

Competing Paramount Duties- Balancing Public Safety, Public Health and the Right to a Public Education

In the McCleary decision The Washington State Supreme Court recently established that educating the citizens' children was a "**Paramount Duty**" of the government.

Doesn't the language "**Paramount Duty**" confirm that the citizens have a "**Paramount Right**" to an education? Doesn't any revocation of that right require extreme cause and careful consideration?

Eliminating certain categories of vaccine exemptions will cancel that right for some students. The issue is not whether children should be vaccinated, it is if the failure to have every injection on the schedule should force a child to forfeit their Free and Appropriate Public Education? Is the case being made to justify this revocation valid?

Exemption elimination bill proponents are claiming that allowing exemptions is causing unsafe levels of vaccination, (refuted elsewhere), and are also claiming that any child who is less than 100% of every injection on the schedule represents such an exigent and extreme risk of causing "Deadly Outbreaks" or "Deadly Epidemics" that they should not be allowed to attend school.

Using this threat Bill supporters are trying to assert a competing, superior "**Public Safety**" based, "**Paramount Duty**", overriding the right to education, to support that exemptions must be banned.

How strong is this argument?

First, recall that the original, rational **Public Safety** intent to require school attendance vaccination was to prevent schools from being infection hubs for Smallpox, a highly contagious airborne infection that was largely untreatable at the time (100 plus years ago, long before antibiotics and other modern medical interventions). Smallpox was an infection that could be caught by airborne, casual exposure, and is reported to have up to a 30% mortality rate. Contrast this with measles, with a mortality rate of 00.0001% prior to the vaccine (1 in 10,000). Should a legal precedent based on the turn of the century medical system care capabilities, for an infection many magnitudes more dangerous than current infection risks apply to the current, modern environment?

There was an understandable **Public Safety** argument to be made for that vaccination, yet even with those facts the vaccination could be avoided by paying a fine, and any school exclusion was only during the time of an active outbreak.

Public Safety vs Public Health

Contrast this with the Hepatitis B vaccine requirement. Hepatitis B is a blood borne infection with the same infective profile as HIV, which is unprotected sex or unsanitary IV drug needle sharing with an infected person. The risk of student to student transmission of HIV is so low HIV positive students are allowed unrestricted, medically confidential school attendance. As Hepatitis B shares the same infective characteristics, WA DOH rules allow a known Hepatitis B infected student confidential, unrestricted school attendance (unless they have a mental status that makes them a risk to bite other students). There is no direct, immediate mortality risk from a Hepatitis B infection. When infected, the person either clears the virus after an acute phase, or they become a chronic carrier with an increased risk of liver cancer 30 to 50 years in the future, with lifestyle behavior factors playing an important role in the development of the disease.

Competing Paramount Duties- Balancing Public Safety, Public Health and the Right to a Public Education

Requiring Hepatitis B vaccination for school attendance for **Public Safety** is to prevent a very unlikely chain of events. First, a child must attend school with a Hepatitis B infected child, which is very, very rare in WA.

Then, the student must engage in unprotected sexual or unsanitary drug activity with, or be bitten by, the infected child. And the vaccination is intended to prevent the newly infected child from transmitting it to another student by having sex, or drug use, or biting a third child. The **Public Safety** argument for this vaccine being needed to stop horizontal pediatric transmission is very weak. This illustrates the contrasts between **Public Health** and **Public Safety**.

From a **Public Health** standpoint, it may be very desirable for all children to be vaccinated for Hepatitis B, but does it rise to qualify as a **Public Safety** issue? If a known infected HIV or Hepatitis B positive student is not a threat to the other children, how could a student simply lacking the Hepatitis B vaccine be considered so dangerous they are not allowed in school?

So, the question is- should the failure to receive 3 injections of this vaccine cause a student to forfeit their constitutionally guaranteed FAPE?

This is not a theoretical question but a real and current situation. There are many students who have all the requirements but exempt from Hepatitis B only. For example, in Bainbridge Island School District 63 students have all requirements except 3 Hepatitis B injections. At least 50 of those students use a non-medical exemption to be less than 3 injections. Should they be thrown out of school?

Vashon Island has 65 students who comply with all requirements except for the Hepatitis B vaccine. Because WA DOH Policy permits identified Hepatitis B positive students unrestricted attendance we know these students are no threat to other children. These children would all be allowed in school if they were Hep B positive infected. Are these parents being irresponsible or reckless in their guardianship of the health of their children by not using the Hepatitis B vaccine?

Vashon Island is in King County. The King County Health Department Hepatitis B webpage only recommends vaccination for adults in risk behavior groups- IV drug users, prostitutes and their customers, men who have unprotected sex with men, people who live with Hep B positive persons, and First Responders who deal with these populations and may be exposed to their blood. Very few adults participate in these activities, and even fewer K-12 students.

How prevalent is Hepatitis B in King County? Out of 1.1 million residents in 2015 there were 9 acute infections, all adult. From the King County Health Department, "Local epidemiology: Nine cases of acute HBV infection were reported in 2015. Five (56%) of the cases were male, and median age was 42 years (range 29 – 63 years). Sexual activity was the suspected route of exposure for four (44%) cases. Six cases were hospitalized, none died. In 2015, 738 chronic hepatitis B cases were reported."

These 738 carriers are primarily centered in the King County Corrections system, sex and drug trades, and immigrant communities from countries where Hepatitis B is endemic.

The greatest risk to children is "vertical transmission", being born to a Hepatitis B positive mother. Hepatitis B screening is standard.

Competing Paramount Duties- Balancing Public Safety, Public Health and the Right to a Public Education

From the King County website, “In 2015, 164 infants in King County were born to women with hepatitis B infection. Of those, all infants received on time post exposure treatment, including hepatitis B immune globulin and the first dose of hepatitis B vaccine.”

Considering the low incidence of Hepatitis B, virtual zero risk of exposure, and effective maternal transmission intervention, is it fair to characterize parents who opt out of the Hepatitis B vaccine to be “anti-vaccine”? Parents with children who have 13 of 16 required injections?

Adults in the Hepatitis B risk groups are notoriously poor participants in preventative vaccination campaigns. The **Public Health** response has been “By the time an adult is at risk to contract Hep B, they won’t get vaccinated, let’s just go ahead and vaccinate all the kids that way we will get the ones that end up being IV drug users, prostitutes, etc., in advance.” Perhaps this is good **Public Health** policy on a population level, but should that objective override a parent’s right to informed consent?

At the other end of the spectrum is Chicken Pox, highly contagious, and rarely serious. There was considerable debate about the need for a vaccine for Chicken Pox, as it is a routine childhood infection that is almost always benign. This vaccine was only licensed in 1995, with the original purpose to protect leukemia patients, but once approved quickly rolled out nationally for all children. Chicken Pox became a Washington requirement only in 2006. Most other developed nations do not “require” vaccines for school or other participation.

The **United States Public Health** rationale for a universal recommendation was that it could save money by preventing parents from having to stay home from work to care for a sick child, and only when the potential savings from that scenario were factored in did the vaccine pencil out. Otherwise the cost of vaccination exceeded the cost of natural infection. But those calculations were originally based on a single injection lifetime immunity, which has now shifted into a 2 injection pediatric series with probable adult boosters, and a rise in shingles incidence in seniors. It does not appear that a reassessment based on the additional factors has been performed.

Contrast US Public Health treatment of Chicken Pox with the **United Kingdom’s National Health Service** determination, which considers the **natural transmission of Chicken Pox to be a Public Health benefit**, and does not provide the vaccine. The UK NHS states,

“The chickenpox vaccine is not part of the routine UK childhood vaccination programme because chickenpox is usually a mild illness, particularly in children. There’s also a worry that introducing chickenpox vaccination for all children could increase the risk of chickenpox and shingles in adults”.

The UK NHS recognizes that the natural infection immunity is superior, longer lasting, and the re-exposure of immune adults to active circulating Chicken Pox infection in children acts as a natural booster, reducing shingles incidence, eliminating the need for that vaccine.

A parent commented on the disparity between the UK and US treatment of Chicken Pox infections. “What is more likely- that the UK NHS has a lower level of care and compassion for their children, or that the US has a higher level of pharmaceutical industry involvement in their policy making? If the US managed Chicken Pox with the UK model, it would eliminate 8 million annual, \$109 pediatric Chicken

Competing Paramount Duties- Balancing Public Safety, Public Health and the Right to a Public Education

Pox injections, adult boosters, and greatly reduce the need for the \$200 per dose shingles vaccine market in seniors.”

Should a student with parents who prefer the lifetime immunity provided by a natural Chicken Pox infection over the temporary vaccine dependent immunity, be forced to forfeit their education?

Again, this is not a theoretical question, Olympia School District has 497 students who exempt from only the Chicken Pox vaccine. Should they be excluded from school? Are these parents reckless, irresponsible, or anti-vaccine if their children have 14 of 16 required injections, but not Chicken Pox?

Future Requirements

Another consideration must be that the schedule is not static but growing. There were originally only 5-7 vaccine doses when school attendance rules began in 1980. There are now 26 injections for a child in State Licensed Facilities birth through 12th grade.

There have been several efforts in states to make the HPV vaccine a requirement for school attendance. HPV is a sexually transmitted infection. While it may be a **Public Health** objective that all people be vaccinated, it is obviously not a school transmissible infection **Public Safety** issue.

Should a student's access to education be conditioned on their receipt of vaccine for a sexually transmitted infection?

There are hundreds of vaccines in development, including vaccines for acne, obesity and tobacco use. If these vaccines are approved, should they be required for school attendance?

Should a child's education be conditioned on complying with Public Health objectives?

Summary

The efforts by the Health System to utilize the education system to implement **Public Health** objectives are very understandable. They have a perceived **Public Health, Paramount Duty**, to get as many people vaccinated as possible as early as possible. School attendance requirements are the quickest way to get full uptake of any vaccine- look at Chicken Pox. Would 90% of parents choose this vaccine if it were not required for school attendance? The threat of the loss of education is extremely persuasive, so it is natural that the Health System would want to use that power to achieve **Public Health** objectives. The affiliation organizations most of our health infrastructure personnel belong to, the WSMA and NACCHO, have written, adopted policy to legislate away non-medical vaccine exemptions, and to make the entire ACIP recommended schedule required for daycare, pre-school, and K-12.

The Education System is at a decision point about how to move forward. They will either abdicate, and cede the qualification for enrollment and attendance to Health System dictates, or they will become an active participant in determining to what extent the Education System can fulfill its “Paramount Duty”, and succeed in educating all children while maintaining student safety.

WA measles mortality range **0.0 to 0.154** per 100,000 population per year in pre-vaccine years 1958-1963. 1960 WA pop. 2.88 million. *"The effects of the post-war "baby boom" are also clear, with a 42 percent increase over 1950 in the number of persons aged 0-14, compared to a 20 percent increase in overall population. The data also shows that the median incomes of women and minorities lags seriously behind that of white males".* <http://www.historylink.org/File/9341> map from <https://doi.org/10.1093/oxfordjournals.aje.a112170>

ROGER M. BARKIN

A. 1958-1963

"...the true death-to-case ratio can be estimated to be approximately 1.0 deaths per 10,000 measles cases."
Pre-vaccine. p.347

"Higher mortality rates were noted in places with less than 10,000 people and in counties having a large percentage of the population with incomes below poverty level. Vaccine should be accessible to all populations, but intensive efforts need to be directed toward groups at high risk of dying from measles who are suffering from a myriad of other health, social, and economic problems."

What is a weaker endorsement than-
"Vaccine should be accessible"?

Restricted?

CDC Manager Barkin had the terms, "critical, compulsory, important, mandatory, necessary, recommended, vital, etc.", yet his conclusion is that vaccine "Vaccine should be accessible".

B. 1968-1970

Note dramatic difference of mortality rates in states with lower per capita income and history of poor access of minorities to medical care and social services.
Mortality 6.7 times higher in poverty counties.

MEASLES MORTALITY: A RETROSPECTIVE LOOK AT THE VACCINE ERA. ROGER M. BARKIN
Barkin, R. M. (**Bureau of Epidemiology, CDC, Atlanta, GA 30333**). Measles mortality: A retrospective look at the vaccine era. Am J Epidemiol 102:341-349, 1975.

Measles was and is a serious infection in populations with poor nutrition and poor access to health care. This is not the case in most of the US.

FIGURE 2. Average annual measles mortality rates, United States, 1958-1970.



Hepatitis B

Acute and chronic infections

[English](#)[Chinese](#)[Korean](#)[Russian](#)[Somali](#)[Spanish](#)[Vietnamese](#)

Hepatitis B virus (HBV) infects the liver. HBV is spread through infected blood and body fluids. Risk factors include being born to an HBV-infected woman, having unprotected sex, sharing injection drug equipment, sharing personal hygiene items (e.g., razors, nail clippers, toothbrushes), and living in a household with infected persons.

Resources for the general public

- [Hepatitis B facts](#), CDC
- [Hepatitis B vaccine information statement](#), CDC
- In addition to translations above, [Hepatitis B facts are also available in Burmese](#) (PDF)

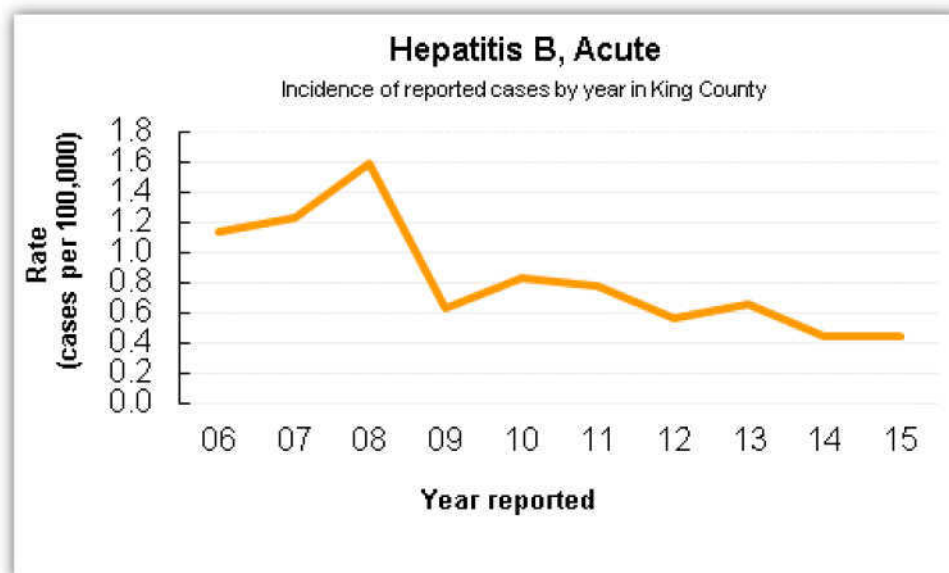
Resources for health care professionals

- **Hepatitis B is a reportable condition in King County: [See disease reporting requirements](#)**
- [Hepatitis B information for health professionals](#), CDC
- [Hepatitis B chapter from *Epidemiology and Prevention of Vaccine-Preventable Diseases*](#), CDC
- [Hepatitis B chapter from *Health Information for International Travel*](#), CDC

Hepatitis B in King County

Purpose of surveillance:

- To identify infectious cases and outbreaks
- To identify exposed persons eligible for post-exposure prophylaxis
- To identify and eliminate sources of transmission
- To identify pregnant women with hepatitis B and ensure prompt treatment to prevent infection of the newborn



Local epidemiology:

Nine cases of acute HBV infection were reported in 2015. Five (56%) of the cases were male, and median age was 42 years (range 29 – 63 years). Sexual activity was the suspected route of exposure for four (44%) cases. Six cases were hospitalized, none died.

In 2015, 738 chronic hepatitis B cases were reported.

Women of childbearing age receive additional follow up from Public Health, since hepatitis B infection can be passed perinatally from mother to infant, but is 85% - 95% preventable when post-exposure prophylaxis (PEP) is administered to the infant at birth. Women with hepatitis B who are reported to Public Health are evaluated for pregnancy status, and pregnant women are enrolled in the Perinatal Hepatitis B Prevention Program (PHBPP). The PHBPP's goal is to ensure these infants receive timely preventive treatment beginning at birth. In 2015, 164 infants in King County were born to women with hepatitis B infection. Of those, all infants received on-time post-exposure treatment, including hepatitis B immune globulin and the first dose of hepatitis B vaccine.

Since chronic HBV infection became reportable in Washington state in December 2000, the number of reports in King County has ranged from 400 to 878 annually. Reports of acute HBV cases in King County and nationally have been declining since the 1980s when hepatitis B vaccine became widely available.

Last Updated November 19, 2016



You are here: [Common health questions](#) / Why aren't children in the UK vaccinated against chickenpox?

Why aren't children in the UK vaccinated against chickenpox?

The chickenpox vaccine is not part of the routine UK [childhood vaccination programme](#) because [chickenpox](#) is usually a mild illness, particularly in children.

There's also a worry that introducing chickenpox vaccination for all children could increase the risk of chickenpox and [shingles](#) in adults.

Chickenpox in adults

In adults, chickenpox tends to be more severe and the risk of complications increases with age.

If a childhood chickenpox vaccination programme was introduced, people would not catch chickenpox as children because the infection would no longer circulate in areas where the majority of children had been vaccinated.

This would leave unvaccinated children susceptible to contracting chickenpox as adults, when they are more likely to get a more serious infection, or in pregnancy, where there is a risk of the infection harming the baby.

Shingles in adults

We could also see a significant increase in cases of shingles in adults.

Being exposed to chickenpox as an adult – for example, through contact with infected children – boosts your immunity to shingles.

If you vaccinate children against chickenpox, you lose this natural boosting, so immunity in adults will drop and more shingles cases will occur.

Pediatric/VFC Vaccine Price List

Vaccine	Brandname/ Tradename	NDC	Packaging	CDC Cost/ Dose	Private Sector Cost/ Dose	Contract End Date	Manufacturer	Contract Number
Varicella [5]	Varivax®	00006-4827-00	10 pack – 1 dose vial	\$92.72	\$115.16	03/31/2018	Merck	200-2017-93273

Adult Vaccine Price List

Vaccine	Brandname/ Tradename	NDC	Packaging	CDC Cost/ Dose	Private Sector Cost/ Dose	Contract End Date	Manufacturer	Contract Number
Varicella-Adult [5]	Varivax®	00006-4827-00	10 pack – 1 dose vial	\$69.94	\$115.16	6/30/2018	Merck	200-2017-94412
Zoster Vaccine Live	Zostavax®	00006-4963-41	10 pack – 1 dose vial	134.16	\$212.666	6/30/2018	Merck	200-2017-94412

After Long Debate, Vaccine For Chicken Pox Is Approved

By LAWRENCE K. ALTMAN

Published: March 18, 1995

After years of controversy and delay, Federal officials yesterday approved the first vaccine in the United States to prevent chicken pox, one of the most contagious childhood diseases.



FACEBOOK



TWITTER



GOOGLE+

The main focus of controversy is whether chicken pox, whose skin lesions are itchy but only rarely fatal, is serious enough to prevent with a vaccine. Though complications from the disease are rare, they add up because about four million Americans develop chicken pox each year. About 90 percent of the cases occur before the age of 15 and 95 percent by young adulthood. There is a higher risk of serious complications when the disease develops in adolescents and adults.

In recommending approval of the vaccine, Federal health officials pointed to a study commissioned by the Centers for Disease Control and Prevention that had been based on a vaccine cost of \$35 and geared to 1990 cost figures. By the study's calculations, if all indirect costs of preventing chicken pox were included, such as a parent's lost wages, there would be a return of \$5.40 in benefits for every \$1 spent on the vaccine. But if only direct costs were considered, like hospitalization, the total benefits would be only 94 cents for every dollar spent on a chicken pox vaccine.

Each state will decide whether to add chicken pox to the list of vaccines required for admission to school. The states usually follow guidelines set by the pediatrics and centers' advisory groups, a spokesman for the pediatric academy said.

11-06

STATEMENT OF POLICY

Eliminating Personal Belief Exemptions from Immunization Requirements for Child Care and School Attendance

Policy

While supporting the continued availability of medical and religious exemptions to school immunization requirements, the National Association of County and City Health Officials (NACCHO) urges that personal belief exemptions be removed from state immunization laws and regulations. To reduce the incidence of vaccine-preventable diseases, protect those who cannot receive vaccine due to age or medical condition, and protect those at greater risk of severe complications if they do become infected and ill, NACCHO encourages eliminating personal belief exemptions. As a way to move toward this goal, NACCHO encourages state and local health departments to limit the **casual** use of personal belief exemptions to the greatest degree possible.

NACCHO acknowledges that there are states that may not be in a position to eliminate personal belief exemptions immediately. States that easily permit personal belief exemptions to immunizations have significantly higher rates of exemption than states that have more complex procedures.⁸ **These states should begin a process to limit the availability of personal belief exemptions to the greatest degree possible.** An initial step might be to review the process of applying for and receiving exemptions: the more educational and demanding the process, the lower will be the rate of exemptions. There should be more involved in the application process than simply signing a form.

To **discourage** casual use of **personal belief exemptions**, NACCHO supports the following courses of action:

- Federal support for conducting routine surveillance of school immunization records to identify gaps in immunization coverage related to personal belief exemptions.
- Federal support and guidance to assist in developing exemption procedures that encourage parents to comply with vaccination requirements rather than claim exemption as a means of convenience.
- Federal support and guidance regarding effective ways to **implement procedures and administrative controls that limit nonmedical, nonreligious exemptions.**
- Federal support to primary care providers, local health departments, school nurses, and/or the state/local immunization coalition to conduct mandatory sessions that provide education about immunizations' impact on public and personal health and integrate information about the responsibilities associated with exercising the parental right to a personal belief exemption.
- School systems and childcare facilities (where appropriate) should use an exemption application form that requires a parental signature acknowledging their understanding that their decision not to immunize places their child and other children at risk for diseases and ensuing complications. The form should also state that in the event of an exposure to a vaccine-preventable illness, **their child would be removed from**



school and all school-related activities for the appropriate two incubation periods beyond the date of onset of the last case, which is standard public health practice.

- School systems and child care facilities (where appropriate) should require annual renewal of exemption forms. This process would provide multiple opportunities for education regarding the value of vaccinations and the responsibilities inherent in choosing not to be vaccinated. The parents would thus be required to make an informed decision annually rather than just once.
- Federal support to ensure compliance with exemption reporting by all schools, monitor exemption rates, and provide public reports of exemption rates over time in order to help define the vaccine-preventable disease risk related to the exemption rate at the school and community level.

Justification

Immunization and child care facilities provide an important opportunity to provide an informed decision. Twenty state

If enacted this legislation would bar any child missing any one of the 26 injections* now required for WA State licensed facilities from Childcare, Pre-School, and K-12 attendance and participation.

(*which includes Chicken Pox)

views or medical restrictions. These are referred to as personal belief exemptions. Exempted children are at increased risk for acquiring vaccine-preventable diseases and pose a risk for transmitting infection to susceptible persons in the community.⁵ Geographic areas with high rates of exemption have been shown to have higher rates of vaccine-preventable diseases.⁶ Rates of exemptions are increasing, resulting in growing rates of vaccine-preventable diseases nationwide.⁷

ures.¹ School coverage and currently, states as reasons.³ in religious

Exemptions place others at increased risk of a preventable illness. Many of those placed at risk are those with greater susceptibility to more severe complications if they become ill. Such exemptions should not be allowed to occur casually because of misinformation or convenience. Exemptions, like immunizations, carry responsibilities that need to be recognized. Every opportunity should be taken to provide accurate and timely information to parents that will encourage compliance with school and child care vaccination requirements.

References

- ¹ Centers for Disease Control and Prevention. (1999) Impact of Vaccines Universally Recommended for Children —United States, 1900–1998. *Morbidity and Mortality Weekly Report*, 48(12):243–248.
- ² Olshen Kharbanda et al. (2010) Changes in Tdap and MCV4 Vaccine Coverage Following Enactment of a Statewide Requirement of Tdap Vaccination for Entry into Sixth Grade. *American Journal of Public Health*, 100(9), 1635-1640.
- ³ Jacobson v. Commonwealth of Massachusetts, 197 U.S. 11 (1905).
- ⁴ States with Religious and Philosophical Exemptions from School Immunization Requirement. (July 2010). *National Conference of State Legislatures*. <http://www.ncsl.org/default.aspx?tabid=14376>
- ⁵ Glanz et al. (2009) Parental Refusal of Pertussis Vaccination Is Associated With an Increased Risk of Pertussis Infection in Children. *Pediatrics* (123), 1446-1451. <http://pediatrics.aappublications.org/cgi/content/full/123/6/1446>
- ⁶ Omer et al. (2008) Geographic Clustering of Nonmedical Exemptions to School Immunization Requirements and Associations With Geographic Clustering of Pertussis. *American Journal of Epidemiology*, 168 (12), 1389-1396. <http://aje.oxfordjournals.org/content/168/12/1389.full>
- ⁷ Omer SB, Pan WK, Halsey NA, Stokley S, Moulton LH, Navar AM, et al. (2006, October 11). Nonmedical exemptions to school immunization requirements: secular trends and association of state policies with pertussis incidence. *JAMA*, 296(14), 1757-63. <http://jama.ama-assn.org/cgi/content/full/296/14/1757>.
- ⁸ Omer et al. (2008) Geographic Clustering of Nonmedical Exemptions to School Immunization Requirements and Associations With Geographic Clustering of Pertussis. *American Journal of Epidemiology*, 168 (12), 1389-1396. <http://aje.oxfordjournals.org/content/168/12/1389.full>

15-10

STATEMENT OF POLICY

School and Child Care Immunization Requirements

Policy

The National Association of County and City Health Officials (NACCHO) supports implementation of child care, school, and university immunization requirements based on recommendations of the Advisory Committee on Immunization Practices (ACIP). NACCHO supports requirements that only allow for medical exemptions due to allergy or medical contraindication to maintain high immunization rates and protect communities from vaccine-preventable diseases.

To successfully enact effective school-entry and child care immunization requirements, NACCHO urges the following actions:

- Implement requirements that follow the ACIP recommended vaccination schedule and require proof of immunization signed by a licensed medical professional.¹
- Implement requirements that include children who attend public and private schools, and homeschooled children who participate in public or private school activities.
- Make school vaccination and exemption rates publicly available.
- Increase resources to conduct school record and medical office record reviews to monitor compliance with immunization and exemption documentation requirements.
- Increase financial support to local health departments, school nurses, and/or state/local immunization coalitions to educate parents, guardians, and college and university students about the immunization requirements and the importance of vaccines.

If immunization requirements that only allow for medical exemptions are not feasible, the following steps can be taken to limit non-medical exemptions:

- Use exemption forms that require parents/guardians or students ≥ 18 years to acknowledge the risks involved in refusing vaccinations.
- Use exemption forms that require parents/guardians or students ≥ 18 years to acknowledge that in the event of an exposure to a vaccine-preventable illness, the exposed individual would be excluded from school and all school-related activities for the appropriate two incubation periods beyond the date of onset of the last case, as per standard public health practice.
- Notify parents, guardians, and college and university students of school and child care vaccination and exemption rates annually.
- Evaluate exemption procedures annually.
- Require that exemption forms be renewed annually.

If enacted this legislation would expanding the current 26 injection Childcare to 12th grade schedule to include all ACIP recommendations. This policy, combined with Policy 11-06, would bar any child missing any one of the 35 injections plus an annual flu shot (or 2) now required, and any future additions, from attendance and participation in WA State licensed Childcare, Pre-School, and K-12.

from a medical provider
(2) require





FOR MEMBERS

PRACTICE
RESOURCE CENTER

EDUCATION AND
EVENTS

LEGISLATIVE ACTION
CENTER

LEGAL RESOURCE
CENTER

A-1 = Top Legislative Priority

A-1 - Elimination of Vaccine Exemptions for Personal Reasons

Introduced by: Frederick Chen, MD, Delegate, King County Medical Society

WHEREAS, Washington state has one of the lowest percentages of kindergarteners who have received all required vaccines at school entry (8.3%); and

WHEREAS, the public health value of immunizations is undisputed and there continues to be vast misinformation about the safety of vaccines; and

WHEREAS, despite a 2011 law requiring physician signatures on certificates of exemption, the personal exemption rate has remained steady and there continue to be outbreaks of vaccine-preventable illnesses such as measles and pertussis; and

WHEREAS, students with exemptions are more at risk of getting and spreading vaccine-preventable diseases; and

WHEREAS, Washington state allows exemptions for medical and religious reasons, but 70% of exemptions are for personal reasons; THEREFORE BE IT

RESOLVED, that the WSMA supports the elimination of personal and philosophical vaccine exemptions for school, child care and preschool immunization requirements. (New HOD Policy)

Leave feedback below

While anonymous commenting is allowed, we prefer for you to use your name. If you're speaking on behalf of an organization, please state as much. The WSMA encourages lively debate, but please behave courteously and responsibly. Comments that include profanity, personal attacks (including language that could potentially identify an individual), or inappropriate, offensive, or illegal material will be removed. [Click here to review the terms and policies of Disqus.](#)

[Back to Virtual Reference Committees](#)

Comments for this thread are now closed.

If enacted this legislation would bar any child missing any one of the 26 injections* now required for WA State licensed facilities from Childcare, Pre-School, and K-12 attendance and participation.
(*which includes Chicken Pox)

[Subscribe](#) [Add Disqus to your site](#) [Add Disqus Add](#) [Privacy](#)

CONNECT

[Career Center](#)
[Find a Physician](#)
[Facebook](#)
[Twitter](#)
[LinkedIn](#)

ABOUT WSMA

[The Organization](#)
[Affiliated Organizations](#)
[WSMA Foundation](#)
[WAMPAC](#)
[Provide CME](#)
[Contact Us](#)

NEWS

[WSMA Doc Talk](#)
[The Capitol Report](#)
[WSMA Membership Memo](#)
[Press Room](#)
[Publications](#)

FOR PATIENTS

[Find a Physician](#)
[Choosing Wisely](#)
[ER is for Emergencies](#)
[End of Life](#)
[WSMA Store](#)
[Partners](#)

Obesity and nicotine vaccines in development.

Should these be required for school attendance?

Daily Mail.com



Home | U.K. | News | Sports | U.S. Showbiz | Australia | Femail | **Health** | Science | Money

Latest Headlines | **Health** | Health Directory | Games

A vaccine to conquer obesity could become reality after scientists find virus linked to weight gain

Among obese patients than healthy
n dying and being flushed away
nsin has already patented a vaccine



Halitosis Vaccines Targeting
FomA, a Biofilm-bridging
Protein of Fusobacteria
nucleatum

Authors: Liu, P.-F.; Huang, I.-F.; Shu, C.-W.; Huang, C.-M.

Source: Current Molecular Medicine, Volume 13, Number 8, September 2013, pp

Publisher: Bentham Science Publishers

California team working to develop acne vaccine

By Rachael Zimlich, RN

May 18, 2017

[Medical Economics Blog](#), [Medical Economics Blog](#), [Modern Medicine Cases](#), [Modern Medicine Feature Articles](#), [Modern Medicine News](#), [Modern Medicine Now Top Story](#), [Category-47287](#), [Vaccines](#)



Acne isn't a condition reserved for the teenage years—stress and hormonal changes can cause breakouts across a lifespan. Relief may be in sight though, thanks to a team of researchers in California who are working on both preventive and therapeutic vaccines to fight acne.

It sounds almost too good to be true for
— a simple jab to prevent unwanted po

But the prospect of a vaccine to stop y
found compelling evidence linking obesity to an infectious virus.

ADDICTION > NICOTINE USE > HOW TO QUIT SMOKING

How Does the Nicotine Vaccine Work?

By [Terry Martin](#) | Reviewed by [Sanja Jelic, MD](#)

Updated September 16, 2018

Share

Flip

Email

PRINT

