PHYSICIANS FOR INFORMED CONSENT

March 9, 2022

Re: SB 871 (COVID-19 vaccine mandate for daycare and K-12 school attendance)
Position: Oppose

Dear California Legislators,

On behalf of hundreds of physician and surgeon members of Physicians for Informed Consent and thousands of our health-freedom members, we oppose SB 871.

The COVID-19 mass vaccination program has unfortunately had no measurable impact on the COVID-19 death rate in the United States.[1] Fortunately, severe cases or deaths from COVID-19 in children are rare occurrences (1 fatality per 126,000 children)[2] but sadly children commonly suffer from severe systemic reactions to the COVID-19 vaccine.[3] Additionally, several studies have shown no measurable impact of the vaccine on the spread of COVID-19.[1] Thus, as is the case with other vaccines[4] wrongly mandated for school attendance in California, the vaccination status of a child is not a significant risk to other schoolchildren.

It is both unethical and unscientific to mandate the COVID-19 vaccine on any population, but coercing parents to indiscriminately vaccinate their children or lose the right to send them to school is antithetical to the health of California's children and antithetical to a free society.

We urge you to oppose SB 871.

Sincerely,

Shira Miller, M.D.
Founder and President
Physicians for Informed Consent

Enclosed:
[1] COVID-19 Vaccine Mandates: 20 Scientific Facts That Challenge the Assumptions
[2] COVID-19 — Disease Information Statement (DIS)
[3] Are Vaccine Mandates Science-Based?
[4] Vaccines: What About Immunocompromised Schoolchildren?

About Physicians for Informed Consent
Physicians for Informed Consent is a 501(c)(3) educational nonprofit organization focused on science and statistics. PIC delivers data on infectious diseases and vaccines, and unites doctors, scientists, healthcare professionals, attorneys, and families who support voluntary vaccination. In addition, the PIC Coalition for Informed Consent consists of over 300 U.S. and international organizations that represent millions of people. To learn more, please visit physiciansforinformedconsent.org.

Reference 1

COVID-19 VACCINE MANDATES: 20 Scientific Facts That Challenge the Assumptions

ASSUMPTIONS

FACTS

PIC Physicians for Informed Consent
Delivering Data on Infectious Diseases & Vaccines™

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? ASSUMPTION: The COVID-19 vaccines significantly reduce the spread of COVID-19, so high universal vaccination rates will prevent outbreaks and end the pandemic.

✓ **FACT 1:** A study of a COVID-19 outbreak in July 2021 published in *Eurosurveillance* found that "all transmissions between patients and staff occurred between masked and vaccinated individuals, as experienced in an outbreak from Finland." The authors state that the study "challenges the assumption that high universal vaccination rates will lead to herd immunity and prevent COVID-19 outbreaks."[1]

✓ **FACT 2:** A Centers for Disease Control and Prevention (CDC) study of another COVID-19 outbreak in July 2021 found that 74% of cases were fully vaccinated.[2]

✓ **FACT 3:** A Harvard study investigating COVID-19 cases across 68 countries and across 2,947 counties in the U.S. found "no significant signaling of COVID-19 cases decreasing with higher percentages of population fully vaccinated."[3]

A study of a COVID-19 outbreak in July 2021 found that all transmissions between patients and staff occurred between vaccinated individuals.

A Harvard study investigating COVID-19 cases across 68 countries and 2,947 counties in the U.S. found no decrease in cases with an increase in vaccination.

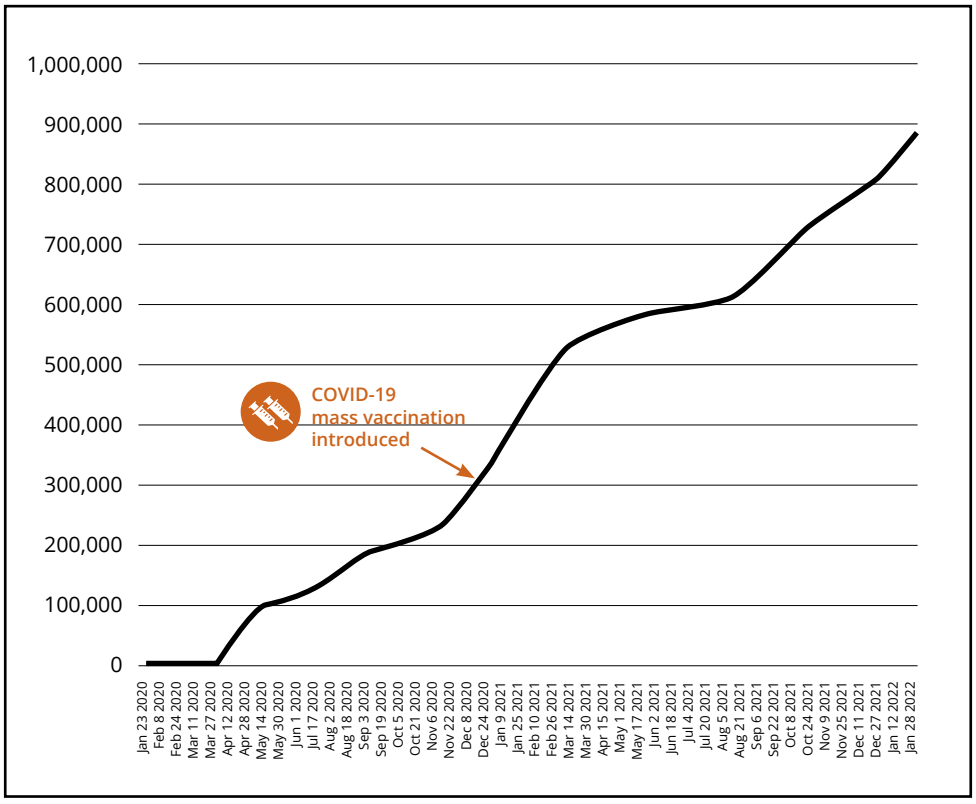
? ASSUMPTION: The COVID-19 vaccines prevent death from COVID-19.

FACT 4: There is no evidence from clinical trials that any of the vaccines prevent death because they did not have enough statistical power to measure the vaccine's ability to prevent deaths.[4-6] The U.S. Food and Drug Administration (FDA) states, "A larger number of individuals at high risk of COVID-19 and higher attack rates would be needed to confirm efficacy of the vaccine against mortality."[4-6]

FACT 5: A study of a COVID-19 outbreak in July 2021 published in *Eurosurveillance* observed that 100% of severe, critical, and fatal cases of COVID-19 occurred in vaccinated individuals.[1]

FACT 6: CDC data show mass vaccination with the COVID-19 vaccine has had no measurable impact on COVID-19 mortality in the U.S. In the nine months before the introduction of mass vaccination (April 2020 through December 2020), there were about 356,000 COVID-19 deaths. In the nine months after the introduction of mass vaccination, there were 342,000 COVID-19 deaths (January 2021 through September 2021), and 182,000 additional COVID-19 deaths occurred in the four months that followed (October 2021 through January 2022).[7]

Total COVID-19 Deaths, United States[7]



CDC data show mass vaccination with the COVID-19 vaccine has had no measurable impact on COVID-19 mortality in the U.S.

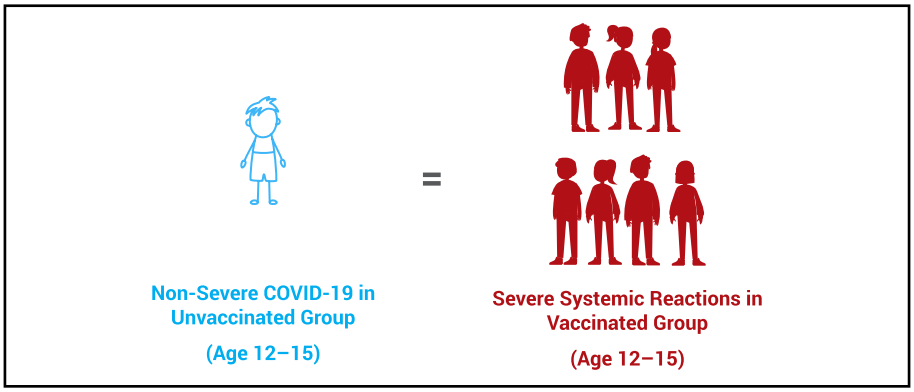
? ASSUMPTION: For children, being injected with COVID-19 vaccines is safer than being infected with SARS-CoV-2.

FACT 7: In the Pfizer clinical trial, there were zero cases of severe COVID-19 in children who did not receive the vaccine.[8,9] In contrast, for children 5 years or older, the Pfizer COVID-19 vaccine clinical trial found that the vaccine causes severe (grade 3) systemic reactions that include fever greater than 102.1° F; vomiting that requires IV hydration; diarrhea of six or more loose stools in 24 hours; and severe fatigue, severe headache, severe muscle pain, or severe joint pain that prevents daily activity.[9-12]

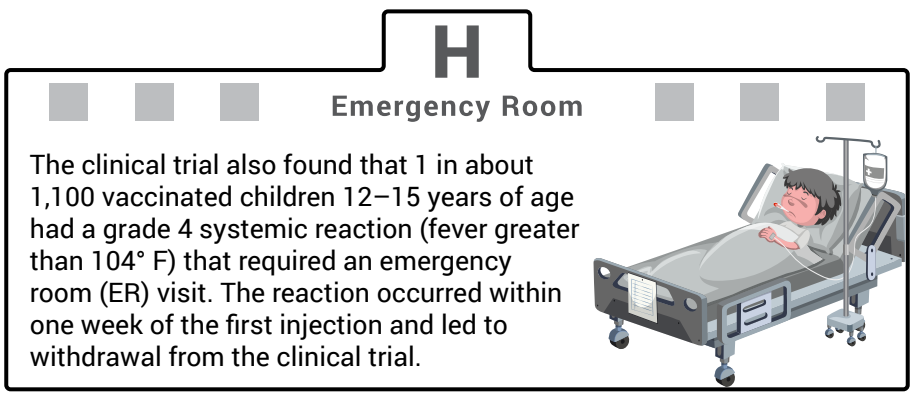
FACT 8: In the clinical trial, a range of 1 in 59 to 1 in 143 vaccinated children 5 to 11 years of age suffered severe systemic reactions within seven days of the second dose. There were 3 to 8 cases of severe systemic reactions observed in the vaccinated group for every 10 cases of non-severe COVID-19 in the unvaccinated group.[9]

FACT 9: In the clinical trial, 1 in 9 vaccinated adolescents 12 to 15 years of age suffered severe systemic reactions within seven days of receiving the second dose. There were 7 times more severe systemic reactions observed in the vaccinated group than non-severe COVID-19 cases in the unvaccinated group.[10-12]

FACT 10: The clinical trial also found that 1 in about 1,100 vaccinated children 12 to 15 years of age had a grade 4 systemic reaction (fever greater than 104° F) after the first dose that required an emergency room (ER) visit and withdrawal from the study.[10,13]



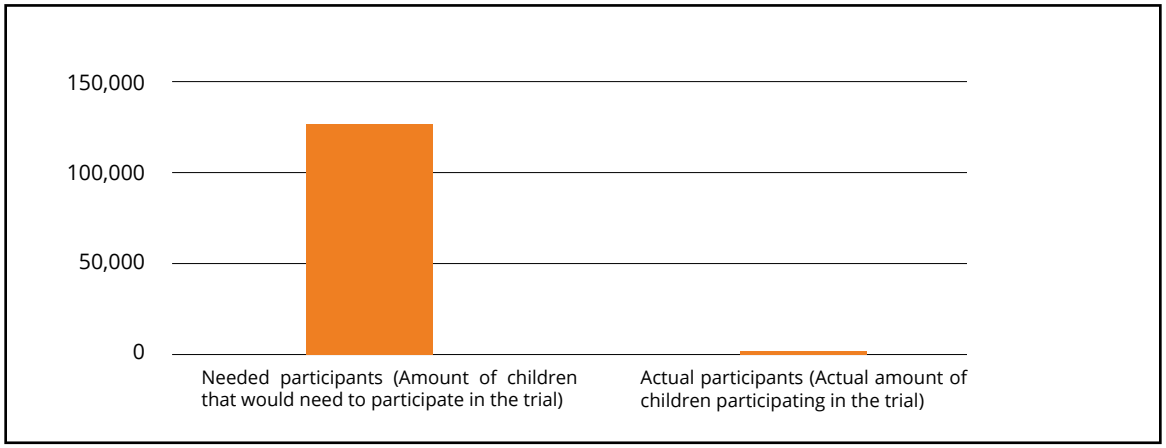
In the Pfizer COVID-19 vaccine clinical trial, zero unvaccinated adolescents 12 to 15 years of age suffered a severe case of COVID-19. In contrast, for every 1 case of non-severe COVID-19 in the unvaccinated group, there were 7 cases of severe (grade 3) systemic reactions in the vaccinated group.



? ASSUMPTION: The COVID-19 vaccine clinical trial was large enough to show safety in children.

FACT 11: The Pfizer clinical trial did not have enough statistical power to show the vaccine is safe in children under 18 years of age, as the study did not include enough subjects to establish safety (i.e., the clinical trial only included about 2,600 vaccinated children aged 5 to 15).[9,14] In comparison, it is known that COVID-19 fatalities are rare in children. As of Nov. 3, 2021, the chance of a child 17 years or younger contracting SARS-CoV-2 and dying from COVID-19 was 1 in 126,000 or 0.0008%.[15]

The COVID-19 Vaccine Clinical Trial Is Inadequate to Show Safety in Children



Because the chance of a child contracting SARS-CoV-2 and dying from COVID-19 is 0.0008% or 1 in 126,000, at least 126,000 children are needed to detect one death from COVID-19. Therefore, there must be at least 126,000 vaccinated participants enrolled in the clinical trial to compare the risk of death from COVID-19 to the risk of death from the vaccine. However, only about 2,600 vaccinated children participated in the clinical trial.

? ASSUMPTION: It's known that COVID-19 vaccines have no long-term side effects.

FACT 12: Because all subjects in clinical trials were observed for only two to six months, the long-term safety of COVID-19 vaccines for any age group is not known. Per the FDA, there are currently insufficient data to make conclusions about the safety of Pfizer, Moderna and Johnson & Johnson vaccines in subpopulations such as pregnant and lactating individuals, and immunocompromised individuals.[4,8,16] Per Pfizer, the vaccine "has not been evaluated for the potential to cause carcinogenicity, genotoxicity, or impairment of male fertility."[17]

FACT 13: Safety surveillance reports have identified serious risks of myocarditis and pericarditis in subjects under age 40, within seven days of vaccination. In boys aged 16 or 17, the FDA has reported an excess risk of myocarditis or pericarditis of 1 in 5,000 after the second dose of the Pfizer COVID-19 vaccine.[18] And in boys aged 12 to 17, also after a second dose of the Pfizer COVID-19 vaccine, a Hong Kong study found an excess risk of myocarditis or pericarditis of 1 in 2,700.[19]

? ASSUMPTION: Booster shots will solve the problem of waning vaccine immunity.

FACT 14: The clinical trials detected that vaccine immunity wanes significantly over a short period of time. For example, the Pfizer vaccine efficacy decreased by 8% to 18% within only six months, and the Johnson & Johnson vaccine efficacy decreased by 25% to 29% within only six months.[20,21] Additionally, the efficacy measured in the clinical trials was against the original Wuhan strain, not the new variants.

FACT 15: In clinical trials, a third dose of Pfizer or Moderna vaccine or a second dose of Johnson & Johnson vaccine has not been evaluated for efficacy against disease, but rather antibody counts were observed in a small number of vaccinated subjects for only one month.[18,21,22]

? ASSUMPTION: There are no known effective treatment or prevention options for COVID-19 except vaccines.

FACT 16: Treatments for COVID-19 have improved significantly since the pandemic began in early 2020, resulting in improved survival rates in hospitalized cases.[23,24] Indeed, for people not living in a nursing home, the overall survival rate of COVID-19 is 99.8% in the U.S., and 99.999% for children specifically.[25,26]

FACT 17: Hundreds of studies have observed the effectiveness of various treatments, the most studied being ivermectin, vitamin D, hydroxychloroquine (HCQ), and monoclonal antibodies.[27-30] These treatments may also be beneficial for prophylaxis (i.e., pre-exposure or post-exposure prevention of symptomatic COVID-19 infections).[31-35]

Treatments for COVID-19 have improved significantly since the pandemic began in early 2020, resulting in improved survival rates in hospitalized cases.

For people not living in a nursing home, the overall survival rate of COVID-19 is 99.8%, and 99.999% for children specifically.

? ASSUMPTION: People who were previously infected with SARS-CoV-2 need to get vaccinated because natural immunity is insufficient.

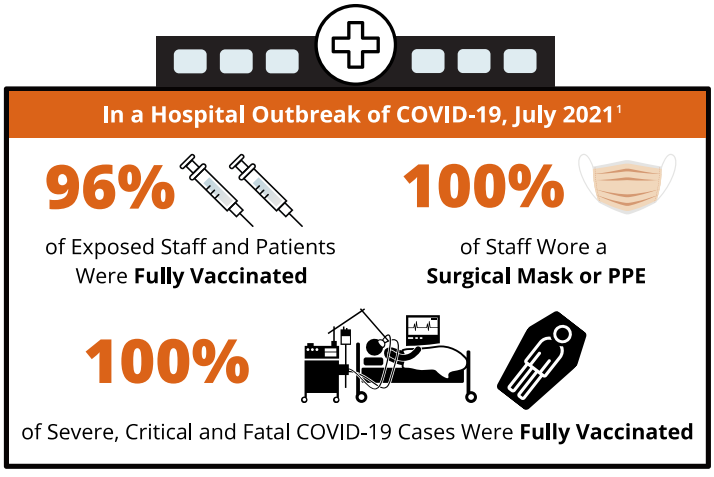
FACT 18: There is evidence that previous SARS-CoV-2 infection is more effective at preventing SARS-CoV-2 infection than COVID-19 vaccines. The Johnson & Johnson COVID-19 vaccine clinical trial included over 2,000 subjects who had contracted SARS-CoV-2 before the study. The trial, which tested unvaccinated and vaccinated people uniformly, recorded the incidence of COVID-19 in that unvaccinated group at least 28 days after the vaccination of the other subjects in the study. The COVID-19 incidence of the unvaccinated group with prior SARS-CoV-2 infection was 0.1% (2/2,021), whereas the COVID-19 incidence of vaccinated subjects was 0.59% (113/19,306). These data suggest that there are 6 times more cases of COVID-19 in vaccinated subjects than in unvaccinated subjects previously infected with SARS-CoV-2.[36]

FACT 19: Data from the Johnson & Johnson clinical trial also indicate that an unvaccinated person previously infected with SARS-CoV-2 has a 99.9% chance of being protected from a repeat infection. Of note, as of July 1, 2021, there have been 177.4 million SARS-CoV-2 infections in the U.S., which is 53.8% of the U.S. population.[26,36]

The Johnson & Johnson vaccine clinical trial found there are 6 times more cases of COVID-19 in vaccinated subjects than in unvaccinated subjects previously infected with SARS-CoV-2.

? ASSUMPTION: Vaccine mandates have been proven to create a safer environment.

FACT 20: Infection and transmission of SARS-CoV-2 occur at high rates in fully vaccinated populations, and a significant proportion of severe, critical and fatal COVID-19 cases occur in fully vaccinated individuals. CDC data show mass vaccination with the COVID-19 vaccine has had no measurable impact on COVID-19 mortality in the U.S. In addition, short-term clinical trial data indicate that 1 in 6 to 1 in 9 people 12–55 years of age who receive mRNA COVID-19 vaccines suffer severe (grade 3) systemic reactions, and long-term safety studies have not been conducted.[13,37] Thus, the scientific data demonstrate that vaccine mandates have not been proven to create a safer environment.



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These statements are intended for informational purposes only and should not be construed as personal medical advice.

Reference 2

SARS-CoV-2

COVID-19:

What You Need To Know

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1. WHAT IS COVID-19?

COVID-19 (coronavirus disease 2019) is an acute respiratory illness caused by SARS-CoV-2, a coronavirus strain among seven coronaviruses known to infect humans.[1] Other coronavirus infections include those due to seasonal (common cold) coronaviruses (229E, NL63, OC43 and HKU1), which cause up to a third of community-acquired upper respiratory tract infections,[2] as well as MERS-CoV and SARS-CoV-1. Approximately 33%[3] of SARS-CoV-2 infections are asymptomatic (never develop symptoms). However, when symptoms do occur, they happen 2–14 days after infection and range from mild to severe fever or chills, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nasal congestion or runny nose, nausea or vomiting, or diarrhea.[4] Most people's symptoms are short-lived, but some do have prolonged symptoms.[5] Overall, more than 99.6% of people infected with SARS-CoV-2 recover.[6] The strongest risk factors for fatal COVID-19 are obesity, anxiety disorders, and diabetes.[7]

2. WHAT IS THE INFECTION-FATALITY RATE OF COVID-19?

The infection-fatality rate (IFR) of COVID-19 is calculated by dividing the number of people who die from COVID-19 by the total number of people infected, including both symptomatic and asymptomatic cases.

A Stanford University systematic review that included 69 antibody studies estimated that the COVID-19 IFR in the United States ranges from 0.3% to 0.4%.[8] Data analysis herein uses the midpoint of that range, 0.35%. See Figure 1.

$$\text{Infection-Fatality Rate} = \frac{\text{\# COVID-19 Deaths}}{\text{\# SARS-CoV-2 Infections}}$$

An IFR of 0.35% is supported by an analysis published in *Clinical Infectious Diseases* that estimated that there were 44.8 million symptomatic COVID-19 illnesses in February–September 2020 in the U.S.[9] Since 33% of all SARS-CoV-2 infections are asymptomatic,[3] there were an estimated 66.9 million (44.8 million/[100%-33%]) total number of SARS-CoV-2 infections in that time period. There were also 213,000 COVID-19 deaths in February–September 2020,[10] resulting in a COVID-19 IFR of 0.32% (213,000/66.9 million).

When the pandemic began in early 2020, it was proposed that COVID-19 may be of comparable lethality to influenza in 1918.[11] However, the IFR of the 1918 flu (2.25%) was about six times greater than the IFR of COVID-19 (0.35%).[12,13] See Figure 2.

3. WHAT IS THE IFR OF COVID-19 IN DIFFERENT AGE GROUPS?

More than 80% of COVID-19 deaths occur in individuals aged 65 years or older, whereas less than 0.1% of COVID-19 deaths occur in individuals aged 17 years or younger (Table 1).[14] In addition, severe COVID-19 is particularly lethal in nursing homes.[8,15] For example, in 2020, 59% of all COVID-19 deaths in the state of Massachusetts occurred in long-term care (LTC) facilities.[16] The national COVID-19 IFR is 0.2% among individuals who do not live in long-term care institutions.[6]

SARS-CoV-2 Infection Outcomes[3,8,9]

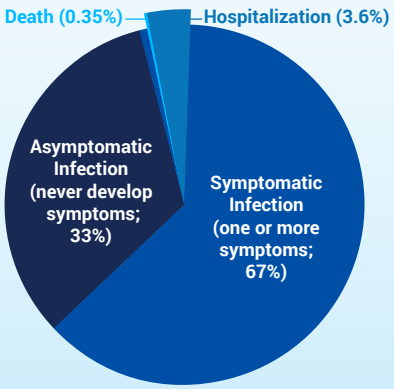

Figure 1: Among individuals infected with SARS-CoV-2, 33% of cases are asymptomatic (never develop symptoms) and 67% are symptomatic (one or more symptoms). Of these infections, 3.6% of cases are hospitalized and 0.35% are fatal.

Infection-Fatality Rate of 1918 Flu and COVID-19[8,12,13]

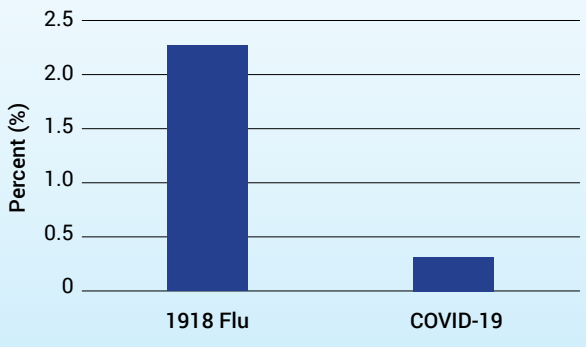

Figure 2: The infection-fatality rate (IFR) of the 1918 flu (2.25%) was about six times greater than the IFR of COVID-19 (0.35%). The IFR is the chance of dying if infected.

Table 1 shows that a COVID-19 infection in an individual 65 years or older dwelling in an LTC facility is almost 30 times more likely to be fatal (37.2%/1.3%) than in an individual 65 years or older not dwelling in an LTC facility. Furthermore, most people who die in nursing homes die within six months of placement; therefore, many COVID-19 nursing home deaths may have occurred in people with a life expectancy of only a few months.[17]

Age Group	% of Infections	% of Deaths	Infection-Fatality Rate (%)
0–17 years	13.2[9]	0.05[14]	0.001
18–49 years	56.4[9]	4.35[14]	0.03
50–64 years	20.1[9]	15.1[14]	0.3
65+ years	10.3[9]	80.5[14]	2.7
65+ years not in LTC	9.9[18]	38.0[26]	1.3
65+ years in LTC	0.4[19,20]	42.5[27]	37.2
75+ years	4.3[21]	58.5[14]	4.8
75+ years not in LTC	4.0[22]	18.3[28]	1.6
75+ years in LTC	0.3[23]	40.2[27]	46.9
All ages	100	100	0.35
All ages not in LTC	99.5%[24]	56.9[24]	0.2[6]
All ages in LTC	0.5%[19,25]	43.1[24]	30.2

Table 1: Age-specific COVID-19 infection-fatality rate in the United States.
LTC = long-term care facility.

COVID-19 cases in people 65 years or older who reside in long-term care facilities (nursing homes) are about 30 times more likely to be fatal than COVID-19 cases in people 65 years or older who do not reside in long-term care facilities.

4. WHAT IS THE DIFFERENCE BETWEEN BEING EXPOSED AND BEING INFECTED WITH SARS-COV-2?

Although the IFR measures the chance of dying assuming infection with SARS-CoV-2, the IFR does not include the chance of being exposed or the chance of being infected. Research shows that not everyone who is exposed to SARS-CoV-2 is necessarily infected with it, as T cells may protect against, or modify, infection.[29-31] A *BMJ* article investigating whether people have pre-existing immunity to SARS-CoV-2 states that "at least six studies have reported T cell reactivity against SARS-CoV-2 in 20% to 50% of people with no known exposure to the virus."[29] In addition, a study published in *Nature Immunology* states: "T cells control viral infections and provide immunological memory that enables long-lasting protection… Cross-reactivity of T cells for different virus species or even among different pathogens is a well-known phenomenon postulated to enable heterologous immunity to a pathogen after exposure to a nonidentical pathogen."[31] The study found, "Cross-reactive SARS-CoV-2 peptides revealed pre-existing T cell responses in 81% of unexposed individuals and validated similarity with common cold coronaviruses."[31]

5. HOW MANY PEOPLE HAVE BEEN INFECTED WITH SARS-COV-2?

As of July 1, 2021, about 53.8% of the 330 million people living in the U.S. have been infected with SARS-CoV-2. Because the COVID-19 IFR is 0.35%, and at that time there were 621,000 COVID-19 deaths,[10] that equates to 177.4 million SARS-CoV-2 infections (621,000/0.35%). The Johnson & Johnson vaccine clinical trial observed that an unvaccinated person previously infected with SARS-CoV-2 has a 99.9% chance of being protected from a repeat infection.[32,33]

- As of July 1, 2021, there have been 177.4 million SARS-CoV-2 infections in the U.S., which is 53.8% of the U.S. population.
- An unvaccinated person previously infected with SARS-CoV-2 has a 99.9% chance of being protected from a repeat infection.

6. WHAT TREATMENT OR PREVENTION OPTIONS ARE AVAILABLE FOR COVID-19?

Treatments for COVID-19 have improved significantly since the pandemic began in early 2020, resulting in improved survival rates in hospitalized cases.[34,35] Dozens of studies have observed the effectiveness of various treatments, the most studied being ivermectin, vitamin D, hydroxychloroquine (HCQ), remdesivir, and monoclonal antibodies.[36,37] Studies have also observed that ivermectin, vitamin D, and hydroxychloroquine may be beneficial for prophylaxis (i.e., pre-exposure or post-exposure prevention of symptomatic COVID-19 infections).[38-42]

As of December 2020, three vaccines have obtained Food and Drug Administration (FDA) approval or emergency use authorization. The vaccines have been shown to significantly prevent symptomatic COVID-19 cases that are not hospitalized or fatal. However, vaccine effectiveness has only been observed for two to six months in clinical trials, and it is not known how effective those vaccines may be at preventing asymptomatic, hospitalized or fatal cases. In addition, overall, people who receive the vaccine have a two-fold to six-fold increased risk of a severe adverse event compared to those who do not receive the vaccine.[33,43,44]

All references are available at physiciansforinformedconsent.org/COVID-19.

SCAN TO VIEW ONLINE

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20. Of the 2.16 million residents of nursing homes and residential care communities in 2016, 1.88 million were 65 or older.[19] Those 1.88 million residents comprised 3.82% of the population 65 or older in 2016; therefore, we estimated that 3.82% of all SARS-CoV-2 infections in that age group occurred in LTCs. The total number of infections in LTCs is 0.4% (3.82%*10.3%) of all infections in the U.S.
21. Since the population 75 or older is 41.9% of the population 65 or older, we estimated that 41.9% of all SARS-CoV-2 infections 65 or older were 75 or older. The total number of infections is 4.3% (41.9%*10.3%) of all infections in the U.S.
22. Since 4.3% of SARS-CoV-2 infections in the U.S. were 75 or older[21] and 0.3% of SARS-CoV-2 infections in the U.S. were 75 or older in LTCs,[23] 4% (4.3% - 0.3%) of SARS-CoV-2 infections in the U.S. were 75 or older and not in LTCs.
23. Of the 2.16 million residents of nursing homes and residential care communities in 2016, 1.55 million were 75 or older.[19] Those 1.55 million residents comprised 7.5% of the population 75 or older in 2016; therefore, we estimated that 7.5% of all SARS-CoV-2 infections in that age group occurred in LTCs. The total number of infections in LTCs is 0.3% (7.5%*4.3%) of all infections in the U.S.
24. Since 0.5% of all infections in the U.S. occurred in LTCs,[25] 99.5% (100% - 0.5%) of all infections occurred outside LTCs. Let X equal the % of all infections in the U.S. that occurred outside LTCs. Since the IFR excluding LTCs is 0.2%[6] and that IFR is also equal to (0.35%*X)/99.5%, X = 56.9%.
25. Of the 2.16 million residents of nursing homes and residential care communities in 2016, 276,000 were <65 and 1.88 million were 65 or older.[19] The 276,000 is 0.44% of the population 50-64 years old in 2016; therefore, we estimated that 0.44% of all SARS-CoV-2 infections in that age group occurred in LTCs. The 1.88 million is 3.82% of the population

65 or older in 2016; therefore, we estimated that 3.82% of all SARS-CoV-2 infections in that age group occurred in LTCs. The total number of infections in LTCs is 0.5% (0.44%*20.1% + 3.82%*10.3%) of all infections in the U.S.

26. Since 80.5% of COVID-19 deaths in the U.S. were 65 or older and 42.5% of COVID-19 deaths in the U.S. were 65 or older in LTCs,[27] 38% (80.5% - 42.5%) of COVID-19 deaths in the U.S. were 65 or older and not in LTCs.

27. Label the LTC population 50-64 years old as population A, the LTC population 65-74 years old as population B, and the LTC population 75 or older as population C. Table 1 shows the IFR of the population 50-64 years old regardless of LTC status (IFR_a) was 0.3%. The IFR of the population 65-74 years of age regardless of LTC status (IFR_b) is the difference in deaths between the 65 or older group and 75 or older group divided by the difference in infections of those groups: 1.3% (0.35%*[80.5%-58.5%]/[10.3%-4.3%]). Table 1 shows the IFR in the population 75 years or older regardless of LTC status (IFR_c) was 4.8%. Table 1 also shows that the total number of LTC COVID-19 deaths is 43.1% of all COVID-19 deaths. Let I_a, I_b, and I_c be the % of all infections comprised by LTC infections in each age group. I_a = 0.09% (0.44%*20.1%);[25] I_b = 0.1% (0.4% - 0.3%, Table 1); and I_c = 0.3% (Table 1). Let D_a, D_b, and D_c be the % of all COVID-19 deaths comprised by each group. D_a, D_b, and D_c can be solved using the following system of equations:

    $D_a + D_b + D_c = 43.1\%$

    $IFR_b / IFR_a = (D_b / I_b) / (D_a / I_a)$

    $IFR_c / IFR_a = (D_c / I_c) / (D_a / I_a)$

    Solving the system of equations above for D_a, D_b, and D_c results in D_a = 0.6%, D_b = 2.3%, and D_c = 40.2%.

28. Since 58.5% of COVID-19 deaths in the U.S. were 75 or older and 40.2% of COVID-19 deaths in the U.S. were 75 or older in LTCs,[27] 18.3% (58.5% - 40.2%) of COVID-19 deaths in the U.S. were 75 or older and not in LTCs.

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Reference 3

Are Vaccine Mandates Science-Based?

In the Pfizer COVID-19 vaccine clinical trial, zero unvaccinated adolescents 12 to 15 years of age suffered a severe case of COVID-19. In contrast, for every 1 case of non-severe COVID-19 in the unvaccinated group, there were 7 cases of severe (grade 3) systemic reactions in the vaccinated group.

Non-Severe COVID-19 in Unvaccinated Group

(Age 12–15)

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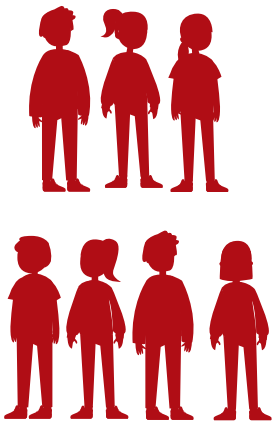

Severe Systemic Reactions in Vaccinated Group

(Age 12–15)

H

Emergency Room

The clinical trial also found that 1 in about 1,100 vaccinated children 12–15 years of age had a grade 4 systemic reaction (fever greater than 104.0° F) that required an emergency room (ER) visit. The reaction occurred within one week of the first injection and led to withdrawal from the clinical trial.

Reference 4

Vaccines: What About Immunocompromised Schoolchildren?

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physiciansforinformedconsent.org/
immunocompromised-schoolchildren

1. WHAT DOES IT MEAN TO BE IMMUNOCOMPROMISED?

Immunocompromised children have weakened immune systems that prevent them from optimally fighting infections on their own. Consequently, they may be at increased risk of complications from infectious diseases and require additional precautions and treatments.

2. CAN IMMUNOCOMPROMISED CHILDREN ATTEND SCHOOL?

The Immune Deficiency Foundation states, "Years ago, a diagnosis of a PI [primary immune deficiency] meant extremely compromised lives... Today, with early diagnosis and appropriate therapies, many patients diagnosed with a PI can live healthy, productive lives." Modern treatments have reduced the risk of many immunocompromised children so that they are able to attend school.[1]

Children who are not severely immunocompromised can attend school with the approval of their doctor.

3. CAN IMMUNOCOMPROMISED SCHOOLCHILDREN BE VACCINATED?

Immunocompromised schoolchildren have the option to receive all the vaccines licensed for children in the United States, except for the live virus vaccines (such as vaccines targeting measles, mumps, rubella, or varicella infections).[2] Although vaccination often results in protective levels of antibodies in immunocompromised children,[3-7] clinical vaccine safety trials typically exclude immunocompromised subjects.[8] In addition, vaccines have not been evaluated for their potential to cause cancer, genetic mutations or impaired fertility in the general or immunocompromised population.[9] Due to these limitations, it is not known whether the benefit of vaccinating an immunocompromised child outweighs the risk of vaccine injury to that child.

4. DOES THE VACCINATION STATUS OF OTHER SCHOOLCHILDREN POSE A SIGNIFICANT RISK TO IMMUNOCOMPROMISED SCHOOLCHILDREN?

The vaccination status of other schoolchildren does not pose a significant risk to immunocompromised schoolchildren for the following reasons (Table 1):

- Some vaccines cannot prevent the spread of the bacteria or viruses they target.
- Immune globulin (plasma containing antibodies) is available for immunocompromised children exposed to certain infectious diseases.
- Some infectious diseases rarely cause complications in immunocompromised schoolchildren.
- Not all infectious diseases are contagious.
- Some infectious diseases are not spread in schools.

Immunocompromised schoolchildren are not put at significant risk by the vaccination status of other schoolchildren.

Table 1: Why the Vaccination Status of Other Schoolchildren Is Not a Significant Risk to Immunocompromised Schoolchildren

Some vaccines cannot prevent the spread of the bacteria or viruses they target.

Children vaccinated with the diphtheria, tetanus, and pertussis (whooping cough) vaccine (DTaP) or the inactivated polio vaccine (IPV) can still be infected with diphtheria-causing bacteria, pertussis bacteria, or poliovirus and spread them to others, even with mild or no symptoms of their own.[10-13] The influenza vaccines (TIV and LAIV) have not been observed to significantly reduce the spread of influenza.[14,15] About half of schoolchildren vaccinated with the measles, mumps, and rubella (MMR) vaccine can still be infected with measles virus and spread it to others, even with mild or no symptoms of their own.[16-19]

Immune globulin (plasma containing antibodies) is available for immunocompromised children exposed to certain infectious diseases.

Immune globulin (IG) is available for the prevention of severe symptoms in immunocompromised children exposed to measles or rubella (IG does not provide protection for fetuses of expectant mothers infected with rubella).[20,21] Varicella-zoster immune globulin (VIG) is available for the prevention of severe symptoms in immunocompromised children exposed to varicella (chickenpox).[22] Hepatitis B immune globulin (HBIG) and tetanus immune globulin (TIG) are also available for immunocompromised children.[2]

Some infectious diseases rarely cause complications in immunocompromised schoolchildren.

Fatal cases of mumps are very rare in schoolchildren (1 mumps death per 100,000 mumps cases),[23] and immunocompromised children have been observed to recover just as well from mumps as the general population.[24] Severe cases of pertussis or rubella rarely occur in schoolchildren, and being immunocompromised has not been observed to be a significant risk factor for complications of pertussis or rubella in schoolchildren.[25,26]

Not all infectious diseases are contagious.

Tetanus is not a communicable disease; that is, it cannot spread from person to person under any circumstances.[27]

Some infectious diseases are not spread in schools.

Hepatitis B is not spread by kissing, hugging, holding hands, coughing, sneezing, or sharing eating utensils,[28] and the main routes of hepatitis B transmission (sexual contact, injection drug use, or being born to an infected mother)[29] do not occur in school. Nearly all cases of *Haemophilus influenzae* type b (Hib) occur among children younger than 5 years of age; therefore, nearly all Hib transmission does not occur in school.[30] Human papillomavirus (HPV) is sexually transmitted and is therefore not spread in school.[31]

All references are available at physiciansforinformedconsent.org/immunocompromised-schoolchildren.

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