

ALLIANCE TO REMOVE HPV VACCINE MANDATE

About the Alliance to Remove HPV Mandate:

The Alliance to Remove HPV Mandate is dedicated to protecting our medical freedom in Rhode Island. We are currently working with our state legislators and government officials to remove the HPV vaccine mandate in RI. We assert that individuals have the right to make vaccination decisions after discussing their healthcare treatment with their physician. Our goal is to protect and preserve our right to medical freedom and to prevent any action that would impose any additional infringement on human rights.

Mandate History:

In 2014, the Rhode Island Department of Health (DOH) made the decision to mandate additional vaccines, including the HPV vaccine (e.g. Gardasil, Gardasil 9, and Cervarix), for students entering seventh grade in both public and private schools. This mandate infringes upon our right to informed consent.

The Rhode Island Department of Health (DOH) offers three options regarding vaccine mandates:

1. Vaccinate, following the vaccine schedule adopted by the RI Department of Health.
2. File a Religious Exemption form.
3. Obtain a Medical Exemption form - The Medical Exemption form requires the patient have certain serious contraindications or medical conditions which may cause possible severe injury or death. This form can only be issued by a physician.

Proposed Legislation:

- Restrict the authority of the RI Department of Health (DOH) to set minimum immunization standards for diseases that are non-transmissible in a school environment.
- Remove the authority of the DOH to mandate HPV vaccination as a condition of school inclusion.
- Require the DOH director to hold three public hearings when changes to the minimum standards for immunizations are planned.
- Reinstate the philosophical exemption while also preserving the religious exemption.

Why We Want Proposed Legislation:

- To preserve and protect the People's right to medical and vaccine informed consent.
- To maintain open and clear communications with the DOH prior to adoption of regulations impacting RI families.
- To require more transparency from the DOH.

Call and email your Representatives and Senators today. Additional resources can be found here: www.VaccineChoiceRI.com/resources

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HPV Vaccine Facts

- Regular cervical cancer screening (Pap and HPV tests) and follow-up can prevent most cases of cervical cancer.
- HPV vaccines do not treat existing HPV infections or HPV-associated diseases.
- HPV vaccines are not recommended for pregnant women.
- Most HPV types cause no symptoms and go away on their own.
- HPV vaccines do not protect against all HPV types.
- Condom use in the risk of HPV has almost a 100% prevention rate. Condom use is also a lower cost alternative to an expensive vaccine.

Sources: <http://tinyurl.com/HPVfacts1>, <http://tinyurl.com/HPVfacts2>)

Informed Consent:

Informed consent is the process by which the treating health care provider discloses all appropriate information on the risks, benefits, and alternatives to a competent patient so that the patient may make a voluntary choice to accept or refuse treatment.

Our Rights to Informed Consent in RI:

- We have the right to be informed of the risks and benefits of each vaccine offered by our physicians.
- We are entitled to complete information on side effects and ingredients not just being told a vaccine is “safe and effective” or that “severe reactions are rare.”
- We deserve statistical data on the effectiveness of a vaccine when it comes to actually preventing disease.
- We deserve more than a few minutes to read the one page Vaccine Information Sheet (VIS) to make our informed consent decisions.
- We have the right to refuse or postpone any medical treatment or procedure if we are not convinced by the information given that it is right for ourselves or our children.

Issues in RI that have been reported which impede our right to informed consent:

- Vaccine Information Sheets (VIS) being given after the vaccine is administered at the end of the office visit or at check-out.
- Parents are not being told which vaccines are being administered.
- Parents are being told that the vaccine(s) are mandatory for school admission. Parents DO have the right to avail themselves of the Religious Exemption.
- That there have been no cases of adverse events. Not being informed about the Vaccine Adverse Events Reporting System. (VAERS)
- Parents are not being informed that their physician is given financial incentives to vaccinate all patients.
- Parents are not being informed that their Physician and the vaccine manufacturers are not liable for injury due to vaccines adverse reactions.

Call and email your Representatives and Senators today. Additional resources can be found here: www.VaccineChoiceRI.com/resources

Sample letter to send to your Legislators

Dear Rhode Island Legislator,

I am writing to you today regarding the Rhode Island HPV Vaccine mandate. The Alliance to Remove HPV Vaccine Mandate in Rhode Island is dedicated to protecting every Rhode Island Resident's right to informed consent. Our group membership has swelled to over 2000 concerned citizens and, to date, more than 2900 supporters have signed the online petition to remove mandatory HPV vaccinations in Rhode Island.

A patient, or the individual responsible for the patient's care, has a right to make an informed choice about treatment after a physician has accurately presented the medical facts. Informed consent is a basic policy in both ethics and law that physicians must generally honor.

In 2014, the Rhode Island Department of Health (DOH) made a decision to mandate additional vaccines, including the HPV vaccine (e.g. Gardasil, Gardasil 9, and Cervarix), for students entering seventh grade in both public and private schools. This mandate infringes upon our right to informed consent.

HPV is a sexually transmitted disease that is non-communicable by participation in normal school activities. At the time the new minimum immunization standards were adopted, there was little opportunity for parents and other engaged citizens to voice their opinions during public hearings.

With this in mind, we propose legislation to accomplish the following:

- Restrict the authority of the DOH to set minimum immunization standards for diseases which are non-transmissible in a school environment.
- Remove the authority of the DOH to mandate HPV vaccination as a condition of school inclusion.
- Require the DOH director to hold three public hearings when changes to the minimum standards for immunizations are planned.

We also propose legislation to reinstate the philosophical exemption while also preserving the religious exemption to vaccinations.

It is our hope that you will join us in our efforts to preserve and protect the People's right to informed consent and to improve clear communications and transparency from the RI Department of Health prior to adoption of regulations which impact families.

I will be following your voting record on this issue with the utmost optimism.

Sincerely,

YOUR NAME

Call and email your Representatives and Senators today. Additional resources can be found here: www.VaccineChoiceRI.com/resources



Religious Immunization Exemption Certificate

For Use in Public and Private Daycare, Preschool, School & College

Instructions for completing a Religious Immunization Exemption Certificate
Section 1: Enter student information.
Section 2: Have parent/guardian or student (if the student is 18 years of age or older) initial, sign, and date after reading Vaccine Information Statement (s).
Section 3: Obtain school signatures.

Name of Daycare, School, or Institution	Street Address	City	Zip Code	Phone
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Section 1. Student Information

Student Name	Date of Birth	Grade
Street Address	City	Zip Code
Name and Address of Healthcare Provider	City	Zip Code
		Phone

Section 2: Immunization Exemptions (To be completed by parent/guardian, or student if the student is 18 yrs. old or older)

I request that the above named student be exempt from the vaccine(s) checked below based on my religious beliefs:

DTaP Hepatitis A Hepatitis B HIB HPV Influenza IPV MCV MMR
 PCV Rotavirus Td/Tdap Varicella

I have received and read the educational materials explaining the disease(s) and vaccine (s) checked above and:

_____	I understand the benefits and the risks of the vaccine(s).
Initials	
_____	I understand the risk of contracting the disease(s) that the vaccine(s) prevent.
Initials	
_____	I understand the risk of transmitting the disease(s) to others.
Initials	
_____	I understand that, if an outbreak of vaccine-preventable disease should occur, an exempt student will be excluded from school by the school administrative head for a period of time as determined by the Health Department based on a case-by-case analysis of public health risk.
Initials	

I understand the above risks of refusing to vaccinate based on my religious beliefs. I know that I may re-address this issue at any time and complete the required vaccinations.

 Signature of Parent/Guardian or Student
 (if the student is 18 years of age or older)

 Date

Section 3: For School Official Use Only – Date, sign, and distribute copies as indicated below.

_____	_____
School Nurse Signature	Date
_____	_____
School Administrative Head Signature	Date

Note: In accordance with the Rhode Island Department of Health’s *Rules and Regulations Pertaining to Immunization and Testing for Communicable Diseases (R23-1-IMM)*, (<http://www.rules.state.ri.us/rules/>), it is the responsibility of the administrative head of the of the daycare, preschool, school or college to secure compliance with the regulations. The administrative head of the daycare, preschool, school or college shall exclude students who have not received the minimum number of required immunizations and who are not exempt pursuant to the regulations.



Medical Immunization Exemption Certificate

For Use in Public and Private Daycare, Preschool, School & College

Instructions for completing a Medical Immunization Exemption Certificate (Press down firmly to mark all copies)
Section 1: Enter school and student information.
Section 2: For health care provider use only. Please provide name, address, vaccine contraindication(s), signature and date.
Section 3: For school use only: Obtain school signatures and dates and distribute copies as outlined below.

Section 1: School and Student Information

Name of Daycare, School, or Institution	Street Address	City	Zip Code	Phone
Student Name		Date of Birth	Grade/Level	
Street Address	City	Zip Code	Phone	

Section 2: For Healthcare Provider Use Only - Provide name, address, vaccine contraindication(s), signature, and date.

Name of Healthcare Provider	Street Address	City	Zip Code	Phone
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1. I certify that due to a contraindication(s) the above named student is exempt from receiving the required vaccine(s):
2. The contraindication(s) marked below is in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines, American Academy of Pediatrics (AAP) guidelines, or vaccine package insert instructions: (Check where applicable)

- | | | | | | | | | |
|-------------------------------|--------------------------------------|--------------------------------------|------------------------------------|------------------------------|------------------------------------|------------------------------|------------------------------|------------------------------|
| <input type="checkbox"/> DTaP | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> HIB | <input type="checkbox"/> HPV | <input type="checkbox"/> Influenza | <input type="checkbox"/> IPV | <input type="checkbox"/> MCV | <input type="checkbox"/> MMR |
| <input type="checkbox"/> PCV | <input type="checkbox"/> Td/Tdap | <input type="checkbox"/> Rotavirus | <input type="checkbox"/> Varicella | | | | | |

Contraindications	Precautions or Temporary Contraindications
<input type="checkbox"/> Serious allergic reaction (e.g., anaphylaxis) after a previous vaccine dose. (General for all vaccines) <input type="checkbox"/> Serious allergic reaction (e.g., anaphylaxis) to a vaccine component. (General for all vaccines) <input type="checkbox"/> Previous encephalopathy not attributable to another identifiable cause within 7 days of administration of previous dose of DTaP/DTP. <input type="checkbox"/> Progressive neurological problem after DTaP/DTP <input type="checkbox"/> MMR contraindicated with immunodeficiency, due to any cause, including HIV <input type="checkbox"/> Varicella contraindicated with substantial suppression of cellular immunity <input type="checkbox"/> Rotavirus contraindicated with severe combined immunodeficiency (SCID).	<input type="checkbox"/> Recent administration of an antibody-containing blood product (MMR, Varicella) <input type="checkbox"/> Student is pregnant. (MMR, Varicella, HPV) <input type="checkbox"/> Thrombocytopenia/thrombocytopenic purpura- now or by history (MMR) <input type="checkbox"/> Rotavirus – altered immunocompetence other than SCID, history of intussusception, chronic GI disease, spina bifida or bladder exstrophy Any of the conditions below after a previous dose of DTP or DTaP: <input type="checkbox"/> Neurologic disorder – unstable or evolving <input type="checkbox"/> Fever of $\geq 105^{\circ}$ F (40.5° C) unexplained by another cause (within 48 hours) <input type="checkbox"/> Seizure or convulsion within 72 hours <input type="checkbox"/> Persistent, inconsolable crying lasting ≥ 3 (within 48 hours) <input type="checkbox"/> Collapse or shock like state (within 48 hours) <input type="checkbox"/> Guillain-Barré Syndrome (within 6 weeks) <input type="checkbox"/> History of arthus-type hypersensitivity, defer Tetanus-toxoid vaccine for at least 10 years since last dose.

Parent/student has been informed that if an outbreak of vaccine -preventable disease should occur, an exempt student will be excluded from school by the school administrative head for a period of time as determined by the Health Department based on a case-by-case analysis of public health risk.

Healthcare Provider Signature _____ Date

Section 3: For School Official Use Only: Please provide date and signatures and distribute copies as outlined below.

School Nurse Signature _____ Date

School Administrative Head Signature _____ Date

Note: In accordance with the Rhode Island Department of Health's *Rules and Regulations Pertaining to Immunization and Testing for Communicable Diseases (R23-1-IMM)*, (<http://www.rules.state.ri.us/rules/>), it is the responsibility of the administrative head of the daycare, preschool, school or college to secure compliance with the regulations. The administrative head of the daycare, preschool, school or college shall exclude students who have not received the minimum number of required immunizations and who are not exempt pursuant to the regulations.