of vaccination, the physician should be aware of the following: (1) In a 10-year survey involving over 700 pregnant women who received rubella vaccine within 3 months before or after conception (of whom 189 received the Wistar RA 27/3 strain), none of the newborns had abnormalities compatible with congenital rubella syndrome;{50} (2) Mumps infection during the first trimester of pregnancy may increase the rate of spontaneous abortion. Although mumps vaccine virus has been shown to infect the placenta and fetus, there is no evidence that it causes congenital malformations in humans;{37} and (3) Reports have indicated that contracting wild-type measles during pregnancy enhances fetal risk. Increased rates of spontaneous abortion, stillbirth, congenital defects and prematurity have been observed subsequent to infection with wild-type measles during pregnancy.{51,52} There are no adequate studies of the attenuated (vaccine) strain of measles virus in pregnancy. However, it would be prudent to assume that the vaccine strain of virus is also capable of inducing adverse fetal effects.

*Nursing Mothers*

It is not known whether measles or mumps vaccine virus is secreted in human milk. Recent studies have shown that lactating postpartum women immunized with live attenuated rubella vaccine may secrete the virus in breast milk and transmit it to breast-fed infants.{53} In the infants with serological evidence of rubella infection, none exhibited severe disease; however, one exhibited mild clinical illness typical of acquired rubella.{54,55} Caution should be exercised when M-M-R II is administered to a nursing woman.

*Pediatric Use*

Safety and effectiveness of measles vaccine in infants below the age of 6 months have not been established (see also CLINICAL PHARMACOLOGY). Safety and effectiveness of mumps and rubella vaccine in infants less than 12 months of age have not been established.

*Geriatric Use*

Clinical studies of M-M-R II did not include sufficient numbers of seronegative subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger subjects.

## ADVERSE REACTIONS

The following adverse reactions are listed in decreasing order of severity, without regard to causality, within each body system category and have been reported during clinical trials, with use of the marketed vaccine, or with use of monovalent or bivalent vaccine containing measles, mumps, or rubella:

*Body as a Whole*

Panniculitis; atypical measles; fever; syncope; headache; dizziness; malaise; irritability.

*Cardiovascular System*

Vasculitis.

*Digestive System*

Pancreatitis; diarrhea; vomiting; parotitis; nausea.

*Endocrine System*

Diabetes mellitus.

*Hemic and Lymphatic System*

Thrombocytopenia (see WARNINGS, *Thrombocytopenia*); purpura; regional lymphadenopathy; leukocytosis.

*Immune System*

Anaphylaxis and anaphylactoid reactions have been reported as well as related phenomena such as angioneurotic edema (including peripheral or facial edema) and bronchial spasm in individuals with or without an allergic history.

# Vaccines Protect Your Community

Did you know that when you get vaccinated, you're protecting yourself *and* your community?

This concept is called **community immunity**, or herd immunity. And it's an important reason for you and your family to get vaccinated — so you can help keep yourselves and your community healthy.

## How does community immunity work?

Germs can travel quickly through a community and make a lot of people sick. If enough people get sick, it can lead to an outbreak. But when enough people are vaccinated against a certain disease, the germs can't travel as easily from person to person — and the entire community is less likely to get the disease.

That means even people who can't get vaccinated will have some protection from getting sick. And if a person does get sick, there's less chance of an outbreak because it's harder for the disease to spread. Eventually, the disease becomes rare — and sometimes, it's wiped out altogether.

## Who does community immunity protect?

Community immunity protects everyone. But it's especially important because some people can't get vaccinated for certain diseases — such as people with some serious allergies and those with weakened or failing immune systems (like people who have cancer, HIV/AIDS, type 1 diabetes, or other health conditions).

# SB20 – 163 Testimony

Thank you Madame Chair, members of the committee. My name is Katy LeVasseur and I represent myself and my family. I oppose Senate Bill – 163. At this moment, my two kids at 10 and 9 yrs old are up to date on their vaccines. My daughter has Type 1 diabetes. My son does not. Just in case some of you don't fully understand what life is like with Type 1, it is constant 24/7 monitoring of blood sugars. Too high can immediately mean developing diabetic ketoacidosis which is life-threatening and requires a stay in the ICU, long term, high blood sugars can lead to the complications you typically hear about with diabetes: kidney issues, blindness, loss of limbs, heart issues, etc later in life. Too low is a more acute problem that can lead to passing out, seizure, or even death. Everything affects blood sugars, not simply what they eat. I don't ever get to sleep through the night. My daughter will have this disease the rest of her life.

I'm not describing this as a way to get pity or tell a sob story. I want you to get to know the types of families that sb163 would affect. You see, Type 1 is listed on the MMR insert as an adverse reaction, I provided a copy of the first page and page 6 that lists adverse reactions which I printed directly from the Merck website. It could very well be the reason my daughter developed Type 1. I have made a very common sense decision to discontinue vaccinating my children, so that my daughter's health isn't further ruined and so my son doesn't suffer the same fate as my daughter. I also included a blurb about community immunity from vaccines.gov which is the website for HHS. As you can see, Type 1 diabetics are mentioned as one of those who can't be vaccinated.

This life already isn't easy. With SB 163, not only do you want me to jump through these silly hoops of an attempt at reeducation or a new burden to doctors to be able to act in my children's best interest for their health, but you also want them in this tracking system mentioned ten times in the bill! This is absolute discrimination against the very types of kids that you are looking to protect!