From: Patrick C Mathias
To: DOH WSBOH
Subject: DOH WSBOH Notifiable Conditions Written Comments
Date: Friday, November 5, 2021 12:00:15 PM
Attachments: Feedback on SBOH COVID October 2021.pdf

External Email

Hello,

Please find attached comments regarding the Notifiable Conditions Rule chapter 246-101 WAC from the Department of Laboratory Medicine and Pathology at the University of Washington School of Medicine. Thank you.

-Patrick

--

Patrick Mathias, MD, PhD
Vice Chair of Clinical Operations, Department of Laboratory Medicine and Pathology
Associate Medical Director, Informatics Division
Assistant Professor
Adjunct Assistant Professor, Biomedical Informatics and Medical Education
University of Washington School of Medicine
1959 NE Pacific St. | Box 357110 | Seattle, WA 98195
pager/text: 206.416.6608 | pcm10@uw.edu

Feedback on SBOH Notifiable Condition Reporting Requirements

UW Department of Laboratory Medicine and Pathology
November 4, 2021

Summary: *The Notifiable Conditions rule, chapter 246-101 WAC introduces requirements that are not technically or operationally feasible, are misaligned with national standards and existing systems, would be extremely costly to implement, and may reduce access to COVID-19 and other laboratory testing by limiting the capacity of collection facilities and clinical laboratories.*

The reporting requirements defined in WAC 246-101, which has not taken into account earlier input provided by the professionals who are conducting the work of laboratory testing and health IT, require significant reconsideration **due to technical limitations of existing production information systems, lack of alignment with existing federal standards, and the potential for a loss in data quality imposed by requiring a range of data elements that degrade the user experience in patient-facing information systems.**

We would note that the DOH itself has pointed out the unappreciated magnitude of the task to implement these requirements and has requested a delay of enforcement until January 1, 2023. We would go further and suggest that some of the specific requirements regarding reporting of race, ethnicity, and language are sufficiently difficult to implement and so misaligned with HHS guidance and standard vocabularies for public health reporting that they should be removed or made optional. The details of the required data elements for ordering and reporting (in particular WAC 246-101-011 and WAC 246-101-225) are problematic not only technically but more importantly from an operational standpoint.

This document represents feedback from the UW Medicine Department of Laboratory Medicine and Pathology that adds to our previous concerns from earlier proposed emergency orders regarding COVID-19 testing. Our Virology laboratory is currently performing 10,000 SARS-CoV-2 PCR tests/day, or approximately 1/3 of the state's daily PCR testing. Our Department is operating or performing testing for 25 open access community testing sites across western and central Washington, with 99% of tests being resulted within 24 hours of receipt in the laboratory. A critical component of enabling rapid turnaround time has been streamlined processes around the wide variety of ordering formats that arrive in our laboratory, from manual paper orders to electronic orders received from a number of EHRs systems of our clients to streamlined community testing site orders for which patients often directly enter information. In addition to the SARS-CoV-2 testing we support, we also provide broad access to specialized infectious disease tests to hospitals and laboratories across the state, particularly for the rarer reportable diseases covered by these requirements. There are a number of specific issues among the items in WAC 246-101-011 and WAC 246-101-215 that present significant technical challenges in our setting:

- The biggest barrier to fulfilling this requirement given the systems we routinely use and interface with is the preferred language field. Preferred language is not included in federal requirements nor in practice when transmitting laboratory data, and there is no corresponding field in our laboratory information system, a relatively common commercial system, to store and use this data. While the HL7 specification does provide a location for "Primary Language" (PID15), because this field is not supported by our laboratory information system, we have no mechanism to store and communicate the data element across our electronic laboratory orders and results interfaces.
- Our laboratory information system and associated interfaces do not all currently support the transmission of multiple categories of race, which is required in WAC 246-101-011.
- The race and ethnicity definitions provided by the state do not align with the categories in common use across laboratory orders and results interfaces. Our laboratory IT group has already spent considerable effort working with multiple health systems/laboratories that send us testing to update interfaces and align reporting with commonly used federal code sets. The CDC race category and ethnicity group are the codesets commonly configured on the laboratory interfaces we build and support, and that is often based on the categories supported by the client transmitting the laboratory orders electronically. It appears that these categories are still allowed to be used but there are broader data quality concerns if capturing more granular data is a requirement. As an example, for our COVID-19 community test sites, patients perform data entry for required fields when scheduling appointments using drop down menus. There are a much larger number of options outlined in the requirement than can fit into a drop-down menu or can fit on a paper requisition and continue be useful for patients and providers, so requiring data at this granularity for every laboratory transaction will likely lead to poorer data quality in settings in which ordering occurs outside of the EHR. Even across EHRs that are capable of supporting more detailed categories, significant revisions to existing interfaces will be required if more granular reporting is required.
- There are multiple additional fields added to list for the content of laboratory reports that are not routinely transmitted over electronic laboratory orders and results interfaces that would take significant revision across each of the clients that send testing and cascade into considerable work on the originating EHR system. These could also require the addition of ask on order entry questions:
    - Pregnancy status
    - Patient's best contact telephone number
    - Medicaid status of patients less than 72 months of age (some interfaces do not transmit insurance information because it is outside of the bare minimum data required for the care and billing relationship)
    - Address where patient received care

The items above that are not routinely provided may not be collected by submitting institutions, are not defined in inbound interfaces or on existing requisitions, and may not be known at the time of order.

Most of our concerns expressed above also apply to the HHS COVID-19 reporting requirements that have been extended in this WAC, but the federal requirements recognized the capabilities of healthcare IT infrastructure and attempted to adhere to existing data standards. The requirements in the WAC do not recognize that passing data elements from physician offices or other testing facilities, through the lab, and to DOH via the electronic laboratory reporting interface (ELR) is only practical in so far as these elements can be accommodated by existing infrastructure.

Despite an earlier dialogue on similar requirements that were proposed for an emergency rule last year (and were deferred for all of the reasons discussed above), the SBOH has failed to consider feedback on costs and technical feasibility from laboratories providing a significant proportion of testing (or even, it would seem, from the team within the DOH responsible for implementing the required reporting infrastructure). We would like to make an appeal for a proper cost/benefit analysis before imposing such a significant regulatory burden. Because there is not a clear technical pathway to support some of these requirements, our teams will be diverted into generating workarounds to determine how to store and transmit data not currently supported by our information systems, as opposed to continuing their work on adding additional electronic interfaces and functionality that support the safety and care of our patients.

Rather than redistributing the effort and costs of data collection very broadly to laboratories and health care providers, we recommend investment in a public-health focused health information exchange. This strategy has been extremely successful in other states, allows unchanging demographics to be collected and shared once for each individual, and is much more flexible in the face of changing requirements.

We strongly recommend that SBOH review the planned changes to the WAC, regardless of the anticipated timeline, to incorporate the overall technical feasibility given the current health information technology landscape in which our health care providers and laboratories operate. We would also encourage a strategy of health information exchange development to manage patient-centric demographic data as opposed to increasing the burden of every laboratory testing transaction.

From: Stephen Schumacher
To: DOH WSBOH
Subject: Public comment re WAC 246-100
Date: Friday, November 5, 2021 11:35:50 AM

External Email

Dear Washington State Board of Health,

I am concerned about overreach regarding implementation of WA 246-100, particularly 246-100-070 that seems to give orders by local health officers jurisdiction over police, sheriffs, etc., so other officers could be arrested if they "fail or refuse to obey" any local health officer edict. This is especially concerning in our current time of legally-questionable mandates trampling over long-established "my body, my choice" rights. Please work to correct or rescind 246-100-070, or at least give clear instructions to local health boards that it must not be used to enforce injection mandates.

This is not just a theoretical concern. Jefferson and Clallam Counties have suffered since Sep. 2 from a local health officer inapplicably claiming "police powers" for a restaurant/bar order based on WAC 246-100-040. Yet that code just gives narrow emergency detention powers for up to 10 days over infected persons posing serious and imminent risk, but only after a long series of provisions and recourses have been exhausted - none of which pertains to or authorizes any open-ended restaurant/bar regulation.

Please safeguard our state from this kind of overreaching misuse of WAC 246-100 and direct the Jefferson and Clallam Health Officer to withdraw her ill-founded order pending legal review.

Yours truly,
Stephen Schumacher
Port Townsend, WA

--- sources ---

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fapp.leg.wa.gov%2FWAC%2Fdefault.aspx%3Fcite%3D246-100-070%26pdf%3Dtrue&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C9d6eea14129f489e450008d9a08aeb14%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C637717341499481258%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=fODquARQfic0DQI0m8OYBM8LQSLCXE3G2QDztEKeZdA%3D&reserved=0>https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fapp.leg.wa.gov%2FWAC%2Fdefault.aspx%3Fcite%3D246-100-070&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C9d6eea14129f489e450008d9a08aeb14%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C637717341499491220%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=vrQ03Ktn3DjO9%2FBdOKrte3Tt%2FwevsIHpsyry7lqSzCc%3D&reserved=0
https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fapp.leg.wa.gov%2Fwac%2Fdefault.aspx%3Fcite%3D246-100-040&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C9d6eea14129f489e450008d9a08aeb14%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C637717341499491220%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=2JFsxI%2BB81ABNMsHDWvHvH2RK%2B0DKdRnBaLq5DY8JMM%3D&reserved=0
https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fjeffersoncountypublichealth.org%2FDocumentCenter%2FView%2F12542%2F2021-92-Jefferson-Bar-and-Restaurant-Vaccination-HO-Order-Signed&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C9d6eea14129f489e450008d9a08aeb14%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C637717341499491220%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=L4o1NHNYjpgQkOgJ%2B2IzhyNbEjqMSLaRBcXrS42Uxgs%3D&reserved=0
https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fsolmaker.com%2Fpublic%2FLegalChallengesToVaccinePapersOrder-JeffersonCounty-210903.pdf&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C9d6eea14129f489e450008d9a08aeb14%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C637717341499491220%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=Oo9zgzV6zJTFQ6vOVkoYTYeo1uyQmrMI8ay%2Be9SOE48%3D&reserved=0
https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fsolmaker.com%2Fpublic%2FLegalChallengesToVaccinePapersOrder-ClallamCounty-210903.pdf&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C9d6eea14129f489e450008d9a08aeb14%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C637717341499491220%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=HAlodwujEgYd3oO1fBfpLPZXAFE1Mj1XjHuNxsW3aKk%3D&reserved=0

From:	Joe A. Kunzler
To:	DOH WSBOH
Cc:	Davis, Michelle (SBOH); DOH WSBOH; Berry, Allison (DOHi); aunthank@co.clallam.wa.us
Subject:	JAK Public Comment for 10 November 2021 WA ST Board of Health
Date:	Sunday, October 24, 2021 12:26:23 PM

External Email

24 October 2021

RE: JAK Public Comment for 10 November 2021 WA ST Board of Health Asking for Vaccine Passports

Dear Washington State Board of Health;

I want to begin by sincerely thanking you for exonerating Dr. Allison Berry of the (many adjectives) charges against her for vaccine passports and I will be quoting her a few times below, hence the CC. As you said Chair Grellner at the October State Board of Health, "The local board appoints the local health officer based upon their credentials to do the work that needs to be done in their jurisdiction. They don't direct a local health officer on a daily basis in every single thing that they do to uphold the law. … It is their (health officers') responsibility to prevent the transmission of disease."

I am asking the State Board please implement the same vaccine passport policy statewide. I now insert a Dr. Berry quotation - namely that, "The places where it is most needed to put in more stringent measures, it's the least possible to do it. Either because you're afraid you're going to get fired, or you're afraid you're going to get killed. Or both."

On such a note, I cannot directly contact my Skagit County Public Health Officer to ask him why he has *not* sought such a policy. I have reason to *suspect* the above Dr. Berry quote applies to him. In part as I have made oral public comment repeatedly to the Sedro-Woolley City Council and several times to the Skagit County Commissioners asking such a policy be considered either mandatory or that there be public health support for those businesses that *choose* to do this. I have also asked those electeds to consider sending out postcards with information where to get vaccinated. All I get is silence or dismissive responses while my Skagit County does nothing new to get our case counts down and more folks vaccinated. I also have asked repeatedly and kindly the local mailbox place to wear masks in compliance with the mask mandate to no effect. Furthermore, my Skagit County Board of Health had to put out a statement earlier this year saying they will not adopt civil penalties for defying health orders. The governance of my Skagit is seemingly held hostage by Covid19-deniers, and we even had Sedro-Woolley City Councilwoman JoEllen Kresti speak at such a rally with her stated intention to protest vaccine mandates. The good soul and high school classmate of mine later publicly regretted the misperceptions it went beyond that, somewhat but still... I want you to get a flavor of what my fellow Skagitonians are dealing with. I ask you pray my classmate be fully forgiven also, please.

This is where *in all fairness* I once again quote Dr. Allison Berry with sadness from the 21 October 2021 Jefferson County Board of Health who said, "Because of polarization in our community now, you're generally vaccinated or not." I read into that statement any efforts to ask nicely are pretty much... done, but I'm *not* Dr. Berry. I'm not smart, I'm certainly neither female nor a hero nor a country female doctor with a heart of solid gold, I don't deserve your prayers - Dr. Berry and her child do, and I'm a bit of a wimp.

Ultimately I did this weekend seriously contemplate a complaint against my own health officer due to the above; but with such statements by the best county-level health officer in the state, genuine concerns of the risk of negative interactions w/ folks plus a sense this State Board of Health would wish to not interfere with local rule-making as Chair Grellner said regarding dismissing the complaint against Dr. Berry; I'd rather just bang out my thoughts this Sunday and ask you to not look at the above as a Skagit problem *per se* but rather a statewide issue. I understand Governor Inslee is looking into adopting Dr. Berry's policies also. Washington State needs the *most aggressive* policies to get Covid19 under control and keep "crisis standards of care" outta here - and sadly there is going to be blowback. I would rather that blowback for vaccine passports be towards the state government that has some insulation and resources to protect themselves.

Very thoughtfully;

Joe A. Kunzler
growlernoise@gmail.com

P.S. I would also add that the quotes here and the decision I made come from listening to public access television. Please rest easy knowing that being on video helps inform folks like me.

From: M. Wallis
To: DOH WSBOH
Subject: Public Comments for WSBOH Members
Date: Friday, November 5, 2021 6:54:34 AM

External Email

When looking at vaccine mandates & safety protocols for K12 schools, take a close look at how sucessfully our university system has become. The current data shows that WWU has a Covid rate approximately 10x lower than surrounding high schools.

WWU has a 95% + Covid vaccination rate for students and staff due to it's recent addition to the required vaccines list. Testing is also readily available for the university community. Masking is required on campus - as it is in k12 settings.

There have been no significant disruptions to learning this semester with the full return to the WWU campus under these new protocols.

During the same time period, Lynden Christian K12 school was closed due to a major outbreak infecting much of the school community. Lynden is an area of Whatcom County that has a low vaccination rate.

The vaccine is clearly working at keeping Covid transmission out of our Washington State universities.

Thank You
Matt Wallis
Parent
Anacortes WA.

From: Molly Hauck
To: DOH WSBOH
Subject: PFAS Drinking Water Standards
Date: Wednesday, October 20, 2021 5:03:28 PM

External Email

Dear WA Board of Health WA State Board of Health,

Please move forward with adopting strong drinking water standards for PFAS. It's crucial we act now to reduce these immune-compromising toxics and follow the lead of other states that have started turning the tap off PFAS pollution. The draft rule is a positive step to begin to address PFAS in drinking water supplies, but I urge you to keep the process moving and incorporate the following recommendations into the final rule:

1. Ensure the state action levels address all PFAS. The rule should recognize that other harmful PFAS may be present in water and should establish monitoring, limits, and action requirements designed to capture as many of the large PFAS class as possible.
2. All Group A water systems should be required to test on an ongoing basis to make sure contaminated water sources are identified; the rule should not exclude important water systems such as churches, motels, or allow for waivers.
3. Since detection of any of these compounds is an indicator of the presence of other PFAS, the final rule should require that water systems take action to address all PFAS when drinking water exceeds the state action levels.
4. Finally, resources should be sought from the state legislature to support testing of other water systems and private wells and to address contamination.

Sincerely,
Molly Hauck
3900 Decatur Ave
Kensington, MD 20895

From: David Streeter
To: DOH WSBOH
Subject: Comment for November 10 Meeting Packet
Date: Friday, November 5, 2021 9:19:23 AM
Attachments: image001.png
WSHA WSBOH Comments on Notifiable Conditions.pdf

External Email

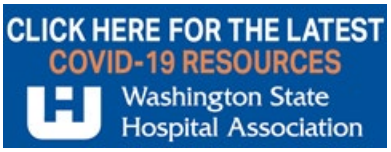
Hello,

I am writing to submit comments from the Washington State Hospital Association for inclusion in the November 10th meeting packet. I am also planning to testify to our comments during the public comment portion. Please let me know if you have any questions or would like additional information.

Thank you very much,

David Streeter

David Streeter
Policy Director, Clinical and Data
Washington State Hospital Association
999 Third Ave, Suite 1400
Seattle, WA 98104
Email: davids@wsha.org| Phone: (206) 216-2508



Washington State Hospital Association

November 5, 2021

Washington State Board of Health
PO Box 47990
Olympia, WA 98504-1990

RE: Notifiable Conditions Effective Date Delay

Dear Chair Grellner, Vice Chair Pendergrass, and Board of Health members,

On behalf of the Washington State Hospital Association, thank you for the opportunity to provide feedback on the Department of Health's (DOH) request to delay the effective date for the updated Notifiable Conditions regulations found in Chapter 246-101 WAC. WSHA strongly supports DOH's recommendation and encourages the Board to adopt the request. Doing so will provide DOH the ability to complete the technical work necessary to implement the updated Notifiable Conditions rules.

However, the steps hospitals must take to comply with the updated rules are complex and will take significant time to implement once DOH finishes its technical work. **Because of this, WSHA requests the Board provide at least a 120-day window between the completion date for DOH's information technology updates and the date hospitals begin reporting.**

Once DOH finishes its technical work, hospitals will need time to adapt to DOH's new systems and forms. Hospitals will need to update their registration systems to collect the new patient demographic information to complete the new case report forms DOH issue. Hospitals will also need to integrate the new data elements into their electronic health record (EHR) systems to ensure proper information input and storage. Doing so will require many hospitals to work with their external EHR vendors to complete the system updates, which could add time to compliance preparations. EHR updates also require staff training to ensure proper data entry. Additionally, hospitals will need to adjust their workflows to ensure that the newly required data is transferred efficiently between departments, such as laboratories and infection control departments.

Providing additional time to hospitals will help ensure that hospitals are fully prepared to report in accordance with the new systems and forms established by DOH. This can help prevent incomplete and inaccurate data submissions to DOH and local health jurisdictions, which will ensure that the data collected by state and local agencies is useful for responding to public health issues.

Thank you again for the opportunity to comment on DOH's recommendation to the Board. Should you have additional questions on WSHA's recommendations, please contact David Streeter, DavidS@wsha.org or Chelene Whiteaker, CheleneW@wsha.org.

Sincerely,

Chelene Whiteaker
Senior Vice President, Government Affairs
Washington State Hospital Association

David Streeter
Policy Director, Clinical and Data
Washington State Hospital Association

(206) 216-2533
CheleneW@wsha.org

(206) 216-2508
davids@wsha.org

From: Kohl-Welles, Jeanne

To: Baker, David-Board of Health; bdaniell@uw.edu; chris.delecki@seattlechildrens.org; Zahilay, Girmay; Levy, Susan (Susie); susan.honda@cityoffederalway.com; debora.juarez@seattle.gov; Kohl-Welles, Jeanne; Lambert, Kathy; krystalm@burienwa.gov; McDermott, Joe (DOHi); teresa.mosqueda@seattle.gov; butchdec@uw.edu; Lorena.gonzalez@seattle.gov; Andrew.lewis@seattle.gov; Tammy.morales@seattle.gov; Zahn, Janice; Worsham, Dennis (DOHi); Allende, Angel; Apa, James (DOHi); bcwitold@aol.com; blconnection@hotmail.com; Braddock, Shannon; Burkland, Anne (DOHi); Burrows, Elaida; Chatalas, Helen; Cihak, Carrie; Coleman, Alan; Costello, Heidi-Shoreline; coomwa@outlook.com; danbent@ymail.com; ddequier@msn.com; dlessler@u.washington.edu; dougfarr@gmail.com; Duchin, Jeffery, MD (DOHi); enick5@uw.edu; ericboutin@msn.com; Evans, Elizabeth; edie.gilliss@seattle.gov; Hill, Kimberly; Holbrook, Garrett; Ing, Jeff; Isaacson, Mari; Janelle Okorogu; jeudiboulom@yahoo.com; jstuber@uw.edu; Karasz, Hilary (DOHi); Larson, Jonathan; manager@sfmamarkets.com; sue.meyer@seattle.gov; onehotpearl@hotmail.com; Plorde, Michele (DOHi); Ritzen, Bruce; Nina Rivkin; Ro, Marguerite (DOHi); rozsolo@comcast.net; Russillo, Christine; Sanchez, Kristie; Shurtleff, David; Scappini, Stephanie; Schaeffer, Cyndi (DOHi); Schneiderman, Howard; Soohoo, Wendy; Starr, Brian-KCTV; sugahlove22@hotmail.com; bryndel.swift@seattle.gov; brianna.thomas@seattle.gov; tuffidolan@yahoo.com; Valenzuela, Matias; DOH WSBOH; Welyczko, Roman; Wysen, Kirsten; soskateg@gmail.com; hilaryagodwin@gmail.com; helenn@3wmedical.org; dennis@dsbarnes.com; Porter, Samantha; Santiago Pastrana, Tania; Gutierrez-perez, Lorena; Fowler, Jonathan; Goff, Tom; Alexis Rinck; Faride.cuevas@seattle.gov; Hannah.Smith@seattle.gov; Sakuma, Jeff; Lewis, Rhonda; Manahan, Clara; Nguyen, Lan (DOHi); Posielski, Aleks; Alexis.Turla@seattle.gov; Yasmin.ali@seattle.gov; Herzer, Pascal; vgrayland@earthlink.net; Hali@SoundCities.org; Pedroza, Melani

Subject: Bike Helmet Materials and Lit Review

Date: Wednesday, November 3, 2021 12:20:37 PM

Attachments: Staff Report_Bike Helmet Policy Options.doc
Bike Helmet Lit Review_11.1.21.docx
Helmet law letter to the King County Board of Health.pdf
Rationale for recommendations on the King County bicycle helmet mandate.pdf

---

External Email

Board Members and Staff, included in this email are some attachments and a link related to our discussions on the proposed helmet law repeal and accompanying resolution that we discussed at our October 21st Board meeting and at which we deferred final action to an upcoming Board meeting. As you likely know, I was the member to offer an amendment to our 2021 Work Plan at our February meeting to take up the important issue of disproportionate enforcement of the helmet law. I also was one of the members who spoke in opposition to taking final action on repeal at our last meeting. My main concern was believing that repeal could send a very negative message with the potential for unanticipated consequences occurring and that we should be sure to make as an informed decision as possible in getting it right. I strongly believe we should focus on both safety and equity. I had felt we were boxing ourselves in to a decision based on a false dichotomy without having accessed all applicable information on the issues involved.

I have been meeting with various groups, which likely some of you have been doing as well, including with one involving health care professionals, researchers and attorneys and one involving advocates for bicycling, safe streets, the environmental, and social services. The common denominator of all has been the unwavering beliefs that helmets help save lives and serious injuries, that there is disproportionate enforcement, and that bicycling should be encouraged, not discouraged, for individual and public health and environmental purposes. There also seems to be near agreement on the need to provide infrastructure that would accommodate safe bicycling.

To gain additional relevant research findings through perusal of citations, I had one of my staff, Clara Manahan, conduct a non-exhaustive but well-done search under severe time constraints with other work obligations last Thursday. Her summary is found in the attachment “Bike Helmet Lit Review…

For the most part she did not include citations included in the two PDF attachments "Helmet law letter to the King County Board of Health" and the "Rationale for recommendations on the King County bicycle helmet mandate." Both were sent to us earlier from the external helmet working group. Also included is an attachment is our excellent BOH "Staff Report on Bike Helmet Policy Options" presented to the Board at our Sep. 16th BOH meeting. Included as well is a link to our June 15 Board of Health meeting which includes the panel we had on this issue (see below).

I believe we all want to make an informed decision and I hope these materials I'm providing here will be of help to you. I encourage in particular to read Clara's lit review as it will be new to you.

June Board of Health Meeting: http://king.granicus.com/MediaPlayer.php?view_id=4&clip_id=8825

Thank you for continuing to address this important issue as we work on our next steps forward.

Jeanne

Councilmember Jeanne Kohl-Welles
Metropolitan King County Council, District Four
www.kingcounty.gov/kohl-welles
p: (206) 477-1004 Sign up for my twice-weekly COVID-19 eNews,
Facebook, Twitter, Blog

May 27, 2021

To members of the King County Board of Health:

We are writing as a coalition of transportation and homeless advocates who have been examining the King County bicycle helmet law since July of last year. Thank you for your responsiveness to the concerns that we and other community members have raised about the disparate impact of the law. We are particularly grateful to King County Councilmember Kohl-Welles for introducing an amendment committing the Board of Health to review the helmet law this year, and to all the board members whose thoughtful discussion and unanimous vote resulted in adoption of the work plan amendment in February.

While the King County helmet law was implemented with the best of intentions almost three decades ago, we must recognize that its impacts have been far from equitable.

- In Seattle, nearly half of all helmet citations since 2017 were issued to people experiencing homelessness. Since 2003, Black cyclists in Seattle have received citations at a rate 3.8 times higher, Indigenous cyclists 2.2 times higher, and Hispanic/Latino cyclists 1.4 times higher than white cyclists. Differences in helmet use between populations cannot explain these disparities.
- This situation is strongly suggestive of biased enforcement by police, which raises concerns beyond those merely associated with disparate impact of the law. Elsewhere in the country, police have been found to disproportionately stop cyclists of color on a pretextual basis, that is, for the purpose of investigating for criminal activity. The helmet law has been used to effect pretextual stops in Seattle, contrary to its intended purpose.
- Minor traffic stops of those riding bikes can be traumatic, and in other cities have led to instances of inappropriate use of force against cyclists and fatal police shootings.
- We have heard stories from homeless community members and people of color, including youth, who were stopped by police for helmet violations in King County and felt harassed, singled out, frightened, intimidated, and discouraged from riding.
- As you may be aware, these concerns have led the Seattle Office of Inspector General to initiate an audit of the Seattle Police Department's helmet citation practices, which is ongoing.

Your body, the Board of Health, has declared racism a public health crisis. We call on you to act swiftly to remove the potential for inequitable impacts of the helmet law by race and housing status. We do not dispute the efficacy of helmets for individuals in crashes, but as discussed below in this letter, we believe that the totality of evidence indicates that our local helmet law offers, at best, negligible benefits for injury prevention. At the same time, the law has opened the door to biased policing and, with it, the possibility for acute harm to be inflicted on vulnerable community members.

Based on this holistic public health view, we urge the Board of Health to fully repeal the helmet law for both adults and youth. Additionally:

- We oppose options that would fall short of preventing dangerous police interactions and ending punitive, armed enforcement, such as reducing fines, authorizing warnings but not citations, downgrading the violation to a secondary offense, or limiting the mandate to youth only.

- If preserving the helmet mandate is regarded as essential, we ask that the current Board of Health Code Title 9 language be revised to explicitly disallow enforcement, similar to Seattle & King County Public Health's COVID-19 mask mandate.

- We recommend the addition of a clause to Title 9 that would prevent a negligent party in a crash from escaping responsibility for their own negligence by blaming a cyclist for not wearing a helmet, similar to Oregon (ORS 814.489) and New York (VAT §1238.7) state law. This would place the responsibility for injuries where it belongs, on the party responsible for the crash.

- We encourage Public Health to increase access to helmets within homeless and low-income populations by expanding existing efforts or establishing a new program to provide subsidized or free helmets at bike shops, homeless service providers and shelters, and community centers.

- We support promotion of helmet use through a renewed public education campaign, as long as such a campaign does not exaggerate the protective effects of helmet use or the risk associated with bicycling.

- We urge Seattle & King County Public Health to recognize that motor vehicles pose the greatest threat to cyclist safety, and to focus on interventions that are vastly more effective than helmet mandates at preventing injuries for bicyclists, pedestrians, and all road users, such as reduced vehicle speeds and safer infrastructure. We ask that the Board of Health commit to researching and discussing these strategies in their 2022 work plan.

To learn about the rationale behind these recommendations, we invite you to read our Q&A companion document (https://tinyurl.com/KC-helmet-law-rationale), which details the extensive research, outreach, and discussion that our coalition, the Helmet Law Working Group, has engaged in since July of last year. The following summarizes a few key points:

- Our call for repeal is consistent with opposition to mandatory helmet laws from transportation professional groups, including the National Association of City Transportation Officials (NACTO) and the Association of Pedestrian and Bicycle Professionals (APBP).

- Published meta-analyses of dozens of studies indicate that bicycle helmets reduce the risk of head injury by around 50% in hospitalization incidents. Some jurisdictions that passed helmet mandates in the 1990s saw increases in helmet use and reductions in head injuries. However, the most rigorous, relevant, and recent studies have found that **helmet mandates contribute minimally to lowering overall rates of head injuries**.

- While the available evidence on the effectiveness of the King County helmet law is limited, a study by Seattle & King County Public Health researchers found that the extension of King County's helmet law to Seattle in 2003 had minimal impact on helmet use and head injuries. This

and other evidence suggest that repeal of the helmet law would have minimal or negligible impact on injury prevention goals. We believe that the benefits of the current helmet law, if any, could be captured through other strategies for increasing helmet use and reducing collisions.

- Enactment of helmet mandates has reduced bicycle ridership in some locales, likely with negative impacts to population health, though the magnitudes of these effects are uncertain.
- We note that about one-third of King County's population lives in cities or towns with municipal helmet laws that would be unaffected by modification or repeal of the county helmet law.
- Over 400 responses to a survey distributed by our group suggest that there is broad support in our local bicycling community for modification or repeal of the helmet law.

We thank you for your attention to this important issue and your consideration of our recommendations.

Sincerely,
The Helmet Law Working Group and additional signatories of this letter

---

Helmet Law Working Group

Central Seattle Greenways (http://centralseattlegreenways.com/racial-equity/)
Brie Gyncild and David Seater, co-leaders (centralseattlegreenways@gmail.com)

Real Change (https://www.realchangenews.org/about)
Tiffani McCoy, Advocacy Director (tiffanim@realchangenews.org)
Jacob Schear, Advocacy Organizer (jacobs@realchangenews.org)

Cascade Bicycle Club (https://cascade.org/about/commitment-anti-racism)
Tamar Shuhendler, Community Organizer (tamars@cascadebicycleclub.org)

Other working group members*:
Alexander Lew, affiliated with Seattle Bicycle Advisory Board and the Whose Streets? Our Streets! working group
Bob Svercl, affiliated with Rainier Valley Greenways-Safe Streets and Beacon Hill Safe Streets
Brett Youngstrom, affiliated with Central Seattle Greenways
Brock Howell, affiliated with Green Lake & Wallingford Safe Streets
Christopher Hoffman, affiliated with Central Seattle Greenways
Emily Davis, affiliated with Central Seattle Greenways and Seattle Pedestrian Advisory Board
Ethan C. Campbell, affiliated with Central Seattle Greenways
Ian Crozier, affiliated with Central Seattle Greenways
Jack Lynch, affiliated with Central Seattle Greenways
Joseph Roberts, affiliated with Central Seattle Greenways and Cascade Bicycle Club
Kian Flynn, affiliated with Central Seattle Greenways
Laura Felice, affiliated with Rainier Valley Greenways-Safe Streets
Robert Getch, chair of Beacon Hill Safe Streets

** Titles and affiliations are for informational purposes only. Unless the organization is itself a member of the Helmet Law Working Group, members represent themselves as individuals and not the organizations they are affiliated with.*

Recommendations endorsed by:

Other organizations:

Whose Streets? Our Streets! Working Group

Pinehurst Greenways (Seattle, WA)

Individuals*:

Isaac Joy, Seattle, WA (President, King County Equity Now)

Charles T. Brown (founder and CEO of Equitable Cities LLC)

Mike Hua, Seattle, WA (affiliated with Central Seattle Greenways)

Graham Golbuff, Seattle, WA (affiliated with Beacon Hill Safe Streets)

Mimi Boothby, Seattle, WA (affiliated with Seattle Randonneurs)

Paul Tolme, Seattle, WA (affiliated with Cascade Bicycle Club and Washington Bikes)

Scott McKinley, Seattle, WA (affiliated with Sportworks Northwest, Inc.)

Sally Norred, Redmond, WA (affiliated with Apptio)

Brian Pratt, Seattle, WA (member of Cascade Bicycle Club)

Peter Hallson, Edmonds, WA (member of Edmonds Bicycle Advocacy Group)

Casey Gifford, Seattle, WA (Board of Directors, Cascade Bicycle Club)

Andrea Learned, Seattle, WA (founder of #Bikes4Climate)

Hank Landau, Woodway, WA (member of Edmonds Bicycle Advocacy Group)

Andrew Reding, Bellingham, WA (Senior Fellow, World Policy Institute)

Alex Brennan, Seattle, WA (Executive Director, Futurewise)

Daigoro Toyama, Seattle, WA (leader of Pinehurst Greenways)

Margaret H., Seattle, WA (Precinct Committee Officer, 43rd Legislative District)

Merlin R. Rainwater, Seattle, WA (affiliated with Central Seattle Greenways)

Dr. Amber D. Marcu, Redmond, WA (member of Cascade Bicycle Club, Adventure Cycling Association, Rails-to-Trails Conservancy)

Matthew D. Bates, Seattle, WA (affiliated with Beacon Hill Safe Streets)

Andy Schwartzmeyer, Seattle, WA (member of Transit Riders Union)

Cliff Mountjoy-Venning, Seattle, WA (affiliated with Central Seattle Greenways)

Jason Rock, Seattle, WA (member of Rainier Valley Greenways-Safe Streets)

Joe Thompson, Seattle, WA

Maimoona Rahim, Seattle, WA

Clara Cantor, Seattle, WA

Reed Olsen, Seattle, WA

Jean Amick, Seattle, WA

Alex Schaefer, Seattle, WA

Ben Braudrick, Port Angeles, WA

Ches, Richland, WA

Matthew J. Clark, Seattle, WA

Brian Knollenberg, Seattle, WA

Sven Freitag, Seattle, WA

Eileen Reichert, ARNP, Seattle, WA

Fred Escher, Bellingham, WA

Apurva Mishra, Seattle, WA

Greg Palmer, Seattle, WA

Matthew H., Seattle, WA

Alex W., Seattle, WA

Nhan Nguyen, Seattle, WA

Arun Ganti, Seattle, WA

Paul Quinn, Sammamish, WA

Devin Wakefield, Seattle, WA

Sarah Saviskas, Seattle, WA

Jacob Lee, Seattle, WA

Beth Fuget, Seattle, WA

Ashley MacDuff, Seattle, WA

Oliver Norred, Seattle, WA

Demian Godon, Seattle, WA

Eric J. Hull, Seattle, WA

Scott Bonjukian, Seattle, WA

Quinton R., Seattle, WA

Eric McDougall, Seattle, WA

Ben Conway, Seattle, WA

David Reeves, Seattle, WA

Jeff Aurand, Shoreline, WA

Harold Pratt, Seattle, WA

David Winiecki, White Center, WA

Rebeckah Johnson, Seattle, WA

Sarah V., Seattle, WA

Solomon Wagner, Seattle, WA

Marike Van Denend, Bremerton, WA

Kevin O'Neill, Seattle, WA

Robin Wilder, Seattle, WA

Conrad M., Seattle, WA

Dylan Glosecki, Seattle, WA

James Harris, Bellevue, WA

Beck Wren, Seattle, WA

Rich Brown, Seattle, WA

Naomi Smith, Seattle, WA

Jacob C., Seattle, WA

Brian Almdale, Seattle, WA

Jon Gould, Seattle, WA

Colleen Kinross, Seattle, WA

John Russell, Portland, OR

Steve Garland, Bozeman, MT

** Titles and affiliations are for informational purposes only. Unless the organization is itself a member of the Helmet Law Working Group, endorsers represent themselves as individuals and not the organizations they are affiliated with.*

Use this form to add your name or organization to the list of endorsements:
https://tinyurl.com/helmet-law-letter-endorsements

This document is accessible at:
https://tinyurl.com/KC-helmet-law-letter

Rationale for recommendations on the King County bicycle helmet mandate (Board of Health Code Title 9)

The Helmet Law Working Group[1]

Table of contents

---

[1] The Helmet Law Working Group includes Central Seattle Greenways, Real Change, Cascade Bicycle Club, and members of other groups. For more information and a list of members, see our letter to the King County Board of Health at http://tinyurl.com/KC-helmet-law-letter. This Q&A document is accessible at https://tinyurl.com/KC-helmet-law-rationale and was last updated on October 19, 2021. Research findings presented within this document should be considered preliminary and subject to change. This document is best viewed using the Google Chrome browser.

How did we develop these findings and recommendations?

Amid calls for racial justice last summer, members of Central Seattle Greenways' Racial Equity Committee[2] discussed the importance of keeping all community members safe on our streets in ways that have been too often neglected by the transportation community. In July 2020, members of Central Seattle Greenways decided to investigate whether racial disparities exist in police stops of cyclists in Seattle, including for enforcement of the King County bicycle helmet law. Later that year, police body-worn video obtained by Real Change[3] showed a homeless Real Change vendor mocked and cited by police for not wearing a helmet after being injured in a collision with a car[4]. This event, as well as the research and reporting on disparities in enforcement described below, led the board of directors of Cascade Bicycle Club[5], the nation's largest statewide bicycle organization, to approve a policy position calling for the repeal of the King County helmet law. The Helmet Law Working Group was formed by members of these three organizations, Central Seattle Greenways, Real Change, and Cascade Bicycle Club, as well as individuals from other transportation and equity-focused groups.

Our working group has held ten meetings between September 2020 and May 2021 and has exchanged hundreds of emails. We studied media reports, academic research, and other literature on helmets, helmet legislation, and the disparate impacts of police enforcement within a variety of contexts. We filed public records requests with eight municipal courts within King County as well as the Seattle Police Department, University of Washington Police Department, King County Sheriff's Office, and the Washington State Administrative Office of the Courts; some of these records requests are still pending. The records we obtained allowed us to conduct an analysis of racial disparities in helmet citations from Seattle (as well as other bicycle-related infractions), which is described in a preliminary technical report[6].

In addition to listening to concerns about helmet law enforcement raised by Real Change vendors, who are experiencing homelessness, our group has conducted extensive public outreach using a Google Form survey that has received over 400 responses[7]. Our goal has been to hear from community members about their experiences with police enforcement while biking and their thoughts about the future of the helmet law. Over a dozen transportation and equity-focused organizations distributed our survey to their membership or boards through email lists. We created flyers that linked to our survey using a QR code and also provided a phone number to contact. We posted these flyers at over a hundred public locations across the Capitol Hill, Central District, Chinatown-International District, SODO, Beacon Hill, and Rainier Valley neighborhoods of Seattle, within the Real Change building in Pioneer Square, at Seattle Neighborhood Greenways' table during an SDOT closure of Lake Washington Boulevard in April 2021, and at a Central Seattle Greenways table near Bailey Gatzert Elementary School during Bike Everywhere Day in May 2021. A summary of survey responses is provided below.

---

[2] Central Seattle Greenways (CSG) is a safe streets advocacy organization whose mission is to make it safer and more comfortable for people to walk, roll, bike, and live in the Central District and Capitol Hill neighborhoods of Seattle. CSG recognizes that this goal can be achieved only by including the needs and experiences of people of all races and ethnicities in our work. For more details, see http://centralseattlegreenways.com/racial-equity/. CSG is a member organization of the Seattle Neighborhood Greenways coalition.

[3] Real Change exists to provide opportunity and a voice to low-income and homeless people while taking action for economic, social and racial justice. For more details, see https://www.realchangenews.org/about.

[4] Tom Fucoloro, "Watch: Person driving injures a biking Real Change vendor, then SPD mocks and blames the victim," *Seattle Bike Blog* (November 13, 2020), https://www.seattlebikeblog.com/2020/11/13/watch-person-driving-injures-a-biking-real-change-vendor-then-spd-mocks-and-blames-the-victim/.

[5] Cascade Bicycle Club recognizes that anti-racism in bicycling matters. Cascade is committed to transforming from being a bicycling club working to diversify itself to one that, through bicycling, works to eliminate inequities in community health outcomes and in mobility and transportation access. For more information, see https://cascade.org/about/commitment-anti-racism.

[6] Ethan C. Campbell, "Technical report on bicycle infractions in Seattle (2003-2020): Methodology and preliminary findings on racial disparities" (last updated March 1, 2021), https://tinyurl.com/Seattle-bicycle-infractions.

[7] Our survey remains open and is accessible at http://tinyurl.com/KC-helmet-law-survey.

Our group also hosted two open listening sessions, to which we invited survey respondents who had expressed an interest in sharing more thoughts with us. We have discussed our advocacy effort and research findings in two public meetings with the Seattle Bicycle Advisory Board, a meeting with staff from Seattle's Office of Inspector General, over a dozen meetings with elected officials on the King County Board of Health and their staff, and informal conversations with leaders in our local bicycling and transportation advocacy communities.

What do we know about disparities in police interactions with users of our transportation system?

Our group first studied the larger context of equity concerns around police stops of drivers, pedestrians, and cyclists. In our reading, we found the following:

- The Seattle Police Monitor conducted an extensive assessment in 2017 of investigatory stops and detentions of drivers and pedestrians by Seattle police, which are known as "Terry stops" after the 1968 case *Terry v. Ohio*[8]. The Monitoring Team found that **Black drivers and pedestrians are stopped at a rate about four times higher than their share of the Seattle population**, and reached the following conclusions: "[The] racial disparity with respect to who is stopped and who is frisked in Seattle cannot be easily explained in terms of underlying societal or social disparities in crime, demographics, or socioeconomic factors manifesting in neighborhood or geographic trends. Even after incorporating those factors, an individual's race alone helps to predict the likelihood of being stopped and the likelihood of being frisked by an SPD officer." Yet the report found that minority subjects were less likely to be found with a weapon and just as likely as white subjects to be found with a firearm.

- A *Seattle Times* report found that **26.1% of jaywalking tickets in Seattle were issued to Black pedestrians from 2011-2015, despite their share of the population being 7.1%**[9]. This represents a risk ratio of 3.7x, or 4.4x compared to white pedestrians. Racial disparities of comparable magnitude identified elsewhere in jaywalking citations have resulted in Virginia decriminalizing jaywalking in March 2021 and California, Texas, and Kansas City advancing legislation that may repeal jaywalking statutes in those locales[10].

- **Stark racial disparities have been identified in police stops of cyclists around the country**, including in Oakland, CA, Washington D.C.[11], and Tampa, FL[12], with Black cyclists being stopped at 5-10 times the rate of white cyclists in these cities. In Minneapolis, MN, police stops of Black cyclists result in incident or

[8] "Tenth Systemic Assessment: Stops, search, and seizure," Seattle Police Monitor (June 2017), https://static1.squarespace.com/static/5425b9f0e4b0d66352331e0e/t/59473ca3b3db2bc40ddf8a6c/1497840805898/Dkt.+394--Stops+Assessment.pdf.

[9] Gene Balk, "Seattle police writing fewer jaywalking tickets, but high rate still issued to black pedestrians," *Seattle Times* (July 20, 2017), https://www.seattletimes.com/seattle-news/data/seattle-police-are-writing-fewer-jaywalking-tickets-but-high-rate-still-issued-to-black-pedestrians/.

[10] Kea Wilson, "How (and why!) to repeal 'jaywalking' laws," *Streetsblog USA* (May 5, 2021), https://usa.streetsblog.org/2021/05/05/how-and-why-to-repeal-jaywalking-laws/.

[11] Dan Roe, "Black cyclists are stopped more often than whites, police data shows," *Bicycling* (July 27, 2020), https://www.bicycling.com/culture/a33383540/cycling-while-black-police/.

[12] Greg Ridgeway et al., "An examination of racial disparities in bicycle stops and citations made by the Tampa Police Department: A technical assistance report," U.S. Department of Justice Office of Community Oriented Policing Services (2016), https://www.tampa.gov/document/report-23341.

arrest reports at over four times the rate of white cyclists[13]. Other reports have found that tickets are more frequently issued to cyclists in minority neighborhoods of Chicago, IL[14], Dallas, TX[15], and New York, NY[16], suggesting that disproportionate police stops and ticketing of cyclists of color are widespread in the United States, if not yet rigorously quantified.

- The analysis of police stops of cyclists in Oakland, CA, Washington, DC, and New Orleans, LA[17] also demonstrated that **Black cyclists are stopped substantially more frequently than white cyclists on the basis of suspicion and probable cause** (so-called "pretextual stops"), and the data from Oakland, CA show that Black riders are subject to searches and arrests far more often (by a factor of 3.3) than white riders.

- **In Tacoma, of the 11 helmet citations in 2019 for which records are available, 45% were issued to Black men (who make up approximately 5% of Tacoma's population)**[18]. Tacoma repealed its helmet law in July 2020 in part due to concerns over racial disparities in enforcement[19].

- A recent People for Bikes report on barriers to cycling in the U.S. conducted focus groups in 10 cities[20]. **The majority of focus group participants, and particularly Black and Hispanic participants, did not view the police as an effective partner in bicycle safety education and enforcement.** Participants expressed fear and distrust of police due to past experiences with racial profiling and police harassment, police shootings in Black communities, and immigration policies that affect Hispanic communities. One focus group member from Tucson said, "We are being questioned on status… they are there to just criminalize us and over-police us. Even when our kids are on bikes, they get hassled by the cops." These experiences match those from past research that found that **racial profiling of Black and Latino cyclists is a "silent barrier" to biking**[21], with 23% of Black cyclists in a survey of New Jersey communities reporting having been unfairly stopped by a police officer while biking[22].

- **Police stops of Black and Latino cyclists have led to tragic incidents.** In August 2020, Dijon Kizzee was shot 16 times and killed by deputies in Los Angeles after being stopped on his bike for a minor traffic infraction[23]. This was not an isolated incident. Reporting by the *Los Angeles Times* has identified 15 other stops of cyclists in L.A. County that led to police shootings, 11 of which were fatal, all suffered by male

---

[13] Melody Hoffmann and Anneka Kmiecik, "Bicycle citations and related arrests in Minneapolis, 2009-2015," *Minneapolis Bicycle Coalition* (October 2016), https://www.ourstreetsmpls.org/citationreport.

[14] Mary Wisniewski, "'Biking while black': Chicago minority areas see the most bike tickets", *Chicago Tribune* (March 17, 2017), https://www.chicagotribune.com/news/breaking/ct-chicago-bike-tickets-minorities-0319-20170317-story.html.

[15] Tom Benning, "With Dallas bike helmet law, rules of the ride enforced unevenly," *Dallas Morning News* (June 3, 2014), https://www.dallasnews.com/news/2014/06/04/with-dallas-bike-helmet-law-rules-of-the-ride-enforced-unevenly/.

[16] Irene Chidinma Nwoye, "Cycling on the sidewalk: the new stop-and-frisk?," *The Village Voice* (October 30, 2014), https://www.villagevoice.com/2014/10/30/cycling-on-the-sidewalk-the-new-stop-and-frisk/.

[17] Dan Roe, "Black cyclists are stopped more often than whites...," *Bicycling.* As above.

[18] Liz Kaster (City of Tacoma), personal communication with Tamar Shuhendler, April 14, 2021.

[19] Allison Needles, "Bicycling without a helmet? You can do that in Tacoma now," *The News Tribune* (July 4, 2020), https://www.thenewstribune.com/news/local/article243960367.html.

[20] "Where do we go from here? Breaking down barriers to bicycling in the U.S.," People for Bikes (2021), p. 39-40, https://www.peopleforbikes.org/reports/where-do-we-go-from-here-breaking-down-barriers-to.

[21] Stefani Cox and Charles Brown, "Silent barriers to bicycling, part III: Racial profiling of the Black and Latino community," *Better Bike Share* (March 3, 2017), https://betterbikeshare.org/2017/03/03/silent-barriers-bicycling-part-iii-racial-profiling-black-latino-community.

[22] Brown et al., "Understanding barriers to bicycle access and use in Black and Hispanic communities in New Jersey," Alan M. Voorhees Transportation Center, Rutgers University (November 2017), http://njbikeped.org/portfolio/barriers-to-bicycle-access-use-in-black-and-hispanic-communities-2016/.

[23] Alene Tchekmedyian, "Sheriff adds details to Dijon Kizzee shooting; says deputies stopped him for riding on wrong side of street," *Los Angeles Times* (September 17, 2020), https://www.latimes.com/california/story/2020-09-17/sheriff-dijon-kizzee-shooting.

and Black or Latino cyclists[24]. In Las Vegas, after being stopped for riding without a light, Byron Williams was killed by police while saying "I can't breathe" 17 times[25]. Closer to home, in Tacoma, 15-year-old Monique Tillman and her brother were stopped by a police officer while biking without helmets[26]. In an incident that resulted in legal expenses of $1M paid by the city of Tacoma, the officer grabbed Tillman by her hair, tossed her around "like a child's doll," threw her to the pavement, then tased and arrested her.

- **Out of the 37 largest U.S. cities, Seattle is ranked 2nd in Black-white disparities in per-capita arrests and is ranked 8th in Black-white disparities in per-capita police killings**[27]. Out of over 200 police departments in Washington assessed by the Police Scorecard Project[28], the Seattle Police Department scores third-worst on an aggregate metric taking into account its use of force, accountability, funding (including funds spent on misconduct settlements), and other outcomes. Out of the 500 police departments nationwide with the most policing data available, the Seattle Police Department scores 487th on this aggregate metric. In this ranking, only one King County city or town scores above the nationwide median (Renton PD, at 220th). Four other King County cities are below the median – Kirkland PD, ranked at 416; Kent PD at 396; Auburn PD at 300; and Federal Way PD at 251.

- **While no police stops of cyclists in King County have, to our knowledge, resulted in a fatal incident, we worry that it is only a matter of time before one occurs.**

[24] Nicole Santa Cruz and Alene Tchekmedyian, "Deputies killed Dijon Kizzee after a bike stop. We found 15 similar law enforcement shootings, many fatal," *Los Angeles Times* (October 16, 2020), https://www.latimes.com/california/story/2020-10-16/examining-dijon-kizzee-bike-stop-police-shootings.

[25] Anita Hassan, "When Byron Williams died saying 'I can't breathe,' few protested. Now his family is fighting for justice," *NBC News* (June 18, 2020), https://www.nbcnews.com/news/us-news/when-byron-williams-died-saying-i-can-t-breathe-few-n1231342.

[26] Christine Clarridge, "Teen tossed 'like a child's doll' by Tacoma cop awarded $500,000," *Seattle Times* (March 23, 2018), https://www.seattletimes.com/seattle-news/crime/teen-tossed-like-a-childs-doll-by-tacoma-cop-awarded-500k/.

[27] Samuel Sinyangwe, "The police departments with the biggest racial disparities in arrests and killings," *FiveThirtyEight* (February 4, 2021), https://fivethirtyeight.com/features/the-biden-administration-wants-to-address-racial-bias-in-policing-what-cities-should-it-investigate/.

[28] "Seattle Police Department," Police Scorecard Project (accessed May 15, 2021), https://policescorecard.org/wa/police-department/seattle.

Are helmets effective at preventing injuries?

Yes. Studies have overwhelmingly shown that bicycle helmets are effective at reducing the risk of head injuries. We look to systematic reviews of the literature, rather than individual studies, for best estimates of helmet efficacy, since different methodologies and sample populations in case-control studies have resulted in a variety of estimates. The following summarizes the conclusions of the two most recent meta-analyses on this subject, which have been widely cited in the academic literature and were regarded by a publication this year as the "best available evidence" on the efficacy of bicycle helmets[29]:

- Olivier and Creighton (2016)[30] analyze 40 studies and find that helmet use is associated with a 51% reduction in the likelihood of head injury, a 69% reduction in the likelihood of serious head injury, and a 65% reduction in the likelihood of fatal head injury.

- Høye (2018a)[31] reviews 55 studies and finds that helmet use is associated with a 48% reduction in the likelihood of head injury, a 60% reduction in the likelihood of serious head injury, and a 34% reduction in death associated with cycling.

These results indicate that helmets are effective at reducing the risk of head injury by about half in hospitalization incidents. From this, two conclusions naturally follow: (1) helmet use is valuable as a mode of injury prevention and should be encouraged, promoted, and incentivized for the safety of cyclists; and (2) other strategies that prevent crashes from occurring in the first place should also be emphasized. Helmets are particularly effective in single-vehicle crashes, such as when a cyclist falls off a bicycle or hits an obstacle[32]. On the other hand, the vast majority of cyclist fatalities that do occur in the U.S. are a result of motor vehicle collisions[33], situations in which helmets are less effective at preventing injury. A study of 119 autopsy reports of cyclists[34] concluded, for example, that 44 of the cyclists (37%) could have survived if they were wearing helmets. Helmets would not have helped cyclists survive in the majority of collisions with motor vehicles, which represent about half (54, or 46%) of the deaths studied. The authors state:

> *"**This study concludes that cyclists should wear helmets**, but they should also be aware that it cannot protect them in particular situations. These facts should be incorporated into safety campaigns to prevent cyclists from feeling protected in such situations when helmets cannot help. Our results also support the building of cycling paths separate from traffic, particularly outside of urban areas."* (emphasis added)

[29] Elvik, "Ch. 4: Cycling safety," in Buehler and Pucher, eds., "Cycling for sustainable cities" (2021), MIT Press.

[30] Olivier and Creighton, "Bicycle injuries and helmet use: a systematic review and meta-analysis," *International Journal of Epidemiology* (2016), 46(1), 278–292, https://academic.oup.com/ije/article/46/1/278/2617198.

[31] Høye, "Bicycle helmets – To wear or not to wear? A meta-analysis of the effects of bicycle helmets on injuries," *Accident Analysis & Prevention* (2018a), 117, 85–97, https://www.sciencedirect.com/science/article/pii/S0001457518301301.

[32] Bíl et al., "Cycling fatalities: When a helmet is useless and when it might save your life," *Safety Science* (2018), 105, 71–76, https://www.sciencedirect.com/science/article/pii/S0925753517302059.

[33] "Every bicyclist counts: A memorial to cyclists by the League of American Bicyclists," League of American Bicyclists (May 2014), https://bikeleague.org/sites/default/files/EBC_report_final.pdf.

[34] Bíl et al. (2018). As above.

Are helmet laws effective at increasing helmet use?

Not necessarily. While there is limited contemporary research on this subject, the available evidence suggests that rates of helmet use in Seattle today are minimally related to the presence of an all-ages helmet mandate.

To start, few studies exist on the *present-day* impact of mandatory helmet laws in a North American context, and particularly on the impact of all-ages helmet laws, which are rare. No U.S. state has an all-ages helmet mandate, and of the 47 cities, towns, and counties in the U.S. known to have all-ages mandates (representing just eight U.S. states), the majority (27) are jurisdictions in Washington state[35]. A 2018 meta-analysis[36] identified 21 studies that assess the impact of helmet mandates on the prevention of head injuries. Of these:

- Only eight studies took place in the United States. The majority – five – of these examined the passage of youth-only helmet laws in the 1990s.
- Only one study[37] examined an all-ages helmet mandate in the United States – the extension of the all-ages King County helmet law to Seattle in 2003 (see discussion below).

Thus, existing research on helmet laws in the U.S. skews heavily towards before-and-after studies of youth-only helmet mandates introduced 2-3 decades ago. The body of literature assessing helmet laws' impact on helmet use, rather than injury rates, is somewhat larger, but is also predominantly composed of older studies of youth-only helmet legislation.

Most studies examining the effect of youth-only helmet legislation passed in the 1990s found notable increases in helmet use. Helmet use in the U.S. prior to the introduction of local mandates (and other interventions to increase helmet use; see following discussion) was exceedingly low. For example, a 1993 study[38] found that helmet use among children in a Maryland county increased from 11% to 37% after the passage of helmet legislation, while helmet use in nearby counties without helmet laws changed by 5% or less. A study conducted in 1999[39] found that Florida counties that had opted out of a statewide youth-only helmet law were observed to have helmet use rates of around 33%, while helmet use among children averaged 79% in counties with the helmet law.

Helmet use rates across the U.S. are now markedly higher than three decades ago (and average 87% in Seattle including bike-share users[40]) owing to a variety of factors: helmet education, promotion, and giveaway campaigns, particularly in schools[41]; role modeling[42,43]; the positioning of the helmet as synonymous with

[35] Merrill-Francis et al., "Local all-age bicycle helmet ordinances in the United States: a review and analysis," *The Journal of Law, Medicine & Ethics* (2019), 47(2), 283–291, https://journals.sagepub.com/doi/abs/10.1177/1073110519857283.

[36] Høye, "Recommend or mandate? A systematic review and meta-analysis of the effects of mandatory bicycle helmet legislation," *Accident Analysis & Prevention* (2018b), 120, 239–249, https://www.sciencedirect.com/science/article/abs/pii/S000145751830397X.

[37] Kett et al., "The effect of an all-ages bicycle helmet law on bicycle-related trauma," *Journal of Community Health* (2016), 41(6), 1160–1166, https://link.springer.com/article/10.1007/s10900-016-0197-3.

[38] Dannenberg et al., "Bicycle helmet laws and educational campaigns: an evaluation of strategies to increase children's helmet use," *American Journal of Public Health* (1993), 83(5), 667–674, https://ajph.aphapublications.org/doi/10.2105/ajph.83.5.667.

[39] Kanny et al., "Effectiveness of a state law mandating use of bicycle helmets among children: an observational evaluation," *American Journal of Epidemiology* (2001), 154(11), 1072–1076, https://academic.oup.com/aje/article/154/11/1072/185308.

[40] Mooney et al., "Free-floating bikeshare and helmet use in Seattle, WA," *Journal of Community Health* (2019), 44, 577–579, https://link.springer.com/article/10.1007%2Fs10900-018-00599-1.

[41] Bergman et al., "The Seattle Children's bicycle helmet campaign," *The American Journal of Diseases of Children* (1990), 144(6), 727–731, https://jamanetwork.com/journals/jamapediatrics/article-abstract/515201.

[42] Dannenberg et al., "Bicycle helmet use by adults: the impact of companionship," *Public Health Reports* (1993), 108(2), 212–217, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1403363/.

[43] Kakefuda et al., "Associations between childhood bicycle helmet use, current use, and family and community factors among college students," *Family and Community Health* (2009), 32(2), 159–166, http://dx.doi.org/10.1097/FCH.0b013e31819947cf.

safety in media and local government narratives[44]; advocacy from bicycling organizations and helmet mandates at bicycling events[45]; and prolonged exposure to the preceding factors over time[46]—all in addition to the passage and enforcement of helmet laws in some locales. Despite the clear need to disentangle the effect of helmet mandates from these other, often concurrent interventions and influences, we are aware of no studies that systematically address this question. Such a study would need to compare rates of helmet use in multiple U.S. jurisdictions with and without helmet mandates, and control for effects from the aforementioned factors as well as other potential demographic influences on helmet use. The role of fines and enforcement would also need to be examined; most helmet laws in the U.S. are associated with weak enforcement and low fines[47]. As far as we know, no study meeting these criteria exists. Thus, the existing literature cannot speak to the degree to which helmet legislation in the U.S. is directly connected, or not, to rates of helmet use today.

Comparing helmet use rates in Seattle to peer cities, however, suggests that the influence of helmet legislation today may be minimal, in contrast to the large effects observed when helmet laws were first introduced three decades ago.

- **In Seattle, an observational study found helmet use among all riders (including bike share users) to be approximately 87% in 2018**[48], though this may be an overestimate as the four counts from this study were conducted in wealthier areas of the city (Fremont Bridge, Burke-Gilman Trail, Broadway PBL, and an intersection in Ballard).

- **In Portland, OR, average helmet use from a citywide count was 81% in 2014**[49] (the most recent year of data available), *despite the absence of an all-ages helmet mandate*. Oregon has a state helmet mandate for riders under the age of 16 only. A time series of observed helmet use in Portland[50] shows little apparent connection between *all-ages* helmet use and the timing of the *youth-only* law, which went into effect in July 1994. Helmet use increased from 44% in 1992 to 55% in 1993, before the law was implemented, while it took seven years to see a similar increase after the passage of the law (from 60% in 1994 to 72% in 2001). Helmet use has steadily increased since, despite the absence of an all-ages helmet mandate. Research indicates that youth-only helmet mandates result in negligible "spillover" effect to adults[51], which suggests this upward trend cannot be directly attributed to the youth-only mandate.

- **In Vancouver, BC, average helmet use was observed to be 78% in 2016**[52]. Similar to King County, British Columbia has a provincial all-ages helmet law that was enforced regularly (with about 1,800 tickets

[44] Culver, "Bike helmets – a dangerous fixation? On the bike helmet's place in the cycling safety discourse in the United States," *Applied Mobilities* (2020), 5(2), 138–154, https://www.tandfonline.com/doi/full/10.1080/23800127.2018.1432088.

[45] Bachynski and Bateman-House, "Mandatory bicycle helmet laws in the United States: origins, context, and controversies," *American Journal of Public Health* (2020), 110(8), 1198–1204.

[46] Farley et al., "Evaluation of a four-year bicycle helmet promotion campaign in Quebec aimed at children ages 8 to 12: impact on attitudes, norms and behaviours," *Canadian Journal of Public Health* (1997), 62–66, https://link.springer.com/article/10.1007/BF03403862.

[47] Bateman-House, "Bikes, helmets, and public health: Decision-making when goods collide," *American Journal of Public Health* (2014), 104(6), 986–992, https://ajph.aphapublications.org/doi/10.2105/AJPH.2013.301810.

[48] Mooney et al. (2019). As above.

[49] "Portland bicycle count report 2013-2014," Portland Bureau of Transportation (2014), https://www.portlandoregon.gov/transportation/article/545858.

[50] "Portland bicycle counts 2008," Portland Bureau of Transportation (2008), https://www.portlandonline.com/shared/cfm/image.cfm?id=217489.

[51] Grant and Rudner, "The effect of bicycle helmet legislation on bicycling fatalities," *Journal of Policy Analysis and Management* (2004), 23(3), 595–611, https://onlinelibrary.wiley.com/doi/abs/10.1002/pam.20029.

[52] Zanotto and Winters, "Helmet use among personal bicycle riders and bike share users in Vancouver, BC," *American Journal of Preventive Medicine* (2017), 53(4), 465–472, https://www.ajpmonline.org/article/S0749-3797(17)30249-0/fulltext.

issued in 2013[53]) but in recent years has been enforced minimally (with only 35 tickets issued in 2017[54]). Both the earlier and more recent rates of enforcement are similar to those in Seattle, where helmet law enforcement has also steeply declined in recent years[55].

In summary, comparison of Seattle to peer cities in the Pacific Northwest suggests that the presence of an all-ages helmet mandate is minimally connected to population-wide rates of helmet use today. Helmet use in Portland, which lacks an all-ages mandate, is just 6% lower than in Seattle, and the difference is likely even less due to the sampling methodology of the helmet use counts in Seattle. However, even this small difference may not be attributable to the lack of an all-ages mandate. Vancouver, BC has somewhat lower helmet use than Portland *despite an all-ages helmet mandate* that has been enforced similarly to the helmet law in Seattle. It is probable that factors other than helmet legislation (e.g., those cultural, educational, demographic, media-related, etc.) exert a strong – and perhaps even dominant – influence on these differences in helmet use between cities.

Evidence from hospitalization records in King County (discussed in more detail below) suggests that the influence of helmet legislation may have been waning as early as two decades ago. While King County's helmet law was introduced in 1993, it did not apply to Seattle until 2003. Kett et al.[56] find that the extension of the helmet law to Seattle in 2003 had no effect on rates of helmet use among injured cyclists. Among cyclists admitted to a hospital for bicycle-related injuries, the proportion of helmet-wearers in Seattle increased by 29% over the study period (from 39% to 68% over 2000-2010), which spans the introduction of the helmet law in Seattle. However, King County outside of Seattle saw a similar – and slightly larger – increase in helmet use of 34% (from 26% to 60% over that period), despite no change to its helmet mandate. Again, this suggests that factors other than the helmet mandate led to substantially greater helmet use in both locales, and that the impact of the helmet law's extension to Seattle was negligible, unlike the large upticks in helmet use observed shortly after the implementation of helmet laws across the U.S. in the 1990s.

[53] Christopher Cheung, "City cyclists dodging helmet laws," *Vancouver is Awesome* (August 7, 2014), https://www.vancouverisawesome.com/courier-archive/news/city-cyclists-dodging-helmet-laws-2983202.

[54] Rafferty Baker, "Helmet laws called into question as Bike to Work Week fills cycling paths," *CBC* (May 31, 2018), https://www.cbc.ca/news/canada/british-columbia/bike-helmet-laws-criticised-in-bc-1.4684916.

[55] Ethan C. Campbell, "Technical report on bicycle infractions in Seattle (2003-2020)... ." As above.

[56] Kett et al. (2016). As above.

Are helmet laws effective at preventing injuries?

Studies have come to mixed conclusions on this question, which has been methodologically challenging and contentious[57,58]. However, the most recent, thorough, high-powered, and relevant studies from North American contexts, summarized below, suggest that the presence or absence of helmet mandates today has little to no association with overall rates of head injuries[59,60]. The results of a smaller-scale study assessing the impact of the King County helmet law in Seattle[61] (which is discussed in the next section) are consistent with this finding of a lack of benefit.

A meta-analysis examining 21 studies concluded that helmet mandates reduce head injuries by about 20%[62]. As discussed previously, however, the large majority of the studies examined focused on the introduction of youth-only helmet mandates in the U.S. during the 1990s, when prior helmet use was minimal, or on legislation in locales outside the U.S., where enforcement is generally more frequent and severe, and cultural and cycling conditions are often significantly different. It is unclear whether results from such different contexts are applicable to the present-day efficacy of a three-decades-old helmet law here in King County (and, in any case, the one study that examines precisely this question finds little benefit; see below). **With these challenges in mind, we believe that two studies stand out as providing the most valuable guidance due to their recency, their relevant geographic contexts in North America, their examination of locales with all-ages helmet mandates (and not solely youth-only mandates), their large sample sizes, and their rigorous methodologies that control for secular (background) trends in injuries and geographic variations in cycling rates:**

- Dennis et al. (2013)[63] examine time series of over 60,000 hospital admissions for cycling-related injuries from 1994-2008 across 10 Canadian provinces, six of which implemented helmet legislation. After controlling for baseline trends in injury rates, which the authors find were already decreasing prior to the introduction of helmet mandates, no independent effects of helmet legislation on injury rates are detected. The authors conclude that **"the incremental contribution of provincial helmet legislation to reduce hospital admissions for head injuries seems to have been minimal."**

- Teschke et al. (2015)[64] compare cycling-related hospitalization rates across 10 Canadian provinces from 2006-2011. The authors control for differences in exposure rates using data on bicycling trips. Examining over 20,000 hospitalization incidents, they find that the presence of **"helmet legislation [is] not associated with hospitalization rates for brain, head, scalp, skull, face, or neck injuries,"** despite apparent higher helmet usage in provinces with helmet laws. The authors suggest that some of the complexities listed below, such as selection and second-round effects, could explain these counterintuitive findings.

On the surface, these findings of no benefit may appear to be in conflict with studies that have shown conclusively that cyclists wearing helmets have a reduced risk of injury (see discussion above). **However, helmet *legislation***

[57] Goldacre and Spiegelhalter, "Bicycle helmets and the law," *BMJ* (2013), 346, f3817, https://www.bmj.com/content/346/bmj.f3817.full?ijkey=I5vHBog6FhaaLzX&keytype=ref.

[58] Høye et al. (2018b). As above.

[59] Dennis et al., "Helmet legislation and admissions to hospital for cycling related head injuries in Canadian provinces and territories: interrupted time series analysis," *BMJ* (2013), 346, f2674, https://www.bmj.com/content/346/bmj.f2674.long.

[60] Teschke et al., "Bicycling injury hospitalisation rates in Canadian jurisdictions: analyses examining associations with helmet legislation and mode share," *BMJ Open* (2015), 5(11), e008052, https://bmjopen.bmj.com/content/5/11/e008052.

[61] Kett et al. (2016). As above.

[62] Høye et al. (2018b). As above.

[63] Dennis et al. (2013). As above.

[64] Teschke et al. (2015). As above.

today may have a negligible effect, or a smaller effect than expected or previously observed, simply because it is not particularly influential at present. There are two main reasons why this may be the case:

1. **Norms around helmet use have shifted from those in the 1990s, both in locations with and without helmet laws.** Annual observations of helmet use over multiple decades in U.S. cities such as Portland[65], where riders are not subject to an all-ages helmet mandate, have shown steady increases in average helmet use over time. This is likely the consequence of the behavioral, normative, and policy-related factors discussed above. Over recent years, the incremental contribution of local helmet mandates to increasing and maintaining rates of helmet use may be so small as to be undetectable at the population level[66].

2. **Research has found that helmet legislation is more effective – or perhaps only effective – when enforced vigorously[67,68], which is often not the case.** Rates of enforcement in Seattle have ranged from between 500-1,000 citations issued annually in past years to 20-50 citations issued annually in recent years (see below), with the total number of police contacts (including those that result in warnings rather than citations being issued) being 4-30x the number of citations issued, as discussed below. 700,000 helmetless personal bicycle trips take place in Seattle annually (as estimated below), not including the approximately 1.5 million annual helmetless dockless bike share trips at present (see references below). This implies that current rates of police contacts resulting from helmet violations could range from a low value of 0.004% of all helmetless trips (including bike share trips, and using low-end estimates of enforcement frequency) to a high value of 0.2% of all helmetless trips (not including bike share trips, and using high-end estimates of enforcement frequency). In any case, enforcement in Seattle is minimal. This is similar to the extremely low or negligible enforcement rates across the Canadian provinces[69] in which helmet legislation was found to be minimally connected to rates of head injuries[70,71].

At the same time, it has been suggested that studies that do find reduced rates of head injuries in hospitalization records following helmet legislation, such as some reviewed by Høye (2018b)[72], are in fact observing the effects of a number of potentially confounding factors:

1. **For one, multiple lines of evidence (observational, hospital, and survey data) indicate that helmet legislation may deter people from biking[73,74,75,76,77]**, though some authors dispute aspects of these

[65] "Portland bicycle counts 2008," Portland Bureau of Transportation. As above.

[66] Dennis et al. (2013). As above.

[67] Gilchrist et al., "Police enforcement as part of a comprehensive bicycle helmet program," *Pediatrics* (2000), 106(1), 6–9, https://pediatrics.aappublications.org/content/106/1/6.long.

[68] Huybers et al., "Long-Term Effects of Education and Legislation Enforcement on All-Age Bicycle Helmet Use: A Longitudinal Study," *Journal of Community Health* (2017), 42, 83–89, https://link.springer.com/article/10.1007%2Fs10900-016-0233-3.

[69] Dennis et al. (2013). As above.

[70] Ibid.

[71] Teschke et al. (2015). As above.

[72] Høye et al. (2018b). As above.

[73] Robinson, "Safety in numbers in Australia: more walkers and bicyclists, safer walking and bicycling," *Health Promotion Journal of Australia* (2005), 16(1), 47–51, https://onlinelibrary.wiley.com/doi/abs/10.1071/HE05047.

[74] Carpenter and Stehr, "Intended and unintended effects of youth bicycle helmet laws" (2010), National Bureau of Economic Research Working Paper 15658, https://www.nber.org/papers/w15658.

[75] Rissel and Wen, "The possible effect on frequency of cycling if mandatory bicycle helmet legislation was repealed in Sydney, Australia: a cross sectional survey," *Health Promotion Journal of Australia* (2011), 22(3), 178–183, https://www.publish.csiro.au/he/HE11178.

[76] Fyhri et al., "Bicycle helmets – A case of risk compensation?," *Transportation Research Part F: Traffic Psychology and Behaviour* (2012), 15(5), 612–624, https://www.sciencedirect.com/science/article/pii/S1369847812000587.

[77] Markowitz and Chatterji, "Effects of bicycle helmet laws on children's injuries," *Health Economics* (2015), 24, 26–40, https://onlinelibrary.wiley.com/doi/full/10.1002/hec.2997.

findings[78,79]. If helmet mandates indeed have this unintended effect, population-wide head injuries would decrease without necessarily requiring an increase in helmet use. It is worth noting that reduced cycling could impact population health negatively in other unintended ways. Studies have found that the benefits of physical activity from biking far outweigh the risks to health from traffic accidents and air pollution[80,81]. Taking this into account, a modeling study found that reduced ridership related to helmet legislation may produce a large unintended negative *net* impact to societal health due to less exercise, which results in increased morbidity and mortality[82]. While troubling, the magnitudes of these effects are not well-quantified at present.

2. **"Selection effects" may occur if a helmet mandate preferentially discourages certain segments of a population from riding[83]**. Different studies have suggested specific groups that are deterred by helmet mandates, for example, some children[84,85] and some occasional cyclists[86]. There is also strong evidence that helmeted cyclists exhibit a lower overall risk profile, while unhelmeted cyclists tend to be at higher risk for crashes and injuries for a variety of reasons[87]. Some risk factors correlated with unhelmeted riding are related to income (e.g., riding a less safe bicycle, not owning a bicycle light, or not riding with high-visibility clothing), while others are more behavioral (e.g., using electronic devices more often, not following traffic laws, or cycling under the influence of alcohol). An observed reduction in injuries following the passage of helmet legislation could stem, at least in part, from reduced riding among those who are less inclined to wear helmets and tend to be at higher risk for injury for correlated reasons, or other groups with a higher risk of injury (e.g., children). **It is challenging, if not impossible, for studies to control for all of these possible selection effects, which involve variables that are "generally unmeasured and perhaps even unmeasurable"[88].**

3. Decreased rates of cycling within a population owing to helmet legislation could result in additional second-round effects related to the "safety in numbers" theory, which posits that increased cycling generally leads to safer conditions for all (and vice versa, i.e., reduced cyclist density results in higher

[78] Olivier et al., "No strong evidence bicycle helmet legislation deters cycling," *Medical Journal of Australia* (2016), 205(2), 54–55, https://www.mja.com.au/system/files/issues/205_02/10.5694mja16.00193.pdf.

[79] Olivier et al., "Does the Australian bureau of statistics method of travel to work data accurately estimate commuter cycling in Australia?," *Journal of Road Safety*, 31(2), 48–54, https://search.informit.org/doi/10.3316/INFORMIT.331256981654732.

[80] de Hartog et al., "Do the health benefits of cycling outweigh the risks?," *Environmental Health Perspectives* (2010), 118(8), 1109–1116, https://ehp.niehs.nih.gov/doi/10.1289/ehp.0901747.

[81] Rojas-Rueda et al., "The health risks and benefits of cycling in urban environments compared with car use: health impact assessment study," *BMJ* (2011), 343, d4521, https://www.bmj.com/content/343/bmj.d4521.

[82] de Jong, "The health impact of mandatory bicycle helmet laws," *Risk Analysis* (2012), 32(5), 782–790, https://onlinelibrary.wiley.com/doi/full/10.1111/j.1539-6924.2011.01785.x.

[83] Goldacre and Spiegelhalter (2013). As above.

[84] Carpenter and Stehr (2011). As above.

[85] Markowitz and Chatterji (2015). As above.

[86] Rissel and Wen (2011). As above.

[87] Høye (2018b) and references therein. As above.

[88] Goldacre and Spiegelhalter (2013). As above.

risk)[89,90,91,92,93]. The potential influence of helmet legislation on the "safety in numbers" effect is not well-characterized at present.

4. On an individual level, it has been suggested that wearing a bicycle helmet may be associated with riskier behavior through a phenomenon known as "risk compensation"[94]. However, a recent meta-analysis of 23 studies on this subject found "little to no support" for this particular effect[95].

5. There is some evidence that the behavior of drivers around people on bicycles, particularly while overtaking a cyclist, may change depending on whether the cyclist is wearing a helmet or not[96,97]. However, the impact of this effect on the risk of crash and injury has not been quantified.

Overall, interventions to prevent collisions from occuring in the first place – not helmet mandates – are widely recognized as the most effective way of preventing injuries for bicyclists, pedestrians, and other vulnerable road users. Strategies known to be powerfully protective include separated bicycle-specific facilities[98,99,100], reduced road speeds[101,102,103], safer intersection design[104], and efforts to increase rates of bicycling mode share[105,106,107]. All of these have been shown to substantially reduce the risk of injury for people riding bicycles. These interventions are readily achievable in King County, and local models exist. The Seattle Department of Transportation, for example, recently found that lowering arterial speeds in Seattle to 25 mph and increasing sign density alone – without any additional enforcement, signal retiming, or engineering changes – has been successful in

---

[89] Jacobsen, "Safety in numbers: more walkers and bicyclists, safer walking and bicycling," *Injury Prevention* (2003), 9(3), 205–209, https://injuryprevention.bmj.com/content/9/3/205.

[90] Robinson (2005). As above.

[91] Teschke et al. (2015). As above.

[92] "Bicycling and walking in the United States: 2018 benchmarking report, 6th Ed.," League of American Bicyclists (2018), https://bikeleague.org/sites/default/files/Benchmarking_Report-Sept_03_2019_Web.pdf.

[93] Aldred et al., "Contextualising Safety in Numbers: a longitudinal investigation into change in cycling safety in Britain, 1991–2001 and 2001–2011," *Injury Prevention* (2019), 25(3), 236–241, https://injuryprevention.bmj.com/content/25/3/236.

[94] Phillips et al., "Risk compensation and bicycle helmets," *Risk Analysis* (2011), 31(8), 1187–1195, https://onlinelibrary.wiley.com/doi/full/10.1111/j.1539-6924.2011.01589.x.

[95] Esmaeilikia et al., "Bicycle helmets and risky behaviour: A systematic review," *Transportation Research Part F: Traffic Psychology and Behaviour* (2019), 60, 299–310, https://www.sciencedirect.com/science/article/pii/S1369847818305941.

[96] Walker, "Drivers overtaking bicyclists: Objective data on the effects of riding position, helmet use, vehicle type and apparent gender," *Accident Analysis and Prevention* (2007), 39(2), 417–425, https://www.sciencedirect.com/science/article/abs/pii/S0001457506001540.

[97] Walker and Robinson, "Bicycle helmet wearing is associated with closer overtaking by drivers: A response to Olivier and Walter, 2013," *Accident Analysis and Prevention* (2019), 123, 107–113, https://www.sciencedirect.com/science/article/abs/pii/S0001457518309928.

[98] Reynolds et al., "The impact of transportation infrastructure on bicycling injuries and crashes: a review of the literature," *Environmental Health* (2009), 8, 47, https://ehjournal.biomedcentral.com/articles/10.1186/1476-069X-8-47.

[99] Thomas and DeRobertis, "The safety of urban cycle tracks: a review of the literature," *Accident Analysis and Prevention* (2013), 52, 219–227, https://www.sciencedirect.com/science/article/abs/pii/S0001457512004393.

[100] Marshall and Ferenchak, "Why cities with high bicycling rates are safer for all road users," *Journal of Transport and Health* (2019), 13, 100539, https://www.sciencedirect.com/science/article/abs/pii/S2214140518301488.

[101] Ibid.

[102] Chen, "Built environment factors in explaining the automobile-involved bicycle crash frequencies: A spatial statistic approach," *Safety Science* (2015), 79, 336–343, https://www.sciencedirect.com/science/article/abs/pii/S0925753515001587.

[103] Pucher and Buehler, "Cycling towards a more sustainable transport future," *Transport Reviews* (2017), 37(6), 689–694, https://www.tandfonline.com/doi/full/10.1080/01441647.2017.1340234.

[104] Harris et al., "Comparing the effects of infrastructure on bicycling injury at intersections and non-intersections using a case–crossover design," *Injury Prevention* (2013), 19, 303–310, https://injuryprevention.bmj.com/content/19/5/303.

[105] Teschke et al. (2015). As above.

[106] "Bicycling and walking in the United States… ," League of American Bicyclists. As above.

[107] Aldred et al. (2019). As above.

decreasing vehicle speeds and achieving a 20-40% reduction in collisions within five neighborhoods examined as case studies[108]. For more information, People for Bikes has put together a useful compilation of research on bicycle safety interventions[109].

On a societal level, helmet legislation has naturally led to a focus on helmets as a primary mode of injury prevention. **Recent research has argued that this emphasis on helmets as one of the most important tools for bicycle safety has been a "dangerous fixation" that has in fact stymied efforts to achieve safer conditions for cyclists through more effective interventions[110]**, such as those discussed below. The author of this research explains how focusing on helmet use has obscured the primary cause of injury risk for cyclists (i.e., unfettered automobility), redistributed blame onto the victims of traffic violence, and distorted the public's perception of the risk associated with bicycling. Our societal focus on helmet use, rather than other interventions, may be in part due to certain early studies that found more powerful effects of helmets on injury prevention than current best estimates, such as those from recent meta-analyses (see above). For example, a widely-reported 1989 study conducted in Seattle[111] found that helmet use conferred an 85% reduction in head injury risk. An effect of this magnitude has not been identified in the large majority of subsequent research efforts[112] and the 1989 study has since been removed as federal guidance[113,114].

It is no coincidence that the countries with the lowest rates of injury for bicyclists – such as the Netherlands, Denmark, and Germany, where biking is 4-5 times safer than in the U.S. on a per-mile basis – have achieved such safety using proven, root-cause-focused strategies and policies rather than helmet mandates[115]. Specifically, these countries have decreased cyclist fatalities by 60-80% between 1970 and 2008 (while increasing cycling rates by similar amounts) despite helmet use among adult cyclists remaining between 1% and 5%.

[108] "Speed limit case studies," Seattle Department of Transportation (July 2020), https://www.seattle.gov/Documents/Departments/SDOT/VisionZero/SpeedLimit_CaseStudies_Report.pdf.

[109] "Safety statistics: bicycling and safety," People for Bikes (accessed on May 27, 2021), https://www.peopleforbikes.org/statistics/safety.

[110] Culver (2018). As above.

[111] Thompson, Rivara, and Thompson, "A case-control study of the effectiveness of bicycle safety helmets," *New England Journal of Medicine* (1989), 320(21), 1361–1367, https://www.nejm.org/doi/10.1056/NEJM198905253202101.

[112] Høye (2018a). As above.

[113] Colleen Coggins, National Highway Traffic Safety Administration, U.S. Department of Transportation, letter to James Titus (May 14, 2013), http://bike.risingsea.net/docs/Legislation/helmet/NHTSA-response-to-Titus.pdf.

[114] Tom Fucoloro, "Feds no longer back 1989 Seattle helmet effectiveness study – City should modify its helmet law before bike share launches," *Seattle Bike Blog* (June 4, 2013), https://www.seattlebikeblog.com/2013/06/04/feds-no-longer-back-1989-seattle-helmet-effectiveness-study-city-should-modify-its-helmet-law-before-bike-share-launches/.

[115] Pucher and Buehler, "Making cycling irresistible: lessons from The Netherlands, Denmark and Germany," *Transport Reviews* (2008), 28(4), 495–528, https://www.tandfonline.com/doi/abs/10.1080/01441640701806612.

Has King County's helmet law been effective at preventing injuries?

No. There is little evidence that King County's helmet law has been effective at preventing injuries. A before-and-after study[116] examining the extension of the helmet law to Seattle in 2003, discussed in detail within this section, found an increase in the total number of head injuries after the passage of the law, no change in the prevalence of head injuries compared to other bicycle-related injuries, and no change in helmet use attributable to the extension of the helmet law to Seattle. The only "positive" effect observed was a small decrease in the *fraction* of cyclist head injuries that were classified as major following the law's introduction, representing, at most, about five head injuries per year in Seattle that were not elevated to "major." But the study does not control for confounding factors that could have contributed to this change, and given the aforementioned results, this small decrease cannot be attributed to the helmet law. **Overall, we believe that the study does not make a convincing case for the efficacy of the King County helmet law.**

This 2016 study by Kett and colleagues[117] – researchers affiliated with Seattle & King County Public Health and the Harborview Injury Prevention and Research Center in Seattle – reached the following conclusions:

- **Seattle saw a total of 10.3 head injuries per year on average from 2000-2002, before the implementation of the helmet law in 2003, compared to an average of 23.6 head injuries per year afterwards (2004-2010).** An increase was also seen in the average annual number of major head injuries (from 8.7 before to 15.3 after). The authors explain that these changes are likely related to increased bicycling in Seattle, as also suggested by Census bike commuting data from 2005-2010[118].

- The study examines all bicycle-related injuries (including, for example, internal trauma) as well as the subset of all injuries that are head injuries. This comparison effectively uses non-head injuries suffered by cyclists to control for changes in exposure over time (e.g., increases in cycling). The proportion of all bicycle injuries in Seattle that were head injuries did not show a significant change from before the law (average of 38% of all injuries) to after the law (average of 39%), indicating that **the helmet law had no detectable impact on the total number of cyclist head injuries**.

- The only positive effect observed was a slight decrease in the proportion of bicycle-related head injuries classified as "major" (from an average of 84% before the law to 65% after the law), translating to about 5 head injuries per year in Seattle that the authors imply were not elevated to "major" due to the helmet law. However, the significance of this result is questionable, given the substantially larger increase in total bicycle-related head injuries in Seattle that occurred concurrently. As mentioned above, the authors attribute this large increase in total head injuries to an uptick in bicycle riding. Due to the "safety in numbers" effect of increased ridership[119,120] (also see above), it is unlikely that the individual risk profile of a cyclist remained constant over this period during which cycling may have more than doubled in Seattle[121]. **In addition to not controlling for changes in cycling risk associated with increased ridership, the authors do not attempt to control for changes in risk conferred by the construction of a significant amount of bicycle infrastructure projects over the study period.** 180 miles of bike lanes were

[116] Kett et al. (2016). As above.

[117] Ibid.

[118] American Community Survey data (2005-2018), U.S. Census Bureau (accessed May 24, 2021), https://docs.google.com/spreadsheets/d/10f2GLG-Qpnv3PhCWCowqoCbW_QsWf2lHxcbFJPmD6iE/edit#gid=9. Link provided in: Tom Fucoloro, "Census data confirms steady climb in Seattle bike commuting, driving alone now below 50%," *Seattle Bike Blog* (September 19, 2013), https://www.seattlebikeblog.com/2013/09/19/census-data-confirms-steady-climb-in-seattle-bike-commuting-driving-alone-now-below-50/.

[119] "Bicycling and walking in the United States: 2018 benchmarking report, 6th Ed.," League of American Bicyclists. As above.

[120] Aldred et al. (2019). As above.

[121] American Community Survey data (2005-2018), U.S. Census Bureau. As above.

constructed in Seattle from 2006-2011 alone[122]. This is not a minor quibble: safety-oriented bicycle infrastructure projects have been shown to substantially reduce the likelihood of serious injury and fatality for cyclists (see above).

- **The authors observe that the introduction of the helmet law in Seattle had no effect on rates of helmet use among injured cyclists. This should call into question their attribution of a slight decrease in injury severity to the helmet law.** Among cyclists admitted to a hospital for bicycle-related injuries, the proportion of helmet-wearers in Seattle increased by 29% over the study period (from 39% to 68% over 2000-2010), compared to a similar – and slightly larger – increase of 34% in King County outside of Seattle (from 26% to 60% over that period). Given that King County outside of Seattle saw no change to its helmet mandate over this period, while Seattle saw the introduction of a helmet mandate in 2003, this suggests that factors other than the helmet mandate led to substantially greater helmet use in both locales, and that the helmet law's extension to Seattle had no discernible impact on the hospitalization rates.

We emphasize that the current state of bicyclist safety in King County is troubling and deserves attention from Seattle & King County Public Health. While bicyclists are involved in only 3% of roadway crashes in Seattle, they represent a much larger percentage of serious (9%) and fatal (14%) events[123]. People riding bicycles in Seattle experience an average of about 30 serious or fatal roadway crashes annually[124], contributing about two-thirds of the serious or fatal collisions experienced by bicyclists in King County as a whole, which saw 2-3 cyclist deaths and 42 serious injuries annually from 2013-2016[125]. **We believe it is time for cities across King County to invest in effective, evidence-based strategies to lower the numbers of bicyclists injured or killed on our streets, such as those discussed above that aim to prevent road collisions from occurring in the first place.**

[122] "Okay, fine, it's war," *The Stranger* (September 14, 2011), https://www.thestranger.com/seattle/okay-fine-its-war/Content?oid=9937449.

[123] "City of Seattle bicycle and pedestrian safety analysis," Seattle Department of Transportation (September 2016), https://www.seattle.gov/Documents/Departments/beSuperSafe/BicyclePedestrianSafetyAnalysis.pdf.

[124] "City of Seattle bicycle and pedestrian safety analysis: Phase 2," Seattle Department of Transportation (February 2020), http://www.seattle.gov/Documents/Departments/SDOT/VisionZero/SDOT_Bike%20and%20Ped%20Safety%20Analysis_Ph2_2420(0).pdf.

[125] Washington Traffic Safety Commission (September 2017), from "Bike helmets and bicycle safety," King County (accessed May 19, 2021), https://kingcounty.gov/depts/health/violence-injury-prevention/traffic-safety/bicycle-safety.aspx.

Can helmet laws have unintended effects?

Yes. As discussed previously, helmet laws may have unintended negative impacts on safety and population health:

- Studies drawing from multiple lines of evidence (observational, hospital, and survey data) indicate that helmet legislation has depressed rates of bicycle ridership in some locales, as discussed above.

- Decreased ridership will impact the safety of cyclists as a whole within a population due to the "safety in numbers effect" (see above). There is evidence that this may also lead to an unintended net negative impact on population health due to foregone exercise (see above).

Additionally, helmet laws run into conflict with bike share programs. For example, King County's helmet law has been cited as a contributing factor in the demise of Seattle's Pronto bike share system in 2017[126,127,128]. In another instance, the incompatibility of bike share with helmet enforcement led Mayor Bloomberg of New York City to oppose a city councilmember's helmet law proposal in 2014 in part due to concerns that it would undermine the city's new Citi Bike system[129]. Some have pointed out that differential enforcement of helmet laws for bike share users creates a problematic legal double standard[130]:

> *"Public health entities throughout the U.S. recommend the use of bicycle helmets, yet bike-shares, which are often public/private partnerships that have, at the very least, permission from local governments to operate, increase the number of cyclists on the streets without more than cursory attempts to ensure that they wear head protection. This, on the face of it, is quite at odds with policies that impose fines and even prison time for not wearing bike helmets."*

Furthermore, the cost of helmets represents an unequal burden for lower-income individuals. While some programs exist in King County for the provision of low-cost, subsidized helmets[131], the points of access for these programs are geographically sparse and, from our discussions and outreach efforts, it was clear that many residents are unfamiliar with these programs. In actuality, the cost of a helmet can be substantial[132]:

> *"It is important to realise that many people are unlikely to skimp when they buy helmets. This is because canny marketing campaigns will lead people to believe, probably erroneously, that the more expensive helmets offer extra levels of protection. Of course, this does not matter too much for those who belong to higher socio-economic groups because even a price tag of $50–$150 will not represent a serious cost. However, for less economically advantaged individuals... this 'extra' cost may well be prohibitive."*

---

[126] Tom Fucoloro, "Times: King County's adult helmet law could hold back Seattle's new bike share system," *Seattle Bike Blog* (December 19, 2016), https://www.seattlebikeblog.com/2016/12/19/times-king-countys-adult-helmet-law-could-hold-back-seattles-new-bike-share-system/.

[127] Angie Schmitt, "Helmet scolds could unwittingly undermine bike safety in Seattle," *Streetsblog USA* (September 5, 2017), https://usa.streetsblog.org/2017/09/05/helmet-scolds-could-unwittingly-undermine-bike-safety-in-seattle/.

[128] Josh Cohen, "Did Seattle's mandatory helmet law kill off its bike-share scheme?," *The Guardian* (April 18, 2017), https://www.theguardian.com/cities/2017/apr/18/seattle-mandatory-helmet-law-kill-bike-share-scheme.

[129] Bateman-House (2014). As above.

[130] Bateman-House and Bachynski, "Putting local all-ages bicycle helmet ordinances in context," *Journal of Law, Medicine, and Ethics* (2019), 47(2), 291–293, https://dx.doi.org/10.1177/1073110519857284.

[131] "Free and low-cost bicycle helmet resources in King County, Washington," King County (accessed May 24, 2021), https://kingcounty.gov/depts/health/violence-injury-prevention/traffic-safety/~/media/depts/health/violence-injury-prevention/documents/low-cost-bike-helmet-providers.ashx.

[132] Hooper and Spicer, "Bike helmets: a reply to replies," *Journal of Medical Ethics* (2015), 41(8), 719–720, https://jme.bmj.com/content/41/8/719.

Cost and other barriers to access may decrease the efficacy of helmet legislation, the impacts of which have been shown to be more durable in higher-income areas than lower-income areas. A study in Toronto, for example, found that rates of helmet use in low-income areas, but not high-income areas, had returned to pre-legislation levels six years after the passage of a youth-only helmet law[133].

Helmets are less accessible for those with big or styled hair; this disproportionately impacts Black individuals. For people with big hair (e.g., afros, locks, braids) or hair that is intentionally styled (e.g., curls, mohawks), finding a bicycle helmet that can accommodate one's hair can be challenging or impossible[134,135,136]. This tends to affect women and Black individuals more than others, and Black women especially. Wearing a helmet also makes one's hair less tidy, a phenomenon known as "helmet hair." This, too, has a disproportionate effect, as Black women are judged more harshly by society for personal grooming that is perceived as deviating from professional standards[137].

The enforcement of helmet legislation contributes to the perpetuation and criminalization of poverty. While the fine for a helmet citation in King County is $30[138], the total burden in Seattle is a minimum of $104 including Seattle Municipal Court fees, or $154 including default penalties that are frequently added[139]. This sum represents a substantially larger burden. Additionally, the majority of recent helmet citations in Seattle from 2017-2020 went unpaid and were sent to collections, suggesting that citations predominately burden low-income riders[140].

As discussed above, it has been argued that helmet legislation has led to a rhetorical focus on helmets as a primary mode of injury prevention, and that this has been a "dangerous fixation" that has in fact stymied efforts to achieve safer conditions for cyclists through more effective interventions[141]. A recent analysis found that disproportionate media coverage of cyclist fatalities may create feedback loops that inhibit cycling growth by warping risk perception, that is, broadcasting the message that cycling is a terribly dangerous activity when that is not the case[142]. This media coverage often focuses on whether a cyclist wore a helmet[143], a form of victim-blaming, while autopsy reports indicate that helmet use would not have prevented death in the majority of cyclist fatalities[144].

---

[133] Macpherson et al., "Economic disparity in bicycle helmet use by children six years after the introduction of legislation," *Injury Prevention* (2006), 12, 231–235, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2586775/.

[134] Kristin Collins Jackson, "How to make a helmet work with your afro," *Bustle* (July 25, 2016), https://www.bustle.com/articles/173930-7-tips-for-wearing-a-helmet-with-afro-textured-hair-photos.

[135] "Styling natural hair for cycling," *Keep it Simpelle* (accessed May 24, 2021), https://www.keepitsimpelle.com/natural-hair-styles-cycling/.

[136] Tweet by Cathasach O'Neill [user @cathasach4bikes], Twitter (April 21, 2021, accessed May 24, 2021), https://twitter.com/cathasach4bikes/status/1385016677939781633.

[137] Powell, "Bias, employment discrimination, and Black women's hair: another way forward," *Brigham Young University Law Review* (2019), 2018(4), https://digitalcommons.law.byu.edu/cgi/viewcontent.cgi?article=3177&context=lawreview.

[138] "Title 9: bicycle helmets," King County Board of Health Code (last updated on November 20, 2013; accessed on May 24, 2021), https://kingcounty.gov/depts/health/board-of-health/~/media/depts/health/board-of-health/documents/code/BOH-Code-Title-9.ashx.

[139] We identified this by searching for citation numbers associated with helmet law violations in the Seattle Municipal Court citation information portal, accessed at https://web6.seattle.gov/courts/ECFPortal/default.aspx. The default penalty of $52 is applied if a defendant fails to respond with 19 days of receiving a citation, according to: "Inventory of criminal and infraction fines and fees at Seattle Municipal Court," Seattle Municipal Court (August 2017), https://www.seattle.gov/Documents/Departments/Court/SMCFineandFeeInventoryCompiledAug2017.pdf.

[140] David Kroman, "Nearly half of Seattle's helmet citations go to homeless people," *Crosscut* (December 16, 2020), https://crosscut.com/news/2020/12/nearly-half-seattles-helmet-citations-go-homeless-people.

[141] Culver (2018). As above.

[142] Macmillan et al., "Trends in local newspaper reporting of London cyclist fatalities 1992-2012: the role of the media in shaping the systems dynamics of cycling," *Accident Analysis and Prevention* (2016), 86, 137–145, https://www.sciencedirect.com/science/article/pii/S0001457515300981.

[143] Culver (2018). As above.

[144] Bíl et al. (2018). As above.

How frequently do police enforce the King County helmet law?

Seattle police have issued between 3,000 and 3,500 helmet citations from 2003-2020, an average rate of about 180 tickets per year. Our analysis of bicycle citation records obtained from the Seattle Municipal Court, detailed in a preliminary technical report[145], found that Seattle police issued about 5,900 bicycle-related citations from 2003-2020 (including those for violations other than helmet noncompliance). Due to court records retention practices, only about 3,000 citation records were provided to us. Of those records provided, 54.9% were helmet infractions, indicating that **helmet-related stops are the most common way that people riding bicycles come into contact with police.** This proportion leads to the estimate of 3,000-3,500 helmet citations from 2003-2020. For unclear reasons, the number of helmet citations issued per year in Seattle has declined steadily since 2011 (when 607 helmet citations were issued) to a rate of about 20-50 citations issued annually in recent years[146].

Most police contacts for helmet enforcement result in the issuance of a warning, rather than a citation. We believe the fraction of police contacts that result in a helmet citation could be as low as 1/30 or as high as 1/4 of all helmet-related stops (see calculation below). In any case, the number of police stops related to helmet violations is likely far greater than the number of citations issued. At the same time, the chance of being stopped for not wearing a helmet is very low. We estimate above that current rates of police contacts resulting from helmet violations could range from a low value of 0.004% of all helmetless trips (including bike share trips, and using low-end estimates of enforcement frequency) to a high value of 0.2% of all helmetless trips (not including bike share trips, and using high-end estimates of enforcement frequency).

As discussed below, rates of enforcement in most other cities and towns in King County are not yet known.

[145] Ethan C. Campbell, "Technical report on bicycle infractions in Seattle (2003-2020)... ." As above.

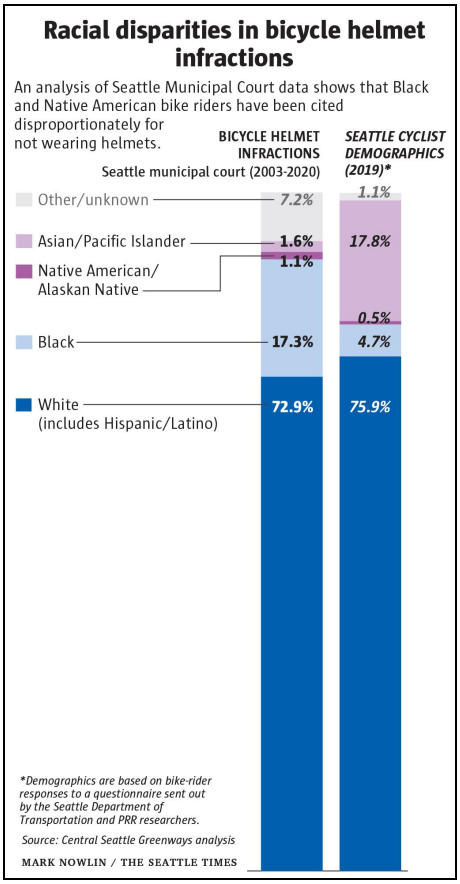
[146] Ibid. The report discusses whether the recent decrease in helmet ticketing could be related to the advent of bicycle share programs in Seattle. We conclude that this hypothesis is unlikely, as rates of enforcement had already begun to decline prior to the launch of Seattle's first bike share system, which itself provided helmets, and were substantially lower than the 2011 peak in enforcement by the introduction of dockless bike share in 2017.

Who has received tickets for not wearing a helmet?

In Seattle, nearly half of all helmet citations since 2017 were issued to people experiencing homelessness. Since 2003, Black cyclists in Seattle have received citations at a rate 3.8 times higher, Indigenous cyclists 2.2 times higher, and Hispanic/Latino cyclists 1.4 times higher than white cyclists.

- Investigative reporting in Crosscut[147] analyzed 117 helmet citation records from the Seattle Municipal Court from 2017-2020. By matching the home addresses of defendants with addresses of homeless shelters or service providers as well as cross-referencing defendant names with other records, it was found that at least 43% of citations since 2017 (and 60% since 2019) were issued to people experiencing homelessness. The report notes that these estimates are almost certainly an undercount.

- Our analysis[148] compares the racial demographics from 1,668 helmet citation records from 2003-2020 obtained from the Seattle Municipal Court with an estimate of the demographics of Seattle cyclists on an approximate per-trip basis, constructed from three population surveys of Seattle residents. For more details, see our technical report. The *Seattle Times* graphic at right summarizes our findings[149]. Disaggregated rates of citations for Hispanic/Latino cyclists, who are classified as "white" in court records, were estimated using defendant names applied to three race/ethnicity classification algorithms trained on Census and voter registration data[150].



[147] David Kroman, "Nearly half of Seattle's helmet citations go to homeless people," *Crosscut*. As above.

[148] Ethan C. Campbell, "Technical report on bicycle infractions in Seattle (2003-2020)... ." As above.

[149] Michelle Baruchman, "Racial disparities prompt calls to repeal King County's bicycle helmet law," *Seattle Times* (Feb. 19, 2021), https://www.seattletimes.com/seattle-news/transportation/racial-disparities-prompt-calls-to-repeal-king-countys-bicycle-helmet-law/.

[150] This portion of the analysis is not detailed in the technical report. We average the result of three algorithms that infer race/ethnicity from defendant names: a last name matching model trained on 2010 U.S. Census data, a second predictive algorithm using last names trained on the same data set, and a third predictive algorithm using full names that was trained on Florida voter registration data. Using 1,472 bicycle-related citations that were provided with full defendant names, the three algorithms estimated the Hispanic/Latino share of all citations to be 9.4%, 11.1%, and 8.0%, respectively, and reproduced known proportions of Black and Asian/Pacific Islander defendants to within 3% and 1%, respectively. We use the average of the three Hispanic/Latino estimates, which is 9.5%. The three algorithms are detailed in: Sood and Laohaprapanon, "Predicting race and ethnicity from the sequence of characters in a name," *arXiV* (May 8, 2018), 1805.02109, https://arxiv.org/abs/1805.02109v1.

Why have certain populations received helmet citations more than others?

In general, disparities in infractions can arise from situations of equitable enforcement if different demographic groups commit a certain offense at different rates, or commit a certain offense at the same rate but have different levels of exposure to policing. **These explanations, however, cannot fully account for the stark disparities in helmet citation issuance in Seattle by race and housing status.** Here is why:

- **Our analysis of racial disparities in helmet citations takes into account differences in cycling frequency.** We quantify differences in the frequency of cycling between demographic groups in Seattle, and find that Black, Hispanic/Latino, Asian/Pacific Islander, and Indigenous cyclists in Seattle are all underrepresented to varying degrees when compared to their census distributions[151]. While our analysis does not account for different average trip lengths or durations, we do not have a reason to believe that Black, Hispanic/Latino, and Indigenous bicyclists take dramatically longer (or shorter) trips than white cyclists on average.

- **Rates of citations issued to Black cyclists compared to white cyclists remain disproportionate after accounting for possible differences in helmet use rates.** While demographic data on helmet use is not available for Seattle or King County, some estimates are available for other U.S. locations and the U.S. as a whole. An observational study in a southeastern U.S. city[152] found that rates of helmet use among white cyclists were 10% higher than for Black cyclists. Weighted results from a national survey[153] found no (0%) difference in the fraction of Black and white adult respondents who always wear a helmet, while an earlier national survey[154] found that rates of helmet use among white youth (ages 5-14) were 12% higher than for Black youth. While hospital records of trauma patients appear to suggest larger Black-white disparities in helmet use[155], we note that the chance of hospital admission is affected by correlated factors other than helmet use (as an example, bicyclists who are least able to afford a helmet may disproportionately ride for purposes of transportation on the busiest, most dangerous streets, and may be disproportionately Black; also see above). Thus we use the observed average city-wide helmet use of 87% in Seattle[156] and assume a 10% Black-white difference in helmet use, which would imply approximate helmet use rates of 88% among white, non-Hispanic cyclists and 78% among Black cyclists given those groups' relative cycling frequencies in Seattle (and neglecting other demographic groups)[157]. **Under a situation of equitable enforcement, these rates of helmet use would result in a Black-white citation disparity of 1.8x, thus explaining 47% of the total disparity (3.8x) assuming a 10% Black-white difference in helmet use rates, which is larger than a national survey-based estimate.** We note that actual average city-wide helmet use is likely lower than 87% (see above), in which case 47% would be an overestimate. However, we emphasize that precise rates of helmet use within demographic groups in Seattle are not known, and so

[151] Ethan C. Campbell, "Technical report on bicycle infractions in Seattle (2003-2020)... ." As above.

[152] Cathorall et al., "Prevalence and predictors of bicycle helmet use in a southeastern, US city," *International Journal of Injury Control and Safety Promotion* (2016), 23(4), 400–404, https://www.tandfonline.com/doi/abs/10.1080/17457300.2015.1047868.

[153] Jewett et al., "Bicycle helmet use among persons 5 years and older in the United States, 2012," *Journal of Safety Research* (2016), 59, 1–7, https://www.sciencedirect.com/science/article/pii/S002243751630278X.

[154] Dellinger and Kresnow, "Bicycle helmet use among children in the United States: The effects of legislation, personal and household factors," *Journal of Safety Research* (2010), 41(4), 375–380, https://pubmed.ncbi.nlm.nih.gov/20846554/.

[155] Chen et al., "Race and insurance status as predictors of bicycle trauma outcome in adults," *Journal of Surgical Research* (2020), 245, 198–204, https://www.journalofsurgicalresearch.com/article/S0022-4804(19)30558-X/.

[156] Mooney et al. (2019). As above.

[157] Ethan C. Campbell, "Technical report on bicycle infractions in Seattle (2003-2020)... ." As above.

this calculation is only approximate. Due to a lack of baseline data on helmet use, we have not performed a similar calculation for the disparities in citations issued to Hispanic/Latino and Indigenous cyclists.

- **The fraction of citations issued to homeless cyclists remains disproportionate after accounting for probable differences in cycling rates and helmet use between homeless and non-homeless riders.** Data on rates of bicycling and helmet use among homeless individuals in King County are not available. However, estimates of homeless cycling rates from other cities are informative: a study of homeless adults in Long Beach, CA found that 5% of trips were taken by bicycle[158]; interviews with homeless individuals in Toronto found that biking was the primary means of transportation for 11% of those surveyed, that biking constituted about 10% of all trips, that 25% owned a bicycle, and that 43% of those who owned a bicycle rode 7 days a week[159,160]; and a study of homeless individuals in and around shelters in a mid-sized city in South Carolina found that 9% used a bicycle as their primary mode of transportation[161]. For the purposes of this estimate, we presume helmet use to be minimal among homeless individuals. The 2020 point-in-time count of the homeless population in King County found about 8,300 homeless individuals in Seattle[162]. Assuming a high-end estimate of 15% of homeless individuals riding, on average, 3 days per week, twice per day (i.e., one round trip), this would result in about 400,000 annual (helmetless) bicycle trips by homeless riders in Seattle. Given an estimate of 8 million annual bicycle trips in Seattle among all riders[163], an average helmet use rate of 87%[164] would translate to 1 million helmetless rides annually. This is not counting homeless riders, who are not likely to be well-represented in the four observational count locations of the study cited; bike share is also not included, as helmet enforcement is presumed to be minimal for bike share users. In this comparison, which adopts the most extreme assumptions for nearly all unmeasured variables, homeless riders would receive 27% of all citations under a situation of equitable enforcement. **Even this extreme scenario does not fully explain the high rate of helmet citation issuance to homeless individuals—homeless bicyclists do not generate enough helmetless trips to merit about half of all citations**. In actuality, we anticipate that average bicycle trip lengths for homeless individuals are shorter than those for housed individuals (leading to reduced exposure to policing), some homeless bicyclists likely use a helmet (rather than 0% of homeless riders), the fraction of the homeless population that rides bicycles is probably lower than the high-end estimate of 15%, the total annual bicycle trips in Seattle may be much higher than 8 million (which was estimated using 2013 data with conservative assumptions), and actual average city-wide helmet use is likely lower than 87% (see above).

---

[158] Jocoy and Del Casino, "Homelessness, travel behavior, and the politics of transportation mobilities in Long Beach, California," *Environment and Planning A: Economy and Space* (2010), 42(8), 1943–1963, https://journals.sagepub.com/doi/abs/10.1068/a42341.

[159] Hui, "Role of urban transportation through the lens of homeless individuals: a case study of the city of Toronto," Master's Thesis, Department of Civil Engineering, University of Toronto (2015), https://tspace.library.utoronto.ca/handle/1807/70394.

[160] Hui and Habib, "Homelessness vis-à-vis transportation-induced social exclusion: an econometric investigation of travel behavior of homeless individuals in Toronto, Canada," *Transportation Research Record* (2017), 2665(1), 60–68, https://journals.sagepub.com/doi/abs/10.3141/2665-07.

[161] Brallier et al., "Rolling forward: addressing needs in the homeless community," *Journal of Social Distress and Homelessness* (2019), 28(2), 186–192, https://www.tandfonline.com/doi/full/10.1080/10530789.2019.1646477.

[162] "Seattle/King County point-in-time count of individuals experiencing homelessness," Vega Nguyen Research and All Home King County (2020), https://regionalhomelesssystem.org/wp-content/uploads/2020/07/Count-Us-In-2020-Final.pdf.

[163] This estimate of 8 million annual trips was computed using the 2013 SDOT/EMC bicycle survey data, available at: Seattle Department of Transportation/EMC Research, *Third Bicycle Participation phone survey* (September 2013), https://www.seattle.gov/Documents/Departments/SDOT/BikeProgram/13-5004bikesdotcrosstab.pdf. We adopt the following conservative correspondences for reported bicycling frequency: "a few times a year" (= 2/year), "a few times a month" (1.5/month), "a few times a week" (1.5/week), "daily" (3/week), and scale the resulting estimate using a Seattle population of 625,000 as of 2013. We believe the total of 8 million trips per year is likely an underestimate, given increases in cycling since 2013. For comparison, individual bicycle counters in Seattle show total annual volumes of similar magnitude, e.g., 1.2M at Fremont Bridge, 0.3M at Spokane Street Bridge, 0.4M at the Elliott Bay Trail, 0.6M at the 2nd Avenue Protected Bike Lane, 0.2M at I-90 Trail, 0.4M at the Burke-Gilman Trail north of NE 70th Street, which sum to 3.1M unique trips annually at just these points, assuming a cyclist will pass one or fewer counters on an average ride. Bicycle counter data for 2019 were obtained from: Tom Fucoloro, "Seattle's 2019 bike boom in 6 charts + Where should Seattle's next bike counters go?," *Seattle Bike Blog* (January 6, 2020), https://www.seattlebikeblog.com/2020/01/06/seattles-2019-bike-boom-in-6-charts-where-should-seattles-next-bike-counters-go/.

[164] Mooney et al. (2019). As above.

If differences in cycling rates and helmet use between demographic groups cannot explain the disparities in enforcement, what can explain them? We believe the answer is most likely uneven and/or biased policing. To start, police officers do not randomly patrol a city[165]:

> *"A department will deploy its officers based primarily on calls for service. Areas that are densely populated and have more commercial activity tend to have more calls for service and so more officers will be deployed there. ... If there are more officers in an area, there will be a greater chance that they will observe suspicious activity or criminal acts and so there is a greater chance of an individual being stopped."*

In Seattle, the neighborhoods with the highest percentage of minority residents are characterized by a higher-than-average population density, lower household income, and lower educational attainment[166]. The latter two factors often correlate with crime rates[167,168]. This suggests the potential for increased calls for service and thus uneven policing, concentrated disproportionately in minority neighborhoods. However, reported crime rates appear to be only weakly related to the geography of communities of color in Seattle[169,170]. With the caveat that we do not have data on patterns of policing at the beat or precinct level in Seattle, this suggests that geographically uneven policing at the neighborhood level (i.e., "over-policing" of certain neighborhoods) may not be a primary cause of the racial disparities in helmet citations. However, geographically uneven policing at smaller geographic scales may still influence racial disparities in citations, and at all scales, uneven exposure to policing may contribute to the high fraction of citations issued to homeless individuals.

Disparities in policing may also manifest from encounters at the individual level. In its 2011 investigation into the Seattle Police Department that led to the opening of a consent decree, the U.S. Department of Justice wrote[171]:

> *"... SPD officers may conduct a disproportionate number of street checks on people of color in certain precincts when compared to population percentages. For example, in the East precinct, non-whites make up only 33% of the population, however, they made up 64% of the street checks. Similarly, in the West precinct, non-whites only make up 26% of the population, but made up 47% of the street checks. In the Southwest precinct, non-whites make up 32% of the population, but made up 49% of the street checks."*

As previously discussed, even after accounting for differences in underlying disparities in crime, demographics, or socioeconomic factors in Seattle, an individual's race alone is predictive of the likelihood of being stopped and frisked by Seattle police as a driver or pedestrian[172]. **This evidence on inequities in police stops by Seattle police raises concerns that the disparities in helmet citations are likely related to biases in who police tend to stop, as well as biases in the outcomes of stops (i.e., whether a citation or warning is issued).**

---

[165] "Demographic disparity analysis of law enforcement data from the Spokane Police Department," Police Strategies LLC (January 2021), https://static.spokanecity.org/documents/opendata/spd/spokane-pd-disparity-report-police-strategies-llc-jan-2021.pdf.

[166] "Growth and equity: analyzing impacts on displacement and opportunity related to Seattle's growth strategy," Seattle Office of Planning & Community Development (May 2016), http://www.seattle.gov/documents/departments/opcd/ongoinginitiatives/seattlescomprehensiveplan/finalgrowthandequityanalysis.pdf.

[167] Kelly, "Inequality and crime," *The Review of Economics and Statistics* (2000), 82(4), 530–539, https://direct.mit.edu/rest/article/82/4/530/57217/Inequality-and-Crime.

[168] Lochner, "Education and crime," Ch. 9, in Bradley and Green, eds., "The economics of education" (2020), Academic Press, https://www.sciencedirect.com/science/article/pii/B9780128153918000094.

[169] "Growth and equity…," Seattle Office of Planning & Community Development. As above.

[170] Gene Balk, "'Mean world syndrome': In some Seattle neighborhoods, fear of crime exceeds reality," *Seattle Times* (June 28, 2018), https://www.seattletimes.com/seattle-news/data/mean-world-syndrome-in-some-seattle-neighborhoods-fear-of-crime-exceeds-reality/.

[171] "Investigation of the Seattle Police Department," Civil Rights Division, United States Department of Justice (December 2011), https://www.justice.gov/sites/default/files/crt/legacy/2011/12/16/spd_findletter_12-16-11.pdf.

[172] "Tenth Systemic Assessment: Stops, search, and seizure," Seattle Police Monitor. As above.

This is ultimately unsurprising. Low rates of enforcement relative to the nearly one million helmetless personal bicycle trips that occur annually in Seattle (see calculation above) imply that **stops for helmet violations are highly discretionary**. A Seattle Police Department spokesperson has acknowledged this[173]:

> *"Do we write tickets? Yes, from time to time. We have the discretion to either write a citation or explain the laws and road safety and provide a warning. I think officers probably do the latter more."*

When enforcement is highly discretionary, existing biases are more easily introduced and magnified. Abundant research has shown that biases in policing can arise from both explicit prejudice as well as deep-seated implicit biases that associate Black individuals with crime[174,175]. Structural aspects of policing's mission to reduce "urban disorder" can also lead to a systematically punitive approach to interactions with people experiencing homelessness[176,177].

Do these patterns of enforcement extend to elsewhere in King County, outside of Seattle?

This is not yet known. We have requested records for helmet violations from all 38 other cities and towns in King County, as well as unincorporated King County. Our request with the Washington State Administrative Office of the Courts is expected to be fulfilled in early June of 2021, at which point we will update this report with a preliminary analysis of rates and patterns of citations within these jurisdictions.

We have already requested and, in most cases, received records of some helmet citations from seven other municipal courts in King County (Des Moines, Federal Way, Kent, Kirkland, Renton, SeaTac, Tukwila) as well as the King County Sheriff's Office and Burien Police Department. However, the data that these requests have yielded has been too incomplete for a meaningful analysis and courts' responsiveness to our requests has been mixed. Additionally, most towns and cities in King County rely on the District Court system (rather than municipal courts), which declined to fulfill our bulk records request due to COVID-19 impacts.

---

[173] David Gutman, "Helmets may be Seattle law, but many bike-share riders don't wear them," *Seattle Times* (August 19, 2017), https://www.seattletimes.com/seattle-news/transportation/helmets-may-be-seattle-law-but-many-bike-share-riders-dont-wear-them/.

[174] Weir, "Policing in black and white," *American Psychological Association* (2016), 47(11), 36, https://www.apa.org/monitor/2016/12/cover-policing.

[175] Fridell, "The science of implicit bias and implications for policing," in "Producing bias-free policing," SpringerBriefs in Criminology (2017), Springer, 7–30, https://link.springer.com/chapter/10.1007/978-3-319-33175-1_2.

[176] Herring et al., "Pervasive penalty: how the criminalization of poverty perpetuates homelessness," *Social Problems* (2020), 67(1), 131–149, https://academic.oup.com/socpro/article/67/1/131/5422958.

[177] Sylvestre, "Policing the homeless in Montreal: is this really what the population wants?," *Policing and Society* (2010), 20(4), 432–458, https://www.tandfonline.com/doi/abs/10.1080/10439463.2010.523114.

If enforcement rates are low, why should one care about changing the helmet law?

Despite low enforcement rates at present in Seattle (see above), the helmet law can still cause harm in a number of ways:

- **The number of police stops related to helmet violations is likely far greater than the number of citations issued.** As a Seattle Police Department spokesperson acknowledged (see above), helmet-related stops can lead to the issuance of a citation or a warning. It is unclear how officers make these decisions, which may be influenced by explicit and implicit biases. The number of warnings issued from helmet stops is probably an order of magnitude greater than the number of citations, representing more frequent police contacts than citation records suggest. While Seattle PD has yet to fulfill a records request asking for this data, several lines of evidence suggest this is the case. In the city of Burien, only about 4% of contacts due to pedestrian- and bicycle-related violations result in a citation being issued[178]. In Tampa, FL, an examination by the U.S. Department of Justice found that just 3-5% of cyclists stopped by police for various reasons received a formal citation[179]. Anecdotally, in responses that we have received to our outreach survey (some provided below), we have heard of five first-hand experiences of bicycle-related citations being issued in King County but 15 first-hand experiences of bicycle-related stops resulting in a warning being issued, rather than a citation. These lines of evidence suggest that the number of police contacts resulting from the helmet law is 4-30x greater than the number of citations issued.

- **Police use the helmet law selectively to conduct pretextual (i.e., investigatory) stops.** In 2016, a police dashboard camera video[180] captured a Seattle police officer pulling over and detaining a homeless Black man who was riding a bike without a helmet or lights, using these as an excuse because, as the officer confided to another officer on the scene, the man matched the description of a burglary suspect. In a tense, 19-minute-long encounter that at times appeared close to escalating, the man protested, "There are people all the time riding their bikes without helmets… why are you picking on me? It's racial profiling." In another instance in 2019, a Seattle police officer stopped a homeless man, ostensibly for riding a bicycle without a helmet, while the real motive was to investigate for warrants, search for drugs, and locate an unrelated individual[181]. These are clear examples of the King County helmet law being used for a purpose it was not intended. We believe these are unlikely to be only instances of police officers in King County using helmet enforcement as an avenue to effect pretextual stops—rather, these instances just happened to be documented. This is consistent with findings from other U.S. cities (see above) that Black cyclists are stopped far more frequently on the basis of "suspicion" and "probable cause," as well as growing evidence that helmet laws are frequently used by police outside the U.S. to conduct pretextual stops of cyclists (e.g., in Australia, where helmet violations are issued disproportionately to Aboriginal people)[182]:

  > *"[P]olicing policy and practice appears to have become wholly detached from the public safety approach that originally ushered in the MHL (mandatory helmet law) offence and focuses more*

[178] Theodore (Ted) Boe (Burien PD chief), personal communication with Burien Deputy Mayor Krystal Marx, via Tiffani McCoy, May 18, 2021.

[179] Ridgeway et al., "An examination of racial disparities in bicycle stops and citations made by the Tampa Police Department… ." As above.

[180] User SPDwatcher, "Seattle Police cop stops black man for riding a bike with no helmet" [video], YouTube (March 23, 2017, accessed on May 24, 2021), https://youtu.be/Bhew1Q9yLsA?t=189.

[181] Tweet by David Kroman [user @KromanDavid], Twitter (December 17, 2020, accessed May 24, 2021), https://twitter.com/KromanDavid/status/1339692243829985280.

[182] Quilter and Hogg, "'[I]f it's a public health and safety thing… why not just give the kids helmets?": Policing mandatory helmet laws in New South Wales," *University of New South Wales Law Journal* (2021), 44(2), https://www.unswlawjournal.unsw.edu.au/article/if-its-a-public-health-and-safety-thing-why-not-just-give-the-kids-helmets-policing-mandatory-helmet-laws-in-new-south-wales-advance/.

closely on proactive fines enforcement. … Under such circumstances the MHL offence becomes little more than an adjunct to street-level police powers unrelated to safety and which are open to arbitrary use as a pretext to stop (and possibly search, question, harass) citizens on grounds that escape any form of meaningful legal accountability. … [T]his is precisely the way the MHL offence is administered in some areas."

- **Helmet-related police stops can lead to arrests for outstanding bench warrants, most of which are for low-level offenses.** The police chief of a city in King County has acknowledged that bicycle helmet-related stops can result in an officer checking and running identification, which can pull up outstanding warrants and lead to an arrest[183]. We found examples of this occurring in Puyallup[184,185], which is in Pierce County. In Dallas, TX, reporting found about 1 in every 6 bicycle helmet-related stops and citations was also associated with an arrest[186]. There are millions of outstanding bench warrants in the U.S.[187], the large majority of which are issued for a failure to show in court or to pay fines for minor offenses, often so-called "crimes of poverty" like failing to pay a parking ticket[188]. In 2019, the Seattle Municipal Court held 5,000 hearings to address bench warrants[189], and of the 795 bench warrants issued to King County youth in 2019 for court order violations and failures to appear in court, more than 80 percent were against Black youth, Indigenous youth, and other youth of color[190]. While the situation is King County is not as severe as in places like New Orleans – where 1 in every 7 adults has a warrant out for their arrest, typically for nonviolent offenses like panhandling or fishing without a license[191] – thousands of warrants remain outstanding in Seattle[192]. Police contacts that allow for arrests on bench warrants actualize the criminalization of poverty in multiple ways[193]:

  "It is important to note that often bench warrants are related to people not paying their fines and fees. … [C]ourts regularly [issue] warrants for people who owed court debt but failed to appear. Furthermore, recent research found that many people did not receive the notices due to being unhoused or because the court had the wrong address. And, right or wrong, many times people fail

[183] Theodore (Ted) Boe (Burien PD chief), personal communication with Burien Deputy Mayor Krystal Marx, via Tiffani McCoy, May 18, 2021.

[184] Puyallup Police Department, "Blotter week of March 4th – 10th" [social media post], Facebook (March 11, 2021, accessed on June 5, 2021), https://www.facebook.com/PuyallupPD/posts/blotter-week-of-march-4th-10thdrug-paraphernalia-warrant-210630045231300-blk-9th/1791103804397875/.

[185] Travis Loose, "Officers arrest WA's most wanted, a bad dad, and a bad son: log," *Patch.com: Puyallup, WA* (June 18, 2019), https://patch.com/washington/puyallup/officers-arrest-was-most-wanted-bad-dad-bad-son-log.

[186] Tom Benning, "With Dallas bike helmet law, rules of the ride enforced unevenly," *Dallas Morning News.* As above.

[187] Mike Wagner, Doug Caruso, Daphne Chen, and John Futty, "Tens of thousands of warrants go unfilled in Ohio," *The Columbus Dispatch* (December 2, 2018), https://www.dispatch.com/news/20181202/tens-of-thousands-of-warrants-go-unfilled-in-ohio.

[188] Doug Caruso, Eli Sherman, and Mike Wagner, "Open arrest warrants are rapidly increasing," *The Milford Daily News* (January 20, 2019), https://www.milforddailynews.com/news/20190120/open-arrest-warrants-are-rapidly-increasing.

[189] Anita Khandelwal, King County Department of Public Defense, letter to Seattle City Council and City Attorney Holmes (June 22, 2020), https://defensenet.org/wp-content/uploads/2020/06/6.22.20-Letter-regarding-SMC.pdf.

[190] "Annual report 2021," King County Department of Public Defense (April 2021), https://kingcounty.gov/~/media/depts/public-defense/Documents/2021-DPD-Annual-Report_reduced.ashx.

[191] Richard A. Webster, "One in 7 adults in New Orleans have a warrant out for their arrest, new data shows," *Washington Post* (September 20, 2019), https://www.washingtonpost.com/national/one-in-7-adults-in-new-orleans-have-a-warrant-out-for-their-arrest-new-data-shows/2019/09/20/db85a5c8-da3d-11e9-a688-303693fb4b0b_story.html.

[192] Steve Miletich, "Seattle moves to quash old misdemeanor warrants involving low-level, nonviolent crimes," *Seattle Times* (November 27, 2018), https://www.seattletimes.com/seattle-news/crime/seattle-moves-to-quash-old-misdemeanor-warrants-involving-low-level-nonviolent-crimes/.

[193] Alexes Harris, "Daunte Wright and the grim financial incentive behind traffic stops," *Vox* (April 15, 2021), https://www.vox.com/first-person/22384104/daunte-wright-police-shooting-black-lives-matter-traffic-stops.

to appear in court out of fear of being incarcerated, missing employment, or not having child care. Just because a warrant is issued does not mean that a person has been or will be dangerous."

- **Research has shown that police stops of youth associated with "proactive policing" cause significant psychological distress that can change one's life trajectory.** A 2019 study found that adolescent Black and Latino boys stopped by police are more likely to engage in delinquent behavior in the following months and years, even after controlling for prior delinquency, and that this is partially mediated by psychological distress (i.e., stress, depression, and anxiety responses)[194]. Similarly, a 2020 study by University of Washington researchers that followed Seattle Public Schools students found that police encounters in childhood increase the risk of arrest in young adulthood for Black youth, but not white youth[195]. This adds to evidence that Black youth are treated more poorly during discretionary police stops, such as those for minor bicycle infractions, as well as evidence that Black boys are more likely to be perceived as older and less innocent than peers of other races during these interactions[196]. Overall, discretionary stops can cause harm and erode trust in the police[197].

- **As detailed above, every minor police stop, including of bicyclists, is inherently dangerous for people of color.** It is for this reason that Seattle Inspector General Lisa Judge, who leads Seattle's civilian police oversight agency, the Office of Inspector General, recently asked the Seattle Police Department to cease conducting routine traffic stops for minor violations[198,199], writing:

  "Stopping a person is a significant infringement on civil liberty and should be reserved for instances when a person is engaged in criminal conduct that harms others. Stops for government-created requirements like car tabs, with nothing but a potential monetary penalty, do not justify the risk to community or to officers. ... While these interactions may create the potential for a tragic outcome, they also generate an encounter that can impact whether and how community members form negative opinions of the police, which can influence public trust in the department. Researchers have documented that persons stopped for traffic violations are significantly less likely to seek help from the police and/or to report non-crime emergencies than those with other types of direct police interactions. Moreover, research has consistently shown that Black and Latino experiences during traffic stops are different from those of white persons. ... For safety of both officers and the public and for racial fairness, [Seattle Police Department] should seek to eliminate routine traffic stops for civil and non-dangerous violations."

- **Even with low rates of enforcement, issuing citations for helmet violations represents a punitive practice that results in disproportionate impact to low-income individuals and contributes to the perpetuation and criminalization of poverty (see discussion above).**

---

[194] Del Toro et al., "The criminogenic and psychological effects of police stops on adolescent black and Latino boys," *Proceedings of the National Academy of Sciences* (2019), 116(17), 8261–8268, .https://www.pnas.org/content/116/17/8261.short.

[195] McGlynn-Wright et al., "The usual, racialized, suspects: the consequence of police contacts with Black and white youth on adult arrest," *Social Problems* (2020), spaa042, https://academic.oup.com/socpro/advance-article/doi/10.1093/socpro/spaa042/5953172.

[196] Goff et al., "The essence of innocence: consequences of dehumanizing Black children," *Journal of Personality and Social Psychology* (2014), 106(4), 526–545, https://pubmed.ncbi.nlm.nih.gov/24564373/.

[197] McGlynn-Wright et al. (2020). As above.

[198] Lisa Judge, Seattle Inspector General, Office of Inspector General, letter to Seattle Police Chief Adrian Diaz (May 18, 2021), https://publicola.com/wp-content/uploads/2021/05/OIG-Diaz-Letter-Minor-Offenses-0518212831.pdf.

[199] Paul Faruq Kiefer, "Police accountability leader asks SPD to phase out routine traffic stops," *South Seattle Emerald* (May 21, 2021), https://southseattleemerald.com/2021/05/21/police-accountability-leader-asks-spd-to-phase-out-routine-traffic-stops/.

Why not just focus on reforming the police?

We acknowledge that the disparities in helmet citations by race and housing status are a symptom of larger, structural problems that systematically disadvantage, punish, and endanger vulnerable community members through the institution of policing and the criminal justice system. Some have suggested that biased police enforcement can be reformed, and that our advocacy should focus on fixing policing rather than modifying the helmet law. While optimistic, we believe this sentiment is shortsighted. As also detailed above, research shows that biases in policing arise from deep-seated explicit, implicit, and structural factors that associate Black and homeless individuals with crime[200,201,202,203]. These associations and structural factors have been proven to influence officers' behavior, affecting decisions regarding stops, arrests, and use of force at an individual level[204] and resulting in racially-biased outcomes that are detectable in millions of police interactions across the nation[205]. These problems are not only individual, but also deeply-rooted at the department and city level. Black neighborhoods around the country are over-surveilled and over-policed, a legacy of policies that created racial segregation and entrenched poverty within communities of color in cities[206,207,208].

We believe that these biases and patterns of over-policing are deeply-rooted and cannot be effectively reformed or reduced through existing accountability mechanisms. Police harassment (see above) and police violence (see above) will remain an urgent public health risk for people of color in King County for years to come. This is why we ask that the helmet law itself be reconsidered to immediately limit encounters between police and people riding bicycles, and reduce the potential for harm to be inflicted on vulnerable community members. Across the nation, Black and Hispanic bicyclists have expressed a lack of trust in the ability of police to serve as an effective partner in bicycle safety education and enforcement (see details above).

[200] Sylvestre (2010). As above.

[201] Weir (2016). As above.

[202] Fridell (2017). As above.

[203] Herring et al. (2020). As above.

[204] Ba et al., "The role of officer race and gender in police-civilian interactions in Chicago," *Science* (2021), 371(6530), 696–702, https://science.sciencemag.org/content/371/6530/696.

[205] Pierson et al., "A large-scale analysis of racial disparities in police stops across the United States," *Nature Human Behavior* (2020), 4, 736–745, https://www.nature.com/articles/s41562-020-0858-1.

[206] Gellman and Adler-Bell, "The disparate impact of surveillance," The Century Foundation (December 2017), https://tcf.org/content/report/disparate-impact-surveillance/.

[207] Fagan et al., "Stops and stares: street stops, surveillance, and race in the new policing," *Fordham Urban Law Journal* (2016), 43(3), 539, https://ir.lawnet.fordham.edu/ulj/vol43/iss3/3/.

[208] Robin Smyton, "How racial segregation and policing intersect in America," *Tufts Now* (June 17, 2020), https://now.tufts.edu/articles/how-racial-segregation-and-policing-intersect-america.

Why is the helmet law particularly damaging for those experiencing homelessness?

For many low-income individuals and, in particular, those experiencing homelessness, access to bicycling means access to mobility, independence, and joy. A lack of reliable and low-cost transportation options often presents a major structural challenge for homeless individuals. A bicycle can lessen this challenge, connecting homeless individuals to places of employment, shelters, medical services, one's social support network, and other critical survival needs[209,210]. Equally important, studies have shown that access to a bicycle leads to increased health, self-esteem, and social interactions for people experiencing homelessness[211,212,213].

However, for homeless individuals already stigmatized by exclusion from public spaces and forms of restricted mobility[214], a helmet law and the police contacts that it invites represent an additional restriction on mobility that can be uniquely damaging for those who bike out of necessity, rather than choice. While Census data indicates that around 4% of all Seattle residents use bicycling as their primary mode of transport to get to work[215], homeless individuals in other cities use bicycling as their main mode of transport at 2-3x that rate (as discussed above). A recent study of homeless and unstably-housed men in Vancouver, BC[216] who use bicycles for informal recycling work, arrives at similar conclusions on the benefits of cycling to those mentioned above. But participants also describe being hassled by police, who conduct "street checks" and hand out tickets for minor infractions, such as violations of British Columbia's provincial helmet law. In the words of one homeless participant:

> *"[The police] went on a spree there a couple years ago and started handing out 29-dollar tickets for no helmet. 'Course, I got nailed, everybody I know got nailed. But, now they want you to pay it. You don't pay it, they say you're gonna go to jail. … I can't pay that bill."*

For homeless individuals, penalties for not wearing a bicycle helmet can trigger – or exacerbate – the crippling cycle of debt and legal consequences that can result from unpaid minor infractions. These practices have the effect of criminalizing poverty and entrenching homelessness[217]. We find that the high rate of helmet citations issued to homeless riders in Seattle is disproportionate, even after accounting for differences in cycling rates and helmet use (see calculation above). We find this pattern even more unacceptable given the highly discretionary nature of current helmet enforcement practices (as mentioned previously), which suggests that police officers may, in fact, be 'singling out' homeless bicyclists for stops, or systematically issuing fewer warnings and more citations during stops of homeless bicyclists.

---

[209] Brallier et al. (2019). As above.

[210] Grimes and Smirnova, "Perspectives on an earn-a-bike intervention on transportation, health and self-esteem among men experiencing homelessness," *Journal of Transport and Health* (2020), 18, 100904, https://www.sciencedirect.com/science/article/abs/pii/S2214140520301080.

[211] Ibid.

[212] Parker, "Bicycle use and accessibility among people experiencing homelessness in California cities," *Journal of Transport Geography* (2019), 80, 102542, https://www.sciencedirect.com/science/article/abs/pii/S0966692318305210.

[213] Crawford et al., "'It's good to have wheels!': Perceptions of cycling among homeless young people in Sydney, Australia," *Youth Studies Australia* (2012), 31(4), 55–63, https://ro.uow.edu.au/sspapers/3691/.

[214] Jocoy and Del Casino (2010). As above.

[215] Tom Fucoloro, "Census survey: Biking, walking and transit up as commute data corrects itself + driving alone down to 44.5%," *Seattle Bike Blog* (September 27, 2019), https://www.seattlebikeblog.com/2019/09/27/census-survey-biking-walking-and-transit-up-as-commute-data-corrects-itself-driving-alone-down-to-44-5/.

[216] Steinmann, "(Re)cycling through poverty: A study of homelessness and bicycling in Vancouver, Canada," Master's Thesis, University of British Columbia (2020), https://open.library.ubc.ca/cIRcle/collections/ubctheses/24/items/1.0394710.

[217] Karen Dolan and Jodi L. Carr, "The poor get prison: the alarming spread of the criminalization of poverty," Institute for Policy Studies (2015), https://ips-dc.org/wp-content/uploads/2015/03/IPS-The-Poor-Get-Prison-Final.pdf.

What stories have we heard from people impacted by helmet enforcement?

- During the February 2021 King County Board of Health meeting, a homeless Real Change newspaper vendor shared his experience with enforcement of the helmet law, which he believes is used by police to harass people who they believe are homeless or don't belong in a certain area. He related two stories of helmet-related stops in the SODO neighborhood of Seattle, one while he was trying to ride around an officer who had pulled over a car, and another in the parking lot of a Denny's restaurant. In his view, **"I don't think it has to do with protection or anything else, it's just total harassment. … I don't see that this is really fair to the entire population. I don't see why some can ride without helmets and others get stopped and harassed."**

- Also during the February 2021 Board of Health meeting, Seattle City Councilmember Teresa Mosqueda shared an experience from one of her staff members. The staff member was biking with her friends, all women of color, and were pulled over in a bike lane by police for not wearing helmets while using bike share (which does not provide helmets). **She and her friends had been feeling the excitement of bicycling, but she reported that this encounter led to trauma, fear, and disappointment.** As previously mentioned, 75-80% of bike share users in Seattle ride without helmets, leading to over 1.5 million helmetless bike share trips annually in Seattle.

- A staff member of another Seattle city councilmember related to us that two of her nephews, both Black boys who were 16 and 17 years old at the time, were stopped by Seattle police for not wearing a helmet while bicycling. The officer eventually let them go with a warning, but first wanted to ask them questions (including, "Do you live around here?") and run their names through SPD's computer system. The children asked if they could call their parents but the officer did not allow them to do so. **They found the experience traumatizing, and believed the purpose of the stop was for the officer to "make contact" for reasons unrelated to the helmet violation.**

- In social media comments on stories about our advocacy effort, we have seen people relate stories of police harassment. For example, a member of the BIPOC-focused NorthStar Cycling Club shared a story on Facebook of being stopped by Seattle police in the Capitol Hill neighborhood for having "such a nice bike and no helmet." The rider, a person of color, was questioned about where his bicycle was from, to which he felt he needed to respond by showing them a registration sticker (which is not required in Seattle). In his words, **"That police interaction could have ended a million different ways... all because of a helmet."**

In addition, respondents to our survey (described above) have shared stories related to helmet enforcement, as well as enforcement of similar bicycle infractions. All respondents quoted here have indicated that their responses and demographic details about themselves could be shared publicly. Emphasis is added to highlight key points:

- *From a local bike shop owner in Seattle:* "I am a white person, and I have brown skin and I have been ticketed or stopped by police while riding my bike more times than I can count, at least a dozen times in the last 20 years in Seattle. I was once on the staff of Bike Works as a teacher and ride leader of groups of mostly POC kids, and on part-time staff at Cascade as a Bike Ambassador. **The disconnect between the experiences of police enforcement for the South End youth and the mostly white Cascade members was jarring**. I remember being told by Cascade staff that, 'No one gets helmet tickets,' in the same week that **two of my Bike Works students were harassed by a LEO [law enforcement officer] and held for an hour riding home from our programs** with no charge or tickets issued."

- "**I'm a male of Hawaiian/Filipino descent and I've always had negative experiences with police enforcement while riding my bike in King County.** In Seattle, I've been yelled at and stopped on several occasions for multiple reasons but lack of helmet was the majority of those interactions. The most interesting but not surprising aspect of all these interactions is that **whenever I was riding with one of my white friends, I was still the focus of these negative interactions**. It became a joke among my white friends that they should always ride with me so that they never have to get a citation."

- "**My good friend is black and had an afro hair style that cannot fit under a bicycle helmet. His afro was part of his identity and to ask him to cut his hair to wear a helmet would have been detrimental to him.** He was a cyclist who used his bike as his primary mode of transportation. He was pulled over by a motorcycle cop for not wearing a helmet and running a red light while biking home from work. There was no one at the red light and he had treated it as a yield, which he considered safe and had no negative consequences for anyone. **My friend has been harassed many times by police due to being black and to have yet another opportunity for police to harass and criminalize him is unacceptable.** Stop policing bicyclists. Repeal the helmet law."

- "I am a white female rider in my 40s and I always wear a helmet. I've never been stopped on my bike and often get friendly treatment by police who direct traffic or are out of their cars for other reasons. **I used to volunteer at a day shelter for youth and one young man (who is white, but who was also experiencing homelessness) told me about getting a ticket for no helmet**. He was seeking resources so that it didn't happen again. I have seen a person of color pulled over for running a stop sign in Fremont and it felt unnecessary on a quiet street early in the morning…"

- "[W]hile volunteering at [a community bike shop], one of our volunteers who was experiencing homelessness was so uncomfortable when a [police] officer came in that he walked out. **After the officer left, he came back and shared that the [police] frequently harasses cyclists who are underhoused/unsheltered/depend on bikes for transportation.** Usually, they use not having a light or reflector as an excuse to initiate contact."

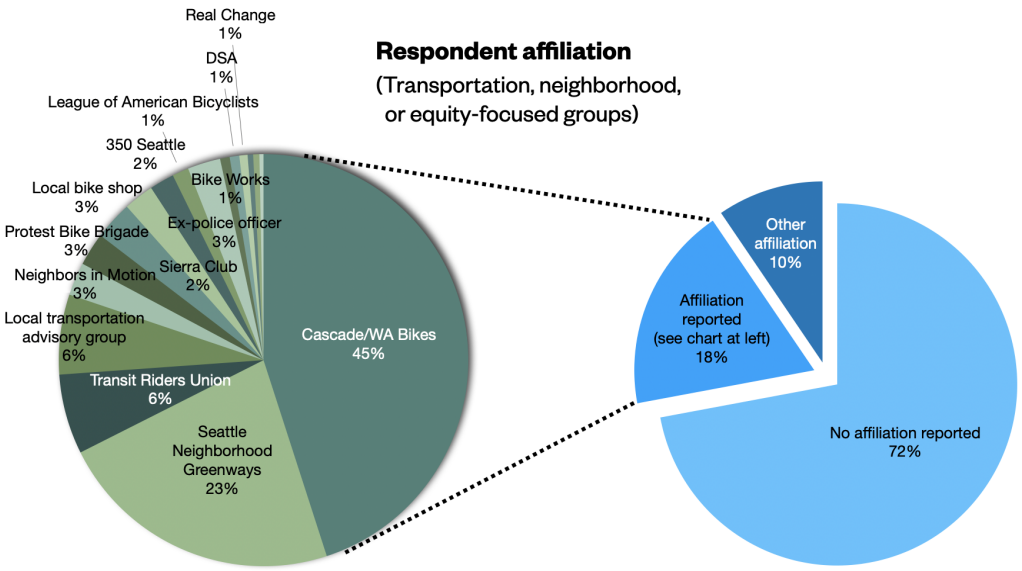
- "I was involved in a collision with a car. **The first question from the officer on the scene was, 'where's your helmet?'** This was more important than any other aspect of the scene or apparently even my well-being. The officer's subsequent behavior made clear he was looking for a reason to ticket me, to prevent insurance repercussions for the driver. These negative experiences occurred to me, a white male. **My conversations with cyclists of color suggest that their experiences with selective enforcement of helmet laws are in general much worse**."

- This respondent, a Hispanic and Asian man, was stopped by Seattle police three years ago under suspicion for a "safety check" while bicycling home from work. The officer gave him a "warning about using lights" after checking his ID. He felt "intimidated and frightened due to other past police threats in other states since childhood." **Since then, he has "reduced late night cycling, and just uses buses."** The motivation for this stop was not a helmet violation, but we believe the interaction that resulted is likely to be qualitatively similar to those experienced by those stopped for helmet violations.

- "I think the King County helmet law does more harm than good for our communities and that investments should be prioritized in better and stricter driver education programs and more education programs for cyclists. **I've been stopped and given warnings by Seattle police officers in relation to the bike helmet law, but never given a ticket. The conversations with the officers were never educational, only stern warnings of intimidation.**"

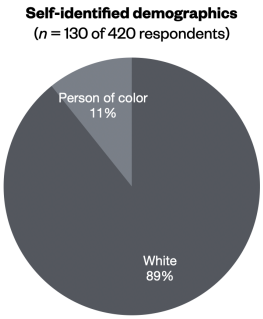
What perspectives have community members shared with us about the future of the helmet law?

Our survey, described above, has received 420 unique responses from community members as of April 2021. The following charts summarize those responses. Note that our survey was not intended to be rigorous or scientific. Its primary purpose was to elicit stories about experiences with helmet law enforcement and to provide a barometer of community opinions on the future of the helmet law.

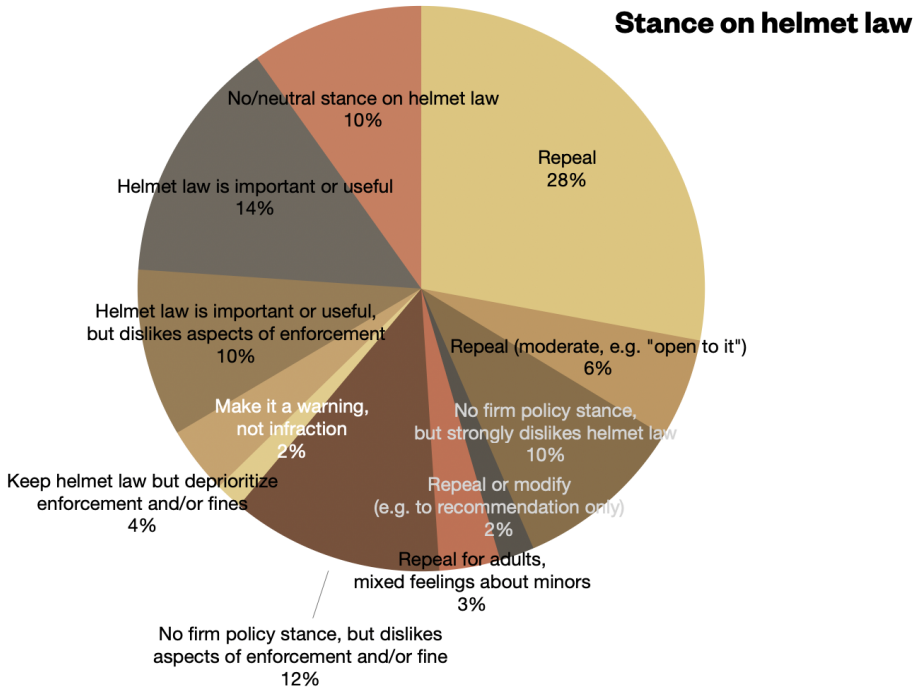


Respondent affiliation: Our survey asked, *"What community organization(s) are you affiliated with, if any? Specifically, we would like to know if you are involved in any neighborhood, transportation, environmental, community-based, or equity-focused organizations."* The pie charts above show that the majority (72%) of respondents did not name an affiliation, while 18% of respondents reported an affiliation also mentioned by at least one other respondent. While just 8% of respondents indicated an affiliation with Cascade Bicycle Club, more than half of our responses (~65%) were received within two days after the survey was advertised in emails from Cascade in February 2021. This suggests that the majority of our survey responses are representative of those involved in some capacity with Cascade, a community whose demographics we recognize skew towards white, recreational cyclists.

Self-identified demographics: Respondents' open-ended written responses were reviewed, and we flagged instances in which a respondent clearly self-identified as white or a person of color. The pie chart at right shows that out of the 31% of respondents who self-identified in their comments, demographics skew more white (89% white) than both the demographics of Seattle as a whole (60% white, from 2017-2018 census data) and the demographics of Seattle cyclists (71% white, from our estimates constructed using three population surveys)[218].

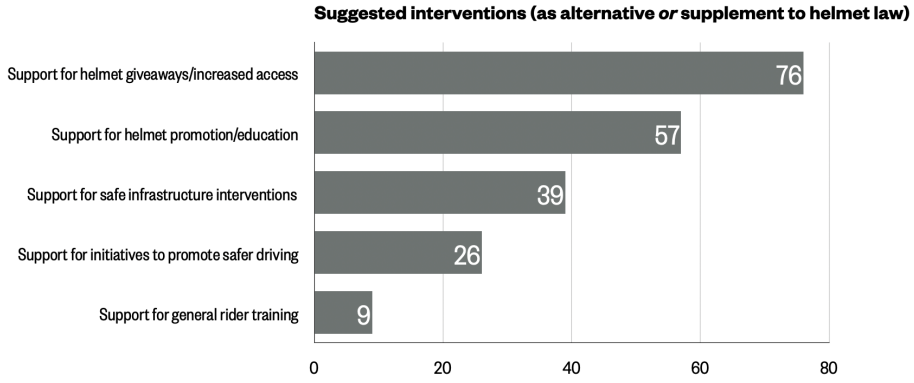


[218] Ethan C. Campbell, "Technical report on bicycle infractions in Seattle (2003-2020)... ." As above.



Stance on helmet law: The chart above illustrates survey respondents' opinions about the helmet law, which were categorized based on answers to the open-ended question, *"What are your thoughts about policing of cyclists in King County, particularly related to the helmet law? We are interested in your perspectives on repealing or modifying the helmet law, alternatives to mandating helmet use, criminalization and/or enforcement of other bicycle infractions, etc."* Responses that fit into more than one of the categories shown above were allocated evenly between the relevant views.

While the subject of the helmet law has been polarizing in the past within the cycling community, **about 70% of survey respondents were supportive or open to modifying or repealing the law, and almost 80% expressed some degree of dissatisfaction with the current helmet mandate or the way that it is enforced**. Respondents were most frequently supportive of efforts to increase helmet use but opposed to using police enforcement to try to accomplish that goal.



Suggested interventions: Many respondents shared ideas about preferred strategies to keep cyclists safe, either in the absence of a helmet law *or* in addition to the existing (or a modified) helmet law. The chart above shows that the

most frequently-mentioned interventions were efforts to increase access to helmets, such as through subsidies or giveaway programs. We note that the lower frequency of comments recommending strategies to prevent collisions from occuring in the first place (e.g., safer infrastructure, safer driving) is not necessarily indicative of a lower level of support for those interventions, as the open-ended question did not specifically ask about these.

Selected comments: Below we share some illustrative survey responses that were generally supportive of changes to the helmet law. All respondents quoted here have indicated that their responses and demographic details about themselves could be shared publicly in our advocacy. Some responses have been condensed, but we have not edited respondents' words except for those in brackets that were substituted for clarity when condensing comments. Emphasis is added to highlight key points:

- "[The helmet law] needs to be repealed. Many people of color barely afford a cheap used bicycle, yet alone a helmet. ... **I'm Black and cycle everyday. But, I'm dressed the part.** I have a couple of high end bikes and nice bicycle clothing. Plus I always wear a helmet."

- "I think it's a bad idea to ride a bike without a helmet but I also don't think people should be ticketed if they're not wearing one. … **I don't have a lot of confidence that the police will change their behavior without decriminalizing helmet wearing**."

- *From a nationally-certified bicycling instructor, a white woman who lives in Seattle:* "Helmets often save lives, but helmet use shouldn't be criminalized, especially if they discourage people of color and homeless people from riding. … People living in poverty can't afford to pay for a gym membership, and it's understandable they wouldn't pay upwards of $40 for an ANSI-certified helmet. Yet there are many ways to make [bicyclists] safer: safe riding education, fixing broken bicycles and/or teaching bicycle maintenance, and safer infrastructure are way more important. **People of color have made it abundantly clear that criminalizing trivial things like wearing helmets affect them negatively."**

- *From a respondent living in Belltown:* "Repealing this law is one small step our community can take for racial and social justice in policing. I am a white man and have never been stopped by Seattle police while cycling. Though I typically wear a helmet, **I have occasionally ridden without one and have never been stopped or cited – even when riding right past police officers**."

- "I am a white male that has been stopped once before for an unrelated reason and was reprimanded for not wearing a helmet. **I suspect my experience would have been different were I a person of color.**"

- *From a white man:* "I never bike without a helmet as I have broken two helmets in falls (one on black ice, one on spilled transmission fluid). Each time I had no injury although my helmet was destroyed. **So I strongly believe in helmets**. But if a helmet law ends up being not a tool for safer biking but rather one for inequitable treatment of certain cyclists, then **the law has failed in its purpose**. I do not object to repeal of the law."

- "**Helmet laws were intended to end an era of people ignoring safety. Nobody today is ignorant of the societal ask for people to wear helmets.** The law now serves as another piece of out of date code to use to harass people of lesser means or status. The science is also fairly clear that 1) every bit about wearing bike helmets improving safety probably also applies to driving or crossing the street, and 2) the best way to improve bike safety is to give bikes spaces away from cars, which means having more riders which means being inclusive, even of people without helmets. ... **Until we establish systems of law enforcement that work substantially better and more fairly, we need to get rid of laws like this that are pointed tools of enforcing inequality.**"

- "That police view those on bicycles – especially those who bicycle for transportation instead of fitness – as somehow deviant from the mainstream whose interests they protect is no secret. Our traffic laws and legal system are also full of people who have negative biases against cyclists. Add institutional or structural racism and anti-homeless biases to the mix, as well as police training that teaches police officers that those they are sworn to protect are in fact a threat to their safety, and **you've got a recipe for more death at the hands of police.**"

- "**I was pulled over for speeding without a helmet at 2 am**, I had been drinking but I didn't volunteer this info, **I am white, I rode my bike home with a 'warning'**. This law is unfairly applied."

- *From a woman who lives in downtown Seattle:* "As someone who has commuted by bicycle in and around downtown Seattle since 2003, I can tell you without data that helmet usage has increased exponentially in the past 4-5 years. It has become normalized by choice so I believe it does not need to be legislated or policed. **As a white woman I have never once been stopped by police much less cited, and until 2-3 years ago I never wore a helmet.** So your data doesn't surprise me at all, the racial profiling is intolerable, and no policing of helmet use will do as much good as peer socialization anyway."

- "... personal safety laws like the helmet law deflect issues around street safety. **Helmets are like surveillance cameras – they only matter after the harm has been done.** What can be done to put the responsibility back on the agencies to make our streets safe from vehicle violence?"

- "The helmet law reminds me of the words of my microeconomics professor: **'If something is good in theory but lousy in practice then it is actually lousy in theory.'** Repeal the law. I suspect that most who wear a helmet do so for safety reasons, not to comply with the law. Have an ongoing campaign promoting the use of a helmet. Use a portion of motor vehicle violations to create a fund to distribute helmets to low income households."

- "**Wanted to say that the helmet law has messaged to my daughter and to everyone as a whole that bicycling is dangerous.** I think it's led to less likelihood of my daughter to ride. If there are helmet laws for bicyclists, there should be helmet laws for vehicle/car occupants as well, for parity in messaging to align with true dangers."

- "Wearing helmets should be encouraged but never punished. **Enforcing it also is not compatible with rental bike operations.**"

- "**I support decriminalizing helmet use.** I always wear one, and when I ride with friends and family members, I insist on helmets in our group. But I recognize that helmet cost (and attitudes) are barriers to people riding bikes in many cases: the cost of a helmet, or just a preference not to wear one, shouldn't keep someone from biking. … **I'd rather see crowds of bareheaded cyclists, like the pics of Swedish cities, than a trickle of people with helmets.** More riders equals more safety for all, as drivers are forced to adapt their habits to more rolling vulnerable humans."

- "**Bicycle helmet laws reduce bicycle usage**, especially among poor (affordability), women (don't like helmet hair), and beginners (just another hassle and item to store at work when commuting). **It is misguided to say helmets save lives**, as by reducing bicycle use they shift people to hazards associated with driving, and to sedentary lives and subsequent heart attacks."

- "**Wearing bike helmets should be a strong safety advisory**, but failure to wear a helmet should not be a criminal infraction. I always wear a helmet and wearing a helmet has protected me from head injuries on several occasions."

- "Make [biking] safe for all people – **enforce bad driving, which harms pedestrians, other drivers and all people on bikes**. On top of that, our supposedly 'progressive' city is notoriously discriminating to black/POC citizens and it is a huge shame. Getting more people on bikes is climate action. **Making biking more accessible and easy to do without being pulled over is KEY!** The helmet law is ridiculous. I'm the daughter of a physician and grew up with his emphasis on helmet wearing. I am now a 30+ year adult cyclist and completely see the other side. I wear a helmet and figure anyone who becomes a more regular cyclist will eventually find their way to helmets, but as it stands it is a ridiculous deterrent to just getting GOING on a bike, and again – more people on bikes is climate action and will contribute to health, freedom and joy. … **I'm not the target of changing this law, it's those newer to bikes or bike curious, and we need to help support more BIPOC folks to learn to ride and feel comfortable using a bike or e-bike for transportation**."

- "**I bought my first bike helmet in 1992 because the law was coming.** In 2010 I was struck by a pick-up truck while riding. My helmet was smashed. It certainly was the difference between life and death for me. That said, the point of the law was to motivate people to wear helmets, **not provide a convenient citation for folks that are not harming others.**"

- "There's no question that current enforcement of bicycling laws targets people of color, as well as people perceived to be homeless. I'm not sure if I'm in favor of repealing helmet laws, but I definitely want to stop racist outcomes caused by enforcing them. **Not sure why enforcement is even necessary: having the law on the books encourages use, which is the point.**"

- "Personally, I'll always wear a helmet when I'm on a bike, but it shouldn't be legally required to do so. **The helmet law discourages people from using bicycles for errands, shopping, and commuting.** Countries that have the highest rates of bicycle use do not have helmet laws. If you want to improve safety through laws and enforcement measures, increase patrols targeting distracted driving, speeding, mobile phone use while driving (make it illegal to use a phone while driving, PERIOD), improper lane use, driving into bike lanes, failure to yield to cyclists, aggressive driving, etc."

- "Decriminalization is a good idea. I guess it means it will be no longer mandatory. It's OK, **the same usage can be achieved with education, awareness, and distribution of helmets to low income people**."

Why not just modify the helmet law?

Our Working Group considered alternatives to repealing the helmet law, such as reducing fines, authorizing warnings but not citations, downgrading the violation to a secondary offense, or limiting the mandate to youth only. However, these avenues would fall short of preventing dangerous police interactions and fully ending punitive enforcement.

- **Reducing fines** would make little difference. As noted above, the majority of the financial burden of a helmet citation is not from the $30 fine, but rather from court fees that raise the total cost to $104 in Seattle, or $154 including default penalties that are frequently added.

- **Authorizing warnings but not citations** would not prevent the helmet law from being used by police to conduct pretextual stops (see discussion above), would not limit arrests for crimes of poverty due to outstanding bench warrants (as explained previously), would not mitigate the psychological harm and erosion of trust associated with police contacts (as discussed earlier), and would not keep people safe from the inherent dangers of policing that have led to tragedy in too many instances (note examples above). In fact, making a warning the only available penalty would be unlikely to significantly decrease the number of police contacts resulting from the helmet law, as most helmet-related stops already result in a warning rather than a citation.

- **Downgrading the violation to a secondary offense** may prevent pretextual stops, but would not end the situation of punitive enforcement that disproportionately impacts low-income individuals and contributes to the perpetuation and criminalization of poverty.

- **Limiting the mandate to youth only** would not prevent incidents of police harassment such as those experienced by Monique Tillman and her brother in Tacoma (details above) and youth riding home from a bicycling program in the South End of Seattle (see story shared above). Keeping a youth-only helmet mandate would leave youth vulnerable to the damaging and lasting psychological consequences of police contacts (as discussed earlier).

Our support for full repeal of the King County helmet law is consistent with research-based opposition to mandatory helmet laws from transportation professional groups, including the National Association of City Transportation Officials (NACTO)[219] and the Association of Pedestrian and Bicycle Professionals (APBP)[220]. Both the Safe Routes to School National Partnership[221] and the Vision Zero Network[222] have also recently removed enforcement as a recommended strategy to achieve safer conditions for street users such as cyclists.

[219] Corinne Kisner, "NACTO statement re: mandatory helmet laws," National Association of City Transportation Officials (NACTO) (November 2019), https://nacto.org/2019/11/08/helmet-laws/.

[220] Jessica Roberts and Caron Whitaker, Association of Pedestrian and Bicycle Professionals (APBP), letter to National Transportation Safety Board (January 10, 2020), https://drive.google.com/file/d/1xVkMBoGrCRFncHKPu2rg7le__JnWToc5/view.

[221] Cass Isidro, "Dropping enforcement from the Safe Routes to School 6 E's framework," Safe Routes Partnership (June 9, 2020), https://www.saferoutespartnership.org/blog/dropping-enforcement-safe-routes-school-6-e's-framework.

[222] Leah Shahum, "Acting for racial justice and just mobility – Vision Zero advocates: let's step up to our responsibilities," Vision Zero Network (June 8, 2020), https://visionzeronetwork.org/acting-for-racial-justice-just-mobility/.

If the helmet law were to be repealed, would bicyclists be less safe?

No. There is strong evidence that helmet legislation offers little benefit from an injury prevention perspective at present (see studies cited above). As discussed previously, the only study examining the King County helmet law[223] actually found an increase in the total number of head injuries after the extension of the law to Seattle in 2003, no change in the prevalence of head injuries compared to other bicycle-related injuries, and no change in helmet use attributable to the helmet law in Seattle. Other evidence also suggests that helmet use rates in King County today are minimally connected to the presence of a helmet mandate (see comparison to Portland and Vancouver above). With this in mind, we strongly believe that repeal of the King County helmet law would have minimal or negligible impact on helmet use and head injuries.

It is important to keep in mind that vehicular collisions, unsafe infrastructure, and low rates of cycling represent the primary risk factors in population-wide cyclist safety, not low rates of helmet use (see previous discussion). While we believe that rates of helmet use would not change upon repeal of the law, bike share presents a recent example of a drastic increase in helmetless bicycle trips that has not resulted in a catastrophic increase in head injuries. To the contrary, in five North American cities that implemented bike share, total numbers of head injuries declined by 14% (compared to a 4% decrease in five control cities), despite none of the bike share programs providing helmets[224,225]. In one powerful example, New York's CitiBike bike share system generated 8.2 million new trips in its first year, while total numbers of cyclists killed or severely injured in New York decreased by 17%[226,227]. In Seattle, dockless bike share contributes over two million trips annually[228], 75-80% of which are without a helmet[229,230], yet Seattle bike share was associated with just one serious injury in 2019[231]. This phenomenon may reflect the "safety in numbers" effect of increased ridership (see above).

We believe that continuing to encourage helmet use is important, and that new efforts to increase access to helmets within homeless and low-income populations in King County would be worthwhile. However, we would urge Seattle & King County Public Health to focus on the larger goal of preventing cyclist injuries and deaths, and to look towards more effective strategies aimed at preventing the most deadly situations – vehicular collisions – from occurring in the first place, such as those described above.

---

[223] Kett et al. (2016). As above.

[224] Salomon et al., "The safety of public bicycle share programs in North America," *American Journal of Public Health* (2014), 104(11), e5–e6, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4202953/.

[225] Angie Schmitt, "WaPo is wrong: head injuries are down, not up, in bike-share cities," *Streetsblog USA* (June 13, 2014), https://usa.streetsblog.org/2014/06/13/wapo-is-wrong-head-injuries-are-down-not-up-in-bike-share-cities/.

[226] "Safer cycling: bicycle ridership and safety in New York City," New York City Department of Transportation (2017), https://www1.nyc.gov/html/dot/html/bicyclists/bike-ridership-safety.shtml.

[227] Rebecca Smith, "A counterintuitive argument against bicycle helmet laws," *Columbia University Urban Health Student Voices* (February 2, 2020), https://www.publichealth.columbia.edu/public-health-now/news/counterintuitive-argument-against-bicycle-helmet-laws.

[228] "2019 free-floating bike share evaluation report," Seattle Department of Transportation (April 2020), https://www.seattle.gov/Documents/Departments/SDOT/BikeProgram/2019_FreeFloat_BikeSharePermit_Evaluation.pdf.

[229] Mooney et al. (2019). As above.

[230] "2017 free-floating bike share pilot evaluation report," Seattle Department of Transportation (August 2018), https://www.seattle.gov/Documents/Departments/SDOT/BikeProgram/2017_BikeShare_Evaluation_Report_113018.pdf.

[231] "2019 free-floating bike share evaluation report," Seattle Department of Transportation. As above.

If the helmet law were to be repealed, would police find other ways to conduct investigatory stops of cyclists?

We regard this as unlikely. Issuance rates of other bicycle-related citations suggest these violations are far less ubiquitous – and less easily enforced – than helmet violations.

Seattle Municipal Court records from 2003-2020 show that helmet infractions represent 55% of all bicycle-related citations[232]. Second most common are "rights and duties of riders" and roadway violations, which contribute 32% of citations, followed by a lack of proper lights or reflectors, at 7%, failing to yield the right of way in a crosswalk or public path, at 3%, and unsafe passing on the right and improper use of hand signals, at 1% each.

Based on experiences shared in responses to our survey, we believe the large majority of tickets for roadway-type violations are for failing to fully stop at a stop sign, a common and safe practice by bicyclists that was legalized in 2020 through Washington state's new "Safety Stop" law[233] and so is no longer enforceable. The third most common violation, a lack of proper lights or reflectors, is only enforceable during nighttime. The remaining violations listed above are much less common, likely because they only occur intermittently within certain contexts, and so are less likely to be observed by a passing police officer on patrol than helmet or lights violations.

Overall, we believe that removing helmet violations from the possible minor infractions that police can use to justify pretextual stops will significantly limit the potential for cyclists to be stopped, detained, and searched for investigatory reasons (see discussion on pretextual stops above).

[232] Ethan C. Campbell, "Technical report on bicycle infractions in Seattle (2003-2020)... ." As above.

[233] Katie Olsen, "Washington State's new bicycle 'Safety Stop' law allows people biking to treat stops signs as yield signs with some exceptions," Seattle Department of Transportation Blog (September 30, 2020), https://sdotblog.seattle.gov/2020/09/30/washington-states-new-bicycle-safety-stop-law-allows-people-biking-to-treat-stops-signs-as-yield-signs-with-some-exceptions/.

What jurisdictions would be affected by changes to the King County helmet law?

There are 39 cities and towns in King County, some of which have local helmet laws separate from the county helmet law. We examined each city and town's municipal code for language about bicycle helmets, which allowed us to characterize the patchwork of helmet laws in King County:

- **17 jurisdictions (representing 35.4% of King County's population) have separate all-age bicycle helmet laws in their municipal or city code that mirror the language from King County Health Code Title 9.** These jurisdictions *would not be affected* by changes to the King County helmet law, and are the following: Auburn, Bellevue, Black Diamond, Burien, Des Moines, Duvall, Enumclaw, Federal Way, Issaquah, Kent, Lake Forest Park, Maple Valley, North Bend, Pacific, Renton, SeaTac, and Snoqualmie.

- **Two more jurisdictions (representing 1.6% of King County's population) have adopted the King County helmet law by reference in their municipal codes**, including all future amendments and changes. These two jurisdictions, Kenmore and Woodinville, *would be affected* by changes to the King County helmet law.

- **20 jurisdictions as well as unincorporated King County (together representing 63.0% of King County's population, of which Seattle represents about half) are covered by only the King County helmet law.** These jurisdictions *would be affected* by changes to the King County helmet law, and are the following: Algona, Beaux Arts Village, Bothell, Carnation, Clyde Hill, Covington, Hunts Point, Kirkland, Medina, Mercer Island, Milton, Newcastle, Normandy Park, Redmond, Sammamish, Seattle, Shoreline, Skykomish, Tukwila, and Yarrow Point.

Are there specific experts with whom we would recommend that the Board consult?

Yes. In addition to researchers affiliated with Seattle & King County Public Health and the Harborview Injury Prevention and Research Center, we strongly recommend that the Board consult external researchers who have expertise in helmet legislation and other aspects of bicycle policy and were not involved in the creation of the King County helmet law. We would suggest the following researchers:

- Kay Teschke, PhD, MPH, Professor Emeritus, School of Population and Public Health, University of British Columbia, Vancouver, BC, Canada (and one of University of Washington Public Health's 50 Changemakers)
    - Examples of work:
        - Teschke et al. (2015) in *BMJ Open*, "Bicycling injury hospitalisation rates in Canadian jurisdictions: analyses examining associations with helmet legislation and mode share"
        - Teschke et al. (2012) in *American Journal of Public Health*, "Route infrastructure and the risk of injuries to bicyclists: A case-crossover study"

- Alison Bateman-House, PhD, MPH, Assistant Professor, Division of Medical Ethics and Department of Population Health, New York University Grossman School of Medicine, New York, NY
    - Example of work: Bateman-House (2014) in *American Journal of Public Health*, "Bikes, helmets, and public health: Decision-making when goods collide"

- Kathleen Bachynski, PhD, MPH, Assistant Professor, Public Health Program, Muhlenberg College, Allentown, PA
    - Example of work: Bachynski and Bateman-House (2020) in *American Journal of Public Health*, "Mandatory bicycle helmet laws in the United States: Origins, context, and controversies"

- Jessica Dennis, PhD, Assistant Professor, University of British Columbia and BC Children's Hospital Research Institute, Vancouver, BC, Canada
    - Example of work: Dennis et al. (2013) in *BMJ*, "Helmet legislation and admissions to hospital for cycling related head injuries in Canadian provinces and territories: interrupted time series analysis"

- Charles T. Brown, MPA, Senior Research Specialist and Adjunct Professor, Alan M. Voorhees Transportation Center, Rutgers University, New Brunswick, NJ
    - Example of work: "Where do we go from here? Breaking down barriers to bicycling in the U.S.," People for Bikes (2021)

- John Pucher, PhD, Professor Emeritus, Alan M. Voorhees Transportation Center, Rutgers University, New Brunswick, NJ; or Ralph Buehler, PhD, Professor and Chair of Urban Affairs and Planning, School of Public and International Affairs, Virginia Tech, Arlington, VA
    - Examples of work:
        - Pucher and Buehler (2008) in *Transport Reviews,* "Making cycling irresistible: Lessons from The Netherlands, Denmark and Germany"
        - Pucher et al. (2010) in *Preventative Medicine*, "Infrastructure, programs, and policies to increase bicycling: An international review"
        - Pucher, Buehler, and Seinen (2011) in *Transportation Research Part A: Policy and Practice*, "Bicycling renaissance in North America? An update and re-appraisal of cycling trends and policies"

Bike Helmet Lit Review and Compiled Resources

Basic agreements of BOH:

- Bike helmets are a good thing that generally keep cyclists safe, and much safer than cycling without them (Thompson, et al; 1996).
- There is a demonstrated pattern of disproportionality when it comes to policing the bike helmet law that has caused harm to individuals of color and low-income or unhoused people.

Note: there are TWO working groups—the outside Bike Helmet Working Group, consisting of representatives from Real Change, Central Seattle Greenways, and other groups. However, there was also an INTERNAL Bike Helmet Working Group within the Board of Health consisting of Anne Burkland, State and Local Affairs, Public Health- Seattle & King County, Tony Gomez, Manager, Violence and Injury Prevention, Public Health- Seattle & King County, and Rebecca Lis, MPH, Target Zero Manger, Public Health- Seattle & King County. They created the policy options that were presented at the September Board of Health Meeting.

"What does the research say about helmet laws?"

Notes: This language is largely taken directly from the articles. Any word choice around "helmet law" vs "helmet legislation" is reflective of the word choice of the author. Further, any decisions around whether "data" is used in its singular or plural form also reflects the will of the original author.

- Teschke et al (2015): Bicycling injury hospitalisation rates in Canadian jurisdictions: analyses examining associations with helmet legislation and mode share
    - In a study looking at the risk of head injury hospitalization in provinces with and without helmet laws in Canada over six years, they found **that helmet legislation was not associated with hospitalization rates for brain, head, scalp, skull or face injuries.** They found that **other factors were associated with different injury rates,** including that females had consistently lower rates of injury than males and that for traffic-related injuries on public roads, higher cycling mode share was associated with lower injury rates.
- Dannenberg et al (2011): Bicycle Helmet Laws and Educational Campaigns: An Evaluation of Strategies to Increase Children's Helmet Use
    - Methods: In 1991, a survey was mailed to fourth-, seventh-, and ninth-grade students attending a stratified sample of public schools in Howard County and in two similar suburban/rural counties without helmet laws.
    - Of 7217 students surveyed, 3494 responded (48.4%). Self-reported helmet use in Howard County rose from 11% to 37% after the law and accompanying educational campaign went into effect. Helmet use changed from 8% to 13% in Montgomery County, where educational efforts were undertaken, and from 7% to 11% in Baltimore County, where helmet promotion activities were minimal. Predictors of helmet use included having friends who wore helmets, believing helmet laws are good, being in fourth grade, living in Howard County, and using seatbelts regularly.

- This study indicates **that helmet laws PAIRED WITH education had a positive effect on self-reported helmet wearing. However, it also indicated that other social factors including the actions of their peers were predictors of use.**

- Gilchrist et al (2000): Police enforcement as a part of a comprehensive bicycle helmet program
  - Methods: During April 1997, about 580 children kindergarten-7th grade received free helmets, fitting instructions and safety education. Police then impounded bicycles of unhelmeted children. They observed several times during the next five months and then once 2 years later.
  - **Without enforcement, the state and local laws did not prompt helmet use in this community, yet active police enforcement, coupled with helmet giveaways and education, was effective and lasting**.
- Hoye (2017): Recommend or mandate? A systematic review and meta-analysis of the effects of mandatory bicycle helmet legislation
  - If all cyclistswere wearing helmets, significant numbers of head injuries might theoretically be prevented. Mandatory bicycle helmet legislation increases helmet use but is a controversial measure. Results from 21 studies of the effects of mandatory bicycle helmet legislation on injuries among crash involved cyclists were investigated by means of meta-analysis and the effects of several potential biases were investigated. **The summary effect of mandatory bicycle helmet legislation for all cyclists on head injuries is a statistically significant reduction by 20%** (95% confidence interval [−27; −13]). Larger effects were found for serious head injury (−55%; 95% confidence interval; [−78; −8]). **Among children, larger effects were found when legislation applies to all cyclists than when it applies to children only.** There is no clear indication of the results being affected by publication bias. However, such a bias, if it exists, is not likely to be large.
  - Empirical evidence for the hypotheses that mandatory bicycle helmet legislation deters people from cycling and that helmet wearing leads to behavioral adaptation is mixed**. In summary, mandatory bicycle helmet legislation can be expected to reduce head injury among crash involved cyclists. Some adverse effects may occur, but will not necessarily be large or long-lasting**. If the overall goal is to improve safety for all cyclists and to increase cycling, mandatory bicycle helmet legislation should be supplemented by other measures, especially improved bicycle infrastructure.
- Robinson (2006): Bicycle helmet legislation: can we reach a consensus?
  - Debate continues over bicycle helmet laws. Proponents argue that case-control studies of voluntary wearing show helmets reduce head injuries. Opponents argue, even when legislation substantially increased percent helmet wearing, there was no obvious response in percentages of cyclist hospital admissions with head injury—trends for cyclists were virtually identical to those of other road users. Moreover, enforced laws discourage cycling, increasing the costs to society of obesity and lack of exercise and reducing overall safety of cycling through reduced safety in numbers. Countries with low helmet wearing have more cyclists and lower fatality rates per kilometre.

  - Cost-benefit analyses are a useful tool to determine if interventions are worthwhile. The two published cost-benefit analyses of helmet law data found **that the cost of buying helmets to satisfy legislation probably exceeded any savings in reduced head injuries.**

Analyses of other road safety measures, e.g. reducing speeding and drink-driving or treating accident blackspots, often show that benefits are significantly greater than costs. Assuming all parties agree that helmet laws should not be implemented unless benefits exceed costs, agreement is needed on how to derive monetary values for the consequences of helmet laws, including changes in injury rates, cycle-use and enjoyment of cycling. Suggestions are made concerning the data and methodology needed to help clarify the issue, e.g. relating pre- and post-law surveys of cycle use to numbers with head and other injuries and ensuring that trends are not confused with effects of increased helmet wearing.

- Kett et al. (2016): The effect of an all-ages bicycle helmet law on bicycle-related trauma
    - NOTE: Frederick Rivara is an author on this article
    - In 2003, Seattle implemented an all-ages bicycle helmet law; King County outside of Seattle had implemented a similar law since 1994. For the period 2000–2010, the effect of the helmet legislation on helmet use, helmet-preventable injuries, and bicycle-related fatalities was examined, comparing Seattle to the rest of King County.
    - Data was retrieved from the Washington State Trauma Registry and the King County Medical Examiner. Results comparing the proportions of bicycle related head injuries before (2000–2002) and after (2004–2010) the law show no significant change in the proportion of bicyclists admitted to the hospital and treated for head injuries in either Seattle (37.9 vs 40.2 % $p = 0.75$) nor in the rest of King County (30.7 vs 31.4 %, $p = 0.84$) with the extension of the helmet law to Seattle in 2003. However, bicycle-related major head trauma as a proportion of all bicycle-related head trauma did decrease significantly in Seattle (83.9 vs 64.9 %, $p = 0.04$), while there was no significant change in King County (64.4 vs 57.6 %, $p = 0.41$).
    - **While the results do not show an overall decrease in head injuries, they do reveal a decrease in the severity of head injuries, as well as bicycle-related fatalities, suggesting that the helmet legislation was effective in reducing severe disability and death, contributing to injury prevention in Seattle and King County. The promotion of helmet use through an all ages helmet law is a vital preventative strategy for reducing major bicycle-related head trauma.**
- Dennis et al (2013): Helmet legislation and admissions to hospital for cycling related head injuries in Canadian provinces and territories: interrupted time series analysis
    - **Objective** To investigate the association between helmet legislation and admissions to hospital for cycling related head injuries among young people and adults in Canada.
    - **Design** Interrupted time series analysis using data from the National Trauma Registry Minimum Data Set.
    - **Setting** Canadian provinces and territories; between 1994 and 2003, six of 10 provinces implemented helmet legislation.
    - **Participants** All admissions (n=66 716) to acute care hospitals in Canada owing to cycling related injury between 1994 and 2008.
    - **Main outcome measure** Rate of admissions to hospital for cycling related head injuries before and after the implementation of provincial helmet legislation.
    - **Results** Between 1994 and 2008, 66,716 hospital admissions were for cycling related injuries in Canada. Between 1994 and 2003, the rate of head injuries among young

people decreased by 54.0% (95% confidence interval 48.2% to 59.8%) in provinces with helmet legislation compared with 33.1% (23.3% to 42.9%) in provinces and territories without legislation. Among adults, the rate of head injuries decreased by 26.0% (16.0% to 36.3%) in provinces with legislation but remained constant in provinces and territories without legislation. After taking baseline trends into consideration, however, we were unable to detect an independent effect of legislation on the rate of hospital admissions for cycling related head injuries.
    - **Conclusions: Reductions in the rates of admissions to hospital for cycling related head injuries were greater in provinces with helmet legislation, but injury rates were already decreasing before the implementation of legislation and the rate of decline was not appreciably altered on introduction of legislation. While helmets reduce the risk of head injuries and we encourage their use, in the Canadian context of existing safety campaigns, improvements to the cycling infrastructure, and the passive uptake of helmets, the incremental contribution of provincial helmet legislation to reduce hospital admissions for head injuries seems to have been minimal.**
- Mooney et al. (2018): Free floating bikeshare and helmet use in Seattle, WA
    - Wearing a helmet when bicycling prevents traumatic brain injury in the event of a crash. Most cyclists nationwide use helmets when riding. **However, the growth of free-floating bike sharing systems, which offer short-term access to bicycles but not helmets, may erode helmet-wearing norms among cyclists.** We counted cyclists over several hours at four locations in Seattle, WA. We categorized each rider according to whether he or she was wearing a helmet and to whether or not he or she was riding a bike share bike. Whereas 91% of riders of private bikes wore helmets, only 20% of bike share riders wore helmets. Moreover, in locations where a greater proportion of riders were on bikes hare bikes, fewer riders of private bicycles wore helmets ($r = -0.96$, $p = 0.04$). **The impact of bike sharing programs on helmet wearing norms among private bike riders warrants further exploration.**
- Huybers et al (2016): Long-Term Effects of Education and Legislation Enforcement on All-Age Bicycle Helmet Use: A Longitudinal Study
    - Bicycle-related injuries are a leading cause of child and youth hospitalizations in Canada. The use of helmets while bicycling reduces the risk of brain injuries. This study investigated the long-term effect of legislation coupled with enforcement to improve helmet use rates. **We conducted a longitudinal observational study of helmet use at 9, 11, and 14 years after bicycle helmet legislation was enacted.** Data were compared to baseline observations collected after legislation was passed in 1997. A comprehensive enforcement and educational diversion program, Operation Headway–Noggin Knowledge (OP–NK), was developed and implemented in partnership with regional police during the study period. **Helmet use was sustained throughout the post-legislation period, from 75.3 % in the year legislation was enacted to 94.2 % 14 years post-legislation.** The increase in helmet use was seen among all age groups and genders. Helmet legislation was not associated with changes in bicycle ridership over the study years. OP– NK was associated with improved enforcement efforts as evidenced by the number of tickets issued to noncompliant bicycle riders. This observational study spans a 16-year study period extending from pre-legislation to 14 years post all-age bicycle helmet legislation. **Our study results demonstrate that a**

comprehensive approach that couples education and awareness with ongoing enforcement of helmet legislation is associated with long-term sustained helmet use rates. The diversion program described herein is listed among best practices by the Public Health Agency of Canada.

- Castle et. Al (2010): Bicycle Helmet Legislation and Injury Patterns in Trauma Patients Under Age 18
    - Background: The California statewide helmet law was enacted in 1994, and required all cyclists under age 18 y to be helmeted when riding a bicycle. The purpose of this study is to describe helmet use patterns, rates of head and intra-abdominal injury in Los Angeles County before and after helmet legislation, and to determine if increasing helmet use is changing injury patterns
    - Methods: We conducted a retrospective review of trauma patients under age 18 y in the Los Angeles County trauma database between 1992 and 2009 injured while riding bicycles. We examined the variables of age, gender, race, Glasgow Coma Score, Injury Severity Score, presence of head injury, presence of abdominal injury, and use of protective helmet.
    - Results: During this time period, there were 44,187 injured children less than 18 y of age, and there were 1684 bike-related traumas with data on helmet use. Injury patterns did not change after the helmet law, with head injuries predominating.
    - Conclusions: **The rate of helmet use did not change after California legislation, and head injury remains a major source of morbidity. Rates of abdominal injury over this time period did not change. Novel strategies are needed to increase helmet use in at-risk populations.**
- Helpful compilation of data: Portland, Oregon 2014 Bike Helmet Usage Data
- Thompson et. Al (1996): Effectiveness of Bicycle Safety Helmets in Preventing Head Injuries: A case-control study
    - Note: Frederick Rivara is an author on this piece
    - This study was conducted in Seattle, and concludes that Bicycle helmets, regardless of type, provide substantial protection against head injuries for cyclists of all ages involved in crashes, including crashes involving motor vehicles.
- De Jong (2012): The Health Impact of Mandatory Bicycle Helmet Laws
    - This article seeks to answer the question whether mandatory bicycle helmet laws deliver a net societal health benefit. The question is addressed using a simple model. The model recognizes a single health benefit – reduced head injuries, and a single health cost – increased morbidity due to foregone exercise from reduced cycling. Using estimates suggested in the literature of the effectiveness of helmets, the health benefits of cycling, head injury rates, and reductions in cycling, leads to the following conclusions. In jurisdictions where cycling is safe, a helmet law is likely to have a large unintended negative health impact. In jurisdiction where cycling is relatively unsafe, helmets will do little to make it safer and a helmet law, under relatively extreme assumptions may make a small positive contribution to net societal health. The model serves to focus the mandatory bicycle helmet law debate on overall health.

Applying the research:

ANSWERS TO QUESTIONS FROM BOARD OF HEALTH—some of the sources cited below have already been covered in more depth above.

This information was provided by the Bike Helmet Working Group (external):

Q: Do we know what helmet use rates are currently in King County? *(Gomez)*

Detailed data across King County do not exist, but a Harborview-led study (Mooney et al., 2019, also attached here) estimated **average helmet use in Seattle to be 87%** including bike share users. This statistic is based on observational counts at four locations in generally wealthier areas of Seattle, so I would advise this may be somewhat of an overestimate. In Seattle, dockless bike share contributes over two million trips annually (SDOT, 2020), of which only about 25% are with a helmet (SDOT, 2018). Nonetheless, Seattle bike share was associated with just one serious injury in 2019 (SDOT, 2020).

Q: Is there data or peer-reviewed literature on whether helmet laws are effective at getting people to wear bike helmets? *(CM González)*

Numerous studies found that youth-only helmet laws introduced 2-3 decades ago were associated with marked increases in helmet use and decreases in injuries (e.g., Dannenberg et al., 1993; Kanny et al., 2001). However, there are virtually no studies assessing whether all-ages helmet laws are effective today, particularly in a North American context. That said, two compelling lines of evidence suggest King County's law is not currently influential:

1. Comparing to peer cities shows little present-day impact of helmet laws or the absence thereof. As mentioned above, Seattle has average helmet use around 87%, and likely slightly lower. Portland, which has never had an all-ages helmet mandate, nonetheless has average helmet use of 81% according to the most recent citywide count in 2014 (PBOT, 2014). Vancouver, BC, which has a provincial all-ages mandate enforced at similar rates to King County's, has average helmet use of 78% (Zanotto and Winters, 2017).

2. Studies have found that helmet laws are not effective when they are not enforced by police (e.g., Gilchrist et al., 2000). King County's law is currently weakly enforced on a per-trip basis – we estimate that between 1-in-25000 to 1-in-500 of helmetless bike trips result in police contacts in Seattle, and even fewer in citations (more info here) – which suggests that it offers a minimal deterrent effect. Our group has also found that community awareness of the county helmet law is limited.

Q: Would helmet law repeal reduce helmet use and increase head injuries? *(Dr. Delecki)*

No, the research indicates it will not. The most recent, rigorous studies show no link between helmet laws and population-wide rates of head injuries. Dennis et al. (2013) and Teschke et al. (2015) (both attached) examined 60,000 and 20,000 hospital admissions of cyclists, respectively, in the 10 Canadian provinces, 6 of which have helmet laws. Dennis et al. concluded that "the incremental contribution of provincial helmet legislation to reduce hospital admissions for head injuries seems to have been minimal." Teschke et al. found that the presence of "helmet legislation [is] not associated with hospitalization rates for brain, head, scalp, skull, face, or neck injuries."

Public Health's study on the King County law (Kett et al. 2016, attached here) found no discernible impact of the introduction of the helmet law to Seattle in 2003 on helmet use among cyclists admitted to hospitals. Over 2000-2010, helmet use among injured cyclists increased by a similar but lesser amount in Seattle (29% increase) compared to King County outside Seattle (34% increase), suggesting that factors other than the 2003 helmet law extension to Seattle (e.g., cultural shifts, education, promotion, etc.) were most influential for increasing helmet use in both areas over that time period.

Follow up questions from Councilmember Kohl-Welles, 10/28/21, response from Public Health Staff

1. Any studies that show that helmet laws help reduce head injuries (if they exist)
    - 2016 Kett et al. attached.
2. Data on victims of TBI: especially showing whether BIPOC communities have greater incidence, whether more victims are young/youth, what the breakdown of TBI causes are for all victims
    - https://pubmed.ncbi.nlm.nih.gov/21969286/ (looks at age but not race)
    - CDC info: https://www.cdc.gov/traumaticbraininjury/data/
3. Effects of helmet repeal
    - I have not seen this. I did reach out to Tacoma and have a call with their DOT lead next week. She did not have any evaluation data but I will loop back if I hear anything more substantive next week.
4. How the laws were changed in other jurisdictions that did so to address disproportionality
    - It looks like Dallas partially repealed their law to make it only apply to youth 17 and under. It looks like this was not about enforcement but expanding ridership via bikeshare programs: https://www.texasmonthly.com/the-daily-post/adult-cyclists-in-dallas-are-no-longer-required-by-law-to-wear-helmets/
    - In Philadelphia, they aimed to address disproportionality in low-level traffic violations by specifying different types of violations that would allow police to stop drivers. This is for motor vehicles rather than cyclists but the idea is there: https://www.cnn.com/2021/10/30/us/philadelphia-driving-equality-bill/index.html

NACo's Response to this issue:

As I'm sure you are aware, there is no federal law in the US requiring use of bicycle helmets. Twenty-one states and the District of Columbia have bicycle helmet laws, though none apply to adults. Around 201 local jurisdictions have ordinances requiring bicycle helmets, some of which apply to riders of all ages. Detailed information of bicycle helmet legislation can be found here.

I was not able to find research or information specifically focusing on the impacts of repealing bicycle helmet laws on brain injuries or death rates. Dallas, Texas repealed their bicycle helmet law for adults in 2014, however I have not found any analysis regarding this repeal and brain injuries or public health/safety impacts.

Motorcycle helmet legislation is quite different, however there has been more research conducted on the impacts of repealing motorcycle helmet laws. In Michigan, a study examining the effects of repealing a 35-year mandatory helmet law in 2012 on a level 1 trauma center in West Michigan finds that after the repeal, non helmeted motorcyclists rose from 7% to 29%, and crash scene fatalities increased significantly. In Florida, researchers examined the impact of repealing the state's mandatory motorcycle helmet-use law, finding that "the repeal of the mandatory helmet-use law in Florida had little observable effect on serious injuries or on fatalities that resulted from motorcycle crashes."

A number of other studies have tried to examine the costs and benefits of bicycle helmet laws. "The Health Impact of Mandatory Bicycle Helmet Laws" finds that "**In jurisdictions where cycling is safe, a helmet law is likely to have a large unintended negative health impact. In jurisdictions where cycling is relatively unsafe, helmets will do little to make it safer and a helmet law, under relatively extreme assumptions may make a small positive contribution to net societal health."** Another study employs a cost-effectiveness analysis in evaluating helmet laws in a Dutch context, and finds that a mandatory helmet use law in the Netherlands would lead to an estimated reduction of 2942 cases of traumatic brain injury (TBI) and 46 deaths. Details of their methodology and specific associated costs can be found in the report.

"Bikes, Helmets, and Public Health: Decision-Making When Goods Collide" evaluates the complexities of this sort of legislation, specifically in the context of New York City. This is a challenging issue, especially since "there are insufficient data to judge the effect of mandatory helmet laws," and "there are often inadequate data to track the number or severity of cycling accidents and injuries."

Regarding programs providing bicycle helmets or vouchers for helmets, there are a few examples. Placer County, California, along with the City of Roseville, has a program entitled "Bucks for Bikes" in which those who work or attend school in the county can apply to received subsidized commuter bicycles and, if necessary, bicycle helmet, light, lock, and/or rack/basket. Details of their program can be found here. Boston, Massachusetts has a program providing bicycle helmets for as low as $5 to Boston residents, health centers, and other local organizations. The City of Sierra Vista, Arizona offers a Bike Helmet Program for children. Additionally, some localities offer incentives for wearing helmets, including Montclair, New Jersey and Evansville, Indiana.

Summary, Analysis, and Considerations from CM

- Everyone agrees that bike helmets provide increase protection against brain injury. (Thompson et al., 2016)
    - Note: Dr. Rivara is an author on this piece.
- The research around the efficacy of bike helmet legislation is mixed:
    - "helmet legislation was not associated with hospitalization rates for brain, head, scalp, skull or face injuries." (Teschke et al., 2015)
    - "While the results do not show an overall decrease in head injuries, they do reveal a decrease in the severity of head injuries, as well as bicycle-related fatalities, suggesting that the helmet legislation was effective in reducing severe disability and death, contributing to injury prevention in Seattle and King County. The promotion of helmet

use through an all ages helmet law is a vital preventative strategy for reducing major bicycle-related head trauma." (Kett et al., 2016)
        - Note: Dr. Rivara is an author on this piece.
    - "The rate of helmet use did not change after California legislation, and head injury remains a major source of morbidity." (Castle et al., 2010)
    - "Reductions in the rates of admissions to hospital for cycling related head injuries were greater in provinces with helmet legislation, but injury rates were already decreasing before the implementation of legislation and the rate of decline was not appreciably altered on introduction of legislation." (Dennis et al., 2013)
- What is clear is that there are significant factors beyond the legislation itself that impact the safety of cyclists:
    - “In jurisdictions where cycling is safe, a helmet law is likely to have a large unintended negative health impact. In jurisdiction where cycling is relatively unsafe, helmets will do little to make it safer and a helmet law, under relatively extreme assumptions may make a small positive contribution to net societal health.” (de Jong, 2012)
    - Predictors of helmet use included having friends who wore helmets, believing helmet laws are good, being in fourth grade, living in Howard County, and using seatbelts regularly." (Dannenberg et al., 2011)
- Taking away the enforcement mechanism but leaving the law on the books still enables police to stop people and may not still create the desired effect of encouraging helmet use.
    - "Without enforcement, the state and local laws did not prompt helmet use in this community, yet active police enforcement, coupled with helmet giveaways and education, was effective and lasting." (Gilchrist et al., 2000)
- What about making it so that the law only applies to youth?
    - "Among children, larger effects were found when legislation applies to all cyclists than when it applies to children only. " (Hoye, 2017)
- In my research today, I did not find anything to support the claim that bike helmet-related brain injuries disproportionately impact low-income people or BIPOC communities.

King County

King County Board of Health

Staff Report

Agenda item No:	7	Date:	September 16th, 2021
Briefing No:	21-B16	Prepared by:	Susie Levy

Subject

Policy considerations to address inequitable enforcement of King County Bicycle Helmet Regulations.

Summary

The Board requested exploration of options to address data and reports of inequitable enforcement of Bicycle Helmet Regulations. On June 17th, 2021, the Board heard briefing 21-B10, a panel discussion on bicycle helmet laws in King County and the disparate impacts of enforcement of the helmet regulations. Data presented demonstrated that citations were issued to black, indigenous, and people of color more frequently than to white cyclists, and that persons experiencing homelessness reported that the helmet requirement is a commonly cited reason for engagement with law enforcement.

Based on Board discussion at the June meeting, the Board Chair requested staff provide policy options to meet two goals: 1) address inequitable enforcement by law enforcement of the Helmet Regulation and 2) maintain a clear message that the Board supports all age helmet use as an essential tool for injury prevention.

Below are two policy options that seek to address the Board's goals:

1. Removing the enforcement section of the King County Bicycle Helmet Regulations and replacing the section with language clearly stating the Board's intent that it is not enforced by law enforcement.
2. Repealing King County Bicycle Helmet Regulations and replace the regulations with a resolution to provide a clear policy statement on the value of all-age helmet usage.

In addition, the Chair requested exploration of programmatic approaches to addressing access and education for helmet usage be presented, recognizing that this is outside of the scope of the Board's authority. While the authority for these actions largely falls outside of the direct scope and authority of the King County Board of Health, the Board indicated interest in exploring options that can lead to increased use of helmets. Such actions may include partnering with and providing investments in community-based organizations and trusted partners to support bike safety and helmet usage.

Background

King County's all-ages bike helmet requirement was established in 1993 and updated in 2003 to include Seattle. It requires bike riders and passengers to wear protective helmets on public roads, bike paths, rights-of-way, and publicly owned facilities. The regulation established a fine of $30, along with additional court costs, if someone was cited for not wearing a helmet. First-time infractions can be dismissed upon proof that a helmet was obtained, and fines may be waived, or alternatives provided by the court (such as reduced fines, community service hours, or an extended payment period).

Bicycle helmets have been shown to prevent head injuries suffered by bicycle riders during a crash or fall. Studies completed by investigators at Group Health Cooperative of Puget Sound and the Harborview Injury Prevention and Research Center (HIPRC)[1] show that helmet use could reduce the number of head injuries involving bicycling by sixty-nine percent (69%) to eighty-five percent (85%).

With expansion of the Rule and Regulation to Seattle, local experience and research by HIPRC and Public Health – Seattle & King County (PHSKC) indicated helmet usage increased, bike ridership increased, the most severe head and brain trauma decreased by 20%, and fatalities decreased. Finally, no child has died from a helmet preventable injury since 2005. In the years prior to the regulation expansion, there were five child deaths examined by the King County Child Fatality Review Committee.

The Washington State Department of Transportation estimated the economic cost burden in King County of bicycle injuries, fatalities, and other costs average to be $276 million per year (average across 2018 and 2019 data). Economic cost components include medical care, emergency services, market productivity, household productivity, legal costs, insurance administrative costs, workplace costs, property damage and congestion. This includes incidents by all riders: those wearing bicycle helmets as well as those not wearing bicycle helmets.

In addition to the Board's Helmet Regulation, seventeen jurisdictions within King County have their own helmet laws including Auburn, Bellevue, Black Diamond, Burien, Des Moines, Duvall, Enumclaw, Federal Way, Issaquah, Kent, Lake Forest Park, Maple Valley, North Bend, Pacific, Renton, SeaTac, and Snoqualmie. The population of these cities represents 35.4% of King County's population. Any change made to the Helmet Requirement by the Board would impact the regulations in twenty-two jurisdictions and Unincorporated King County; however,

---

[1] Thompson RS, Rivara FP, Thompson DC. A case-control study of the effectiveness of bicycle safety helmets. N Engl J Med. 1989;320:1361-1367.

Thompson DC, Nunn ME, Thompson RS, Rivara FP. Effectiveness of bicycle safety helmets in preventing serious facial injury. JAMA. 1996;276:1974-1975.

the requirement in the remaining seventeen jurisdictions would remain unchanged due to the nature of those cities' laws.

Analysis

The policy options below seek to address inequitable enforcement while continuing to express the Board's recognition of the importance of helmet usage as a tool to prevent head injury. As part of this policy review, PHSKC sought feedback from the Pandemic and Racism Community Advisory Group (PARCAG) as well as PHSKC's Equity Response Team (ERT). This feedback is included in the below analysis.

The Pandemic and Racism Community Advisory Group (PARCAG): PARCAG was first convened by PHSKC in March 2020 as a multisector table of community, business, and public sector representatives to respond to the COVID-19 pandemic. It has expanded its purpose to address regional racial inequities more effectively. PARCAG is being co-led by community representatives and PHSKC. PARCAG works to identify, inspire, and mobilize bold solutions in response to the urgent, interconnected crises of COVID-19 and systemic racism. PARCAG members have been key thought partners for policy making for PHSKC throughout the pandemic.[2]

Equity Response Team (ERT): PHSKC and its Health and Medical Area Command (HMAC) explicitly incorporated equity into its operational structures in its response to the COVID19 pandemic. The formation of an Equity Response Team (ERT) worked in concert with HMAC's Equity Officer during pandemic response. Comprised of community members, including tribal members and a bioethicist, as well as city and county staff, the ERT addresses cross-cutting issues and works to assure that equity considerations are included in public health policy decisions, resource allocation and response priorities related to the COVID19 crisis response.

Policy Options:

1) **Repeal enforcement section:**
The Board could choose to remove Section 9.15 of BOH Code, the enforcement section of the Code, and leave the requirement to wear a helmet while riding a bicycle. The Board could replace the existing enforcement code Section 9.15 with language explicitly stating that the Board does not intend for the regulation to be enforced by law enforcement.

Enforcement of the BOH Code is governed by chapter 1.08 which allows for the enforcement of violations through misdemeanor penalties, civil penalties, abatement and any other legal or equitable remedy. Section 9.15.010 limits enforcement of Title 9 to a civil infraction and fine. Removing section 9.15.010 may broaden the enforcement of Title 9 to include all

[2] Pandemic and Racism Community Advisory Group: https://kingcounty.gov/depts/health/covid-19/community-faith-organizations/PARCAG/about-us.aspx

available options available under chapter 1.08 and would have the opposite effect than what is desired by the board. If the Board determines this as the appropriate direction, the Board could review the policy in a few years to ensure there has not been unintended consequences and that enforcement is no longer happening.

Equity considerations:

- PARCAG and ERT expressed concerns around this approach, both in terms of potential enforcement consequences beyond a $30 fee as well as the potential for unnecessary interactions with law enforcement officials.

2) Repeal the regulation and replace with Board resolution:

The Board could consider repealing BOH Code Title 9 and replacing it with a resolution that expresses the policy intent that helmets should be worn by all bicycle riders to prevent head injury. The Board may also include language in a resolution to encourage jurisdictions with their own helmet requirements to take similar action.

Equity considerations:

- Both ERT and PARCAG preferred this policy approach to addresses concerns around disproportionate impact on communities of color. Repeal would remove the potential for additional interactions with law enforcement officials.
- If this approach is taken, the Board should consider additional action to ensure other jurisdictions also repeal these regulations and encourage alignment with this policy.

3) No action

The Board could leave the existing regulation as is.

Equity considerations:

This approach may not accomplish goal of addressing inequitable enforcement of the helmet regulations.

Additional Community and Public Health Investment in Bicycle Safety:

While outside of the scope and authority of the King County Board of Health, additional actions and investments may be made to address bicycle safety within King County. PHSKC recommends a comprehensive approach that includes considering bicycle safety infrastructure, monitoring injuries and fatalities, tracking helmet usage and bicycle ridership as well as bicycle promotion, safety, and helmet programs. PHSKC currently has limited resources to support bicycle promotion and safety work.

Below are several ways in which local jurisdictions may support investment in bicycle usage, safety, and helmet access and promotion that are outside the authority and scope of the Board of Health.

Community investments:

- Provide increased access locally to low or no cost bike helmets and bicycles through community outreach programs that focus specifically on underserved, homeless, youth, and BIPOC communities.[3]
- Fund and support community events to provide free or low-cost helmets, bicycles, lights, and safety education[4] to community members, with a focus on underserved, homeless, and BIPOC communities. Seattle Department of Transportation recently partnered with East African Community Services on an event[5] to distribute free bikes and bike-related gear to a youth cohort based in the New Holly community. This event could be used as a model by other local jurisdictions.
- Engage with local bicycle, pedestrian, and BIPOC community partners to identify key needs for investment in infrastructure, bike helmet education and distribution, and other applicable methods to support bicycle safety and bicycle promotion. This work includes Complete Streets[6] . Many local examples exist including Seattle and Bellevue's efforts as part of their Vision Zero collaborative campaign to build "safe, healthy, equitable mobility for all."[7]

Board member opportunities:

- Support messaging and education as elected leaders and health leaders through media and engagement opportunities such as media events, interviews, bicycle and helmet giveaways, bicycle infrastructure improvements, etc.
- Use local crash data to inform education and advocacy on infrastructure improvements that provide a protected bicycle and pedestrian lanes/rights of way, in major bicycles areas within the community.

County coordination:

- Allocate funding for and hire a countywide bicycle safety planner to lead multi-sector partnerships with community organizations, local government, and other partners to implement bicycle safety and helmet programs.

---

[3] This would add to existing resources identified in the PHSKC document, "Free & Low-Cost Bicycle Helmet Resources in King County, Washington. https://kingcounty.gov/depts/health/violence-injury-prevention/traffic-safety/~/media/depts/health/violence-injury-prevention/documents/low-cost-bike-helmet-providers.ashx

[4] Bike and Multi-Sport Helmets: Quick Fit Check: https://www.seattlechildrens.org/health-safety/keeping-kids-healthy/prevention/bike-helmet-safety/

[5] Seattle Department of Transportation Blog, "We partnered with East African Community Services and Superpedestrian to distribute 100 bikes to BIPOC youth last week!" https://sdotblog.seattle.gov/2021/08/09/we-partnered-with-east-african-community-services-and-superpedestrian-to-distribute-100-bikes-to-bipoc-youth-last-week/

[6] U.S. Department of Transportation, Complete Streets: https://www.transportation.gov/mission/health/complete-streets

[7] Vision Zero Network | Making our streets safer,

Equity considerations:

Both PARCAG and ERT expressed support in investing resources in trusted community-based partners including BIPOC-led organizations to provide education and access to helmets, as well as bicycles more broadly. They do not recommend using law enforcement officials to help with education and access strategies. PARCAG members also recommended using data on helmet usage to target resources to populations with the lowest helmet usage.

From: Charles Whitman
To: DOH WSBOH
Cc: Bodden, Jaime (DOHi); Chris Seubert; Brian Shinn
Subject: Local Board of Health Membership Rulemaking - Informal Draft Available for Comment
Date: Tuesday, November 2, 2021 9:32:54 AM
Attachments: House Bill 1152.docx

External Email

Per you October 26, 2021 e-mail of this subject line, the attached is submitted on behalf of Asotin County.

Chuck Whitman
Asotin County Commissioner Dist. 3
P.O. Box 250
Asotin, WA 99403
Office: 509-243-2070
Cell: 509-780-2839

Asotin County Input to Engrossed Second Substitute House Bill 1152

In order to retain District Health Board continuity in the response to the pandemic and the changing guidelines from the Governor and Department of Health (DOH) in dealing with the pandemic, it is recommended that the changes to Health Districts, as outlined in Engrossed Second Substitute House Bill 1152, be delayed until at least 90 days after the Governor terminates the Emergency Declaration for COVID-19. In addition DOH is just now asking for public comment on Draft Rules to Implement. Single County Health Boards currently must reorganize by 1 January 2022, during a Pandemic, which may cause not only a disruption in continuity of the Boards but a loss to the communities they serve of the experience and knowledge acquired during the Pandemic by current Boards.

The due date for public review to DOH of November 19th, will not allow sufficient time for DOH to review and then finalize and publish the Final Rules prior to 1 January 2022. With 3 Major Holidays (Thanksgiving, Christmas and New Year's) it is doubtful that the review and publishing of the final Rules can be accomplished in such a time that the Counties who are required to reorganize by 1 January will even have the rules to follow. The resulting impact will be to create confusion, loss of continuity and possible harm to the counties the current Boards serve.

To make such a major change to the County Boards of Health during a Pandemic makes absolutely no sense and would be a failure of planning on the part of State Leadership and a disservice to the Counties in Washington State. What the heck, lets reorganize the Washington Department of Health by 1 January also.

POC: Chuck Whitman, Commissioner District 3 and Health Board Chair

509-243-2070 Office

509-780-2839 Cell

cwhitman@co.asotin.wa.us

From: Nik Perron
To: DOH WSBOH
Subject: Communicating With Board Members (vaccine mandates)
Date: Tuesday, October 26, 2021 10:48:59 AM

External Email

KDH,
My name is Nik Perron. I am a kitsap county resident. My family and I are vaccinated but we are COMPLETELY AGAINST any unconstitutional vaccine mandates anywhere, especially kitsap county..whether you deem them unconstitutional or not, NO MANDATES!!you are using skewed infection number to sway the data in the direction of mandates. This is wrong. Do not do this to kitsap county residents. We do not deserve this. You are dividing and destroying this country.
IN CLOSING I AM ASKING AS A HUMAN BEING, PLEASE STAY THE HELL OUT OF MY FAMILIES LIFE!!
Nik Perron

From: Julie Kongs
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 5:11:50 PM

External Email

--

This, my dear, is the greatest challenge of being alive: To witness the injustice of the world and not allow it to consume our light.
(Author unknown)

_____

From: Rachel Baker
Sent: 11/5/2021 11:38:56 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Our kids do not need a covid-,19 vaccine. This vaccine is experimental and children are not at risk of dying from the virus. If this Mandate continues into our schools this will only hurt kids and not keep them safe. parents will pull their kids out funding will go down and it all spirals from there.
If you guys care about our children stop the mandate and get rid of masks

---

From: Pamela Pollock
Sent: 11/5/2021 8:52:11 AM
To: DOH WSBOH
Cc:
Subject: Mandates and vaccines

External Email

WSBOH,

We are over vaccinating our children. We need to be protecting them not adding additional vaccines to the LONG list of vaccines they already get.

Parents should be deciding what goes into their children's bodies.

What about Natural immunity?

What about My Body My Choice? Or is that only applicable to the abortion agenda?

Pam Pollock

Bonney Lake

_____
From: terri@reeddow.com
Sent: 11/5/2021 9:59:45 AM
To: DOH WSBOH
Cc:
Subject: DO NOT MANDATE COVID VAXXes for CHILDREN!!!!

External Email

* There is no Covid health emergency in children ages 5 to 11.
* Natural immunity needs to be part of the risk-benefit analysis; it can no longer be ignored.
* Injury from these products is real, not rare; parents must have the final say in their children's medical care.
* According to data published by the CDC, 99.99815% of children who contract Covid-19 survive.
* Transmission of Covid-19 among children in schools and daycares is very rare.
* There are no long-term safety studies of mRNA Covid vaccines, nor have they been evaluated for carcinogenic or mutagenic potential or for impairment of fertility.
* Pfizer's BNT162b2 is NOT FDA-approved; it has merely received EUA. In other words, it is experimental.
* According to data available <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Furldefense.proofpoint.com%2Fv2%3A__0x124.mjt.lu_lnk_AVoAABI8TpcAAABBguwAAAr0KcYAAAAAu9MAALoOABkwhABhhFlmNOmb5Xj6TB6oFv5A_CdpgnVfiiMM%26r%3DyZLeMMdVzGJIscgF9zuhmYsbUJVwzzlNftowyIJ4W5s%26m%3Ds6aGtg1qfkZhkV0YWiT-0yU5EqVLIYpW0RAxY9_dSY%26s%3Dib1NoNhs5-fDUZFio9JBG_Rc7VwmewDxXvw-EZPwYCU%26e%3D&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C88a994f3cacf4b3488ef08d9a07d584 from the Vaccine Adverse Event Reporting System (VAERS), as of October 22, there had been a total of 16,716 reports of adverse events, including 1,435 serious reactions and 27 deaths in the 12- to 17-year-old age group.
* The Pfizer mRNA vaccine has caused devastating injuries in some youth, including myocarditis and pericarditis. The CDC's own analysis of "Myopericarditis following Covid-19 vaccination: Updates from the Vaccine Adverse Event Reporting System" shows astonishingly high incidence in the youngest age brackets.
* Healthy adolescents ages 12-17 who have been given Covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.
* The vaccine does not prevent infection, transmission, hospitalization, or death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."
* Children are not a significant threat to the elderly and vulnerable, as most Covid cases are spread from adults to children.
* Printable flyers with referenced disgraceful quotes from FDA, CDC, and Pfizer are available at InformedChoiceWA.org. <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Furldefense.proofpoint.com%2Fv2%3A__0x124.mjt.lu_lnk_AVoAABI8TpcAAABBguwAAAr0KcYAAAAAu9MAALoOABkwhABhhFlmNOmb5Xj6TB6oFv5A_CdpgnVfiiMM%26r%3DyZLeMMdVzGJIscgF9zuhmYsbUJVwzzlNftowyIJ4W5s%26m%3Ds6aGtg1qfkZhkV0YWiT-0yU5EqVLIYpW0RAxY9_dSY%26s%3DOx1cwmI78JYuSJYLxJExPiZQOgdcWTgAHNbSUX-

mdh0%26e%3D&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C88a994f3cacf4b3488ef08d9a07d5843%7

* You can share or cite from Senator Ron Johnson's four-hour roundtable <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Furldefense.proofpoint.com%2Fv2%3A__0x124.mjt.lu_lnk_AVoAABI8TpcAAABBguwAAAr0KcYAAAAAu9MAALoOABkwhABhhFlmNOmb5Xj6TB6oFv5A_CdpgnVfiiMM%26r%3DyZLeMMdVzGJIscgF9zuhmYsbUJVwzzlNftowyIJ4W5s%26m%3Ds6aGtg1qfkZhkV0YWiT-0yU5EqVLIYpW0RAxY9_dSY%26s%3Dn6QEIAgNeDwgq-gi2z33BZqVEBh9CSw3HnlcnbxFV8U%26e%3D&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C88a994f3c of vaccine injury victims and medical experts on federal vaccine mandates and the importance of health care freedom.
* ACIP member Dr. Camille Kotton publicly admitted <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Furldefense.proofpoint.com%2Fv2%3A__0x124.mjt.lu_lnk_AVoAABI8TpcAAABBguwAAAr0KcYAAAAAu9MAALoOABkwhABhhFlmNOmb5Xj6TB6oFv5A_CdpgnVfiiMM%26r%3DyZLeMMdVzGJIscgF9zuhmYsbUJVwzzlNftowyIJ4W5s%26m%3Ds6aGtg1qfkZhkV0YWiT-0yU5EqVLIYpW0RAxY9_dSY%26s%3D4ZlcEjUw1u7O1dkFwKUSm35FF2ZIAxhjH2qI0cVx74Y%26e%3D&dat that the number of Covid deaths in ages 5 to 11 for one year was 66. She did not distinguish between "from Covid" and "with Covid." In any event, it does not justify putting hundreds of thousands of children at risk of short- and long-term harm from the vaccines.

From: Stuart King
Sent: 11/5/2021 11:19:53 AM
To: DOH WSBOH
Cc:
Subject: No mandate for kids

External Email

Parents are the ones responsible for their kids.You should not be mandating vaccines when parents are the ones who will have to care for their children if injured by the vaccine. Vaccine injuries are real and COVID is not even an emergency among children. There's very little risk for healthy children to die from COVID.

From: cuanabear
Sent: 11/5/2021 9:35:17 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Remember that it wasn't just the general who were prosecuted in the Nuremburg trials. Please be on the right side of history.

There is no Covid health emergency in children ages 5 to 11. Refer to the CDC for deathrates for this age group. The same chart will show you there's no emergency for even the most vulnerable as their survival rate is 94+%.

Natural immunity needs to be part of the risk-benefit analysis; it can no longer be ignored. Do some research beyond the "safe and effective" marketing.

Injury from these products is real, not rare; parents must have the final say in their children's medical care. You might want to read your Constitution.

According to data published by the CDC, 99.99815% of children who contract Covid-19 survive. And this is without any treatment by the way.

Transmission of Covid-19 among children in schools and daycares is very rare. And studies in China and the US of just under a million kids in China and @10,000 in North Carolina showed NO transmission from child to adult.

There are no long-term safety studies of mRNA Covid vaccines, nor have they been evaluated for carcinogenic or mutagenic potential or for impairment of fertility.

Pfizer's BNT162b2 is NOT FDA-approved; it has merely received EUA. In other words, it is experimental. The only licensed product is one not yet available in the US.

According to data available <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2F0x124.mjt.lu%2Flnk%2FAVYAAD-Y-NIAAABBguwAAAr0InIAAAAAu9MAALoOABkwhABhhFj5ZmmnV6NfRR2nha2jDcLeLgAYgA4%2F7%2F3v8ExX from the Vaccine Adverse Event Reporting System (VAERS), as of October 22, there had been a total of 16,716 reports of adverse events, including 1,435 serious reactions and 27 deaths in the 12- to 17-year-old age group. This number rises daily.

The Pfizer mRNA vaccine has caused devastating injuries in youth, including myocarditis and pericarditis. Even though this was minimized, it is a LIFELONG ailment, and causes early death. The CDC's own analysis of "Myopericarditis following Covid-19 vaccination: Updates from the Vaccine Adverse Event Reporting System" shows astonishingly high incidence in the youngest age brackets.

DON'T EVEN THINK ABOUT RECOMENDING THIS DANGEROUS, EXPERIMENTAL PRODUCT! WE ARE WATCHING.

*

* Healthy adolescents ages 12-17 who have been given Covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.

* The vaccine does not prevent infection, transmission, hospitalization, or death. A recent study from the Harvard Center for Population and Development Studies states it plainly: “Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States.” Researchers found that “countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days.”

* Children are not a significant threat to the elderly and vulnerable, as most Covid cases are spread from adults to children.

* Printable flyers with referenced disgraceful quotes from FDA, CDC, and Pfizer are available at InformedChoiceWA.org. <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2F0x124.mjt.lu%2Flnk%2FAVYAAD-Y-NIAAABBguwAAAr0InIAAAAAu9MAALoOABkwhABhhFj5ZmmnV6NfRR2nha2jDcLeLgAYgA4%2F8%2FibLSP-rRl3g8PFyyhTFDEg%2FaHR0cHM6Ly9pbmZvcm1lZGNob2ljZXdhLm9yZy9jb3ZpZC0xOS9wcmludGFibGUtZm

* You can share or cite from Senator Ron Johnson's four-hour roundtable <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2F0x124.mjt.lu%2Flnk%2FAVYAAD-Y-NIAAABBguwAAAr0InIAAAAAu9MAALoOABkwhABhhFj5ZmmnV6NfRR2nha2jDcLeLgAYgA4%2F9%2Fhoy-FKcRdvAGmscEFHAYGw%2FaHR0cHM6Ly9ydW1ibGUuY29tL3Zva3JmNy1zZW4uLWpvaG5zb24tZXhwZXJ0LX of vaccine injury victims and medical experts on federal vaccine mandates and the importance of health care freedom.

* ACIP member Dr. Camille Kotton publicly admitted <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2F0x124.mjt.lu%2Flnk%2FAVYAAD-Y-

NIAAABBguwAAAr0InIAAAAAu9MAALoOABkwhABhhFj5ZmmnV6NfRR2nha2jDcLeLgAYgA4%2F10%2F1Ki3M
d5FN2m8BZP1oAbJw%2FaHR0cHM6Ly9wb3B1bGFycmF0aW9uYWxpc20uc3Vic3RhY2suY29tL3AvbmV3LWRp
that the number of Covid deaths in ages 5 to 11 for one year was 66. She did not distinguish between "from Covid" and "with Covid." In any event, it does not justify putting hundreds of thousands of children at risk of short- and long-term harm from the vaccines.

Sent with ProtonMail
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fprotonmail.com%2F&data=04%7
Secure Email.

From: Janet O'Donnell
Sent: 11/5/2021 11:34:50 AM
To: DOH WSBOH
Cc:
Subject: No COVID Mandates

External Email

I am TOTALLY against any and all forced vaccination for COVID vaccines for children to enter schools. This is an experimental vaccination in all regards and even if the CDC wants to pretend it’s not, it scientifically is!

Our children should not be forced to take it!

Janet O’Donnell

From: dnaburns
Sent: 11/5/2021 11:23:22 AM
To: DOH WSBOH
Cc:
Subject: NO VACCINE MANDATES FOR CHILDERN!

External Email

A vaccine mandate for children to attend school, is categorically the definition of discrimination AND AGAINST THE LAW! I will take legal action against any individuals who advocates for this or implements this along with the entities they represent. You will loose, not just government monies, but your own wealth. Don't beleive me? You have no implied immunity. You will be held accountable for discrimination, don't make that mistake. NO DISCRIMINATION AND NO VACCINE MANDATES FOR CHILDERN!

Dylan Burns

Sent from my T-Mobile 5G Device

_____

From: heatherannpare
Sent: 11/5/2021 11:33:21 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

We are against mandatory vaccination policy and feel it's against medical freedom and against how we want to raise and protect our own children.

Sincerely,
Concerned citizens

Sent via the Samsung Galaxy S10, an AT&T 5G Evolution capable smartphone

From: sarahoffman02@aim.com
Sent: 11/5/2021 11:53:50 AM
To: DOH WSBOH
Cc:
Subject: Proposed mandate

External Email

Hello, my name is Sarah Trivett and I have a daughter in the Snohomish school district. I'm writing to add my voice to the masses in opposition of the proposed mandate to require children to receive the covid vaccination in order to attend school. If this mandate comes to fruition, I will immediately pull my child from the public school district.

Thank you.
Sarah Trivett

Sent from my iPhone

From: LouiseCK
Sent: 11/5/2021 11:47:23 AM
To: DOH WSBOH
Cc:
Subject: children's vaccinations...

External Email

It should be the parent’s decision to vaccinate their own children, not the school board or the board of health or the governor. It should only be the parent’s decision whether their children should take the risk of receiving the vaccination or not. Our children to do not belong to the state, they belong to their mother and father, the parents are the people responsible for their children’s health and welfare.

Sincerely, Vic and Louise Khvoroff

From: Payton Thompson
Sent: 11/5/2021 10:48:13 AM
To: DOH WSBOH
Cc:
Subject: 5-11 Covid Mandates

External Email

Hello,

I would like to voice my request to the SBOH to not mandate Covid vaccines to children. I have a 5 year old who attends public school in North Bend. We have always supported our public schools and want to see our public schools continue to thrive. We will be discussing the vaccine with our child's pediatrician and we will make an educated decision based on our child's specific needs. This is how all medial decisions should be made. I'm not antivaccine and I come from a place of deep understanding for the complexity of dealing with Covid. But in this case, a mandate feels wrong and I wanted to voice my concern.

-Payton

From: Ann Lapinsky
Sent: 11/5/2021 11:21:26 AM
To: DOH WSBOH
Cc:
Subject: Vaccine

External Email

To whom it may concern…
I heard a rumor you will be mandating vaccines for kids. I refuse. My kids are my choice and They will not be getting the vaccine. Please do not go forward with this!!
Concerned and angry parent…

Sent from my iPhone

From: Dianna Lettau
Sent: 11/5/2021 10:38:41 AM
To: DOH WSBOH
Cc:
Subject: No vax mandate for kids

External Email

I encourage the committee to not mandate covid vax for kids!
1) 99.99% of children survive covid.

2) No long term safety studies have been done.

Leave our bodies alone!

Sincerely,

Dianna Lettau
DiannaLettau@gmail.com

Sent from my iPhone

_____

From: Marilee Carter
Sent: 11/5/2021 11:06:21 AM
To: DOH WSBOH
Cc:
Subject: Covid vax for ages 5-11

External Email

Sent from my iPhone

I just heard that comments are being taken today regarding the possible mandating of the new experimental covid "vaccine" for children 5-11. In my opinion, this still experimental "vaccine" should never be mandated for anyone and definitely not for children. Yes, children from 5-18 have contracted the virus, but the numbers that tell how many have died always fail to mention the fact that most in that number have had some type of health issue that weakened their immune system in the first place. To me, that appears to be "lying by omission" in order to push a certain narrative. We have known from the beginning of Covid that children are not at great risk from this virus, nor are they spreaders of the virus. The risk from the "vaccine" would appear to outweigh any benefit, based on the heart conditions due to the "vaccine"we have seen in the 12-18 year old group. When the recovery rate for those young people who contract the virus is just shy of 100%, it makes little sense to inject something into their bodies that we have absolutely no idea what the long term effects may be. We also know now that in adults the "vaccine" does not prevent people from getting covid and it does not prevent fully vaccinated adults from spreading the virus. It may help those who contract the virus from being as sick with the virus. With over 17,000 deaths from the "vaccine" and thousands of permanent disabilities (according to the VAERS reporting system), why would we even approve giving the "vaccine" in the first place to children, let alone making it mandatory in children (or adults)! Our increasing rates of vaccines in children, along with other factors, have caused our children to be among the most unhealthy of the industrialized nations. And no one is held accountable since the makers of vaccines were granted immunity from liability for any vaccine injuries with the bill passed back in 1986. This "vaccine" is no different-if a child is injured, a parent has no recourse with the vaccine manufacturer. And all of the current covid "vaccines" are still under EUA, even Pfizer (the "vaccine" that was approved is actually Comirnaty, which is supposedly the same formula but is legally distinct [apparently it has no liability shield yet] and Comirnaty is not yet available in the US). Why would we ever mandate a "vaccine" for children that is still under EUA (which we should have the right to refuse based on that alone) and that we really have no idea what any long term effects may be. To me, even considering this at all is criminal and unconscionable! I urge you NOT to mandate this for children!

From: Margie Lou Colyar
Sent: 11/5/2021 11:53:48 AM
To: DOH WSBOH
Cc:
Subject: Do Not Mandate This Gene Therapy For Our Children

External Email

To Whom it May Concern,

I am writing to you today as a concerned citizen and parent of 2 children in Washington State. My children are all current on all their vaccinations, but we will not be opting to have them get the COVID-19 shot. There are too many risks and unknowns associated with this still-experimental shot especially to children, and I am not comfortable with exposing my children to such a risk.

By their own admission, the CDC acknowledges that the risk of children dying from covid is exceptionally low, and vaccinating 1 million children ages 5-11 would likely result in 106 vaccine-induced myocarditis cases. That's a side effect we know of now, but that's only after three months of testing. Myocarditis is an infection of the heart! That's a dangerous, known side effect.

I don't feel we should be sacrificing our children's health to in the slight chance they may pass on Covid to an adult. The vaccine doesn't prevent transmission, so why risk our children's health, who largely aren't even affected by covid?

Thank you,

Margie Lou Colyar

From: seattleswfreedom
Sent: 11/5/2021 10:16:30 AM
To: DOH WSBOH
Cc:
Subject: Please increase your awareness of these issues

External Email

Washington State Board of Health Member -

I am a parent. In the spirit and concern of keeping the children of WA state healthy and strong, please increase your awareness of the following issues:

There is no Covid healthy emergency in children ages 5 to 11. According to date published by the CDC, 99.99815% of children who contract Covid-19 survive.

There is no long term safety studies of mRNA Covid vaccines. It is not acceptable for anyone in leadership and/or a decision making role have this perspective voiced by a voting FDA Advisory panel member, Dr. Eric Rubin during the FDA hearing on Tuesday October 26, "We're never gonna learn about how safe the vaccine is until we start giving it. That's just the way it goes."

Pfizer's BNT162b2 is NOT FDA-approved; it has merely received EUA. In other words, it is experimental.

According to data available <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2F0x124.mjt.lu%2Flnk%2FAMYAAGlU mzxvQO9po16AAYgA4%2F7%2FLiQCIRdSaCeWvkEDhZezhQ%2FaHR0cHM6Ly9tZWRhbGVydHMub3JnL3Zh from the Vaccine Adverse Event Reporting System (VAERS), as of October 22, there had been a total of 16,716 reports of adverse events, including 1,435 serious reactions and 27 deaths in the 12- to 17-year-old age group. Healthy adolescents ages 12-17 who have been given Covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.

Since the vaccine does not prevent infection, transmission, hospitalization, or death what is the rationale of injecting healthy children. ACIP member Dr. Camille Kotton publicly admitted <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2F0x124.mjt.lu%2Flnk%2FAMYAAGlU mzxvQO9po16AAYgA4%2F10%2FEXDlpjoqag7jU6T-Xf4WKQ%2FaHR0cHM6Ly9wb3B1bGFycmF0aW9uYWxpc20uc3Vic3RhY2suY29tL3AvbmV3LWRpc2Vhc2UtZG that the number of Covid deaths in ages 5 to 11 for one year was 66. She did not distinguish between "from Covid" and "with Covid." In any event, it does not justify putting hundreds of thousands of children at risk of short- and long-term harm from the vaccines.

A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest

COVID-19 cases per 1 million people in the last 7 days.”

If you are unaware of the adverse reactions due to the vaccine, please view Senator Ron Johnson's four-hour roundtable <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2F0x124.mjt.lu%2Flnk%2FAMYAAGlU mzxvQO9po16AAYgA4%2F9%2Foely3KOgRKkro6pbtX4S9g%2FaHR0cHM6Ly9ydW1ibGUuY29tL3Zva3JmNy of vaccine injury victims and medical experts on federal vaccine mandates and the importance of health care freedom.

I ask that you consider these issues with utmost care for the children of our state of Washington and to stand for truth.

Sincerely,

Jennifer Fernandez

Sent with ProtonMail <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fprotonmail.com%2F&data=04%7C Secure Email.

From: CLAIRE KATZUNG
Sent: 11/5/2021 11:53:31 AM
To: DOH WSBOH
Cc:
Subject: E5E53C24-F542-4DED-AAE1-5E2519A46AC8

External Email

DO NOT MANDATE THE COVID VACCINE FOR 5-11 YEAR OLDS!!!!! THAT'S PATHETICALLY REDICULOUS!!! THEIR MORTALITY RATE IS ZERO. WHAT WOULD VACCINATING THEM DO?? PROVE THEIR MORTALITY RATE IS ZERO WITH THE VACCINE WHEN IT ALREADY IS????? THERE'S NO LONG TERM SAFETY STUDIES AND THAT DON'T NEED IT!!! DO NOT MANDATE THIS!!!!!!

Claire Katzung

From: Allyson Miller
Sent: 11/5/2021 11:49:05 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

I oppose adding the Covid-19 vaccine as a mandate for any child, anywhere.

There is no covid health emergency for children. According to CDC data, 99.99815% of children survive Covid-19. The vaccine does not prevent transmission, infection, or death, but risks of serious heart and neurological problems have and do occur. The risk/ benefit ratio is absolutely NOT in favor of the vaccine vs the illness in children.

Transmission among children has proven to be extremely rare; adults are the primary spreaders, and children very rarely have a serious reaction to the illness.

Please do the right thing, and follow actual science and data, not politicized talking points and agendas. No Covid-19 mandates for anyone, particularly children.

From: Joey D
Sent: 11/5/2021 11:33:03 AM
To: DOH WSBOH
Cc:
Subject: Don't require COVID vaccine for children

External Email

Under no circumstances should this be required. This is a free country and this is not informed consent - this is forced compliance.

DO NOT require these Covid "vaccines" for children.

From: irene ortiz
Sent: 11/5/2021 9:43:24 AM
To: DOH WSBOH
Cc:
Subject: 97748B7D-341F-4FF1-9E56-6AEEB20968DD

External Email

Dear citizens:
Please consider these points,
Vaccine injury from these vaccines is “real, not rare” and parents must have the final say in their children’s medical care.

This is NOT a FDA approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental
drug.
God bless you all and you families

Sent from my T-Mobile 4G LTE Device

From: Bill
Sent: 11/5/2021 11:39:50 AM
To: DOH WSBOH
Cc:
Subject: Mandated Bacvined gor Children

External Email

I am writing to request that Washington State not mandate Covid vaccines for school children as a condition of attending school.

Sincerely,
William Correll
Ephrata, WA

From: Bettye Ham
Sent: 11/5/2021 10:31:17 AM
To: DOH WSBOH
Cc:
Subject: COVID-19 vaccine

External Email

Sent from my iPad
To the Washington Board of Health
I would like to address my concern over any mandate for children 5-11 being required to have this vaccine for attending school or being in a daycare setting. I am a Washington state resident.
We are aware there is no COVID-19 health emergency for children 5-11. Natural immunity is apparent in this age group. We cannot ignore this fact. Vaccine injury is real and occurs frequently.
The transmission of COVID-19 among children in school and daycare is very rare. According to the published data by the CDC 99.9815% of children who contract COVID-19 survive.
Therefore I am asking that you not consider a COVID-19 requirement for this age group
Thank you,
Bettye Ham

From: Ron Behrens
Sent: 11/5/2021 11:29:47 AM
To: DOH WSBOH
Cc:
Subject: Mandatory Vax requirements for children

External Email

We are not in favor of mandatory vaccine for young children. The risk seems greater then the benefit. We do not know any of the long term risks, if there are any.

Ron and Kay Behrens

Sent from my iPhone

From: Jeremy Bowen
Sent: 11/4/2021 9:25:51 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

No mandatory shots for anyone..my kid will be pulled from public school instantly.. this is insane people getting fired over a virus...gov and state over reach is out of control..no no no!

Sent from Yahoo Mail on Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.onelink.me%2F107872968%3F

From: Sherri Aust
Sent: 11/5/2021 11:25:27 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Children are not statistically at risk for this virus. They have practically a 100% survival rate. It seems unconscionable to subject them to a vaccine which has not gone through the rigorous trials and tests which, historically takes years before being administrated to the public.

NO ONE knows the long term effects of this NEW type of mRna style of hypodermic.

There has been misinformation, suppressed information, contradictory information, and mismanagement of the information regarding everything about this medical rollout.

PROTECT the children from this unknown concoction and allow their strong immune systems to protect them from Covid while they are the least vulnerable to the disease.

From: Minh-Nguyet Trinh
Sent: 11/5/2021 11:05:53 AM
To: DOH WSBOH
Cc:
Subject: Public comment on kids vaccination

External Email

We do not need to impose this mandate of 5-11 y.o. There are real injury from these vaccines and they are not rare. Transmission in schools and daycare is very rare, with 99.99% survival. Researchers found that in countries with higher Covid 19 cases per million are among those with higher vaccinated people. According to the VAERS as of Oct. 8th, there have been a total of 21,652 reports of adverse reaction, including 1,304 serious reactions and 24 deaths in the 12-17 y.o. age group. Please respect parents' final say in their children's medical care.

Thank you for considering these comments as you navigate through your process.

Minh-Nguyet

Sent from Mail
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.microsoft.com%2Ffwlink%2F%
for Windows

_____

From: Debby Swecker
Sent: 11/5/2021 11:41:06 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

I am 100% opposed to giving the Covid vaccine to children or teens. There is NO scientific/health justification for this. Don’t even think about approving this!!!
Thank you.
Debby Swecker

Sent from my iPhone

From: Curtis Nelson
Sent: 11/5/2021 7:58:45 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Hello,

I am opposed to COVID vaccine mandates for children. The risk of COVID to children is extremely low, nearly zero. The vaccines do not appear to decrease transmission of COVID except for a very short time. Therefore, it is morally wrong to give this vaccine to children using them as a shield for older people.

Curtis Nelson

2521 227th PL NE

Sammamish, WA 98074

_____

From: Tonya Peeler
Sent: 11/5/2021 9:28:42 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Dear Board,

I'm writing this note because I am very concerned that there is consideration of making it mandatory for students to receive the Covid19 vaccination in order to attend school. How is this even a consideration? Parents should be allowed to make the choice for their child. No other state is making this type of decision. It is already outrageous that healthy unvaccinated students are kept out of school while the vaccinated kids remain in school when both groups were in close contact of a covid case. My son was out of school for 14 days - he had no symptoms, tested negative but yet he missed all those days of school. We know that people who have received the vaccine can still get sick. This is really hard for me to understand. Keep the sick home, send the healthy to school. But - this is not what the district is choosing to do. Now, there is consideration for unvaccinated kids to not be able to attend school. Don't we want our youth to have an education without all these other stresses? Isn't there already enough issues out there. How can a single group of people force medical decisions on my family? What if my child had terminal cancer, and we decided not to get treatment. Would this same group of people be able to make a decision for my family. What ever happened to the right to choose?

We do come from a vaccinated family - but many of our friends and family have chosen a different route. We respect their choice, and we hope you do as well.

Kind regards,

Tonya

_____

From: Don Jacobson
Sent: 11/5/2021 6:39:17 AM
To: DOH WSBOH
Cc:
Subject: I do NOT Consent to Mandatory Vaccines!

External Email

* There is no Covid health emergency in children ages 5 to 11.
* Natural immunity needs to be part of the risk-benefit analysis; it can no longer be ignored.
* Injury from these products is real, not rare; parents must have the final say in their children's medical care.
* According to data published by the CDC, 99.99815% of children who contract Covid-19 survive.
* Transmission of Covid-19 among children in schools and daycares is very rare.
* There are no long-term safety studies of mRNA Covid vaccines, nor have they been evaluated for carcinogenic or mutagenic potential or for impairment of fertility.
* Pfizer's BNT162b2 is NOT FDA-approved; it has merely received EUA. In other words, it is experimental.
* According to data available <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2F0x124.mjt.lu%2Flnk%2FAUwAAD3 from the Vaccine Adverse Event Reporting System (VAERS), as of October 22, there had been a total of 16,716 reports of adverse events, including 1,435 serious reactions and 27 deaths in the 12- to 17-year-old age group.
* The Pfizer mRNA vaccine has caused devastating injuries in some youth, including myocarditis and pericarditis. The CDC's own analysis of "Myopericarditis following Covid-19 vaccination: Updates from the Vaccine Adverse Event Reporting System" shows astonishingly high incidence in the youngest age brackets.
* Healthy adolescents ages 12-17 who have been given Covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.
* The vaccine does not prevent infection, transmission, hospitalization, or death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."
* Children are not a significant threat to the elderly and vulnerable, as most Covid cases are spread from adults to children.
* Printable flyers with referenced disgraceful quotes from FDA, CDC, and Pfizer are available at InformedChoiceWA.org. <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2F0x124.mjt.lu%2Flnk%2FAUwAAD3

* You can share or cite from Senator Ron Johnson's four-hour roundtable <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2F0x124.mjt.lu%2Flnk%2FAUwAAD3 of vaccine injury victims and medical experts on federal vaccine mandates and the importance of health care freedom.
* ACIP member Dr. Camille Kotton publicly admitted <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2F0x124.mjt.lu%2Flnk%2FAUwAAD3 fV7v6b2Xkz9nzb0Isew%2FaHR0cHM6Ly9wb3B1bGFycmF0aW9uYWxpc20uc3Vic3RhY2suY29tL3AvbmV3LWF that the number of Covid deaths in ages 5 to 11 for one year was 66. She did not distinguish between "from Covid" and "with Covid." In any event, it does not justify putting hundreds of thousands of children at risk of short- and long-term harm from the

vaccines.

From: Audrey Phillips
Sent: 11/5/2021 10:54:08 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

To Whom It May Concern:

I'm writing in request that you do not approve the Covid Vaccinations for children ages 5-11.

* There is no Covid health emergency in children ages 5 to 11.
* Natural immunity needs to be part of the risk-benefit analysis; it can no longer be ignored.
* Injury from these products is real, not rare; parents must have the final say in their children's medical care.
* According to data published by the CDC, 99.99815% of children who contract Covid-19 survive.
* Transmission of Covid-19 among children in schools and daycares is very rare.
* There are no long-term safety studies of mRNA Covid vaccines, nor have they been evaluated for carcinogenic or mutagenic potential or for impairment of fertility.
* Pfizer's BNT162b2 is NOT FDA-approved; it has merely received EUA. In other words, it is experimental.
* According to data available <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2F0x124.mjt.lu%2Flnk%2FAM0AALOl from the Vaccine Adverse Event Reporting System (VAERS), as of October 22, there had been a total of 16,716 reports of adverse events, including 1,435 serious reactions and 27 deaths in the 12- to 17-year-old age group.
* The Pfizer mRNA vaccine has caused devastating injuries in some youth, including myocarditis and pericarditis. The CDC's own analysis of "Myopericarditis following Covid-19 vaccination: Updates from the Vaccine Adverse Event Reporting System" shows astonishingly high incidence in the youngest age brackets.
* Healthy adolescents ages 12-17 who have been given Covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.
* The vaccine does not prevent infection, transmission, hospitalization, or death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."
* Children are not a significant threat to the elderly and vulnerable, as most Covid cases are spread from adults to children.

Quotes from CDC and FDA linked below also.

No studies performed on long-term outcomes of the COVID Pfizer vaccine in children.
-Dr. Fiona Havers
CDC

Oct. 26, 2021
@1:20:30

"...but we're never going to learn about how safe this vaccine is unless we start giving it."
-Dr. Eric Rubin
FDA Advisor
Oct. 26, 2021
@6:52:33

"The question really becomes, does this vaccine offer any benefits to (children) at all?"
-Dr. Michael Kurilla
FDA Advisor
Oct. 26, 2021
@7:41:52

https://www.fda.gov/advisory-committees/advisory-committee-calendar/vaccines-and-related-biological-products-advisory-committee-october-26-2021-meeting-announcement

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.fda.gov%2Fadvisory-committees%2Fadvisory-committee-calendar%2Fvaccines-and-related-biological-products-advisory-committee-october-26-2021-meeting-announcement&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C42d7e3c8954d4f0f9daf08d9a08542b6%7C

Please spend some time watching the link below.

https://rumble.com/vokrf7-sen.-johnson-expert-panel-on-federal-vaccine-mandates.html

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Frumble.com%2Fvokrf7-sen.-johnson-expert-panel-on-federal-vaccine-mandates.html&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C42d7e3c8954d4f0f9daf08d9a08542b6%7C

We have tons of information available and it has been proven that treatment options are available.
Please visit HealthyImmunityNow.org for more information.

Sincerely

-Audrey Phillips
Olympia, WA

_____

From: Trish Warfel
Sent: 11/5/2021 8:49:14 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

To all who may be concerned,

Hello, my name is Trish Warfel and I live in Renton Washington. I raised three children in the Kent School District and now have nine grandchildren. I am also an RN of 40+ years.

I would like to comment on the possible mandate of experimental drugs on anyone, especially children. I am urging you to not mandate these drugs, as I refuse to call them vaccines, for children. And these drugs, as you know, are not at all FDA approved and have only been given emergency use authorization. To force this on our children is to use them as guinea pigs for a grandiose science experiment. I can think of nothing more abusive. This rings of the Nuremberg trials, and you will share guilt in crimes against humanity if you allow a mandate to happen in the state.

There are other reasons why mandating this for children, or anyone for that matter, is abusive and frankly, absolutely unnecessary: According to the CDC, 99.99% of children who contract Covid survive. Transmission of Covid among children is very rare. There are no long-term safety studies of these drugs, and in the short-term, there have been tens of thousands of severe adverse reactions, including among children. Some of those reactions have been life altering, as in forever.

Some of the life altering reactions are related to the heart. Make no mistake about it, pericarditis and myocarditis are not one time problems. If you have one of those conditions when you are young, you are set up for a lifetime of recurrence. This means kids will be sidelined from actually attending school, from participating in sports possibly forever, and will be set up for mental illness because of the severe reactions to these drugs and the unnecessary negative consequences on their lives. This infuriates me, as a human being and an RN, that anyone would force this on another human being, especially children.

I urge you during your deliberations, not to be swayed by leftist emotion and desire for power and control, and instead truly be led by the scientific facts, some of which I have mentioned above.

No one can say these drugs are safe. No one. They have not even been in use for one year. Why would anyone mandate something which remains experimental, harmful and most of all unnecessary?

I urge you to hear my plea and the pleas of others like me who love our children and want them to remain healthy and engaged, not sickly and discouraged. Covid is no threat to them, nor a threat from them. Therefore, drastic measures such as any experimental drug mandate is simply beyond ridiculous.

Sincerely,

Trish Warfel

From: Jessica Haselby
Sent: 11/5/2021 7:52:12 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Mandating vaccines with not enough long-term safety data for young children seems like a risky idea. Please consider how even one rare adverse event could alter a family's life. If the risk of death and hospitalization from covid for children is so low, why mandate something whose long term safety data is still unknown. Children whose parents want it, can surely get it and feel they themselves made the choice and thus they accept the responsibility of some risk. Children who are obese their parents could decide they want to get it as that is a huge comorbidity.

Mandates take away responsibilities for outcomes and pressuring people to give to their children seems irresponsible at this point when long term effects or rare side effects do happen.

As children cannot consent for themselves but will bear any possible negative outcomes rare or adverse, mandatory medical procedures imposed on children are something not to impose lightly. One child would be terrible to lose due to a heart or blood vessel adverse event. Think how covid may really never have made them very sick anyway and then that could happen! The risk is too awful to be responsible for. Please consider this.

Jessica Haselby
10345 32nd Ave NE
Seattle WA 98125

Sent from my iPhone

_____
From: Vanessa Reiter
Sent: 11/5/2021 10:36:18 AM
To: DOH WSBOH
Cc:
Subject: Comments for next board meeting

External Email

To Whom it may concern:
There should be NO COVID vaccine mandate for children!

- There is no COVID health emergency in children 5 to 11

- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.

- Vaccine injury from these vaccines is "real, not rare" and parents must have the final say in their children's medical care.

- Transmission of COVID-19 among children in schools and daycares is very rare.

- According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.

- There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine.

- This is NOT a FDA approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental

drug.

- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12-

to 17-year-old age group.

- The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event

Reporting System (VAERS)" showed astonishing increases in the youngest age brackets.

- Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.

- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that, "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their

population fully vaccinated had the highest COVID-19 cases per 1 million people in the

last 7 days.”

- Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children

Sincerely,

Vanessa

From: Cami Huntting
Sent: 11/5/2021 10:42:59 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

So since Our kids were not hardly effected by COVID-19 now you want to vaccinate them to help kill them off? Stop this insanity NOW!!!! You need to take a look at history. Let a virus run its course. Let our natural GOD GIVEN immunities Take care of it instead of trying to play God and suppress our natural immunity's. And don't try to lie to us and tell us that having this poison in our system is going to strengthen our natural immune system. Anybody that's done any research at all knows better than that. We the people are sick and tired of all the socialist and communistic acts of big Pharma and hospitals and companies that are going along with the evil agenda. PLEASE WAKE UP!!!!!

Sent from my iPhone

From: jdcan1956
Sent: 11/4/2021 9:59:00 PM
To: DOH WSBOH
Cc:
Subject: Children's vaccine

External Email

To whom it may concern and it should concern every American.
Our children and grandchildren are not the test projects for this shot neither are they lab rats. With this age group being the lowest percentage of infection rate it is unconscionable that we would even subject them to this. Kids can have underlying health issues that have we don't know about that this vaccine could trigger deadly consequences. Take Kawasaki's disease. If a child had a mild case of it and was never diagnosed or properly diagnosed they could have an underlying heart condition that has gone unchecked. Looking at the rate of myocarditis in young adult men should have been concerning enough but you now want to take it further? Who will be responsible and take a stand against this Unscientific vaccine that is clearly Not for children. The science is not in your favor as we've heard f and we've all seen the charts that this age group is at the lowest end of infection rates. So it is clearly not needed for our children and grandchildren. Debra Canfield

Sent from my Verizon, Samsung Galaxy smartphone

From: sue coffman
Sent: 11/5/2021 10:40:06 AM
To: DOH WSBOH
Cc:
Subject: Covid 19 discussion Public Comment

External Email

Whatever happened to "My Body My Choice" and parental responsibility and integry?? Children are at an extremely low risk of getting Covid19. There is no Covid emergency in children 5 to 11, and now you want to advocate that they get an untested, experimental, and risky gene therapy injection? Injury from the "vaccine" is Real, not Rare, and parents must always have the final say in their children's medical care! The proposed FDA approval simply means they expand the EUA to include young children in an EXPERIMENTAL drug! Abominable. Plus, children are not a threat to the elderly or other vulnerable, as most Covid cases are spread from adults TO children.

The data from VAERS currently states that in the 12-17 year old age group there have been 21,652 reported adverse events, including 1304 serious reactions and 24 deaths. And now you want to injure even younger children?? Why is it being ignored that myocarditis and pericarditis (as well as blood clots and extreme fatigue) increases in the younger age brackets, and that these risks are higher than getting Covid itself? This makes no scientific sense.

The CDC has admitted that the Covid "vaccine" does not stop infection, transmission, hospitalization, nor death. So the only reason to get an injection is to continue to line the pockets of those conglomerates who seek to make billions from the sales of these experimental treatments.

Additionally, natural immunity must become a part of risk-benefit analysis in all cases; it can no longer be ignored. Covid19 is extremely treatable and not as lethal as they have led us to believe. Indeed, other states are starting to realize this:
https://informedchoicewa.org/covid-19/open-letter-to-the-washington-medical-commission/
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Finformedchoicewa.org%2Fcovid-19%2Fopen-letter-to-the-washington-medical-commission%2F&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C07d98715d801401e4f1108d9a0834ce6%

Adults in America must stand up to segregation and discrimination that once again is infiltrating this country. Separating people by masking, distancing, and vaccination status is unconstitutional. Luckily there are states that are starting to understand that:
https://standforhealthfreedom.com/uncategorized/montana-common-sense/
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fstandforhealthfreedom.com%2Fu
common-sense%2F&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C07d98715d801401e4f1108d9a0834ce6%7C11

I stand for my Medical Rights, Informed Choice, and mostly I STAND FOR THE CHILDREN!!

Sue Coffman
714-337-4331
ICWA Team Leader

Legislative District #24
https://informedchoicewa.org/
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Finformedchoicewa.org%2F&data=

From: Heather Kovacs
Sent: 11/5/2021 11:11:13 AM
To: DOH WSBOH
Cc:
Subject: Please No Vaccine Mandate for Children

External Email

Dear WA Board of Health,
I am writing to you today to express my strong request that the Board of Health does not adopt a vaccine requirement for children and day care‘s and public schools. The actual risk of death to children is extremely minimal and vaccine side-effects are real concerns. If children do contract Covid-19 they don’t get very sick and yet they help to build a natural immunity base which is a key component to ending this pandemic.

These factors and others are reasons why it should be up to the parents to decide if they approve of this vaccine for their child or not.

My children already had COVID, they have natural immune and if a vaccine is mandated, we will be withdrawing from public school, just like we did in 2020.

Thank you,
Heather Kovacs

Sent from my iPhone

_____

From: Chris Hansen
Sent: 11/4/2021 9:33:01 PM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Dear Board members, you are in a position of deciding about the most important impact upon children's health in the history of WA state! I pray you Choose wisely, with real science, free of political, corporate, and media overreach. Individuals are never exempt from personal liability- parents, grandparents, never quit.

Please consider: so many options with real time infection rates dropping rapidly

-therapeutic treatment must match a disease or in this case, a potential disease, that is EASILY survivable in kids

- vaccines have a great place when nothing else works, the disease is serious, and survival rates are low

-99.9% of kids survive Covid without vaccination…99.9% means way more will die from accidents

-just because you have a therapy you don't have to use it

-will you vote next month to hold tiny hands, line up innocent kids, and force kids without cancer to take permanently body damaging chemo or radiation, only to prevent possible cancer????…of course not, yet cancer is wayyyyy more serious, so that would be crazy… unless

- C19 vax's so far have made somebody $55 Billion in PROFIT and that happens to be what is funding the media

-SAFE,WELL TESTED, EXTREMELY EFFECTIVE options exist to treat kids who rarely ever need treatment for C19

-the most number of deaths ever attributed to a drug was the swine flu vax in the '70's

when it got pulled off market with less than 100 deaths after millions and millions used it

-our VAERS government data has over 17,000 deaths and over 700,000 serious injuries related to C19 Vax's….and you tube videos galore of crying, damaged, families, kids, parents who can't file VAERS since it keeps kicking them out of logging complaints

-we plead that you VOTE YOUR HEART that doesn't lie

-this is America the land of Choice and Freedom, not media and profit taking away parents and kids rights

-never anti vax, pro-choice and freedom

With gratitude and appreciation,

May Blessings of Karma and the Golden Rule follow you all the days of your life.

Christopher Hansen

_____

From: Alisha Kym
Sent: 11/5/2021 9:42:39 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

My comments and concerns for the WA State Board of Health webinar on 11/10/21 @ 10 am - 2:35 pm.

Dear Board of WA state Health Dept:

I do not expect you to answer any of my questions directly, but I want it on the record that I supplied this info and my comments before 12 pm on 11:5 and want my voice to be heard kn 11/10. I also want notes that these are real concerns (formed as questions) that millions of Americans are asking themselves everyday, and is why you have so much non-compliance. Have you ever asked yourselves why? By the way I am NOT ANTI-VAX, actually far from it. I get the flu shot every time, so do my kids, they are all fully vaxed with the normal kids vaccines, but because of this because of you all, I will never put another injection in me or my kids body ever again. Because of this, you all have made me and millions of others not trust any one in government or a sector thereof like yours. And the reasons are formed in questions below.

1) why are we giving a vaccine to children that has an efficacy of 90.5% against covid when the average death rate for children under 12 is better at 99.97%?

2) Why are we still in a pandemic when rates in infection and deaths are actually at major decline ? In Washington the average death rate per day is actually about 0.8% according to cdc's own website.

3) Why are we wearing masks when the box on the mask even says (and so do many many infectious disease doctors say) that it doesn't protect against diseases including covid-19?

4) Why do my children have to continuously wear masks at school during class but yet at lunch they can sit squished together eating WITHOUT a mask and spitting food particles and matter all over one another?

5) Why are you not listening to the thousands of people that have either had family members die from the vaccine or have been eternally hurt by the vaccine? Some victims just spoke the other day at the capital to raise awareness and yet you all still chosen it to hear them, why is that?

6) Why is it that we need to get a vaccine that is proven to not even protect against getting the disease or spreading it? It only lowers the symptoms if we catch covid, and even then, the chance of dying from Covid are still over 99%. I have a greater chance of being in a horrendous car accident then I do dying from Covid. So why should we het it other than it reduces our symptoms?

7) Why do we have to get a vaccine that isn't actually a vaccine because it isn't directly FDA approved? EUA does not make this a vaccine - a vaccine is something that stops you from getting that "said" disease and this injection does not. So why should we get it?

8) What about people with immunities?people that have had covid and beat it?

9) and what about herd immunity? According to your own Dr Falsi - sorry Fauci, he even said when more than 50% have had covid then we will have reached her immunity. Well, more than half the country is vaccinated, so if the vaccine works then that would mean we reached herd immunity - right?

10) How are we supposed to believe anything you all say, when we went from
A) 15 days to stop the spread
B) wear a mask
C) don't wear a mask
D) wear 2 masks
E) We will never mandate anything
F) mask mandates for all
G) we will never mandate an injection
H) Injections mandated everywhere
I) we won't force the private sector
J) private sector must comply or fines Of upwards of $100K will be administered

Lastly, like I prefaced before, I don't expect you to answer any of my questions directly or even honestly, but these questions alone should lead you to believe that the citizens of America aren't as dumb as you assumed us to be. And we are FREE PEOPLE, and have the choice to decide what goes into our bodies, you do not decide that for us.

Alisha

□□God Bless□□
Sent from my iPhone XS Max

_____

From: Chris Melvin
Sent: 11/5/2021 9:44:13 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

WSBOH,

In regard to vaccination policies for school and day care attendance. I do not agree with mandatory vaccination or vaccine mandates for any person, especially children. This is a personal and private medical decision that effects all families differently. The choice on whether or not to vaccinate children should be determined by parents, and parents only. Informed consent seems to have vanished in this country. That's the idea that we have the right to be informed of risks and then make a decision or determination YES or NO as to receiving medical treatments or procedures. As Americans and individuals we have the right to choose and make informed decisions, according to the laws, and constitution of the United States. That no longer seems valid or lawful these days. Pressure exists from government and government entities (FDA, CDC, NIH) to list a few, who claim to have our best interests in mind, Wolves in sheep's clothing. The amount of vaccinations on the schedule for children is alarming. Especially when side effects of these vaccinations listed in package insert warnings are rising in children at a concerning rate. Worst of all children and parents have no protection or recourse if injured, because the government protects the pharma companies from liability (National childhood vaccine injury act of 1986). Now you'd think if the government had our best interests in mind they would hold big pharma liable. This would force them to perfect their products or abort their use if unable to produce a safe and effective product. Human rights and the basic freedoms of a democracy are not being taken into account by government and government entities when mandatory vaccines and vaccine mandates are being imposed. I do not agree with the COVID-19 vaccines being mandated!

Thanks,

Chris Melvin

Father

Sent from my iPhone

From: Leslie Castanha
Sent: 11/5/2021 9:36:50 AM
To: DOH WSBOH
Cc:
Subject: Vaccine mandate

External Email

Calling for no forced vaccine mandates on our kids. The CDC even states kids even if they catch Covid the have a 99.9802% chance of surviving, it is a fact the vaccine(MRNA gene therapy) injuring more kids and adults than actual Covid. It is a fact kids and adults are getting myocarditis and pericarditis and other ailments as well. The vaccine doesn't even work even in Israel were they have the highest inoculation rates in the world have the highest delta break thru cases. Protect our kids our future and nobody knows how this will effect their offspring in the future. We are calling you to protect our kids with no experimental vaccines that are forced. If this is a disaster genocide will occur.

Thank you for your consideration and I am counting on you to protect our kids.

Sent from my iPhone

_____

From: Patrick Warfel
Sent: 11/5/2021 10:58:19 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

I would like to comment on the possible mandate of experimental drugs on anyone, especially children. I am urging you to not mandate these drugs, as I refuse to call them vaccines, for children. And these drugs, as you know, are not at all FDA approved and have only been given emergency use authorization. To force this on our children is to use them as guinea pigs for a grandiose science experiment. I can think of nothing more abusive. This rings of the Nuremberg trials, and you will share guilt in crimes against humanity if you allow a mandate to happen in the state.

No one can say these drugs are safe. No one. They have not even been in use for one year. Why would anyone mandate something which remains experimental, harmful and most of all unnecessary?

I urge you to hear my plea and the pleas of others like me who love our children and want them to remain healthy and engaged, not sickly and discouraged. Covid is no threat to them, nor a threat from them. Therefore, drastic measures such as any experimental drug mandate is simply beyond ridiculous.

_____

From: Betsie Elliott
Sent: 11/5/2021 10:03:39 AM
To: DOH WSBOH
Cc:
Subject: COVID Vaccine Mandate of Washington State School Children

External Email

Good Morning,

I am writing to you today as a concerned citizen and parent of 2 children in Washington State. Both of my children are younger than 11 years old and we will not vaccinate our children. Our children have had COVID infections. One was asymptomatic and one had a slight fever for 8 hours. What is new and concerning is the direction that it would appear many states are going with - mandating vaccines for school age children to attend public school. Many of the VBRPAC doctors were concerned that their approval would result in mandates of this vaccine. Many approved just because they didn't want to deny high risk children access to this vaccine. I implore you to listen to these doctors.

I keep on hearing people speaking about how vaccines have always been required to go to school, that's true, but this vaccine can't be equated to that. We don't know the impact of these vaccines on our children - we don't know what these could cause in 10-15 years. As Cody Meisner, one of the pediatricians who sits on the VBRPAC panel said, “This is quite different from the MMR vaccine,” referring to the measles, mumps, and rubella vaccine given to all children in the U.S. “We know that vaccine is safe. We have tested that vaccine for decades. And we know, we have a very good sense, of what the adverse events are. We do not have that with this particular messenger RNA vaccine.” There has always been an option to opt out of vaccines with little to no issue from the school districts. As school districts will follow your recommendation, I implore you to NOT make the Covid 19 vaccine required to attend public school in Washington State. By mandating this in the Washington State schools you would be leaving children out, many children who have shouldered so much burden already.

Hearing the terms "safe and effective" with regards to the COVID vaccine isn't accurate. We know that it was "safe" for around 2000 children country-wide, we know that it "may" also be effective for 2 months. We don't know beyond that. The Pfizer Study was very limited in scope and time.

I shouldn't have to uproot my children from all they've known because they'll be excluded from Washington State Schools. As a parent, I should have the choice about the medical procedures my children receive. Last night my youngest child, who's 7, was sobbing because someone at school told him he wouldn't be able to go to school next year if he didn't have the vaccine. This simply isn't right. It's cruel and borderline mental abuse. How much stress have they been under the last 18 months, only to have this stress and burden added.

The impact this will have on many families is awful. Many will be forced to homeschool their children which will result in job loss due to the hours needed to facilitate these needs. The impact on our most vulnerable children would be great and many would never recover.

Thank you in advance for hopefully making decisions that take into account the entire population of Washington State and not just the ones that are most vocal.

Sincerely,

Betsie Elliott
Snohomish School District

_____

From: Megan Matthews
Sent: 11/5/2021 10:47:08 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

To whom it may concern,
I am opposed to any Covid injection mandates regarding children (birth-18).
*There are zero long term studies.
*Children are at a near zero risk of death to Covid.
*The risk for all children with respect to the Covid injection is a complete unknown.
*There is zero liability for the manufacturer of this product. Why not?? Who IS liable for any injuries?
*No exemptions are being discussed for those children (and adults) regarding natural immunity. Why not??
*No studies have been conducted on previously infected receiving the injection. What is the risk factor??
*Relative risk reduction is being used to promote the injections, rather than absolute risk reduction.
Thank you for allowing public comment,
Megan Matthews

Sent from my iPad

From: frieda stephens
Sent: 11/4/2021 8:50:35 PM
To: DOH WSBOH
Cc:
Subject: No Covid vaccine for children 5-11 yrs

External Email

I am asking that this Covid Vaccine mandate for children in daycares or schools not be implemented. Since these vaccines are only authorized for emergency use and no one, not even children, should be forced to take these vaccines. Covid-19 and all its mutations are not a high risk for infection in children. Children, ages 12-17 have suffered more harm from the vaccine than the number of children who suffered death or permanent injury from Covid-19. It's unlikely children will ever pass the illness to an adult.

Why would you subject a child's risk of injury or death from the emergency use vaccine in order to possibly protect the life of an adult?

I am asking that you make the right decision to allow parents to decide NOT COERCED and FULLY informed of the risks, if any, of the Covid Vaccines are right for their children.

Scot Stephens

PO BX 9201
Yakima, Wa 98909

From: Loretta Hemingwam
Sent: 11/5/2021 10:56:04 AM
To: DOH WSBOH
Cc:
Subject: Public comment for Nov 10 BOH meeting

External Email

To the health board,
I am mother of two wonderful children and it concerns me greatly that a one size fits all health approach is being considered for children 5-11. Each family is different and health risks are handled differently by situation, diet, and family medical history. I strongly oppose any mandates on vaccines for children. According to the data available from the Vaccine Adverse Event Reporting System (VAERS), there were 1,435 serious reactions and 27 deaths in the 12 to 17 year old age group, and that is only what is reported to system. Reporting is not requirement and the correlation versus causation might prevent some injury reporting. Possible vaccine injury is unacceptable risks for younger children that, according to data published by the CDC, have a 99.99815% survivability rate. We are past a health emergency and definitely don't need a mandate for young children.
Loretta Armstrong, Kitsap County

From: sbucari2108
Sent: 11/5/2021 1:10:40 AM
To: DOH WSBOH
Cc:
Subject: No Vaccines For Kids!

External Email

Sent from my T-Mobile 5G Device
This is utterly ridiculous! Violation of human, civil, and constitution rights and no way will we allow this for our kids!
Samantha Bucari

_____

From: Christina Carpenter
Sent: 11/5/2021 11:31:02 AM
To: DOH WSBOH
Cc:
Subject: DDB1DB00-BF2E-476F-A32D-1D516D4B9BF3

External Email

For the Nov 5th public comment deadline RE: Mandates for Public Schools.

As a parent I stand firm in my beliefs that the the State of Washington should not possess Emergency Powers over health concerns which impact a small/fraction of a percentage of people. The State, regardless of any laws or codes that are on the books, is out of bounds for coercively required medications, especially when it comes to children who are known to be near absolute absent of risk.

I have already considered withdrawing my teenage children from their regularly scheduled programming at high school, and enrolling them in homeschooling.

In addition to vaccine requirements for school, I also do not subscribe to the theory that vaccine passports or any other form of medical coercion or mandates are appropriate.

Should this state of Washington implement ANY of these measures on my children in order to maintain their basic day to day life, Washington will be losing at least 4 residents. I am sure many will be doing the same.

Should the requirements or mandates be imposed on us without our consent prior to us being able to respond accordingly, it could force an undesirable outcome of a wide spectrum, depending on the situation that presents itself.

Statistics show a vaccine injury rate of over 800k in just 10 months. Statistics show there have been less Covid deaths than vaccine injuries. Data and evidence shows the Covid death rates were inflated by reporting co-morbidities.

Most importantly, data shows that children are almost at zero risk from Covid.

I am writing to let my voice be heard. I will NOT vaccinate my children. As a taxpaying citizen of this beautiful but increasingly draconian state, I am respectfully requesting that careful consideration is given to this.

The risk benefit of mandating vaccines on children is absolutely and statistically unnecessary.

Thank you

Christina carpenter

Clinton, Wa

From: BradSarah Roth
Sent: 11/5/2021 10:59:45 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

To whom it may concern:

I am concerned you are considering mandating Covid 19 vaccines for children to attend public schools. This is far reaching.

Many parents don't want to give their children a vaccine that is still under Emergency Use Authorization (EUA). I understand Comirnaty was approved, but it is not in production in the US. The vials for children are labeled Pfizer BioNtech, which is under EUA. Meaning it is not approved. You cannot legally require a vaccine that is still considered experimental.

If this shot is mandated, many parents will take their children out of school. This will impact school funding; lower numbers will impact the amount of staff schools need, thus Teachers and support staff risk job loss.

Children are the least impacted by COVID19. Achieving natural immunity now while they are young protects them in the future against new variants.

It's not in the best interest for the schools, or the children to mandate this shot to attend school.

Sarah Roth

From: Bethany Hunt
Sent: 11/5/2021 11:15:43 AM
To: DOH WSBOH
Cc:
Subject: COVID Vaccine

External Email

To who it may concern:

- There is no COVID health emergency in children 5 to 11

- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.

- Vaccine injury from these vaccines is "real, not rare" and parents must have the final say in their children's medical care.

- Transmission of COVID-19 among children in schools and daycares is very rare.

- According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.

- There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine.

- This is NOT a FDA approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental

drug.

- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12-

to 17-year-old age group.

- The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event

Reporting System (VAERS)" showed astonishing increases in the youngest age brackets.

- Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.

- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that, "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their

population fully vaccinated had the highest COVID-19 cases per 1 million people in the

last 7 days.”

- Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children.

Vaccine mandates should not be allowed for these reasons.

Sincerely,

Mrs. Hunt

Sent from my iPhone

_____

From: Melinda Wilkes
Sent: 11/5/2021 6:40:17 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Hello,
I am writing to inform the powers that be our concerns and understanding of your "power".

First, I as a parent and now grandparent of 11, I've raised children in the Chehalis school district or many years (my oldest is 41). I now have a grandchild living with me whom I've pulled from the district and have her totally online with the Internet Academy out of Federal Way.

I see no reason that the WA. State schools are teaching CRT, other than to try and divide these children. Making one child feel different from another is exactly what I lived through in the '60's. Just because you've changed the color, vaccination status or sexual status doesn't mean you've helped even one child.

This state has told the masses that you don't care about children as a whole, you've taught them that the 3 people that believe they are "cats" should be allowed to live their lives as cats, you'll provide the litter box and put the 40k others in harms way in order to provide said litter box.

Morals, while I understand are few and far between in this day and age, are important. Self worth is just as important, and the school districts are singling out our children. They're teaching them it's okay to lie, it's okay to sexually assault others if that's how you feel today, it's okay to do as you please and there is no authority above you. Here's the problem! There is indeed authority above everyone! You're trying to teach these children that they run the show, and they don't. Employers will not keep people who can't follow direction or rules. Life will be harder if you can't conform to rules.

Please stop the madness! Stop CRT, stop the vaccine mandate and stop playing God with our children. Parents know best how their children should grow up!

Melinda Wilkes
Chehalis, WA.
Rpmmrsklean@gmail.com

Sent from my iPad

From: Stephanie Benna
Sent: 11/5/2021 11:44:39 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Dear Department of Health Board members,

With the recent FDA emergency use authorization of Pfizer's COVID vaccine for 5-11 year children I am very concerned that this will be followed by states making this vaccination required for children to go to school.

We know that COVID is not a threat to our children, in this age group symptoms are generally mild. According to data published by the CDC, 99.99815% of children who contract Covid-19 survive. The infection will provide durable immunity which is completely ignored by the state of Washington.

Instead, vaccination is pushed as a one size fits all solution regardless of age, health status and immune status. It keeps being pushed even though we know that the vaccine does not prevent infection, transmission, hospitalization, or death. A recent study from the Harvard Center for Population and Development Studies states: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."

I am urging you not to ignore the information that is available from vaccinating our 12-17 year olds: the vaccine has caused devastating injuries in some youth, including myocarditis and pericarditis. The CDC's own analysis of "Myopericarditis following Covid-19 vaccination: Updates from the Vaccine Adverse Event Reporting System" shows astonishingly high incidence in the youngest age brackets. Healthy adolescents ages 12-17 who have been given Covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.

Thank you for listening and being brave,

Stephanie Benna

From: Rex R
Sent: 11/5/2021 10:10:11 AM
To: DOH WSBOH
Cc:
Subject: Vaccinations for TSD students.

External Email

Why does Tahoma feel it nessasary to enforce government mandates upon students?

A virus with a 99.7 percent survivability rate?

And a far less chance of children contracting this virus?

Rex A. Raney.

Get Outlook for Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Faka.ms%2Fghei36&data=04%7C0

_____

From: Sharron Bailey
Sent: 11/4/2021 10:36:38 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

My husband and I are completely against mandatory vaccines for any school age children. It is completely unacceptable to take that decision away from parents. Only parents should make that decision about their children. No mandatory vaccines!!

Sent from my iPhone

From: garciaheather430@yahoo.com
Sent: 11/5/2021 12:38:38 AM
To: DOH WSBOH
Cc:
Subject: No on mandate

External Email

Hello, not sure if this is the right place to send this, but wanted to voice my opinion on the covid 19 vaccine mandate for schools. My vote is No, these vaccines are not safe and shouldn't be giving, especially to children. My father was backed into a corner to get one and within a week had 4 clots and had to have open heart surgery! And was trying to get his doctor to void his 2nd but they said they can't go against the mandate or they get fired. This is just madness, and shouldn't be forced on anyone. Please do not pass anything making the vaccine mandated. Thank you for your time.

Sent from Yahoo Mail on Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.onelink.me%2F107872968%3F

From: Shannon Hagen
Sent: 11/5/2021 9:11:05 AM
To: DOH WSBOH
Cc:
Subject: Nov 5th Meeting

External Email

Good Morning,

I am writing to you today as a concerned citizen and parent of 3 children in Washington State. All 3 of my children are above the age of 12 and are not vaccinated for Covid 19.

We have chosen to not vaccinate them based on family medical history. We have opted out of a number of vaccines over the year, so this is nothing new for us.

What is new and concerning is the direction that it would appear many states are going with. Mandating vaccines for school age children to attend public school.

There has always been an option to opt out of vaccines with little to no issue from the school districts. As school districts will follow your recommendation, I implore you to NOT make the Covid 19 vaccine required to attend public school in Washington State.

The impact this will have on many families is awful. Many will be forced to homeschool their children which will result in job loss due to the hours needed to facilitate these needs.

Thank you in advance for hopefully making decisions that take into account the entire population of Washington State and not just the ones that are most vocal.

Sincerely,

Shannon Hagen
Snohomish School District

Sent from my iPhone

From: Heidi Hartnell
Sent: 11/5/2021 10:33:16 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Hello,

I am writing because I am concerned for the increasing push for children to have the covid vaccine. The risk that young children have of being hospitalized or dying is very minimal and there is no need to ever consider the idea of a requirement for children to have the covid vaccine for school, sports, etc. Since the covid shot doesn't prevent transmission of covid, it only possibly lessens the symptoms, everyone could be vaccinated and covid would continue to be passed around. My understanding is that only 500 children between the ages of 0-17 have died of covid in the last 20 months. While my heart hurts for the families of those children, this is a small number in comparison to the number of children who had covid, recovered and now have robust lasting immunity. If families choose to vaccinate their child, that should be their choice. It should never be forced upon a child or a family. There are risks to every medical procedure, including this one, yet those who are pushing it are not responsible for any injury that could take place as a result of taking the shot.

Thank you for following the data that shows children are a low risk and thus should not be told they have to get a vaccine to go to school.

-Heidi Hartnell

509-312-5568

Sent with ProtonMail
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fprotonmail.com%2F&data=04%7
Secure Email.

From: Ben Bartell
Sent: 11/5/2021 11:16:42 AM
To: DOH WSBOH
Cc:
Subject: No vaccine mandates for kids PLEASE!

External Email

Hi there,
I can only imagine how difficult of a decision this is going to be for many of you. I am sure there is political pressure to get as many kids vaccinated as possible. But you need to ask yourselves "why"?

Are kids a vector point of transmission at schools?

According to the Journal of the American Medical Association, NO. As outlined in this article:

https://www.healthline.com/health-news/study-finds-kids-under-10-unlikely-to-spread-coronavirus-at-school
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.healthline.com%2Fhealth-news%2Fstudy-finds-kids-under-10-unlikely-to-spread-coronavirus-at-school&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C3c95d75299df48a29e4108d9a08845e1%7C11d0e2

Here is a directly link to the JAMA Study:

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2778940?utm_source=For_The_Media&utm

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fjamanetwork.com%2Fjournals%2

Do normal, healthy kids die of Covid-19?

The CDC Reports that as of November 3rd, 2021 206 kids under the age of 5 and 474 between the ages of 5 - 18 have died with a positive Covid test. There is no data that I can find about comorbidities. How many of these kids were already terminally ill?

https://data.cdc.gov/NCHS/Provisional-COVID-19-Deaths-Focus-on-Ages-0-18-Yea/nr4s-juj3
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdata.cdc.gov%2FNCHS%2FProvisi
COVID-19-Deaths-Focus-on-Ages-0-18-Yea%2Fnr4s-juj3&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C3c95d75299df48a29e4108d9a08845e1%7C11d0e21

There are over 73 millions people under the age of 18 in the USA. How can we justify forcing a vaccine on 73 million kids, when they have a 99.99% survivability rate, and the dats shows that they aren't a vector point?

According to the VAERS database, 128 people under the age of 24 have died OF THE VACCINE and all of those were between the ages of 12 - 24!

https://openvaers.com/covid-data/mortality
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fopenvaers.com%2Fcovid-data%2Fmortality&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C3c95d75299df48a29e4108d9a08845e1

How many of those 128 kids that died from the Covid vaccine would have lived normal, healthy lives? Their survivability rate is nearly 100%. Can you sleep at night if you mandate a shot that kills a child? As a parent of 2 healthy kids, I am very concerned that mandates are coming. My 12 year old recently had covid and was only sick for 36 hours, and then felt run down for a couple of days. But she completely recovered, as is the case with 99.9% of kids.

Please don't mandate the vaccine for children under the age of 18. America was founded on FREEDOM and we need parents to make well informed decisions, not a government mandate.

Thank you for your time.
-Ben

Ben Bartell
Principal
West Coast Distributors
Phone/Text: (425) 738-5195
Email: Ben@WestCoastDistributors.com

_____

From: Tiffany Atwood
Sent: 11/4/2021 9:38:40 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Dear Board Members,

If you are considering mandating this vaccine for schools and our children, be prepared for a fight! There will be parental Outrage and you will see a Massive decline in students in the public school system. We will NOT tolerate this and will PROTECT our children at all costs, and we as a collective are prepared to fight this every step of the way.

This vaccine is untested, unethical, dangerous and this mandate is Unconstitutional. We as parents and families, know our rights, and will not comply. We will move our children out of the schools. The public school system will indeed lose its funding as the numbers of students enrolled WILL decline. We will file lawsuits, protest and boycott!
This vaccine does not protect our children, it does not prevent the spread of covid and its effects on children are NOT known with no long term studies! We as parents will NOT have our right to medical freedom taken from our children for an untested vaccine.

Be very clear about the ramifications of mandating this vaccine in schools as you consider your decision. A Mandate isn't a law. Look at the facts and use your best judgement here.

Sincerely,
Tiffany Atwood

From: Kristina Linkem
Sent: 11/5/2021 8:12:08 AM
To: DOH WSBOH
Cc:
Subject: 7107ADC0-7759-4067-AE8F-E2534156E187

External Email

I am writing to oppose any madate or requirement for children to receive any COVID-19 vaccine in order to attend school in person, on line, a mix of, or play any sports activity therein.

- There us no Covid health emergency in our State whatsoever. Science and current data prove this.

- There is no COVID health emergency in children 5 to 11 and never has been. Science and current data prove this.

- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored. Science and current data prove this.

- Vaccine injury from these vaccines is "real, not rare" and parents must have the final say in their children's medical care. Science and current data prove this.

- Transmission of COVID-19 among children in schools and daycares is very rare. Science and current data prove this.

- According to published data by the CDC, 99.99815% of children who contract COVID-19 survive. Science and current data prove this.

- There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine. Science and current data prove this.

- This is NOT a FDA approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental drug. Science and current data prove this.

- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12 to 17-year-old age group.

- The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event Reporting System (VAERS)" showed astonishing increases in the youngest age brackets. Science and current data prove this.

- Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue. Science and current data prove this.

- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and

2,947 counties in the United States.” Researchers found that, “countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days.” That's just a few citations of the science and data available to support this.

- Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children. Science and current data prove this.

Do not allow this.

Kristina Linkem

From: Margi Trevino
Sent: 11/4/2021 10:31:15 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

As a concerned parent and grandparent, I am vehemently opposed to any sort of jab mandate and/or masking for children of any age in any setting including public schools.

Sent from my iPhone

From: George Barragan
Sent: 11/5/2021 9:41:52 AM
To: DOH WSBOH
Cc:
Subject: My Public Comments

External Email

Board Members,

As a parent and WA resident I oppose the Cov19 vaccine be a requirement for our children to attend school. There is plenty of evidence that children have very little to no risk from the virus. Exposing a healthy child to the potential dangers of advers affects is not worth the risk. FDA and CDC have full knowledge that there are negative impacts to this vaccines, yet chose to ignore. The risk don't outweigh the benefits. Children will still catch and pass the virus with same viral load whether vaxxed or not. We won't know if it will even help any of the symptoms either as most children are not impacted by the virus. I do work in healthcare but I don't see patients. I have been tracking a lot of the data and even the data release CDC which has a breakdown of deaths. Even with that dirty data we can see that risk for healthy children is very low risk. If a parent wants to make a choice to move forward and get their child vaxxed then let it be their choice. I hope you are all reasonable people that are not driven by fear and can review any existing data. Thank you.

George
Auburn, WA

From: Lyndsay Snypp
Sent: 11/5/2021 11:48:58 AM
To: DOH WSBOH
Cc:
Subject: Mandates

External Email

To whom it might concern,

We will be pulling our kids out of school immediately if you mandate vaccines and we will be pulling our kids out of school by the beginning of the new year if you are still mandating masks. Praying you guys actually follow the real science that shows how damaging masks and vaccines are especially for children!

Thank you for your time.

Sent from my iPhone

From: brad kaul
Sent: 11/4/2021 10:25:32 PM
To: DOH WSBOH
Cc:
Subject: No Covid vaccine requirement for our children

External Email

To whom it may concern,
I am a parent of an 8, 15, and 16 year old. I beg you not to require the covid 19 vaccine for school age children. Children have over 99% recovery rate from covid with no adverse effects. The mRNA vaccine has not been in any long term studies on the effects it has on young children. We do not know enough about the vaccine.

Please consider natural immunity. Please consider the recovery rate. Please consider the damage of the vaccine to young males from the vaccine on their hearts. These are our children and our future.

- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that, "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their

population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."

Thank you,
Melina Kaul
206-430-0044

Sent from Outlook
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Faka.ms%2Fweboutlook&data=04%

From: Clayton Buerkle
Sent: 11/5/2021 10:31:57 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Hello,

I understand you are not voting on the topic of mandatory Covid vaccination for children at the upcoming BOH meeting. You are though likely to be thinking about it and maybe having informal discussion with colleagues. Please remember that the science does not show young children to be at any significant risk for COVID. It also shows that children are not a significant source of transmission to adults. Considering that there are no long term studies on the long term effects of the Covid Vaccine on children, or even adults, and that an ACIP member said that the only way to know of any particular dangers of it to children is to just give it to very large numbers of them, it does look to be unethical, and likely immoral, to require them to be injected with this experimental product.

So please consider holding off on this idea until much more research can be conducted.

Sincerely,
Clayton Buerkle

From: Jennifer Jones
Sent: 11/4/2021 10:54:51 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members

External Email

Dear Board Members,
I am writing to ask you deny Seattle Public Schools request to implement a Covid vaccine mandate for all school children. The vaccine is only authorized under emergency use therefore it is still an experimental drug for ages 5-11. According the CDC, children have a 99.99815% chance of surviving covid. Numerous studies have shown the vaccine does not prevent the infection or transmission of covid. Mandating children get the covid vaccine to attend school will not protect vulnerable populations.
This is a very personal medical decision that should be made between parents, doctors, and children, carefully weighing individual medical history and risks. This cannot be a blanket mandate.
If implemented, you will see a dramatic exodus from schools and WA state as families flee to protect their children from government overreach.
Sincerely,
Jennifer Jones

_____

From: John Galt
Sent: 11/5/2021 10:16:36 AM
To: DOH WSBOH
Cc:
Subject: Vaccination policy and opposition to proposed mandated

External Email

Please consider these important and clearly, scientifically-supported points in the decision as consideration moves forward in Washington state vaccination policy:

* According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.

* There is absolutely NO COVID health emergency in children 5 to 11, nor in any school-aged children or young adults.

* Natural immunity MUST BE part of any risk-benefit analysis and cannot be ignored. This is anti-science to inject people coercively/mandatorily with known natural immunity.

* Vaccine injury from these vaccines is very real, reported, and substantially consequential. Parents must have the final say in their children's medical decisions.

* Transmission of this COVID-19 among children in schools and daycares is very rare.

* There are NO adequate long-term safety studies of mRNA Covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine.

* This is NOT a FDA-approved vaccine they are looking to give children, the FDA will expand the Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental drug. (The licensure for Comirnaty is something completely different, and not available in the US (or even at all, perhaps). Please don't obfuscate this relevant fact.)

* Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms, and extreme fatigue.

* Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children.

Thank you for NOT requiring this experimental injection upon the population of Washington State.

Kind regards,

John

Bremerton, WA

Sent with ProtonMail <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fprotonmail.com%2F&data=04%7C
Secure Email.

_____

From: Stacie Neiswanger
Sent: 11/5/2021 11:23:55 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

WSBOH:

I implore you as you go to consider making vaccines mandatory in children that you have looked at all of the data, are listening to the parents and what they want, and being mindful of personal choice. There is no COVID public health emergency among children 5 to 11, therefore a mandatory vaccine is not necessary. There are enough studies out there now that prove the risk of vaccines outweigh the risk of COVID in healthy kids for the age group of 12-18 year old's. The death rate among children infected with COVID is (last time I checked) still at .0003, which in statistics is essentially 0!

The case study for COVID vaccines in kids is still at an experimental stage and was WAY too small and too short, there is 0 long term side effects known in a larger population. I agree, one kid dying from COVID is too many but one kid dying from the vaccine is also too many and we know the mortality rate in kids is essentially 0. I urge you to let the parents (and their doctors) decide what is best for their family and child - ONLY they know their child and family history, not the government. The government should not be involved in these decisions, that is an overstep of power and position.

Thank you.

_____

From: Heather LaRue
Sent: 11/5/2021 10:08:24 AM
To: DOH WSBOH
Cc:
Subject: Against pediatric vaccines

External Email

Thank you for your consideration of public comment regarding pediatric vaccines . We are asking that you not make them mandatory and allow parents to retain the choice to direct their children's medical decisions for the following reasons…

- There is no C0V!D health emergency in children 5 to 11
- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.
- Jab injuries are "real, not rare" and parents must have the final say in their children's medical care.
- Transmission among children in schools and daycares is very rare.
- According to published data by the CDC, 99.99815% of children who contract survive.
- There are no adequate long-term safety studies of mRNA jabs because the placebo group was "unblinded" and allowed to get the jab.
- This is NOT FDA approved. FDA will expand the EUA to include children as young as 5. In other words, any mandate for children is of an experimental drug.
- According to the data from VAERS as of Oct 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12 to 17-year-old age group.
- The Pfizer mRNA jab causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis: Updates from VAERS" showed astonishing increases in the youngest age brackets.
- Healthy adolescents aged 12-17 who have been given the jab have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.
- The jab does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in c0v!d are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States."

There are also many studies indicating ivermectin and HCQ are safe and effective in treating this virus and therefore a vaccine is not needed.

We need to avoid politicizing the health of our children and ask again that you not mandate the vaccines

Scott and Heather LaRue

Sent from my iPhone

_____
From: dbt@tds.net Dusty Belcher Trucking Inc.
Sent: 11/5/2021 11:42:34 AM
To: DOH WSBOH
Cc:
Subject: Vaccine mandates on children

External Email

To whom it may concern,

I would like to ask you to please review the data that the DOH is using for this pandemic. It is skewed. The PCR tests are highly inaccurate, the virus is not distinguishable when testing from a cold or flu, and there are a high rate of false positives. They are using a formula for symptom onset date that is multiplying cases by 5x. The data is unusable for public use decisions. Dr. Clifford Knopik (Doctorate in Computer Science) has a very informative presentation in rumble (WA DOH COVID Data Issues - Full Presentation) which lays out how the information that has been gathered is skewed, which then gave emergency powers to our governor which he isn't going to relinquish.

The vaccines are on the market and are not fully approved as they are still under the emergency use authorization. There are early treatments available that are approved that can treat Covid that are being suppressed. Ivermectin being one of them. If there is a treatment then the emergency use authorization has to go away. Phizer has made billions and will continue to make a fortune off of the deaths of patients that aren't getting an early treatment just so they can keep pushing their medicine. There are many side effects and vaccine injuries listed in the VAERS site. These are just from the brave souls who are willing to enter them.

With the pandemic not being what it is said to be and the vaccine not being the only answer I beg you to please wait until more information on the safety of the vaccines are known before you require our sweet little 5 year olds to have to take this. If it causes 1 child to die or have long term health effects it isn't worth it and it's on your hands. I have 4 grandchildren ages 4 through 8 who will not be getting this experimental shot and I know many more parents that will withhold their children from public schools if this goes into effect. It's bad enough already that they are being forced to cover their faces and not have an option to breath air all day just to get an education in the public schools.

Ask yourselves this question. If this virus is so deadly then why aren't there thousands of bodies in the streets in the states that are open and having massive people at football games and open commerce? It's a treatable virus!

If parents choose to inject their children then so be it, but it should be accompanied by the information on side effects like with other medicines.

NO MANDITORY COVID VACCINES FOR OUR CHILDREN PLEASE!!!!!

Janette Belcher
Mom and Grandma

From: Diane De Yager
Sent: 11/4/2021 9:49:34 PM
To: DOH WSBOH
Cc:
Subject: Vaccines for children

External Email

WE DON'T WANT TO SEE OUR KIDS VACCINATED!!
There is NO COVID health emergency in children. There is NO COVID health emergency in children 5-11.
Vaccine injury from these vaccinations is real, not rare and parents must have the final say in their children's medical care. Parents also need to be told the truth. I know of a 12 year old boy who got the vaccine, started to have breathing problems and they had to rush him to the hospital. He was totally healthy. He ended up with Myocarditis. How would you feel if that was your child, grandchild or someone you knew?
There is NO adequate long-term safety studies of mRNA Covid vaccines because the placebo group was " unblinded" and allowed to get the vaccine.
This is NOT a FDA approved vaccine they are looking to give children. The FDA will expand the emergency Use Authorization to include children as young as 5. In other words, any mandate for children is an EXPERIMENTAL drug.
That makes me sick!!
This vaccine DOES NOT STOP infections, transmission, or hospitalization, nor death.
Healthy adolescents 11-17 who have been given Covid vaccines have experienced blood clots, Myocarditis, neurological symptoms and extreme fatigue.
Studies states it plainly. "Increases in Covid-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States". Researchers found that, "Countries with higher percentage of population fully vaccinated have HIGHER Covid-19 cases per 1 million people in the last 7 days."
Children are NOT a significant threat to the elderly and vulnerable as most cases are spread from adults to children.
According to data available from VAERS as of October 8 there has been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12 - to 17-year old ages group. One death that did not need to happen.
Please do NOT VACCINATE OUR CHILDREN!!!
Thank you

Sent from my iPhone

_____

From: Olivia Rose
Sent: 11/5/2021 8:38:36 AM
To: DOH WSBOH
Cc:
Subject: OPPOSE MANDATES

External Email

To Whom It May Concern,

- There is no COVID health emergency in children 5 to 11
- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.
- Vaccine injury from these vaccines is "real, not rare" and parents must have the final say in their children's medical care.
- Transmission of COVID-19 among children in schools and daycares is very rare.
- According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.
- There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine.
- This is NOT an FDA-approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental drug.
- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12- to 17-year-old age group.
- The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event Reporting System (VAERS)" showed astonishing increases in the youngest age brackets.
- Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms, and extreme fatigue.
- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to the level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that "countries with a higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."
- Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children.

Olivia Naatus

_____

From: Kristina Putnam
Sent: 11/5/2021 10:23:35 AM
To: DOH WSBOH
Cc:
Subject: COVID 19 vaccine concerns

External Email

To whom it may concern,

- There is no C0VID health emergency in children 5 to 11
- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.
- Jab injuries are "real, not rare" and parents MUST have the final say in their children's medical care.
- Transmission among children in schools and daycares is very rare.
- According to published data by the CDC, 99.99815% of children who contract survive.
- There are no adequate long-term safety studies of mRNA jabs because the placebo group was "unblinded" and allowed to get the jab.
- This is NOT FDA approved. FDA will expand the EUA to include children as young as 5. In other words, any mandate for children is of an experimental drug

I sincerely hope you'll take all of this into consideration. We, as parents, know our children more than anyone else, more than the government, and should ultimately have the final sat when it comes to their health and wellness.

Thank you for your time and your understanding regarding this topic.

Sincerely,
Kristina putnam
--

Kristina Putnam
Licensed Broker
Keller Williams Tacoma
(253)948-2861

_____

From: Erik Naatus
Sent: 11/5/2021 8:37:22 AM
To: DOH WSBOH
Cc:
Subject: OPPOSE MANDATES

External Email

To Whom It May Concern,

- There is no COVID health emergency in children 5 to 11
- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.
- Vaccine injury from these vaccines is "real, not rare" and parents must have the final say in their children's medical care.
- Transmission of COVID-19 among children in schools and daycares is very rare.
- According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.
- There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine.
- This is NOT an FDA-approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental drug.
- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12- to 17-year-old age group.
- The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event Reporting System (VAERS)" showed astonishing increases in the youngest age brackets.
- Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms, and extreme fatigue.
- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to the level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that "countries with a higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."
- Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children.

Erik Naatus

_____

From: Jacob Swartz
Sent: 11/5/2021 11:44:12 AM
To: DOH WSBOH
Cc:
Subject: Nov 10 agenda item

External Email

Hello,

I understand that the Nov. 10 meeting agenda encompasses the discussion on vaccine mandates for children ages 5 and up. I am deeply concerned about this possibility, and feel it my responsibility to voice my opposition. Children under 18 are 99.998% likelihood of not dying of this virus. That is far higher than even recovering from the flu based on CDC's own statistics, and there are many proven adverse side affects like myocarditis and the spike protein depositing in young women's ovaries. We cannot possibly know the long term effect of vaccinating children, and therefore, you must not do this. This is something you should allow every parent to decide for their own children.

Sincerely,

Jake Swartz

From: sydney schofield
Sent: 11/4/2021 10:17:26 PM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10th BoH meeting

External Email

RE: public comments for Nov. 10th BoH meeting

Dear Board Members:

Aware you are responsible for setting vaccination policies, including the vaccinations required for school and/or daycare attendance in the state of Washington, please note my comments below should the specific topic of COVID "vaccinations" for children be brought forth.

I urge you to table any thought of requiring COVID vaccination of children for school and/or daycare attendance.

Transmission of COVID-19 among children in schools and daycares has been very rare. There is no COVID "health emergency" in children 5 to 11.

To date, all data reported to the CDC shows the risks associated with all current side-effects of COVID-19 vaccines for children outweigh the health risks associated with contracting the COVID-19 virus itself.

According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of early last month (October), there have been more than 21,000 reports of adverse events, including more than 1,000 serious reactions and 24 deaths in the 12-to-17-year-old age group.

None of the current COVID-19 vaccines has undergone the test of time, the years required to ensure the vaccine will have no serious undesired side-effects in subsequent years. This is particularly important when considering vaccines for children, the younger the child, the more carefully this factor must be weighed.

Clearly, such medical risk versus benefit must be assessed for each individual child, a responsibility only parents can accept.

With thanks for your consideration,

Mary W. Schofield

King County, Washington

_____
From: Deborah Vosler
Sent: 11/5/2021 8:44:26 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Hello!
Please please please do not mandate the covid vaccine for school children.

We know so little about the medium and long-term effects of these vaccines, and it is taking a huge risk that is not even needed, our children are our future!

Thank you!!
Deborah Vosler

Sent from my Verizon, Samsung Galaxy smartphone
Get Outlook for Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Faka.ms%2FAAb9ysg&data=04%7

From: Gary Savela
Sent: 11/5/2021 9:01:15 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Dear Board Members:
There is strong data that the 'vaccines' have a lot of serious side effects even resulting in a lot of deaths. It is untested. The data shows that children rarely get Covid and when they do the cases are very mild. I encourage you to stand up for the children. Let parents take care of their children. This has always been the way our system worked. Forcing vaccines on children goes against all that is right, legal, and constitutional.
Thank you for your consideration
Gary Savela

From: C Stang
Sent: 11/5/2021 10:59:14 AM
To: DOH WSBOH
Cc:
Subject: Vaccine mandates for children

External Email

There is no Covid emergency in children. They don't need a vaccine.
What is real is injuries and deaths from the vaccine. You can't deny it. Go to
openvaers.com
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fopenvaers.com%2F&data=04%7C0
, which is under reported by the medical community, and look at injuries,
hospitalizations, heart attacks even in your people, and deaths.
Parents are the ones to decide for their children. Not some agency.
Cynthia Stang

_____

From: Suzanne Cordell
Sent: 11/4/2021 8:37:10 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

To All Concerned,

Your work focuses on analyzing policies, developing rules, promoting partnerships, and encouraging public engagement in the public health system.
Will you consider your statement, and work to resovle the divisiveness that is breaking America and their families down!

I am a resident of the state of Washington and a Grandmother of 8.
Please, vaccine mandates and wearing masks for children stifles children curiosity, desire to explore and discover and effects emotional physical and social growth. Family relationships too!

Given the responsibility as parents and grandparents we look at the numbers and facts. We should be given all information that doesn't divide us and give us the choice we make for our families. Teach truth, independent decision making, not fear, threats, controll, and half of the facts.
Here are only a few facts, that somehow are not getting to the minds of young families.

-According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.
-Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.
-Vaccine injury from these vaccines is “real, not rare” and parents must have the final say in their children’s medical care.
-The vaccine does not stop infection, transmission, hospitalization, nor death.

Sincerely,
Suzanne Cordell
Washington Resident

From: Robin Hess
Sent: 11/5/2021 11:21:41 AM
To: DOH WSBOH
Cc:
Subject: Vaccine for children 5-11

External Email

I am greatly concerned of the announced Emergency Authorization of the Covid 19 vaccine for children 5-11. These kids have almost no threat of dying from this virus. Everything is always evaluated on a benefit to risk ratio. This by far is not a benefit to these kids. It is only a risk!! Please do not consider mandating this to our kids! Most of the time this vaccine does not stop people from being infected or stop the transmission. So there would be zero benefit to our young children. They can not protect others by getting this shot. However they can potentially have a bad side effect like the reported myocarditis.

Please do not require this for children in school.

Thank you,
Robin Hess
360-772-1506

Sent from my iPad

_____

From: Jason Behrens
Sent: 11/5/2021 11:18:17 AM
To: DOH WSBOH
Cc:
Subject: Public Comment

External Email

For the Nov 5th public comment deadline RE: Mandates for Public Schools.

As a parent I stand firm in my beliefs that the the State of Washington should not possess Emergency Powers over health concerns which impact a small/fraction of a percentage of people. The State, regardless of any laws or codes that are on the books, is out of bounds for coercively required medications, especially when it comes to children who are known to be near absolute absent of risk.

I have already considered withdrawing my teenage children from their regularly scheduled programming at high school, and enrolling them in homeschooling.

In addition to vaccine requirements for school, I also do not subscribe to the theory that vaccine passports or any other form of medical coercion or mandates are appropriate.

Should this state of Washington implement ANY of these measures on my children in order to maintain their basic day to day life, Washington will be losing at least 4 residents. I am sure many will be doing the same.

Should the requirements or mandates be imposed on us without our consent prior to us being able to respond accordingly, it could force an undesirable outcome of a wide spectrum, depending on the situation that presents itself.

Statistics show a vaccine injury rate of over 800k in just 10 months. Statistics show there have been less Covid deaths than vaccine injuries. Data and evidence shows the Covid death rates were inflated by reporting co-morbidities.

Most importantly, data shows that children are almost at zero risk from Covid.

I am writing to let my voice be heard. I will NOT vaccinate my children. As a taxpaying citizen of this beautiful but increasingly draconian state, I am respectfully requesting that careful consideration is given to this.

The risk benefit of mandating vaccines on children is absolutely and statistically unnecessary.

Thank you
Jason Behrens
Marysville WA

_____

From: karen.thelin@yahoo.com
Sent: 11/5/2021 7:29:31 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Since this topic is likely to become a meeting agenda item today or in the near future, I want to add my voice to the side of those parents who are NOT in favor of mandating an injection, as a school requirement, that has ZERO long term studies to determine safety or potential consequences.

Karen Thelin

From: Tahnee Birkeland
Sent: 11/5/2021 11:17:45 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Please discuss the 1.2% death rate, and why it justifies the entire state having to wear masks. Please discuss why immunity from already having Covid counts for nothing, and those people have to get the same two shots as everyone else, even though there is plenty of emerging research indicating otherwise.

Please discuss the REAL honest rate of death of children due to Covid. Please free our children from illogical control.

If there are people with underlying health conditions, and/or are concerned and afraid of going out and interacting with people in public settings, then those people can take all of the precautions they want. They can get vaccinated. They can wear masks. Don't punish the 98.8%.

If the vaccine works so well to protect oneself, why is there so much concern about whether someone ELSE gets the vaccine? If it works like the CDC is claiming, let the most at risk and most fearful get the vaccine. Leave the rest of us to make the decision for ourselves.
Instead, what you're essentially saying is, the vaccine doesn't really work. It's not doing it's job. And control is your answer.

_____

From: Sara Rogers
Sent: 11/5/2021 8:48:43 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Hello!
I wish to add my comment to your discussion. I am adamantly opposed to requiring the covid vaccine for children. I feel that the risk of the vaccine is higher than the risks of contracting Covid. I choose as a parent to not vaccinate my 10 year old son for his personal health and safety.

Sara Rogers

From: David Carson
Sent: 11/4/2021 9:21:42 PM
To: DOH WSBOH
Cc:
Subject: Vaccine mandate for children 5-11

External Email

Hello,
A vaccine mandate for our children is unscientific and harmful. Study after study has shown that young children rarely catch Covid, even more rarely pass it on to an adult, and extremely rarely die (less than 500 for the entire United States with 10 of millions of children infected).

In contrast, the vaccines do not have the long term studies to determine if they are safe, regardless of the FDA opinions (not long term scientific phase III and IV safety trials). We know of many side effects, many very serious, and that they are likely very underreported.

Until we have long term safety studies, that factor in natural immunity, no vaccines should be mandated. Thank you.
Dave Carson

From: Nancy J Walker
Sent: 11/5/2021 2:09:19 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

November 5, 2021

To whom it may concern at the Washington State Board of Health

I would respectfully urge you in any future considerations of vaccines for adults AND children that you never mandate them or make them a requirement for employment, school attendance, or any normal life events and activities.

If you look at public records of 20 of the largest settlements reached between the United States Department of Justice <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fen.wikipedia.org%2Fwiki%2FUnite and pharmaceutical companies <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fen.wikipedia.org%2Fwiki%2FPhar from 1991 to 2012, ordered by the size of the total settlement, you will see alarming results for Pfizer and Johnson and Johnson. That alone is enough to cause serious concerns and doubts about coercing anyone to use their products, especially products that are still considered experimental for which there has not been sufficient time for safety studies that ought to involve years, not merely a few days or months!

Especially alarming is to read this comment by Dr. Ruben:
"FDA panel voted 17-0 in favor of authorizing the Pfizer COVID-19 injection in children aged 5 - 11 years in the U.S.

Dr. Ruben on the FDA panel said this:

"We're never gonna learn about how safe the vaccine is until we start giving it. That's just the way it goes."

The so-called "vaccines" of the mRNA type ought NOT be coerced upon any individual.

Thank you for your consideration!

Sincerely,

Nancy J. Walker

Sent with ProtonMail <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fprotonmail.com%2F&data=04%7 Secure Email.

_____

From: Julie Sedgwick
Sent: 11/5/2021 10:01:37 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Experimental and un-long term tested “vaccines” have no place in our children or schools. Do not push the agenda.

Sent from my iPhone

_____

From: Rebecca Gilman
Sent: 11/5/2021 9:00:23 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

This is wrong. Why are you doing this? It is no different than the flu and the flu shot is not mandated. I'm so tired of of this country trying to MAKE someone do something. It's wrong.

Sent from my iPhone

From: Leslie Castanha
Sent: 11/5/2021 9:26:57 AM
To: DOH WSBOH
Cc:
Subject: Vaccine mandate

External Email

Calling for no vaccine mandates on our kids.
The CDC even says if kids get Covid they have a 99.9802% chance of surviving and natural immunity from exposure lasts longer. The risk of injury and death with the vaccine (gene therapy) is more at risks to kids than Covid. Plus it is fact kids and adults myocarditis and pericarditis with this shot. Please stand for the future our kids immunity, future offspring and their protection.

Sent from my iPhone

From: Deborah Mahon
Sent: 11/4/2021 9:36:55 PM
To: DOH WSBOH
Cc:
Subject: Don’t mandate vaccines!

External Email

- The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC’s own analysis of “Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event Reporting System (VAERS)” showed astonishing increases in the youngest age brackets.

- Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.

- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: “Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States.” Researchers found that, “countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days.”

Sent from my iPhone

_____

From: Lindsey Allen
Sent: 11/5/2021 7:37:28 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Hello,
I do not support mandated covid vaccines for children to attend school. Covid does not impact children in the same way that it affects adults. In addition, the CDC has long known that the vaccine does not stop transmission. This means that the vaccinated and unvaccinated can equally spread covid. Because they are not personally benefiting and it isn't stopping the spread, it should not be mandated. If this does become mandated then there will be a large exodus outside of public schools. It will strip children of an education. I know that I personally will not send my children.
Thank you,
Lindsey

Sent from my iPhone

From: Lisa Collins
Sent: 11/5/2021 11:26:23 AM
To: DOH WSBOH
Cc:
Subject: School vaccine mandates

External Email

Dear members of the Washington State Board of Health,

I am a parent of WA State school—aged children who are currently enrolled in public school. Please do not create a vaccine mandate for COVID for our kids in our public schools.
This should be an individual, parental and provider-based decision similar to getting children their annual flu shot, which has similarly low long-term efficacy compared to the vaccines currently on the mandatory state public school schedules, which we are all up-to-date on in our household.

Thank you,

Lisa Collins

From: Steve Spurgeon
Sent: 11/5/2021 11:01:39 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Please! Please! Please! Do not make this a mandate and subject our kids to this.
When you see the data and the lack of common sense given as the children are at such a very low rate of contracting Covid.
Please stop and say no to this.
Thank you Cheryl

Sent from my iPhone

_____

From: Jason Fox
Sent: 11/4/2021 10:44:49 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

I am 100% AGAINST mandates for vaccination for our students. It is disgusting that our leadership is even considering something so utterly out of touch with scientific results. Jason Fox. Parent of 1 Gen Ed student (7th grade) and one Special Education student (5th grade).
Sent from my iPhone

From: mnartea
Sent: 11/5/2021 10:07:45 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

To mandate these injections for children is absolutely criminal. Covid 19 is not a childhood disease and therefore not subject to being mandated for children to attend schools as with other diseases such as measles, mumps, etc.. Children are at low risk from covid 19 and are more likely to die being hit by a car. The risk of them dying from a covid 19 shot is higher than a covid 19 infection. You people will answer to God for the harm you will be inflicting on innocent children, precious children

Sent from ProtonMail for iOS

From: Shelanne L.
Sent: 11/5/2021 6:31:09 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

I want to urge lawmakers and all those in positions of influence to advocate for freedom regarding the COVID 19 vaccine. I am a nurse and was working in the hospital when COVID first hit, caring for some of the first COVID patients in our area (Tri-Cities) many of whom did not leave the hospital alive. It is agonizing and frustrating to care for patients who are going downhill and to not have a lot, in the way of treatment, to offer them. My heart goes out to nurses and doctors who have been dealing with this pandemic for almost 2 years now. I am sure that many are beyond burned out and it is tempting to want to mandate a potential "solution" like a vaccine.

However, we must consider the other side of the coin. The vaccine is not a magic solution. It absolutely carries risks and we have to understand that the risk/benefit ratio is not the same for everyone. First, I want to remind you that the vaccine has not been shown to be effective at preventing the transmission or infection of COVID. I now personally know dozens of individuals who are fully vaccinated, but still contracted (or unintentionally spread) COVID. Some individuals became quite seriously ill. I do believe that the data indicates the vaccine is effective in mitigating the severity of the disease thus decreasing hospitalizations and mortality.

Regarding potential risks, there have been relatively high numbers of serious side effects reported after receiving the COVID vaccine. Previously healthy individuals receiving the vaccine have experienced blood clots, myocarditis, neurological symptoms, and lasting extreme fatigue. These reports are concerning, particularly when one considers children and adolescents who are still developing and are thus more vulnerable and also will have to live the rest of their lives with any lasting side effects they may experience. There are no long term studies on the COVID vaccine because it is new. We simply DON'T KNOW if there is any carcinogenic or mutagenic potential with the vaccine or if it might impair fertility. These are not terribly major concerns for someone who is in their late 40's or older, but for a young person they could be potentially devastating.

I want to speak regarding the risk vs. benefit ratio. Children and younger adults have generally not been the population getting seriously ill with COVID. Yes, there have been a few outlying cases, but they are not the norm. I personally believe that for young, healthy individuals, the risks of the vaccine are higher than the risks of COVID. As a parent (I have 4 young children), it is a truly awful thing to be forced to submit your child to something that you sincerely (with reasonable scientific background and data) do not believe is in their best interest. I have a daughter who does competitive gymnastics and another child who attended an alternative educational community all during the entire past year. They were in relatively close quarters and while they did take some general precautions such as extra cleaning and hand washing, trying to stay in separate class groups, and avoiding large gatherings, life continued fairly normally and there were no COVID outbreaks in either group. Why would we mandate vaccines on these innocent, healthy ones?

Finally, I want to mention that even within certain subsets of the population, the risk vs. benefit ratio is not the same among different individuals. My family is an example of this. In my family of origin, there seems to be a genetic predisposition to be sensitive to certain chemicals, pollutants, preservatives, etc. I have found that certain chemicals, additives, artificial colorings, and preservatives in food all have an adverse effect on my

health and that of several of my children. For this reason, I am very careful about the food we eat (I make almost everything from scratch and try to use organic, whole foods as much as feasible) and about chemicals we use in our home... from cleaning supplies to lotions, shampoos, etc. Likewise, I am also wary regarding any kind of medicine or injection that might enter my body or that of my children. My husband, on the other hand, does not really seem to be affected by what he eats or which products he uses. I cannot stress enough that we are not all the same! What is right, beneficial, or good for one person may not be the best for another. This is the main reason why I strongly believe that the COVID vaccine should not be mandated and why I urge you to advocate for freedom.

Thank you for your time and consideration.

Sincerely,

Shelanne Lighthouse

_____

From: Dave and Marilyn Robertson
Sent: 11/5/2021 11:11:50 AM
To: DOH WSBOH
Cc:
Subject: NO to Covid 19 vaccine mandates for children

External Email

To WA Board of Health,

Mandating an experimental vaccine on children who have a 99.99815% survival rate (CDC data) is CRIMINAL. We all know that kids that contract Covid 19 handle it well, do not carry a high viral load, do not pass it on and have a very high survivability rate.

Children contracting Covid 19 is a positive for them, for they will then achieve Natural Immunity. This is far, far better than what they receive from the mRNA injections, which also prevents ever achieving natural immunity. With natural immunity they become a strong asset toward herd immunity.

The 1,000's of adverse reactions & deaths attributable to the mRNA injections are well beyond the previous, long-standing protocol of when 50 such reactions/deaths triggered pulling a vaccine. Again,it is criminal that you would want to mandate exposure to our children of the far worse risk (and unknowns) of being injected with the experimental mRNA vaccine.

Stop this insanity! No to vaccine mandates for children.

Marilyn Robertson

Bellevue, WA

425-881-6092

From: Teri Johnson (Lake Stevens)
Sent: 11/5/2021 10:56:43 AM
To: DOH WSBOH
Cc:
Subject: COVID vaccine for children

External Email

I am writing to you today as a concerned citizen and parent of 2 children in Washington State. We will NOT vaccinate our children. Our children have had COVID infections. One was asymptomatic and one had mild headache and body aches for 3 days. What is new and concerning is the direction that it would appear many states are going with - mandating vaccines for school age children to attend public school. Many of the VBRPAC doctors were concerned that their approval would result in mandates of this vaccine. Many approved just because they didn't want to deny high risk children access to this vaccine. I implore you to listen to these doctors.

I keep on hearing people speaking about how vaccines have always been required to go to school, that's true, but this vaccine can't be equated to that. We don't know the impact of these vaccines on our children - we don't know what these could cause in 10-15 years. As Cody Meisner, one of the pediatricians who sits on the VBRPAC panel said, "This is quite different from the MMR vaccine," referring to the measles, mumps, and rubella vaccine given to all children in the U.S. "We know that vaccine is safe. We have tested that vaccine for decades. And we know, we have a very good sense, of what the adverse events are. We do not have that with this particular messenger RNA vaccine." There has always been an option to opt out of vaccines with little to no issue from the school districts. As school districts will follow your recommendation, I implore you to NOT make the Covid 19 vaccine required to attend public school in Washington State. By mandating this in the Washington State schools you would be leaving children out, many children who have shouldered so much burden already.

Hearing the terms "safe and effective" with regards to the COVID vaccine isn't accurate. We know that it was "safe" for around 2000 children country-wide, we know that it "may" also be effective for 2 months. We don't know beyond that. The Pfizer Study was very limited in scope and time.

I shouldn't have to uproot my children from all they've known because they'll be excluded from Washington State Schools. As a parent, I should have the choice about the medical procedures my children receive. This simply isn't right. It's cruel and borderline mental abuse. How much stress have they been under the last 18 months, only to have this stress and burden added.

The impact this will have on many families is awful. Many will be forced to homeschool their children which will result in job loss due to the hours needed to facilitate these needs. The impact on our most vulnerable children would be great and many would never recover.

Thank you in advance for hopefully making decisions that take into account the entire population of Washington State and not just the ones that are most vocal.

Teri Johnson
Assurance Property Management/John L Scott
8933 Market Place Suite H
Lake Stevens, WA 98258
206-919-7687 Direct

Please excuse the brevity and any errors as this is sent from my mobile device.

_____
From: mdueceone@gmail.com
Sent: 11/5/2021 11:22:51 AM
To: DOH WSBOH
Subject: 5-11 Inoculations Recommendation - Documentation Conflicts


attachments\AD06AA5F2AB045DD_image.png


attachments\1605990FAA92483A_image.png

External Email

Dear WSBOH,

In regards to these potentially being mandated, I highly suggest because of the language used on various documentation that the 5-11 inoculations be RECOMMENDED vs MANDATED for personal protection vs community protection.

1. Change in formulation was not in the original EUA formulation and laboratory tests are not equivalent to human study trials.

Page 3 – Pfizer-BioNTech COVID-19 Vaccine EUA LOA reissued October 29 2021
Pfizer Inc. On October 29, 2021, having concluded that revising this EUA is appropriate to protect the public health or safety under Section 564(g)(2) of the Act, FDA is again reissuing the October 20, 2021 letter of authorization in its entirety with revisions incorporated to: 1) authorize the use of Pfizer-BioNTech COVID-19 Vaccine for children 5 through 11 years of age; and 2) authorize a manufacturing change to include an additional formulation of the PfizerBioNTech COVID-19 Vaccine that uses tromethamine (Tris) buffer instead of phosphate buffered saline (PBS) used in the originally authorized Pfizer-BioNTech COVID-19 Vaccine.

2. MAY does not equal WILL

Page 7 of Pfizer-BioNTech COVID-19 Vaccine EUA LOA reissued October 29 2021
"Based on these data, FDA concluded that it is reasonable to believe that Pfizer-BioNTech COVID□19Vaccine may be effective in individuals 5 through 11 years of age. Additionally, FDA determined it is reasonable to conclude, based on the totality of the scientific evidence available, that the known and potential benefits of Pfizer-BioNTech COVID□19 Vaccine outweigh the known and potential risks of the vaccine, for the prevention of COVID-19 in individuals 5 through 11 years of age."

3. IT IS NOT UNKNOWN if the vaccine will protect against ASYMPTOMATIC and 5-11 cases presented mostly as ASYMPTOMATIC

https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine-frequently-asked-questions <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.fda.gov%2Femergency-preparedness-and-response%2Fcoronavirus-disease-2019-covid-19%2Fpfizer-biontech-covid-19-vaccine-frequently-asked-questions&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C40e67608c8b84656f71108d9a0893f19%7C11d

4. DATA IS NOT YET AVAILABLE TO INFORM THE DURATION OF PROTECTION THAT THE VACCINE WILL PROVIDE

For ONLY these minimal reasons which are notwithstanding many more supported by scientist, medical personnel, parents, and children themselves should the WSBOH be careful to mandate this treatment for school enrollment, daily activities, school activities, etc. Rather, parents with their children and personal medical team, should they come to the decision and conclusion to choose to inoculate their child to personal protection for which they see the benefits outweighing the risk.

With utmost respect,

Mary Grace

_____

From: Jed Bothell
Sent: 11/4/2021 9:37:38 PM
To: DOH WSBOH
Cc:
Subject: Stong OPPOSITION to mandating COVID-19 'Vaccination' for children & youth

External Email

Dear Washington Board of Health:

I am writing you to strongly discourage you from mandating COVID-19 vaccinations for children and youth.

There are no studies of the long term health consequences of these radical new COVID-19 ‘vaccinations’ . These so called vaccinations did not exist 2 years ago and no one knows how the human body will react to these novel therapies 5, 10, 20, 30, 50, 75+ year from now.

Furthermore the risks to our children and youth from COVID-19 are very small. The relatively large unknowns regarding the long term effects of these novel ‘vaccines’ do not justify the potential near term improvements to children’s health because their actual risk is so small.

As for the COVID risk children pose to their elders, lets please realize that long term health of children comes first! We must protect our future and not endanger them for our benefit. We must not selfishly endanger our children for sake of the adults.

I recognize you are not currently considering mandatory vaccination for children or youth but I want to make sure you are aware that there is strong parental opposition to such measures.

Our children have their entire life ahead of them. Let’s do very best to protect them and take a calm, measured approach to this issue!

Please do not mandate COVID-19 vaccinations for our children and youth.

Thank you,

Respectfully,

Jed Bothell

_____

From: Lynnette Mathias
Sent: 11/4/2021 9:03:50 PM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Dear Washington State Board of Health,

I am writing this note to you to let you all know that I firmly oppose any mandates of Covid vaccination for children 5-11 years old.

These vaccines are still under EUA, therefore experimental.

Vaccines are medical treatment, and as a nurse, I know that there is no medical treatment that works unequivocally for everyone.

Children in this age group have a 99.9% of full recovery if they get Covid. This is per the CDC's own data.

I ask that if the question of mandates for children in this age group comes before you, that you will each advocate to put this decision into the hands responsible for making it... parents of the children.

Thank you,
Lynnette Mathias

Sent from ProtonMail Mobile

From: Carrie Tolley
Sent: 11/5/2021 10:24:39 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

WA State Board of Health members,

My husband and I are concerned parents who are opposed to required covid vaccinations for public school children.

This vaccine is not thoroughly tested and vetted. Requiring millions of children to get the shot in order to attend school is not safe.

Are you willing to take responsibility for the adverse reactions and death that will result from this? Have you researched it and by that I mean not on Google. The truth is being suppressed and it you pass this you will be guilty of damaging children's health.

Sincerely,
Jon and Carrie Tolley

From: Rodney Thompson
Sent: 11/5/2021 10:59:07 AM
To: DOH WSBOH
Cc:
Subject: COVID Mandate For Children

External Email

WSBOH,
Please do not implement a COVID Vaccine Mandate requiring our children to be vaccinated. Also do not require a mask mandate for our children. This should be a parental choice after consultation with their doctor. Keep government out of the decision. Children have not been seriously affected by COVID as have vulnerable adults.

Rodney Thompson
12750 444th Avenue SE
North Bend, WA 98045
Rodthompson52@hotmail.com
432-296-9799

Sent from Rod's iPhone

From: Dawn Guiberson
Sent: 11/5/2021 11:29:32 AM
To: DOH WSBOH
Cc:
Subject: Mandatory Shots

External Email

I am writing to you today as a concerned citizen and parent of two children in Washington State. Both of my children are 16 years old and we will not vaccinate our children, and we will not subject them to invasive testing (a spit test is the only test we would potentially allow). What is new and concerning is the direction that it would appear many states are going with - mandating vaccines for school age children to attend public school. Many of the VBRPAC doctors were concerned that their approval would result in mandates of this vaccine. Many approved just because they didn't want to deny high risk children access to this vaccine. I implore you to listen to these doctors.

I keep on hearing people speaking about how vaccines have always been required to go to school, that's true, but this vaccine can't be equated to that. We don't know the impact of these vaccines on our children - we don't know what these could cause in 10-15 years. As Cody Meisner, one of the pediatricians who sits on the VBRPAC panel said, "This is quite different from the MMR vaccine," referring to the measles, mumps, and rubella vaccine given to all children in the U.S. "We know that vaccine is safe. We have tested that vaccine for decades. And we know, we have a very good sense, of what the adverse events are. We do not have that with this particular messenger RNA vaccine."

There has always been an option to opt out of vaccines with little to no issue from the school districts. As school districts will follow your recommendation, I implore you to NOT make the Covid 19 vaccine required to attend public school in Washington State. By mandating this in the Washington State schools you would be leaving children out, many children who have shouldered so much burden already.

Hearing the terms "safe and effective" with regards to the COVID vaccine isn't accurate. We know that it was "safe" for around 2000 children country-wide, we know that it "may" also be effective for 2 months. We don't know beyond that. The Pfizer Study was very limited in scope and time. The issues we are seeing, especially in young men, are cause for concern.

I shouldn't have to uproot my children from all they've known because they'll be excluded from Washington State Schools. As a parent, I have the choice about the medical procedures my children receive. The masks are abusive, requiring shots is even more abusive. Families deserve choice.

The impact this will have on many families is awful. Many will be forced to homeschool their children which will result in job loss due to the hours needed to facilitate these needs. The impact on our most vulnerable children would be great and many would never recover.

Thank you in advance for hopefully making decisions that take into account the entire population of Washington State and not just the ones that are most vocal. I implore you to look outside of our state, and to see what other states and countries are doing, those that have given their residents choice.

Respectfully,
Dawn Guiberson

From: Don Running
Sent: 11/5/2021 11:28:42 AM
To: DOH WSBOH
Cc:
Subject: Covid Vaccine for Children

External Email

The unknown risks from the administration of the covid vaccines to children outweighs their risk of a poor outcome from the disease. Under no circumstances should the state mandate the administration of experimental medicine upon the future of our country.

Don Running

Sent from Mail <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.microsoft.com%2Ffwlink%2F% for Windows

From: Dennis Lapchis
Sent: 11/5/2021 8:09:27 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

WA State Board of Health,

I'm writing to share my thoughts about Covid-19 vaccination and our children. Mountains of evidence exist to support the stance that should you support mandates that require children to receive the Covid-19 vaccination that you will have blood on your hands from the number of child deaths and permanent disabilities that will occur. The evidence is being censored, and you are either ignorant of this fact or choosing to dismiss it. It makes no sense to mandate this vaccination for all children. The deaths, grieving parents, and children living in constant pain will be on your watch. When you go to sleep at night, they will haunt you. You have the power to stop this... please do!

Sincerely,

-Dennis

206-979-2578

_____

From: crystal bowen
Sent: 11/4/2021 9:11:48 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

I am writing this as a very concerned mom!
I OPPOSE adding the Covid vaccine to the required list for Daycare and ALL Schools, public or private.
This should never be forced on parents our on our children. I can tell you that Wa State schools and Wa State will lose a tremendous amount money because they won't have any children in these achy. I can say that 75% of people will pull their children from school and home school them.
These are our children and again, this vaccine should never be forced just to go to school or daycare!
Sincerely a concerned and pissed off mom
Crystal
Wa State

Sent from my iPhone

_____

From: Jen Johnson
Sent: 11/4/2021 10:17:41 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

To whom it may concern.
We do not agree or concent. We do not concent to our children of any age getting a vaccination when we are not present.
My child was birthed by my body and is blood from my blood.
At no time do I or will my husband Jonathan and I ever allow or give permission for any of our 4 children to take part in any vaccinations.
Jennifer Johnson
Jonathan Johnson
Spokane Washington

From: Anneliese Rollins
Sent: 11/5/2021 11:13:39 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

To whom it may concern,

Mandating our children to have an experimental vaccine not only endangered their health and well being but it also infringes upon our religious and constitutional rights as parents to make the best choice for the family/children God has entrusted to us.

• "In the paths of the wicked are snares and pitfalls, but those who would preserve their life stay far from them. Start children off on the way they should go, and even when they are old they will not turn from it."
□□Proverbs 22:5 □□NIV□□

• "Children are a heritage from the Lord, offspring a reward from him. Like arrows in the hands of a warrior are children born in one's youth. Blessed is the man whose quiver is full of them. They will not be put to shame when they contend with their opponents in court."
□□Psalms 127:3-5 □□NIV□□

Personally, this mandate will violate our religious rights to not harm or defile our bodies, or our children's bodies, and our right not to introduce something that could harm it.

•"Don't you know that you yourselves are God's temple and that God's Spirit dwells in your midst? If anyone destroys God's temple, God will destroy that person; for God's temple is sacred, and you together are that temple."
□1 Corinthians 3:16-17 □□NIV□□

• "Do you not know that your bodies are temples of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore honor God with your bodies."
□1 Corinthians 6:19-20 □□NIV□□

2) The COVID-19 shot is a gene therapy. By manipulating genetic operations, the COVID-19 shot will alter what God has made (literally assuming the position of God), which I believe to be a sinful practice. These vaccines (by the very disclosure of the van vaccine manufacturers) contain carcinogens, neurotoxins, animal viruses, animal blood, allergens and heavy-metal.

• "I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well. My frame was not hidden from you when I was made in the secret place, when I was woven together in the depths of the earth. Your eyes saw my unformed body; all the days ordained for me were written in your book before one of them came to be."
□□Psalms 139:14-16 □□NIV□□

3) Perhaps one of the most significant reasons why this mandate on school children is a

direct violation of our religious freedom is the fact that fetal stem cell lines from aborted babies were used in either the initial development and/or testing of the COVID-19 shots. Mandating the COVID-19 shots infringes upon our religious freedom and right to not participate in acts contributing to, encouraging, and or supporting the heinous acts of abortion Which are strictly prohibited in the Bible.

• "You shall not murder."
□□Exodus 20:13 NIV□□

• "Before I formed you in the womb I knew you, before you were born I set you apart; I appointed you as a prophet to the nations."
□□Jeremiah 1:5 NIV□□

• "Can a mother forget the baby at her breast and have no compassion on the child she has borne? Though she may forget, I will not forget you! See, I have engraved you on the palms of my hands; your walls are ever before me."
□□Isaiah 49:15-16 NIV□□

• "Children are a heritage from the Lord, offspring a reward from him."
Psalms 127:3 NIV□□

From: MeLisa
Sent: 11/5/2021 10:34:01 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Washington state Board of Health,

I am writing as a concerned Seattle parent of three children ages 15, 12 and 9. As you weigh the implementation of covid vaccine distribution and mandates for developing, healthy children ages 5-11, I implore you to STOP the further push for these vaccines until further research is done. As an informed, responsible parent I reserve the right to oversee the health decisions for my children and my family and should not be coerced to choose between their health and their education.

* This vaccine does NOT prevent infection, transmission, hospitalization, or death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."
* Children are not a significant threat to the elderly and vulnerable, as most Covid cases are spread from adults to children.

PLEASE DO NOT PUT THE HEALTH OF OUR STATE'S CHILDREN AND GRANDCHILDREN AT RISK BY PUSHING A RECKLESS AGENDA FOR BIG PHARMACEUTICAL COMPANIES WHO HAVE ZERO ACCOUNTABILITY IF THESE CHILDREN ARE INJURED FOR LIFE.

The rights of parents and their children to true informed consent must be paramount over money, politics or pressure from the medical community. Please do the right thing and do not mandate this experimental vaccine on our children. We do not consent.

Urgently I implore you as a concerned citizen of Washington State,

MeLisa VanderVeen

From: Kathryn Mbithi
Sent: 11/4/2021 8:40:26 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

I encourage the committee to oppose any vaccine mandates for children in order to attend school or daycare. Children are at an extremely low risk of severe disease or death from Covid and it does not make sense to force children to get an vaccine for a disease that is not a severe threat to them. In addition this vaccine has not been tested over a long period of time and it's long term effects are unknown. It would be unjust to force children to receive this vaccine in order to attend school. Parents have the right to make medical decisions for their children that align with their values and concerns, the government should not be in the business of dictating to parents what they should or should not do with their children's health. That is a conversation for the parent, child, and their personal doctors. Any infringement on their freedoms in this matter will result in a decline in school enrollment and funding as parents (including myself) remove their children from a system that disregards their concerns. It is not in the best interests of anyone to mandate covid vaccines for children.

Sincerely,
Kathryn Mbithi

Sent from my iPhone

From: mike kidwell
Sent: 11/5/2021 8:53:21 AM
To: DOH WSBOH
Cc:
Subject: I pay elected officials !

External Email

Time to stop making this far left policy hurting children. Stop and look at the data. We will be seeing you in the mid-terms everyone of this far left killing our kids mandates.

Michael

From: sbucari2108
Sent: 11/5/2021 1:11:15 AM
To: DOH WSBOH
Cc:
Subject: No Vaccines

External Email

Sent from my T-Mobile 5G Device

_____

From: Hannah Hefely
Sent: 11/5/2021 11:20:25 AM
To: DOH WSBOH
Cc:
Subject: COVID Mandate Concern

External Email

To whom it may concern,

I am writing to you today as a concerned citizen in Washington State. What is concerning me is the direction that it would appear many states are going with mandating vaccines for school age children to attend public school. Many of the VBRPAC doctors were concerned that their approval would result in mandates of this vaccine. Many approved just because they didn't want to deny high risk children access to this vaccine. I implore you to listen to these doctors.

I keep hearing people speak about how vaccines have always been required to go to school; that's true, but this vaccine can't be equated to that. We don't know the impact of these vaccines on our children - we don't know what these could cause in 10-15 years. As Cody Meisner, one of the pediatricians who sits on the VBRPAC panel said, “This is quite different from the MMR vaccine,” referring to the measles, mumps, and rubella vaccine given to all children in the U.S. “We know that vaccine is safe. We have tested that vaccine for decades and we have a very good sense of what the adverse events are. We do not have that with this particular messenger RNA vaccine.”

There has always been an option to opt out of vaccines with little to no issue from the school districts. As school districts will follow your recommendation, I implore you to NOT make the Covid 19 vaccine required to attend public school in Washington State. By mandating this in the Washington State schools you would be leaving children out, many children who have shouldered so much burden already.

Hearing the terms "safe and effective" with regards to the COVID vaccine isn't accurate. We know that it was "safe" for around 2000 children country-wide, we know that it "may" also be effective for 2 months. We don't know beyond that. The Pfizer Study was very limited in scope and time.

Parents shouldn't have to uproot their children from all they've known because they'll be excluded from Washington State Schools. As parents, we should have a choice about the medical procedures our children receive. This simply isn't right. It's cruel and borderline mental abuse. How much stress have they been under the last 18 months, only to have this stress and burden added? Not to mention the fact that school-aged children are the least vulnerable to catching and becoming severely ill from the virus.

The impact this will have on many families is awful. Many will be forced to homeschool their children which will result in job loss due to the hours needed to facilitate these needs. The impact on our most vulnerable children would be great and many would never recover. Not to mention the detrimental effect this will have on our society in the future, when these children will be the ones making the decisions.

Thank you in advance for hopefully making decisions that take into account the entire population of Washington State and not just the ones that are most vocal.

Thank you,

Hannah Hefely

From: Lisa Plymale
Sent: 11/5/2021 9:24:13 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

To Whom it May Concern,

Please do not consider a mandatory COVID vaccination for our children. As you know, there are no long term safety studies at this time which puts our children at potential risk of adverse events. According to the CDC, 99.99815% of children that get COVID survive. The vaccination does not stop infection or transmission.

All of these facts clearly indicate a mandatory vaccination for children would not be prudent.

Thank you for your time.

Sincerely,

Lisa Plymale
Woodland, WA

_____

From: Jessica Engel
Sent: 11/5/2021 10:41:02 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Do not mandate the vaccine for kids in schools and daycares!!! You are using these kids as experiments!

* There is no Covid health emergency in children ages 5 to 11.

* Natural immunity needs to be part of the risk-benefit analysis; it can no longer be ignored.

* Injury from these products is real, not rare; parents must have the final say in their children's medical care.

* According to data published by the CDC, 99.99815% of children who contract Covid-19 survive.

* Transmission of Covid-19 among children in schools and daycares is very rare.

* There are no long-term safety studies of mRNA Covid vaccines, nor have they been evaluated for carcinogenic or mutagenic potential or for impairment of fertility.

They are 107 times more likely to die from impacts of the vaccine than from covid! Do not do this!

Jessica Engel

Get Outlook for iOS
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Faka.ms%2Fo0ukef&data=04%7C0

From: chatterhall
Sent: 11/5/2021 10:16:39 AM
To: DOH WSBOH
Cc:
Subject: NO covid mandate for children

External Email

Parents know that there are vaccines for children and PARENTS should be the one to decide on whether to vaccinate their children!

The children are THEIR responsibility & if a child is injured by the vaccine, the responsibility will be on their shoulders to care for that injured child. The state has no business mandating the vaccine for children. There is no covid emergency in children!

Valerie King

Sent from my T-Mobile 4G LTE Device

From: Monica Schwarz
Sent: 11/4/2021 11:49:17 PM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Please do not mandate vaccine for kids 5-11.

Thank you.

From: Amanda Kugel
Sent: 11/5/2021 11:34:27 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

To the Board of Health members,

I strongly oppose mandating vaccines for any age. My particular concern arises from damage to the muscular system, both cardiac and skeletal. We have proof through known reports of myocarditis, of which the side effects in the long term for related to heart damage is unknown. The studies have not followed these youths for longer than a few months.

Have you or others considered that the location of injecting the vaccine into the deltoid region gives the mRNA containing lipid nanoparticles direct access to the heart? Through uptake into the lymphatic vasculature in the upper extremity, the vaccine products are given a quick route to the subclavian vein for access to the venous circulation and then on to the heart. You wonder why endocarditis occurs? With this access route , the lipid nanoparticles can easily be absorbed by cells of the endocardium, which then produce the spike proteins as the vaccine intends, but leaves these endocardium cells as targets for destruction when recognized by the adaptive immune system as "infected." The same can be said for the pulmonary vasculature if that absorbed vaccine is sent to the lungs.

What about skeletal muscle damage?Covid vaccine is injected directly into the deltoid muscle, making skeletal muscle the target for spike antigen presentation.

Body cells exhibiting antigenic fragments in the MHC-1 are targeted for destruction either by autophagy or apoptosis from cytotoxic T cells. The mRNA vaccine as an intramuscular injection specifically targets skeletal muscle, and no study has explored the damaging effects of spike protein presentation. Are we asking our population to destroy parts of their body with each injection? What is the impact going to be on our youth over the course of their lifetime?

I have further concerns for chronic elevation of active neutralizing plasma antibodies. The humoral arm of the adaptive immune response is only meant to be elevated for the 1-3 weeks during pathogenic battle. After that the memory portion will be protective, but not actively secreting vast quantities of neutralizing antibodies. I foresee booster shots which are currently proposed for adults will also become part of the kids' mandates. No one knows the implications of retaining an immune system on high alert for years. I have very strong concerns for sensitized immune systems that will either fatigue or go awry, adding to the population with autoimmune dysfunction.

The FDA has a history of retracting more than 30% of approved drugs. I do not approve of my children being active guinea pigs for pharmaceutical mandates because of the current pandemic.

Do not mandate Covid vaccines for ANY age group, especially our young adults who have decades of life ahead of them. We don't have the research and data to show the long-term repercussions on their bodies if repeatedly injected.

You have been given a position of power by some in the state, but that is not representative of all those who live here. When you mandate medical products, you make assumptions about everyone's body. You cannot peg myself or my family into the

same category as people who are actually in higher-risk categories such as the obese, those who smoke/use inhalants and drink, all which suppress the immune system.

Your job may be to protect the public, but as of late your role had been to punish the public. Assuming that all people, even the healthy ones capable of fighting a respiratory virus naturally, as contributors to the pandemic is frankly asinine.

The current stance is that production of natural antibodies from natural infection is not protective against further Covid infection. Yet the assertion that artificial production through vaccination is the only accepted method of "immunity" would thus have no ground to stand on if natural antibodies are invalid. This continued stance shows the ineptitude and/or corruption of those put in charge of the state and country. You are in that position when you continue to mandate vaccines.

Until you accept the natural production of antibodies, I have no respect for the decisions you force on the public. Until you consider the long-term consequences of muscular damage and aggressive over-stimulation of humoral immune responses, I cannot support your position. It's time to find your moral ground and stand up to the monetary forces pushing your decisions. I strongly oppose mandates, for all ages.

With concern,

Amanda M. Kugel

_____

From: Tristin Mclaren
Sent: 11/5/2021 8:32:37 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Dear Members of the Board,

Regarding the resolution pending approval from the Seattle School Board requesting the State Board of Health add the Covid-19 vaccination to the school schedule upon approval:

At this time, many parents, myself included, have concerns about the safety of this drug, especially in regard to children. Though reports of myocarditis, pericarditis, blood clots and other inflammatory related pathologies have been reported as rare, the studies performed thus far have been small and are lacking the scrutiny parents deserve before injecting a product into children, whose immune systems, including the blood-brain barrier are premature.

Additionally, long-term adverse effects have not been evaluated and historically take years, if not decades to identify. For example, the medication ranitidine (brand name, Zantac) was recalled in 2020 after unacceptable levels of the carcinogen, N-Nitrosodimethylamine (NDMA), were reported by third-party scientists in 2019. Prior to this, evaluation and safety trials were unable to detect the increasing levels of this impurity in the medication, which was found to increase over time while stored on the shelf. "The FDA conducted thorough laboratory tests and found NDMA in ranitidine at low levels. At the time, the agency did not have enough scientific evidence to recommend whether individuals should continue or stop taking ranitidine medicines, and continued its investigation and warned the public in September 2019 of the potential risks and to consider alternative OTC and prescription."* This drug has since been recalled and reformulated, but only after nearly 40 years on the market.

While the safety of our communities is important, the long-term safety and health of our children is the most valuable resource we have and if there are unintended and unforeseen consequences of a campaign to force all children who wish to access their right to education to choose between attending school and unknown risks of this product, what choice are we really giving our future? What is the potential outcome if the long-term health effects are much worse than we anticipate? How will that impact our health system, our economy, and the spirit of America?

Please consider carefully, as a decision that moves further toward forced vaccination could also mean thousands of Washington's children will be withdrawn from the public school system, which could result in a crippling effect on our public education funding and operation. Parents are simply asking for a right to choose what is best for their child's wellbeing.

I hope our state and our country have the insight and wisdom of history to elevate the safety and health of our children, who are at very low risk for morbidity or mortality from COVID-19, above hasty decisions and mandates being made based on incomplete science with unknown long-term results.

Thank you for taking the time to read my message and for taking the time to make a carefully considered decision.

Sincerely,
Tristin McLaren

*https://www.fda.gov/news-events/press-announcements/fda-requests-removal-all-ranitidine-products-zantac-market <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.fda.gov%2Fnews-events%2Fpress-announcements%2Ffda-requests-removal-all-ranitidine-products-zantac-market&data=04%7C01%7Cwsboh%40sboh.wa.gov%7Cbfc01ad8b7714cac25f908d9a07175c9%7C11d0e2

_____

From: B C
Sent: 11/5/2021 11:35:06 AM
To: DOH WSBOH
Cc:
Subject: NO vaccine mandates.

External Email

For the Nov 5th public comment deadline RE: Mandates for Public Schools.

As a parent I stand firm in my beliefs that the the State of Washington should not possess Emergency Powers over health concerns which impact a small/fraction of a percentage of people. The State, regardless of any laws or codes that are on the books, is out of bounds for coercively required medications, especially when it comes to children who are known to be near absolute absent of risk.

I have already considered withdrawing my teenage children from their regularly scheduled programming at high school, and enrolling them in homeschooling.

In addition to vaccine requirements for school, I also do not subscribe to the theory that vaccine passports or any other form of medical coercion or mandates are appropriate.

Should this state of Washington implement ANY of these measures on my children in order to maintain their basic day to day life, Washington will be losing at least 4 residents. I am sure many will be doing the same.

Should the requirements or mandates be imposed on us without our consent prior to us being able to respond accordingly, it could force an undesirable outcome of a wide spectrum, depending on the situation that presents itself.

Statistics show a vaccine injury rate of over 800k in just 10 months. Statistics show there have been less Covid deaths than vaccine injuries. Data and evidence shows the Covid death rates were inflated by reporting co-morbidities.

Most importantly, data shows that children are almost at zero risk from Covid.

I am writing to let my voice be heard. I will NOT vaccinate my children. As a taxpaying citizen of this beautiful but increasingly draconian state, I am respectfully requesting that careful consideration is given to this.

The risk benefit of mandating vaccines on children is absolutely and statistically unnecessary.

Thank you

Bryan Crouch

Oak Harbor, WA

Sent from my iPhone

_____

From: Judy Moisant
Sent: 11/4/2021 9:56:20 PM
To: DOH WSBOH
Cc:
Subject: Covid vaccine requirement for school age children & daycare

External Email

I am writing to express my concern and opposition for a vaccine mandate for school age children and daycare. None of the vaccines are FDA approved but merely given EUA. There have been no long term studies on any of these vaccines. Already there are injuries of myocarditis and periocarditis among teens and adults not to mention other life altering injuries from the vaccines. Besides the obvious fact that it is extremely rare for children to die from COVID and to be carriers to adults.

Sent from my iPad

From: elisabob
Sent: 11/5/2021 8:20:43 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Dear Board Members:

Please do not mandate COVID 19 vaccines for children, or introduce propagandizing campaigns directed at children or discriminatory policies based on students vaccine status.

The decision as to whether to give children the COVID 19 vaccines must be left to parents, not mandated by government.

COVID 19 is not a childhood disease. Its chances of killing or seriously harming children are vanishingly small (manifold less than 1%). Additionally, there is no evidence that children play any significant role in transmission of this disease in the community. Thus the benefit of giving this vaccine to children is virtually nil. We know that it can and does cause serious side effects in teens and adults, including blood clots, myocarditis, neurologic symptoms and extreme fatigue. See VAERS.

I urge you not to force this vaccine on children.

Sincerely,

Elisa Bob
Tacoma, WA

From: Mandi Reinken
Sent: 11/4/2021 8:38:52 PM
To: DOH WSBOH
Cc:
Subject: Public Comment

External Email

To Whom It May Concern,
I am a parent of two elementary aged children. I am not anti-vaccine, I recognize that Covid-19 is a real virus and know that there can be severe issues related with contracting Covid-19. But in regards to vaccinating children, or anyone for that matter, I am a strong supporter of freedom for medical choice and a believer of our Bill of Rights and the freedoms this country has fought for!

There is no COVID health emergency in children 5 to 11, natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored. Transmission of COVID-19 among children in schools and daycares is very rare. According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.

Vaccine injury from these vaccines is "real, not rare" and parents must have the final say in their children's medical care. There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine. This is NOT a FDA approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental drug. According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12-to 17-year-old age group. The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event Reporting System (VAERS)" showed astonishing increases in the youngest age brackets. Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.

The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States."

Please take all these scientific studies into consideration before forcing parents' into medical procedures for their children they don't want or need.

Thank you,
Mandi Hurd

Sent from my iPhone

_____

From: Melissa Perez
Sent: 11/5/2021 10:28:16 AM
To: DOH WSBOH
Subject: Covid vaccine mandate for children

External Email

Dear Board Members,

As our state begins offering covid vaccinations for children ages 5-11, I am contacting you to implore you not to mandate this vaccine for school attendance.
I strongly oppose vaccinating my children with this unproven vaccine that could have serious side effects to their health. Covid cases have proven to be mild in children.

According to the WA DOH website covid deaths in children are rare:

Age 0-11: **Zero** in 2020, **4** in 2021

Age 12-19: **6** in 2020, **4** in 2021

According to Seattle Children's Pulmonologist, the children that died were already seriously ill.

Children clearly are not at risk of serious covid cases and should not be forced to be vaccinated to attend school. And I refuse to make them the guinea pigs for my own health safety. Adults can choose to be vaccinated to protect themselves but it is unethical to think we should vaccinate children to protect adults. If the vaccine is that unreliable then it’s not worth giving to our children either. There are so many reasons why I disagree with this vaccine.

It seems obvious that our children are at a greater risk from the vaccine than from the virus itself.

I ask you to think of the consequences of mandating a vaccine on children. If a mandate is implemented for elementary children you’ll see a huge exodus from public schools with parents unwilling to use their children as experimentation. It saddens me to have to consider pulling my children from public school again because my children are so happy to be back at their local public school with friends and teachers and they are thriving in their learning. But I am prepared to withdraw them if there is a mandate.

We will not comply with forced vaccinations.

Here is further research to aupport why children should NOT be vaccinated:

- There is no COVID health emergency in children 5 to 11

- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.

- Vaccine injury from these vaccines is “real, not rare” and parents must have the final say in their children’s medical care.

- According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.

- There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine.

- This is NOT a FDA approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental drug.

- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12- to 17-year-old age group.

- The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event Reporting System (VAERS)" showed astonishing increases in the youngest age brackets.

o Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.

- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that, "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."

o Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children.

PLEASE DONT MANDATE THIS VACCINE TO CHILDREN. We will not comply.

Sincerely,
Melissa Perez
Snohomish School District
206.604.3830

Sent from my iPhone

From: Gregg Kramer
Sent: 11/5/2021 11:43:00 AM
To: DOH WSBOH
Cc:
Subject: Covid requirememts

External Email

To whom it may concern

Forcing children to take the vaccine is against our personal right and should not be mandated for schools.

As a parent of 3 kids in the Washington State school system I will pull all 3 of my kids out immediately.

Gregg Kramer

From: Brian Thompson
Sent: 11/5/2021 10:36:47 AM
To: DOH WSBOH
Cc:
Subject: Public Comment for BOH Meeting

External Email

Dear Honorable Board:

Please oppose adding any COVID-19 vaccines to the childhood immunization schedule.

There is not a health emergency in school children that could be resolved with such intervention.

The efficacy of adult doses has been found to wane in just months, so the sustained efficacy of reduced childhood doses is extremely suspect.

There are known injuries to children attributed to these injections and there are no long-term safety studies.

Vaccinated individuals are still contracting, and capable of spreading, the virus.

Please oppose adding these shots as part of the childhood immunization schedule.

Sincerely,

Brian Thompson
Edmonds, WA
98026

From: The Hannons
Sent: 11/4/2021 11:54:42 PM
To: DOH WSBOH
Cc:
Subject: Covid-19 vaccines for children

External Email

To Whom it May Concern:
It has come to my attention that your board is responsible for setting vaccination policies for school and daycare attendance in Washington State. In making these decisions, I hope you will take these facts into account:

1) There is no long term data safety data on any of these vaccines. No scientist or doctor has any idea if this brand-new technology will produce long-term negative affects on the health of those who take it.
2) Vaccine adverse events have skyrocketed this year since the Covid vax rollouts.
https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fvaersanalysis.info%2F2021%2F10%
summary-for-covid-19-vaccines-through-9-24-
2021%2F&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C27d893c678374c671dda08d9a028ff98%7

3) Myocarditis (inflammation of the heart) in the young and healthy has already generated enough concern to have merited the need for further studies.
https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.ncbi.nlm.nih.gov%2Fpmc%2F

4) A year and a half of data shows clearly that Covid is NOT dangerous for children.
https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.nature.com%2Farticles%2Fd4
020-03496-
7&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C27d893c678374c671dda08d9a028ff98%7C11d0e2

5) A year and a half of data shows clearly that Covid transmission from children to adults is low.
https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Facademic.oup.com%2Fjpids%2Farti

The above data shows that children are not at great enough risk from Covid to merit a vaccine mandate. Please protect the next generation from possible life-long health issues due to an experimental vaccine. Do not mandate Covid-19 vaccines for children.

Thank you for your time,
Kari Hannon
7503 Bittner Rd.
Yakima, WA 98901

_____

From: Michelle Storlie
Sent: 11/5/2021 10:46:16 AM
To: DOH WSBOH
Cc:
Subject: Forced Vaxx

External Email

I believe it is imperative that C-19 vaccine is NOT implemented on children, or anyone else.

Not Only The State Of Washington Watching. The Whole World Is Watching.

We Know The Truth

Signed,
"We The People "
Sent from my iPhone

_____

From: Lisa Templeton
Sent: 11/5/2021 11:26:40 AM
To: DOH WSBOH
Cc:
Subject: public comment for the board for Wednesday's meeting

External Email

Dear Board members,

Now that ACIP has recommended the experimental Covid injections for children as young as age 5, I am gravely concerned at the prospect of their being added to the pediatric schedule in Washington.

I am sure that you are already aware that the shots do not prevent transmission or infection, that children's recovery rate from Covid is extremely high, and that effective preventive measures (such as sufficient vitamin D) and treatments exist.

I encourage you to watch Senator Ron Johnson's roundtable discussion of Covid vaccine-injured people and medical experts <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Frumble.com%2Fvokrf7-sen.-johnson-expert-panel-on-federal-vaccine-mandates.html&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C09c8efe221524f1d0ff908d9a089ce52%7C regarding the Covid biologics and mandates. The event begins at the 30:26 minute mark, which means the video is about 3.3 hours long, although you can watch it on high speed. I pray that your moral compass –your care for humanity--will encourage you to act on this information and support the risk/benefit calculation that must be made by each person or parent, free of coercion, prior to deciding whether to take the Covid vaccine.

I respectfully urge you to exercise the precautionary principle. Wait until the clinical trials are complete and FDA gives full approval--not merely emergency use authorization--to Covid vaccines before even considering adding them to Washington's pediatric schedule. There is no emergency for children. Thousands of families are counting on you to protect us from an agenda that will result in profits for drug makers and harm to our children.

Thank you,

Lisa Templeton

50-year Washington State resident

From: Tomas Kral
Sent: 11/4/2021 9:16:39 PM
To: DOH WSBOH
Cc:
Subject: kids don't need the VAX

External Email

You prey to the Covid 19 Vaccine like its your new god. Mandate medical freedom!!!

From: Sarah Hiam
Sent: 11/5/2021 10:05:35 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

I am a mom to a 7 year old and an urgent care physician. I and my husband are vaccinated. I stand against vaccine mandates for kids. These should wait until the trials are complete in a few years, at least.

Healthy kids are at low risk from this virus. The most recent stats from the AAP show that hospitalizations and mortality among kids remain low while cases are still high. This hardly fulfills the definition of an emergency.

The vaccine is very leaky and doesn't prevent infection. I've lost count of the number of breakthrough cases I've seen in patients and among family members and friends. In fact, I might even be a breakthrough case and am awaiting my result as we speak!

Also, the severity of illness among kids in both arms of the trials was so mild that investigators had to use antibody levels to evaluate immune response.

A recent BMJ investigative piece also discovered that one of the research firms involved with the study did not use proper practices when conducting the trial.

I just now read an article which said that staffing issues will affect COVID vaccine appointments at many locations, meaning that high risk individuals in need of a booster will be competing with low risk children for these appointments. How is that equitable? We should prioritize people who are high risk and delay scheduling appointments for kids, at least for now.

We should celebrate the fact that kids are at low risk of complications from this virus and allow their immune systems to fight off illness as they were designed to do. High risk individuals have access to vaccines and need to take responsibility for their personal health. This burden shouldn't fall on kids.

Think you for your time.

Sincerely,

Sarah Hiam, DO

Sent from Yahoo Mail on Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.onelink.me%2F107872968%3F

From: Wendi Modarelli
Sent: 11/5/2021 8:39:45 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Hello,

Please ensure there is no mandated COVID vaccine for children in order to attend school. The safety seems very uncertain, and the public has not been provided with adequate safety information. Children have had serious side effects to the vaccine, including myocarditis, and the trials were much too small to pick up these safety signals. One of the FDA panelists noted that we won't know how safe the vaccine is until it's given to kids - where there is risk, there must be choice.

Even if serious side effects are rare, we know a certain number of children will develop very serious and/or life threatening side effects. It is wrong to sacrifice any children in the hopes of saving older people.

In addition, as pointed out in a recent Reuters article, there are very limited avenues for seeking compensation for those who are harmed by vaccines. This is another reason that informed consent is needed (not compulsion).

Thank you for your attention to this extremely important matter.

Wendi Modarelli
Resident

From: Jen Rodriguez
Sent: 11/5/2021 10:03:47 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

We will NOT be vaccinating our kids! If we have to shut down schools, I will take that over a forced vaccine! I do not care! No one will force me to vaccinate my children!! NO ONE!!

From: Kelly Lynn Glab
Sent: 11/5/2021 9:33:19 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Hello, I am writing to request your opposition to a Covid-19 vaccine mandate for children in schools and daycare.

The idea of a mandate for a Covid-19 vaccine for children is not evidence-based. From the data we have to date, the Covid vaccine does not prevent contraction transmission, severe illness, or hospitalization, therefore the cost does not outweigh the benefit, the cost being that it is experimental, VAERS reporting statistically depicts a large number children who already have been seriously harmed by the vaccine through blood clots, heart issues such as myocarditis and pericarditis, etc, and ultimately parents need to have the final say in health choices for their children.

Thank you for your time and attention to this very serious matter!
Sincerely,
Kelly Glab

From: Stephen C.
Sent: 11/5/2021 11:36:51 AM
To: DOH WSBOH
Cc:
Subject: 41A7A758-CE55-4E19-A956-3124A0E9B213

External Email

I am writing to you today as a concerned citizen and parent of 2 children in Washington State. My children are all current on all their vaccinations, but we will not be opting to have them get the COVID-19 shot. There are too many risks and unknowns associated with this still-experimental shot and I am not comfortable with exposing my children to such a risk.

By their own admission, the CDC acknowledges that the risk of children dying from covid is exceptionally low, and vaccinating 1 million children ages 5-11 would likely result in 106 vaccine-induced myocarditis cases. That's a side effect we know of now, but that's only after three months of testing. Myocarditis is an infection of the heart! That's a dangerous, known side effect.

I keep on hearing people speaking about how vaccines have always been required to go to school, that's true, but this vaccine can't be equated to that. The CDC actually changed the definition of vaccinations earlier this year on its website to bring them more in alignment with the COVID-19 shot. Previously, a vaccine was "a product that stimulates a person's immune system to produce immunity to a specific disease, protecting the person from that disease." Since it has now been proven that people can still get and transmit COVID-19 even after being "vaccinated" they obviously don't have immunity to that specific disease, so really, what has happened here, is these shots have been brought to market, they've used "positioning" to make them appear equal to tried and true vaccines that have been tested and proven over many, many years, and we're supposed to recognize them just like every other vaccine out there. But we don't know the impact of these shots on our children - we don't know what these could cause in 10-15 years. As Cody Meisner, one of the pediatricians who sits on the VBRPAC panel said, "This is quite different from the MMR vaccine," referring to the measles, mumps, and rubella vaccine given to all children in the U.S. "We know that vaccine is safe. We have tested that vaccine for decades. And we know, we have a very good sense, of what the adverse events are. We do not have that with this particular messenger RNA vaccine."
I implore you to NOT make the COVID-19 shot required to attend public school in Washington State. By mandating this in the Washington State schools you would be leaving children out, many children who have shouldered so much burden already.

Hearing the terms "safe and effective" with regards to the COVID shot isn't accurate. We know that it was "safe" for around 2000 children country-wide, we know that it "may" also be effective for 2 months. We don't know beyond that. The Pfizer Study was very limited in scope and time.
I shouldn't have to uproot my children from all they've known because they'll be excluded from Washington State Schools. As a parent, I should have the choice about the medical procedures my children receive.
The impact this will have on many families is awful. Many will be forced to homeschool their children which will result in job loss due to the hours needed to facilitate these needs. The impact on our most vulnerable children would be great and many would never recover.

Thank you in advance for hopefully making decisions that take into account the entire population of Washington State and not just the ones that are most vocal.

From: Linda Hee
Sent: 11/5/2021 10:59:02 AM
To: DOH WSBOH
Cc:
Subject: My Public Comments

External Email

Dear Washington State Board of Health,

As you meet to discuss policies regarding the Covid-19 vaccination plan, please consider the data from the CDC regarding the actual mortality rates for those who had Covid-19. https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.cdc.gov%2Fnchs%2Fnvss%2

For those 0-17 years of age in the entire United States, out of the 60,811 children who died in all of 2020 to the present (11/03/2021 as of this email), only 576 died of Covid-19 including those with co-morbidities. If you scroll further down on the CDC link, you will see that those 0-24 who died of Covid-19 had the following co-morbidities: obesity (464), diabetes (188), injury/poisoning/adverse events (143), to name just a few.

There is absolutely no need to authorize, let alone mandate a vaccine for any child under 18. Please focus your policies, plans, and budget on all the other causes of death for 99% of children 0-17 years old. Covid-19 did not and is not killing 99% of the children.

Thank you,

Linda Hee

_____

From: Kim Orange
Sent: 11/5/2021 2:23:00 AM
To: DOH WSBOH
Cc:
Subject: Opposition to Mandatory COVID Vaccine for Children

External Email

To Whom it may concern:

Mandatory COVID vaccines for children (and for ANYONE) is a horrible idea, for many reasons:

1. Natural Immunity is REAL but is often ignored when considering COVID vaccine mandates.
2. Life threatening COVID in children ages 5 to 11 is RARE. 99.99815% of children who contract COVID survive.
3. There has been no longitudinal testing of the mRNA COVID vaccines; indeed, clinical trials on adults haven't been completed and available vaccines are still used under EUA.

4. Previously healthy adolescents between the ages of 12 and 17 have experienced blood clots, myocarditis, and a variety of neurological issues as adverse effects to the COVID mRNA vaccines.

5. Vaccines do NOT prevent infection or transmission of the COVID virus.

Please do NOT recommend COVID vaccination for children between the ages of 5 and 11!

Sincerely,

Kim Naranjo

From: Tera Tagliabue
Sent: 11/4/2021 8:54:10 PM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Washington State Board of Health,

It is critical that you oppose adding the COVID-19 vaccine to the list of vaccines required for children to attend daycare or schools!

There is no Covid health emergency in children ages 5 to 11. According to data published by the CDC, 99.99815% of children who are infected by Covid-19 survive. Transmission of Covid-19 among children in schools and daycares is very rare. Children are also not a significant threat to the elderly and vulnerable, as most Covid cases are spread from adults to children.

It's estimated that 30-40% of children have already recovered from SARS-COV2 infection and therefore they are protected from reinfection by their natural immunity. Natural immunity is longer lasting than the protection from vaccines and provides better protection against all variants.

Additionally, the vaccine does not prevent infection, transmission, hospitalization, or death. A recent study from the Harvard Center for Population and Development Studies states: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."

These products are under Emergency Use Authorization (EUA), which means they are still experimental. There are no long term safety data. Injury from these products is real, not rare; and parents must have the final say in their children's medical care. The clinical trials were too short and not large enough to detect some of the more infrequent adverse reactions.

There are no long-term safety studies of mRNA Covid vaccines, for adults or children. Nor have they been evaluated for carcinogenic or mutagenic potential or for impairment of fertility, which would all impact children more than adults and these effects may not show up for years. We know vaccine effectiveness wanes, so if children require a booster every 6-8 months they will be subjected to the cumulative effects and increased risk of adverse effects with each subsequent injection, possibly for decades. For young children this risk is simply not reasonable if they already have a 99.99% survival rate. (See https://tobyrogers.substack.com/p/ten-red-flags-in-the-fdas-risk-benefit <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Ftobyrogers.substack.com%2Fp%2
red-flags-in-the-fdas-risk-
benefit&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C1ecd44a9e16c4015018e08d9a00feb15%7C11d0e
for an analysis of the FDAs risk benefit analysis).

Additionally the Under Reporting Factor (URF) has not been calculated by the FDA or the CDC, and is essential for a proper risk/benefit analysis (https://stevekirsch.substack.com/p/its-time-for-john-su-to-go <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fstevekirsch.substack.com%2Fp%2
time-for-john-su-to-
go&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C1ecd44a9e16c4015018e08d9a00feb15%7C11d0e2172
).

Healthy adolescents ages 12-17 who have been given Covid vaccines have experienced adverse reactions including blood clots, myocarditis, neurologic symptoms and extreme fatigue. According to data available <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2F0x124.mjt.lu%2Flnk%2FANAAALSX
8AAAAAu9MAALoOABkwhABhhFmGeLqPMzClTM-_0eY6Ey6pggAYgA4%2F7%2F-
JoBnCKQvIc-
1U8fAz1YEA%2FaHR0cHM6Ly9tZWRhbGVydHMub3JnL3ZhZXJzZGIvaW5kZXgucGhw&data=04%7C01%7Cw
from the Vaccine Adverse Event Reporting System (VAERS), as of October 22, there had been a total of 16,716 reports of adverse events, including 1,435 serious reactions and 27 deaths in the 12- to 17-year-old age group. The Pfizer mRNA vaccine has caused devastating injuries in some youth, including myocarditis and pericarditis. The CDC's own analysis of "Myopericarditis following Covid-19 vaccination: Updates from the Vaccine Adverse Event Reporting System" shows astonishingly high incidence in the youngest age brackets. There is at least a 75-fold increase in the rate of myocarditis for fully vaccinated 16 year old boys over the baseline rate expected. Myocarditis is not mild and doesn't go away. It's heart damage and 20% typically die in 1 year while 50% typically die in 5 years. We must not experiment on our children to find out if this will happen to them!

Please oppose any mandates of this vaccine for our children to participate in daycare or education. As with all health and medical choices, these are individual choices and should be made by families based on their own health circumstances, beliefs, and their own risk/benefit analysis.

Thank you,

Tera Tagliabue

Shoreline, WA

_____

From: Troy Naatus
Sent: 11/5/2021 8:39:47 AM
To: DOH WSBOH
Cc:
Subject: OPPOSE MANDATES

External Email

To Whom It May Concern,

- There is no COVID health emergency in children 5 to 11
- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.
- Vaccine injury from these vaccines is "real, not rare" and parents must have the final say in their children's medical care.
- Transmission of COVID-19 among children in schools and daycares is very rare.
- According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.
- There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine.
- This is NOT an FDA-approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental drug.
- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12- to 17-year-old age group.
- The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event Reporting System (VAERS)" showed astonishing increases in the youngest age brackets.
- Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms, and extreme fatigue.
- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to the level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that "countries with a higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."
- Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children.

Troy Naatus

_____

From: Leah Taff
Sent: 11/5/2021 10:25:53 AM
To: DOH WSBOH
Cc:
Subject: No covid vaccine mandate

External Email

Do not mandate the covid vaccine for children! I'm all for the vaccine. My husband and I are vaccinated. We are open to having our children vaccinated in the future. But to force or coerce parents and caregivers into vaccinating children under the current circumstances is simply immoral. Encourage, not mandate!

- There is no covid health emergency in children 5 to 11
- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.
-parents must have the final say in their children’s medical care.
- Transmission among children in schools and daycares is very rare.
- According to published data by the CDC, 99.99815% of children who contract survive.

Sent from my iPhone

From: Lindy Mullen
Sent: 11/5/2021 1:20:11 AM
To: DOH WSBOH
Cc:
Subject: November 10 BOH meeting comments

External Email

When do pandemics end? According to an Oxford University Medical history doctor, pandemics end when they "change from something that we as a society deem to be unacceptable, into things that can be fatal, but are just in the background", when "public attention is redirected to the moral and social crises that the disease has exposed". Not when case numbers have gone to 0, not when we have "flattened the curve," not when fatalities end. We as a society can regain our lives when we have accepted that covid is here to stay.

I like many other individuals, states and countries have accepted that covid is part of normal life. I understand the risk that I take when I engage in activities and I take the precautions I feel are necessary to protect myself and my family.

The CDC's current best estimate for deaths from covid is:

* 20 in a million for ages 1-17 or 0.002%

Other activities with similar death rates include, death from bee stings, cataclysmic storms, and exposure to hot surfaces and substances (https://injuryfacts.nsc.org/all-injuries/preventable-death-overview/odds-of-dying/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Finjuryfacts.nsc.org%2Fall-injuries%2Fpreventable-death-overview%2Fodds-of-dying%2F&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C924ef3eb7ae14a3a9d3208d9a034f264%7C11d
).

There are no mandates related to bee stings, storms or hot surfaces that supposedly protect our children. It would be absurd to require that everyone wear beekeeper suits at all times while outdoors to protect themselves from a 0.002% chance of death, especially knowing that bees can still sting through those suits.

When do pandemics end? According to an Oxford University Medical history doctor, pandemics end when they "change from something that we as a society deem to be unacceptable, into things that can be fatal, but are just in the background", when "public attention is redirected to the moral and social crises that the disease has exposed". Not when case numbers have gone to 0, not when we have "flattened the curve," not when fatalities end. We as a society can regain our lives when we have accepted that covid is here to stay.

I like many other individuals, states and countries have accepted that covid is part of normal life. I understand the risk that I take when I engage in activities and I take the precautions I feel are necessary to protect myself and my family.

The CDC's current best estimate for deaths from covid is:

* 20 in a million for ages 1-17 or 0.002%

Other activities with similar death rates include, death from bee stings, cataclysmic storms, and exposure to hot surfaces and substances (https://injuryfacts.nsc.org/all-injuries/preventable-death-overview/odds-of-dying/

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Finjuryfacts.nsc.org%2Fall-injuries%2Fpreventable-death-overview%2Fodds-of-dying%2F&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C924ef3eb7ae14a3a9d3208d9a034f264%7C11d
).

There are no mandates related to bee stings, storms or hot surfaces that supposedly protect our children. It would be absurd to require that everyone wear beekeeper suits at all times while outdoors to protect themselves from a 0.002% chance of death, especially knowing that bees can still sting through those suits.

Masks are harmful and they do not prevent covid infections in our children. Covid vaccination has unquantified risk of harm and the vaccines do not prevent covid infections in our children. According to VAERS (Vaccine adverse event reporting system), 9,367 deaths have been reported following covid vaccinations. Many other serious adverse events are prevalent as well, including Bells Palsy, Pulmonary embolism, stroke, DVT, myocarditis, pericarditis and cardiac arrest.

The latest Department of Health report lists 64,971 covid breakthrough cases in WA and 630 fully vaccinated individuals in our state that died from covid.

The virus that causes Covid is here to stay. Masks, vaccines, and lockdowns have all failed. It is not possible to get rid of it. Health authorities claim the Covid vaccines are highly effective, but the rate of death due to Covid is the statistically the same for vaccinated and unvaccinated individuals. Look at the data. Do the math yourself (# covid deaths/# covid infections).

The pandemic ends when we as a society have accepted the disease. I am tired of my son missing out on school merely because of society's perceptions. We need to restore parents' rights to decide what risks their family chooses to accept and what precautions are taken.

IT IS TIME TO STOP THE MASK AND VACCINE MANDATES!

C.S. Lewis wrote, "Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive…those who torment us for our own good will torment us without end for they do so with the approval of their own conscience."

Thank you,

Lindy Mullen Doyle

From: Hope
Sent: 11/5/2021 11:44:05 AM
To: DOH WSBOH
Cc:
Subject: Public Comment To Washington State Board of Health Regarding Injections Which Have Had Deadly Effects

External Email

There is no COVID health emergency in children 5 to 11.

Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.

Vaccine injury from these vaccines is “real, not rare,” and parents must have the final say in their children’s medical care.

From: Courtney Dethlefs
Sent: 11/4/2021 9:06:27 PM
To: DOH WSBOH
Cc:
Subject: School/daycare vax covd policy

External Email

Hello dear members of the WA Board of Health,

Please seriously consider your policy on covid vaccines for schools and daycares!

* Covid is NOT an health emergency for children 5-11
* Natural immunity MUST be considered (as it is for chicken pox and measles)
* This is NOT an FDA-approved vaccine; it is a research product approved for emergency use
* There is no long-term safety data!

Thank you for your time and consideration of the facts surrounding covid and its associated vaccines!

Courtney Dethlefs

From: Tori Helberg
Sent: 11/5/2021 12:14:49 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

I do not believe it is wise to introduce this untested (normal testing protocols for ALL previous childhood vaccines up to and including flu one) our children are the future and you could possibly, probably be endangering them. It is a grave responsibility to make sure outcomes for them are as good as possible and you personally will be held accountable for their safety. Thank you for doing your due diligence.

Concerned parent/grandmother

Tori Helberg
Grays Harbor County

Sent from my iPhone

From: Bethany Nightingale
Sent: 11/5/2021 10:01:16 AM
To: DOH WSBOH
Cc:
Subject: NO TO “VACCINE” MANDATES

External Email

We do not want vaccine mandates for children.

This is ridiculous and we will not comply.

I’m an RN, this proposed “mandate” must be ditched quickly.

Thank you.

Sent from Yahoo Mail for iPhone
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Foverview.mail.yahoo.com%2F%3F

_____

From: Judy Moisant
Sent: 11/4/2021 10:04:52 PM
To: DOH WSBOH
Cc:
Subject: Opposing Vaccine mandate for school age children and daycare

External Email

I am writing to oppose and express my concern for any consideration of a vaccine mandate for school age and daycare children. The Covid vaccines are experimental, only have EUA and are not fda approved. Not to mention there are no long term studies on their effects on adults and certainly not children! There have been serious issues with myocarditis, periocarditis and other life altering injuries from the vaccines that need to be addressed. It is extremely rare for a child to die from COVID and rare for them to be carriers to adults. There is science to support this as well as the superiority of natural immunity over vaccination. Parents should be allowed to choose for their own children whether or not they get vaccinated. It is unconstitutional, against our freedoms to force injections!

Judy Moisant

Sent from my iPad

_____

From: Nicholas Elliott
Sent: 11/5/2021 10:35:34 AM
To: DOH WSBOH
Cc:
Subject: COVID Vaccine Mandate of Washington State School Children

External Email

Good Morning,

I am writing to you today as a concerned citizen and parent of 2 children in Washington State. Both of my children are younger than 11 years old and we will not vaccinate our children. Our children have had COVID infections. One was asymptomatic and one had a slight fever for 8 hours. What is new and concerning is the direction that it would appear many states are going with - mandating vaccines for school age children to attend public school. Many of the VBRPAC doctors were concerned that their approval would result in mandates of this vaccine. Many approved just because they didn't want to deny high risk children access to this vaccine. I implore you to listen to these doctors.

I keep on hearing people speaking about how vaccines have always been required to go to school, that's true, but this vaccine can't be equated to that. We don't know the impact of these vaccines on our children - we don't know what these could cause in 10-15 years. As Cody Meisner, one of the pediatricians who sits on the VBRPAC panel said, “This is quite different from the MMR vaccine,” referring to the measles, mumps, and rubella vaccine given to all children in the U.S. “We know that vaccine is safe. We have tested that vaccine for decades. And we know, we have a very good sense, of what the adverse events are. We do not have that with this particular messenger RNA vaccine.” There has always been an option to opt out of vaccines with little to no issue from the school districts. As school districts will follow your recommendation, I implore you to NOT make the Covid 19 vaccine required to attend public school in Washington State. By mandating this in the Washington State schools you would be leaving children out, many children who have shouldered so much burden already.

Hearing the terms "safe and effective" with regards to the COVID vaccine isn't accurate. We know that it was "safe" for around 2000 children country-wide, we know that it "may" also be effective for 2 months. We don't know beyond that. The Pfizer Study was very limited in scope and time.

I shouldn't have to uproot my children from all they've known because they'll be excluded from Washington State Schools. As a parent, I should have the choice about the medical procedures my children receive. Last night my youngest child, who's 7, was sobbing because someone at school told him he wouldn't be able to go to school next year if he didn't have the vaccine. This simply isn't right. It's cruel and borderline mental abuse. How much stress have they been under the last 18 months, only to have this stress and burden added.

The impact this will have on many families is awful. Many will be forced to homeschool their children which will result in job loss due to the hours needed to facilitate these needs. The impact on our most vulnerable children would be great and many would never recover.

Thank you in advance for hopefully making decisions that take into account the entire population of Washington State and not just the ones that are most vocal.

Nicholas Elliott

Sent from my iPhone

From: Jennifer Jones
Sent: 11/5/2021 11:33:09 AM
To: DOH WSBOH
Cc:
Subject: Public comments

External Email

Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.

☐There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine.

☐The vaccine does not stop infection, transmission, hospitalization, nor death a recent study from the Harvard Center for Population and Development Studies states.

The vaccines should be a choice and not mandated.

Dee Jones

Sent from my iPhone

From: Rose Myers
Sent: 11/5/2021 11:30:08 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Governments should not be allowed to mandate vaccines for kids. Nor should they be allowed to mandate vaccines for employees.

Thank you.

From: Jill Overfield
Sent: 11/5/2021 10:20:23 AM
To: DOH WSBOH
Cc:
Subject: Leave my kids alone

External Email

From vaccinated parents, this is about freedom. Bottom line, it's my choice as a parent. Leave my kids alone.

- There is no C0V!D health emergency in children 5 to 11

- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.
- Jab injuries are "real, not rare" and parents must have the final say in their children's medical care.
- Transmission among children in schools and daycares is very rare.
- According to published data by the CDC, 99.99815% of children who contract survive.
- There are no adequate long-term safety studies of mRNA jabs because the placebo group was "unblinded" and allowed to get the jab.
- This is NOT FDA approved. FDA will expand the EUA to include children as young as 5. In other words, any mandate for children is of an experimental drug
--

Sincerely, Jill Overfield

_____

From: Brendan Curran
Sent: 11/5/2021 9:14:23 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Dear Board

This input is to voice my strong opinion to, at your upcoming meeting,

DO NOT VOTE TO IMPOSE MANDATORY VACCINATIONS FOR OUR SCHOOL CHILDREN.

Given the limited risk with vaccinations, or impacts of COVID, with our youth the unknowns associated with long term effects mRNA technologies are too great.

Sincerely

Brendan J Curran

Kirkland

From: DL B
Sent: 11/4/2021 8:39:49 PM
To: DOH WSBOH
Cc:
Subject: Kid vaccines

External Email

DO NOT force this experimental vaccine on children or anyone for that matter. Medical freedom is paramount. We must have a voice in what our children get.
Thanks

From: Tara Taylor
Sent: 11/5/2021 9:04:24 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Concerning mandatory vaccination of 5 to 11 year old children…this vaccine is experimental. To use our children and grandchildren as test subjects for a vaccine that has had such adverse effects on adults is dangerous. Our children are still growing, how will this affect the reproductive systems? Have there been long term studies conducted that guarantee no long term adverse reactions to our children? Who will cover the cost of health care if they are affected, if insurance won't cover the costs because this vaccine is still considered experimental? I implore you to hold off on mandating this vaccine until further studies can be done! These children are our future and they deserve to grow up strong and healthy. It is our responsibility to look out for them and to insure their safety.

Sent from my iPhone

From: Cindy Rakoz
Sent: 11/5/2021 11:38:56 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

I am opposed to vaccinating children.

I believe that it is the parents' right to have their child/children vaccinated and that it should not be mandatory.

While all children are capable of getting the virus that causes COVID-19, they don't become sick as often as adults. Most children have mild symptoms or no symptoms.

I have not seen any long term studies on children that have been vaccinated to show that it is safe for them. We do not know how this will affect them in the future.

I do not feel that there is enough evidence of the safety of vaccinations on children.

Sent from Mail <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.microsoft.com%2Ffwlink%2F%
for Windows

From: Chanel Hoffman
Sent: 11/5/2021 9:21:31 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

We just don’t know enough about the long term effects of this vaccine and yet we want to give it to the future of this society. I have seen the adverse effects in adults and I myself don’t feel comfortable taking the jab let alone my child!!!

Coercion is exactly what the government is doing… no jab no job. Why should we do this to our children? No jab no education. That just doesn’t seem right.

There will be lots of parents taking their kids out of the system, but what does it matter when our taxes pay for the public system?

I sincerely hope you look at the requirement and at least give people the same opportunity to exempt their kids from this the way we were allowed to as adults; religious or medical.

Chanel Hoffman

From: Crystal Hoover
Sent: 11/5/2021 8:53:18 AM
To: DOH WSBOH
Cc:
Subject: Vaccine policies

External Email

Hello,

I wanted to note I am AGAINST the government telling me what vaccines I can or cannot give my children.

AMERICA is a free country. Many have died for yours and my freedom to choose.

I am OPPOSED to forcing this experimental drug on our precious children.

The risk of the vaccine is greater than the risk of the child dying from this flu strain. According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.

Can we get back to being the land of the free?

Thank you for your time.

Cheers,

Crystal R Hoover
206-409-8244

From: Amy Kay
Sent: 11/5/2021 10:38:48 AM
To: DOH WSBOH
Cc:
Subject: Covid Vaccine for School Aged Children

External Email

To Whom It May Concern,

I need to express my concern regarding vaccination for my 8 year old.
This vaccine has not been tested long enough to determine long term effects if given to young children. There is not enough data or studies to prove the mRNA vaccine is safe. Natural immunity needs to be given a chance and no longer ignored as part of the risk assessment. It is not FDA approved.

If it is determined that the vaccine is required to attend school my children will be withdrawn from their respective schools and homeschooled or relocated out of state.

We are adamantly opposed to mandated forced Covid 19 vaccines and loss of freedom if medical choice.

Amy Kay

From: Stacey Scott
Sent: 11/5/2021 9:04:43 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Please do not use this drug that has not been through final trials and approvals and is still under experimental use on our future generations. Protect these innocent children from the side effects that have not been fully researched.
Please do not use this drug that has not been through final trials and approvals and is still under experimental use on our future generations. Protect these innocent children from the side effects that have not been fully researched.

Stacey Scott
Olympia, WA 98502
360-490-5619

Sent from my iPhone

From: Jonathan Anderson
Sent: 11/5/2021 10:41:56 AM
To: DOH WSBOH
Cc:
Subject: No to Vaccine Mandates!

External Email

To whom it may concern:

Mandating vaccinations is wrong. It is especially wrong when it comes to children who are at very low risk when it comes to COVID. Individuals and parents are responsible for making the risk assessment regarding vaccinations. Yes, there is a risk to every decision including whether or not to receive a vaccination. It is not unreasonable or anti-science to weigh the risks and benefits of this decision. This decision does not belong to the board of health. Continuing the attempt to force vaccinations on the citizens of our state isn't going to change anything and is only causing many of us to not comply who would otherwise probably take the vaccine of our own free will. Not any more. We are taking names and won't forget.

Jonathan

From: Everett Waddle
Sent: 11/5/2021 7:17:25 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

I completely oppose mandatory vaccination for all children but especially mine. If the schools start requiring this to attend I will be pulling my child out of the public school system and start homeschooling. This is absolutely absurd. Please do not force any of us against our will.

Sincerely ,

Everett Waddle

_____

From: Bev and Doug Knudsvig
Sent: 11/5/2021 11:14:02 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

My name is Beverly Knudsvig
Thank you for all you do to protect our children as I am a mother and grandmother if 10 beautiful healthy children...I say no to mandating this coronavirus or any related virus...I do not feel like we have enough testing to proceed with forcing anyone to recieve this vaccine...and the data that we have shows that children are at low risk for this...please be brave and stand for Medical Freedom...for our children.

_____

From: Sarah Teague
Sent: 11/5/2021 11:39:28 AM
To: DOH WSBOH
Cc:
Subject: Don't mandate!

External Email

I am writing to you today as a concerned citizen and parent of 2 children in Washington State. My children are 14 years old and 5 years old and we will not vaccinate our children. What is new and concerning is the direction that it would appear many states are going with - mandating vaccines for school age children to attend public school. Many of the VBRPAC doctors were concerned that their approval would result in mandates of this vaccine. Many approved just because they didn't want to deny high risk children access to this vaccine. I implore you to listen to these doctors.

I keep on hearing people speaking about how vaccines have always been required to go to school, that's true, but this vaccine can't be equated to that. We don't know the impact of these vaccines on our children - we don't know what these could cause in 10-15 years. As Cody Meisner, one of the pediatricians who sits on the VBRPAC panel said, “This is quite different from the MMR vaccine,” referring to the measles, mumps, and rubella vaccine given to all children in the U.S. “We know that vaccine is safe. We have tested that vaccine for decades. And we know, we have a very good sense, of what the adverse events are. We do not have that with this particular messenger RNA vaccine.” There has always been an option to opt out of vaccines with little to no issue from the school districts. As school districts will follow your recommendation, I implore you to NOT make the Covid 19 vaccine required to attend public school in Washington State. By mandating this in the Washington State schools you would be leaving children out, many children who have shouldered so much burden already.

Hearing the terms "safe and effective" with regards to the COVID vaccine isn't accurate. We know that it was "safe" for around 2000 children country-wide, we know that it "may" also be effective for 2 months. We don't know beyond that. The Pfizer Study was very limited in scope and time.

I shouldn't have to uproot my children from all they've known because they'll be excluded from Washington State Schools. As a parent, I should have the choice about the medical procedures my children receive. Last night my youngest child, who's 7, was sobbing because someone at school told him he wouldn't be able to go to school next year if he didn't have the vaccine. This simply isn't right. It's cruel and borderline mental abuse. How much stress have they been under the last 18 months, only to have this stress and burden added.

The impact this will have on many families is awful. Many will be forced to homeschool their children which will result in job loss due to the hours needed to facilitate these needs. The impact on our most vulnerable children would be great and many would never recover.

Thank you in advance for hopefully making decisions that take into account the entire population of Washington State and not just the ones that are most vocal.

Concerned,
Sarah Teague-Schmeltz

Sent from Yahoo Mail on Android

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.onelink.me%2F107872968%3F>

From: Tanya Metz
Sent: 11/5/2021 10:49:03 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

To whom it may regard
I am a mother of two Elementry students and I am slsending this to state that my husband and I are firmly against the covid vaccine as it pertains to children and we wanted to state that if the vaccine becomes a requirement for schools in WA state we will be forced to pull our children from public school and homeschool.
Thank you for your consideration
Tanya and Mark Metz

Sent from my iPhone

_____

From: Renay Bennett
Sent: 11/4/2021 8:55:46 PM
To: DOH WSBOH
Cc:
Subject: NO to Covid shots for children

External Email

To Whom It May Concern,

The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that, "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."

You all know this. Please do not mandate this for kids who do not need it!

Sincerely,

Renay Bennett

From: Kd Jojo
Sent: 11/5/2021 7:08:24 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Dear Washington State Board of Health,

I'm writing today due to my grave concerns regarding this fast-tracked Covid Vaccine. The Trump Administration cut through many safety barriers to get these "Operation Warp Speed" vaccines to the public. Like most Washingtonians, I believe what we put into our bodies matters. Unfortunately, with unprecedented mandates and government overreach, it seems like we are assuming these drugs are safe, and we don't know that yet. Only time will tell, and pushing our children (our future) into this already volatile mix is absolutely reckless. Time is what is needed to monitor these vaccines to make sure they are safe and effective. We know that our older population is the at-risk population. Children are not at risk, and injecting children with an experimental vaccine (tested on only 1,500 kids for a few months) to try and protect our older community or whatever nonsense floating out there is not okay. I don't believe we sacrifice our children to save our old ones. I believe we sacrifice ourselves to protect our children.

Another argument floating out there is that children are already required to take certain vaccines. This is an unfair comparison because those vaccines went through years and years of rigorous safety trials, which we know these have not. The amount of money these pharmaceutical companies are making is also concerning. You would think people wouldn't be profiting at such extremes from human suffering in a time of an emergency.

Please say no to attempts to mandate these experimental fast-tracked vaccines for our children.

Thank you for your time.

Catherine Jodoin

3011 Unick Rd.

Ferndale WA 98248

From: kdarmstrong05
Sent: 11/5/2021 10:09:28 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

To the board,

I am a father of two young children and am very concerned about the push for vaccines for children under 12 without any long term safety studies. The risk of Covid is simply not high enough to justify mandating a vaccine with potentially lifelong adverse effects. Injury from the vaccines is real, despite how much it is downplayed by various organizations and pharmaceutical companies. According to the data available from the Vaccine Adverse Event Reporting System (VAERS), there were 1,435 serious reactions and 27 deaths in the 12 to 17 year old age group, and that is only what is reported to the system, so it can be reasonably assumed that those numbers are low. It is possible that younger children may be more likely to develop severe side effects. This is too high a cost for a disease that, according to data published by the CDC, has a 99.99815% survivability rate for children. That is not a health emergency.

We cannot afford to put our children at risk for so little gain. Parents must have the final say in their children's medical care. This is vital to provide a buffer to protect our children from the drastic changes of a constantly changing political and social landscape, creating an environment of stability and security so they can grow to their full potential.

Please resist mandating an experimental vaccine for children.

Kevin Armstrong

From: Aya Bobinsana
Sent: 11/4/2021 9:50:50 PM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

To whom it may concern,

Firstly, thank you for your commitment to looking after the health and well being of the public.

As a parent, I'm writing to share my concerns about potential mandates that children ages 5-11 receive the Covid vaccine. As I know you put much effort and attention into making sure every public health measure will do no harm to children, I am requesting that you please consider my concerns, such as the following:

* The Covid vaccine does not prevent infection, transmission, hospitalization, or death. This is a known fact. Harvard's Center for Population and Development Studies stated plainly in a recent study: "Increases in Covid-19 are unrelated to the level of vaccination across 68 countries and 2,947 counties in the United States. The study also states that "countries with higher percentage of the population fully vaccinated have higher Covid-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest Covid-19 cases per 1 million people in the last 7 days."
* Most Covid cases are spread from adults to children so children are NOT a significant threat to the elderly and vulnerable.
* It is very rare that transmission of Covid-19 among children in schools and day care centers.
* Data published by the CDC shows that 99.99815% of children who contract Covid-19 survive. Therefore, there is no Covid health emergency in children ages 5-11.
* To date, there are NO long-term safety studies of mRNA Covid vaccines. These vaccines have not been evaluated for carcinogenic or mutagenic potential or for impairment of fertility. It is highly questionable that, when my friend's young adult daughter was vaccinated with the Covid vaccine, she was warned by the person who administered the vaccine that there is a risk of fertility concerns.
* As of October 22, data available from the Vaccine Adverse Event Reporting System (VAERS) reveals 16,716 reports of adverse events, including 1,435 serious reactions and 27 deaths in the 12-17 year old age group.
* Updates from the VAERS reveal high incidence of injuries in the youth sector, which includes mycarditis and pericarditis.
* Injury from these products are real.

As a family, we have chosen to live a healthy lifestyle, eating a balanced diet, regular exercise, integrated health care, etc. We believe and have experienced that natural immunity is real; it is historically justified. As parents, we should not have to demand that we have the final say in our children's medical care.

Thank you for considering our voices and for taking the time to look into the above-mentioned concerns.

Sincerely,

Aya Bobinsana
Parent for Health Choices and Freedom

From: Kimberly Whalen
Sent: 11/5/2021 10:36:32 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

I am writing in opposition for forced vaccinations on anyone at any age. Especially school aged children and those who have already had and recovered from Covid. Studies show and support that natural immunity is more effective than any vaccinations. Please do NOT vote for any mandates that force vaccines on people. My body- my choice. My immune system has already recovered naturally from covid. VOTE NO ON MANDATES!

Kim Whalen

From: Wendy Drexler
Sent: 11/5/2021 10:39:05 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

This is child abuse to vaccinate children when their natural immunity is so high. Leave the children be and have NATURAL immunity. Injury from these products is real, not rare; parents must have the final say in their children's medical care.

From: Heidi Mann
Sent: 11/5/2021 11:17:02 AM
To: DOH WSBOH
Cc:
Subject: Covid Vaccine for school kids

External Email

To whom it may concern,

I believe getting the Covid vaccine should not be a mandate for our kids to go to public school!

This is too new and I am not willing to experiment with my 3 children's lives.

If this becomes a mandate I will pull all 3 out of public school!

Heidi Mann

From: sherri heilman-fennel
Sent: 11/5/2021 10:48:19 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Children are NOT a target of CV-19 and forcing a Vax on them is uncalled for. If children are forced to take it then the government needs to signa liability form stating that any I'll effects, or conditions caused by the Vax will be paid for 100% by local and or federal government with ZERO funds from the parents.

Sent from Yahoo Mail on Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.onelink.me%2F107872968%3F

_____

From: pnwpianoplayer
Sent: 11/5/2021 7:52:51 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

I strongly oppose any discussion or consideration of children being forced to take the covid vaccination.

This vaccine has not been tested enough for the possible risks that might be experienced by our children. Also, the potential for our children to actually catch covid and experience serious symptoms, or even death is the smallest of percentages.

For the mental health of our children, please let them get back to normal! No masks. No vaccine requirement.

Sincerely,
Deborah Gannon

From: Brandy Precious
Sent: 11/5/2021 11:39:55 AM
To: DOH WSBOH
Cc:
Subject: NO VAX MADATE FOR OUR KIDS

External Email

Please do not make a mandate for kids to need the covid vaccine to attend school. I want my child to be a part of public schools as I did as it was the best times of my life. I do not want my child to have this vaccine until there are long term studies done. Thank you for your attention to this subject.

Sent from my T-Mobile 5G Device
Get Outlook for Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Faka.ms%2Fghei36&data=04%7C0

_____

From: Sarah Braun
Sent: 11/5/2021 11:16:23 AM
To: DOH WSBOH
Cc:
Subject: Vaccine Mandate

External Email

Good Morning,

I am writing to you today as a concerned citizen and parent of a child in Washington State. My son is 7 years old and I will not vaccinate him. My son is healthy, as am I and the many family members that have had covid. Our symptoms varied from losing taste/smell to having flu like symptoms. My son has a strong immune system and I fully believe that the covid vaccine is detrimental to children, as I have many friends and family (adults) that have died immediately after receiving the covid vaccines. I could write two emails with all of the alarming side effects I have observed in my friends and family and it is nothing short of genocide. I am seeing healthy people deteriorate before my eyes after receiving these vaccines. That, I cannot and will not ignore.
What is incredibly concerning is the direction that it would appear many states are going with - mandating vaccines for school age children to attend public school. Many of the VBRPAC doctors were concerned that their approval would result in mandates of this vaccine. Many approved just because they didn't want to deny high risk children access to this vaccine. I implore you to listen to these doctors.

I keep on hearing people speaking about how vaccines have always been required to go to school, that's true, but this vaccine can't be equated to that. We don't know the impact of these vaccines on our children - we don't know what these could cause in 10-15 years. As Cody Meisner, one of the pediatricians who sits on the VBRPAC panel said, “This is quite different from the MMR vaccine,” referring to the measles, mumps, and rubella vaccine given to all children in the U.S. “We know that vaccine is safe. We have tested that vaccine for decades. And we know, we have a very good sense, of what the adverse events are. We do not have that with this particular messenger RNA vaccine.” There has always been an option to opt out of vaccines with little to no issue from the school districts. As school districts will follow your recommendation, I implore you to NOT make the Covid 19 vaccine required to attend public school in Washington State. By mandating this in the Washington State schools you would be leaving children out, many children who have shouldered so much burden already.

Hearing the terms "safe and effective" with regards to the COVID vaccine isn't accurate. We know that it was "safe" for around 2000 children country-wide, we know that it "may" also be effective for 2 months. We don't know beyond that. The Pfizer Study was very limited in scope and time.

I shouldn't have to uproot my child from all they've known because they'll be excluded from Washington State Schools. As a parent, I should have the choice about the medical procedures my children receive.

I will pull my child from school and homeschool my son if the vaccine is mandated.

The impact this will have on many families is awful. Many will be forced to homeschool their children which will result in job loss due to the hours needed to facilitate these needs. The impact on our most vulnerable children would be great and many would never recover as adults.

Thank you in advance for hopefully making decisions that take into account the entire

population of Washington State and not just the ones that are most vocal.

Sarah

From: Tiffany Atwood
Sent: 11/5/2021 11:40:20 AM
To: DOH WSBOH
Cc:
Subject: I have done my research - Have you -Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Dear Board Members,
I have done my homework...have you and will you? Why the rush and all the enticement for this untested vaccine? As a parent, I go to great lengths to make sure my kid is safe and I know all my friends and family would do the same! So why do we need to be coerced into giving our children a "vaccine" that has not been tested and we know at this point does not stop someone from getting covid or spreading it.

I have looked into the numbers and this is what I found on the CDCs and www.childstats.gov <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.childstats.gov%2F&data=04% websites. THere are 73 million children in the United States and a total of 185 kids between ages 5-14 have died due to Covid... according to their numbers. No children should be dying, but the fact is, this "vaccine" has not been tested on children. We have no idea the side effects this may have on them! With odds that slim and not knowing what the vaccine may do in the long term, I will choose my choice of medical freedom for my child and protect him naturally!

Our kids DESERVE a state/government who is truely out for their good and parents who are willing to do the research and CHOOSE for themselves.

The FDA conceded it doesn't know the long term effects of the vaccine on kids. I will leave you with this quote from a voting FDA Board Member:

FDA Voting Member: "We're never gonna learn about how safe the vaccine is until we start giving it"

Listen, if other parents want their children to be in the test pool for this, it is their choice to do so.... but do not mandate this for all parents for their kids to attend school. You will most likely see a mass exodus from the public school system at that point!

Sincerely
Tiffany Atwood

From: Hope
Sent: 11/5/2021 11:46:43 AM
To: DOH WSBOH
Cc:
Subject: The vaccine does not stop infection, transmission, hospitalization, nor death.

External Email

The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that, "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."

_____

From: Kathy Luplow
Sent: 11/5/2021 10:44:16 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members

External Email

To whom it may concern:

It concerns me you are considering mandating Covid 19 vaccines for children to attend public schools. This decision is far reaching.

Many parents don't want to give their children a vaccine that is still under Emergency Use Authorization (EUA). Yes, Comirnaty was approved, but it is still not in production in the US. The label on the vials for children is still the Pfizer BioNtech, which is under EUA. That means it is not approved. You can't legally require a vaccine that is still considered experimental.

If this shot is mandated, many parents will pull their children out of school. This will impact funding to the schools, lower numbers will impact the amount of staff schools need, thus Teachers and support staff risk losing their jobs.

Children are the least impacted by COVID19. Letting them get the natural immunity now while they are young, protects them in the future against all new variants.

As you can see, it's not in the best interest for the schools, or the children to mandate this shot to attend school.

Kathy Luplow

Sent from my iPad Sent from my iPad

From: Kandice Ripplinger
Sent: 11/5/2021 7:53:04 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Good morning,

I respectfully ask that you do not enforce COVID-19 vaccinations be enforced on my children nor add these vaccines to the requirements to attend public school. Children are at an extremely low risk for infection of SARS-CoV2. In addition, these vaccines do not stop infection nor stop the spread from an infected person. Finally, lack of long term side effects have not been established and I do not intend to allow my children to participate in this experimental vaccine. Please look at the scientific research that is currently available worldwide and consider alternative practices in keeping the public safe. My childrens' health and safety are of utmost importance to me and my concerns are valid.

Respectfully,

Kandice Ripplinger

_____

From: Cori
Sent: 11/5/2021 7:00:13 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

I would like to make a comment on the upcoming decisions on mandating vaccinations for our children. I am a healthcare provider and have seen first hand the injuries being sustained from the vaccines. I have also seen - with the right support early on- many people - especially children recover from Covid.
I would not under any circumstance vaccinate my children. Both my husband and I (he is a fire fighter) work full time. If we have to homeschool our kids- one of us is out of a job. Now you have lost another health care worker or firefighter and robbed my children of normal education.
I am stating this because I am not the only parent that feels this way.
Mandating this will not help protect us it will create the worst economic crisis this country has seen.

Again- mandate or not- there is no way I would do this to my children. The only thing the mandate will do is make our lives harder to live.

Thank you
Cori Goodmansen

Sent from my iPhone

_____

From: Wendy Butzerin
Sent: 11/4/2021 10:01:13 PM
To: DOH WSBOH
Cc:
Subject: Please do not Mandate Covid Vaccines in our Schools

External Email

Members of the Washington State Board of Health,

Although Covid Vaccines are not mandated in our schools yet, I would like to be proactive and share my concerns about this subject. I am writing to you both from the perspective of a parent and of a paraprofessional. I have not seen any serious cases of Covid in children in our school. Children are not at great risk of hospitalization or death of Covid. The CDC admits this, and yet there are real risks with the vaccine as shown already with other age groups. My greatest concern with the vaccine is myocarditis. I know of a teenager and a young adult who now have myocarditis after taking the Pfizer vaccine. The Vaccine Adverse Effects Reporting System has shown a big increase in cases of myocarditis in our teenagers. How do we know that the young children will not develop myopericarditis? In fact, because there is a real risk, parents should be allowed to make this choice with their doctor. Schools should not require this vaccine. An advisor on the FDA council Eric Rubin said "We are never going to learn how safe this vaccine is unless we start giving it" Do we really want to experiment with our children?

Sincerely,
Wendy Butzerin

_____

From: Laurie Angiuli
Sent: 11/4/2021 9:33:23 PM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

November 4, 2021

To Whom it May Concern:

As a mom, I understand we all want what is best for our children. We want the best health, education, safety, home environment, friends, opportunities, etc. So it is with grave concern that I am writing you with great urgency to please stop from mandatory vaccines for our young children.

The education should be focused on natural immunity of eating right, exercising, taking vitamins, good mental and emotional health and loving relationships. The focus the entire time Covid has been known to the general public, it has always been about the unproven solution and reaction with masks, social distancing, quarantine and vaccines. Covid is hardly a threat to 5-11 year olds with a 99.99% survival rate in that age group. Why put anyone, especially kids, at a risk of infection or worse with a vaccine that has not been out very long and for most of it's shelf life been an experiment?

We believe as parents, the choice to vaccine or not should not be a choice of the state but of the family. The Nuremberg Code and Hippocratic Oath must also come into play here. No one administering these shots can say there isn't a risk of injury or death because those things have clearly happened with countless people around the world. Vaccine injury has affected my immediate family actually due to the J&J Covid vaccine and it's tragic. It needs to stop immediately. People are being injured and people are dying.

I am actually quite disgusted at the ingredients of these vaccines. To offer MRNA, fetal tissue and countless harmful toxins into anyones body should not be allowed or even a consideration. And to make mandatory vaccines to a group of people who aren't even a threat or being threatened by Covid is highly suspect and wrong.

Employees from the CDC and the drug companies that manufacture these shots are recorded as saying how wrong they are. Doctors and nurses all over the world are risking their livelihood by not agreeing to have these vaccines themselves. Does this make you ponder? Wonder? Contemplate? Question? It does me and that is why I am writing you and imploring you NOT to make this mandatory for anyone. I believe in the facts I have not only gathered but seen with my own eyes.

This is big-time over-reach when it comes to government control. I don't tell you what to insert or inject into your body, so you don't have the right to tell us.

Sincerely,

A very concerned citizen,
Laurie Angiuli
Edmonds, WA.

From: Debbie Kennedy
Sent: 11/5/2021 10:56:09 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

I am sending this email, to voice my opposition to mandating the covid 19 vaccine for kids. Your willingness to even consider something like this that is hurting and killing adults, should in no way be considered for children. If you are considering this and pass anything that requires children to be vaccine with this potentially harmful vaccine, then the suffering and blood of so many children will be on your hands!!

Debbie Kennedy
Toledo, wa

Sent from Yahoo Mail on Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.onelink.me%2F107872968%3F

From: Sarah Petersen
Sent: 11/4/2021 9:32:02 PM
To: DOH WSBOH
Cc:
Subject: My Public Comments

External Email

As a concerned parent I am asking that you do not require this Experimental Injection for children to attend WA schools. There is still not enough long term data to support safety and effectiveness for adults let alone child. Especially with a relatively low impact on this virus for these age groups. The date reflects these injections do not prevent the spread or prevent illness. The data that is coming out from multiple reporting systems is that is is causing more harm than good. Our children have suffered enough, let's not cause life long suffer for them. Please we are begging you put our children's futures, mental, physical and health first !!!!! They are not test subjects they are innocent human beings.

Best Wishes
Concerned Parent

From: Chris Lapins
Sent: 11/4/2021 8:45:07 PM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

To the Washington State Board of Health:

I am writing to express my disapproval regarding possible Covid-19 vaccine mandates for elementary school children. My disapproval comes directly from the fact that children are at the lowest risk for infection & as a result there is no health crisis among them. Additionally, each available vaccination has been only approved by the FDA under "emergency use authorization". As such these vaccines are all experimental and their long term effects are unknown. It would be not only superfluous to require this particular vaccine for young children, but also heinous. I hope that this be taken seriously into consideration by the BOH during the next meeting and all sequential meetings thereafter.

Thank you for your time,
Chris Lapins
King County Resident

From: Cathy Schlieman
Sent: 11/5/2021 6:38:13 AM
To: DOH WSBOH
Cc:
Subject: NO to vaccines for kids

External Email

To The Washington State Board of Health:
I heard you are responsible for setting vaccination policies, including the vaccinations required for school/daycare attendance, in Washington. In your November 11 meeting, If you happen to talk about whether to mandate the Covid vaccine for kids, please say, "NO!"
- There is no COVID health emergency in children 5 to 11
- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.
- Vaccine injury from these vaccines is "real, not rare" and parents must have the final say in their children's medical care.
- Transmission of COVID-19 among children in schools and daycares is very rare.
- According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.
- There are no adequate long-term safety studies of mRNA covid vaccines for kids
- This is NOT a FDA approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental
drug.
- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12-
to 17-year-old age group.
- The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event
Reporting System (VAERS)" showed astonishing increases in the youngest age brackets.
- Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.
- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that, "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their
population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."
- Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to adults.
Please say, "NO!" to any and all vaccine mandates for our children. And All vaccine mandates for adults should STOP now too!
Thank you for listening.
Jeff and Cathy Schlieman, very concerned grandparents who do NOT want their grandchildren nor anybody required/mandated to be vaccinated.

From: leanne ojala
Sent: 11/4/2021 10:18:10 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Hello-
Fully vaccinated mother of fully vaccinated kids here…but not this experimental injection. I will not touch this substance for myself or my family until the long term effects can be studied. This is not now. If you mandate this, you are subject to the Nuremberg code. End tyranny now! This is a thinly veiled political power grab.
EUA is granted when there is no other treatment available. We know there are other effective treatments for COVID. EUA should be rescinded immediately. Pharmaceutical companies are relieved from liability when substances are approved under EUA. Rescind the EUA, as cheaper options are available and effective in their application. The FDA approved experimental vaccine, COMIRNATY has been approved. Who is getting this one? Available in America? No. So all injections offered here are still under a liability shield. Stop this monkey business. This virus exists, it just has a small mortality rate. Especially in children. Asymptotic spread has been disproven. There are therapeutics available. The risks of myocarditis, pericarditis, clots, and reproductive issues outweigh the risks stemming from this treatable virus. Do NOT mandate this experimental vaccine for our children.
Sincerely,
Leanne Ojala

Sent from my iPhone

From: TKfamily 96
Sent: 11/5/2021 8:34:17 AM
To: DOH WSBOH
Cc:
Subject: OPPOSE mandates

External Email

To Whom It May Concern,

I stand against mandated Covid vaccines for children for the following reasons:

- There is no COVID health emergency in children 5 to 11
- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.
- Vaccine injury from these vaccines is "real, not rare" and parents must have the final say in their children's medical care.
- Transmission of COVID-19 among children in schools and daycares is very rare.
- According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.
- There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine.
- This is NOT an FDA-approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental drug.
- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12- to 17-year-old age group.
- The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event Reporting System (VAERS)" showed astonishing increases in the youngest age brackets.
- Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms, and extreme fatigue.
- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to the level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that "countries with a higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."
- Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children.

Respectfully,

Kati J Naatus

From: Coley Mowers
Sent: 11/5/2021 11:29:12 AM
To: DOH WSBOH
Cc:
Subject: Mandate

External Email

Hi, I am writing to say I am highly against the school mandate for the vaccine. If it is required I will be homeschooling my kids. Thank you!
Nicole M

_____

From: Stacy Rody
Sent: 11/5/2021 10:33:34 AM
To: DOH WSBOH
Cc:
Subject: Leave My Kids Alone

External Email

To whom it may concern-

Please listen to us parents! I do NOT co-parent with the government!!

- There is no C0VID health emergency in children 5 to 11

- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored

- Jab injuries are "real, not rare" and parents must have the final say in their children's medical care

- Transmission among children in schools and daycares is very rare

- According to published data by the CDC, 99.99815% of children who contract survive

- There are no adequate long-term safety studies of mRNA jabs because the placebo group was "unblinded" and allowed to get the jab

- This is NOT FDA approved. FDA will expand the EUA to include children as young as 5. In other words, any mandate for children is of an experimental drug

Stacy Rody
--

Sincerely,

Stacy Rody
253.576.5676

From: inspire aware
Sent: 11/5/2021 6:53:32 AM
To: DOH WSBOH
Cc:
Subject: Item of concern

External Email

Hello,
I wish to express my significant reservations about any vaccine mandates for our young children ages 5-11.
As a Child Psychiatrist I am particularly concerned about the potential impact on children's developing neurologic and musculoskeletal systems.
The COVID vaccines remain experimental and less than adequate testing was done before release to the public.

* The Pfizer mRNA vaccine has caused devastating injuries in some youth, including myocarditis and pericarditis. The CDC's own analysis of "Myopericarditis following Covid-19 vaccination: Updates from the Vaccine Adverse Event Reporting System" shows astonishingly high incidence in the youngest age brackets.
* Healthy adolescents ages 12-17 who have been given Covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.
* I am all for public health measures to support the healthy immune systems of children. Sadly our public health system is failing in equipping parents to attend to fundamentals like good diet in support of the body's innate immune system.
* I greatly appreciate your time in reading this message and request that you thoughtfully decline any hasty measures to fast track the COVID 19 vaccines in youth.
* Respectfully submitted,
* Mary F Zesiewicz, MD

From: Becky Gallagher
Sent: 11/5/2021 11:21:15 AM
To: DOH WSBOH
Cc:
Subject: Proposed covid vax school requirement

External Email

To whom it may concern,
My family is 100% opposed to the proposed requirement to have covid vaccination added to the list of required immunizations for school.

Children are at an extremely low risk for contracting covid, and it is unnecessary to inject them with a rushed vaccine that has had no time passed to see the long term effects. We have already seen the short term effects (such as myocarditis), and I am not risking my children's health to an unknown vaccine.

Respectfully,
Rebecca Gallagher

Get Outlook for iOS
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Faka.ms%2Fo0ukef&data=04%7C0

From: Karam Mann
Sent: 11/5/2021 11:20:55 AM
To: DOH WSBOH
Cc:
Subject: Covid Vaccine for Kids!

External Email

To whom it may concern,

I believe forcing our kids to get the Covid vaccine in order to attend PUBLIC SCHOOL is NOT right!

This vaccine is too new and I am not willing to experiment with my children's lives.

We have all gotten Covid, and for all 5 in our family was nothing more than the flu! Not to mention 5 of our friends who are vaccinated ALL have gotten Covid!

If this becomes a mandate I will pull all 3 out of public school!

Karamvir Mann

From: Gary Eduardo Perless
Sent: 11/4/2021 10:38:20 PM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

As a parent of a 9th grade student, as well as a certified Science Teacher for 30 years, I am appalled that the Board of Health is denying the science of natural immunity and pushing a vaccine agenda for kids. Science shows kids are at low risk from covid, so why risk the side effects on your own kids?
The safety and efficacy of these experimental shots is questionable, and since there is evidence that injecting spike proteins has led to serious injuries, including blood clotting, heart problems (myocarditis), and miscarriage in pregnancy, I demand that you stop promoting covid vaccination of kids! Instead, promote real science education on nutrition, improve the quality of school lunches, and encourage more time outdoors to make Vitamin D!
Thanks for listening.

--

Gary "Eduardo" Perless
Ecological Education, Conservation,
and Restoration
photo galleries: travelswitheduardo.photoshelter.com
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Ftravelswitheduardo.photoshelter.cc

From: asoffes
Sent: 11/5/2021 10:05:04 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

I am a longtime Washington state resident and want to voice my opinion in regards to Washington state's Covid19 rules. Please don't mandate that children age 5 and up

need a Covid19 shot for attending school or extracurricular activities. I have done a lot of research on the subject and looked at both sides of the issues andfound the following to be true:

-there is no health emergency for children 5 - 24

-natural immunity is part of herd immunity
- 99.99815% of children that get Covid19 survive

-transmission in and by children is rare

-the available Pfizer vaccine is NOT FDA approved; it is experimental

-vaccine does not prevent infection

-injuries from the vaccine are real, not rare and parents should have the final say, not

the government or its departments.

-there are a lot of parents who want to have their kids vaccinated which is their decision, but don't force the others to have to do something they don't agree with.

Sent with ProtonMail
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fprotonmail.com%2F&data=04%7
Secure Email.

From: Christi Davisson
Sent: 11/5/2021 11:12:29 AM
To: DOH WSBOH
Cc:
Subject: Opposed to mandate

External Email

Hello,

I am writing to oppose any mandate for kids to get the Covid vaccine to go to school. My kids need to be in school but I am not ready to get them the Covid vaccine. I need much, much more time before I can make that decision. Please do not impose a mandate for an emergency only approved vaccine that is largely unnecessary for children as they are not high risk for Covid.

Regards,
Christi Davisson

Get Outlook for iOS
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Faka.ms%2Fo0ukef&data=04%7C0

From: A.J. Johnson
Sent: 11/5/2021 8:21:01 AM
To: DOH WSBOH
Cc:
Subject: comments for 11/10 board meeting

External Email

Dear Mr. Grellner, Mr. Pendergrass, Mr. Kutz, Ms. Crawford, Ms. Lentz, Ms. Crockrell, Ms. Bessermin, Mr. Lutz, and Dr. Shah:

PLEASE DO NOT mandate the COVID-19 inoculation(s) for our children in WA State! There is NO COVID-19 health emergency in children 5 to 11! According to the published data by the CDC, 99.99815% of children who contract COVID-19 survive!

Thank you for your time and sincere, unbiased consideration!

Respectfully,

Anthony Johnson

Spokane Home Owner in the Mead School District with four children all under 12 years of age.

From: jaden.singh@yahoo.com
Sent: 11/5/2021 11:31:06 AM
To: DOH WSBOH
Cc:
Subject: Vaccine and School Kids!

External Email

To whom it may concern,

I believe getting the Covid vaccine should not be a mandate for our kids to go to public school!

This is too new and I am not willing to experiment with my children's lives.

If this becomes a mandate I will pull all of mine out of public school!

Jaden

Sent from Yahoo Mail on Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.onelink.me%2F107872968%3F

From: Georgia Klinkenberg
Sent: 11/5/2021 10:18:04 AM
To: DOH WSBOH
Cc:
Subject: F277795C-758B-4EBE-BBAD-D61C53C43A8C

External Email

LEAVE OUR CHILDREN ALONE, WE, THE PARENTS ARE RESPONSIBLE FOR ANYTHING THAT GOES IN THEIR BODIES. AND ALSO OUR BODIES. NO SHOTS

Sent from Mail <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.microsoft.com%2Ffwlink%2F% for Windows

---

From: Johanna Longacre
Sent: 11/5/2021 11:01:51 AM
To: DOH WSBOH
Cc:
Subject: Covid Vaccine for Children

External Email

Dear Board Members,

There is much talk lately about vaccinating children between the ages of 5 and 12 years of age. As a pediatric nurse this greatly concerns me. According to published data by the CDC children have a 99.998% chance of survival after contracting Covid-19. Statistically this is considered 100% survival rate. The argument that we need to vaccinate children in order to protect those around them is not valid. Vaccines are intended to protect the one who receives the vaccine. This has historically been the sole purpose of vaccination.

Earlier this week (Nov. 1, 2021) Senator Ron Johnson hosted a roundtable discussion of numerous people who have had serious adverse reactions to the Covid-19 vaccine. All these individuals took the vaccine willingly. Each confessed to being pro vaccine. Senator Johnson invited members of the CDC, the NIH, Fauci and numerous others to come listen to those who have been harmed by the vaccines. Not one accepted the invitation. I beg you all to listen. To view this discussion click here <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Frumble.com%2Fvokrf7-sen.-johnson-expert-panel-on-federal-vaccine-mandates.html&data=04%7C01%7Cwsboh%40sboh.wa.gov%7Ca00144300b634f7151b008d9a0863ad8%7 and fast forward to the 30 minute mark. Please do not harden your hearts.

Playing with our children's lives is unconscionable. Dr. Eric Rubin, editor-in-chief of the New England Journal of Medicine, expressed concern about the possible severe side effects of the vaccine that cannot be measured. However he went on to say "We're never going to learn about how safe the vaccine is unless we start giving it." His comment chills me. Our children are not lab rats. They are human beings created in the image of God.

Studies in Israel have shown that vaccination does not prevent one from contracting or transmitting Covid-19 or its variants. Anecdotal evidence confirms the studies. I have known several people who have contracted Covid-19 after vaccination and one family friend who died of Covid-19 three days ago even though fully vaccinated.

Please, do right!

Johanna Longacre

From: Sadie Arnold
Sent: 11/4/2021 8:49:18 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

To whom it may concern,

I am a mother of two teen boys. My children are fully vaccinated for all vaccines, except covid 19. Our family all had covid 19 in August 2021. We have tested our antibodies and our markers are well over 4000. The standard vaxxed individual has .4 antibodies.
It is unequivocally unethical and flat out deadly to require covid 19 vaccinations among children. The flu kills more children and adults each year than covid has. Schools do not require the flu vax! The risk implications of the covid 19 vax far outweigh the benefit.
I urge you to not require covid 19 vaccinations for children to attend school. Who is held accountable when an emergency vax is administered to a child who must get the vaccine to attend school, then is injured due to the vaccine? The state.

Sincerely,

Sadie Arnold

From: btimpke@comcast.net
Sent: 11/5/2021 10:02:27 AM
To: DOH WSBOH
Cc:
Subject: November 10 Washington State Board of Health Meeting

External Email

I am writing concerning the State Board of Health meeting on November 10 to discuss a Covid-19 update. I am very concerned about the safety issues concerning the Covid vaccines, especially concerning the push to vaccinate children. I'm concerned because the Pfizer mRNA vaccine has caused devastating injuries in some youth, including myocarditis and pericarditis. It's very troubling that the CDC's own analysis of "Myopericarditis following Covid-19 vaccination: Updates from the Vaccine Adverse Event Reporting System" shows astonishingly high incidence in the youngest age brackets. I urge the Board of Health to take this into consideration when giving updates on Covid-19.

Belinda Timpke
Tacoma

From: Ann Lapinsky
Sent: 11/5/2021 11:37:40 AM
To: DOH WSBOH
Cc:
Subject: Vaccine mandate

External Email

I have two children in the snohomish school district. We will not be getting the vaccine for our children and will pull our children from the schools if you go forward with this mandate.
Thank you
Ann Lapinsky

Sent from my iPhone

From: Sara Scheidt
Sent: 11/4/2021 10:15:37 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

attachments\F8C9D23A840C47D1_Screenshot_20210909-185958_Facebook.jpg

attachments\5B9F28FEE29A4A35_Screenshot_20210909-060623_Facebook.jpg

attachments\51A0BFDE023C4818_Screenshot_20210912-202014_Facebook.jpg

attachments\ED3486983E8F4A49_Screenshot_20210911-131936_Facebook.jpg

attachments\BB198EFED60C443D_Screenshot_20210910-055106_Facebook.jpg

attachments\335E1EE36A724BF7_Screenshot_20210911-131900_Facebook.jpg

attachments\73A1A5C4A0554C2D_Screenshot_20210911-123025_Facebook.jpg

attachments\C917443A3C194815_Screenshot_20210909-072751_Facebook.jpg

External Email

Sent from Yahoo Mail on Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.onelink.me%2F107872968%3F

From: Jessica Welcome
Sent: 11/4/2021 9:11:50 PM
To: DOH WSBOH
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Hello,

We have 5 kids in the Washington school system and I pray you aren't going to mandate this Covid vaccine for the kids. This has not been tested long enough and is not even proven to be safe and effective for all adults. Besides the fact that our kids have such a low risk of contracting let alone dying from Covid, this mandate is morally wrong. If you decide to mandate this Covid vaccine for our kids we will be pulling all 5 out of the public school system. I have talked to many other families who are prepared to do the same. We live in America where we are free to chose what to do with our God given bodies. Nobody has the right to tell us what will be injected into our bodies! These are our children and nobody messes with our children. I hope you are prepared for the fall out you will have with thousands leaving the public schools if you go thru with this mandate. Please give us the right to chose what is best for our children and our families. This is a personal choice, not a government choice. I hope you make the ethical decision for our kid's sake by protecting them from this vaccine.

Thank you,

Jessica Welcome

Sent from my iPhone

From: Bev and Doug Knudsvig
Sent: 11/5/2021 11:14:39 AM
To: DOH WSBOH
Cc:
Subject: Yes, add my name to the Board's email distribution list

External Email

Beverly and Douglas Knudsvig

From: melbar62@gmail.com
Sent: 11/5/2021 10:28:27 AM
To: DOH WSBOH
Cc:
Subject: Vaccine mandates

External Email

Please don’t mandate vaccines, especially for children.

Melinda

From: Kerry & Debbie Horner
Sent: 11/5/2021 10:19:12 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Dear Sirs/Madams,

We sincerely thank you for considering our comments and concerns in this matter. We ask you in the strongest possible terms to please prohibit the administration of the experimental COVID vaccines to young children. The potential of long term adverse effects of these products is not yet borne out. Young children are at extremely low risk of severe illness from the COVID virus. If they do become ill with this virus, the odds are nearly 100% that they will recover completely. The risks of these experimental products outweigh the possible benefits in young children. Please do what is right and err on the side of caution by preventing this troubling trend from becoming policy in Washington State.

Sincerely,

Kerry & Debbie Horner

From: Beth Brown
Sent: 11/4/2021 9:13:05 PM
To: DOH WSBOH
Cc:
Subject: WA Board of Hlth Webinar 11/10/2021

External Email

Board Members,

There is no COVID health emergency in children ages 5 to 11, as data published by the CDC shows that 99.99815% of children who contract COVID-19 survive.

Transmission of COVID-19 among children in schools and daycares is also very rare.

Pfizer's BNT162b2 is NOT FDA-approved, it has simply received EUA. In other words, it is still in an experimental stage.

There are no long-term safety studies of mRNA COVID vaccines, and they have not yet been evaluated for carcinogenic potential or for impairment of fertility.

Injury from these products is real, not rare, and so the parents must have the final say in their children's medical care.

According to data available from the Vaccine Adverse Event Reporting System (VAERS), as of October 22, there had been a total of 16,716 reports of adverse events, including 1,435 serious reactions and 27 deaths in the 12- to 17-year-old age group. It is logical to surmise that younger children who cannot tolerate pharmaceuticals as well as older kids will have more reactions and more deaths.

The Pfizer mRNA vaccine has caused devastating injuries in some children, including myocarditis and pericarditis. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event Reporting System" shows astonishingly high incidence in the youngest age brackets.

Healthy adolescents ages 12-17 who have been given COVID vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.

Please seriously consider these facts. Encouraging good hygiene and social distancing is a reasonable solution, but encouraging constant mask-wearing and experimental, irreversible vaccines to children of any age is not.

Thank you,

Elizabeth Brown

Sent from ProtonMail mobile

From: lisa macrina
Sent: 11/5/2021 10:42:42 AM
To: DOH WSBOH
Cc:
Subject: Vaccines

External Email

With all due respect we are against forced experimental vaccines for our children as well as the general population. Who is responsible if something goes wrong? Can the safety of a child who has severe unknown allergies be guaranteed? What about natural immunity? There are now well over 90 studies with results saying natural immunity is as good or better. Why isn't science being followed? What about all the reported vaccine injuries? When will the FDA approved version be available in the US?
There just seems to be too many unknowns with this experiment. I hope you will consider not making them mandatory until more safety data is known.
Sincerely,
John and Lisa Macrina

Sent from my iPhone

From: The Foremans
Sent: 11/4/2021 11:05:43 PM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Say no to covid 19 vaccination for children. They are not in a high risk group and it looks to me like the risk of vaccine injury is high, especially compared to covid19 severity in children. A lot of kids are testing positive and having no symptoms. Their body is learning how to fight this disease without a need for a vaccine. Especially now, with time on our side. So much has been learned about early prevention, and fighting this with the proper protocol.

From: Jennifred62
Sent: 11/5/2021 10:33:50 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Please do NOT mandate the injection for students. They are not at risk from the Covid virus. Where there is a risk of vaccine side effects, there should be a choice. Please protect our kids! Thank you.
Jennifer Holmes
Renton, WA
Educational Tutor

From: frieda stephens
Sent: 11/4/2021 8:45:35 PM
To: DOH WSBOH
Cc:
Subject: No Covid Vaccine for children

External Email

To Whom it May Concern,

I am asking that this Covid Vaccine mandate for children in daycares or schools not be implemented. Since these vaccines are only authorized for emergency use and no one, not even children, should be forced to take these vaccines. Covid-19 and all its mutations are not a high risk for infection in children. Children, ages 12-17 have suffered more harm from the vaccine than the number of children who suffered death or permanent injury from Covid-19. It's unlikely children will ever pass the illness to an adult.

Why would you subject a child's risk of injury or death from the emergency use vaccine in order to possibly protect the life of an adult?

I am asking that you make the right decision to allow parents to decide NOT COERCED and FULLY informed of the risks, if any, of the Covid Vaccines are right for their children.

Thank you

Frieda Stephens

PO BX 9201
Yakima, WA 98909

_____

From: Moriah Hawkins
Sent: 11/5/2021 9:22:34 AM
To: DOH WSBOH
Cc:
Subject: NO CHILD VACCINATION MANDATE!!!!

External Email

To the Washington State Board of Health

As a parent with children in the school system in Washington, I have grave concerns about the covid vaccinations for any child and I hope you take into consideration the reasons why a vaccine mandate should NOT happen.

- There is no C0V!D health emergency in children 5 to 11
- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.
- Jab injuries are "real, not rare" and parents must have the final say in their children's medical care.
- Transmission among children in schools and daycares is very rare.
- According to published data by the CDC, 99.99815% of children who contract survive.
- There are no adequate long-term safety studies of mRNA jabs because the placebo group was "unblinded" and allowed to get the jab.
- This is NOT FDA approved. FDA will expand the EUA to include children as young as 5. In other words, any mandate for children is of an experimental drug.
- According to the data from VAERS as of Oct 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12 to 17-year-old age group.
- The Pfizer mRNA jab causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis: Updates from VAERS" showed astonishing increases in the youngest age brackets.
- Healthy adolescents aged 12-17 who have been given the jab have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.
- The jab does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in c0v!d are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States."

Thank you!

From: Gerald Braude
Sent: 11/5/2021 12:18:06 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

To the Washington Board of Health:

During a panel hearing held by United States Senator Ron Johnson on Tuesday, November 2, Ernest Ramirez reported that his sixteen-year-old son, following a Pfizer COVID-19 EUA shot, which according to the CDC and other studies does not prevent transmission, collapsed on the basketball court and died from myocarditis. The father cried to the panel and said, "This is murder." As my throat choked with tears, I nodded in agreement.

During the same panel hearing, a mother reported that her daughter, at the age of twelve, received her second dose as a Pfizer clinical trial participant for twelve through fifteen-year-olds. Her reactions to the second dose on January 20 disabled her badly enough that she is now in a wheelchair.

The VAERS web page on the CDC site currently shows twenty-five deaths reported for twelve through seventeen-year-olds. The most recent death involves a twelve-year-old girl (VAERS I.D. 1784945) who died from a respiratory tract hemorrhage twenty-two days after receiving her first dose of Pfizer's EAU shot. Another recent death was a fifteen-year-old male who died six days after receiving his first dose of Pfizer's EUA shot. An autopsy showed a small subgaleal hemorrhage — a rare, but lethal bleeding disorder — over the left occiput. In addition, the boy had a mildly elevated cardiac mass, increased left ventricular wall thickness and small foci of myocardial inflammation of the lateral wall of the left ventricle with myocyte necrosis consistent with myocardial infarction.

According to the VAERS web page on the CDC site, these twenty-five deaths are just part of the 17,619 reported deaths in the United States and its territories, such as Puerto Rico and Guam. Of the 8,068 deaths reported in the United States as of October 22, 11% occurred within twenty-four hours of vaccination, 15% occurred within forty-eight hours of vaccination, and 27% occurred in people who experienced an onset of symptoms within forty-eight hours of being vaccinated. The CDC notes on its web site that their studies have shown no causal relationship between these deaths and the EAU shots. They have yet to make these studies available to the public.

The VAERS web page shows that 167 of these deaths following the EUA jabs have occurred in our state of Washington. As a widower and father of a twenty-three-year-old son, the death of Jessica Berg Wilson shook me up the most. She was mandated to take the shot in order to be a classroom mom with her kids. The continuing mandates by our governor and attorney general show that they believe in utilitarianism, which is the sacrificing of the few for supposedly the benefit of the whole. I do not share this belief. Do you share this belief?

Gerald Braude
Port Townsend

From: Debbie
Sent: 11/4/2021 9:08:05 PM
To: DOH WSBOH
Cc:
Subject: Comment for 11/10 board Meeting

External Email

COMMENT FOR 11/10 BOARD MEETING

Dear Mr. Grellner, Mr. Pendergrass, Mr. Kutz, Ms. Crawford, Ms. Lentz, Ms. Crockrell, Ms. Bessermin, Mr. Lutz, and Dr. Shah:

PLEASE DO NOT mandate the COVID-19 inoculation(s) for our children in WA State! There is NO COVID-19 health emergency in children 5 to 11! According to the published data by the CDC, 99.99815% of children who contract COVID-19 survive!

Thank you for your time and sincere, unbiased consideration!

Respectfully,
Debbie Roth
Spokane Home Owner in the Mead School District

Sent from my iPad

_____

From: Vui Hoang
Sent: 11/4/2021 9:28:23 PM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

To Whom It May Concern:

Given the infections of Covid-19 and its adverse effects on children are so very low and so much less serious than the critical population group, to push these Covid-19 vaccines on young children appears excessive and unwise. There has never been any drugs or vaccines in history that has moved through warp speed like the Covid-19 vaccines, which skipped key time-tested trials, ignored abundant negative side effects resulted thus far, and bullied by over-reaching parental / citizen rights to care for themselves or their minors as the Covid-19 vaccines have. Something is truly wrong here! This must cause one to wonder the true motive for the massive push of these vaccines: what are we doing to our children. The state and the nation are wasting time, money, and resources on segments of the population (children) that have the natural strength and ability to fend natural diseases such as these.

I implore you to please stop the push of Covid-19 vaccines on the children!

Thank you,
V. Hoang

From: Elizabeth
Sent: 11/5/2021 9:06:50 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

As a 70-year old retiree who worked all my life and raised a healthy and contributing famlly to our country, I wish to go on record as OPPOSING COVID 19 vaccine mandate for children here in the great state of Washington.

* There is no need for this ... therefore we should not impose a mandate for something unnecessary. There is no proven COVID 19 health emergency in children ages 5-11.

* There are no long-term studies showing what effects the injection can have on this age group of children. The risk/benefit is not there to call for a mandate at this time.

* The injection does not prevent infection or transmission. Over 90% of our elderly are already vaccinated ... and they are the key demographic for deathly infection ... and the rest of our population has a 99.5% recovery rate that provides them with natural immunity. Again, it is unnecessary and unknown risks to our children is reason enough to not have a MANDATE for them.

I expect the Washington State Board of Health to OPPOSE COVID 19 mandates for both preschool and school age children in our state.

Thank you in advance for considering my input and I anxiously await your decision to OPPOSE children vaccine mandates.

Elizabeth Storey
3600 57th Lane SE Unit 203
Olympia, WA 98501

_____

From: Christi Maggs
Sent: 11/5/2021 7:28:29 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Washington State Board of Health,

I implore you to not make the vaccine a requirement for our children to attend public school. A drug that is still considered investigational should not be mandated in children during their developmental years. There is not enough research to know the long term effects of the vaccine. Please keep the vaccine optional and allow the parents to make the decision that best suits their family.

Thank you

Sent from my iPhone

_____

From: Sharon Cattich
Sent: 11/5/2021 8:38:02 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

To whom it may concern,
My name is Sharon Cattich and I am the parent of 4 wonderful children, 3 of whom are in public school and one son who is autistic and in day programs outside of school.

It has recently come to my attention that the WA State Board of Health is meeting today to discuss mandating the Covid Vaccine for children for school attendance. I am writing to express my extreme dismay that you would consider requiring an emergency use authorized vaccine for children and urge you to vote no to this concerning Mandate.

The research on whether this vaccine is safe in children is extremely rushed and has had no long term data compiled, which makes me very worried that there is no knowledge of the long term effect of this on children. Particularly concerning is the VAERS data on the vaccine in children who develop myocardial inflammation, stroke, blood clots and paralysis. If this were any other time in history, our medical community would label this vaccine as a black-label product and it would be pulled by the FDA amid concerns for public health and safety.

Given the grave risks this poses to children I urge you to vote NO to this Mandate. If this is required for children in WA I will pull my children from public school, as will millions of other families. That would mean possibly bankrupting school districts as federal funding is removed for each child who is taken out of the public school system.

There is no way this Mandate will benefit the education system in WA, the children, the educators or prevent the spread of Covid. As it is, children are more likely suffer grave injury from this vaccine than death from Covid. I, for one, an not willing to allow the state to injur my children with an experimental vaccine that has no long term data , but which has presented such severe side effects.

I once again urge you to put an end to this proposal and do your civic duty to do what is best for the public health interest of Washingtonians.

Sincerely,
Sharon Cattich

_____

From: Angie Burns
Sent: 11/5/2021 11:32:35 AM
To: DOH WSBOH
Cc:
Subject: WA State proposed mandate for our kids to get the Covid shot in order to attend school

External Email

To whom it may concern,

Getting the covid vaccine should not be mandated for children of this state to attend public school.

This vaccine is too new and parents should not be expected to experiment with their children's lives.

Angela Burns

From: Patti Jo McGrath
Sent: 11/5/2021 11:33:40 AM
To: DOH WSBOH
Cc:
Subject: Mandatory vaccines

External Email

I’m against them and I will lobby and work to replace every single person collecting a paycheck for supporting this. It’s unconstitutional and more so immoral to tell people what they should and should not put in their bodies and it’s parental duty and responsibility to protect their children from oppressive communists. The health department in the state of Washington needs a serious overhaul. That’s my 2 pennies.

Sent from my iPhone

From: malinda lattin
Sent: 11/5/2021 8:49:07 AM
To: DOH WSBOH
Cc:
Subject: COVID-19

External Email

Hello,
Writing in strenuous opposition to any mandates of the Pfizer vaccine for kids. It's up to each parent to decide what's best for their family, and what risks they're comfortable with. The risks for kids in getting COVID are extremely small, and it IS NOT up to children to accept the unknown risks of a new, experimental vaccine in order to protect adults. The BOH should NOT inflict violence on families by forcing them to choose between school attendance and possibly a needed second income, and injecting their children with a new pharmaceutical in violation of their personal beliefs about what's best for their child. This is coercion, and frankly, it's rape culture.
Thanks,
Malinda

From: Reni Storm
Sent: 11/5/2021 11:42:09 AM
To: DOH WSBOH
Cc:
Subject: testimony and comment

External Email

Concerning the mislabeled and misnamed 'vaccine' for covid19, As a retired RN of over 40 years, that is familiar with infection control, medications, and injections, I remit the following:
The vaccine does not prevent infection, transmission, hospitalization, or death. A recent study from the Harvard Center for Population and Development Studies states it plainly. This is not a vaccine, it is an experimental injection,. As such, Human beings, not animals are the control study currently being done without our disclosure.
This egregious injection is given without full INFORMED CONSENT as there is little to NO

package insert on the elements of this injection, nor information from the ones administering it prior to the act; compare this to widely distributed vaccines or injections, medications that is standard for the industry.

ANY Public Health Agency should know this and honor its tenets.
By mandating something that is totally against this tenet, is participating in genocide at the most and murder at the least for every death that occurs from these injections.

From: Becky Black
Sent: 11/5/2021 10:22:32 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

The vaccine should not be mandated for schools and daycares. It is available and people can get it if they want, but children have a very low risk of dying from the disease. So many people have gotten covid that herd immunity is likely already achieved between all the vaccinated people and all the people who have gotten covid in the past. Mandating the vaccine will only cause strife and side effects to those with preexisting conditions that are not healthy enough to receive another vaccine. A person needs to be perfectly healthy in order to get a vaccine, and so the people who have a medical conditions should be able to get an exemption with no difficulty. Religious exemptions should be honored as well. There is no greater purpose in person's life than to glorify their God through care of their body and obeying the god's rules, whatever they may be. Also we cannot know the long-term effects of this vaccine. Children are still developing and if the vaccine causes them harm as they grow up then the next generation will struggle very much. Schools should recommend things to parents, but the final say is the parent's. Schools should not exclude a group because of race or religion or sexual orientation. We should respect each other and each other's decisions.

Sent from Yahoo Mail on Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.onelink.me%2F107872968%3F

_____

From: Jessica Welcome
Sent: 11/4/2021 9:16:50 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Hello,

We have 5 kids in the Washington school system and I pray you aren't going to mandate this Covid vaccine for the kids. This has not been tested long enough and is not even proven to be safe and effective for all adults. Besides the fact that our kids have such a low risk of contracting let alone dying from Covid, this mandate is morally wrong. If you decide to mandate this Covid vaccine for our kids we will be pulling all 5 out of the public school system. I have talked to many other families who are prepared to do the same. We live in America where we are free to chose what to do with our God given bodies. Nobody has the right to tell us what will be injected into our bodies! These are our children and nobody messes with our children. I hope you are prepared for the fall out you will have with thousands leaving the public schools if you go thru with this mandate. Please give us the right to chose what is best for our children and our families. This is a personal choice, not a government choice. I hope you make the ethical decision for our kid's sake by protecting them from this vaccine.

Get Outlook for iOS
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Faka.ms%2Fo0ukef&data=04%7C0

From: Dave McOmie
Sent: 11/4/2021 8:52:35 PM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

No jab mandate for little children, please!

From: Elizabeth Stewart
Sent: 11/5/2021 11:10:37 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

My name is Elizabeth Stewart and I declare children's vaccinations need to be the parents' decision and no one else's. Covid or other.
Thank you for consideration.

From: Cheryl Thompson
Sent: 11/5/2021 10:57:24 AM
To: DOH WSBOH
Cc:
Subject: NO vaccine mandates for children

External Email

To the Washington State Board of Health:

Please DO not require a Covid vaccine mandate to our children. Do NOT mask mandate our children either. Actually no one should be mandated. Most children who test positive for Covid are able to fight it off with their own immunities. We really do not know exactly what is in these vaccines. The decision to shoot up a body should be between the person and their doctor NOT the government. Not only that, many people who have been vaccinated are still getting the Covid. I personally know some of these people. It seems like there is just as much risk in getting the vaccine itself as getting the Covid. This is insane. Seriously NO mandates!!!

Sincerely,
Cheryl Thompson
12750 444 Avenue SE
PO Box 644
North Bend WA 98045
425-442-0242

Get Outlook for iOS
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Faka.ms%2Fo0ukef&data=04%7C0

From: Tammie Springs
Sent: 11/5/2021 11:35:42 AM
To: DOH WSBOH
Cc:
Subject: Vaccine Mandate for Children

External Email

I am writing to you today as a concerned citizen and parent of 3 children in Washington State. My children are all current on all their vaccinations, but we will not be opting to have them get the COVID-19 shot. There are too many risks and unknowns associated with this still-experimental shot and I am not comfortable with exposing my children to such risks.

By their own admission, the CDC acknowledges that the risk of children dying from covid is exceptionally low, and vaccinating 1 million children ages 5-11 would likely result in 106 vaccine-induced myocarditis cases. That's a side effect we know of now, but that's only after three months of testing. Myocarditis is an infection of the heart! That's a dangerous, already known side effect.

I keep on hearing people speaking about how vaccines have always been required to go to school, that's true, but this vaccine can't be equated to that. The CDC actually changed the definition of vaccinations earlier this year on its website to bring them more in alignment with the COVID-19 shot. Previously, a vaccine was "a product that stimulates a person's immune system to produce immunity to a specific disease, protecting the person from that disease." Since it has now been proven that people can still get and transmit COVID-19 even after being "vaccinated" they obviously don't have immunity to that specific disease, so really, what has happened here, is these shots have been brought to market, they've used "positioning" to make them appear equal to tried and true vaccines that have been tested and proven over many, many years, and we're supposed to recognize them just like every other vaccine out there. But we don't know the impact of these shots on our children - we don't know what these could cause in 10-15 years. As Cody Meisner, one of the pediatricians who sits on the VBRPAC panel said, "This is quite different from the MMR vaccine," referring to the measles, mumps, and rubella vaccine given to all children in the U.S. "We know that vaccine is safe. We have tested that vaccine for decades. And we know, we have a very good sense, of what the adverse events are. We do not have that with this particular messenger RNA vaccine."

I implore you to NOT make the COVID-19 shot required to attend public school in Washington State. By mandating this in the Washington State schools you would be leaving children out, many children who have shouldered so much burden already.

Hearing the terms "safe and effective" with regards to the COVID shot isn't accurate. We know that it was "safe" for around 2000 children country-wide, we know that it "may" also be effective for 2 months. We don't know beyond that. The Pfizer Study was very limited in scope and time.
I shouldn't have to uproot my children from all they've known because they'll be excluded from Washington State Schools. As a parent, I should have the choice about the medical procedures my children receive.

The impact this will have on many families is awful. Many will be forced to homeschool their children which will result in job loss due to the hours needed to facilitate these needs. The impact on our most vulnerable children would be great and many would never recover.
Thank you in advance for hopefully making decisions that take into account the entire

population of Washington State and not just the ones that are most vocal.

Sincerely,
Tammie Springs

From: April Harzynski
Sent: 11/5/2021 11:17:48 AM
To: DOH WSBOH
Cc:
Subject: Mandate for covid-19 in children

External Email

To whom it may concern,

I am writing you to ask that you do NOT mandate that children ages 5 to 17 get the covid 19 vaccination, to attend school. It should be up to the parents, whether they feel it is a safe choice or not. Please do the right thing and say no to vaccine mandates, especially for our kids.

Thank you,
April

From: Alissa Miller
Sent: 11/4/2021 10:37:44 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

I strongly urge you to protect the freedom and rights of all parents in this state to make personal decisions about their children's healthcare. The Covid vaccine is new, experimental, and long-term side effects can't be known at this early stage. If this issue is forced and the Covid vaccine becomes mandatory for school attendance, be prepared to have thousands of parents stand up and fight for their children. Lawsuits will be filed, children will be unenrolled by the thousands, and families will suffer the negative consequences of having their freedom of medical choice stolen from them. It would be a mistake to try and force this issue. Many of us simply refuse to compromise our children. We will not comply with any unconstitutional tyrannical mandate that violates our rights as parents.
-Alissa Miller

Sent from my iPhone

From: Stephanie Allen
Sent: 11/5/2021 10:54:32 AM
To: DOH WSBOH
Cc:
Subject: Vaccine mandate 5-11

External Email

This email is to comment on rumored vaccine mandates for children ages 5-11. Please do not mandate this vaccine. Severe cases leading to hospitalization with the flu is a greater threat to children in this age group and flu vaccines are not required. Children in this age group are not likely to impact the number of hospital beds due to COVID. There's not enough data on long term impacts with a high level of variability to shot responses during this critical developmental time. There is no basis for mandating this shot for the young age groups. If family's are concerned, and live in a multigenerational household for example, the shot is available but not appropriate for everyone. Thank you.

Sent from Yahoo Mail on Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.onelink.me%2F107872968%3F

_____

From: Elaws151
Sent: 11/4/2021 9:43:07 PM
To: DOH WSBOH
Cc:
Subject: Fwd: Covid vaccine

External Email

Sent from ProtonMail for iOS

---------- Forwarded message ----------
From: Elaws151<Elaws151@protonmail.com <mailto:Elaws151@protonmail.com>
>
Date: On Thu, Nov 4, 2021 at 9:36 PM
Subject: Fwd: Covid vaccine
To: wsboh@snoh.wa.gov <wsboh@snoh.wa.gov <mailto:wsboh@snoh.wa.gov> >

Cc:
Dear Washington State BOH members,

I urge you to vote NO on mandating the COVID vaccine.

It is too new to know the long term ramifications.

Kids are at an extremely low risk of COVID.

Kids have an extremely low chance of passing the virus on to adults.

The risk of pericarditis or myocarditis in young males creates a far higher rate of hospitalization than COVID itself. This can cause PERMANENT heart damage for a vaccine that is not needed.

Let this be a personal, parental choice.

PLEASE, do the right thing. Do not mandate these vaccines.

Sincerely,

Erin Laws
Lake Stevens

Sent from ProtonMail for iOS

From: jan provazek
Sent: 11/5/2021 8:37:46 AM
To: DOH WSBOH
Cc:
Subject: No mandatory vax for kids!

External Email

Sent from my iPhone

From: Susan Pilon
Sent: 11/5/2021 1:46:39 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

I urge you to protect our children from being harmed and even killed by the MRNa vaccines that we all know are not actual vaccines. They are gene therapy. The VAERS site reports through October 22, 2021 there have been 17,619 deaths, 32,305 severe allergic reactions, 27,277 permanently disabled, 10,956 myocarditis/pericarditis, 10,465 Bell's palsy,8,656 heart attacks, 7,706 anaphylaxis and more. This is not "rare" as the CDC has said. It has been stated many times that only up to 10% of cases are even reported to VAERS.
The real question here is why give these "vaccines" to children when we know that they do not pose a threat to anyone? Covid19 has a 99.98% recovery rate.
It is not the governments job or the schools to implement any healthcare decisions when it comes to our children, that belongs to the parents.

Susan Pilon

Sent from my iPhone

_____

From: Erin Moore
Sent: 11/5/2021 8:33:18 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

Hi,

I am a Washington parent who OPPOSES these mandates! Here are just a few of my reasons why:

- There is no COVID health emergency in children 5 to 11

- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.

- Vaccine injury from these vaccines is "real, not rare" and parents must have the final say in their children's medical care.

- Transmission of COVID-19 among children in schools and daycares is very rare.

- According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.

- There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine.

- This is NOT a FDA approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental

drug.

- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12-

to 17-year-old age group.

- The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event

Reporting System (VAERS)" showed astonishing increases in the youngest age brackets.

- Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.

- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that, "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their

population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."

- Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children.

Please do what is right for our children instead of putting your "funding" before their health and wellness!

Kind regards,

Erin Moore

From: Debbie Correll
Sent: 11/5/2021 11:37:42 AM
To: DOH WSBOH
Cc:
Subject: Vaccine mandate for children

External Email

I am writing to you today as a concerned citizen of Washington State.
I implore you to NOT make the COVID-19 shot required to attend public school in Washington State.
Thank you,
Debbie Correll

From: corey Lapinsky
Sent: 11/5/2021 11:40:46 AM
To: DOH WSBOH
Cc:
Subject: Vaccine Mandate for Kids

External Email

My kids attend a Snohomish school. I oppose making it mandatory for kids to attend school.
Sent from my iPhone

From: Madey Lopes
Sent: 11/4/2021 8:51:14 PM
To: DOH WSBOH
Cc:
Subject: No Vaccine for school attendance

External Email

Requiring the COVID vaccine for children to attend in person school is not something I support. Some of us prefer to have the choice of what we do with our health and bodies. If masks are worn and social distance is maintained why is this required. If the mask and social distancing is ineffective why have we been required to do so for so long.
A pandemic does not go on indefinitely.
At some point this becomes a discrimination against those that choose not to be vaccinated. There is so much division on the topic and how has this changed the stats? There is so many different outcomes to the vaccine and side affects why not let us decide for ourselves?
I vote no mandatory vaccine for children to attend school.
My kids lost a year of education. They were also depressed. Recently I was invited to a party only to read the fine print which said I could only attend if vaccinated.
Give us the choice or divide the school for those vaccinated and those not.
Madey Widmer
Kirkland Wa
Lake Washington School district
Arch Bishop Murphy High

Sent from my iPhone

From: Rianne Melvin
Sent: 11/5/2021 11:04:56 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

I am greatly concerned of the announced Emergency Authorization of the Covid 19 vaccine for children 5-11. These kids have almost no threat of dying from this virus. I have worked in the medical field for over 15 years and everything is always evaluated on a benefit to risk ratio. This by far is not a benefit to these kids. It is only a risk!! Please do not consider mandating this to our kids! This vaccine does not stop people from being infected or stop the transmission. So there is literally zero benefit to our young children. They can not protect others by getting it. They can only potentially have a bad side effect like the reported myocarditis.
Please do not require this for children in school.
Thank you,
Rianne Melvin
3607721844
Sent from my iPhone

_____

From: Tricia Curran
Sent: 11/5/2021 5:13:56 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Dear Board Members,

I am writing to oppose vaccine mandates for our children to attend school. The K-12 population is at almost zero risk of death from COVID-19. A vaccine cannot increase their chances of a positive outcome. It can only increase their chances of an adverse reaction from the vaccine, particularly in the male population. I implore you to do the right thing and protect our children. Vaccines are available for the at risk population (which does NOT include children) so there is no need to vaccinate children "to keep others safe" if vaccines do in fact work.

Respectfully,

Patricia Curran

Sent from my iPhone

From: Brooke Siglin
Sent: 11/4/2021 8:32:35 PM
To: DOH WSBOH
Cc:
Subject: Health Advisor

External Email

Hello,

I would like to respectfully request consideration of covid 19 natural immunity when setting vaccine policy.

The body, once infected, can subsequently mount a robust defense when exposed to a similar virus. This immunity has served humans since the beginning of time. Many essential workers had the virus during the first year of the pandemic. They survived and now have immunity. They do not want to mess with the body's way (which is far superior to any invented medicine) by injecting a therapy.

Injection therapy or medical intervention should never be required of a survivor with natural immunity. Shots should never be required to be able to work. Sovereignty over one's own body is the most fundamental human right.

Sincerely,

Brooke Siglin
5715 E 21st Ave
Spokane, WA 99223

From: Brandi Ohashi
Sent: 11/4/2021 10:48:14 PM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Covid vaccines should NOT be mandated or required for children. There are far too many unknowns with the vaccine and how it may affect children, and no parent should be forced to make the decision to vaccinate when they do not want to. It is abhorrent that any kind of vaccine mandate for children with this experimental vaccine is even being considered.

From: maggie martin
Sent: 11/5/2021 11:30:51 AM
To: DOH WSBOH
Cc:
Subject: Proposed Mandate

External Email

My name is Maggie Garrett and my husband and I have two elementary age children in the Snohomish School District. We strongly oppose a mandate for our children to get the COVID vaccine to attend school. If this mandate come to fruition, we will immediately pull our children from the public school system.

-Maggie and Matthew Garrett
Get Outlook for Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Faka.ms%2FAAb9ysg&data=04%7

_____

From: Sunset 17
Sent: 11/5/2021 7:07:23 AM
To: DOH WSBOH
Cc:
Subject: Public Comment about Covid Vaccine Mandates for Children and Young Adults

External Email

Statement Opposing ALL Covid Vaccine Mandates for Children and Young Adults

Children and young adults are MORE at risk from the Covid vaccines than from Covid illness. There is NO good reason for any young person to be injected with this EXPERIMENTAL pharmaceutical. It is experimental because there are NO long-term safety studies. Developing natural immunity is the safest way for 99.99% of our young people to deal with Covid. Their health should NOT be risked for profit, politics or virtue signaling.

Marie Heins

Port Townsend, WA

From: Joe Frank
Sent: 11/5/2021 10:37:37 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

To whom it may concern:

I would like to submit comments regarding the covid vaccination for children. This should not be required. This should not even be available for use in children. Shame on you for even considering it. Please look into the VAERS report. Requiring this for children will be considered crimes against humanity.
God bless the children.
Sincerely
Susan Frank

Sent from my U.S. Cellular® Smartphone

_____

From: Sarah Franklin
Sent: 11/5/2021 12:29:55 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

With the CDC approving this vaccine for children 5 and up now please do NOT consider this to be a requirement for any public school.
I have already moved my kids to an online school due to the ridiculous mask mandates, as I will not have my children wear a mask for 6+ hours a day when masks are proven not to work and shown to only be harmful for them. This school is still public and you still receive money for them going to a public school. If you require a vaccination, you can bet I will completely pull my kids from any type of public school as well as many other families.
Kids need natural immunity! For them to have little to no symptoms if they get COVID-19, they should in no way be forced to get a vaccine that is still experimental, approved for emergency use only (as Cominaty is not even offered in the US yet). For a vaccine that has not proven to slow the spread and has proven to have severe side effects up to and including death, we should in no way be experimenting with our kids.
This virus has about a 99% survival rate and even higher for kids, more die from the flu than this and we have never been forced to get a flu vaccine.
The vaccine mandates are unconstitutional and unethical. This is unlike any other vaccine as it is new and has not been tested long enough and it has not proven to do the job a vaccine is meant to do. All other required vaccines for kids to go to school were tested over many years and have proven to work with low risk, this has not.

Consider carefully when deciding whether you want to push this agenda onto our children.

V/R

Sarah Franklin

From: A Davis
Sent: 11/5/2021 11:55:10 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

Children have strong immunity and there is no Covid health emergency in children ages 5 to 11.

Natural immunity needs to be part of the discussion. It is real and MUST BE CONSIDERED!

According to cdc's own statistics, 99.99815% of children who contract Covid-19 survive.

These are just a few facts that must be considered. You must not make any recommendations to inject our children with this unproven injection. There is simply not enough data available. Only years of study would provide the kind of data necessary to make a truly informed decision. We are just not there.

This is dangerous and totally unwarranted
Do the right thing. Do not recommend. In fact, recommend that we need the years of study necessary to make an informed choice.

From: A Lohla
Sent: 11/5/2021 11:59:36 AM
To: DOH WSBOH
Cc:
Subject: Public comments for Nov. 10 BOH meeting

External Email

Dear Members of the State of Washington Board of Health:

Each of you has been entrusted to safeguard the well-being of all of us. It is a heavy duty.

I think that your upcoming decision whether to recommend mandating the injection of a new technology into any population, much less children, is the most serious one you will undertake in your lives.

The potential for a state-sponsored mandate for schoolchildren to receive the current EUA vaccines for COVID-19 is something that has required me, by my morals, to speak up against it.

I write with a heavy heart at the prospect that the State of Washington may take it upon itself to mandate a new technology be injected into every child for the ostensible reason of protecting them and others they encounter. It is clear that the vaccines do not always prevent infection, nor do they stop transmission of this illness to others. These vaccines cannot make that claim.

I am grateful that we live in a country with innumerable people of advanced scientific learning and that we as a country have the financial resources to make great moves against enormous challenges. I am a proponent of having the right to try experimental medicines, by choice, under full informed consent. Parents have the right to make these same decisions for their children, not appointed members of boards or elected or non-elected executives.

Where there is risk, there must be choice, and it is apparent that the risk/benefit of these vaccines tilts strongly towards risk in children, where there is infinitesimal benefit. The VAERS data, which I encourage you to peruse and query independently, makes clear that previously healthy people, including children, are incurring deaths and lifelong injuries from these vaccines. Young people are experiencing myocarditis and pericarditis at much higher than background rates.

Dr. Pendergrass, are you prepared for a surge in pediatric patients with coagulation disorders and thrombocytopenias? As you are most certainly aware, these are potential effects from the COVID-19 vaccines, as evidenced by VAERS and numerous personal accounts.

Please consider whether your public duty isn't just to "prevent disease," but rather also to allow health as a possibility. Allow our children to grow up healthy. COVID-19 does not endanger a healthy child.

Respectfully,

Andrea Lohla

_____

From: Lindsey Martin
Sent: 11/5/2021 12:00:24 PM
To: DOH WSBOH
Cc:
Subject: Opposed to Vaccine Mandate

External Email

Good morning,

As a resident of the state of Washington, I wanted to send a brief note to indicate my opposition to any sort of COVID vaccine mandate for children to attend school.

Parents have the right to choose what immunizations and health choices are being made for our children. We do this by staying informed and in good communication with our primary doctors. At this time, a COVID vaccine mandate for children's school eligibility is not necessary and should not be approved.

Thank you for your time.
Lindsey Martin
Concerned WA parent and resident

Sent from my iPhone

From: Franey
Sent: 11/5/2021 11:49:04 AM
To: DOH WSBOH
Cc:
Subject: vaccination policies

External Email

Why risk hurting our children if the Jab does not keep covid from spreading, and children tend to live through covid?

There is no COVID health emergency in children 5 to 11

Transmission of COVID-19 among children in schools and daycares is very rare.

According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.

Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.

Natural immunity is extremely important to those who experience it.

Vaccine injury from these vaccines is "very real, not rare" and parents must have the final say in their children's medical care. It is especially persal and real to those who get to see it and experience it.

In peace and love for our children and for all,

Sincerely
Fran Isbell

_____

From: Nola Coston
Sent: 11/5/2021 11:57:29 AM
To: DOH WSBOH
Subject: Comment for Washington State Board of Health (BOH) 11/10/21Meeting

External Email

Dear members of the Washington State Board of Health (BOH),

I understand that you will be discussing the state's vaccination policies for school and daycare attendance on Wednesday, November 10, 2021.

I am writing as a grandmother of two grandchildren in school.

I oppose any mandated shot for covid-19.

Dr. Eads said this is not a vaccine. This a bioweapon.

Whistleblowers in big pharma are revealing that this is a true statement.

Dr. Robert Malone, vaccinologist and inventor of the mRNA, strongly opposes mandated shots for anyone, including children. Government mandated shots comes between patient and doctor. This decision must be made by doctor and parents in the best interest of each individual child, and not mandated.

There are no long-term safety studies of mRNA Covid vaccines, nor have they been evaluated for carcinogenic or mutagenic potential or for impairment of fertility.

The vaccine does not prevent infection, transmission, hospitalization, or death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."

There's no justification for putting hundreds of thousands of children at risk of short- and long-term harm from mandated shots for covid-19.

Do not mandate covid-19 shots on anyone, especially our children.

Nola Coston

Newcastle, WA

From: caleb.childs
Sent: 11/5/2021 11:51:43 AM
To: DOH WSBOH
Cc:
Subject: The covid shot

External Email

The fact that you want to experiment with our kids as test subjects for your cocktail that you call Is a vaccination is purely politically motivatedIs there is no science to backup the mandate. If you the public health department decides to make this a mandate I will take it as an act of war I will never comply and you guys will lose all credibility. there is an old saying mess with the bull you get the horns.

Sent from my Verizon, Samsung Galaxy smartphone

_____

From: Jaclyn Swanson
Sent: 11/5/2021 11:56:02 AM
To: DOH WSBOH
Cc:
Subject: Mandating covid vaccine for children to go to school

External Email

To whom it concerns:

I am writing to you today as a concerned citizen and parent of 3 children in Washington State Schools. We will not vaccinate our children. What is new and concerning is the direction that it would appear many states are going with - mandating vaccines for school age children to attend public school. Many of the VBRPAC doctors were concerned that their approval would result in mandates of this vaccine. Many approved just because they didn't want to deny high risk children access to this vaccine. I implore you to listen to these doctors.

I keep on hearing people speaking about how vaccines have always been required to go to school, that's true, but this vaccine can't be equated to that. We don't know the impact of these vaccines on our children - we don't know what these could cause in 10-15 years. As Cody Meisner, one of the pediatricians who sits on the VBRPAC panel said, “This is quite different from the MMR vaccine,” referring to the measles, mumps, and rubella vaccine given to all children in the U.S. “We know that vaccine is safe. We have tested that vaccine for decades. And we know, we have a very good sense, of what the adverse events are. We do not have that with this particular messenger RNA vaccine.” There has always been an option to opt out of vaccines with little to no issue from the school districts. As school districts will follow your recommendation, I implore you to NOT make the Covid 19 vaccine required to attend public school in Washington State. By mandating this in the Washington State schools you would be leaving children out, many children who have shouldered so much burden already.

Hearing the terms "safe and effective" with regards to the COVID vaccine isn't accurate. We know that it was "safe" for around 2000 children country-wide, we know that it "may" also be effective for 2 months. We don't know beyond that. The Pfizer Study was very limited in scope and time.

I shouldn't have to uproot my children from all they've known because they'll be excluded from Washington State Schools. As a parent, I should have the choice about the medical procedures my children receive. My daughters, who are normally very shy and dislike going to school, chose to go in person. I gave them the option of online. They'd been cooped up too long. This simply isn't right. It's cruel and borderline mental abuse. How much stress have they been under the last 18 months, only to have this stress and burden added.

The impact this will have on many families is awful. Many will be forced to homeschool their children which will result in job loss due to the hours needed to facilitate these needs. The impact on our most vulnerable children would be great and many would never recover.

Not to mention, these mandates are unconstitutional, against the Civil Rights Act and the Nuremburg Code.

Thank you in advance for hopefully making decisions that take into account the entire population of Washington State and not just the ones that are most vocal. And I hope you realize how unconstitutional this is.

Regards,

Jaclyn Swanson

From: ashlya_mccall@yahoo.com
Sent: 11/5/2021 11:50:02 AM
To: DOH WSBOH
Cc:
Subject: Proposed Mandate

External Email

Hello,

My name is Ashly McCall and I have 2 children, one in 2nd grade and another in 9th grade. I strongly oppose a mandate for children to receive COVID vaccinations in order to attend school. If this mandate comes to fruition, we will immediately pull our children from the public school system.

Sincerely,
Ashly A. McCall

From: Val Mullen
Sent: 11/5/2021 11:57:10 AM
To: DOH WSBOH
Cc:
Subject: email for the November 10 Board of Health meeting

External Email

November 5, 2021

To the Board of Health:

It is time to declare an end to the Covid-19 "pandemic." We have lived with this disease for nearly 2 years now, have instituted lockdowns, masking and social distancing mandates and none of these actions have stopped the virus. Vaccine mandates are faring no better.

According to the Covid-19 Data Dashboard, 73.1% of Washingtonians age 12 and older are fully vaccinated. COVID-19 Data Dashboard :: Washington State Department of Health <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.doh.wa.gov%2FEmergencies
And yet, according to the Vaccine Breakthrough report of November 3, 2021, there have been 64,971 vaccine breakthrough cases and 630 deaths in the vaccinated. This is a 0.97% fatality rate. Compare that to the statewide % of deaths, which is 1.2%. These are not significantly different numbers, so where is the great benefit of vaccinations?

Public Health England's Technical Briefing 23 (SARS-CoV-2 variants of concern and variants under investigation (publishing.service.gov.uk) <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fassets.publishing.service.gov.uk%
, Table 5, shows deaths by vaccination status. From February 1 to Sept 12, 2021, there were 2,542 deaths attributed to Covid-19. Unvaccinated people accounted for 722 of those deaths (~28%). More than twice that many fully vaccinated people died during that same time period (1,613 or 63%)! An August, 2021 MMWR Report (Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021 | MMWR (cdc.gov) <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolum
described 469 Covid-19 cases in Barnstable County, MA, 74% of which occurred in fully vaccinated persons. Again, where is the benefit of vaccination?

According to the CDC, people below the age of 65 have a 99.4% chance of survival of this respiratory infection. COVID-19 Pandemic Planning Scenarios | CDC <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F
ncov%2Fhcp%2Fplanning-scenarios.html&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C184b3fc2cfcb4683e0cf08d9a08e08e0%7C
(table 1). Washington State Department of Health Situation Report 40 (SitRep 40: COVID-19 transmission across Washington State <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.doh.wa.gov%2FPortals%2F1
tables%2F820-114-SituationReport-20211020.pdf&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C184b3fc2cfcb4683e0cf08d9a08e08e0%7C1
) shows that from late August through October 2, in Washington State, the effective Sars-CoV-2 reproductive number (Re) was (best estimate) 0.83. Having an Re of <1

means the disease is diminishing, not maintaining or accelerating. The reproduction number of COVID-19 and its correlation with public health interventions (nih.gov) <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.ncbi.nlm.nih.gov%2Fpmc%2
This disease is no longer a threat!

Also in SitRep 40, the overall prevalence (that is, the % of Washington State residents with active Covid-19 infection) is estimated at 0.41% (best estimate) on October 8, 2021. If you do the math, you can estimate the infection fatality rate, as it is defined as the number of deaths/the total number of infections. An overall Covid-19 prevalence of 0.41% means that 0.41% of Washington's population (7,766,925) is estimated to be infected with Covid-19 (~31,844 people). (Population data taken from this site: State population steadily increases, tops 7.7 million residents in 2021 | Office of Financial Management (wa.gov) <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fofm.wa.gov%2Fabout%2Fnews%
population-steadily-increases-tops-77-million-residents-
2021&data=04%7C01%7Cwsboh%40sboh.wa.gov%7C184b3fc2cfcb4683e0cf08d9a08e08e0%7C11d0e217

The death data is incomplete on the DOH website for October 8; the most recent date for complete data is October 2. On that day, 16 people died of Covid-19 in Washington State. The infection fatality rate is calculated at 16 deaths/31,844 Covid-19 prevalence, or .05%. In an email to Jon LaPook, dated Sunday February 16, 2020, Anthony Fauci explained that a very severe seasonal flu had an infection fatality rate of 0.2-0.4% and a regular seasonal flu was 0.1%. The infection fatality rate of 0.5% means we are dealing with a respiratory infection with half the death rate of a typical seasonal flu! I see no reason for us to be in a perpetual state of emergency with this disease.

It is time that the board of health declare this emergency over. The science certainly does not support a continued state of emergency. Covid-19 will never completely disappear, as it has animal reservoirs. It has become just another respiratory infection that can, in this case, kill the elderly and people with pre-existing conditions. It has little effect on kids and kids are unlikely to spread it to adults. Let's bring some common sense back to this state. Thank you.

Val Mullen

31262 Prevedell Rd.

Sedro Woolley, WA 98284

_____

From: Mindy Muglia
Sent: 11/5/2021 11:53:53 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

To the members of the Washingston State Board of Health,

Thank you for all you do in promoting overall health for the citizens of Washington State! I am sure you have the best practices in mind when you make policy for public health. With that being said I ask you to be servants to children of our state by NOT requiring any COVID 19 vaccines for children through 18 years of age. Data proves there is NO emergency with the disease in this age group and almost 100% survival rate when they do experience it. It has also been stated in the CDC study that there is insufficient data to claim asymptomatic individuals a great contributor of the illness which makes vaccinating children to protect other individuals bears no scientific merit.
The parents of Washington need you as an advocate in the medical decisions THEY make for their children. Informed consent is crucial.

In health and liberty,

Mindy Muglia

Sent from my Verizon, Samsung Galaxy smartphone

From: T and L Andrew
Sent: 11/5/2021 11:55:23 AM
To: DOH WSBOH
Cc:
Subject: Stop vaccine mandates now

External Email

Stop vaccine mandates, especially for children.

Educate and allow people to choose.

Mandates are the tool of those who cannot educate, persuade, or use science and logic. They are a tool of the weak seeking power who cannot enter the arena of truth seeking.

Please be better. We are not animals.

Laura Andrew

From: Liliya Melnychenko
Sent: 11/5/2021 11:53:58 AM
To: DOH WSBOH
Cc:
Subject: Covid-19 vaccinations for kids

External Email

Hello, Washington State Board of Health.
I just became aware that you will be discussing Covid-19 during your zoom meeting on the 10th of November, 2021.
I am writing to express my concern over a possibility of Seattle School District's mandating this particular vaccine to as a requirement for attendance. It is very troubling to me considering how new this mRNA technology is. We have no long term studies available. And when I look at high survival rate and low transmission rates among children or children to adults, it is very irresponsible to mandate something that does not prevent infection, spread, hospitalization or death from Covid-19. The data from Israel, a country with some of the highest vaccination rates, is particularly of interest. As well as data from Ireland, in the counties with 99.5% vaccination, having the highest Covid cases. Again, if a parents makes an informed decision to vaccinate their child, that is fine. But mandating something so new, considering the risks of injury and low transmission and death among children, is highly irresponsible and unnecessary.
Thank you for your time and consideration.
Liliya Melnychenko

From: Cot Guy
Sent: 11/5/2021 11:58:03 AM
To: DOH WSBOH
Cc:
Subject: comments for board meeting

External Email

Hello Board

Doe the covid vaccine does not stop infection, transmission, hospitalization, nor death?

A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that, "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."

Why are you advoicating the shot in light of above information and data?

Why are you approving the minor children of this state to be guinea pigs for a disease that is not wide spread or common amongst that population?

Look to the Scandinavian countries for a guide model that allows for freedom and has knocked the corona virus down to a super minor issue.

You will be held accountable professionaly and personally for your your actions. Act accordingly.

Sincerely
Jose

From: Jené Miller
Sent: 11/5/2021 11:57:53 AM
To: DOH WSBOH
Cc:
Subject: TAG for adding Covid19 mRNA treatment

External Email

Hello,

I'm inquiring for more information regarding the October decision to create a technical advisory committee and what that entails.

What is the criteria for joining or being eligible for the committee and what specific questions will the committee be answering? Will there be a yes/no decision by the TAG for adding this medical treatment or will they simply be offering their advice/summary/opinion?

Will there be opportunities for public comment?

Will the committee members be named?

Lastly, what sources of information will the TAG or WaBOH be using to make their determination?

For the record, my opinion is that until any treatment is well established, it should never be a requirement. Thorough and transparent research by third parties, and with voluntary subjects should be minimum criteria always.

Thank you for your thoughtful reply.

Jené Miller

From: Kristi Carmichael
Sent: 11/5/2021 11:49:54 AM
To: DOH WSBOH
Cc:
Subject: Mandates

External Email

If you don't want to see a massive pulling of children from this district, I suggest you don't mandate this jab for our children. How dare anyone tell us what to inject into our kids. Especially a vaccine that has not been out long, and that we don't know the long term effects of. We already know it causes myocarditis in some teens. Not my kids. Keep your hands off our children. Enough is enough.

Sent from my iPhone

From: Angela Lambert
Sent: 11/5/2021 11:57:43 AM
To: DOH WSBOH
Cc:
Subject: Vaccination for children

External Email

Please do not under any circumstances make it mandatory to vaccinate children under 17 years of age. This is a crime against humanity, especially our growing children who haven't even started life yet.

-Angela Lambert

Covington, WA

From: Kurt Vande Vanter
Sent: 11/5/2021 11:54:03 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

To whom this may concern,
I completely understand that you want to keep children safe at schools both public and private but mandating that children who attend these schools get the covid vaccine is NOT okay! This should be left up to the parents/guardians of the children, not the state or school boards. This is completely unnecessary due to the very low chance that a child is placed in critical condition due to covid. Again, a mandate to vaccinate children with covid-19 vaccine children so they can attend school is completely irresponsible and is blatant overreach by our government. Please STOP this from happening, thank you.
Best regards,
Kurt Vande Vanter
Spokane, WA

Sent from my iPhone

From: Nathan DeLorenzo
Sent: 11/5/2021 11:48:19 AM
To: DOH WSBOH
Cc:
Subject: Public Health comments for WSBOH Members March EH Committee Special Meeting

External Email

Please do not consider mandating the Covid-19 vaccine in our schools. This vaccine does not have any long term data behind it and without knowing the possible negative long term health affects I do not feel safe allowing my kids to take this vaccine. My children's safety is my number one priority and with there being as low of a risk as there is to having serious outbreak infection versus unknown long term health risks of the vaccine I do not think this should be mandated in our schools. Where there is risk there should be choice.

From: Julee Tibbetts
Sent: 11/5/2021 11:58:33 AM
To: DOH WSBOH
Cc:
Subject: Public Comment

External Email

To Whom It May Concern:
I want my voice to be heard that I am AGAINST a mandate to force our kids to get the Covid-19 “vaccine” to attend school. It is unnecessary and unconstitutional to require this for a population that is virtually unharmed by the virus. Many of these kids have already contracted the virus and recovered. Their natural immunity is far better (and less risky) than any “vaccine.”
Sincerely,
Julee Tibbetts

Sent from my iPhone

From: Kristine Reese
Sent: 11/5/2021 11:55:18 AM
To: DOH WSBOH
Cc:
Subject: Daycare & School Vaccination Policy Opposition

External Email

State Board of Health,

I am informing you a Covid vax mandate for children is unnecessary as there is no Covid health emergency in children ages 5 to 11 as well as young adults for the following reasons:

1.

Natural immunity exists and needs to be part of the risk-benefit analysis; it can no longer be ignored.
2.

Injury from these products is real, not rare; parents must have the final say in their children's medical care.
3.

According to data published by the CDC, 99.99815% of children who contract Covid-19 survive.
4.

There are no long-term safety studies of mRNA Covid vaccines, nor have they been evaluated for carcinogenic or mutagenic potential or for impairment of fertility.
5. Pfizer's BNT162b2 is NOT FDA-approved; it has merely received EUA. In other words, it is experimental.
6. According to data available (https://medalerts.org/vaersdb/index.php <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fmedalerts.org%2Fvaersdb%2Find) from the Vaccine Adverse Event Reporting System (VAERS), as of October 22, there had been a total of 16,716 reports of adverse events, including 1,435 serious reactions and 27 deaths in the 12- to 17-year-old age group.
7. The Pfizer mRNA vaccine has caused devastating injuries in some youth, including myocarditis and pericarditis. The CDC's own analysis of "Myopericarditis following Covid-19 vaccination: Updates from the Vaccine Adverse Event Reporting System" shows astonishingly high incidence in the youngest age brackets.

Choosing to mandate a vaccination policy for Covid puts you in a precarious position for lawsuits both at the state level as well as personally. Are you willing to be responsible for harming your child or the child of someone you know? If you have children, do you desire them to have healthy children of their own, or at least the ability to conceive and bear a child? Only you know the answers to these questions as well as the weight of remorse they might cause you to carry if the Covid vaccine is mandated.

I OPPOSE adding the Covid vaccine to the required list for all public and private daycare, schools and universities in this state. Think wisely and listen to your heart when you are presented with this mandate.

Respectfully with Love Strength,
Kristine

_____

From: Hope
Sent: 11/5/2021 11:50:54 AM
To: DOH WSBOH
Cc:
Subject: No adequate long-term safety studies of mRNA covid vaccines

External Email

Transmission of COVID-19 among children in schools and daycares is very rare.

According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.

There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was “unblinded” and allowed to get the vaccine.

Although this is NOT an FDA-approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is an experimental drug.

From: Joshua Pinz
Sent: 11/5/2021 11:51:02 AM
To: DOH WSBOH
Cc:
Subject: Vaccine mandate.

External Email

To whom it may concern.

If this mandate becomes approved my children will not be attending public school in this state any longer. It is not 100 percent safe nor is it guaranteed to protect from getting or transmitting the virus. Stop forcing an experimental drug on people.

Sent from Yahoo Mail on Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgo.onelink.me%2F107872968%3F

_____

From: Bobbi Criswell
Sent: 11/5/2021 11:57:45 AM
To: DOH WSBOH
Cc:
Subject: Covid-19 Update comments

External Email

To whom it may concern:

I am writing to you today as a concerned citizen and parent of 3 children in Washington State. Our children have had COVID infections.

It concerns me you are considering mandating Covid 19 vaccines for children to attend public schools. This decision is far reaching.

Many parents don't want to give their children a vaccine that is still under Emergency Use Authorization (EUA). Yes, Comirnaty was approved, but it is still not in production in the US. The label on the vials for children is still the Pfizer BioNtech, which is under EUA. That means it is not approved. You can't legally require a vaccine that is still considered experimental.

If this shot is mandated, many parents will pull their children out of school. This will impact funding to the schools, lower numbers will impact the amount of staff schools need, thus Teachers and support staff risk losing their jobs.

Children are the least impacted by COVID19. Letting them get the natural immunity now while they are young, protects them in the future against all new variants.

As you can see, it's not in the best interest for the schools, or the children to mandate this shot to attend school.

What is new and concerning is the direction that it would appear many states are going with - mandating vaccines for school age children to attend public school. Many of the VBRPAC doctors were concerned that their approval would result in mandates of this vaccine. Many approved just because they didn't want to deny high risk children access to this vaccine. I implore you to listen to these doctors.

I keep on hearing people speaking about how vaccines have always been required to go to school, that's true, but this vaccine can't be equated to that. We don't know the impact of these vaccines on our children - we don't know what these could cause in 10-15 years. As Cody Meisner, one of the pediatricians who sits on the VBRPAC panel said, "This is quite different from the MMR vaccine," referring to the measles, mumps, and rubella vaccine given to all children in the U.S. "We know that vaccine is safe. We have tested that vaccine for decades. And we know, we have a very good sense, of what the adverse events are. We do not have that with this particular messenger RNA vaccine." There has always been an option to opt out of vaccines with little to no issue from the school districts. As school districts will follow your recommendation, I implore you to NOT make the Covid 19 vaccine required to attend public school in Washington State. By mandating this in the Washington State schools you would be leaving children out, many children who have shouldered so much burden already.

Hearing the terms "safe and effective" with regards to the COVID vaccine isn't accurate. We know that it was "safe" for around 2000 children country-wide, we know that it "may"

also be effective for 2 months. We don't know beyond that. The Pfizer Study was very limited in scope and time.

I shouldn't have to uproot my children from all they've known because they'll be excluded from Washington State Schools. As a parent, I should have the choice about the medical procedures my children receive. Last night my middle child, who's 16, was very concerned because she was afraid she wouldn't be able to go to school next year and complete her running start if she didn't have the vaccine. This simply isn't right. It's cruel and borderline mental abuse. How much stress have they been under the last 18 months, only to have this stress and burden added.

The impact this will have on many families is awful. Many will be forced to homeschool their children which will result in job loss due to the hours needed to facilitate these needs. The impact on our most vulnerable children would be great and many would never recover.

Thank you in advance for hopefully making decisions that take into account the entire population of Washington State and not just the ones that are most vocal.

Sincerely,
Bobbi Criswell

Sent from my Verizon, Samsung Galaxy smartphone
Get Outlook for Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Faka.ms%2FAAb9ysg&data=04%7

From: Katherine Johann
Sent: 11/5/2021 11:54:38 AM
To: DOH WSBOH
Cc:
Subject: No Mandate for School Attendance in Washington State

External Email

Hello,

I just received a text that you are receiving emails until noon today regarding mandating our kids to receive the vaccine. I believe there are too many unknowns when it comes to the longevity of our children's health to enforce this across all populations. For example, the impact to boys hearts!

It appears that medical exemptions are hard to get as well. I have a patient who was told by all of his specialists that he should not take the vaccine and yet none of his physicians will step up and sign the waiver. He is now forced to take the vaccine in order to keep his job at Boeing.

By the way, all of my family is vaccinated including my 12 year old son and I still stand against mandatory vaccinations. What are the statistics in our school system to support this?

Thank you,
Katherine Johann, LMT

From: C French
Sent: 11/5/2021 11:52:18 AM
To: DOH WSBOH
Cc:
Subject: public comments for Nov. 10 BOH meeting

External Email

I do NOT want or accept in any form of covid vaccination mandates for children. They are stronger and healthier without it.

From: Testify Online Survey
Sent: 11/5/2021 12:00:18 PM
To: DOH WSBOH
Cc:
Subject: Survey Response: Testify Online *

The following survey response is submitted:

1.

State Board of Health Meeting Date:

November 10, 2021

2.

Agenda Item or Issue:

Covid-19 vaccination requirement to attend public school.

3.

Your Name:

_____

Carl Sutherland

4.

Do you have a professional title?

2. No

5.

Are you representing an organization?

2. No

6.

Address:

_____

339 Tracy Ave N Port Orchard, Wa. 98366

7.

Email:

_____

carl48usn@gmail.com

8.

Phone Number (Include Area Code):

_____

210-837-7029

9.

Do you have any special expertise relevant to this topic?

2. No

10.

Are you testifying on a specific proposal under consideration by the board?

1. Yes

_____

Requiring Covid-19 vaccination to attend public school.

11.

Are you Pro or Con on the proposal?

2. Con

Parental rights regarding their childs immunization shall not be dictated regarding experimental drugs.

From: Hope
Sent: 11/5/2021 11:48:47 AM
To: DOH WSBOH
Cc:
Subject: VAERS: As of Oct. 8, there have been a total of 21,652 reports of adverse events.

External Email

According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12- to 17-year-old age group.

The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event Reporting System (VAERS)" showed astonishing increases in the youngest age brackets.

Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.

_____

From: zachsmith85@yahoo.com
Sent: 11/5/2021 11:51:05 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

I do not think there should be any vaccine mandate for any age. If a person wants to get the shot on their on that is fine. It should not be required

_____

From: McKayla Macomber
Sent: 11/5/2021 11:56:09 AM
To: DOH WSBOH
Cc:
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting

External Email

To our WSBOH Members,

I urgently request that you reconsider your decision to allow and promote covid vaccines for children. With all of the negative side effects or harmful health reactions to the vaccine in some adults, there has not been proof that the vaccine would be safe for children. Please do not use the Washington state children as guinea pigs to this vaccine. The lasting effects of using this vaccine on our children will be seen long after you are gone. Please be careful in your decisions.

Thank you for your time,

McKayla Miller
Chehalis, WA

From: Jennifer Bihary
Sent: 11/5/2021 11:51:39 AM
To: DOH WSBOH
Cc:
Subject: WA State proposed mandate for kids to get the Covid 19 vaccine to attend school.

External Email

To whom it may concern,

Getting a covid vaccine should not be mandated in Washington State for children to attend school.
There is not long term data on the safety of the vaccine and the vaccine is too new.
Parents should not be expected to experiment with their children's lives.

My child will be removed from public schools if this is mandated.

Jennifer Bihary

Get Outlook for Android
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Faka.ms%2Fghei36&data=04%7C0

From: Terri-Google
Sent: 11/5/2021 11:58:41 AM
To: DOH WSBOH
Cc:
Subject: DO NOT MANDATE COVID VAXXes for CHILDREN!!!!

External Email

* There is no Covid health emergency in children ages 5 to 11.
* Natural immunity needs to be part of the risk-benefit analysis; it can no longer be ignored.
* Injury from these products is real, not rare; parents must have the final say in their children's medical care.
* According to data published by the CDC, 99.99815% of children who contract Covid-19 survive.
* Transmission of Covid-19 among children in schools and daycares is very rare.
* There are no long-term safety studies of mRNA Covid vaccines, nor have they been evaluated for carcinogenic or mutagenic potential or for impairment of fertility.

* Pfizer's BNT162b2 is NOT FDA-approved; it has merely received EUA. In other words, it is experimental.
* According to data available <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Furldefense.proofpoint.com%2Fv2%3A__0x124.mjt.lu_lnk_AVoAABI8TpcAAABBguwAAAr0KcYAAAAAu9MAALoOABkwhABhhFlmNOmb5Xj6TB6oFv5A_CdpgnVfiiMM%26r%3DyZLeMMdVzGJIscgF9zuhmYsbUJVwzzlNftowyIJ4W5s%26m%3Ds6aGtg1qfkZhkV0YWiT-0yU5EqVLIYpW0RAxY9_dSY%26s%3Dib1NoNhs5-fDUZFio9JBG_Rc7VwmewDxXvw-EZPwYCU%26e%3D&data=04%7C01%7Cwsboh%40sboh.wa.gov%7Cdbded4f9e7a74f9eb99008d9a08df55> from the Vaccine Adverse Event Reporting System (VAERS), as of October 22, there had been a total of 16,716 reports of adverse events, including 1,435 serious reactions and 27 deaths in the 12- to 17-year-old age group.
* The Pfizer mRNA vaccine has caused devastating injuries in some youth, including myocarditis and pericarditis. The CDC's own analysis of "Myopericarditis following Covid-19 vaccination: Updates from the Vaccine Adverse Event Reporting System" shows astonishingly high incidence in the youngest age brackets.
* Healthy adolescents ages 12-17 who have been given Covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.
* The vaccine does not prevent infection, transmission, hospitalization, or death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."
* Children are not a significant threat to the elderly and vulnerable, as most Covid cases are spread from adults to children.
* Printable flyers with referenced disgraceful quotes from FDA, CDC, and Pfizer are available at InformedChoiceWA.org. <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Furldefense.proofpoint.com%2Fv2%3A__0x124.mjt.lu_lnk_AVoAABI8TpcAAABBguwAAAr0KcYAAAAAu9MAALoOABkwhABhhFlmNOmb5Xj6TB6oFv5A_CdpgnVfiiMM%26r%3DyZLeMMdVzGJIscgF9zuhmYsbUJVwzzlNftowyIJ4W5s%26m%3Ds6aGtg1qfkZhkV0YWiT-0yU5EqVLIYpW0RAxY9_dSY%26s%3DOx1cwmI78JYuSJYLxJExPiZQOgdcWTgAHNbSUX-mdh0%26e%3D&data=04%7C01%7Cwsboh%40sboh.wa.gov%7Cdbded4f9e7a74f9eb99008d9a08df55b%

* You can share or cite from Senator Ron Johnson's four-hour roundtable <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Furldefense.proofpoint.com%2Fv2%3A__0x124.mjt.lu_lnk_AVoAABI8TpcAAABBguwAAAr0KcYAAAAAu9MAALoOABkwhABhhFlmNOmb5Xj6TB6oFv5A_CdpgnVfiiMM%26r%3DyZLeMMdVzGJIscgF9zuhmYsbUJVwzzlNftowyIJ4W5s%26m%3Ds6aGtg1qfkZhkV0YWiT-0yU5EqVLIYpW0RAxY9_dSY%26s%3Dn6QEIAgNeDwgq-gi2z33BZqVEBh9CSw3HnlcnbxFV8U%26e%3D&data=04%7C01%7Cwsboh%40sboh.wa.gov%7Cdbded4f9e of vaccine injury victims and medical experts on federal vaccine mandates and the importance of health care freedom.
* ACIP member Dr. Camille Kotton publicly admitted <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Furldefense.proofpoint.com%2Fv2%3A__0x124.mjt.lu_lnk_AVoAABI8TpcAAABBguwAAAr0KcYAAAAAu9MAALoOABkwhABhhFlmNOmb5Xj6TB6oFv5A_CdpgnVfiiMM%26r%3DyZLeMMdVzGJIscgF9zuhmYsbUJVwzzlNftowyIJ4W5s%26m%3Ds6aGtg1qfkZhkV0YWiT-0yU5EqVLIYpW0RAxY9_dSY%26s%3D4ZlcEjUw1u7O1dkFwKUSm35FF2ZIAxhjH2qI0cVx74Y%26e%3D&dat that the number of Covid deaths in ages 5 to 11 for one year was 66. She did not distinguish between "from Covid" and "with Covid." In any event, it does not justify putting hundreds of thousands of children at risk of short- and long-term harm from the vaccines.

From: Angela Amdur
To: DOH WSBOH
Subject: OVID vaccines for children
Date: Thursday, November 4, 2021 4:58:56 PM

External Email

Hello,

I am the parent of a child who had ever worsening reactions to vaccines. There was a clear link between the "well child visits" and rapid drops in health. It took a while before we could admit to ourselves what was causing the severe effects on his health.

I urge you to avoid any mandates or mandate recommendations for children . We have already seen that boys have a higher reaction rate and as a parent whose child had vaccine reactions, I can tell you that the freedom to stop the in the face of a poor reaction is essential for a child's long term health.

Respectfully,

Angela Amdur
Ronald, WA

From:	Testify Online Survey
To:	DOH WSBOH
Subject:	Survey Response: Testify Online *
Date:	Thursday, November 4, 2021 3:55:18 PM

The following survey response is submitted:

1. State Board of Health Meeting Date:

November 10th, 2021

2. Agenda Item or Issue:

Covid 19 vaccine

3. Your Name:

Anita D Abhold

4. Do you have a professional title?

2. No

5. Are you representing an organization?

2. No

6. Address:

1747 SKEENA CT .

7. Email:

AnitaAbhold0261@gmail.com

8. Phone Number (Include Area Code):

509-679-7625

9. Do you have any special expertise relevant to this topic?

2. No

10. Are you testifying on a specific proposal under consideration by the board?

2. No

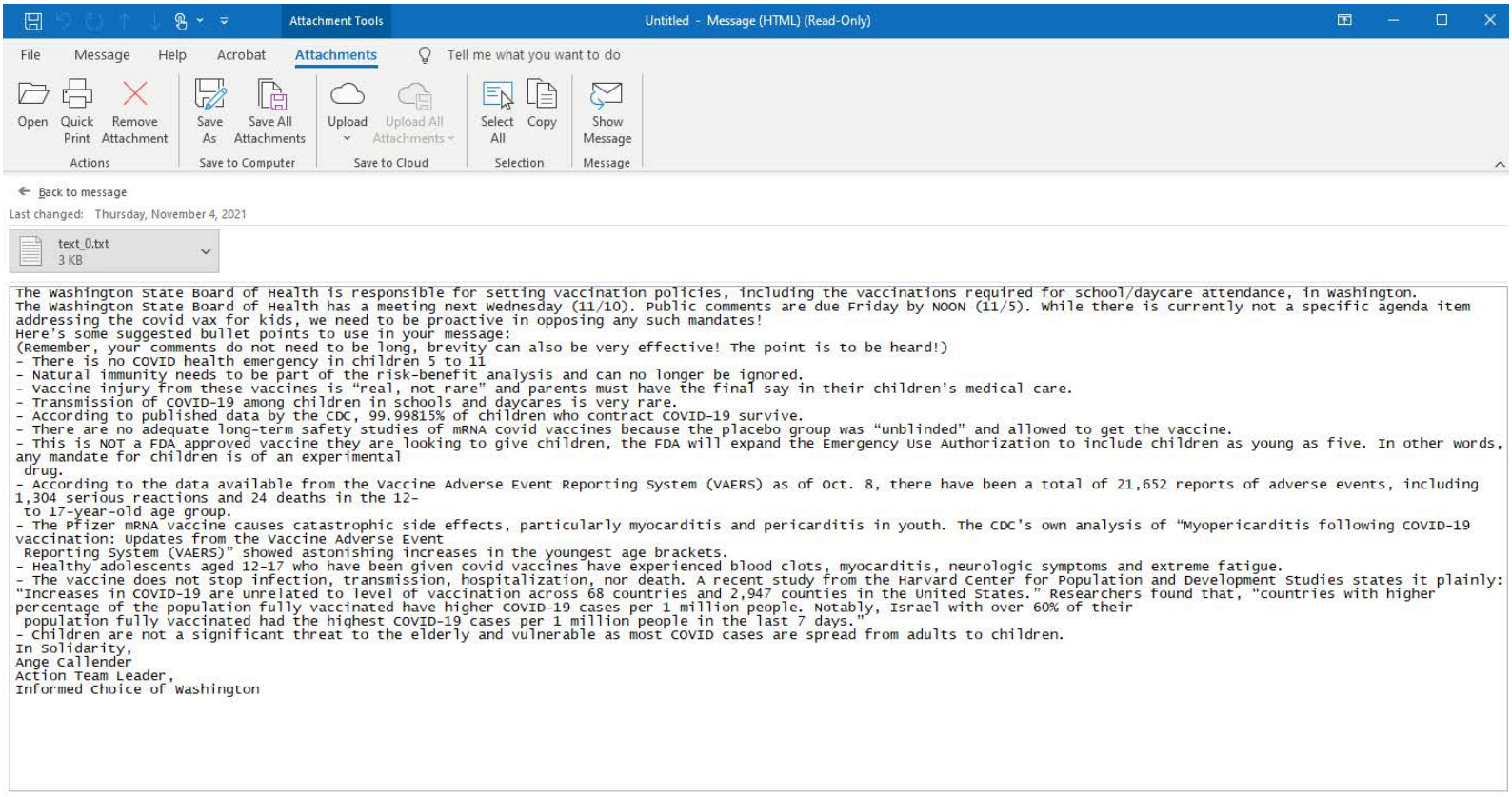
11. Are you Pro or Con on the proposal?

2. Con

With so very few Covid 19 total deaths in our young children (My last research showed 73M total cases with less than 800 deaths in the entire US throughout this pandemic) I don't believe it's would be good judgement to require this vaccine for children. We have absolutely no information on the

"long term effects" this vaccine might have! Please use good judgement and don't require!!

From: +15099394045@tmomail.net
To: DOH WSBOH
Date: Thursday, November 4, 2021 7:06:33 PM
Attachments: text_0.txt



The Washington State Board of Health is responsible for setting vaccination policies, including the vaccinations required for school/daycare attendance, in Washington.
The Washington State Board of Health has a meeting next Wednesday (11/10). Public comments are due Friday by NOON (11/5). While there is currently not a specific agenda item addressing the covid vax for kids, we need to be proactive in opposing any such mandates!
Here's some suggested bullet points to use in your message:
(Remember, your comments do not need to be long, brevity can also be very effective! The point is to be heard!)
- There is no COVID health emergency in children 5 to 11
- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.
- Vaccine injury from these vaccines is "real, not rare" and parents must have the final say in their children's medical care.
- Transmission of COVID-19 among children in schools and daycares is very rare.
- According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.
- There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine.
- This is NOT a FDA approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental
drug.
- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12-
to 17-year-old age group.
- The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event
Reporting System (VAERS)" showed astonishing increases in the youngest age brackets.
- Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.
- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that, "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their
population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."
- Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children.
In Solidarity,
Ange Callender
Action Team Leader,
Informed Choice of Washington

From: Ammon Fisher
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 3:46:55 PM

External Email

If you are going to be talking about kids being required to get the Covid shot to attend school, then the first and most important thing to understand is the definition of a vaccine. The Covid shots were granted an EUA with a 95% effectiveness for reducing severe Covid 19 period. They did not stop and do not stop the transmission of sars-cov-2. They reduce symptoms which means they are prophylactic drugs. So if you vote on requiring these shots you are effectively requiring kids to take a prophylactic drug for an illness with a 99% survival rate. You might as well mandate chemotherapy for all kids prophylactically since cancer kills around 20,000 people yearly in Washington. To date there are 17,000 deaths associated with prophylactic Covid shots and around 900,000 adverse events. In comparison do you know how many people have died using prophylactic drugs like Ivermectin, hydroxychloroquine, Mono clonal antibodies etc? I sincerely hope you use common sense and sound science in your decision making.

Sent from my iPhone

From: Amy Grady
To: DOH WSBOH
Subject: Covid vaxx for 5-11 year olds
Date: Thursday, November 4, 2021 7:56:07 PM

External Email

To those decision makers concerning the covid vaccine for kids,

As a Washington resident and a grandmother of 8 precious healthy kids, I strongly oppose giving this vaccine to children for the following reasons-

- There is no COVID health emergency in children 5 to 11 yr olds

- Vaccine injury from these vaccines is “real, not rare” and parents must have the final say in their children’s medical care.

- Transmission of COVID-19 among children in schools and daycares is very rare.

- According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.

- There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was “unblinded” and allowed to get the vaccine.

- This is NOT a FDA approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental drug.

- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12- to 17-year-old age group.

- Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.

- Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children.

Amy Grady
Spokane, WA

Sent from my iPhone

From: A Rarson
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 7:18:28 PM

External Email

Hi there,

I am a mother of four kids, ages 4-13. I am writing to express my concern about vaccine mandates as a requirement for public school attendance.

Public school attendance has always been offered tuition free, regardless of legal status, gender, race, health. We are also taxpayers.

We firmly believe in natural immunity. While the vaccine targets certain strains, my children have already had and recovered from Covid, so they have immunity against all strains.

Seattle has always been a progressive, natural, and compassionate place. We're still hoping that holds to give our children their best chances in life.

Thank you,

Andréa Larson

From: Amy Shin McKamey
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 4:39:57 PM

External Email

What happens when there are unintended consequences (as there usually is in life, particularly pharmaceuticals)? What is our plan B, plan C, and fail safes for people who are adversely affected by the shots? Shouldn't there be better systems and policies in place, along with better and long term safety studies, prior to universally injecting people with a medical intervention, especially children who are virtually no risk?

Also, is international data being considered? The outcomes of regions who vaccinated higher and sooner than us… do they warrant us to continue down this path? Do the outcomes warrant the risks and violations? These consequences will not be able to be undone.

https://www.science.org/news/2021/08/grim-warning-israel-vaccination-blunts-does-not-defeat-delta

https://swprs.org/israel-highest-infection-rate-in-the-world/

https://www.beckershospitalreview.com/public-health/nearly-60-of-hospitalized-covid-19-patients-in-israel-fully-vaccinated-study-finds.html

https://www.timesofisrael.com/portugal-sweden-slap-covid-entry-ban-on-israelis-including-those-vaccinated/

https://www.worldometers.info/coronavirus/country/israel/

https://www.cnbc.com/2021/05/13/seychelles-most-vaccinated-nation-on-earth-but-covid-19-has-surged.html

https://www.msn.com/en-us/money/other/singapore-reports-highest-single-day-rise-in-covid-19-cases/ar-AAP09rV

https://www.abc.net.au/news/2021-09-13/singapore-has-80-per-cent-vaccination-but-life-is-not-normal/100450154

https://www.theguardian.com/world/2021/sep/15/singapore-reports-biggest-spike-in-covid-cases-in-a-year-despite-81-vaccination-rate

https://thethaiger.com/coronavirus/with-nearly-60-of-their-population-vaccinated-why-is-chiles-covid-rate-surging

https://www.news.com.au/world/coronavirus/global/iceland-deals-with-growing-delta-

outbreak-as-high-vaccination-rates-stop-deaths/news-story/b970a814615715e573d67b3a1c1525f0

https://www.cnbc.com/2021/07/30/cdc-study-shows-74percent-of-people-infected-in-massachusetts-covid-outbreak-were-fully-vaccinated.html

https://fortune.com/2021/09/28/singapore-covid-reopening-record-cases-vaccines/

https://www.irishpost.com/news/ireland-records-highest-number-of-covid-19-cases-since-january-222961

https://www.thejournal.ie/90-fully-vaccinated-ireland-5552921-Sep2021/

Please, make it make sense.

Amy

From: Angela Pifer
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Friday, November 5, 2021 11:07:37 AM
Attachments: image002.png

External Email

Hello,

I am the mother of a 12 year old in LWSD. I am also a healthcare provider, in practice for 17 years. I am pro-vaccine. I am not pro-this vaccine. During the FDA committee meeting, a doctor states 'we just won't know about the safety until we start giving these shots, that's just the way it is.'

The attached slide summarizes Maddy's case. This is Maddy. She was in the Pfizer trial and they reported her symptoms as a stomach ache. Does a stomach ache relegate you to a wheel chair? To be tube fed?

After this vaccine damaged her for life, she was kicked out of the trial and she was grouped and reported as a subject who voluntarily left the study and her symptoms were reported only as a stomach ache. Look at the list of symptoms that she had (on the slide). This damage came after only one dose of Pfizer was given to her. This is her mother's testimony (Maddy is sitting next to her). Please watch at the 2:29 mark https://rumble.com/vokrf7-sen.-johnson-expert-panel-on-federal-vaccine-mandates.html

Also, CNBC reported on the Pfizer study stats: https://www.cnbc.com/2021/11/01/covid-vaccines-for-kids-are-coming-soon-some-families-are-counting-the-minutes.html

Mainstream media - "fully vaccinating 1 million kids ages 5-11, will prevent 241 hospitalizations, but, it will cause 106 vaccine induced myocarditis "but MOST would recover." This is a very conservative estimate of ONE adverse side effect. AND, according to the FDA data, it will prevent 241 hospitalizations, but, it will cause 106 hospitalizations (and possibly more deaths - if MOST will recover)?

"Fully vaccinating 1 million kids ages 5 to 11 would prevent 58,000 Covid infections, 241 hospitalizations, 77 ICU stays and one death, according to a modeled scenario published by the Food and Drug Administration last week. Up to 106 kids would suffer from vaccine-induced myocarditis but most would recover, according to the agency."

Our children are not at risk with COVID. Our children are not guinea pigs in this worldwide

study. Please do not make parents choose between an experimental shot that has known side effects and unknown safety profiles - both short and long term - with in person education.

If this shot is mandated for our children to go to school, I will pull my child and she will never return. I will fight this on the streets, I will scream this from the mountain tops. We need to protect our children, not the other way around.

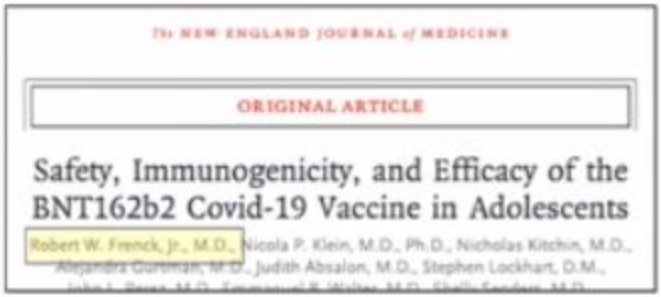
Warmly,

Angela.

Angela Pifer, Ms, Functional Medicine Nutritionist, LCN, CN
Bastyr University Alumni '05, Adjunct Faculty, Meticulous Researcher

Pfizer vaccine for 12 -15 year olds

What does *NEJM* article & FDA EUA Amendment Review Memorandum say about Maddie?



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Safety, Immunogenicity, and Efficacy of the BNT162b2 Covid-19 Vaccine in Adolescents

Robert W. Frenck, Jr., M.D., Nicola P. Klein, M.D., Ph.D., Nicholas Kitchin, M.D., Judith Absalon, M.D., Stephen Lockhart, D.M.,

Frenck et al.. N Engl J Med. May 27 2021;385(3):239 -250.
https://doi.org/10.1056/NEJMoa2107456

BNT162b2:

- 3 participants, all with pre-existing anxiety and depression, were hospitalized for medical management of depression exacerbation that started 7 days after Dose 1, 1 day after Dose 2, and 15 days after Dose 1, respectively. All 3 participants reported treatment with a selective serotonin reuptake inhibitor (SSRI) that began within 1-2 months prior to vaccination. Worsening suicidal ideas with initial SSRI treatment in adolescents is a recognized risk and provides a reasonable alternative explanation for depression exacerbation in these BNT162b2 recipients.

- One participant experienced an SAE reported as generalized neuralgia, and also reported 3 concurrent non-serious AEs (abdominal pain, abscess, gastritis) and 1 concurrent SAE (constipation) within the same week. The participant was eventually diagnosed with functional abdominal pain. The event was reported as ongoing at the time of the cutoff date.

Page 30 of FDA's EUA Review Memorandum. May 10, 2021.
https://www.fda.gov/media/148542/download

(9) ER Trips, (3) Hospital Stays *(64 days by 6/1/21)*

***Discharged on 3/13 unable to walk & with dysphagia*

Frenck diagnosed with virus vs vaccine reaction on 1/23/21...

***EKG (tachycardia/left axis dev), blood in urine, CRP (2.90)*

- **Principal Investigator** for Maddie's trial is **lead author** of NEJM article
- **"ADVERSE EVENTS"** ... 308 words, 76 words describing one participant with temp >40 °C and **NO MENTION OF ANY OF MADDIE'S ADVERSE REACTIONS**
- FDA memo: **Maddie's reaction reduced to 5 lines**
- **Data cutoff** for publication was **3/13/21**

By then Maddie experienced:

- Severe Abdominal Pain (LRQ)
- Muscle Pain & Spasms all over body
- Tingling, Numbness & Weakness in Legs
- Gait Abnormality & Inability to Walk
- Sharp/Electric Pain - Neck down Spine
- Chest pain & Tachycardia
- Headache/Migraines
- Nausea, Reflux, Vomiting & Dysphagia
- Diarrhea then Gastroparesis
- Cold/white fingers & toes
- Fever, sore throat, white tongue, ulcers
- Blood in her urine in 7 urinalysis
- Erratic blood pressure
- Abnormal blood tests
- Vulvar boil
- Irregular/Heavy Periods
- Vision Loss
- Tinnitus
- Brain fog/Mixing words
- Peeling feet
- Rash on her arms
- Dizziness and Fainting
- Verbal & Motor Tics
- Tremors
- Urinary Retention
- Fatigue

WHAT ABOUT THE PARTICIPANTS WHO WITHDREW DUE TO ADVERSE EVENTS?

From: ali pepper
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 3:54:03 PM

External Email

To whom it may concern,

I am writing with concern that vaccine mandates are coming for the children of this state to attend school and daycare settings.

Children have a very high percent of recovery and minimal complications from naturally processing the COVID-19 virus.

The injections do not prevent people from passing the virus to others. They are only protecting those receiving the injection for a limited amount of time and have risk of adverse reaction. The risk of a child having complications or dying from the COVID virus is very minimal and should not result in mandates of vaccination.

Please stop using coercion through government power to force families to make medical decisions they do not agree with.

Thank you for you time,
Ali Pepper

From: andreasehmel
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 3:32:19 PM

External Email

With the Oct 28th AAP / Children's Hospital Association report telling us that there is a very low mortality rate of 0.01% for children, please do NOT vaccinate school children with a minimally-tested and scarcely needed vaccine.

This all brings to mind Josef Mengele. How do you sleep at night?

Sent from my Verizon, Samsung Galaxy smartphone

From: Ana Le
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 5:13:04 PM

External Email

Please do not force the dangerous C19 "vaxx" on kids. There have been thousands of severe or fatal adverse reactions to the shots.

CDC and hospitals are under reporting deaths and adverse reactions to the "vaxx".

See damning report from VAERS:
https://openvaers.com/covid-data

https://nypost.com/2021/10/16/fda-delays-moderna-vaccine-for-teens-until-heart-condition-studied-report/

Ana Tran

From: Ben Greving
To: DOH WSBOH
Subject: Policies
Date: Thursday, November 4, 2021 7:24:50 PM

External Email

- There is no COVID health emergency in children 5 to 11
- Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.
- Vaccine injury from these vaccines is "real, not rare" and parents must have the final say in their children's medical care.
- Transmission of COVID-19 among children in schools and daycares is very rare.
- According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.
- There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine.
- This is NOT a FDA approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental drug.
- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12- to 17-year-old age group.
- The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event Reporting System (VAERS)" showed astonishing increases in the youngest age brackets.
- Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.
- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that, "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."
- Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children.

From: Bernadette Pajer
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Friday, November 5, 2021 11:59:27 AM
Attachments: November 5 2021 BOH.pdf

External Email

Please find ICWA's comment attached

InformedCHOICEWA.org

ATTN: WA State Board of Health November 5, 2021

Dear Board Members:

Despite your past unwillingness to support or acknowledge COVID-19 effective early treatments, robust natural immunity, and alarming, unprecedented COVID-19 vaccine safety signals, we, the board and members of ICWA, have not abandoned our hopes that you have the humanity to change course.

We do understand that most information channelled to you states the opposite of what we provide, and the journey of questioning "official" sources can be life-altering. Yet you have all certainly witnessed that the reality of Covid illness and serious vaccine issues do not match the official "safe and effective and necessary for all" vaccine narrative or the policies being driven. The corporate capture of regulatory agencies, public health agencies, and legacy media outlets has created the dangerous ability for control of society by saturation messaging. Good people are caught up in a corrupt system. In such times, it requires good people to find the moral courage to stand up and speak out.

We provide to you today just four resources we beg you to explore.

New OTC Early Treatment: "In a randomized, double-blind, placebo-controlled Phase 2 trial that evaluated 79 confirmed cases of COVID-19, SaNOtize's early treatment for COVID-19 significantly reduced the level of SARS-CoV-2, including in patients with high viral loads. The average viral log reduction in the first 24 hours was 1.362, which corresponds to a decline of about 95%. Within 72 hours, the viral load dropped by more than 99%." https://sanotize.com/enovid-virx/

Natural Immunity: *106 Research Studies Affirm Naturally Acquired Immunity to Covid-19: Documented, Linked, and Quoted* https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/

Vaccine Injury: Senator Ron Johnson's roundtable discussion with vaccine injured and medical experts on federal vaccine mandates. Includes testimony by U.S. Army Lieutenant Colonel Theresa Long, Brigade Surgeon; Dr. Linda Wastila, professor and Parke-Davis chair in Geriatric Pharmacotherapy, University of Maryland School of Pharmacy; and Dr. Robert Kaplan, Stanford School of Medicine Clinical Excellence Research Center. https://rumble.com/vokrf7-sen.-johnson-expert-panel-on-federal-vaccine-mandates.html

No Mandates for Children: From the FDA's VRBPAC meeting on October 26, 2021, " . . . but we're never going to learn about how safe this vaccine is unless we start giving it." -Dr. Eric Rubin, FDA Advisor at 6:52:33. "The question really becomes, does this vaccine offer any benefits to (children) at all?" -Dr. Michael Kurilla, FDA Advisor at 7:41:52: https://www.fda.gov/advisory-committees/advisory-committee-calendar/vaccines-and-related-biological-products-advisory-committee-october-26-2021-meeting-announcement

Sincerely,

Bernadette Pajer, ICWA Public Policy Director

From: becky spangle
To: DOH WSBOH
Subject: Public Comments for WSBOH Members
Date: Thursday, November 4, 2021 7:28:37 PM

External Email

Although there is no agenda item specific to vaccine mandates for our children, I wish to share my opinion on the topic. I strongly oppose any mandates of vaccinations for our children. This should be a decision for parents to make. The comparison of COVID vaccines to Polio or measles vaccines is absolutely ridiculous and should not even be mentioned as they are nothing alike. There is no medical need for our children to be vaccinated for COVID as it poses no real risk to our children. The suggestion that having our children vaccinated provides a safety benefit to family members is also completely false as vaccinated people can still contract and transmit COVID. There are possible risks to our children from the vaccines. The risks outweigh the benefits for healthy children. Cases are decreasing. Vaccines for children are EUA only and should not be made mandatory while still experimental; especially when no medical need exists. Our children are not becoming seriously ill or dying from COVID. The CDC has estimated that 40% of children likely have had COVID and therefore have natural immunity. Please don't jeopardize our children's God given, strong immune systems by requiring an experimental treatment that is not necessary.
Thank you.
Becky Spangle

Sent from Yahoo Mail on Android

From: Testify Online Survey
To: DOH WSBOH
Subject: Survey Response: Testify Online *
Date: Thursday, November 4, 2021 2:57:38 PM

The following survey response is submitted:

1. State Board of Health Meeting Date:

November 5th, 2021

2. Agenda Item or Issue:

No Covid vaccine on the required list for participation in WA Schools

3. Your Name:

Charmaine Eppler

4. Do you have a professional title?

2. No

5. Are you representing an organization?

2. No

6. Address:

7. Email:

clheppler@gmail.com

8. Phone Number (Include Area Code):

9. Do you have any special expertise relevant to this topic?

2. No

10. Are you testifying on a specific proposal under consideration by the board?

1. Yes

Proposal to add Covid vaccine to required school vaccines, as well as allowing minors to receive vaccines without parental consent.

11. Are you Pro or Con on the proposal?

2. Con

Despite past precedent of multi-year delays between the licensure of new vaccines and their addition to the childhood immunization schedule due to a wise decision to use an overabundance of caution in inoculating children with an untested, unknown substance, the FDA and CDC has imprudently rushed to approve covid vaccines. Vaccines Do Not Stop the Spread of COVID: Though the data available on

the efficacy of the vaccines correlates to reducing severe illness, hospitalization, and death against both the alpha and delta variants of COVID-19, vaccine advocates have walked back claims that vaccination would eliminate the disease's spread as the delta variant has surged through even substantially vaccinated populations worldwide. Data from state health departments, hospital systems, and health resource entities shows that the vast majority of hospitalizations and fatalities over the past six months have been among the unvaccinated. The hostility within parts of the medical community to early treatment upon diagnosis, favoring instead waiting until symptoms worsen substantially and require hospitalization, has contributed to overburdening our healthcare system as well as unnecessarily resulting in fatalities in both the vaccinated and unvaccinated populations. More recently, data is also revealing that an increasing number of those who are getting seriously ill are vaccinated. Instances of vaccinated people contracting COVID-19 are dubbed "breakthrough cases." For example, in Florida, which currently has the lowest per capita case rate of any state, the vaccinated are accounting for up to 15 percent of COVID-19 patients in some hospital systems. An internal memo from the CDC that was published by the Washington Post in July revealed that an estimated 140,000 breakthrough cases per month were occurring in the US amid the summer surge. A recent paper reprinted by the Oxford University Clinical Research Group revealed that vaccinated individuals who experience breakthrough cases of the delta variant shed roughly 250 percent more virus than the unvaccinated individuals who were infected with the initial alpha variant. It should be noted that unvaccinated individuals who contract the delta variant also shed similar viral loads. This suggests, however, that the virus is mutating in a manner that is more transmissible and that the mRNA vaccines do not prevent fully vaccinated individuals from getting sick and shedding significant amounts of the virus. The Biden administration was slow to acknowledge the significance of breakthrough cases, possibly due to its efforts to cast vaccination as a path to ending the spread of COVID-19. The messaging incoherence significantly undermined public trust in the White House's vaccination campaign. Americans found themselves urged, simultaneously, to take the vaccine so that they would not spread the virus to those around them and also urged to continue wearing masks despite their vaccination status. The uncertainties and nuance surrounding the actual state of knowledge about vaccine efficacy remain largely unacknowledged by public health officials, intent as they are to coerce Americans into deferring to the judgment of the Biden administration regarding personal health decisions. #2: The Vaccines Have Side Effects with Varying Significance Based on Medical Health: In addition to evidence of waning vaccine efficacy, it is clear that there are potential side effects of the vaccine for some who receive the shot. These range from such minor issues as fatigue to potentially fatal side effects like blood clots and myocarditis. The Johnson & Johnson vaccine was briefly paused in April 2021 due to 28 documented cases of blood clots. Both the Pfizer and Moderna vaccines have also shown 789 documented myocarditis cases, particularly in younger adults. These numbers only reflect documented patient reports and may not account for unreported side effects. Many Americans agree with public health experts that the risks of these side effects are outweighed by the benefits of vaccination. Many others, however, believe that the unprecedentedly rapid rollout of these novel vaccines justifies continued caution. The Biden administration's vaccine mandate denies Americans the right to exercise that caution, effectively telling Americans who fear the downside risk of further adverse vaccine reactions that they do not deserve access to gainful employment. While it is empirically true that COVID-19 can also cause fatal cases of myocarditis and blood clots, this juxtaposition between side effects of the vaccine and symptoms of COVD-19 suggests that mandating that everyone get vaccinated is a misguided approach as there are potential risks involved with inoculation as well as viral exposure. The takeaway from these realities is that patients should consult with their doctors to determine the best course of action regarding their personal health decisions. #3: COVID-19 Vaccines Are Not "Perfect" Like Many Existing Vaccines Unlike existing vaccines for things like measles, mumps, and rubella, which are regarded as "perfect" vaccines, the mRNA vaccines developed to provide protection against COVID-19 do not provide similar full-spectrum immunity or completely stop the transmission of the virus. Andrew Read, author of the 2015 study on the impacts of imperfect vaccination and an Evan Pugh professor of biology and entomology at Penn State University, explained the criteria for what constitutes a perfect vaccination: "When a vaccine works perfectly, as do the childhood vaccines for smallpox, polio, mumps, rubella and measles, it prevents vaccinated individuals from being sickened by the disease, and it also prevents them from transmitting the virus to others." Vaccines that do not both provide immunity to catching a disease and block transmission of the disease to others can be referred to as "leaky" vaccines. There is still a statistically significant chance that vaccinated individuals can catch the virus, transmit the virus, and die from the virus. In light of that, it may be more accurate to view the vaccine as one of many emerging therapeutics as opposed to an immunization that grants full protection. #4: Health Officials Increasingly Disagree About Recommending Additional Vaccines: Currently, some 58 percent of Americans have received two doses of an mRNA COVID-19 shot. The CDC has recommended a booster dose for certain vulnerable populations, and some health officials, such as Dr. Anthony Fauci, are now pushing for a third shot to be incorporated into the standard vaccine regimen for the general public. This remains a controversial policy even within the medical community, as two top FDA officials recently resigned over the Biden administration's political push for wide scale use of boosters before data had been properly reviewed by the FDA's Vaccines and Biological Products Advisory Committee. When the committee finally met to discuss boosters, it rejected a proposal aimed at the general population in lieu of more targeted risk categories, despite urging from the Biden administration for a broader recommendation. In the words of Dr. Paul Offit, reflecting widespread non-expert sentiment that public health authorities have been overbroad in

their prescriptions, "We're being asked to approve this as a three-dose vaccine for people 16 years of age and older, without any clear evidence if the third dose for a younger person when compared to an elderly person is of value." #5: The Enthusiasm for Vaccines Ignores the Benefits of Natural Immunity: A critical component missing from the public debate is whether or not natural immunity confers equal or perhaps greater protection than the mRNA vaccinations. Some elected officials, such as Sen. Rand Paul (R-KY), have repeatedly pressed health officials concerning the need to know what impact previous infection has on an individual's immune system. The response to such questions has revealed an astonishing lack of both knowledge and intellectual curiosity. Dr. Fauci admitted during an interview that he simply does not have a "firm answer" on what kind of protection natural immunity provides. This is despite the fact that nearly 46 million Americans have already contracted COVID-19. As not every case is reported and a significant share of COVID positive cases are asymptomatic, 46 million is undoubtedly a conservative figure. At minimum, nearly 15 percent of the US population has been infected with COVID-19. Yet, the Biden administration's mandate offers no accommodation to account for this enormous population of Americans, for whom the benefits of vaccination remain ambiguous. Public health officials should want to know what impact prior infection may have on an individual's immune system, propensity to be reinfected, and ability to transmit the virus to others. To date, there has been no wide range longitudinal study embraced by the US federal government outlining the full effects of natural immunity. A recently-released CDC study says that the mRNA vaccines provide more protection than natural immunity. The study looked at some 7,000 adults hospitalized with COVID-19 and presented data suggesting those hospitalized patients who were not vaccinated but had been previously infected were five times more likely to test positive than those who had been vaccinated. The study has serious limitations that even its authors acknowledge. These include: Potential for misclassification of patients and their source of immunity Inability to control for the likelihood of vaccinated individuals to get tested Potential for selection bias based on whether or not vaccination or previous infection influences likelihood of testing Limited focus on just nine states and usage of a statistical model that is subject to error if the authors mis specified parts of the data In short, this CDC data might be helpful for determining the efficacy of natural immunity compared to vaccination, but its limitations leave many unanswered questions and suggest that additional studies need to be performed. A highly-touted study out of Israel has shown those who are vaccinated are six times more likely to have a breakthrough case than those with natural immunity are to have a reinfection. This data begins to at least address the relative potency of natural immunity when it comes to future infection potential. The Israeli study also found that the highest level of protection is a combination of both natural immunity and vaccination. The limited amount of information and data collected by federal health officials regarding natural immunity has contributed substantially to mistrust toward public health authorities and policies such as the Biden vaccine mandates. The Biden administration has made no effort to explain why an individual who already possesses immunity to infection should be required to take the shot. #6: Vaccine Mandates are Premised on an Artificial Public Policy End-Game: Public health officials have repeatedly emphasized the importance of "herd immunity" as a key element in ending the pandemic. Yet, there has been no official effort made to incorporate those with natural immunity alongside vaccinated individuals in the tally of those who have some degree of protection from COVID-19. Moreover, some public health officials, such as Dr. Fauci, have intentionally misled the public about their views on the thresholds required to achieve herd immunity, while others have conceded that COVID-19 is likely to become endemic regardless of vaccinations. The shifting goalposts on herd immunity have served to sow further distrust toward elected officials and public health bureaucrats. The United States has anywhere between 60 and 70 percent of its population with some degree of immunity. This percentage is a combination of the vaccinated population (roughly 190 million Americans) and the minimum 15 percent of the US population that has already had COVID-19 (some 45 million Americans) and takes into account some degree of overlap. Simply put, the vast majority of Americans now have some measure of protection against COVID-19. Additionally, when one looks at the case fatality rate of those under the age of 18 (0.01 percent), it is clear that COVID-19 poses relatively little risk to this population group. Despite this low risk, FDA approval of childhood vaccinations is almost certain to kickstart a new wave of debate over mandatory vaccinations of this population. Given the declining rate of vaccinations, it is reasonable to be concerned about the potential for the Biden administration to use childhood vaccinations to boost the topline vaccination number. Children, particularly those 12 and under, comprise a significant percentage of the remaining unvaccinated population. And, according to the CDC, at least 2.7 million kids under the age of 12 have already been infected with the virus. This leads to another outstanding issue, which is whether or not herd immunity to COVID-19 has been reached and whether or not an endemic version of the virus affects the public policy endgame. For months, Americans have been told that the herd immunity threshold was between 60 and 70 percent. Dr. Anthony Fauci, who admitted to intentionally changing that estimate, then claimed it could be as high as 90 percent in what appears to be ever shifting goal posts. Aside from creating obvious public mistrust, the constant change in herd immunity thresholds is concerning because it bears heavily on whether public health officials know what metric is necessary to recognize the pandemic's end or manifest any willingness to get there. Relatedly, highly vaccinated states are currently experiencing some of the highest case rates per capita in the nation. For example, at the time of publication, New Hampshire has the 6th highest number of cases per capita, despite having the 3rd most-vaccinated population per capita. Several questions naturally follow in light of this reality: Is herd immunity actually possible with COVID-19? If so, what percentage of the population needs to have protection and why are public health officials not counting the vaccinated and those with natural immunity as

part of that assessment? Are the mRNA vaccines actually effective at mitigating viral transmission? If so, then why such high case rates in heavily vaccinated populations? Is the protection conferred with mRNA vaccines waning faster than the protection conferred by natural immunity? #7: Vaccine May Leave People Vulnerable to Newer Variants: Another lingering issue regarding the virus and the vaccines is whether or not the mRNA shots are potentially reducing long term societal protections from COVID-19. Specifically, do the mRNA vaccines' existing effectiveness against the alpha and delta variants, whatever that may be, present a scenario that could make large segments of the population vulnerable to mutations and future variants of COVID-19? The existing data we have shows a relatively significant reduction in protection for the vaccinated against the delta variant in comparison to the alpha variant. The Pfizer vaccine went from roughly 94 percent effectiveness against symptomatic infection against alpha to as low as 40 percent against delta. Moderna saw its efficacy reduced by half against delta. Will the emerging mu variant or lambda variant or a future zeta variant cause similar immunity gaps and vaccine efficacy loss among vast swaths of the population? This is not to definitively state, by any stretch, that the existing mRNA vaccinations are leading to more virulent variants of COVID-19. There is no hard evidence of that. However, concerns over the reduced efficacy from alpha to delta remain valid because a scenario wherein a vaccine may provide relatively strong personal protection against significant sickness or death, but does not stop a person from getting infected and does not stop viral transmission to others, could very well lead to a long-term "leaky" vaccine scenario. There is recent history that shows how a leaky vaccine could greatly enhance the deadliness and infectiousness of a disease over time. What started out as a mild, but highly contagious, virus in chickens known as Marek's disease became more virulent and dangerous after wide scale implementation of a leaky vaccine. Although the Marek's vaccine does not prevent transmission by or infection in its hosts, the mRNA COVID vaccines do provide statistically significant reductions in transmissibility and serious infection. The result of the Marek's leaky vaccine made the disease even more dangerous than it was prior to the development and implementation of the vaccine. A comparison of chickens and people may seem questionable at a glance, but the concept of a leaky vaccine bolstering the very disease it is designed to mitigate is a prevailing concern. After all, there is a long history of animals being used in the development and testing of medicines and treatments for humans. The mRNA vaccines were tested in both mice and primates. All of these considerations ultimately emphasize the importance of the patient-doctor relationship to determine what is in an individual's best interests with regard to the vaccine. Furthermore, while these lingering issues form the foundation of health-focused concerns about the vaccine mandate from the administration, substantive opposition to such an unlawful edict is far broader in its scope. (Policy Brief from Center for Renewing America, Nov. 4, 2021)

From: Corina Galoia
To: DOH WSBOH
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting
Date: Thursday, November 4, 2021 7:20:44 PM

External Email

If you are considering mandating this vaccine for children, be prepared for parental OUTRAGE and a MASSIVE DECLINE in public school students. We are prepared to fight against this every step of the way. We will protect our children AT ALL COSTS. This vaccine is unethical, untested & a mandate is UNCONSTITUTIONAL. As parents, grandparents, aunts, uncles & other caregivers, we know our rights and will not comply. The public school system will lose an astronomical amount of funding as they watch their numbers of enrolled students fall right before their eyes. Lawsuits, protests and boycotts will be just the tip of the iceberg that is to come from the thousands of people who REFUSE to have their right to medical freedom taken from them.

Use your very best judgment when deciding whether or not you even want to toy with the mere IDEA of mandating this vaccine for children.

Sincerely,
Corina Galoia

Sent from my iPhone

From: Colleen Harrison
To: DOH WSBOH
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting
Date: Thursday, November 4, 2021 7:23:14 PM

External Email

I am a grandparent of school age children, and a retired RN. I am opposed to having young children be exposed to this experimental vaccine .

Our children will be removed from any public school system which attempts to create the mandated vaccine. Medical freedom is a constitutional right.

Colleen Harrison
Shoreline, WA

Sent from my iPhone

From: Chloe Gerardi Smyers
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 6:32:53 PM

External Email

Hello,

The COVID-19 vaccine has risk to it, and with risk there should be choice. I understand the reluctance to give people a choice with the pandemic, however it is common knowledge that people with the vaccine can still get COVID. I have had many vaccinated friends experience this- some really bad. It is completely NOT nessescary for one to get the vaccine- people are still going to get sick. The vaccine is only semi-effective and there are much better solutions to help this, maybe even start the stop of this pandemic (ISCAN, see in references)! Our attentions should be on helping people, not this.

This vaccine presents a risk to children, and parents should at least have choice over whether their child gets the vaccine. From October 22, there have been 16, 716 adverse events from the vaccine in the 12-17 year old age group (Informed Choice WA, see in references). This includes 27 deaths and 1,435 serious reactions.

There is much more information on InformedChoiceWA.org I beg you to research further on this issue before making a descision.

And remember, there is so much more information out there. This is only short blurb of what I had the time and energy to write.

I'm sure you agree with me, in that, no matter what people have a right to their bodies, especially when taking something that poses a risk to them. Please don't mandate this- it will have disastrous effects on our children- my own little sister will get very ill from the vaccine as they affect her very badly. Maybe there will be medical exemptions, but people have talked about taking those away, too. They're already restricting them (Bill Q and A on the restriction, see in references). Please don't do this.

Please don't vote to hurt my sister among others.

Thank you,

Matteo (Chloe) Smyers

References:

https://www.usnews.com/news/best-states/articles/2019-09-24/california-law-to-restrict-medical-vaccine-exemptions-raises-questions-over-control (Note: this source is the only one without bias on my list. It is an analysis on the ethics of these problems when they were beginning to show in 2019,
which has since increased dramatically by Prof. Drabiak, JD)

http://0x124.mjt.lu/lnk/AVsAABDYgekAAABBguwAAAr0Iz0AAAAAu9MAALoOABkwhABhhFkFOD9tgboARdSG42tNa45YpAAYgA4/7/fSBKR_tOSdTgvg-VQnrSLg/aHR0cHM6Ly9tZWRhbGVydHMub3JnL3ZhZXJzZGIvaW5kZXgucGhw

https://www.chhs.ca.gov/blog/2019/09/09/senate-bill-276-and-senate-bill-714-vaccinations-and-medical-exemptions-questions-and-answers/.

http://0x124.mjt.lu/lnk/AVsAABDYgekAAABBguwAAAr0Iz0AAAAAu9MAALoOABkwhABhhFkFOD9tgboARdSG42tNa45YpAAYgA4/7/fSBKR_tOSdTgvg-VQnrSLg/aHR0cHM6Ly9tZWRhbGVydHMub3JnL3ZhZXJzZGIvaW5kZXgucGhw

From: Just Bme
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 5:55:52 PM

External Email

Please do not mandate the vaccine make it a choice not only can you still get the diseases after the vaccines where there is harm there must be choice please let's not pretend that people are not being harmed and have not died from vaccines when we've all very well known that many people have. We the people are not blind to this we listen to our fellow Americans and do not call them liars. Plus there is also the United States Constitution which clearly States freedom of religion and a part of that regardless of what leaders are trying to say possibly paid off to say so is freedom to choose what is best for your health what is injected and enters one's body. My body my choice.

Thank you,

Donna Blakley

From: Deborah Fletcher
To: DOH WSBOH
Subject: Comment for 11/10 Board Meeting
Date: Thursday, November 4, 2021 7:14:33 PM

External Email

Dear Mr. Grellner, Mr. Pendergrass, Mr. Kutz, Ms. Crawford, Ms. Lentz, Ms. Crockrell, Ms. Bessermin, Mr. Lutz, and Dr. Shah:

PLEASE DO NOT mandate the COVID-19 inoculation(s) for our children in WA State! There is NO COVID-19 health emergency in children 5 to 11! According to the published data by the CDC, 99.99815% of children who contract COVID-19 survive!

Thank you for your time and sincere, **unbiased** consideration!

Respectfully,
Deborah Fletcher
Spokane Home Owner in the Mead School District with four grandchildren all under 12 years of age.

From: Bowentherapy
To: DOH WSBOH
Subject: Public Comment
Date: Thursday, November 4, 2021 6:45:00 PM

External Email

I

- Based on all scientific, medical, US government information there is no Covid emergency for ages 5 to 11. Very few children have die from Covid, and those that did actually were very sick from everything I've read and know to be fact.

- Based on all we have known and we know now - Natural immunity needs to be part of the risk-benefit analysis and can no longer be ignored.

- I know of 15 aduts age 20 to 70 that have died as a direct result of taking the Covid-19 Vaccine. I know 3 people with serious injuries. Vaccine injury from these vaccines is "real, not rare" and parents must have the final say in their children's medical care. I have a friend who's son now has Guillain-Barre syndrome as a direct result of the covid-19 vaccine. There are hundreds of children age 15 - 20 with this syndrome now, and heart issues.

- The TRUTH IS Transmission of COVID-19 among children in schools and daycares is very rare.

- This is the TRUTH - According to published data by the CDC, 99.99815% of children who contract COVID-19 survive. I have seen this study!

- There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was "unblinded" and allowed to get the vaccine.

- This is NOT a FDA approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental drug.

- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12- to 17-year-old age group.

- The Pfizer mRNA vaccine causes catastrophic side effects, particularly myocarditis and pericarditis in youth. The CDC's own analysis of "Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event Reporting System (VAERS)" showed astonishing increases in the youngest age brackets.

- Healthy adolescents aged 12-17 who have been given covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue. As I said earlier I know one young man - age 17 with Guillain-Barre Syndrome - directly related to the vaccine.

- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that, "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."

o Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children.

IF YOU AS A DEPARTMENT CHOOSE TO CONTINUE THIS INSANITY OF INJECTING THE CHILDREN OF WASHINGTON STATE, WE WILL HOLD YOU ALL PERSONALLY ACCOUNTABLE FOR EVERY INJURY AND EVERY DEATH!! THEY WILL HAPPEN, BECAUSE THEY ARE ALREADY HAPPENING ALL OVER THE WORLD AND YOU CAN NOT DENY IT.

Sincerely,
Diane Gerig
Pasco, WA

.

From: happydog023@centurylink.net
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 6:47:25 PM

MEMBERS OF THE SCHOOL BOARD,

We have heard that you are deciding whether or not to mandate or require school age children to receive the Covid biologic in order to attend school. This is an unlawful trespass against the property of living men and women.

There is no reason for this to occur, as it is a biologic, not meant for health reasons, and does not qualify as a vaccine, which is how you are misrepresenting it. This is an unlawful action in itself. To trespass against the property of a living man or woman is in violation of Common Law.

There is no higher law in the land than the Law of the Land; Common Law, given to us by our Creator, God. You are operating under Corporate and Admiralty Law, which is unenforceable on a living man or woman, and a trespass on their property. It is wrong and you surely know this.

We order you to cease and desist now. Keep your bloody hands off of our property.

we the people

From: Eve Parshall
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 3:31:28 PM

External Email

Please stop with the mandates. The COVID-19 shot is still new and we are still learning on a daily basis what side effects there are and how effective it really is. It is inhumane to mandate something that still has so many unknowns.

From: Fabiana Pierce
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 6:12:08 PM

External Email

To whom it may concern,
It is unethical to condone the use of experimental medical interventions in children. Be mindful that mandates are unlawful.

Chad and Fabiana Pierce

"The world is my mirror and I polish this mirror so it reflects the truth of my being".

Sent from my iPhone

From: GEORGE DOANE
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 6:29:30 PM

External Email

No vaccine mandate period. It should be the right of the individual to make that decision

Sent from my iPhone

From: Geri Rubano
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 4:33:32 PM

External Email

To The Clark County Board of Health,

I oppose any and all Covid-19 vaccine mandates for children to attend public and/or private schools in Clark County. There is no long term safety data for children (for anyone, really). Children are not dying from this virus nor do they pose a threat in the spread. Allow parents to make a decision for their family on what medical decisions they chose and don't allow coercion to take hold.

Thank you,

Geri Rubano

From: Hailey Nutt
To: DOH WSBOH
Subject: Let Parents Call the Shots
Date: Wednesday, November 3, 2021 5:35:37 PM

External Email

Dear Washington State Board of Health,

As a Washington resident and mother, I am writing to express my concern for COVID-19 policies, including possible COVID-19 vaccine requirements for school/daycare attendance in Washington.

The following events have been brought to my attention:

-The Emergency Use Authorization (EUA) granted to Pfizer by the FDA for kids 5-11

-The existing EUA for kids 12 and older

-The resolution pending approval from the Seattle School Board requesting the State Board of Health add the Covid-19 vaccination to the school schedule upon approval.

I am grateful for the development and availabilty of several COVID-19 vaccines in the past year, and I believe every American who wants a COVID-19 vaccine should be able to get one. However I do not support vaccine mandates, and I believe that parents should decide whether a COVID-19 vaccine is appropriate for their child based on information from their children's pediatrician regarding the benefits and risks of the vaccine.

Parents are concerned about the health of their children and anything that could jeopardize that health, whether it be risks associated with a COVID-19 infection or risks with COVID-19 vaccine injury. Since there is data showing rare, yet very real risk to both infection and vaccination, it is best to leave the decision whether to vaccinate to the parents who will shoulder 100% of the burden of those risks.

If you feel it is in every child's best interest to be vaccinated with a COVID-19 vaccine, then I suggest your efforts should be aimed at educating parents on the benefits and risks, so they can feel confident in their decision about whether to vaccinate their child or not. Establishing mandates and requiring COVID-19 vaccination for school or daycare would only decrease the trust us parents have in you and the vaccine. I believe unbiased and honest education is the the answer to the complex challenges we face in this pandemic, not forcing medical decisions on those who don't want them.

As I have said repeatedly, I do not believe in one-size-fits-all healthcare. Every child is

biologically unique and will respond to a COVID-19 infection or a COVID-19 vaccine differently. It is up to us as parents to do our best to learn as much as we can, weigh the benefits and risks, and then choose what is best for our children individually.

Liberty is a foundational value of our nation, and I sincerely hope that you will not support a mandate that limits an individual's freedom to make their own healthcare decisions. I expect you to oppose any mandates for schools as well as oppose adding any COVID-19 vaccine to the required list for participation in school.

Thank you for listening to my concerns,

-Hailey de Paula

From: V
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 3:39:57 PM

External Email

OPPOSE COVID VACCINE MANDATE FOR SCHOOL

There are no long-term safety studies of mRNA Covid vaccines, nor have they been evaluated for carcinogenic or mutagenic potential or for impairment of fertility.

Clinical trials for adults aren't even to be completed until 2023 and VAERS is showing that these vaccines are not safe.

Causing unknown long term damage to children and young adults for a virus that is not a threat to them is medically unnecessary.

From: Barbara Amidon
To: DOH WSBOH
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting
Date: Wednesday, November 3, 2021 1:57:19 PM

External Email

Regarding the Agenda Items addressing Covid 19:

Since the Covid-19 vaccines are now available for children ages 5-11, I STRONGLY urge you NOT to mandate this vaccine for children, NOR make it a part of the required vaccine schedule for children for the following reasons:

*There is NO FDA approved m-RNA Covid-19 vaccine for children, which makes this an experimental vaccine for everyone, especially children in this age group. The fact that Pfizer has recently approved a drug which targets blood clots for children ages 5-11, makes this trial vaccine more alarming.

*Vaccine injury in adults and teens from these vaccines is seen in the thousands of VAERS reports. Mandating these unproven vaccines is wildly irresponsible. Adults, and now healthy adolescents aged 12-17 who have received the CV-19 vaccine have developed blood clots, myocarditis, pericarditis, and lasting neurological symptoms.

*The CDC has published data which states the survival rate for children in this age group (5-11) is 99.99%. This is not a health crisis for children in this age group.

Vaccine injury from these m-RNA vaccines is real and often has life altering effects. Parents, not the governor, nor OSPI, nor the Washington DOH should have the final word in their children's health care.

Barbara Amidon
Olympia WA

From: Janet Ellis
To: DOH WSBOH
Subject: MRNA vaccines in children.
Date: Thursday, November 4, 2021 7:17:37 PM

External Email

I want to express my great concern and I'm urging you to vote no on vaccinating young children. There is no Covid health emergency and children 5 to 11.
Natural immunity can no longer be ignored as a benefit against this virus.
Vaccine injury is very real not rare, parents must have the final say in their children's healthcare. There has been no long-term adequate studies proving the safety of the mRNA vaccine.
This vaccine is not FDA approved.
Pfizer MRNA vaccine can cause myocarditis, pericarditis, blood clots and neurological damage to youth.
The makers of these vaccines won't even take responsibility if damage is done to someone from getting the mandated vaccine.
The vaccine hasn't proved to stop infection, hospitalization nor death.
I am ya Washington State citizen and business owner, I'm urging you to vote no.

Sent from my iPhone

From: 1Saorsa
To: DOH WSBOH
Subject: Public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 6:05:02 PM

External Email

Washington State BOH members; It is my understanding you may discuss/consider adding the EUA Covid-19 vaccines to the required list/vaccine schedule for children to attend public school. If that is the case, I am providing my input/indisputable facts in opposition to that action.

- According to data published by the CDC, 99.99815% of children who contract Covid-19 survive.
- There are no long-term safety studies of mRNA Covid vaccines, nor have they been evaluated for carcinogenic or mutagenic potential or for impairment of fertility.
- Pfizer's BNT162b2 is NOT FDA-approved; it has merely received EUA. In other words, it is experimental.
- According to data available from the Vaccine Adverse Event Reporting System (VAERS), as of October 22, there had been a total of 16,716 reports of adverse events, including 1,435 serious reactions and 27 deaths in the 12- to 17-year-old age group.
- The Pfizer mRNA vaccine has caused devastating injuries in some youth, including myocarditis and pericarditis. The CDC's own analysis of "Myopericarditis following Covid-19 vaccination: Updates from the Vaccine Adverse Event Reporting System" shows astonishingly high incidence in the youngest age brackets.
- Healthy adolescents ages 12-17 who have been given Covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue.
- The vaccine does not prevent infection, transmission, hospitalization, or death. A recent study from the Harvard Center for Population and Development Studies states it plainly: "Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States." Researchers found that "countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days."

Thank you for your consideration, sincerely Jeffery P Eiffert

From: Jack Grady
To: DOH WSBOH
Subject: Vaccinations to kids
Date: Thursday, November 4, 2021 8:16:17 PM

External Email

As a Washington citizen, tax payer, grandfather of 8 and father of 4 I oppose giving Covid vaccines to kids. Please do not mandate.
Jack Grady
Spokane, WA

From: Jessica Martin
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 6:20:13 PM

External Email

> Children and youth need a natural immunity, adults need natural immunity. The vaccine is not truly approved as safe it was approved for emergency measures only.
> Thank you for your time

Sent from Yahoo Mail on Android

From: Janet Sedy
To: DOH WSBOH
Subject: No Covid vax mandates for kids
Date: Thursday, November 4, 2021 8:13:46 PM

External Email

To Whom it May Concern,
Please do not implement a Covid Vaccine mandate for children in daycares or schools. These vaccines are still only authorized for emergency use and therefore no one, especially children, should be forced to take these vaccines. Covid-19 in all of its mutations is a very survivable infection for children. More children in the 12-17 age range have suffered harm from the vaccine than the number of children who suffered death or permanent injury from Covid-19. Children are also very unlikely to pass the illness to adults. Even so, it would be morally wrong to subject a child to the risk of injury or death from the emergency use vaccine in order to possibly protect the life of an adult.
Do the right thing. Allow parents to decide UNCOERCED and FULLY informed of the risks if any of the Covid Vaccines are right for their children.

Regards,
Janet Sedy
313 N 50th Ave, Yakima WA
--

Janet

From: KerriAnne Dizon
To: DOH WSBOH
Cc: KerriAnne Dizon
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting
Date: Thursday, November 4, 2021 7:46:09 PM

External Email

Hello,
As a lifetime resident of Washington, I would like to ask you to oppose ANY Covid-19 vaccine mandate for our children in all public & private schools. Covid-19 vaccines shall not be required for participation in learning. Learning is a fundamental right, as is our medical freedoms. The vaccine injection shall remain a right of each and every parent. The safety of the vaccine is unknown at this time, which has been confirmed by a member of the FDA panel on 10/26/2021, which he states “We are never going to learn about how safe this vaccine is unless we start giving it”. With this statement alone, the safety of this vaccine should remain in question, until all data is available. Parents shall have the right to make this decision and their decisions shall be respected. Thank you for your consideration.
Federal Way Resident,
Kerrianne Dizon

From: Kathryn A. Garberich
To: DOH WSBOH
Subject: Covid Vaccine Mandate for Kids for School attendance
Date: Thursday, November 4, 2021 4:08:44 PM

External Email

To whom it may concern:

I just wanted to submit my sincerest concerns for the possibility of vaccine mandates for young children coming soon. From all the studies I read, and the reports that support so many sides in this pandemic, there is almost zero risk for children from Covid-19. They could die of head trauma, car accident, and cancer more than Covid-19 I suspect. Children with underlying health conditions would of course want to vaccinate if the benefits were in their favor! I am vaccinated myself and all the teachers at my kids school are as well.

Please consider allowing parents to make the decision to vaccinate their kids or not. Both my kids, ages 11 and 9 had covid-19, 2 weeks ago, with mild symptoms for one and completely asymptomatic for the other. This is the norm for every single child I personally know of. I suspect they caught it at urgent care when we sent in for a concussion appointment. Please allow previous infection as an approved exemption for these mandates. We are preparing to move out of state should mandatory vaccines become required for my kids. I have lived in Washington all my life and I am so disturbed at the rate of decisions that government is making for Washingtonians.

I understand and know so many in the medical field that have both been overwhelmed with the very sick and completely frustrated by the inability to treat their patients as they would want to. I firmly believe that the hospital rate would be lower if the medical community was allowed to treat early (EARLY I SAY) and were given some advice from the Wa State Board of Health. It's just criminal. Israel is now at over 60% of their population vaccinated and has one of the highest Covid -19 case count right now. It should be what can we do to treat during the first few days before anything gets so severe that people can't breathe or worse.

I was contacted by the Snohomish County Health Office 2 weeks ago regarding my kids Covid-19 and I heard no fear, no craziness, just calm informative staff that gave and confirmed common sense information. Stop letting the fear drive our policies. I have lost a brother in law and a neighbor to Covid-19 so I understand the risks, but both of them were overweight and died under the ventilator protocols. Please help people to get treated early and never get to the hospital stages. Please don't subject our children to vaccinations for Covid-19, we need so much more testing. We can do better by our kids!

Kathryn Garberich
Snohomish County Resident
425-210-0777

From: Katie Krombein
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 4:15:06 PM

External Email

It is absolutely unacceptable for WA state to require a vaccine mandate of any type, ESPECIALLY for children for whom covid-19 poses almost no health risk, whereas the vaccine causes health problems of varying degrees. We know a 12 year old with myocarditis because of the vaccine and are horrified that lawmakers would continue to dish money to drug companies while our children suffer the consequences. Let parents make the choices for their children!

From: K Lewis
To: DOH WSBOH
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting
Date: Friday, November 5, 2021 11:55:48 AM
Attachments: KL - Public Comments for WSBOH Members from March EH Committee Special Meeting.docx

---

External Email

Please accept my attached comments for your upcoming Board Meeting and discussion of the COVID-19 vaccine in our young children.

November 5, 2021

Dear Chair Grellner and Members of the Board:

In regard to the upcoming Board meeting to consider school vaccines, the recently approved Emergency Use Authorization of the COVID-19 mRNA vaccine for children 5 though 11 and state mandates, please accept the following comments as my **vehement opposition** to any mandate of the Pfizer-BioNTech amended Emergency Use Authorization (EUA) for administration of its COVID-19 mRNA vaccine to children 5 through 11 years of age. For reasons explained briefly below, there is no justifiable rationale to mandate the Pfizer-BioNTech amended EUA (not fully approved for children 5-11). Furthermore, as described below, approval or tacit support of the EUA amendment can only be made by willfully and recklessly ignoring severe adverse effects in younger populations. The data submitted in support of the EUA amendment is so selective and limited that it suffers from Sample Size Neglect. This fatal flaw in the data mean that the Board must consider the data within the proper context, which is that it is too small, selective, underrepresented of the target population and inherently biased to allow any meaningful conclusions to be drawn from it. Further, the FDA EUA amendment was made with serious concerns from FDA experts in a mandate being applied to the 5-11 age group.

Reviewing the EUA amendment, it was surprising to see that the company didn't provide adequate data to support its broad request, given the potential risk to children. It is clear that the industry believes that there will be no scrutiny of its data or relevant review of the proposal. Since Dr. Anthony Fauci and the White House have already started advertising a program to vaccinate children of all ages, the FDA's review of the amendment was seemingly predetermined. In addition to the lack of meaningful data, the EUA amendment broadly applies to all children 5-11, instead of focusing on those that may have a medical reason to have the vaccine, children that have serious underlying comorbidities or more appropriately requesting Expanded Access for use of its vaccine in children 5-11.[1] The discussion of adopting the EUA amendment for 5-11 children shows a complete disregard for any meaningful benefit to the targeted population in the EUA amendment.

- **Children comprised 0.00%-0.25% of all COVID-19 deaths, and 7 states reported zero child deaths**
- **In child COVID-19 cases, 0.00%-0.03% resulted in death[2]**
- **<u>Compare these numbers to the EUA Pfizer-BioNTech Fact Sheet for Vaccination Providers showing that there is a .4% reported "Serious Adverse Events" in study participants between 12 and 15 years old.</u>**

[1] 21 U.S. Code § 360bbb - Expanded access to unapproved therapies and diagnostics

[2] https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/children-and-covid-19-state-level-data-report/

In addition to the lack of an emergency for the target population, the data submitted by Pfizer to support the EUA amendment deceptively stated a 90% success rate. The COVID-19 rate in children 5-11 is so low that there were ZERO cases of severe COVID-19 and ZERO cases of death from COVID in either the treatment or control group of the trial study. The 90% calculation was made from inferring MILD cases of COVID which were more subjective and negates the stated benefits from the assessment, when compared to the risks.

Along with the deceptive success rate, the clinical trial was intentionally conducted in a group smaller than KNOWN severe adverse effects populations. The rate of some of the severe adverse effects are 1 in 5,000 so the trial conveniently and deceptively only enrolled 1,518. Potentially worse than the small number of candidates, Pfizer did not conduct research in those that had previously been infected and therefor negated the ability to determine if the vaccine hinders or wipes out natural immunity.

The Board must also consider that Pfizer lost contact, or selectively eliminated at least 4.9% of the trial participants. That means that the group did not get included in final results on severe adverse effects. This is in light of a very deceptive and intentional short follow up period (cohort 1 followed for 2 months, cohort 2 followed for 17 days for adverse effects). In addition to a severely shortened follow up period, the FDA only required the company to look for myocarditis. There are known and documented adverse effects that include anaphylaxis, Bells Palsy, heart attack, thrombocytopenia, low platelet, shingles, GBS, autoimmune disorders, endocrine disruption and more but they were completely ignored.

The allowance of Pfizer and the FDA to use vaccine effectiveness as measured by immunobridging ("borrowing data from other studies because yours isn't sufficient").

At its core, the federal government and those involved in leading efforts to bring the pandemic to an end, has been reduced to a polarizing and divisive strategy of vaccinate everyone and it's the only answer. This "all or nothing" approach underscores the little publicized but glaring fact that the COVID-19 vaccines available to the public are at best an "imperfect vaccine" (which presents serious risks).[3] The push then by the government is to compensate for the vaccines deficiencies by forcing vaccination on as large a percentage of the population as possible (birth to death bed), regardless of the impact to a small percentage of the population (severe adverse effects, death, and disability of a few are worth the comfort of the many). The goal of this forced vaccination and erosion of regulatory ethics is to achieve herd immunity. The herd immunity threshold calculus can allow for an "imperfect" vaccine that is less than 100% effective at preventing infections—it simply raises the proportion of people who need to be vaccinated.[4] Ironically, had the government taken the approach of looking at levels of immunity, instead of forced vaccination, then there would have been an opportunity to productively engage the public, earn public trust and have better data on what a true herd

[3] Imperfect Vaccination Can Enhance the Transmission of Highly Virulent Pathogens, July 2015
[4] https://www.pnas.org/content/118/21/e2107692118

immunity level would be.

A brief example highlighting the lack of public notice and information available by the federal government and the limited attention being paid to risks of severe adverse effects regarding vaccinating children can be noted in the August report by the CDC stating that the "CDC reviewed 14 reports of death after vaccination. Among the decedents, four were aged 12–15 years and 10 were aged 16–17 years. All death reports were reviewed by CDC physicians; impressions regarding cause of death were pulmonary embolism (two), suicide (two), intracranial hemorrhage (two), heart failure (one), hemophagocytic lymphohistiocytosis and disseminated Mycobacterium chelonae infection (one), and unknown or pending further records (six)."

With everyone wanting to make a headline that there is a "cure" to COVID-19 and to give the public hope that an end was in sight, the regulatory review of the COVID-19 vaccines has been given a "light touch" in critical analysis of its clinical trials and the real efficacy. Having absolutely no data integrity, introducing known and critical biases into the clinical trials and using a very selective and underrepresented sample population the vaccines achieved their advertised percentage of success. However, the truth has been playing out in the real world and regardless of vaccination levels, COVID-19 continues to be a "statistical anomaly". If the vaccines truly protected at 90% or higher, if they prevented a vaccinated individual (even asymptomatic) to note pose any risk of infecting others or if it provided protection at a consistent level then we would not see the "outbreaks" that we have witnessed globally. Due to these failures of the vaccines, it seems like a stretch to consider them as meeting the federal definition/standard, "the term "vaccine" means any substance designed to be administered to a human being for the **prevention of 1 or more diseases**.[5] The data shows, and government reports, that the vaccines have been effective at **reducing the risk of severe COVID-19 symptoms**. A vaccine that does not "**prevent**" the disease but only **reduces** the risk of **severe symptoms** does not qualify as a vaccine.

Another factor that needs to be considered in the EUA amendment pertains to the impact to the COVID-19 vaccination efforts by the federal government, when a severe adverse effect strikes a child 5-11, when all available data clearly shows that the mortality rate of COVID-19 in children without underlying comorbidities is **zero**. Pfizer's own data for 12–17-year-old children show a higher risk through vaccination than COVID-19 in young children.

The national/global discussion regarding COVID-19 vaccines is largely very short-sighted, establishing dangerous precedents for future vaccination programs and the authority of regulators as it relates to public safety. Authorization from the FDA, as outlined in the EUA, is a lower safety bar for pharmaceutical companies to meet showing no "immediate" or very short-term negative health effects that can be directly tied to the vaccines. This is the standard that the U.S. allowed the first ever messenger RNA (mRNA) vaccine to be brought to market for human use and later mandated by federal and state government. However, after the country

[5] 26 U.S. Code § 4132 (2)

and world inoculates its populations, there will be virtually nothing known about the long-term safety of the vaccines or unintended consequences of the vaccine mandates that follow every EUA authorization.

Regardless of the new and innovative technology used to develop the vaccine, the dangerous influence the pharmaceutical industry has over the federal government, and the intellectual property associated with the vaccines demonstrate how complex and potentially problematic the EUA approvals are for the country moving forward. New technology often brings new risks and disruptive technology like mRNA vaccines, which advance faster than its regulatory oversight, often reveal risks that were previously unknown.

"There is a race to get the public vaccinated, so we are willing to take more risks."[6]

[6] Tal Brosh, head of the Infectious Disease Unit at Samson Assuta Ashdod Hospital

As detailed below, there are systemic failures within the federal government's response to the pandemic that make the EUA amendment an unviable proposition. Unfortunately, many of those concerns have a much broader application than what is before the committee in this docket. The disregard by the federal government and pharmaceutical industry in ensuring data integrity is criminal. Clinical trials have been far too small and seemingly intentionally omitted diverse population segments to bolster stated "safety" data.

Unfortunately, due to the truncated comment period of less than 15 days on the amendment, the federal government and industry have continued to suppress public comment and valid concerns to the unnecessarily fast pace to approve the vaccine for 5–11-year-old children, despite no medical need. The areas that should be discussed further, in addition to those contained in this letter, include the following:

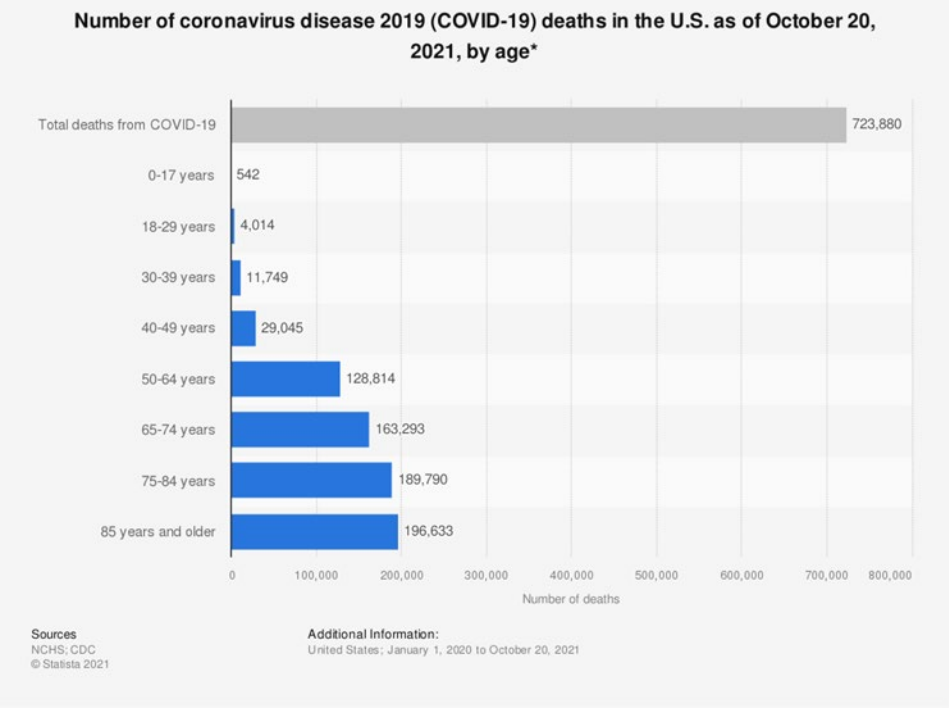
- There is a lack of evidence to support the targeted population in the EUA amendment.
    - As detailed below, the available data and relative risk to children, especially in the 5-11 age group, do not substantiate the EUA amendment.
    - Known adverse effects and severe adverse effects for the target population dwarf any societal benefit that may be argued in support of the EUA amendment.
- Compromised Data Integrity and Blatant Bias in Data Analysis.
    - Overreporting of unvaccinated COVID-19 infections compared to FDA directed underreporting of vaccinated individuals
- Government's Shortsighted Reliance on Vaccinations as Primary Strategy and the Stifling Impact to Critical Advances in New Treatment Options.
    - Dismissal of any discussions of immunity, regardless of how it was achieved
- Political Influence Over Vaccine Development, EUA Approval and Widespread Mandates.
- Government's Push in Polarizing Vaccination Concerns.
- Insufficient and Inadequate Clinical Trial Data, Analysis and Represented Population.
- Willful and Intentional Silencing of Discussion and Concerns Regarding the Unintended Consequences of the COVID-19 Imperfect Vaccination Record.
    - Clear indications of viral mutation based on both vaccinated and unvaccinated population with potential for more aggressive mutations occurring in vaccinated segments at a higher rate than unvaccinated
- Contradictory and Biased Antibody Level and Natural Immunity Analysis in Discussions and Decisions Impacting the Country.
- Inherent Acceptance and Silent Support on Government's Insistence in Mandating Every EUA Amendment Regardless of Risk.
- Distrust of the Guidance and Leadership in Battling the Pandemic and Receiving Reliable Information.
- Personal Experience Regarding Adverse Reaction to Vaccine; and
- Vaccine Ethics and Options for Alternative Considerations to the Pfizer-BioNTech EUA Amendment

Lack of Evidence to Support and Determination of Emergent Need for the Targeted Population in the EUA Amendment

The EUA amendment by Pfizer-BioNTech is a critical one since it will most likely, as reflected in the FDA's recent history, create a regulatory roadmap for all COVID-19 vaccines to follow. The committee must consider if it wants that roadmap to be a revolving door, with little oversight, by allowing an amendment for children ages 5-11 years old under a looser, less safe standard found in the EUA of a new product being evaluated under a very short and limited data set, with a standard of "may be safe and effective". Or, alternatively to the EUA amendment would be for any expansion of the COVID-19 vaccine to children ages 5-11 through a biologics license application (BLA) with a minimum of two to three years of data. The BLA also requires that the expansion of the vaccine to children be "proven to be safe and effective" instead of the EUA's "may be" standard. Considering the amendment being targets a population that will not benefit from the vaccine, it seems like gross negligence to consider adoption.

Regardless of the regulatory process the Committee considers, there is no legal, ethical, moral or medical justification that can be made to approve the amended EUA authorization for children ages 5-11. The FDA can only approve a medical product in a population if the **benefits outweigh the risks in that population** (in this case children 5-11). The impact of COVID-19, to the targeted population in the amendment, is far below any medically necessary standard and statistically insignificant (see table 1).

Table 1



As provided by the FDA, "Assessment of benefits and risks from clinical data—FDA reviewers evaluate clinical benefit and risk information submitted by the drug maker, taking into account any uncertainties that may result from imperfect or incomplete data. Generally, the agency

expects that the drug maker will submit results from two well-designed clinical trials, to be sure that the findings from the first trial are not the result of chance or bias… **Evidence that the drug will benefit the target population should outweigh any risks and uncertainties."**[7][8]

A review of the Committee's records also shows blood test data presented to the Committee from samples around the country looking for evidence of past infection. In these studies, about 27% of children under the age of 17 had antibodies to COVID — the most of any age group (more than 1 in 4 kids already has some natural immunity).[9] While the FDA, along with state and federal government agencies and health care providers, dismiss any adverse effects, imposing an impossible "event must be conclusively linked to inoculation" standard, there are significant uncertainties that exist regarding some serious health impacts due to the vaccines. A few tragic examples of severe adverse effects include:

Jacob Clynick, 13-year-old Michigan boy dies three days after his second dose of Pfizer Vaccine

Jacob Clynick died in his sleep, three days after receiving his second dose of the Pfizer vaccine. Health officials described Jacob as a healthy young boy with no underlying health conditions. Family members said he received his second shot of Pfizer at a Walgreens store, on June 13 and passed away in the middle of the night on June 16. His family stated that before his passing, he suffered similar symptoms to most persons after being vaccinated that were: fever, fatigue, and a slight stomachache. A preliminary autopsy report stated that his heart was enlarged with fluid around it when he died.[10]

At the time of his death, the CDC indicated that it would investigate Jacob's death following his vaccination. Investigations like this can take between three to five months to determine cause of death. **The length of time to conduct the investigation and lack of notice to parents and the public is significant, especially in relation to the FDA's data integrity and unblinding decisions (discussed later).**

Ernesto Ramirez Jr. – 16-year-old

Ernesto died five days after receiving the Pfizer vaccine. His father has been attempting to share his son's story, so parents are aware of something he was not. This is an example of how suppressed and dismissed severe adverse effects are treated by the government, media and medical community.

"My son received the vaccine, and he died a few days later, and the only explanation that was

---

[7] https://www.fda.gov/drugs/development-approval-process-drugs

[8] For an EUA to be issued for a vaccine, for which there is adequate manufacturing information to ensure quality and consistency, FDA must determine that the known and potential benefits outweigh the known and potential risks of the vaccine. https://www.fda.gov/vaccines-blood-biologics/vaccines/emergency-use-authorization-vaccines-explained

[9] Data presented to the Committee by Hannah Kirking, MD, a medical epidemiologist with the CDC

[10] 13-year-old Michigan boy dies three days after his second dose of Pfizer Vaccine. - Public Services Association; psatrinbagott.org

given to me was an enlarged heart," Ramirez told Life Site News earlier this year.

Ramirez told former Fox 26 Houston journalist Ivory Hecker that he was told the vaccine was one hundred percent safe and effective, which is why he allowed his son to get the shot.

"I kept hearing more advertisements about how it was safe for the teenagers, so I said 'OK,'" Ramirez told Hecker. "Two or three weeks later the CDC started announcing children were having enlarged hearts."[11]

Simone Scott, 19-year-old girl dies weeks after second COVID-19 vaccine dose

Simone Scott, following her second COVID-19 vaccine dose, grew tired, weak and dizzy leading her to the doctor's office and the discovery that she had developed an irregular heartbeat. Simone eventually had to be hospitalized for heart failure where she received several procedures including a heart transplant but ultimately died on June 11th. Her death was described as a medical mystery because there was no reason or rationale for her heart to fail.[12]

15-year-old high school boy in Sonoma County died less than 48 hours after second dose of COVID-19 vaccine

Sonoma County officials have stated that the 15-year-old boy had died within 48 hours of his second COVID-19 vaccine dose and that the California Department of Public Health and CDC had thoroughly investigated the case. The information available on the cause of death was that it was the result of stress cardiomyopathy with perivascular coronary artery inflammation. However, when asked by a news agency conducting a "fact checking" exercise, the outlet was told that the reason for the heart attack was "unknown" and that no one ruled the vaccine as the reason for the boy's death.

This example is given to illustrate the reluctance to tie any severe adverse effect to the COVID-19 vaccines. In fact, more often than not, severe medication complications related to the vaccine are dismissed by the medical community, as our family has experienced personally with my husband's adverse reaction to his vaccination and through family friends that have lost family members or suffered medical trauma as a result of vaccination.

In determining a risk to the population targeted by the EUA amendment it is critical to give the request its proper context.[13] The risk of hospitalization from COVID-19 in kids ages 5 to17 was 0.3 per million for the week ending July 24, 2021, according to the CDC. During the same time period the risk of hospitalization after the second vaccine dose due to myocarditis, or inflammation of the heart muscle, was about 50 per million in that same age group. According

[11] https://fee.org/articles/why-gofundme-deleted-this-grieving-father-s-fundraiser-after-his-son-s-death/

[12] Mason High School grad's cause of death remains medical mystery; fox19.com

[13] WHO COVID-19 Vaccines Advice page, June 25: Children and adolescents tend to have milder disease compared to adults, so unless they are part of a group at higher risk of severe COVID-19, it is less urgent to vaccinate them than older people, those with chronic health conditions and health workers. More evidence is needed on the use of the different COVID-19 vaccines in children to be able to make general recommendations on vaccinating children against COVID-19

to the CDC, at the same time, there were 19 other deaths in youth under age 25. These risks were well known to the CDC and despite them, during the same timeframe, and in stark contrast to public safety, the federal government's Advisory Committee on Immunization Practices adamantly recommended a two-dose vaccine regimen for all children ages 12 and up, regardless of circumstances. The data used by the advisory committee has been described by some in the medical community as "incomplete at best".[14]

Supporting the aforementioned information, detailing risk far above any benefit when applied to the EUA amendment, the EUA Pfizer-BioNTech Fact Sheet for Vaccination Providers states that there is a .4% reported "Serious Adverse Events" in study participants between 12 and 15 years old. To put the "Serious Adverse Event" number the company listed in context and assuming that children younger than 11 years old would react equally or better than the 12–15-year-old age group, a mandate requiring vaccination of children in the United States would conservatively equate to over 29,000 incidences of "Serious Adverse Events".

A serious adverse event is defined as:

- Death
- A life-threatening adverse event
- Inpatient hospitalization or prolongation of existing hospitalization
- A persistent or significant incapacity or substantial disruption of the ability to conduct normal life functions
- A congenital anomaly/birth defect

The known risks associated with the EUA amendment are so much greater than any possible benefit that the approval would border on gross negligence.[15]

There is also a broadly believed but no more less false belief that the country needs to vaccinate every person, regardless of age or level of immunity (natural or vaccine) to end the pandemic. A growing percentage of the population believes that the only way they will be safe, is to ensure that everyone they may come in contact with is fully vaccinated (a definition that is ever evolving). The assumption that the risk of dying from COVID-19 is equally distributed in the population incorrect and the government's policy on vaccinations perpetuates that false assumption. It is very difficult for the virus to hurt someone who is young and healthy and those that are vaccinated, as the FDA has recently reported, are unlikely to be hospitalized or

[14] Dr. Marty Makary, Professor at Johns Hopkins University School of Medicine and editor in chief of MedPage Today

[15] "Dr. Anthony Fauci recently anticipated that teenagers across the country will be vaccinated in the autumn and younger children in early 2022, and the UK is awaiting trial results to commence vaccination of children under 18. There is a lack of scientific justification for subjecting healthy children to experimental vaccines, given that the Centers for Disease Control and Prevention estimates that they have a 99.997% survival rate if infected with SARS-CoV-2. Not only is COVID-19 irrelevant as a threat to this age group, but there is no reliable evidence to support vaccine efficacy or effectiveness in this population or to rule out harmful side effects of these experimental vaccines." SARS-CoV-2 mass vaccination: Urgent questions on vaccine safety that demand answers from international health agencies, regulatory authorities, governments and vaccine developers

die from COVID-19.

Compromised Data Integrity and Blatant Bias in Data Analysis

Data integrity, unbiased analysis and data collection and consistency in the record sets are paramount to determining long term safety and effectiveness of a vaccine, along with identifying mutations that warrant further study. In the case of the tracking of COVID-19 in vaccinated versus unvaccinated individuals, the federal government has made policy decisions that create a blatant bias in the data collected, shielding valuable markers in vaccinated individuals while continuing to collect them for the unvaccinated. In addition to this, the definition of vaccinated, as used in policy decisions impacting the country as a whole, defines "vaccinated" as only those that have received the necessary dose to be "fully vaccinated" and had the two weeks post vaccination. This means that "unvaccinated" figures showing COVID-19 infection would not only include asymptomatic and moderate infections that wouldn't be counted in the vaccinated population, but also individuals that have received one or two vaccine doses and are still in their two-week waiting period. In looking at the impact of the vaccine on an individual's immune system and ability to fight off viral attack, it is especially concerning that the federal government chose to inflate the unvaccinated figures in that way.[16]

Several experts have criticized the agency for not tracking mild and moderate breakthrough cases on a broader scale, arguing it makes it difficult to know how rare these cases really are. The COVID-19 vaccines are not designed to create "sterilizing" immunity. The virus can infect the nose and begin replicating before the immune system rallies its range of defenses.

Paul Offit, a vaccine expert at Children's Hospital of Philadelphia, said it's like the fire extinguisher in your kitchen. The immune system ensures you have that fire extinguisher standing by for an emergency. But it can't prevent the initial conflagration. "You still had a little fire in the kitchen," Offit said.[17]

Larry Corey, a virologist at the Fred Hutchinson Cancer Research Center, said it would not be surprising to see a variant emerge that is better at replicating in people's noses. Animal studies, he said, indicated that vaccines were better at protecting animals' lungs from infection than their noses. That might help explain why vaccinated people can become infected but rarely develop severe disease.[18]

As discussed in the recent publication, "SARS-CoV-2 mass vaccination: Urgent questions on vaccine safety that demand answers from international health agencies, regulatory authorities, governments and vaccine developers" that was distributed globally:

> Vaccines for other coronaviruses have never been approved for humans, and data

[16] The CDC on May 1 said it would stop tracking mild and moderate breakthrough cases and focus only on hospitalizations and deaths.

[17] CDC under fire for decision to limit tracking of Covid-19 cases in vaccinated people; Rachel Roubein, David Lim

[18] CDC under fire for decision to limit tracking of Covid-19 cases in vaccinated people; Rachel Roubein, David Lim

generated in the development of coronavirus vaccines designed to elicit neutralizing antibodies show that they may worsen COVID-19 disease via antibody-dependent enhancement (ADE) and Th2 immunopathology, regardless of the vaccine platform and delivery method. Vaccine-driven disease enhancement in animals vaccinated against SARS-CoV and MERS-CoV is known to occur following viral challenge and has been attributed to immune complexes and Fc-mediated viral capture by macrophages, which augment T-cell activation and inflammation.

In March 2020, vaccine immunologists and coronavirus experts assessed SARS-CoV-2 vaccine risks based on SARS-CoV vaccine trials in animal models. The expert group concluded that ADE and immunopathology were a real concern but stated that their risk was insufficient to delay clinical trials, although continued monitoring would be necessary. While there is no clear evidence of the occurrence of ADE and vaccine-related immunopathology in volunteers immunized with SARS-CoV-2 vaccines, safety trials to date have not specifically addressed these serious adverse effects (SAE).

Rick Bright, the senior vice president of pandemic prevention and response at the Rockefeller Foundation, was quoted that the U.S. must document "a fully representative sample" of breakthrough infections. Creating a surveillance testing system to collect data on more vaccinated people with asymptomatic or mild infections could equip public health officials with a better understanding of how virus variants are spreading, he said.
"Tracking a full range of breakthrough viruses is the only way to understand where the next variants may appear, where mutations are happening, and to finally get ahead of the virus and end the pandemic everywhere for everyone," said Bright, who led the Biomedical Advanced Research and Development Authority.
"That's why CDC's decision to focus on only some of these viruses
from vaccine breakthrough cases is extremely worrisome."

The FDA also undermined data integrity through EUA's that weren't directly related to COVID-19 vaccines. In spring of 2020, the FDA decided to address widespread testing shortages by issuing "umbrella" EUAs for entire categories of diagnostic and antibody tests — allowing those tests to come to market before reviewing them on a case-by-case basis. In doing so, the FDA allowed a multiplying factor of an unknown level to exaggerate positive COVID-19 cases, reasoning that the risk of allowing unreliable tests to come to market, creating inaccurate and unreliable data about infection rates, was outweighed by the value of having more testing data at all.

Other influences on the federal agencies policies in handling the pandemic include political influence, which is more difficult to illustrate given the efforts made by high-ranking officials to keep those types of communications out of the public sphere. During the FDA's decision to grant its first vaccine authorization to Pfizer-BioNTech, White House Chief of Staff Mark Meadows allegedly contacted FDA Commissioner Stephen Hahn the day the vaccine would be

authorized, demanding his resignation if it was not authorized by end of day.[19] This is one example but more recent examples can be found on CNN nightly through the White Houses continued and unpreceded push to dictate the science, safety and efficacy of decisions regarding COVID-19 vaccine policy by announcing programs, timelines and processes for EUA amendments that haven't even been heard by the agency.

Data integrity and process issues are not new to the COVID-19 pandemic but the attention the FDA has received and scrutiny of its data collection and analysis have come under a microscope.

> Data woes have plagued the CDC throughout the pandemic, said Ali Mokdad, who, after years monitoring vaccine coverage at the federal agency, is now a professor of epidemiology at the University of Washington.
>
> "We're flying blind," he said, pointing out that U.S. decisions around Pfizer booster shots were based on data from Israel and Qatar, where vaccination numbers are collected in a more standardized fashion, due to a dearth of reliable U.S. data. From the CDC's decision to scale back tracking for breakthrough infections to their flip-flop on indoor masking for vaccinated individuals, the agency has come under fire at multiple points throughout the pandemic.
>
> In past months, the epidemiology professor said, many Americans received unauthorized booster doses by crossing state lines or lying about their vaccination status thanks to lax immunization tracking.
>
> "There is a big problem at CDC right now," said the epidemiologist. Mokdad himself was involved in a high-profile incident in 2004 where he co-authored a CDC paper that overestimated the number of annual deaths caused by obesity.[20]

Data integrity issues also arise when the FDA, despite noting the value of essential data in clinical trials, allows the industry to dictate favorable terms. This was the case in October of 2020, when the FDA issued guidance to manufacturers of covid-19 vaccines urging them to devise a method to allow volunteers in their studies' placebo arms to receive the vaccine while also maintaining the integrity of ongoing scientific data collection. The industry wanted to "unblind" the clinical trials under the guise of ethical concerns and difficulty in adopting the FDA's "unblinding" plan. Blinding is commonly used in clinical research study designs and is one of the critical methodologic features intended to reduce the risk of bias allowing a realistic statistical comparison of the study outcomes.

The FDA had contended that, unlike, a highly effective cancer drug, "the vaccine is not literally a life-and-death issue today and tomorrow" for most trial participants, Goodman said. So, he noted, those running COVID-19 vaccine trials shouldn't feel obligated to unblind participants and vaccinate placebo recipients right away. Doing so implies "you can just blow up the trial" on the basis of promising preliminary results, establishing "an ethical model for future trials

[19] From 9/11 to COVID-19: A Brief History of FDA Emergency Use Authorization Bill of Health; Jonathan Iwry
[20] Exclusive Analysis: CDC COVID Youth Vaccination Figures Clash — Sometimes by Double-Digits — With Locally Reported Rates; Asher Lehrer-Small

that we maybe don't want to set," Goodman said.[21] By unblinding trial participants, "you lose a valid comparison group," Goodman said. "There will be this sense, and it will be sort of true, that the study is over."

What was the result of the FDA offering an alternative unblinding that allowed for a semblance of data integrity? Even before the FDA advisory committee meeting to discuss the vaccine manufacturers alternatives, Moderna notified volunteers that they could learn their status if they chose to receive the vaccine. Pfizer also sent a letter to its trial participants one week after its vaccine was authorized on December 10th, 2020.

One of the lead advocates for unblinding the clinical trials was Moderna Senior Vice President Jacqueline Miller, MD. Ms. Miller recalled the impact of 1 of the 185 placebo recipients in Moderna's phase 3 trial who developed symptomatic, laboratory-confirmed COVID-19 and died. "That death weighs very heavily on me," Miller said at the meeting. She continued, "Additional severe cases and death [among placebo recipients] is not a question of 'if' but of 'when.'" "That also weighs heavily on me." This example is not given to make light of the volunteer's death or minimize the impacts to their family but rather to highlight that there are processes in place to allow a volunteer to be unblinded and receive treatment if there are life threatening circumstances. And, unfortunately, the pharmaceutical industry seems more concerned with one clinical trial participant than with countless individuals that are severely affected by the vaccine and the mandates imposed.

The impacts of unblinding the clinical trials aren't just a short-term problem, however. Data is forever lost and tainted due to the introduction of a bias in the process. The COVID-19 vaccines have had a deliberate bias, as explained above, by policy makers and the industry but this bias relates to the knowledge of the patient's treatment leading to conscious or unconscious bias in the way the site staff recruits the patients (selection bias), how they are treated (performance bias), the assessment of endpoints (detection bias), the handling of withdrawals, and how data is excluded from analysis.[22]

The above point is better detailed by Diana Zuckerman, president of the National Center for Health Research, when she indicated that the failure of the FDA to retain blind data meant the loss of future reliable data, which is especially concerning given that preliminary data are insufficient to determine efficacy. She was quoted as saying, "I'm especially concerned that Pfizer's vaccine trials included only five people aged 75 and older who were diagnosed with covid-19, with an unspecified number of those defined by Pfizer as severe cases." "That makes it impossible to determine how effective the vaccine is for frail elderly patients." The data are now likely to be scanty and less reliable given that the trials are effectively being unblinded.

[21] The Challenge of Conducting Placebo-Controlled Trials as COVID-19 Vaccines Become Authorized, Rita Rubin, MA

[22] Bias due to lack of patient blinding in clinical trials. A systematic review of trials randomizing patients to blind and nonblind sub-studies; Hróbjartsson, Asbjørn, Emanuelsson, Frida, Skou Thomsen, Ann Sofia, Hilden, Jørgen, Brorson, Stig

In conclusion, I have serious concerns over the risks of the vaccine being mandated to children ages 5-11 and believe the censorship and stigmatization being promulgated by the government in discussions on the vaccine have placed the entire country in dire straits.

Sincerely,

Katrina Lewis

From: Karen Morgan
To: DOH WSBOH
Subject: comments
Date: Thursday, November 4, 2021 7:10:17 PM

External Email

Thank you for giving me an opportunity to make my concerns known
As a grandparent, I am gravely concerned about vaccinating our children when their risk for infection is so low, as well as their ability to spread COVID. This should not be mandatory. Especially for children ages 5-11.
What should be considered seriously and discussed is the reality of natural immunity. We ought to be recognizing this. Israel does.

Thank you for listening.

Karen Morgan
Bellingham, WA

From: Krista Sanders
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 3:22:16 PM

External Email

Dear BOH,

With the rise in mandates surrounding the COVID vaccination, and the discussions on the table with regards to children I plead with you to leave this important decision between a medical provider, parents and their children. Children, especially under 11 years old have very little risk with contracting COVID, and natural immunity needs to be a part of the risk-benefit analysis, as many children have already obtained natural antibodies. I know many people that have had side effects from COVID vaccination and to ignore this risk possibility, especially in a vulnerable, growing a developing age category, would be unwise. With no long term studies yet available, and the ability for transmission to still occur in the vaccinated population makes a possible mandate appear to not have anyones best interest in mind. In fact, some arguments could be made that contracting COVID at this age group would be the very best time for natural immunity to be developed. When the risk is extremely low, and symptoms typically mild. Please leave these decisions to families, as we all have individual and unique risks and benefits when it comes to our medical health. Having the freedom to choose what is the healthiest option for each of our children and families would serve us all better.

Thank you,
Krista Sanders

From: Lora Cunha
To: DOH WSBOH
Subject: Public comments for WSBOH for November Meeting
Date: Thursday, November 4, 2021 2:17:34 PM

External Email

Good afternoon,
I respectfully request that the WSBOH prohibit any and all mandates for COVID-19 vaccinations. These vaccines are proving harmful for many adults, juveniles and are unnecessary to protect our children's safety. These vaccines are one year old; there is no long-term data on these treatments. We do know that the efficacy is waning in the first 6 months after injection. These vaccines are not stopping transmission nor are they decreasing hospital stays in the vaccinated as promised.

I urge you to hold back on mandates, to not add COVID-19 vaccines to required lists, to not require vaccines to attend schools. Should your office and that of the Education office mandate these vaccines for my children, I will be forced to withdraw my child from the public school system. This action will decrease funding to schools where it is desperately needed.

I implore you to do the right thing, to truly look at these vaccines from all angles, outside of political narratives, to save our children and the citizens of Washington State.

Thank you,

Lora Cunha
714.856.2390

From: Lynn
To: DOH WSBOH
Subject: Comments, COVID mandates
Date: Thursday, November 4, 2021 6:38:46 PM

External Email

To Whom This May Concern,

COVID mandates are not only a violation of the rights of the people; they are unjustified, as follows …

1. The jabs being offered do not stop anyone of contracting COVID.
2. The jabs being offered do not stop anyone, receiving the jabs, from exposing others to COVID.
3. The jabs being offered do not protect those who have chosen not to get the jab from those who have, and can spread COVID without knowing they are sick.
4. The jabs are not necessary, given that therapeutics have been 100% effective in stopping the virus.
5. The side effects of the jabs are being ignored in the name of promoting a so-called vaccine that does not have even close to the efficacy of therapeutics.
6. The COVID survival rate of COVID is over 99.5%, COVID is no more lethal than the influenza.
7. The COVID hype and panic porn, being promoted, has not basis in science.

It's time to put a stop to what is going on. It is ridiculous. It is not based in sicence. It is based in a political agenda.

If the outcome of the Virginia elections tell you nothing else, it should tell you that the American people are tired of what is a trumped up crisis.

Sincerely,

Lynn M Finney
Spokane, WA 99207

From: Lyn Kerschen
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 6:29:57 PM

External Email

COVID vaccines for young children should not be recommended. According to the American Academy of Pediatrics, less than 2% of Children known to be infected by the corona virus are hospitalized, and less than 0.03 of those who are infected die. VAERS reports that as of August 2021 there have been 11,940 deaths following the vaccine. 40,911 hospitalizations have been reported following the COVID vaccine. These results are the tip of the iceberg as an estimated 90-95% of reactions to the vaccine are not reported. We must not subject our children to this experimental toxin.

I worked in a public school system for 20 years. Children survived quite well without receiving vaccines for every virus that came around. The COVID virus uses the ACE receptor to gain entry to the host cell, and the ACE 2 receptor has less expression and presence in the nasal epithelium in young children. So children are less likely to be infected in the first place, and less likely to spread the virus to other children or adults, or to even get severely ill. There is no reason to vaccinate children for the COVID vaccine. Remember the Nuremberg Code? This vaccine is experimental and there is no liability for injury or death from this vaccine. Stop this vaccine madness. CHILDREN'S HEALTH SHOULD NOT BE COMPROMISED BY GIVING THEM THIS VACCINE.

Lyn Kerschen

From: Laird Leavitt
To: DOH WSBOH
Subject: Student Vaccine
Date: Tuesday, November 2, 2021 10:21:03 AM
Attachments: ACSI Covid student mandate letter 10.19.21.pdf

External Email

Dear WA State Board of Health Board Members,

On behalf of the school leaders, staff, parents and children in our state schools, thank you so much for the very important and hard work you have been doing to help our state navigate the health crisis. We know and truly appreciate the many long hours you have put in over the last 18+ months as you work with so many others to craft a way forward that attempts to balance the variety of needs of the people of Washington State. The way you and others have framed for our state is working and we are grateful.

As a local representative of a network of affiliated independent schools, I'd like to submit the attached letter that asks the state to allow for schools and parents to be the decision makers with regards to whether students should be vaccinated to be attending in-person in our schools.

Feel free to reach out if you have any questions or would like more information.

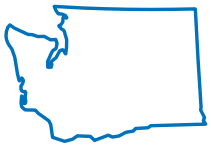
Very gratefully yours,

Laird

Laird Leavitt, MEd
Field Director | Western Division
Seattle Area Schools

Association of Christian Schools International

Mobile: 623-693-3617
ACSI.org



ACSI
Association of Christian Schools International
WASHINGTON
School Network

October 2021

To Whom It May Concern,

As a network of 72 Washington schools, we are expressing our concerns that the Governor's recent vaccine mandate proclamation (COVID-19 Vax Washington Amendment.pdf) for employment in all state-approved, Christian/private schools could be a preview of vaccination mandates for students in K-12 settings. We are aware California has very recently made such a vaccine mandate decision and we would like to communicate to Washington state health, school, and government officials that we believe the State of Washington should avoid issuing any forced mandates regarding COVID vaccinations for students. Especially, if such mandates would be a requirement for private school attendance and therefore interfere with the operation of private religious schools. Based on the information and data we have, we believe the COVID vaccine for students is a decision best made by a child's parent, in consultation with their family physician, and not the state, for the following reasons.

Parent/Physician Responsibility - The assessment of a child's overall health risk and any such risk in the context of an in-person private school environment is the primary responsibility of the parent and their personal physician. Therefore, the state should only overstep the parent's natural rights and responsibility, and a private religious organization's own policies and procedures, in the rarest of circumstances involving an imminent threat to the health and safety. As outlined below, we do not see mandatory COVID vaccines for students as necessary for health and safety based on current information and data.

School Safety - The following measures have already been implemented and have demonstrated that private school campuses are healthy and safe environments. Additionally, that data shows that the at-risk individuals in Washington are being protected in the general population for whom the disease is a serious health threat.

- WA has immunized its at-risk population - seniors represent over 80% of COVID deaths and are already over 95% fully vaccinated. WA State has seen a drastic reduction in the instances of hospitalizations and deaths from COVID.
- A vaccinated person is protected from serious illness or death whether they contract COVID from a vaccinated or unvaccinated individual.
- Schools are already utilizing a number of effective mitigation strategies including ventilation, cleaning regiments, washing of hands, masking, cohorting, physical distancing, and going remote when needed continue to keep our school communities safe.
- Pathology for children and adults does not warrant mandatory student vaccination.
    - For example, in Snohomish County (population 822,000 residents) there have been no COVID deaths in anyone under the age of 20 (see page 19) and 10 deaths for those in the 20-40 age range.
    - Individuals under the age of 50 represent 5% of WA COVID deaths.
- Parents desiring greater protection for their children already have ready access to multiple COVID vaccines and can freely choose to vaccinate their children at any time.

Legal Liability/Vulnerability - Schools could potentially be at risk of legal action and possibly in violation of Federal Law in the following areas if attendance is impeded based on a student COVID vaccine status.

- Children having adverse effects from the vaccine.
- Discrimination based on deeply held views of conscience by either parents or students.
- Usurping parental and student rights.
- Violating contractual agreements with parents.

Historical COVID Childhood Pathology – COVID does not have the same pathology for children as it does for those over the age of 50 and those with comorbidities at every age.

A recent report of daily hospitalization rates for King County confirm that PS-12th grade students are 60-95% less likely to be hospitalized from COVID than fully vaccinated adults ages 65 and older. Children ages 1-14 are more likely to die of traffic accidents, drowning, or homicide than they are from COVID. Since the state is not requiring extraordinary and invasive measures to mitigate these greater risks of death in children and they are not creating the emergency in state hospitals, it seems inappropriate for the state to issue mandates that supersede parents and children's rights with respect to COVID risks and individual health decisions regarding vaccination.

Negative Student and Educational Impact - The past 18 months of remote learning demonstrate the need for students to be in-person at school. Because of vaccine hesitancy, a student vaccine mandate would result in more families moving their children to remote learning and/or homeschooling. As we have already seen, the result of having less students in-person negatively impacts student learning, particularly for students who are already at academic risk. Even if parents were allowed an exemption policy for vaccinations and students could remain in-person, this would result in segregating of students into different types of educational settings and environments that may negatively impact students.

In conclusion, we agree in principle that student vaccine mandate is not justified or needed to keep our network school communities safe and believe this health decision is best made by parents and their physician. As a result, we strongly urge the State of Washington to reject and avoid any new forced mandate requiring COVID vaccines for students but leave this as a decision for each parent to decide in consultation with their family doctor.

Cecil Swetland, Ed.D.
Senior Director

Association of Christian Schools International

Laird Leavitt, M.Ed.
Field Director

ACSI Schools of Washington

From: Les Pilon
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 7:51:55 PM

External Email

Children in this age group of 5-11 do not pose a threat to adults or their peers. CDC states cases of transmission between these ages is very rare if at all. Research shows adverse side effects from this vaccine far out weigh the death of children in COVID cases. I ask for protection for these children don't make them test subjects for a vaccine that has not had enough time for study for long term side effects or effectiveness natural immune system is a wonderful thing and basic science tells us if someone has already recovered from COVID they have those immunities. Please Save Our Children!
Les Pilon Blaine Wa.

Sent from my iPhone

From: PooleFamily
To: DOH WSBOH
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting
Date: Thursday, November 4, 2021 2:41:34 PM

External Email

Dear Board of Health,

I am opposed to any and all Covid-19 vaccine mandates, especially for children. Please consider the following:

-- There are no adequate long-term safety studies of mRNA covid vaccines because the placebo group was “unblinded” and allowed to get the vaccine.
-- According to published data by the CDC, 99.99815% of children who contract COVID-19 survive.
--This is NOT a FDA approved vaccine they are looking to give children, the FDA will expand the Emergency Use Authorization to include children as young as five. In other words, any mandate for children is of an experimental drug.
-- According to the data available from the Vaccine Adverse Event Reporting System (VAERS) as of Oct. 8, there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12- to 17-year-old age group.
-- The vaccine does not stop infection, transmission, hospitalization, nor death. A recent study from the Harvard Center for Population and Development Studies states it plainly: “Increases in COVID-19 are unrelated to level of vaccination across 68 countries and 2,947 counties in the United States.” Researchers found that, “countries with higher percentage of the population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days.”
-- Children are not a significant threat to the elderly and vulnerable as most COVID cases are spread from adults to children.

Vaccine injuries are real, not "rare". Please do not mandate these shots for our children. Thank you.

Lisa Poole, Seabeck, WA

From: Linda Ryan
To: DOH WSBOH
Cc: Linda Ryan
Subject: Natural immunity needs to be part of the risk-benefit analysis; it can no longer be ignored.
Date: Thursday, November 4, 2021 3:26:27 PM

External Email

I am writing to you today to encourage you to NOT push the COVID vaccine onto children who are little to no risk of severe complications or death from Covid-19.

Injuries/Death from the Pfizer as massive and very under reported. It's a proven fact that transmission of Covid-19 among children in schools and daycares is very rare. There is NO Covid health emergency in the 5-11 year old age group either.

According to data that is readily available from the Vaccine Adverse Event Reporting System (VAERS) as of October 22, 2021, there had been a total of 16,716 reports of adverse events, including 1,435 serious reactions and 27 deaths in the 12-17 year old group. Injuries/death from the Pfizer vaccine is grossly underreported - also a known fact.

Dr. Camille Kotton, member of ACIP, publicly admitted that the number of Covid deaths in the 5 to 11 age group for one year was 66. She not distinguish between "death from Covid" and "with Covid". In any even, it doesn't justify putting millions of children at risk of short and long-term harm from these vaccines.

I urge you to NOT require this unproven, most un-tested vaccine to be used in our children.

Linda Ryan

From: Leah
To: DOH WSBOH
Subject: Public comment 11/10
Date: Thursday, November 4, 2021 12:52:43 PM

External Email

I oppose COVID vaccination for schools/daycares. There is no health emergency for kids and natural immunity beats a vaccine that doesn't prevent the infection. There are no adequate long-term safety studies of MRNA covid vaccines. Do not use our children to gain the data that is needed for the studies.

Leah Rooslet

From: Lisagean
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 6:17:43 PM

External Email

Children are not and have never been at risk of Covid. The data supports this. There should be no interest at all to vaccinate this population. They are already used as human pin cushions for profit by the pharmaceutical industry. Let's leave the children alone.
Thank you

Lisa Scott.

Sent from my iPhone

From: Lauren Welch
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 5:47:00 PM

External Email

Forced injections are a humanitarian crisis. Underneath these forced vaccines, is a sinister insanity, which is the idea of mandating that people must be perfectly healthy (yet in a subjective way, by guaranteeing that they be covid-free and yet free to carry all the other viruses that exist) in a germ-infested world. You are asking human beings to engage in an impossible mission. Nothing about these mandates is holistic or healthy. Nothing about this is scientific.

From:	Testify Online Survey
To:	DOH WSBOH
Subject:	Survey Response: Testify Online *
Date:	Thursday, November 4, 2021 5:25:57 PM

The following survey response is submitted:

1. State Board of Health Meeting Date:

November 10th, 2021

2. Agenda Item or Issue:

Covid 19 vaccine

3. Your Name:

Michael Abhold

4. Do you have a professional title?

2. No

5. Are you representing an organization?

2. No

6. Address:

1747 Skeena Ct

7. Email:

Harleys1560@gmail.com

8. Phone Number (Include Area Code):

509-679-5582

9. Do you have any special expertise relevant to this topic?

2. No

10. Are you testifying on a specific proposal under consideration by the board?

1. Yes

Covid 19 vaccine mandate

11. Are you Pro or Con on the proposal?

2. Con

With so few child deaths in our state and the United States throughout this pandemic I don't believe

the vaccine should be mandated for children. There is no information regarding the "long term effects" of this vaccine and I think the risks outweigh the benefits!

From: Dr Michael Breneman
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 6:01:51 PM

External Email

Please protect our citizens from vaccine mandates. They are unethical, unproven, dangerous and especially to children who are at little to NO RISK!

From: Meliah Looney
To: DOH WSBOH
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting
Date: Thursday, November 4, 2021 8:07:11 PM

External Email

Medical freedom for our children is of the utmost importance! No one knows the long term effects of the Covid vaccine. We must protect our children! Please stand strong and support American freedom.
Thank you,
Meliah Bamford

From: Mary Deitch
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 6:36:30 PM

External Email

Please do not even think of mandating Covid shots for young children. Their risk of death from Covid is near zero. Long term effects from these shots won't be known for many years. They are not the ones transmitting the virus. Please leave it up to the parents to decide for their own children.

Mary Deitch

From: Melody Faber
To: DOH WSBOH
Subject: Children and Vaccines
Date: Thursday, November 4, 2021 8:23:29 PM

External Email

Children already have too many vaccinations. There isn't a serious health risk for children with COVID-19 and it hasn't proven to be highly transmissible with children. However, there are serious side effects from the vaccines in children. We have to protect the children. Parents should have the right to decide what is best for their child.

It's way past time we start doing the right thing.

Melody Faber

Get Outlook for Android

From: MARK FLETCHER
To: DOH WSBOH
Subject: NO! To school age vaccinations!
Date: Thursday, November 4, 2021 7:12:28 PM

External Email

The is absolutely no logical reason to vaccinate young children for this particular virus. Please do what's right not what you're told. We are playing with fire on so many levels. Mandating this for adults, though wrong, is one thing, but you start messing with peoples kids and there will be hell to pay.

From: Mary C Kasprzyk
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 6:17:29 PM

External Email

We do not need government interferrance in deciding what is good for children. Govenment doesn't raise them and injecting a child you don't know with a shot you know little about is not going to fix anything. As a matter of fact it may cause more problems that were never considered. Think about it.
Thank you.

Mary Kasprzyk

From: Megan Mauch
To: DOH WSBOH
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting
Date: Thursday, November 4, 2021 5:27:04 PM

External Email

To whom it may concern,
COVID vaccines should not be mandatory for anyone. They are emergency use only at this time. There should not be a pandemic. Treatment is being suppressed.
Mandating COVID vaccines for kids is criminal. Not only is it totally unnecessary- as kids have 0 trouble with the virus and are way more at risk for death in multiple other ways, but their risk for more severe health problems caused by the shot is so high. Myocarditis from the shot has killed more kids than COVID.
So NO NO NO NO NO mandatory shots for kids.
Thank you,
Megan Mauch
Sent from my iPhone

From: Testify Online Survey
To: DOH WSBOH
Subject: Survey Response: Testify Online *
Date: Thursday, November 4, 2021 1:25:19 PM

The following survey response is submitted:

1. State Board of Health Meeting Date:

Nov. 10, 2021

2. Agenda Item or Issue:

Covid 19 Vaccines

3. Your Name:

Michele Madasz

4. Do you have a professional title?

2. No

5. Are you representing an organization?

2. No

6. Address:

4015 NE 64th Ave, Vancouver WA 98661

7. Email:

mmadasz77@yahoo.com

8. Phone Number (Include Area Code):

9. Do you have any special expertise relevant to this topic?

1. Yes

I am a parent.

10. Are you testifying on a specific proposal under consideration by the board?

2. No

11. Are you Pro or Con on the proposal?

2. Con

The CDC recently announced the approval of Covid 19 vaccines for 5-11 year olds. I'd like to urge all of you to remain cautious with the EUA approval of the new vaccine for this age group as less than 3,000 children were studied for a median follow up time of 2.3 months! 1500 of those participants

reported adverse reactions of nausea, vomiting and diarrhea, localized reactions, fever, fatigue. Parents need to be further educated about this vaccine and long term data is needed before mandating this vaccine for this age group!

From: Marina Smith
To: DOH WSBOH
Subject: My Public Comments
Date: Thursday, November 4, 2021 12:59:41 PM

External Email

Dear Washington BOH,

I would like to urge you to keep in mind, when you are discussing the COVID-19 vaccine for our children, that this experimental biologic has harmed children, and that children are by and large very capable of recovering from COVID-19 with no adverse effects. According to the CDC, fewer children have died from this virus than the number of kids who will die every "flu season" from influenza. Robust immunity results from natural infection as well, and many people in WA state have already recovered from COVID and will not benefit from (and may actually respond poorly to) the vaccine. Please keep this experimental product optional, so that people (including children) can make an informed choice with their provider.

Thank you,

Marina Smith
Bainbridge Island, WA

From: Michelle Whitlow
To: DOH WSBOH
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting
Date: Thursday, November 4, 2021 5:41:17 PM

External Email

Regarding mandating the covid vaccines for children to attend school. I am not anti-vax.
I do hold a Master of Science from an accredited university.
It is this education that affords me the knowledge that science cannot prove a negative. The same that the adult vaccines were originally touted as 100% effective, we now know that CDC's own research shows that 40% of people vaccinated die from covid.
We need longitudinal studies conducted over years before allowing these products to be injected into children who are not high risk.
It is not the job of children to protect the adults in their lives, it is the job of adults to protect vulnerable children. Especially from something of this unknown scientific nature.
There are alternatives to vaccines for treating Covid-19.
I know of at least 500 parents who will pull their children from the schools if this is mandated. That is likely a low estimate.
This is not a conversation about vaccine efficacy.
We already know these vaccines leave much to be desired.
WHY THE RUSH? WHY NO DISCUSSION OF ALTERNATIVE TREATMENT MEASURES?

Honestly,
Michelle Whitlow
(Mother of four)

From: Rich and Nancy Lindsley
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 6:43:52 PM

External Email

Long term effects of this vaccine are NOT known, therefore children should NOT be subjected to experiments perpetrated by the pharmaceutical industry and those who will gain financially.
Nancy Lindsley

From: pat engberg 2
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 3:20:22 PM

External Email

No free person should be told they have to take an experimental shot and this particularly includes children. What is happening in our country and around the world is a disgrace. As you probably know censorship is rampant and this includes the VAERS CDC reporting system showing that there have been over 17,000 deaths and countless vaccine injuries from this injection. The children are the future for all of us adults so I hope you do not cave into those behind this Plandemic that is destroying our country. Let the children live and thrive without forcing medical procedures on them that they do not need!!!

Thank you,
Pat Engberg

From: Paula Herbert
To: DOH WSBOH
Subject: comment for 11/10 board meeting
Date: Thursday, November 4, 2021 7:46:43 PM

External Email

Dear Mr. Grellner, Mr. Pendergrass, Mr. Kutz, Ms. Crawford, Ms. Lentz, Ms. Crockrell, Ms. Bessermin, Mr. Lutz, and Dr. Shah:

As a concerned parent, grandparent and homeowner in Washington State, I ask you NOT to mandate the COVID-19 inoculation(s) for our school children. There is no health emergency in children ages 5 to 11. Healthy adolescents aged 12-17 who have been given Covid vaccines have experienced blood clots, myocarditis, neurologic symptoms and extreme fatigue. According to data from the Vaccine Adverse Event Reporting System there have been a total of 21,652 reports of adverse events, including 1,304 serious reactions and 24 deaths in the 12-17 year old age group as of 10/8/2021. There are no adequate long-term safety studies of mRNA covid vaccines. I am not only concerned for the health of our children today, but also for the future.

Thank you for your unbiased consideration.

Respectfully,

Paula Herbert

From: Penny West
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 6:23:47 PM

External Email

Dear BOH,
As a grandmother I am appalled that the FDA and Acip voted to give the UNAPPROVED Phizer experimental injection to our children 5-11. We do not know enough as the study was very small and SHORT in duration. We know Covid is NOT A REAL DANGER TO THIS AGE GROUP! It is 99.999% survivable. It must NOT BE MANDATED. In fact EUA PRODUCTS BY LAW CANNOT BE MANDATED. If Inslee tries I will be offering to help homeschool my grandkids and encouraging others to do the same. I wonder what would happen if 30% of children were pulled out of school? Parents need to decide for their children, NOT THE GOVERNMENT!!
Sincerely,
Penny West
1731 Grand Ave
Mount Vernon, Wa.

Sent from my iPhone

From: Rachel Albrecht
To: DOH WSBOH
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting
Date: Thursday, November 4, 2021 4:17:07 PM

External Email

I oppose the requirement for school age children to be required to ne vaccinated in order to attend school. There has not been any long-term studies done on the effects the vaccine may have on growing children and I do not want my children to be used as guinea pigs for your testing. I will pull children from in-person learning and opt for online or other alternatives. Do Not Require our children be vaccinated in order to learn!

Thank you,
Rachel Albrecht

From: Rebecca Collodi
To: DOH WSBOH
Subject: C-19 Vaccines for school children
Date: Thursday, November 4, 2021 7:06:38 PM

External Email

I am writing this email to you to urge you to leave C-19 vaccines for children as voluntary to attend school. There is no reason to mandate this for school children (or anyone else for that matter). Children are at the very lowest risk for severe illness from C-19. They are at more risk from the vaccines than they are from the actual virus. They are more likely to die from a car accident, the flu or drowning than they are likely to die from C-19. Do not impose C-19 vaccines as a condition to attend school. Leave it to the families and their doctors to make the decision for themselves.

-Rebecca Collodi
Washington State citizen (for now....)

Sent from my T-Mobile 4G LTE Device

From: (null) yotasupra
To: DOH WSBOH
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting
Date: Thursday, November 4, 2021 6:48:42 PM

External Email

Any drug or vaccine that is still being studied, or an ongoing trial, or under EUA status for usage, should not be a required vaccine for children. Just as with actual Covid, the Covid-19 mRNA, viral vector vaccines, the long term effects are not known. There are millions of us adults, who were willing to take the Covid vaccine, knowing it was under EUA, doing our part to help provide data on a large scale. We consented to possible long term effects, possible vaccine injury, and the extreme possibility of a severe reaction leading to death.
Our children are too little to grasp the magnitude of that consent. A lot of parents are ok providing that consent for themselves, but not their children.
Parents should be provided the choice, as they are with Recommended vaccines. If anything, place it on the list for recommended vaccine, after the trial is completed in 2022.

Thank you,
Rena Lowenstein

Sent from my iPhone

From: radiantdiamonds@1791.com
To: DOH WSBOH
Cc: Rhonda Quayle
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 4:23:07 PM

External Email

Dear Board of Health WA,

https://rumble.com/vog7yf-the-truth-laid-out-by-dr.-david-e.-martin-.html

It is my hope that you will watch this brief and crucial video. It will prove to you that the course that you are directing in regards to Covid-19 and the citizens of this state makes you culpable.

Please correct course and protect this states citizenry rather than risking them harm.

Respectfully,

Rhonda Quayle

From: Rose Waterfiled
To: DOH WSBOH
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting
Date: Thursday, November 4, 2021 8:26:18 PM

External Email

I will 100% not support a mandatory testing or covid vaccine for my children in any school! Not a chance. No way.

Signed
Rose Waterfield

From: Stephanie Breuner
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 7:38:42 PM

External Email

NO TO VACCINE MANDATES FOR CHILDREN.

-CDC says 99.99815% of children who contract Covid-19 survive

-Since most cases of COVID spread from adults to children, children are not a significant threat to the elderly and vulnerable.

-The CDC admits that studies have not been done to determine any long-term results and outcomes of the COVID vaccine. It has not been around long enough to do so, however in the short term we have already seen adverse reactions and deaths of adults and children 12-17 years old:

- According to data available from the Vaccine Adverse Event Reporting System (VAERS), as of October 22, there had been a total of 16,716 reports of adverse events, including 1,435 serious reactions and 27 deaths in the 12- to 17-year-old age group.

Covid-19 Vaccines Do Not Prevent Transmission.
-Rochelle Walensky
CDC Director, Aug. 8, 2021 https://youtu.be/TKFWGvvlVLI?t=80

No studies performed on long-term outcomes of the COVID Pfizer vaccine in children.
-Dr. Fiona Havers CDC
Oct. 26, 2021 @1:20:30 timestamp

"...but we're never going to learn about how safe this vaccine is unless we start giving it."
-Dr. Eric Rubin FDA Advisor Oct. 26, 2021 @6:52:33 timestamp

"The question really becomes, does this vaccine offer any benefits to (children) at all?"
-Dr. Michael Kurilla FDA Advisor
Oct. 26, 2021 @7:41:52 timestamp

See links below that correspond with timestamps of quotes above:
https://www.fda.gov/advisory-committees/advisory-committee-calendar/vaccines-and-related-biological-products-advisory-committee-october-26-2021-meeting-announcement

Or here:

https://m.youtube.com/watch?v=laaL0_xKmmA&feature=youtu.be

Thank you for your consideration,
Stephanie Breuner
Camas, WA

From: susan cole
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 4:03:25 PM

External Email

There should NEVER be allowed an eu
“vaccine” mandate tor our children or any age tor that matter—
As admitted by the W.H.O. —
They admitted in their December 5, 2019 Geneva Vaccine Conference— there have never been safety studies on the short and long term effects of these injectables nor is there a protocol for follow up and the collecting of data .
ZERO science!
Please don’t allow this to happen!!!!

Sent from my iPhone

From: susan cole
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 3:51:47 PM

External Email

There should NEVER be allowed a eu
“vaccine” mandate tor our children or any age tor that matter—
As admitted by the W.H.O. —
They admitted in their December 5, 2019 Geneva Vaccine Conference— there have never been safety studies on the short and long term affects of these injectables nor is there a protocol for follow up and the collecting of data .
ZERO science!
Please don’t allow this to happen!!!!

Sent from my iPhone

From: steven.debolt@gmail.com
To: DOH WSBOH
Subject: Public Comments for WSBOH Members from March EH Committee Special Meeting
Date: Thursday, November 4, 2021 7:04:54 PM

External Email

Hello and to whom it may concern;

I have lived my whole life in Washington state. I'm fully vaccinated (less Covid) and I am NOT opposed to vaccines. I am however DEEPLY concerned and opposed to rushed vaccines with insufficient long-term data being FORCED onto people.

Our children are our future and are our everything. Research data is showing that children / young people are MUCH more susceptible to heart conditions as a side effect of these vaccines. Research data shows and supports that young adults or children are at the lowest risk for serious Covid issues. PLEASE do NOT mandate this vaccine for our children. Once adequate study data is available for long term potential effects, then revisit it or allow antibody tests as a valid alternative; the same way one can bypass chicken pox or other commonly vaccinated ailments.

Thank you for your time.
Steven DeBolt - Marysville, Wa

Sent from my iPhone

From: Stephanie Guerra
To: DOH WSBOH
Subject: Please oppose mandatory COVID-19 vaccinations for children
Date: Thursday, November 4, 2021 5:39:22 PM

External Email

To the Washington State Board of Health:

I am a concerned citizen and parent writing to urge you to oppose mandatory COVID-19 vaccination for children. I recently attended a Zoom panel of the British Medical Journal on the ethics of vaccinating children against COVID-19, and the recommendations were nearly unanimous (with the exception of one representative of a Swedish pharmaceutical company). This international board of medical professionals agreed that it is unethical to vaccinate children against COVID-19. The risks of vaccine injury and the long-term unknowns are significant, and outweigh any potential benefits. Children are at extremely low risk of mortality and injury from COVID-19. On the other hand, several countries have stopped their vaccine rollouts for youth due to high incidences of myocarditis. Never in history has it been acceptable to use children as a screen to protect adults. Please do not compromise the safety of our children with unethical mandates. Families who wish to vaccinate have ready access.

Sincerely,

Stephanie Guerra
Seattle, WA

From: Shilah Gould
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 8:10:50 PM

External Email

Dear WSBOH,

Please look deep into your heart and realize that Covid vaccines are an unnecessary risk for children, who are not at risk from Covid. Please do not require an experimental shot to be given to kids. Please, just remember what life was like before all this madness- that's what we want back- not more government mandates. Life is precious and beautiful and we do not need to inject new medical technology into our kids, having NO IDEA what the long-term effects will be. NOBODY KNOWS what these shots will do to our immune systems down the road. Please stand up for our kids. Please.

Shilah Gould
parent

From: Sam Krautscheid
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 4:14:03 PM

External Email

I am against a vaccine mandate on all children.

Thank you

Sam Krautscheid

From: Sweina McJunkin
To: DOH WSBOH
Subject: Covid Vaccine mandate
Date: Thursday, November 4, 2021 8:28:26 PM

External Email

To whom it may concern;

We are 150% against any covid vaccine mandates on kids. In addition, we are fully against a covid vaccine mandate for school attendance.

Please add this to your comments.

--

Sweina McJunkin | Broker
Residential Broker

www.SWEINA.com

From: Samantha Ness
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 3:26:56 PM

External Email

Dear Board,
Children have almost a ZERO fatality rate for Covid. The Covid shot does not provide immunity nor does it stop transmission. There is no reason to mandate this shot for the children of WA state.

Samantha Ness
Mother of 4 school age children
Mill Creek, WA

Sent from my iPhone

From: Teresa Granger
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 6:11:42 PM

External Email

To whom it may concern, my grandchildren had delta covid and had no problems they were just tired for two days, please don't vaccinate these kids they don't need it they are immune, also with the new information coming out of the UK about how Pfizer ran their trials it should be unlawful to make people take this vaccination, plus it does not make for immunity.
As a Grandparent I am asking you to give the family's choice in this matter, thank you, Teresa Granger

From: Valery Byrd
To: DOH WSBOH
Subject: public comments for Nov. 10 BOH meeting
Date: Thursday, November 4, 2021 4:45:31 PM

External Email

Dear Board of Health Members,

I strongly oppose making the Covid-19 vaccine mandatory for children of ANY AGE to attend school. All of the data collected so far shows that children are the least likely demographic to experience severe reactions, hospitalizations, or death from Covid-19. Additionally, their immune systems and neurological systems are still developing, and this vaccine is largely untested on children. In youth who have received it so far, cases of pericarditis and partial paralyzation have occurred in a significant number of them, according to VAERS data. We have no idea how the vaccine will affect very young children - and the risks are NOT worth it!! Last, but not least, parents need to have the final say in whether or not they want their child to have this vaccine - and they should be informed of the risks prior to consenting to it! Schools, government, and the Dept of Health should NOT be able to mandate the Covid-19 vaccination for children to attend school!! Please vote NO and stop this deliberate power grab attempt that will only cause devastation to our children and families!!

Thank you, -Valery Byrd

From: xavier.figueroa
To: DOH WSBOH
Subject: Nov 5 BoH Meeting Public Comment - No COVID19 Injection Requirement for our children
Date: Friday, November 5, 2021 10:25:32 AM
Attachments: image.png
Why Are We Vaccinating our Children Against COVID19_2021.pdf
A Report on Myocarditis Adverse Events in the U.S. Vaccine Adverse Events Reporting System (VAERS) in Association with COVID-19 Injectable Biological Products - ScienceDirect.pdf

---

External Email

Board of Health,

This needs to be stated now and clearly: requiring or mandating that 5-11 years old children take the Pfizer, ModeRNA or J&J biologics in order to attend school is illogical, unethical and unsupported by the evidence. Here in WA state, the need for this EUA therapy in our youngest and least vulnerable population is not supported by public health metrics.

		Deaths (SARs-CoV-2)	
Age catergory	Pop	2020	2021
0-19	1,885,561	6	7
20-34	1,575,682	25	63
35-49	1,471,187	136	259
50-64	1,442,332	534	792
65-79	1,005,452	1546	1286
80+	275,986	2211	1251
All	7,656,200	0.058%	0.0478%

We are in far greater danger from car accidents than we are from SARs-CoV-2.

The under-reported dangers of the biologic injections from Pfizer, ModeRNA and J&J are well summarized and analyzed by the recent peer-reviewed and published papers of Dr. Ronald Kostoff et al (Toxicology Rerports, 8 (2021) 1665-1684) and the published work of Dr. Jessica Rose and Dr. Peter McCullough (A Report on Myocarditis Adverse Events in the U.S. Vaccine Adverse Events Reporting System (VAERS) in Association with COVID-19 Injectable Biological Products, Current Problems in Cardiology). Both are attached for your convenience.

The fact that the State DoH and King County DoH cannot provide any consistent guidance on what constitutes a threshold value for the PCR test is of great concern. The repeated statement that the laboratories are relying on the manufacturer's recommendations and assurances that the established cycle-thresholds will provide sufficient accuracy, sensitivity and low false-positivity is concerning. The peer-reviewed literature on the PCR test demonstrates that Ct number of >30 lead to false positive rates of 31%-97% (see Kostoff, Appendix Da). We cannot rely on case numbers and positive tests, to diagnose or label patients as COVID cases (which are reliant on PCR tests). I am copying it verbatim for the board to read:

"*PROBLEMS WITH TEST CRITERIA FOR DETERMINING COVID-19*

Consider the criteria for determining whether an RT-PCR test result is positive for SARS-CoV-2. The CDC instruction (until 1 May 2021) specifies running the RT-PCR tests for 45 amplification cycles. Then, to interpret the data: when all controls exhibit the expected performance, a specimen is considered positive for SARS-CoV-2 if all SARS-CoV-2 marker (N1, N2) cycle threshold growth curves cross the threshold line within 40.00 cycles (<40.00 Ct). The RNase P may or may not be positive as described above, but the SARS-CoV-2 result is still valid ([103]a).

Many false positives are possible in the upper part of this cycle threshold range, especially in areas of low prevalence. In particular, virus culture has been found to be unfeasible in cases with a Ct value exceeding 33. A prospective cohort study involving the first 100 COVID-19 patients in Singapore also showed that attempts to culture the virus failed in all PCR-positive samples with a Ct value >30" [121]. During mass testing in Germany, it was found "that more than half of individuals with positive PCR test results are unlikely to have been infectious" [122]. Another study found that tests with low specificity (deriving from use of many cycles) cannot provide strong evidence for the presence of an infection [123]. A systematic review of PCR testing concluded "Complete live viruses are necessary for transmission, not the fragments identified by PCR. Prospective routine testing of reference and culture specimens and their relationship to symptoms, signs and patient co-factors should be used to define the reliability of PCR for assessing infectious potential. Those with high cycle threshold are unlikely to have infectious potential." [89].

As skeptics have argued, in the buildup of the pandemic, the rapid increase in numbers of COVID-19 cases was due in part to the high values of cycle threshold used in the tests. Unfortunately, the true numbers of false positives will probably be unobtainable if an audit were performed, since these values are not reported with the test results: all currently-available nucleic acid tests for SARS-CoV-2 are FDA-authorized as qualitative tests, and Ct values from qualitative tests should never be used to direct or inform patient management decisions. Therefore, it is not good for laboratories to include Ct values on patient reports [124].

After mass inoculations started, a large number of "breakthrough" cases emerged, and a total of 10,262 SARS-CoV-2 vaccine breakthrough infections had been reported from 46 U.S. states and territories as of April 30, 2021 [18]; the number of reported COVID-19 vaccine breakthrough cases is likely a substantial undercount of all SARS-CoV-2 infections among fully vaccinated persons. The national surveillance system relies on passive and voluntary reporting, and data might not be complete or representative. Many persons with vaccine breakthrough infections, especially those who are asymptomatic or who experience mild illness, might not seek testing [18].

This negative outcome of increased "breakthrough" cases motivated the CDC to change a number of reporting and test procedures and issue new regulations for identifying and investigating hospitalized or fatal vaccine breakthrough cases starting 1 May 2021, stating: "For cases with a known RT-PCR cycle threshold (Ct) value, submit only specimens with Ct value ≤28 to CDC for sequencing. (Sequencing is not feasible with higher Ct values.)". Thus, the Ct values for sequencing were lowered from the high false positive range allowed during the pandemic buildup to a limit that would eliminate many of these false positives in the 'breakthrough case' identification phase [101]."

Very Respectfully,

Xavier A. Figueroa, Ph.D.

Current Problems in Cardiology
Available online 1 October 2021, 101011
In Press, Journal Pre-proof

A Report on Myocarditis Adverse Events in the U.S. Vaccine Adverse Events Reporting System (VAERS) in Association with COVID-19 Injectable Biological Products

Jessica Rose PhD, MSc, BSc [1], Peter A. McCullough MD, MPH [1]

https://web.archive.org/web/20211007005939/https://doi.org/10.1016/j.cpcardiol.2021.101011

Abstract

Following the global rollout and administration of the Pfizer Inc./BioNTech BNT162b2 and Moderna mRNA-1273 vaccines on December 17, 2020, in the United States, and of the Janssen Ad26.COV2.S product on April 1st, 2021, in an unprecedented manner, hundreds of thousands of individuals have reported adverse events (AEs) using the Vaccine Adverse Events Reports System (VAERS). We used VAERS data to examine cardiac AEs, primarily myocarditis, reported following injection of the first or second dose of the COVID-19 injectable products. Myocarditis rates reported in VAERS were significantly higher in youths between the ages of 13 to 23 ($p<0.0001$) with ~80% occurring in males. Within 8 weeks of the public offering of COVID-19 products to the 12-15-year-old age group, we found 19 times the expected number of myocarditis cases in the vaccination volunteers over background myocarditis rates for this age group. In addition, a 5-fold increase in myocarditis rate was observed subsequent to dose 2 as opposed to dose 1 in 15-year-old males. A total of 67% of all cases occurred with BNT162b2. Of the total myocarditis AE

reports, 6 individuals died (1.1%) and of these, 2 were under 20 years of age - 1 was 13. These findings suggest a markedly higher risk for myocarditis subsequent to COVID-19 injectable product use than for other known vaccines, and this is well above known background rates for myocarditis. COVID-19 injectable products are novel and have a genetic, pathogenic mechanism of action causing uncontrolled expression of SARS-CoV-2 spike protein within human cells. When you combine this fact with the temporal relationship of AE occurrence and reporting, biological plausibility of cause and effect, and the fact that these data are internally and externally consistent with emerging sources of clinical data, it supports a conclusion that the COVID-19 biological products are deterministic for the myocarditis cases observed after injection.

Keywords

SARS-CoV-2; COVID-19; myocarditis; VAERS; adverse events (AEs); COVID-19-Injection-Related Myocarditis (CIRM)

Background

Myocarditis is inflammation of the myocardium or 'musculature' of the heart. [1,2,3,4] The myocardium is made up of many cell types however the greatest mass of tissue is accounted for by cardiomyocytes. [4,5,6] Cardiomyocytes are the principal contractile cells and are supported by specialized conduction and stromal cell types. [4,5,6,7,8] Both systole and diastole are active processes that expend energetic resources of cardiomyocytes which are organized into myofibrils. [8,9,10] Myocarditis can manifest as sudden death, chest pain or heart failure. The symptoms of heart failure from myocarditis include effort intolerance, dyspnea, fatigue, and ankle swelling. [1,2,3,4,6,11,12,13] The cause is an inflammation of the heart muscle, often following a viral infection, but not exclusively so. The damaged muscle is prone to lethal cardiac arrythmias as well as having the potential to develop both right and left ventricular dysfunction (cardiomyopathy). [3,4,12,13]

Myocarditis is a major risk for cardiac death among the young. [11] The high-risk age population for myocarditis is from puberty through early 30s, and it is the third leading cause of sudden cardiac death in children and young adults. 1 per 100,000 children per year are affected by myocarditis and it has been reported that 0.05% of all pediatric hospitalizations are for myocarditis. Between 0.5 and 3.5% of heart failure hospitalizations are due to myocarditis. Most cases of myocarditis are identified in young adults with males affected more often than females. [12,13,14, 15,16]

In the context of COVID-19 respiratory illness, there are a significant number of patients who are otherwise healthy experiencing heart-related complications, including myocarditis, but the majority of clinical reports and diagnoses claim cardiac injury based on ICU-related-related injury to the heart. [17,18,19,20,21,22,23,24,25] This is relevant in terms of contextualizing the potential

risk of myocarditis from the COVID-19 products against COVID-19 itself and establishing a background rate of myocarditis in specific contexts. Cardiac injuries associated with COVID-19 respiratory illness reveal a set of parameters based on a combination of measurements of troponin levels, electrocardiogram (ECG/EKG), echocardiogram readings, cardiac magnetic resonance imaging (MRI) and clinical symptoms that are different from the clinical picture of vaccine-induced myocarditis. COVID-19-Injection-Related Myocarditis (CIRM) can be defined as the onset of clinical myocarditis that is temporally associated with COVID-19 mRNA or adenoviral DNA vaccine administration and in the absence of another known cause. CIRM presents with clinical symptoms (chest pain, effort intolerance) combined with excessively elevated troponin levels, EKG changes (diffuse ST segment elevation) and in some cases left and right ventricular dysfunction on echocardiography. In cases where the echocardiogram is unrevealing, cardiac MRI can detect changes in tissue characterization consistent with myocardial inflammation. [22,23,24,25,26,27]

The Vaccine Adverse Event Reporting System (VAERS) was created and implemented in 1990 by the Food and Drug Administration (FDA) and Centers for Disease Control and Prevention (CDC) to receive reports about adverse events that may be associated with vaccines. [28] The primary purpose for maintaining the database is to serve as an early warning or signaling system for adverse events not detected during pre-market testing. In addition, the National Childhood Vaccine Injury Act of 1986 (NCVIA) requires health care providers and vaccine manufacturers to report to the DHHS specific adverse events following the administration of those vaccines outlined in the Act.[1] Under-reporting is a known and serious disadvantage of the VAERS system. [28,29,30]

An Adverse Event (AE) is defined as any untoward or unfavorable medical occurrence in a human study participant, including any abnormal physical exam or laboratory finding, symptom, or disease, temporally associated with the participants' involvement in the research, whether or not considered related to participation in the research. A serious or severe adverse event (SAE) is defined as any adverse event that results in death, is life threatening, or places the participant at immediate risk of death from the event as it occurred, requires, or prolongs hospitalization, causes persistent or significant disability or incapacity, results in congenital anomalies or birth defects or is another condition which investigators judge to represent significant hazards. [28,30,31] These classifications are based on the Code of Federal Regulations. The VAERS handbook states that approximately 15% of reported AEs are classified as severe. [28] Myocarditis qualifies as an SAE as it is often associated with hospitalization.

The BNT162b2, mRNA-1273, Ad26.COV2.S products have **not** been approved or licensed by the U.S. Food and Drug Administration (FDA), having been authorized instead for emergency use by FDA under an Emergency Use Authorization (EUA) to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 16 years of age and older.[2] [32,33,34] Ultimately, the roll-out of COVID-19

injectable biologicals are actively being monitored, but all of the risks are not yet known. [16,17,31,32,33,34,35,36,37,38,39,40,41,42,43,44,45,46]

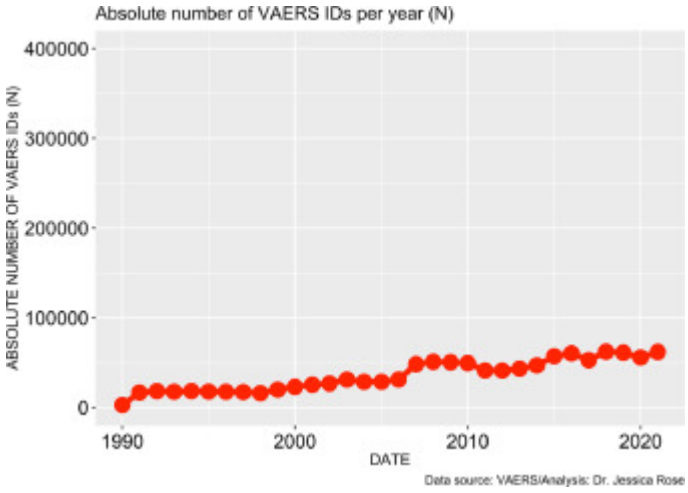
Methods and results

To analyse the VAERS data set the Language and Environment for Statistical Computing, R, was used. The VAERS data set is available for download (https://web.archive.org/web/20211007022707/https://vaers.hhs.gov/data/datasets) in three separate comma-separated values (csv) files representing i) general data for each report; ii) the reported AEs or 'symptoms', and iii) vaccine data including vaccine manufacturer and lot number, for each report. The VAERS dataset is updated approximately once a week and the uploaded set is approximately one week behind the reports. Upon individual reporting of vaccine side effects or adverse events, a VAERS ID number is provided to the individual to preserve confidentiality, and a detailed description of the side effects are transcribed along with the individual's age, residence by state, past medical history, allergies and gender and many other details. In addition, the vaccine lot number, place of vaccination and manufacturer details are included in the report. In order to maximize the input variables for my analysis, the three files were merged by VAERS ID that is included as a linking variable in all three files. The merged data set comprises data collected pertaining to all reported AEs associated with BNT162b2, mRNA-1273, and Ad26.COV2.S products: the three primary vaccine manufacturers responsible for nCoV-2019 products currently being administered in the U.S. Data was sorted according to vaccine type (data reported for COVID-19) and relevant variables were sorted including VAERS ID, AEs, age, gender, state, vaccination date, date of death, incident of death, dose series, treatment lot number, treatment manufacturer, hospitalizations, emergency department visits and onset date of AEs. Myocarditis as a standalone AE was extracted by keyword and cardiac events were grouped by extracting multiple keywords according to MedDRA nomenclature. Statistical analysis was done using the Student's t-Test to determine statistically significant differences between ages in the myocarditis AE. Skewing in distribution of data was tested using Pearson's Skewness Index, I, which is defined as $I=(\text{mean}-\text{mode})/\text{standard deviation}$. The data set is significantly skewed if $|I| \geq 1$.

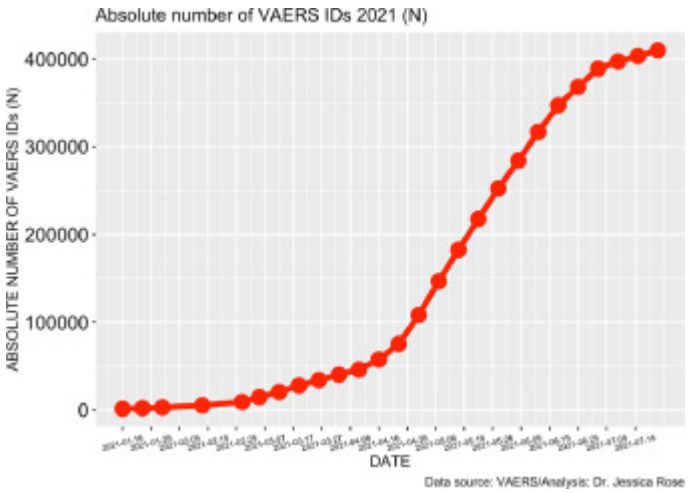
Results: General information

To date, approximately 56% of the total US population has been 'fully vaccinated' against COVID-19. As of July 9th, 2021, 397,262 AEs have been reported in the VAERS system. This number is very atypical and large when compared to frequencies of AE reports from previous years. Figure 1 illustrates the stark contrast between what the count would be if the trend of past 30 years continued through to the end of 2021: ~65,000 for the entire 2021 year as opposed to ~400,000 over 6 months. There are almost 4,000 different AE types reported (to date) in the context of COVID-19 products and among them, many SAES. As previously stated, the VAERS handbook

maintains that ~15% of all the AEs should classify as SAEs yet the percentage holds at 18% for COVID-19-related AEs.



Download : Download high-res image (134KB) Download : Download full-size image

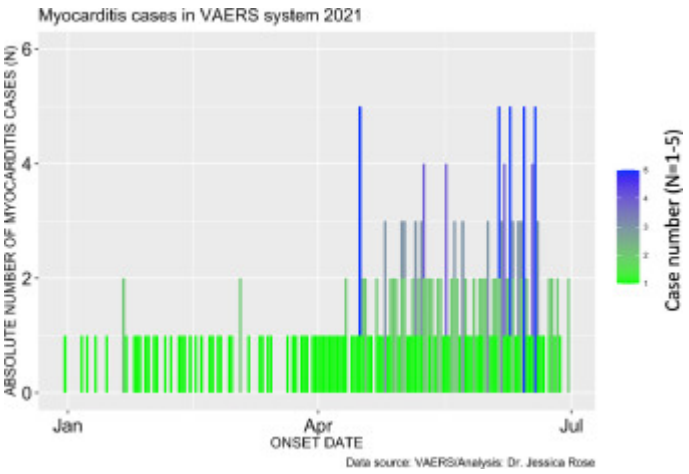


Download : Download high-res image (188KB) Download : Download full-size image

Figure 1. Time series plots – all VAERS reports in association with all vaccines administered to the U.S. population by year (left) and VAERS reports in association with COVID-19 products for 2021 (right).

Among these SAEs are cardiac AEs that include cardiac arrest, myocardial infarction, and myocarditis. Myocarditis reports in the context of the COVID-19 products are atypically high in the context of prior vaccine rollouts and in the context of baseline levels with respect to high-risk groups. The number of cases of myocarditis reported to the VAERS database dramatically outnumber case counts seen in previous years with 1 single case having been reported in 2019 and 1 single case being reported in 2020 (Refer to Section 1.4). Figure 2 shows the absolute

numbers of myocarditis cases reported for 2021 as per Onset Date. It is clear from this bar plot that the frequency of myocarditis cases reported to VAERS has increased starting at the beginning of June. This is just shortly after the roll-out of injections into children aged 12-15 began. On May 10, 2021, the Food and Drug Administration (FDA) issued an Emergency Use Authorization (EUA) for BNT162b2 vaccine in children aged 12-15. Of note, 67% of myocarditis cases were in the context of administration of BNT162b2.

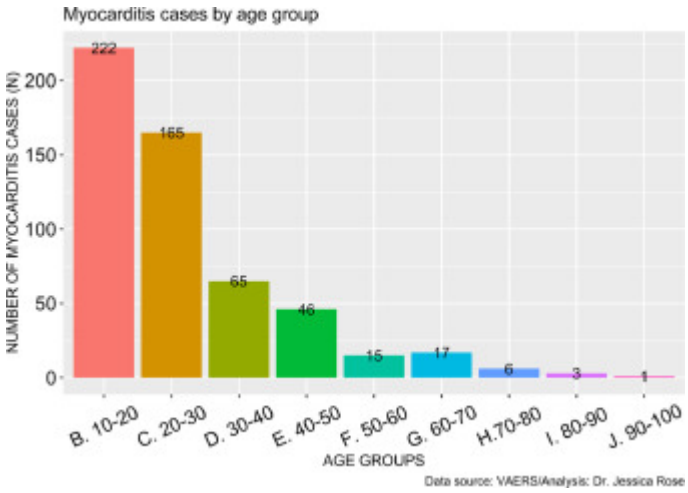


Download : Download high-res image (197KB) Download : Download full-size image

Figure 2. Bar plot showing the number myocarditis cases reported from January 1st to July 9th, 2021.

Incidence rates of myocarditis in youths

As of July 9th, 2021, a total of 559 myocarditis AEs (0.14% of all AEs) have been reported. Of the reports, 80% of the gender classification was male. In general, 71% of all VAERS reports are made by females so this statistic is particularly telling. The increase in myocarditis reports coincides with the COVID-19 injection rollouts in children aged 12-15, thus, we hypothesized that the increased cases of myocarditis were in fact occurring in children of these ages. Figure 3 shows the distribution of myocarditis cases by age grouped by decade. 41% of all myocarditis reports were made for children aged 10 through 20 and 72% of all myocarditis reports were made for young adults aged 10-30 years of age. The distribution is right-skewed toward the younger age groups, and this is statistically significant (I=1.61). This provides strong evidence to support our hypothesis.



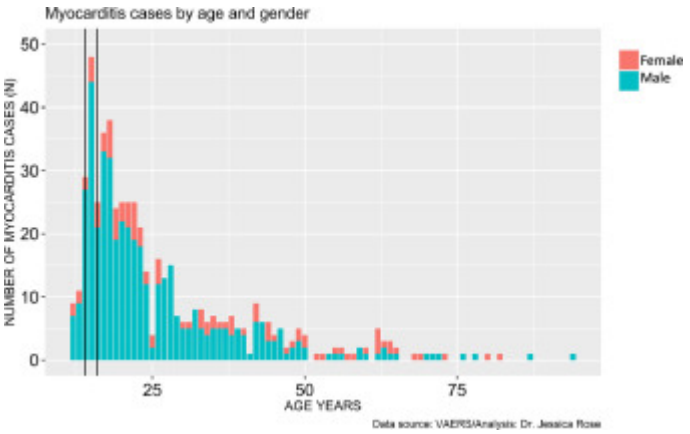
Download : Download high-res image (141KB) Download : Download full-size image

Figure 3. Histogram showing the number of reported VAERS cases of myocarditis by age group.

As of May 18th, 2021, 600,000 children aged 12-15 had been injected with COVID-19 products[3]. [14] The CDC estimated that 3,430,741 children aged 12-15 have received at least one dose of the COVID-19 products as of June 7th, 2021.[4] Since 1 per 100,000 children per year are affected by myocarditis[5] then, statistically, we would expect ~5 myocarditis cases if we calculate the expected number of cases using the June 7th CDC sample. To date (up to and including July 2nd, 2021), 97 children aged 12-15 have had reports submitted to VAERS representing 17.4% of all myocarditis reports – and these are merely the cases that we are aware of. Thus, after 8 weeks of roll-out into the 12-15 years-old age group, we are at ~19 times the expected number of cases within this sample. Thus, the number of VAERS-reported cases far outnumber what would typically be expected to date. It is important to note that of the 559 myocarditis VAERS reports, 6 died (1.1%) and 33% of these deaths were in individuals under 20 years of age: 1 individual was 13 and one was 19 years of age.

Data right-skewed in statistically significant way toward young males

In addition to very high rates of myocarditis cases in children aged 12-15, these rates are observed much more commonly in males. Figure 4 shows the distribution of myocarditis cases by age in males versus females. The distribution is right-skewed toward the younger age groups, and this is statistically significant (I=1.28), and males represent 80% of all cases. The most frequent occurrences were in 15-year-old boys (N= 44) and 18-year-old girls (N= 6).

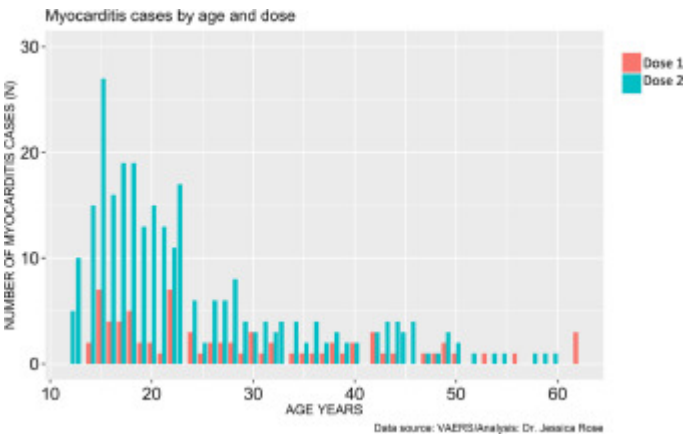


Download : Download high-res image (142KB) Download : Download full-size image

Figure 4. Histogram showing Myocarditis cases reported in VAERS following injection with COVID-19 products according to age and gender.

Acute myocarditis following 2nd dose

The prevalence of myocarditis reports in the VAERS system is much higher in the context of dose 2 when comparing by age (t-test: p-value = 0.00092) and more highly associated with BNT162b2 (74% of all dose 2 reports are in the context of BNT162b2. It is also much higher in males when comparing by age (t-test: p-value = 0.000009). Dose 2 is generally administered 3 weeks following the first dose assuming the individual survives dose 1 without any major complications, including death. The BNT162b2 maintains a 21-day interval between dose 1 and 2 while the mRNA-1273 maintains a 28-day interval.[6] Figure 5 reveals that myocarditis reports peak in frequency at 6X for dose 2 in 15-year-old males. It also reveals that regardless of age, myocarditis cases are more frequently reported following dose 2.



Download : Download high-res image (141KB) Download : Download full-size image

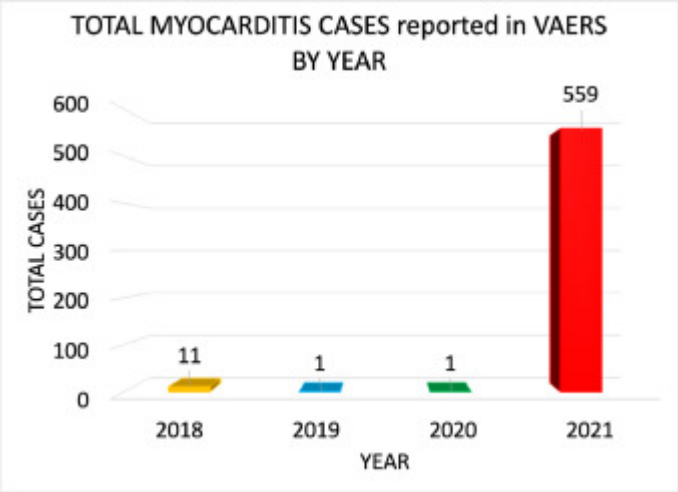
Figure 5. Histogram showing Myocarditis cases reported in VAERS following injection with COVID-19 products according to age and dose.

Since the high-risk age population for myocarditis is from puberty through early 30s, myocarditis should be considered diagnostically in any young adult who experiences shortness of breath, palpitations or chest pain following injection with dose 1 of any COVID-19 injectable product. It is notable that chest pain is a prevalent tandem AE (25% of individuals who filed myocarditis reports into VAERS also experienced chest pain following dose 1) and this may not be acknowledged by a teenager, or even a medical professional, as a warning sign of cardiac insult. The data is right-skewed toward the younger ages, and this is statistically significant (I=1.2).

COVID-19 products highly associated with myocarditis – a case for causation?

About 1.5 million cases of acute myocarditis occurred in 2013. In 1990, 294,000 individuals died from cardiomyopathy (including myocarditis) which increased to 354,000 deaths in 2015. Myocarditis is a rare disease and typically presents in males and younger individuals as previously stated. The trigger for myocarditis is considered idiopathic but generally thought to be the result of infection or toxin. [2] However, in the context of vaccine-induced myocarditis, report numbers have typically been very low. That is, however, until recently. Consider that 2021 is the only year we have been able to collect AE data for the COVID-19 products and prior years are exclusively non-COVID products, except for 2 weeks in December 2020.

The average number of myocarditis reports in VAERS in the context of all vaccines combined for the past 3 years is 4: 11 (0.02% of total) reports were made in 2018, and 1 report was made for 2019 (0.002% of total) and 2020 (0.002% of total), respectively. The number of myocarditis case reports for 2021 are at 559 (0.14%); far higher than last year for all vaccine products combined as shown in Figure 6. Myocarditis case rates for 2018-2021 reveal that the rates of myocarditis, when normalized to the number of fully vaccinated/injected individuals, are exceedingly higher in 2021 than for previous years as shown in Table 1.



Download : Download high-res image (113KB) Download : Download full-size image

Figure 6. Bar plot showing Myocarditis cases reported in VAERS by year. *2021: up to and including July 9th, 2021.

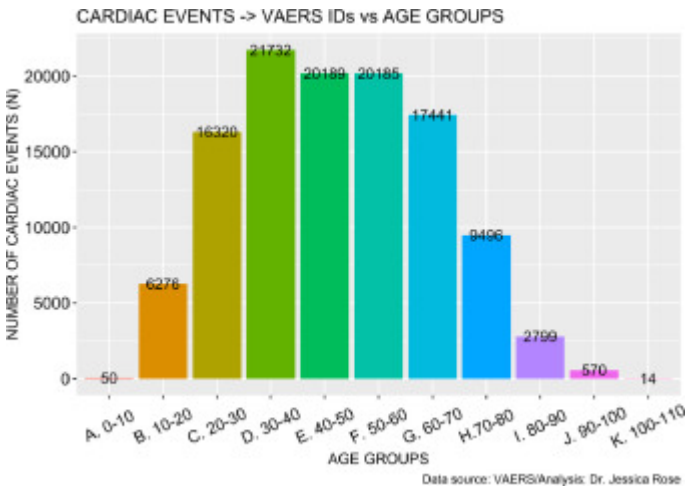
Table 1. Case rates of myocarditis per year based on estimated number of doses per year with respect to the population size for the season normalized to the number of doses administered per vaccine. *Population data extracted from Worldometer[9] and vaccine data extracted from Our World in Data[10] and CDC database[11]. [45,46,48]

Year	Rate/million doses
2018	0.067
2019	0.006
2020	0.024
2021	3.092

Cardiac events associated with COVID-19

There are 129,522 AEs to date (July 9th, 2021) that are directly related to clinical diagnosis of serious cardiac issues such as myocarditis. These AEs are shown Supplementary Tables 1 and 2 whereby Supplementary Table 1 shows clinical effects such as chest pain and pericarditis and Supplementary Table 2 shows clinical markers or diagnostic elements such as elevated Troponin

and Fibrin D dimer levels. This number was calculated using a function that extracts field entries from the VAERS updated AE dataframe that match the list, and subsequently counts them. Figure 7 shows the distribution of cardiac events by age group generated just from this short list of keywords. The highest number of reports was made by individuals aged 30-40 but overall, the distribution is symmetric and unimodal with no statistically significant skewing toward any specific age group (I=0.32). This means that cardiac AEs are being heavily reported, regardless of age.



Download : Download high-res image (172KB) Download : Download full-size image

Figure 7. Histogram showing Cardiac cases reported in VAERS by year.

Discussion

In the context of COVID-19, and according to Dr. Leslie Cooper, there are a significant number of patients who present clinically as healthy who are experiencing heart-related complications, including myocarditis. [7] [2,17,18,19] There is a high risk of cardiac involvement both from COVID-19 infection and from COVID-19 injectable products and the risks of the latter must be further assessed and evaluated. Because of the spontaneous reporting of events to VAERS, we can assume that the cases reported thus far are not rare, but rather, just the tip of the iceberg. Again, under-reporting is a known and serious disadvantage of the VAERS system. [28,29,30] The only way to understand how common myocarditis is after COVID-19 vaccination, is to perform a prospective cohort study where all vaccinated individuals undergo clinical assessment, ECG, and troponin measurement at regular intervals post-administration.

The fact that the VAERS reporting of myocarditis is 6X higher in 15-year-olds following dose 2 may be indicative of a cause-effect relationship. If we assume that following dose 1, a certain percentage of healthy young males who lack co-morbidities or co-factors experience cardiac-

related AEs mild enough so as not to dissuade them from receiving dose 2 (ie: pallor, chest pain and shortness of breath, for example), then it is not difficult to imagine that they may have been experiencing symptoms of myocarditis. If a percentage of young males had experienced primary damage to the heart as a result of inflammation following dose 1, then dose 2 may have induced a much more noticeable clinical impact, or cardiac 'insult'. In other words, these young males may receive a definitive diagnosis of myocarditis only following dose 2. What this implies, based on these assumptions, is that if there is a causal relationship then it might manifest with overlooked/unreported AEs following dose 1 and a diagnosis of myocarditis following dose 2. It is noteworthy that 'Vaccine-induced myocarditis' was in fact used as the descriptor by medical professionals as the reason for the myocarditis in the VAERS database.

During phase III clinical trials for the mRNA COVID-19 products, safety was assessed based on a *maximum* observation period of 6 months. This is not adequate to assess long-term safety outcomes as it is a requirement, even in an accelerated timeline setting, to spend up to 9 months in Phase III trials.[8] The typical timeline is up to 10 years for safety and efficacy assessment. [47,48] There are many examples of biological product recalls historically. In 2010, rotavirus vaccines licensed in the U.S were found to contain Porcine circovirus (PCV) type 1 and were subsequently suspended. In 2009, an increased risk of narcolepsy was found following vaccination with a monovalent H1N1 influenza vaccine that was used in several European countries during the H1N1 influenza pandemic. Between 2005 and 2008, a meningococcal vaccine was suspected to cause Guillain-Barré Syndrome (GBS). In 1998, a vaccine designed to prevent rotavirus gastroenteritis was associated with childhood intussusception after being vaccinated. Also in 1998, a hepatitis B vaccine product was linked to multiple sclerosis (MS). [49] It is also vital to address that pregnant woman were in the exclusion criteria list for the Phase III trials (ref: NCT04368728) and thus it is unclear how a safety assessment can be made for pregnant women when the products were only tested for 6 months. [50] In this context, it is worth reiterating that BNT162b2, mRNA-1273, and the Ad26.COV2.S products have **not** been approved or licensed by the U.S. Food and Drug Administration (FDA), having been authorized instead for emergency use by FDA under an Emergency Use Authorization (EUA) to prevent Coronavirus Disease 2019 (COVID-19), and was originally meant for use in individuals 16 years of age and older. [32,33,34] mRNA platforms have never before been implemented for use in human subjects on a global scale in the context of viruses and it has recently been shown that the spike protein itself systemically traffics inducing damage within cells, at the cell surface, and through circulation with endothelial damage and thrombosis. [44,45] It is unknown which cells and organs are seeded with mRNA, the cellular half-life of the products, duration of spike protein production, reverse transcription, future regulation, and ultimate disposal of mRNA technology. [51,52] Safety is always a point of relevance with regards to new biological agents and given these new findings, it would be prudent to pay particular attention to the AEs being reported to the VAERS system in the context of these experimental products with known dangerous mechanisms of action. When evidence of harm appears, we need to follow the evidence and immediately take steps to mitigate risks.

Based on this study, the risk of suffering myocarditis subsequent to injection with the mRNA-based products is low with an average of 4 individuals suffering myocarditis per million fully injected. However, the Israeli Ministry of Health recently announced that approximately 1 in 4,500 men ages 16 to 24 who received BNT162b2 developed myocarditis. [46] This rate is much higher than the rate estimated based on VAERS data and could reflect variation in reporting. Nonetheless, the risk is higher for the young with an average of 28 12-15-year-olds succumbing to myocarditis per million fully immunized. Discerning between ICU-related mild cardiac injury with SARS-CoV-2 respiratory infection and myocarditis in the context of COVID-19 and the injectable biologicals is important. In establishing background rates of myocarditis in the context of both COVID-19 and injection-associated cardiac injuries, it is vital to ensure that true myocarditis is ensuing for diagnostic purposes. This can be achieved by definitively quantifying the levels of markers for myocarditis such as troponin (I and T), EKG/echocardiograms, and detecting deviations in ST and T waves, PR and QT intervals and T wave inversion. Changes the overall area under the curve for cardiac troponin, reductions in left ventricular ejection fraction, and changes in tissue characterization by cardiac MRI can also be used as diagnostic quantifiers to aid in discerning between CIRM and ICU-related cardiac injuries. As a general rule, the ICU cardiac injury described in COVID-19 illness is subclinical and largely reflected by a minor elevation of cardiac troponin, whereas CIRM is characterized by a clinical syndrome often warranting hospitalization, dramatic ECG changes, and very large elevations of cardiac troponin that are sustained over time. [53,54,55,56,57,58,87]

It is vital to recall that children have a negligible risk for COVID-19 respiratory illness, and yet they are a high-risk group for myocarditis with vaccination. Newly-published evidence of Vaccine-Induced Autoimmune Myocarditis, [58] demonstrates the risks of myocarditis associated with vaccination. [87,88,89,92,93,94,95] Despite this, a recent CDC report (May 31, 2021) claimed no danger signal was detectable from the VAERS AE data in the context of myocarditis and as such, they continue to support administration of these products into children 12 years of age and older despite reports of myocarditis and pericarditis in youth in temporal proximity to dose administration. [94]

It possible that vaccine-induced myocarditis is amplified by prior infection and pathogenic priming. Higher uptake of genetic material in some younger individuals who have been previously recovered from COVID-19 and were vaccinated, may partially explain why some individuals suffer from CIRM and others do not. Nevertheless, the background rate for children aged 12-15 has been established outside of the COVID-19 context and the rates in the context of CIRM are 19 times higher than the expected value.

A recent study shows increased myocardial ACE-2 expression in individuals with ‘basic heart failure disease’ indicating an intrinsic susceptibility of the heart to SARS-CoV-2 infection and worse prognosis. [55] Another study in *Hypertension* from 2008 claims that cardiac over-expression of ACE-2 exerts protective influence on the heart during myocardial infarction by preserving left

ventricular wall motion and contractility, and by attenuating LV wall thinning. [56] However, we postulate the pathogenesis of CIRM must be much different with isolated production of spike protein over a sustained period of time and expression of the cell surface of cardiomyocytes, which would be considerably different than virion replication. The implications are the ACE-2 expression probably plays a smaller role in vaccine-induced myocardial injury and it has been noted by the co-author that the latter is more highly-associated with maintained elevated troponin levels. [unpublished clinical findings]

Additional information may be gleaned from routine EKG readings and cardiac troponin measurement in volunteers post-injection. It is unknown if in-situ production or perfusion with blood carrying spike protein are the major mechanisms by which CIRM is initiated. Once, damaged, inflammation in the myocardium may last for weeks or months after the original insult is removed. [55,58] The exact mechanisms of action for induction and progression of CIRM needs to be elucidated to ensure improved and safer products for the future.

The clinical implications of acute myocarditis in younger individuals as a result of uncontrolled production of the SARS-CoV-2 spike protein within cardiac myocytes and cardiac support cells is unknown. If myocarditis has developed after the first injection, then second administrations and boosters should be avoided. Sustained elevations of cardiac troponin, reduction in left and right ventricular function, large areas of inflammation or scar on imaging, and cardiac arrhythmias all portend a poor prognosis for the development of heart failure and cardiac death. Because the duration of action of genetic material coding for spike protein is unknown, follow-up with cardiology consultation is advised in all cases and repeat imaging and biomarkers is wise. Empiric treatment with renin-angiotensin system inhibitors and evidence-based beta-blockers is advised for those at risk for or with manifest left ventricular dysfunction.

Conclusions

These data are derived from a rushed, non-FDA-approved, ongoing investigational product roll-out, and our conclusions are thus limited by the information at hand. In addition to the 12-15-year-old age group data being *very* early, it is vital to acknowledge that these reports represent a fraction of the actual total. Thus, due to both the problems of under-reporting and the known lag in report processing, this analysis reveals a strong signal from the VAERS data that the risk of suffering CIRM – especially males is unacceptably high. Again, children are not a high-risk group for COVID-19 respiratory illness, and yet they are the high-risk group for CIRM.

Efficacy of these products needs to be assessed by immunological assays and long-term studies are required, while safety needs to be evaluated by rigorous clinical, laboratory and imaging assessments of severe reported adverse events such as CIRM. Autopsies should be done in cases of cardiovascular-related deaths temporally associated with COVID-19 injectables. It is reasonable to use the precautionary principle in this particular setting since an alarming number of reports are coming from young males between the ages of 12 and 15. Boys of these ages should

be carefully monitored for warning signs of myocarditis which many may pass off such as pallor, chest pain, shortness of breath or lethargy, following dose 1 with the aim of seeking prompt evaluation and avoiding dose 2.

Effective multidrug therapy is available for rare case of serious COVID-19 respiratory illness in the forms of antivirals, immunomodulators, and anthrombotics. [59,60,61,62,63,64,65,66,67,68,69,70,71,72] The combination of a low IFR in children indicating effective and robust immune responses [73,74,75,76,77,78,79,80,81,82,83], and the ability to treat with medical therapy, should the need arise, bodes well for clinical outcomes in children [69,70,71,72].

As part of any risk/benefit analysis which must be completed in the context of experimental products, the points herein must be considered before a decision can be made pertaining to agreeing to 2-dose injections of these experimental COVID-19 products, especially into children and by no means, should parental consent be waived under any circumstances to avoid children volunteering for injections with products that do not have proven safety or efficacy.

Future work may include on-site clinical observations of Troponin, BNP, galectin-3, ST2, IL-6 and D-dimer levels to corroborate temporal effects of onset of myocarditis following injections with particular COVID-19 products. Delineation between COVID-19 respiratory infection with mild ICU-related cardiac injury and true CIRM using these and other clinical diagnostic markers would be incredibly useful for clinicians and should become the standard for differential diagnosis of suspected CIRM. Correcting the inherent limitations of the VAERS dataset must be a priority as part of future studies. Incomplete VAERS dataset field entries describing prior COVID-19 infection and diagnostic tests such as cardiac MRIs in individuals diagnosed with myocarditis, for example, would make this particular study even more potent. However, despite these limitations, and the limitation of using the VAERS dataset for studies like this one, the usable sample sizes have good statistical power. Ultimately, it remains vital to share the results herein to allow true pharmacovigilance to take place.

Author's contributions

Dr. Jessica Rose completed the data analysis and wrote and edited the manuscript. Dr. McCullough provided critical edits and content.

Uncited References:

[84, 85, 86, 90, 91, 96, 97, 98, 99, 100]

Supplementary Materials

Supplementary Table 1 : List of cardiac AEs used to produce general compact list of AEs related myocarditis

Supplementary Table 2 : List of cardiac AEs used to produce general compact list of tests and markers related to myocarditis

Declaration of Competing Interest

Nothing to disclose. Author had access to data and wrote the manuscript.

Funding source(s)

none related

Appendix. Supplementary materials

Download : **Download Word document (42KB)**

Recommended articles Citing articles (0)

References

1 LT Cooper Jr.
Myocarditis
N Engl J Med, 360 (15) (2009 Apr 9), pp. 1526-1538, 10.1056/NEJMra0800028
PMID: 19357408; PMCID: PMC5814110
View Record in Scopus Google Scholar

2 National Organization for Rare Disorders (NORD)
https://web.archive.org/web/20211007022707/https://rarediseases.org/rare-diseases/myocarditis/
Google Scholar

3 G Sinagra, M Merlo, B Pinamonti
Dilated Cardiomyopathy: From Genetics to Clinical Management [Internet]
Springer, Cham (CH) (2019)
Google Scholar

4 ESC Textbook of Cardiovascular Medicine, 3rd edition
Google Scholar

5 P Libby, FK Swirski, M. Nahrendorf
The Myocardium: More Than Myocytes
J Am Coll Cardiol, 74 (25) (2019 Dec 24), pp. 3136-3138, 10.1016/j.jacc.2019.10.031

PMID: 31856970
Article Download PDF View Record in Scopus Google Scholar

6 DB Tran, C Weber, RA. Lopez
Anatomy, Thorax, Heart Muscles. [Updated 2020 Sep 19]
StatPearls [Internet], StatPearls Publishing, Treasure Island (FL) (2021 Jan)
Available from:
https://web.archive.org/web/20211007022707/https://www.ncbi.nlm.nih.gov/bookb/NBK545195/
Google Scholar

7 I Banerjee, JW Fuseler, RL Price, TK Borg, TA. Baudino
Determination of cell types and numbers during cardiac development in the neonatal and adult rat and mouse
Am J Physiol Heart Circ Physiol, 293 (3) (2007 Sep), pp. H1883-H1891,
10.1152/ajpheart.00514.2007
Epub 2007 Jun 29. PMID: 17604329
CrossRef View Record in Scopus Google Scholar

8 M.F. Wendt-Gallitelli, G. Isenberg
Electrophysiology and Microinjection
Methods in Neurosciences (1991)
Google Scholar

9 https://web.archive.org/web/20211007022707/https://www.britannica.com/science/myocyte
Google Scholar

10 A.J. Weinhaus, K.P. Roberts
Anatomy of the Human Heart
Iaizzo P. (Ed.), Handbook of Cardiac Anatomy, Physiology, and Devices, Humana Press (2009), 10.1007/978-1-60327-372-5_5
https://web.archive.org/web/20211007022707/https://doi.org/
Google Scholar

11 KM Harris, S Mackey-Bojack, M Bennett, D Nwaudo, E Duncanson, BJ. Maron
Sudden Unexpected Death Due to Myocarditis in Young People, Including Athletes
Am J Cardiol, 143 (2021 Mar 15), pp. 131-134, 10.1016/j.amjcard.2020.12.028
Epub 2020 Dec 19. PMID: 33347841
Article Download PDF View Record in Scopus Google Scholar

12 https://web.archive.org/web/20211007022707/https://www.mayoclinic.org/diseases-conditions/myocarditis/symptoms-causes/syc-20352539
Google Scholar

13 **Myocarditis Education Updates and How to Potentially Diagnose the Disease**
Myocarditis Foundation (Aug 4, 2020)
Google Scholar

14 **Myocarditis in children: incidence, clinical characteristics and outcomes**
Myocarditis Foundation (Jul 29, 2020)
Google Scholar

15 https://web.archive.org/web/20211007022707/https://www.cdc.gov/dhdsp/myocarditis.htm
Google Scholar

16 https://web.archive.org/web/20211007022707/https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/myocarditis.html
Google Scholar

17 B Siripanthong, S Nazarian, D Muser, *et al.*
Recognizing COVID-19-related myocarditis: The possible pathophysiology and proposed guideline for diagnosis and management
Heart Rhythm, 17 (9) (2020), pp. 1463-1471, 10.1016/j.hrthm.2020.05.001
Article Download PDF View Record in Scopus Google Scholar

18 D Mele, F Flamigni, C Rapezzi, R. Ferrari
Myocarditis in COVID-19 patients: current problems
Intern Emerg Med (2021 Jan 23), pp. 1-7, 10.1007/s11739-021-02635-w
Epub ahead of print. PMID: 33484452; PMCID: PMC7823176
CrossRef Google Scholar

19 T Castiello, G Georgiopoulos, G Finocchiaro, *et al.*
COVID-19 and myocarditis: a systematic review and overview of current challenges [published online ahead of print, 2021 Mar 24]
Heart Fail Rev (2021), pp. 1-11, 10.1007/s10741-021-10087-9
Google Scholar

20 E Albert, G Aurigemma, J Saucedo, DS. Gerson
Myocarditis following COVID-19 vaccination
Radiol Case Rep, 16 (8) (2021), pp. 2142-2145, 10.1016/j.radcr.2021.05.033
Article Download PDF View Record in Scopus Google Scholar

21 **How Can COVID-19 Affect the Heart?**
Myocarditis Foundation (Aug 18, 2020)
Google Scholar

22

J Montgomery, M Ryan, R Engler, D Hoffman, B McClenathan, L Collins, D Loran, D Hrncir, K Herring, M Platzer, N Adams, A Sanou, LT Cooper Jr.
Myocarditis Following Immunization With mRNA COVID-19 Vaccines in Members of the US Military
JAMA Cardiol (2021 Jun 29), 10.1001/jamacardio.2021.2833
Epub ahead of print. PMID: 34185045
Google Scholar

23 MW Martinez, AM Tucker, OJ Bloom, G Green, JP DiFiori, G Solomon, D Phelan, JH Kim, W Meeuwisse, AK Sills, D Rowe, II Bogoch, PT Smith, AL Baggish, M Putukian, DJ. Engel
Prevalence of Inflammatory Heart Disease Among Professional Athletes with Prior COVID-19 Infection Who Received Systematic Return-to-Play Cardiac Screening
JAMA Cardiol, 6 (7) (2021 Jul 1), pp. 745-752, 10.1001/jamacardio.2021.0565
PMID: 33662103; PMCID: PMC7934073
CrossRef View Record in Scopus Google Scholar

24 VO Puntmann, ML Carerj, I Wieters, M Fahim, C Arendt, J Hoffmann, A Shchendrygina, F Escher, M Vasa-Nicotera, AM Zeiher, M Vehreschild, E. Nagel
Outcomes of Cardiovascular Magnetic Resonance Imaging in Patients Recently Recovered From Coronavirus Disease 2019 (COVID-19)
JAMA Cardiol, 5 (11) (2020 Nov 1), pp. 1265-1273, 10.1001/jamacardio.2020.3557
Erratum in: JAMA Cardiol. 2020 Nov 1;5(11):1308. PMID: 32730619; PMCID: PMC7385689
CrossRef View Record in Scopus Google Scholar

25 MDMDMDMD, PhDMD
Gregorio Tersalvi, Marco Vicenzi, Davide Calabretta, Luigi Biasco, Giovanni Pedrazzini, Dario Winterton
Elevated Troponin in Patients with Coronavirus Disease 2019: Possible Mechanisms
Review article Volume, 26 (ISSUE 6) (June 01, 2020), pp. P470-P475,
10.1016/j.cardfail.2020.04.009
Published:April 18, 2020
Google Scholar

26 JHP Nascimento, BFO Gomes, GMM. Oliveira
Cardiac Troponin as a Predictor of Myocardial Injury and Mortality from COVID-19
Arq Bras Cardiol, 115 (4) (2020 Oct), pp. 667-668, 10.36660/abc.20200862
English, PortuguesePMID: 33111867
CrossRef View Record in Scopus Google Scholar

27 FM Ucar, C Ozturk, MA. Yılmaztepe
Tp-e/QT ratio and Tp-e/QTc ratio in patients with acute myocarditis
BMC Cardiovasc Disord, 19 (1) (2019 Oct 22), p. 232, 10.1186/s12872-019-1207-z

PMID: 31640548; PMCID: PMC6805629
View Record in Scopus Google Scholar

28 VAERSDataUseGuide_November2020
Google Scholar

29 https://web.archive.org/web/20211007022707/https://vaxopedia.org/2017/08/26/underreporting-of-side-effects-to-vaers
Google Scholar

30 NIA Adverse Event and Serious Adverse Event Guidelines
Google Scholar

31 https://web.archive.org/web/20211007022707/https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/cfrsearch.cfm?frexternalicon
Google Scholar

32 https://web.archive.org/web/20211007022707/https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html
Google Scholar

33 Temporary_Authorisation_Patient_Information_BNT162_7_0_UK.pdf
Google Scholar

34 Fact Sheet for Vaccination Providers-Full EUA PI_Final_2.25.2021.pdf
Google Scholar

35 M.D. Noa Dagan, *et al.*
BNT162b2 mRNA Covid-19 Vaccine in a Nationwide Mass Vaccination Setting
New England Journal of Medicine (February 24, 2021), 10.1056/NEJMoa2101765
Google Scholar

36 EE Walsh, RW Frenck Jr, AR Falsey, N Kitchin, J Absalon, A Gurtman, S Lockhart, K Neuzil, MJ Mulligan, R Bailey, KA Swanson, P Li, K Koury, W Kalina, D Cooper, C Fontes-Garfias, PY Shi, Ö Türeci, KR Tompkins, KE Lyke, V Raabe, PR Dormitzer, KU Jansen, U Şahin, WC Gruber
Safety and Immunogenicity of Two RNA-Based Covid-19 Vaccine Candidates
N Engl J Med, 383 (25) (2020 Dec 17), pp. 2439-2450, 10.1056/NEJMoa2027906
Epub 2020 Oct 14. PMID: 33053279; PMCID: PMC7583697
CrossRef View Record in Scopus Google Scholar

37 FP Polack, *et al.*
C4591001 Clinical Trial Group. Safety and Efficacy of the BNT162b2 mRNA Covid-19 Vaccine

N Engl J Med, 383 (27) (2020 Dec 31), pp. 2603-2615, 10.1056/NEJMoa2034577
Epub 2020 Dec 10. PMID: 33301246; PMCID: PMC7745181
CrossRef View Record in Scopus Google Scholar

38 Johns Hopkins University Coronavirus Resource Center. COVID-19 dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University. 2020, CDC, WHO, T Khan, K Agnihotri, A Tripathi, S Mukherjee, N Agnihotri, G. Gupta
COVID-19: A Worldwide, Zoonotic, Pandemic Outbreak
Altern Ther Health Med, 26 (S2) (2020 Aug), pp. 56-64
PMID: 32412918
View Record in Scopus Google Scholar

39 IPAK Report 2021-1. 2021. Post-vaccination Death Causality Likely Given Temporal Distribution of Deaths Following COVID19 Vaccinations. Interim results.
Google Scholar

40 S. Tinari
The EMA covid-19 data leak, and what it tells us about mRNA instability
BMJ, 372 (2021), p. n627, 10.1136/bmj.n627
CrossRef View Record in Scopus Google Scholar

41 K.S. Corbett, D.K. Edwards, S.R. Leist, *et al.*
SARS-CoV-2 mRNA vaccine design enabled by prototype pathogen preparedness
Nature, 586 (2020), pp. 567-571, 10.1038/s41586-020-2622-0
https://web.archive.org/web/20211007022707/https://doi.org/
CrossRef View Record in Scopus Google Scholar

42 https://web.archive.org/web/20211007022707/https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/specific-groups/allergies.html
Google Scholar

43 https://web.archive.org/web/20211007022707/https://www.cdc.gov/vaccines/covid-19/info-by-product/pfizer/reactogenicity.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fcovid-19%2Finfo-by-manufacturer%2Fpfizer%2Freactogenicity.html
Google Scholar

44 https://web.archive.org/web/20211007022707/https://www.docdroid.net/xq0Z8B0/pfizer-report-japanese-government-pdf#page=17
Google Scholar

45 Yuyang Lei, *et al.*
SARS-CoV-2 Spike Protein Impairs Endothelial Function via Downregulation of ACE2

Circulation Research (April 30, 2021)
Google Scholar

46 Gretchen Vogel, Jennifer Couzin-Frankel
Israel reports link between rare cases of heart inflammation and COVID-19 vaccination in young men
Jun, 1 (2021)
Google Scholar

47 Johns Hopkins University of Medicine Coronavirus Resource Centre. Vaccine Research and Development. 2021
Google Scholar

48 https://web.archive.org/web/20211007022707/https://www.cdc.gov/vaccines/
Google Scholar

49 https://web.archive.org/web/20211007022707/https://www.cdc.gov/vaccinesafety/concerns/concerns-history.html
Google Scholar

50 https://web.archive.org/web/20211007022707/https://clinicaltrials.gov/ct2/show/NCT04368728
Google Scholar

51 RW Malone, PL Felgner, IM Verma. Cationic liposome-mediated RNA transfection. Proceedings of the National Academy of Sciences (PNAS) 86 (16), 6077-6081.
Google Scholar

52 JA Wolff, RW Malone, *et al.*
Direct gene transfer into mouse muscle in vivo
Science, 247 (4949 Pt 1) (1990), pp. 1465-1468
CrossRef View Record in Scopus Google Scholar

53 B Siripanthong, S Nazarian, D Muser, *et al.*
Recognizing COVID-19-related myocarditis: The possible pathophysiology and proposed guideline for diagnosis and management
Heart Rhythm, 17 (9) (2020), pp. 1463-1471, 10.1016/j.hrthm.2020.05.001
Article Download PDF View Record in Scopus Google Scholar

54 D Mele, F Flamigni, C Rapezzi, R. Ferrari
Myocarditis in COVID-19 patients: current problems
Intern Emerg Med (2021 Jan 23), pp. 1-7, 10.1007/s11739-021-02635-w
Epub ahead of print. PMID: 33484452; PMCID: PMC7823176

CrossRef Google Scholar

55 Liang Chen, Xiangjie Li, Mingquan Chen, Yi Feng, Chenglong Xiong
The ACE2 expression in human heart indicates new potential mechanism of heart injury among patients infected with SARS-CoV-2
Cardiovascular Research, 116 (6) (1 May 2020), pp. 1097-1100, 10.1093/cvr/cvaa078
VolumeIssuePageshttps://doi.org/
CrossRef View Record in Scopus Google Scholar

56 Shant Der Sarkissian, Justin L. Grobe, Lihui Yuan, Dhruv R. Narielwala, Glenn A. Walter, Michael J. Katovich, Mohan K. Raizada
Cardiac Overexpression of Angiotensin Converting Enzyme 2 Protects the Heart From Ischemia-Induced Pathophysiology
Hypertension, 51 (2008), pp. 712-718
Google Scholar

57 G Peretto, S Sala, S Rizzo, G De Luca, C Campochiaro, S Sartorelli, G Benedetti, A Palmisano, A Esposito, M Tresoldi, G Thiene, C Basso, P Della Bella
Arrhythmias in myocarditis: State of the art
Heart Rhythm, 16 (5) (2019 May), pp. 793-801, 10.1016/j.hrthm.2018.11.024
Epub 2018 Nov 24. PMID: 30476544
Article Download PDF View Record in Scopus Google Scholar

58 Bishwas Chamling, Volker Vehof, Stefanos Drakos, Mareike Weil, Philipp Stalling, Christian Vahlhaus, Patrick Mueller, Michael Bietenbeck, Holger Reinecke, Claudia Meier & Ali Yilmaz
Occurrence of acute infarct-like myocarditis following COVID-19 vaccination: just an accidental co-incidence or rather vaccination-associated autoimmune myocarditis?
Clinical Research in Cardiology (2021), 10.1007/s00392-021-01916-w
Received: 25 June 2021 /Accepted: 28 Julyhttps://doi.org/
Google Scholar

59 P Colson, JM Rolain, JC Lagier, P Brouqui, D. Raoult
Chloroquine and hydroxychloroquine as available weapons to fight COVID-19
Int J Antimicrob Agents, 55 (4) (2020 Apr), Article 105932, 10.1016/j.ijantimicag.2020.105932
Epub 2020 Mar 4. PMID: 32145363; PMCID: PMC7135139
Article Download PDF View Record in Scopus Google Scholar

60 SA Meo, DC Klonoff, J. Akram
Efficacy of chloroquine and hydroxychloroquine in the treatment of COVID-19
Eur Rev Med Pharmacol Sci, 24 (8) (2020 Apr), pp. 4539-4547,
10.26355/eurrev_202004_21038

PMID: 32373993
View Record in Scopus Google Scholar

61 S Ibáñez, O Martínez, F Valenzuela, F Silva, O. Valenzuela
Hydroxychloroquine and chloroquine in COVID-19: should they be used as standard therapy?
Clin Rheumatol, 39 (8) (2020 Aug), pp. 2461-2465, 10.1007/s10067-020-05202-4
Epub 2020 Jun 3. PMID: 32495226; PMCID: PMC7267470
CrossRef View Record in Scopus Google Scholar

62 Esposito S N
Chloroquine or hydroxychloroquine for prophylaxis of COVID-19
Lancet Infect Dis, 20 (10) (2020 Oct), p. 1118, 10.1016/S1473-3099(20)30296-6
Epub 2020 Apr 17. PMID: 32311322; PMCID: PMC7164862
Google Scholar

63 RE Ferner, JK. Aronson
Chloroquine and hydroxychloroquine in covid-19
BMJ, 369 (2020 Apr 8), p. m1432, 10.1136/bmj.m1432
PMID: 32269046.; Hernandez AV, Roman YM, Pasupuleti V, Barboza JJ, White CM. Hydroxychloroquine or Chloroquine for Treatment or Prophylaxis of COVID-19: A Living Systematic Review. Ann Intern Med. 2020 Aug 18;173(4):287-296. doi: 10.7326/M20-2496. Epub 2020 May 27. PMID: 32459529.
CrossRef View Record in Scopus Google Scholar

64 S Shah, S Das, A Jain, DP Misra, VS. Negi
A systematic review of the prophylactic role of chloroquine and hydroxychloroquine in coronavirus disease-19 (COVID-19)
Int J Rheum Dis, 23 (5) (2020 May), pp. 613-619, 10.1111/1756-185X.13842
Epub 2020 Apr 27. PMID: 32281213; PMCID: PMC7262257
CrossRef View Record in Scopus Google Scholar

65 E. Rizzo
Ivermectin, antiviral properties and COVID-19: a possible new mechanism of action
Naunyn Schmiedebergs Arch Pharmacol, 393 (7) (2020 Jul), pp. 1153-1156, 10.1007/s00210-020-01902-5
Epub 2020 May 27. PMID: 32462282; PMCID: PMC7251046
CrossRef View Record in Scopus Google Scholar

66 F Heidary, R. Gharebaghi
Ivermectin: a systematic review from antiviral effects to COVID-19 complementary regimen

J Antibiot (Tokyo), 73 (9) (2020 Sep), pp. 593-602, 10.1038/s41429-020-0336-z
Epub 2020 Jun 12. PMID: 32533071; PMCID: PMC7290143
CrossRef View Record in Scopus Google Scholar

67 K Sharun, K Dhama, SK Patel, M Pathak, R Tiwari, BR Singh, R Sah, DK Bonilla-Aldana, AJ Rodriguez-Morales, H. Leblebicioglu
Ivermectin, a new candidate therapeutic against SARS-CoV-2/COVID-19
Ann Clin Microbiol Antimicrob, 19 (1) (2020 May 30), p. 23, 10.1186/s12941-020-00368-w
PMID: 32473642; PMCID: PMC7261036
View Record in Scopus Google Scholar

68 RD Shih, HM Johnson, DG Maki, CH. Hennekens
Hydroxychloroquine for Coronavirus: The Urgent Need for a Moratorium on Prescriptions
Am J Med, 133 (9) (2020 Sep), pp. 1007-1008, 10.1016/j.amjmed.2020.05.005
Epub 2020 Jun 2. PMID: 32502485; PMCID: PMC7265864
Article Download PDF View Record in Scopus Google Scholar

69 S Lam, A Lombardi, A. Ouanounou
COVID-19: A review of the proposed pharmacological treatments
Eur J Pharmacol, 886 (2020 Nov 5), Article 173451, 10.1016/j.ejphar.2020.173451
Epub 2020 Aug 6. PMID: 32768505; PMCID: PMC7406477
Article Download PDF View Record in Scopus Google Scholar

70 PA McCullough, RJ Kelly, G Ruocco, E Lerma, J Tumlin, KR Wheelan, N Katz, NE Lepor, K Vijay, H Carter, B Singh, SP McCullough, BK Bhambi, A Palazzuoli, GM De Ferrari, GP Milligan, T Safder, KM Tecson, DD Wang, JE McKinnon, WW O'Neill, M Zervos, HA. Risch
Pathophysiological Basis and Rationale for Early Outpatient Treatment of SARS-CoV-2 (COVID-19) Infection
Am J Med, 134 (1) (2021 Jan), pp. 16-22, 10.1016/j.amjmed.2020.07.003
Epub 2020 Aug 7. PMID: 32771461; PMCID: PMC7410805
Article Download PDF View Record in Scopus Google Scholar

71 PA McCullough, PE Alexander, R Armstrong, C Arvinte, AF Bain, RP Bartlett, RL Berkowitz, AC Berry, TJ Borody, JH Brewer, AM Brufsky, T Clarke, R Derwand, A Eck, J Eck, RA Eisner, GC Fareed, A Farella, SNS Fonseca, CE Geyer Jr, RS Gonnering, KE Graves, KBV Gross, S Hazan, KS Held, HT Hight, S Immanuel, MM Jacobs, JA Ladapo, LH Lee, J Littell, I Lozano, HS Mangat, B Marble, JE McKinnon, LD Merritt, JM Orient, R Oskoui, DC Pompan, BC Procter, C Prodromos, JC Rajter, JJ Rajter, CVS Ram, SS Rios, HA Risch, MJA Robb, M Rutherford, M Scholz, MM Singleton, JA Tumlin, BM Tyson, RG Urso, K Victory, EL Vliet, CM Wax, AG Wolkoff, V Wooll, V. Zelenko

Multifaceted highly targeted sequential multidrug treatment of early ambulatory high-risk SARS-CoV-2 infection (COVID-19)
Rev Cardiovasc Med, 21 (4) (2020 Dec 30), pp. 517-530, 10.31083/j.rcm.2020.04.264
PMID: 33387997
View Record in Scopus Google Scholar

72 PA McCullough, K. Vijay
SARS-CoV-2 infection and the COVID-19 pandemic: a call to action for therapy and interventions to resolve the crisis of hospitalization, death, and handle the aftermath
Rev Cardiovasc Med, 22 (1) (2021 Mar 30), pp. 9-10, 10.31083/j.rcm.2021.01.301
PMID: 33792243
CrossRef View Record in Scopus Google Scholar

73 J.P. Ioannidis
Reconciling estimates of global spread and infection fatality rates of COVID-19: an overview of systematic evaluations
Eur J Clin Invest. Accepted Author Manuscript (2021), p. e13554, 10.1111/eci.13554
https://web.archive.org/web/20211007022707/https://doi.org/
View Record in Scopus Google Scholar

74 J Noh, G Danuser
Estimation of the fraction of COVID-19 infected people in U.S. states and countries worldwide
PLoS ONE, 16 (2) (2021), Article e0246772, 10.1371/journal.pone.0246772
https://web.archive.org/web/20211007022707/https://doi.org/
CrossRef View Record in Scopus Google Scholar

75 SM Toor, R Saleh, V Sasidharan Nair, RZ Taha, E Elkord
T-cell responses and therapies against SARS-CoV-2 infection
Immunology, 162 (1) (2021 Jan), pp. 30-43, 10.1111/imm.13262
Epub 2020 Oct 27. PMID: 32935333; PMCID: PMC7730020
CrossRef View Record in Scopus Google Scholar

76 DF Robbiani, *et al.*
Convergent antibody responses to SARS-CoV-2 in convalescent individuals
Nature, 584 (7821) (2020 Aug), pp. 437-442, 10.1038/s41586-020-2456-9
Epub 2020 Jun 18. PMID: 32555388; PMCID: PMC7442695
CrossRef View Record in Scopus Google Scholar

77 B Sun, *et al.*
Kinetics of SARS-CoV-2 specific IgM and IgG responses in COVID-19 patients
Emerg Microbes Infect, 9 (1) (2020 Dec), pp. 940-948, 10.1080/22221751.2020.1762515

PMID: 32357808; PMCID: PMC7273175
CrossRef View Record in Scopus Google Scholar

78 N Le Bert, *et al.*
SARS-CoV-2-specific T cell immunity in cases of COVID-19 and SARS, and uninfected controls
Nature, 584 (7821) (2020 Aug), pp. 457-462, 10.1038/s41586-020-2550-z
Epub 2020 Jul 15. PMID: 32668444
CrossRef View Record in Scopus Google Scholar

79 J Mateus, *et al.*
Selective and cross-reactive SARS-CoV-2 T cell epitopes in unexposed humans
Science, 370 (6512) (2020 Oct 2), pp. 89-94, 10.1126/science.abd3871
Epub 2020 Aug 4. PMID: 32753554; PMCID: PMC7574914
CrossRef Google Scholar

80 M Lipsitch, YH Grad, A Sette, S. Crotty
Cross-reactive memory T cells and herd immunity to SARS-CoV-2
Nat Rev Immunol, 20 (11) (2020 Nov), pp. 709-713, 10.1038/s41577-020-00460-4
Epub 2020 Oct 6. PMID: 33024281; PMCID: PMC7537578
CrossRef View Record in Scopus Google Scholar

81 K.S. Corbett, D.K. Edwards, S.R. Leist, *et al.*
SARS-CoV-2 mRNA vaccine design enabled by prototype pathogen preparedness
Nature, 586 (2020), pp. 567-571, 10.1038/s41586-020-2622-0
https://web.archive.org/web/20211007022707/https://doi.org/
CrossRef View Record in Scopus Google Scholar

82 P Zimmermann, N. Curtis
Factors That Influence the Immune Response to Vaccination
Clin Microbiol Rev, 32 (2) (2019 Mar 13), pp. e00084-e00118, 10.1128/CMR.00084-18
PMID: 30867162; PMCID: PMC6431125
Google Scholar

83 WA Orenstein, RH Bernier, TJ Dondero, AR Hinman, JS Marks, KJ Bart, B. Sirotkin
Field evaluation of vaccine efficacy
Bull World Health Organ, 63 (6) (1985), pp. 1055-1068
PMID: 3879673; PMCID: PMC2536484
View Record in Scopus Google Scholar

84 D Furman, MM. Davis
New approaches to understanding the immune response to vaccination and infection
Vaccine., 33 (40) (2015 Sep 29), pp. 5271-5281, 10.1016/j.vaccine.2015.06.117

Epub 2015 Jul 29. PMID: 26232539; PMCID: PMC4581990
Article Download PDF View Record in Scopus Google Scholar

85 R Vaidyanathan, RP O'Connell, M Deo, *et al.*
The ionic bases of the action potential in isolated mouse cardiac Purkinje cell
Heart Rhythm, 10 (1) (2013), pp. 80-87, 10.1016/j.hrthm.2012.10.002
Article Download PDF View Record in Scopus Google Scholar

86 ME Singer, IB Taub, DC. Kaelber
Risk of Myocarditis from COVID-19 Infection in People Under Age 20: A Population-Based Analysis
medRxiv [Preprint] (2021 Jul 27), 10.1101/2021.07.23.21260998
2021.07.23.21260998PMID: 34341797; PMCID: PMC8328065
Google Scholar

87 **Myocarditis and Pericarditis After Vaccination for COVID-19**
JAMA (August 4, 2021)
Published online
Google Scholar

88 HW Kim, ER Jenista, DC Wendell, CF Azevedo, MJ Campbell, SN Darty, MA Parker, RJ. Kim
Patients With Acute Myocarditis Following mRNA COVID-19 Vaccination
JAMA Cardiol (2021 Jun 29), Article e212828, 10.1001/jamacardio.2021.2828
Epub ahead of printPMID: 34185046; PMCID: PMC8243258
Google Scholar

89 KE Shaw, JL Cavalcante, BK Han, M. Gössl
Possible Association Between COVID-19 Vaccine and Myocarditis: Clinical and CMR Findings
JACC Cardiovasc Imaging (2021 Jun 16), 10.1016/j.jcmg.2021.06.002
S1936-878X(21)00485-XEpub ahead of print. PMID: 34246586; PMCID: PMC8245050
Google Scholar

90 R Mei, E Raschi, E Forcesi, I Diemberger, F De Ponti, E. Poluzzi
Myocarditis and pericarditis after immunization: Gaining insights through the Vaccine Adverse Event Reporting System
Int J Cardiol, 273 (2018 Dec 15), pp. 183-186, 10.1016/j.ijcard.2018.09.054
Epub 2018 Sep 14. PMID: 30236504
Article Download PDF View Record in Scopus Google Scholar

91 BB Das, WB Moskowitz, MB Taylor, A Palmer

Myocarditis and Pericarditis Following mRNA COVID-19 Vaccination: What Do We Know So Far?
Children (Basel), 8 (7) (2021 Jul 18), p. 607, 10.3390/children8070607
PMID: 34356586; PMCID: PMC8305058.Hudson B, Mantooth R, DeLaney M. Myocarditis and pericarditis after vaccination for COVID-19. J Am Coll Emerg Physicians Open. 2021 Jul 26;2(4):e12498. doi: 10.1002/emp2.12498. PMID: 34337595; PMCID: PMC8313036
CrossRef View Record in Scopus Google Scholar

92 A Luk, B Clarke, N Dahdah, A Ducharme, A Krahn, B McCrindle, T Mizzi, M Naus, JA Udell, S Virani, S Zieroth, M. McDonald
Myocarditis and Pericarditis following COVID-19 mRNA Vaccination: Practical Considerations for Care Providers
Can J Cardiol (2021 Aug 7), 10.1016/j.cjca.2021.08.001
S0828-282X(21)00624-3Epub ahead of print. PMID: 34375696; PMCID: PMC8349442
Google Scholar

93 MK Vidula, M Ambrose, H Glassberg, N Chokshi, T Chen, VA Ferrari, Y. Han
Myocarditis and Other Cardiovascular Complications of the mRNA-Based COVID-19 Vaccines
Cureus, 13 (6) (2021 Jun 10), p. e15576, 10.7759/cureus.15576
PMID: 34277198; PMCID: PMC8270057
Google Scholar

94 A Dionne, F Sperotto, S Chamberlain, AL Baker, AJ Powell, A Prakash, DA Castellanos, SF Saleeb, SD de Ferranti, JW Newburger, KG. Friedman
Association of Myocarditis With BNT162b2 Messenger RNA COVID-19 Vaccine in a Case Series of Children
JAMA Cardiol (2021 Aug 10), Article e213471, 10.1001/jamacardio.2021.3471
Epub ahead of print. PMID: 34374740; PMCID: PMC8356143
Google Scholar

95 J Montgomery, M Ryan, R Engler, D Hoffman, B McClenathan, L Collins, D Loran, D Hrncir, K Herring, M Platzer, N Adams, A Sanou, LT Cooper Jr.
Myocarditis Following Immunization With mRNA COVID-19 Vaccines in Members of the US Military
JAMA Cardiol (2021 Jun 29), Article e212833, 10.1001/jamacardio.2021.2833
Epub ahead of printPMID: 34185045; PMCID: PMC8243257
Google Scholar

96 M Imazio, K Klingel, I Kindermann, A Brucato, FG De Rosa, Y Adler, GM. De Ferrari
COVID-19 pandemic and troponin: indirect myocardial injury, myocardial inflammation or myocarditis?

Heart, 106 (15) (2020 Aug), pp. 1127-1131, 10.1136/heartjnl-2020-317186
Epub 2020 Jun 4. PMID: 32499236
CrossRef View Record in Scopus Google Scholar

97 SS Fatmi, R Basso, A Liaqat, F Tariq, R. Swamiappan
COVID-19 Myocarditis: Rationale for Early Diagnosis and Intervention
Cureus, 13 (7) (2021 Jul 19), p. e16494, 10.7759/cureus.16494
PMID: 34430109; PMCID: PMC8373509
Google Scholar

98 HM Salah, JL. Mehta
COVID-19 Vaccine and Myocarditis
Am J Cardiol (2021 Jul 12), 10.1016/j.amjcard.2021.07.009
S0002-9149(21)00639-1Epub ahead of print. PMID: 34399967; PMCID: PMC8272967
Google Scholar

99 B Singh, P Kaur, L Cedeno, T Brahimi, P Patel, H Virk, F Shamoon, M. Bikkina
COVID-19 mRNA Vaccine and Myocarditis
Eur J Case Rep Intern Med, 8 (7) (2021 Jun 14), Article 002681, 10.12890/2021_002681
PMID: 34268277; PMCID: PMC8276934
Google Scholar

100 B Bozkurt, I Kamat, PJ. Hotez
Myocarditis With COVID-19 mRNA Vaccines
Circulation, 144 (6) (2021 Aug 10), pp. 471-484, 10.1161/CIRCULATIONAHA.121.056135
Epub 2021 Jul 20. PMID: 34281357; PMCID: PMC8340726
CrossRef View Record in Scopus Google Scholar

[9] https://web.archive.org/web/20211007022707/https://www.worldometers.info

[10] https://web.archive.org/web/20211007022707/https://ourworldindata.org/covid-vaccinations

[11] https://web.archive.org/web/20211007022707/https://www.cdc.gov/vaccines/

[1] It must be noted that the reported adverse events as part of the VAERS represent a fraction of the actual number of incidents. Studies have shown that the percentage of incidents reported can be quite low (1-10%) but, for the purposes of this report, in order to do the necessary calculations, VAERS numbers were used, and the results should be considered to reveal trends. [23,24]

[2] mRNA biologicals are not true vaccines. True vaccines are a preparation of a weakened or killed pathogen, such as a bacterium or virus, or of a portion of the pathogen's structure that upon administration to an individual stimulates antibody production or cellular immunity against the pathogen but is incapable of causing severe infection. Vaccines undergo an extremely rigorous testing time-dependent protocol to ensure safety and efficacy typically enduring between 10 and 15 years. The mRNA biologicals do not satisfy either these requirements and are thus more akin to experimental gene therapy.

3 Dr. Rochelle Walensky, director of the Centers for Disease Control and Prevention

4 VRBPAC-06.10.21-Meeting-Presentation-COVID-19-Adolescent-Vaccination.pdf

5 Myocarditis in children: incidence, clinical characteristics, and outcomes. Jul 29, 2020. MYOCARDITIS FOUNDATION

6 FDA Statement on Following the Authorized Dosing Schedules for COVID-19 Vaccines

7 Dr. Leslie T. Cooper, Chair, Enterprise Department of Cardiovascular Medicine for Mayo Clinic and the Executive Medical Director and founder of the Myocarditis Foundation

8 https://web.archive.org/web/20211007022707/https://coronavirus.jhu.edu/vaccines/timeline

Toxicology Reports 8 (2021) 1665–1684

Contents lists available at ScienceDirect

Toxicology Reports

journal homepage: www.elsevier.com/locate/toxrep

Why are we vaccinating children against COVID-19?

Ronald N. Kostoff [a,*], Daniela Calina [b], Darja Kanduc [c], Michael B. Briggs [d], Panayiotis Vlachoyiannopoulos [e], Andrey A. Svistunov [f], Aristidis Tsatsakis [g]

[a] Independent Consultant, Gainesville, VA, 20155, USA
[b] Department of Clinical Pharmacy, University of Medicine and Pharmacy of Craiova, 200349, Craiova, Romania
[c] Department of Biosciences, Biotechnologies and Biopharmaceutics, University of Bari, Italy
[d] Independent Consultant, Roscommon, MI, 48653, USA
[e] Department of Pathophysiology, Medical School, National and Kapodistrian University of Athens, Athens, Greece
[f] Department of Pharmacology, I.M.Sechenov First Moscow State Medical University (Sechenov University), 119146, Moscow, Russia
[g] Department of Forensic Sciences and Toxicology, Faculty of Medicine, University of Crete, 71003, Heraklion, Greece

ARTICLE INFO

Handling Editor: Dr. Aristidis Tsatsakis

Keywords:
COVID-19
SARS-CoV-2
Inoculation
mRNA vaccines
Viral vector vaccines
Adverse events
Vaccine safety

ABSTRACT

This article examines issues related to COVID-19 inoculations for children. The bulk of the official COVID-19-attributed deaths per capita occur in the elderly with high comorbidities, and the COVID-19 attributed deaths per capita are negligible in children. The bulk of the normalized post-inoculation deaths also occur in the elderly with high comorbidities, while the normalized post-inoculation deaths are small, but not negligible, in children. Clinical trials for these inoculations were very short-term (a few months), had samples not representative of the total population, and for adolescents/children, had poor predictive power because of their small size. Further, the clinical trials did not address changes in biomarkers that could serve as early warning indicators of elevated predisposition to serious diseases. Most importantly, the clinical trials did not address long-term effects that, if serious, would be borne by children/adolescents for potentially decades.

A novel *best-case scenario* cost-benefit analysis showed *very conservatively* that there are five times the number of deaths attributable to each inoculation vs those attributable to COVID-19 in the most vulnerable 65+ demographic. The risk of death from COVID-19 decreases drastically as age decreases, and the longer-term effects of the inoculations on lower age groups will increase their risk-benefit ratio, perhaps substantially.

1. Introduction

Currently, we are in the fifteenth month of the WHO-declared global COVID-19 pandemic. Restrictions of different severity are still in effect throughout the world [1]. The global COVID-19 mass inoculation is in its eighth month. As of this writing in mid-June 2021, over 800,000,000 people globally have received at least one dose of the inoculation and roughly half that number have been fully inoculated [2]. In the USA, about 170,000,000 people have received at least one dose and roughly 80 % of that number have been fully inoculated [2].

Also, in the USA, nearly 600,000 deaths have been officially attributed to COVID-19. Almost 5,000 deaths following inoculation have been reported to VAERS by late May 2021; specifically, "Over 285 million doses of COVID-19 vaccines were administered in the United States from December 14, 2020, through May 24, 2021. During this time, VAERS received 4,863 reports of death (0.0017 %) among people who received a COVID-19 vaccine." [3] (the Vaccine Adverse Events Reporting System (VAERS) is a passive surveillance system managed jointly by the CDC and FDA [3]. Historically, VAERS has been shown to report about 1% of actual vaccine/inoculation adverse events [4]. See Appendix 1 for a first-principles confirmation of that result). By mid-June, deaths following COVID-19 inoculations had reached the ~6000 levels.

A vaccine is legally defined as any substance designed to be administered to a human being for the prevention of one or more diseases [5]. For example, a January 2000 patent application that defined vaccines as "compositions or mixtures that when introduced into the circulatory system of an animal will evoke a protective response to a pathogen." was rejected by the U.S. Patent Office because "The immune response produced by a vaccine must be more than merely some immune response but must be protective. As noted in the previous Office Action, the art recognizes the term "vaccine" to be a compound which prevents infection" [6]. In the remainder of this article, we use the term

* Corresponding author.
E-mail address: rkostoff@gmail.com (R.N. Kostoff).

https://doi.org/10.1016/j.toxrep.2021.08.010
Received 16 July 2021; Received in revised form 11 August 2021; Accepted 29 August 2021
Available online 14 September 2021

'inoculated' rather than vaccinated, because the injected material in the present COVID-19 inoculations prevents neither viral infection nor transmission. Since its main function in practice appears to be symptom suppression, it is operationally a "treatment".

In the USA, inoculations were administered on a priority basis. Initially, first responders and frontline health workers, as well as the frailest elderly, had the highest priority. Then the campaign became more inclusive of lower age groups. Currently, approval has been granted for inoculation administration to the 12–17 years demographic, and the target for this demographic is to achieve the largest number of inoculations possible by the start of school in the Fall. The schedule for inoculation administration to the 5–11 years demographic has been accelerated to start somewhere in the second half of 2021, and there is the possibility that infants as young as six months may begin to get inoculated before the end of 2021 [7].

The remainder of this article will focus on the USA situation, and address mainly the pros and cons of inoculating children under eighteen. The article is structured as follows:

Section 1 (the present section) introduces the problem.

Section 2 (Background):

1) provides the background for the declared COVID-19 "pandemic" that led to the present inoculations;
2) describes the clinical trials that provided the justification for obtaining Emergency Use Authorization (EUA) from the FDA to administer the inoculations to the larger population;
3) shows why the clinical trials did not predict either the seriousness of adverse events that have occurred so far (as reported in VAERS) or the potential extent of the underlying pre-symptomatic damage that has occurred as a result of the inoculations.

Section 3 (Mass Inoculation) summarizes the adverse events that have occurred already (through reporting in VAERS) from the mass inoculation and will present biological evidence to support the potential occurrence of many more adverse effects from these inoculations in the mid-and long-term.

Section 4 (Discussion) addresses these effects further

Section 5 (Summary and Conclusions) presents the conclusions of this study.

There are four appendices to this paper.

Appendix A provides some idea of the level of under-reporting of post-inoculation adverse events to VAERS and presents estimations of the actual number of post-inoculation deaths based on extrapolating the VAERS results to real-world experiences.

Appendix B provides a detailed analysis of the major clinical trials that were used to justify EUA for the inoculants presently being administered in the USA.

Appendix C summarizes potential adverse effects shown to have resulted from past vaccines, all of which could potentially occur as a result of the present inoculations.

Appendix D presents a novel *best-case scenario* cost-benefit analysis of the COVID-19 inoculations that have been administered in the USA.

2. Background

2.1. Pandemic history

In December 2019, a viral outbreak was reported in Wuhan, China, and the responsible coronavirus was termed Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) [8,9]. The associated disease was called Coronavirus Disease 2019, or COVID-2019. The virus spread worldwide, and a global pandemic was declared by the WHO in March 2020 [10,11]. Restrictive measures of differing severity were implemented by countries globally, and included social distancing, quarantining, face masks, frequent hand sanitation, etc. [12,13]. In the USA, these measures were taken as well, differing from state-to-state [14]. At the same time, vaccine development was initiated to control COVID-19 [15]. In the USA, non-vaccine treatments were not encouraged at the Federal level, but different treatment regimens were pursued by some healthcare practitioners on an individual level [11,16,17].

By the end of May 2021, the official CDC death count attributed to COVID-19 was approaching 600,000, as stated previously. This number has been disputed for many reasons. First, before COVID-19 testing began, or in the absence of testing, after it was available, the diagnosis of COVID-19 (in the USA) could be made by the presumption of the healthcare practitioner that COVID-19 existed [4,18]. Second, after testing began, the main diagnostic used was the RT-PCR test. This test was done at very high amplification cycles, ranging up to 45 [19–21]. In this range, very high numbers of false positives are possible [22].

Third, most deaths attributed to COVID-19 were elderly with high comorbidities [1,22]. As we showed in a previous study [22], attribution of death to one of many possible comorbidities or especially toxic exposures in combinations [23] is highly arbitrary and can be viewed as a political decision more than a medical decision. For over 5 % of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death [24]. These deaths with comorbidities could equally have been ascribed to any of the comorbidities [22]. Thus, the actual number of COVID-19-based deaths in the USA may have been on the order of 35,000 or less, characteristic of a mild flu season.

Even the 35,000 deaths may be an overestimate. Comorbidities were based on the clinical definition of specific diseases, using threshold biomarker levels and relevant symptoms for the disease(s) of interest [25,26]. But many people have what are known as pre-clinical conditions. The biomarkers have not reached the threshold level for official disease diagnosis, but their abnormality reflects some degree of underlying dysfunction. The immune system response (including pre-clinical conditions) to the COVID-19 viral trigger should not be expected to be the same as the response of a healthy immune system [27]. If pre-clinical conditions had been taken into account and coupled with the false positives as well, the CDC estimate of 94 % misdiagnosis would be substantially higher.

2.2. Clinical trials

2.2.1. Clinical trials to gain FDA Emergency Use Authorization (EUA) approval

The unprecedented accelerated development of COVID-19 vaccines in the USA, dubbed Operation Warp Speed, resulted in a handful of substances available for clinical trials by mid-2020 [28]. These clinical trials were conducted to predict the safety and efficacy of the potential vaccines (which have turned out to be treatments/inoculations as stated previously), and thereby gain approval for inoculating the public at large [29]. An overview of the Pfizer clinical trials is presented in this section, and a more detailed description of the main clinical trials is shown in Appendix B.

Two types of inoculants have gained FDA EUA in the US: mRNA-based inoculants and viral vector-based inoculants, with the mRNA inoculants having the widest distribution so far. Comirnaty is the brand name of the mRNA-based inoculant developed by Pfizer/BioNTech, and Moderna COVID-19 Vaccine is the brand name of the mRNA-based inoculant developed by Moderna [30]. Both inoculants contain the genetic information needed for the production of the viral protein S (spike), which stimulates the development of a protective immune response against COVID-19 [31]. Janssen COVID-19 Vaccine is the brand name of the viral vector-based inoculant developed by Johnson and Johnson. Janssen COVID-19 vaccine uses an adenovirus to transport a gene from the coronavirus into human cells, which then produce the coronavirus spike protein. This spike protein primes the immune system to fight off potential coronavirus infection [32].

The results of these trials that allowed granting of EUA by the FDA

Table 1
Demographics (population for the primary efficacy endpoint). The number of participants who received vaccine and placebo, stratified by age.

AGE GROUP	Pfizer-BioNTech COVID-19 Vaccine (N = 18,242) n (%)	Placebo (N = 18,379) n (%)
≥12 through 15 years[b]	46 (0.3 %)	42 (0.2 %)
≥16 through 17 years	66 (0.4 %)	68 (0.4 %)
≥16 through 64 years	14,216 (77.9 %)	14,299 (77.8 %)
≥65 through 74 years	3176 (17.4 %)	3226 (17.6 %)
≥75 years	804 (4.4 %)	812 (4.4 %)

Symbols: b: "100 participants 12 through 15 years of age with limited follow-up in the randomized population received at least one dose (49 in the vaccine group and 51 in the placebo group). Some of these participants were included in the efficacy evaluation depending on the population analyzed. They contributed to exposure information but with no confirmed COVID-19 cases, and did not affect efficacy conclusions.", N: number of test subjects, n: number of controls.

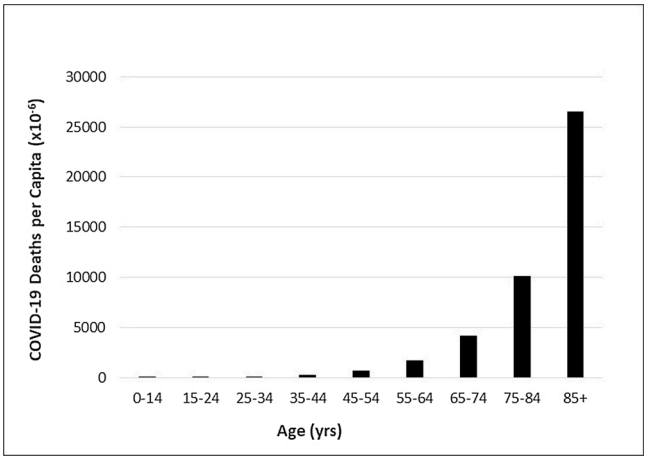


Fig. 1. COVID-19 Deaths per capita by age in the United States (as of Jun 5, 2021). Population-based on U.S. CDC WONDER Bridge-Race Population Estimate 2019. Data obtained from https://wonder.cdc.gov/bridged-race-v2019.html on 6/15/2021. Provisional COVID-19 deaths based on CDC data provided by the National Center for Health Statistics for the period 1/1/2020 – 6/5/2021. Data obtained from https://data.cdc.gov/NCHS/Provisional-COVID-19-Deaths-by-Sex-and-Age/9bhg-hcku on 6/10/2021.

can be found in the inserts to the inoculation materials. For example, the Pfizer inoculation trial results are contained in the fact sheet for healthcare providers administering vaccine (vaccination providers) [33].

There were two clinical trials conducted to gain FDA EUA for Pfizer: a smaller Phase 1/2 study, and a larger Phase 1/2/3 study. The age demographics for the larger clinical study are as follows (from the Pfizer insert): "Of the total number of Pfizer-BioNTech COVID-19 Vaccine recipients in Study 2 (N = 20,033), 21.4 % (n = 4,294) were 65 years of age and older and 4.3 % (n = 860) were 75 years of age and older." Additionally: "In an analysis of Study 2, based on data up to the cutoff date of March 13, 2021, 2,260 adolescents (1,131 Pfizer-BioNTech COVID-19 Vaccine; 1,129 placebo) were 12 through 15 years of age. Of these, 1,308 (660 Pfizer-BioNTech COVID-19 Vaccine and 648 placebo) adolescents have been followed for at least 2 months after the second dose of Pfizer-BioNTech COVID-19 Vaccine. The safety evaluation in Study 2 is ongoing."

The relevant demographics are presented in Table 7 on p.31 of the Pfizer insert. The age component of those demographics is shown below in Table 1.

There are very minor differences between most of the data in the above table and the preceding narrative shown, and they are probably due to different time horizons. The major difference is the number of adolescents used and appears to result from a much later reporting time.

Fig. 1 uses the official large CDC numbers (coupled with USA census data estimates from CDC Wonder) to show the COVID-19 deaths per capita as a function of age, circa early June 2021. Unfortunately, the most critical range, 85+, has the least resolution. It is obvious that most of the deaths occurred in the 55 to 100+ range, and the remaining individuals in the other ranges (especially under 35) have negligible risk of dying from the disease.

The age distribution in Fig. 1 differs substantially from the age distribution in Table 1. Why is this important? When designing a trial for the efficacy and safety of a potential treatment, the focus should be on the target population who could benefit from that treatment. There is little rationale for including participants in a trial for whom the treatment would not be relevant or warranted.

For the COVID-19 Pfizer trials, based on the data from Fig. 1, the trial population should have been limited at most to the 45−100+ age segment, appropriately weighted toward the higher end where the deaths per capita are most frequent. That was almost the exact opposite of what was done in the Pfizer clinical trials. In Fig. 1, approximately 58 % of the deaths occurred in the age range 75+, whereas 4.4 % of the participants in the Pfizer clinical trial were 75 + . Thus, the age range most impacted by COVID-19 deaths was minimally represented in the Pfizer clinical trials, and the age range least impacted by COVID-19 deaths was maximally represented in the Pfizer clinical trials. This skewed sampling has major implications for predicting the expected numbers of deaths for the target population from the clinical trials.

Besides age, the other metric of importance in determining COVID-19 deaths is the presence of comorbidities. The more comorbidities, and the more severe the comorbidities, the greater the chances of death or severe adverse outcomes from COVID-19. It is not clear how well the number and severity of comorbidities in the clinical trial sample matched those reflected in Fig. 1, but the insert does mention the large number of conditions that excluded participation in the trials. In sum, the results from the clinical trials could not be expected to reflect the results that could occur (and have occurred) from mass inoculation of the public, given the unaffected nature of the bulk of the trial population from SARS-CoV-2 exposure.

The prior discussion on the clinical trials has focused on the efficacy and safety of the inoculants, and the relationship of the trial test population to the total target population. We have limited the focus so far to the safety and efficacy issues since these constituted the core of what was presented to the FDA for EUA approval. We have not focused on the trials from an early warning indicator perspective.

We will address summarily the science/early warning indicator issues associated with the Pfizer trials, and how the neglect of these issues has translated into disastrous consequences during the mass inoculation rollout. Standard practice for determining and understanding the impact of new technology (such as mRNA "vaccines") on a system involves measuring the state and flux variables of the system before the new technology intervention, measuring the state and flux variables of the system after the new technology intervention, and identifying the types and magnitudes of changes in the state and flux variables attributable to the intervention. This would be in addition to evaluating performance metrics before and after the intervention.

In Pfizer's proposed clinical trials for the mRNA "vaccine" (Study to Describe the Safety, Tolerability, Immunogenicity, and Efficacy of RNA Vaccine Candidates Against COVID-19 in Healthy Individuals - https://clinicaltrials.gov/ct2/show/NCT04368728), the focus was on determining 1) adverse events/symptoms, 2) SARS-CoV-2 serum neutralizing antibody levels, 3) SARS-CoV-2 anti-S1 binding antibody levels and anti-RBD binding antibody levels, and 4) effectiveness. These metrics are all related to safety at the symptom level and performance.

However, symptoms/diseases are typically end points of processes

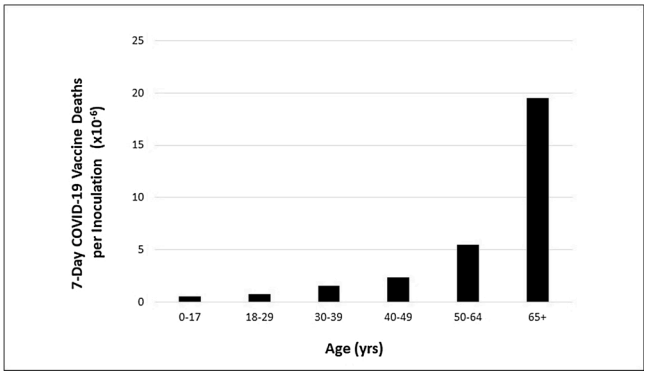


Fig. 2. Post-inoculation deaths per dose of inoculant. 7-day COVID-19 vaccine deaths per inoculation by age in the United States (as of 5/28/2021). Data shown includes the total number of all deaths up to 7 days after receiving the vaccine for both those administered 1 dose and the complete series of doses by age in the United States as of 5/28/2021 reported in VAERS (updated on 5/28/2021). COVID-19 Vaccinations (Inoculations) based on CDC data provided by ISSInfo up thru 5/28/2021. Data obtained from https://data.cdc.gov/Vaccinations/COVID-19-Vaccination-Demographics-in-the-United-St/km4m-vcsb on 6/10/2021. COVID-19 Vaccinations Deaths based on CDC WONDER VAERS Database as of 5/28/2021, obtained from https://wonder.cdc.gov/controller/datarequest/D8;jsessionid=4B5522C8D1DA68F1A364646B0DA5 on 6/9/2021.

that can take months, years, or decades to surface. During that symptom/disease development period, many biomarker early warning indicators tend to exhibit increasing abnormalities that reflect an increasing predisposition to the eventual symptom/disease. Thus, serious symptoms/diseases that ordinarily take long periods to develop would be expected to be rare events if they occurred shortly following an inoculation. If the clinical trials that were performed by Pfizer and Moderna were designed to focus on efficacy and *only adverse effects at the symptom level of description* as an indicator of safety, the trial results would be limited to the identification of rare events, and the trial results would potentially under-estimate the actual pre-symptom level damage from the inoculations.

Credible safety science applied to this experiment would have required a much more expansive approach to determining effects on a wide variety of state and flux metrics that could serve as early warning indicators of potentially serious symptoms/disease, and might occur with much higher frequencies at this early stage than the rare serious symptoms. The only mention of these other metrics in the above proposal is in the Phase I trial description: "Percentage of Phase 1 participants with abnormal haematology and chemistry laboratory values", to be generated seven days after dose 1 and dose 2.

A paper published in NEJM in December 2020 [34] summarized the Phase 1 results. The focus was on local and systemic adverse events and efficacy metrics (antibody responses). The only metrics other than these reported were transiently decreased lymphocyte counts.

We view this level of reporting as poor safety science for the following reasons. Before the clinical trials had started, many published articles were reporting serious effects associated with the presence of the SARS-CoV-2 virus such as hyperinflammation, hypercoagulation, hypoxia, etc. SARS-CoV-2 includes the S1 Subunit (spike protein), and it was not known how much of the damage was associated with the spike protein component of SARS-CoV-2. A credible high-quality safety science experiment would have required state measurements of specific biomarkers associated with each of these abnormal general biomarkers before and after the inoculations, such as d-dimers for evidence of enhanced coagulation/clotting; CRP for evidence of enhanced inflammation; troponins for evidence of cardiac damage; occludin and claudin for evidence of enhanced barrier permeability; blood oxygen levels for evidence of enhanced hypoxia; amyloid-beta and phosphorylated tau for evidence of increased predisposition to Alzheimer's disease; Serum HMGB1, CXCL13, Dickkopf-1 for evidence of an increased disposition to autoimmune disease, etc. A credible high-quality safety science experiment would have required flux measurements of products resulting from the mRNA interactions, from the LNP shell interactions, from dormant viruses that might have been stimulated by the mRNA-generated spike protein, etc., emitted through the sweat glands, faeces, saliva, exhalation, etc.

Most importantly, these types of measurements would have shown changes in the host that did not reach the symptom level of expression but raised the general level of host abnormality that could predispose the host to a higher probability of serious symptoms and diseases at some point in the future. Instead, in the absence of high-quality safety science reflected in these experiments, all that could be determined were short-term adverse effects and deaths. This focus on symptoms masked the true costs of the mRNA intervention, which would probably include much larger numbers of people whose health could have been degraded by the intervention as evidenced by increased abnormal values of these biomarkers. For example, the trials and VAERS reported clots that resulted in serious symptoms and deaths but gave no indication of the enhanced predisposition to forming serious clots in the future with a higher base of micro-clots formed because of the mRNA intervention. The latter is particularly relevant to children, who have a long future that could be seriously affected by having an increased predisposition to multiple clot-based (and other) serious diseases resulting from these inoculations.

3. Mass inoculation

3.1. Adverse events reported for adults

This section describes the adverse effects that followed COVID-19 mass inoculation in the USA. The main source of adverse effects data used was VAERS. Because VAERS is used to estimate adverse event information by many other countries as well, a short overview of VAERS and its intrinsic problems is summarized in Appendix 1.

The period in the present study covered by the reported inoculations is mid-December 2020 to the end of May 2021. The population inoculated during this period is mainly adults. Child inoculations did not begin until mid-May. Because the different age groups were inoculated starting at different times based on priority, the elapsed times after inoculation will be different, and any adverse event comparisons across age groups will require some type of elapsed post-inoculation time normalization.

We examined VAERS-reported deaths by age group, normalized to:

1) the number of inoculations given
2) the period within seven days after inoculation.

This allows a credible comparison of very short-term adverse effects post-inoculation for all age groups. During this period, which is eight days post-inoculation (where day zero is the day of inoculation), sixty percent of all post-inoculation deaths are reported in VAERS.

Fig. 2 below shows the results circa late May 2021 [3]. The age band ranges are different from those in Fig. 1 because the CDC provides inoculation after-effect age bands differently from COVID-19 death age bands. In general, the inoculation deaths by age per inoculant roughly parallel the COVID-19 deaths by age per capita (the curve structures are very similar), with one exception: the 0–17 demographic. In the normalized COVID-19 death graph (Fig. 1), the deaths per capita in the 0–17 demographic are negligible, while in the normalized inoculant death graphs (Fig. 2) the normalized deaths are small, but not negligible. The members of the 65+ demographic, where the bulk of deaths are occurring in Figs. 1 and 2, have been receiving inoculations for five months, whereas the members of the youngest demographic have been receiving inoculations only for a few weeks. More time needs to pass

before more definitive conclusions can be drawn about the youngest demographic, and how its members are impacted adversely following the inoculations.

The high death rates from both COVID-19 and the inoculations in the 65+ demographic should not be surprising. In both cases, the immune system is challenged, and in both cases, a dysfunctional immune system characteristic of many elderly people with multiple comorbidities cannot respond adequately to the challenge.

3.1.1. Specific short-term adverse events reported in VAERS

The most comprehensive single evaluation of VAERS-reported adverse events (mainly for adult recipients of the COVID-19 "vaccines") we have seen is a non-peer-reviewed collection of possible side effects by Dr. Ray Sahelian [35]. We recommend reading this short data-rich summary of the broad types of events reported already, in the context that these events are very short-term. Dr. Sahelian identifies five mechanisms he believes are responsible for most of these events, with research potentially uncovering other mechanisms. These five mechanisms include:

1 "An overreacting inflammatory response is known as systemic inflammatory response syndrome (SIRS). This SIRS reaction, perhaps a cytokine storm, can range from very mild to very severe. It can begin the very first day of the shot or begin days or weeks later as a delayed reaction."
2 "Interaction of the spike proteins with ACE2 receptors on cell membranes. Such cells are found widely in the body including the skin, lungs, blood vessels, heart, mouth, gastrointestinal tract, kidneys, and brain."
3 "Interaction of spike proteins with platelets and/or endothelial cells that line the inside of blood vessels. This can lead to clotting or bleeding (low number of circulating platelets in the bloodstream). Some of the clots, even if tiny, cause certain neurological symptoms if the blood supply to nerves is compromised."
4 "Immediate or delayed release of histamine from mast cells and basophils (mast cell activation syndrome, MCAS)."
5 5. "Swelling of lymph nodes in various areas of the body could interfere with blood flow, put pressure on nerves causing pain, or compromise their proper function."

These reactions can be classified as Hyperinflammation, Hypercoagulation, Allergy, and Neurological, and can contribute to many symptoms and diseases, as VAERS is showing.

An excellent review of acute and potential long-term pathologies resulting from the COVID-19 inoculations [36] showed potential relationships to blood disorders, neurodegenerative diseases and autoimmune diseases. This review discussed the relevance of prion-protein-related amino acid sequences within the spike protein.

3.1.2. Potential mid- and long-term events and serious illnesses for adults and children from past vaccines

A detailed description of potential mid- and long-term events and serious illnesses for adults and children from past vaccines is presented in Appendix C. Most of these events and illnesses are not predictable, and most, if not all, would be possible for the COVID-19 inoculations in the mid- and long-term for adults and children.

3.1.3. Potential short-, mid-, and long-term risks of mass COVID-19 inoculation for children

3.1.3.1. Intrinsic inoculant toxicity. Children are unique relative to COVID-19. They have negligible risks of serious effects from the disease, as shown in Fig. 1. Given that the COVID-19 inoculants were only tested for a few months, and mid-or long-term adverse effects are unknown, any mid- or long-term adverse events that emerge could impact children adversely for decades.

We believe that mid-or long-term adverse effects are possible based on the recent emergence of evidence that would support the probability of mid-and long-term adverse effects from the COVID-19 inoculants, such as:

1) The spike protein itself can be a toxin/pathogenic protein:
2) S protein alone can damage vascular endothelial cells (ECs) by downregulating ACE2 and consequently inhibiting mitochondrial function [37].
3) it is concluded that ACE2 and endothelial damage is a central part of SARS-CoV2 pathology and may be induced by the spike protein alone [38].
4) the spike protein of SARS-CoV-1 (without the rest of the virus) reduces ACE2 expression, increases angiotensin II levels, exacerbates lung injury, and triggers cell signaling events that may promote pulmonary vascular remodeling and Pulmonary Arterial Hypertension (PAH) as well as possibly other cardiovascular complications [39].
5) the recombinant S protein alone elicits functional alterations in cardiac vascular pericytes (PCs) [40]. This was documented as:
6) increased migration
7) reduced ability to support EC network formation on Matrigel
8) secretion of pro-inflammatory molecules typically involved in the cytokine storm
9) production of pro-apoptotic factors responsible for EC death. Furthermore, the S protein stimulates the phosphorylation/activation of the extracellular signal-regulated kinase 1/2 (ERK1/2) through the CD147 receptor, but not ACE2, in cardiac PCs, the S protein may elicit vascular cell dysfunction, potentially amplifying, or perpetuating, the damage caused by the whole coronavirus [40].
10) "even in the absence of the angiotensin-converting enzyme 2 receptors, the S1 subunit from SARS-CoV-2 spike protein binding to neutral phospholipid membranes leads to their mechanical destabilization and permeabilization. A similar cytotoxic effect of the protein was seen in human lung epithelial cells." [125].
11) The LNP layer encapsulating the mRNA of the inoculant is highly inflammatory in both intradermal and intranasal inoculation [41] and "Polyethylene glycol (PEG) is a cause of anaphylaxis to the Pfizer/BioNTech mRNA COVID-19 vaccine" [42]. "Humans are likely developing PEG antibodies because of exposure to everyday products containing PEG. Therefore, some of the immediate allergic responses observed with the first shot of mRNA-LNP vaccines might be related to pre-existing PEG antibodies. Since these vaccines often require a booster shot, anti-PEG antibody formation is expected after the first shot. Thus, the allergic events are likely to increase upon re-vaccination" [43].

    There is also the possibility that the components of the LNP shell could induce the ASIA Syndrome (autoimmune/inflammatory syndrome induced by adjuvants), as shown by studies on post-inoculation thyroid hyperactivity [44] and post-inoculation subacute thyroiditis [45].
12 The spike protein has been found in the plasma of post-inoculation individuals, implying that it could circulate to, and impact adversely, any part of the body [46].
13 The spike protein of SARS-CoV-2 crosses the blood-brain barrier in mice [47], and "the SARS-CoV-2 spike proteins trigger a pro-inflammatory response on brain endothelial cells that may contribute to an altered state of BBB function" [48].
14 The spike proteins manufactured in vivo by the present COVID-19 inoculations could potentially "precipitate the onset of autoimmunity in susceptible subgroups, and potentially exacerbate autoimmunity in subjects that have pre-existing autoimmune diseases", based on the finding that anti-SARS-CoV-2 protein

antibodies cross-reacted with 28 of 55 diverse human tissue antigens [49].

15 "The biodistribution of ChaAdOx1 [Astra Zeneca's recombinant adenovirus vaccine candidate against SARS-CoV-2] in mice confirmed the delivery of vaccine into the brain tissues [50]. The vaccine may therefore spur the brain cells to produce CoViD spike proteins that may lead to an immune response against brain cells, or it may spark a spike protein-induced thrombosis. This may explain the peculiar incidences of the fatal cerebral venous sinus thrombosis (CVST) observed with viral vector-based CoViD-19 vaccines" [51,52].

A complementary perspective to explain adenovirus-based vaccine-induced thrombocytopenia is that "transcription of wildtype and codon-optimized Spike open reading frames enables alternative splice events that lead to C-terminal truncated, soluble Spike protein variants. These soluble Spike variants may initiate severe side effects when binding to ACE2-expressing endothelial cells in blood vessels." [100].

16 A Pfizer Confidential study performed in Japan showed that "modRNA encoding luciferase formulated in LNP comparable to BNT162b2″ injected intramuscularly concentrated in many organs/tissues in addition to the injection site [53]. The main organs/sites identified were adrenal glands, liver, spleen, bone marrow, and ovaries. While damage to any of these organs/sites could be serious (if real for humans), adverse effects on the ovaries could be potentially catastrophic for women of childbearing or pre-childbearing age.

The main objective of credible biodistribution studies (of inoculants for eventual human use) is to identify the spatio-temporal distribution of the actual inoculant in humans; i.e., how much of the final desired product (in this case, expressed protein antigen/spike protein) is produced in different human tissues and organs as a function of time. That's not what was reported in the Pfizer Confidential study.

Rats were used for the in vivo studies; the relationship of their biodistribution to that of humans is unclear. They were injected in different locations (hindpaw/intramuscular); the relationship to human injections in the deltoid muscle is unclear. They were injected with "modRNA encoding luciferase formulated in LNP comparable to BNT162b2″; it is unclear why they weren't injected with BNT162b2, it is unclear why spike protein expression wasn't evaluated rather than LNP concentration, and it is unclear how well the biodistribution from the actual inoculant used in the experiments compares to the biodistribution from BNT162b2.

They were injected once per rat. Given that a second injection would not be in the same exact location as the first, and that the circulatory system might have changed due to clotting effects from the first injection and other potential vascular complications, it is unclear how the biodistribution change with the second injection would compare with the first. If a booster injection is given to counter variants, it is unclear how its biodistribution would be altered as a consequence of the preceding two injections.

Clotting will occur with the highest probability where the blood flow is reduced (and more time is available for LNP-endothelial cell interaction). It is unclear whether the clotting process would show *positive feedback* behaviour where the initial inoculation constricts the flow in low-velocity regions even further by enhanced clotting, and subsequent inoculations further amplify this reduced flow-enhanced clotting cycle.

The rats were injected under pristine conditions; how that compares with humans, who have been, are being, and will continue to be exposed to multiple toxic substances in combination, is open to question. We know these combinations can act synergistically to adversely impact myriad organs and tissues throughout the body [23]. We don't know how these toxic exposures in humans affect the permeability of the blood/tissue barriers, and especially the ability of the injected material to diffuse into the bloodstream (and also the ability of the manufactured spike proteins to diffuse from the bloodstream into the surrounding tissue).

Higher-level primates should have been used for these short-term experiments, to obtain a more realistic picture of the biodistribution of inoculant in human organs and tissues. In other words, these laboratory experiments may be just the tip of the iceberg of estimating the amount of inoculant that concentrates in critical organs and tissues of human beings.

The many studies referenced above indicate collectively that the mRNA-based COVID-19 inoculations (the most prolific inoculations used in the USA for COVID-19 so far) consist of (at least) two major toxins: the instructions for the spike protein (mRNA) and the mRNA-encapsulating synthetic fat LNP. The vaccine is injected into the deltoid muscle, at which time it contributes to inflammation at the injection site due in part to the LNP and potentially to anaphylaxis from the LNP PEG-2000 component. Some of the injected material stays at the injection site, where it combines with cells through endocytosis to express spike protein on the cell surface, stimulating the adaptive immune system to eventually produce antibodies to the spike protein [54].

The remainder of the injected material enters the lymphatic system and the bloodstream, and is distributed to tissues and organs throughout the body: e.g., "Drugs administered by the intramuscular (IM) route are deposited into vascular muscle tissue, which allows for rapid absorption into the circulation" [55]. The basis of this process is that the bulky muscles have good vascularity, and therefore the injected drug quickly reaches the systemic circulation and thereafter into the specific region of action, bypassing the first-pass metabolism [56]. The widespread distribution is greatly enhanced by the LNP PEG-2000 coating as follows: building from the success of PEGylating proteins to improve systemic circulation time and decrease immunogenicity [57]. PEG coatings on nanoparticles shield the surface from aggregation, opsonization, and phagocytosis, prolonging systemic circulation time. [57]. PEG coatings on nanoparticles have also been utilized for overcoming various biological barriers to efficient drug and gene delivery associated with other modes of administration. [57]

In the bloodstream, one possible outcome is that the LNPs coalesce with the endothelial cells on the inner lining of the blood vessels and transfer the mRNA to the cells through endocytosis. The endothelial cells would then express the spike protein on their surface. Platelets flowing by the spike protein express ACE2 receptors on their surface; therefore, one possible outcome would be activation of the platelets by the spike protein and initiation of clotting. Another possible outcome would be the modified endothelial cells being recognized by innate immune system cells as foreign. These immune killer cells would then destroy parts of the endothelium and weaken the blood-organ barriers. The LNPs would inflame the endothelium as well, both increasing barrier permeability and increasing the blood vessel diameter. This weakening of the blood-organ barriers would be superimposed on any inflammation due to the myriad toxic contributing factors operable [4]. The newly-formed cells with spike proteins would penetrate the blood-organ barriers and bind to tissue with expressed ACE2 receptors. Any LNPs that did not coalesce with the endothelial cells, but remained intact, could also pass through the permeable blood-organ barrier, and coalesce directly with the organ cells. This could lead to an attack by innate immune system cells, and be a precursor to autoimmunity [4].

In the preceding discussion of the Pfizer biodistribution studies, the issue of multiple inoculations on changes in biodistribution was raised. Similarly, the alteration of effects as described above by multiple inoculations must be considered. Each inoculation will have positive aspects and negative aspects. The positive aspects are the formation of antibodies in the muscle cells and lymphatic system. The negative aspects include, but are not limited to, the potential clotting effects and permeability increases for that fraction of the inoculant that enters the bloodstream. The first inoculant dose can be viewed as priming the immune system. The immune response will be relatively modest. The second inoculant dose can be expected to elicit a more vigorous immune

Table A1
Expected deaths from non-COVID-19 causes for inoculees (Thousands).

Potential covid deaths/# non-covid expected	Mean time location/five months									
	0	%REP	1/3	%REP	1/2	%REP	2/3	%REP	1	%REP
0	723	0.5	482	0.74	362	0.98	242	1.47	4.77	75
.5	1085	0.33	723	0.5	543	0.66	363	0.98	7.14	50
1	1446	0.25	964	0.37	724	0.49	484	0.74	9.51	37

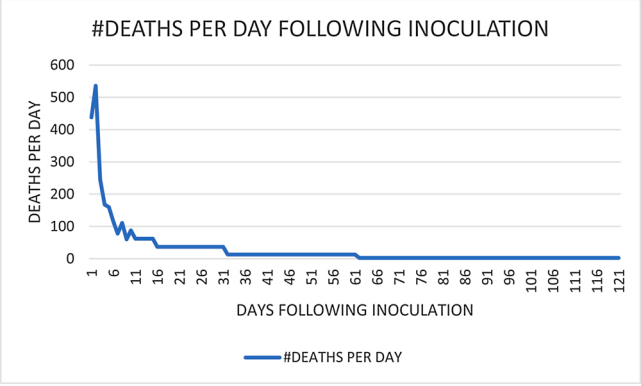


Fig. A1. Figure A1-1 is a plot of number of deaths from COVID-19 inoculation (reported to VAERS and obtained from the CDC search engine CDC Wonder) as a function of days from inoculation (zero reflects day of inoculation). If there were no effect from the inoculation, as claimed by the CDC and other official government agencies, the curve would be essentially a straight horizontal line, reflecting normal expected deaths in a non-COVID-19 year. The curve is stepped past the tenth day because the data after that point is provided in bands by CDC Wonder. The knee of the curve, which will denote the beginning of the transition of 1) deaths **from** inoculation to 2) deaths **expected**, appears somewhere in the range between day ten and day thirty.

Table A2
Actual COVID-19 inoculation-based deaths.

Actual COVID-19 inoculation-based deaths from vaers reporting				
	Separate Groups		Overlapping Groups	
Expected Deaths Reported	37	20	37	20
Range Of Days Inoculation Deaths	0–30	0–30	0–30	0–30
Total Reported Deaths Over Range	2901	2901	2901	2901
Total Expected Deaths Over Range	1147	620	1147	620
Inoculation-Based Deaths Reported	1754	2281	2901	2901
Expected Deaths Reported/Total Expected	.0077	.0041	.0077	.0041
Total Actual Inoculation-Based Deaths Using Expected Ratio (Above)	227792	556341	376753	707561

Table A3
Possible COVID-19 inoculation-based deaths.

Possible COVID-19 inoculation-based deaths from vaers reporting				
	Separate Groups		Overlapping Groups	
Expected Deaths Reported	10	15	10	15
Range Of Days Inoculation Deaths	0–30	0–30	0–30	0–30
Total Reported Deaths Over Range	2901	2901	2901	2901
Total Expected Deaths Over Range	310	465	310	465
Inoculation-Based Deaths Reported	2591	2436	2901	2901
Expected Deaths Reported/Total Expected	.0021	.0031	.0021	.0031
Total Actual Inoculation-Based Deaths Using Expected Ratio (Above)	1233810	785806	1381429	935806

response. This will enhance the desired antibody production in the muscle cells and lymphatic system, but may also enhance the immune response to both the blood vessel-lining endothelial cells displaying the spike protein and the platelets, causing more severe damage. If a booster (s) inoculation is also required, this may further enhance both the positive and negative immune responses resulting from the second inoculation. While the positive effects are reversible (antibody levels decrease with time), adverse effects may be cumulative and irreversible, and therefore injury and death rates may increase with every additional inoculation [58].

These effects can occur throughout the body in the short term, as we are seeing with the VAERS results. They can occur in the mid- and long-term as well, due to the time required for destructive processes to have full effect and the administration of further inoculations. For example, micro-clots resulting from the inoculation that were insufficient to cause observable symptoms could in effect raise the baseline for thrombotic disease [92]. Lifestyle activities that contribute to enhanced blood clotting would have less distance to travel to produce observable symptoms, and thus the serious effects of clotting would have been accelerated [59,60]. As an example: the risk of venous thrombosis is approximately 2- to 4-fold increased after air travel [61]. How much this rate would increase after the inoculations, where microthrombi have formed in some recipients, is unknown. These potential baseline-raising effects could impact the interpretation of the VAERS results, as we show at the end of Appendix 1.

3.1.3.2. Adverse inoculant effects on children. What are the potential mid- and long-term adverse health effects from the COVID-19 inoculation on children specifically, taking into account that they will be exposed not only to the spike protein component of the SARS-CoV-2 virus but also to the toxic LNP encapsulating-shell? This toxic combination will have bypassed many defensive safeguards (typically provided by the innate immune system) through direct injection [62]. As we have shown, the main reasons why we believe the spike protein could be harmful to children even though they don't seem to get sick from exposure to SARS-CoV-2 are 1) the bypassing of the innate immune system by inoculation, 2) the larger volume of spike protein that enters the bloodstream, and 3) the additional toxic effects of the encapsulating LNP layer.

3.1.3.2.1. Potential mid-term adverse health effects. Examination of the myriad post-COVID-19 inoculation symptoms/biomarker changes for the 0–17 age demographic reported to VAERS circa mid-June 2021 provides some indication of very early damage [84]. Main region-s/systems affected adversely (VAERS symptoms/biomarkers shown in parentheses) include:

- Cardiovascular (blood creatine phosphokinase increased, cardiac imaging procedure abnormal, echocardiogram abnormal, electrocardiogram abnormal, heart rate increased, myocarditis, palpitations, pericarditis, tachycardia, troponin I increased, troponin increased, fibrin D-Dimer increased, platelet count decreased, blood pressure increased, bradycardia, brain natriuretic peptide increased, ejection fraction decreased, migraine)
- Gastrointestinal (abdominal pain, diarrhoea, vomiting, alanine aminotransferase increased, aspartate aminotransferase increased.)
- Neural (gait disturbance, mobility decreased, muscle spasms, muscle twitching, seizure, tremor, Bell's Palsy, dyskinesia)

- Immune (C-Reactive Protein increased, red blood cell sedimentation rate increased, white blood cell counts increased, inflammation, anaphylactic reaction, pruritis, rash, lymphadenopathy)
- Endocrine (heavy menstrual bleeding, menstrual disorder)

In addition, there were large numbers of different vision and breathing problems reported.

All the major systems of the body are impacted, and many of the major organs as well. Given the lag times in entering data into VAERS and the fact that inoculations of children started fairly recently, we would expect the emphasis to be immediate symptomatic and biomarker reactions. More time is required for organ and system damage to develop and emerge. Cardiovascular problems dominate, as our model for spike protein/LNP circulation and damage predicts, and it is unknown how reversible such problems are. Many of the VAERS symptoms listed above were also found in COVID-19 adult patients [64].

Consider the example of Multisystem Inflammatory Syndrome in Children (MIS-C). It has emerged in VAERS with modest frequency so far, and it also occurred about a month after COVID-19 infection [65]. In both cases, the presence of the spike protein was a common feature. Many of its characteristic symptoms are those listed above from VAERS. MIS-C has similarities with known disease entities like Kawasaki Disease (KD), toxic shock syndrome (TSS) and macrophage activation syndrome (MAS)/secondary hemophagocytic lymphohistiocytosis (HLH) [66]. One presentation of MIS-C is in adolescents with a high disease burden as evidenced by more organ systems involved, almost universally including cardiac and gastrointestinal systems, and with a higher incidence of shock, lymphopenia, and elevated cardiac biomarkers indicating myocarditis [67]. Since the first reports of children developing MIS-C, it was evident that others presented with some of the classic symptoms of the well-recognized childhood illness KD [68]. Further, despite KD being ordinarily incredibly rare in adults, patients with MIS-A have also been reported with KD-like features. [68] Thus, an examination of the adverse effects from COVID-19 as evidenced through these diseases might shed some light on what can be expected further down the line from the inoculations.

The following section addresses Kawasaki disease (KD) and Multisystem Inflammatory Syndrome in Children (MIS-C) [65].

KD is an acute vasculitis and inflammation that predominantly affects the coronary arteries and can cause coronary artery aneurysms. Other KD manifestations include systemic inflammation of arteries, organs, and tissues, with consequent hepatitis and abdominal pain; lung interstitial pneumonitis, aseptic meningitis due to brain membrane inflammations; myocarditis, pericarditis, and valvulitis; urinary tract pyuria, pancreatitis; and lymph-node enlargement [69]. In general, although almost all children fully recover, some of them later develop coronary artery dilation or aneurysm [70]. Etiologically and pathologically, numerous studies indicate that KD is triggered by an abnormal autoimmune response caused by an infection [71]. The infection hypothesis is supported by epidemiology data showing that an infectious disease is involved at least as a starting point. Previously proposed infectious agents include Herpesviridae, retroviruses, Parvovirus B19, bocavirus, and bacterial infections such as staphylococci, streptococci, Bartonella, and Yersinia infections [72].

SARS-CoV-2 adds to these infectious agents by eliciting autoantibodies likely via molecular mimicry and cross-reactivity with autoantigens [72,73].

Then, the formation of antigen–antibody immune complexes can lead to KD symptoms via activation of the receptors of mast cells, neutrophils, and macrophages with consequent release of pro-inflammatory cytokines and increase of blood vessel permeability; activation of the complement system, stimulation of neutrophils and macrophages to secrete proteases and more proinflammatory cytokines [74], thus merging into the "cytokine storm" that characterizes MIS-C [75]. Indeed, features of KD are raised levels of Interleukin (IL)-6, IL-8, IL-15, and IL-17, with the cytokine level predicting coronary aneurysm formation in KD patients [76,77]

3.1.3.2.2. Potential long-term adverse health effects. In the long-term, SARS-CoV-2-induced KD vasculitis can lead to severe pathologies. Vasculitis has a predilection for coronary arteries with a high complication rate across the lifespan for those with medium to large coronary artery aneurysms [78]. The cytokine-induced inflammation produces endothelial dysfunction and damage to the vascular wall, leading to aneurysmal dilatation. Successively, vascular remodeling can also occur, but this does not imply resolution of the disease or reduction of risk for future complications. A rigorous follow-up to detect progressive stenosis, thrombosis and luminal occlusion that may lead to myocardial ischemia and infarction becomes mandatory [78]. Of equal importance, among other long-term outcomes, children with KD may have increased risks not only for ischemic heart disease, but also for autoimmune disorders, cancer as well as an increased all-cause mortality [71].

Additional questions regarding mass inoculation of children and adolescents include:

a) Do children, being asymptomatic carriers of SARS-CoV-2, transmit the virus?
b) Do recently vaccinated people, infected with SARS-CoV-2, transmit the virus?

There is evidence of children transmitting SARS-CoV-2 in community settings, but the existing literature is heterogeneous with regards to the relative rate at which they do so compared to adults [79].

Studies from South Korea and Thailand found a very limited number of secondary cases [80,81]. On the contrary, a large contact tracing study from India concluded that the highest probability of transmission was between case-contact pairs of similar age and that this pattern of enhanced transmission risk was highest among children 0–4 years of age as well as adults 65 years of age and older [80]

With regard to the second question, it was shown that household members of healthcare workers inoculated with a single dose of either Pfizer or Astra Zeneca COVID-19 inoculant were at significantly reduced risk of PCR-confirmed SARS-CoV-2 infection but at non-statistically significant reduced risk of hospitalization, compared to household members of uninoculated healthcare workers, fourteen days after inoculation [82]. This finding again underlines the association of severe disease to the characteristics of the infected person and not directly to the transmission, implying that the elderly should be inoculated and not the children.

3.2. Novel best-case scenario cost-benefit analysis of COVID-19 inoculations for most vulnerable

Traditional cost-benefit analyses are typically financial tools used to estimate the potential value of a proposed project. They involve generating cost streams over time, benefit streams over time, and then comparing the net present value of these two streams (including risk) to see whether the risk-adjusted discounted benefits outweigh the risk-adjusted discounted costs. Appendix D presents a detailed non-traditional *best-case scenario* pseudo-cost-benefit analysis of inoculating people in the 65+ demographic in the USA. In this incarnation of a cost-benefit analysis, the costs are the number of deaths resulting from the inoculations, and the benefits are the lives saved by the inoculations. The time range used was from December 2019 to end-of-May 2021. No discounting was done; an inoculation-based death occurring immediately post-inoculation was given the same importance/weighting as an inoculation-based death months after inoculation.

Why was this non-traditional approach selected for a cost-benefit analysis? In a traditional non-financial cost-benefit analysis relative to inoculations, the adverse events prevented by the inoculations would be compared with the adverse events resulting from the inoculations. Presently, in the USA, definitions, test criteria, and reporting incentives

for COVID-19 and its inoculants have shifted over time, and we believe a standard approach could not be performed credibly. Appendix Da presents some of the problems with the COVID-19 diagnostic criteria on which the above statements are based.

In contrast to the pandemic buildup phase, where many who died *with* COVID-19 were assumed to have died *from* COVID-19 by the medical community and the CDC, the post-inoculation deaths reported in VAERS are assumed by the CDC to be mostly from causes other than the inoculations. We wanted to use a modified cost-benefit analysis that would have less dependence on arbitrary criteria and subjective judgments.

The approach selected can be viewed as a *best-case scenario* pseudo-cost-benefit analysis. We assume the inoculations prevent ***all*** the deaths ***truly*** attributable to COVID-19 (these are the total deaths attributed to COVID-19 officially minus 1) the number of false positives resulting from the PCR tests run at very high amplification cycles and 2) the number of deaths that could have been attributed to one of the many comorbidities that were typical of those who succumbed, as shown in our results section) over the period December 2019 to end-of-May 2021, and relate that number to the deaths ***truly*** attributable to the inoculation (from January 2021 to end-of-May 2021) based on our computations in the results section. The results show ***conservatively*** that there are five times the number of deaths ***truly*** attributable to each inoculation vs those ***truly*** attributable to COVID-19 in the 65+ demographic. As age decreases, and the risk for COVID-19 decreases, the cost-benefit increases. Thus, if the best-case scenario looks ***poor*** for benefits from the inoculations, any realistic scenario will look ***very poor***. For children the chances of death from COVID-19 are negligible, but the chances of serious damage over their lifetime from the toxic inoculations are not negligible.

4. Discussion

Two issues arise from these results.

First, where is the data justifying inoculation for children, much less most people under forty? It's not found on Fig. 1, where the most vulnerable are almost exclusively the elderly with many comorbidities [83]. Yet, in the USA, Pfizer has been approved to inoculate children 12–17, and the goal is to accomplish this by the start of the school year in the Fall. As stated previously, there are plans to inoculate children as young as six months starting before the end of 2021.

What is the rush for a group at essentially zero risks? Given that the inoculations were tested only for a few months, only very short-term adverse effects could be obtained. It is questionable how well even these short-term effects obtained from the clinical trials reflect the short-term effects from the initial mass inoculation results reported in VAERS. Figs. 1 and 2 reflect only these very short-term results. A number of researchers have suggested the possibility of severe longer-term autoimmune, Antibody-Dependent Enhancement, neurological, and other potentially serious effects, with lag periods ranging from months to years. If such effects do turn out to be real, the children are the ones who will have to bear the brunt of the suffering. There appear to be no benefits for the children and young adults from the inoculations and only Costs!

The second issue is why the deaths shown on Fig. 2 were not predicted by the clinical trials. We examined the Pfizer trial results (based on a few months of testing) and did not see how (potentially) hundreds of thousands of deaths could have been predicted from the trials' mortality results. Why this gap?

As we showed in the clinical trials section, 17.4 % of the Pfizer sample members were over 65, and 4.4 % were over 75. When the later phases of the trials started in late July 2020, the managers knew the COVID-19 age demographics affected from the July 2020 analog of Fig. 1. Rather than sampling from the age region most affected, they sampled mainly from the age region least affected! And even in the very limited sampling from the oldest groups, it is unclear whether they selected from those with the most serious comorbidities. Our impression is that the sickest were excluded from the trials, but were first in line for the inoculants.

It is becoming clear that the central ingredient of the injection, the recipe for the spike protein, will produce a product that can have three effects. Two of the three occur with the production of antibodies to the spike protein. These antibodies could allegedly offer protection against the virus (although with all the "breakthrough" cases reported, that is questionable), or could suppress serious symptoms to some extent. They could also cross-react with human tissue antigen, leading to potential autoimmune effects. The third occurs when the injected material enters the bloodstream and circulates widely, which is enabled by the highly vascular injection site and the use of the PEG-2000 coating.

This allows spike protein to be manufactured/expressed in endothelial cells at any location in the body, both activating platelets to cause clotting and causing vascular damage. It is difficult to believe this effect is unknown to the manufacturer, and in any case, has been demonstrated in myriad locations in the body using VAERS data. There appears to be modest benefit from the inoculations to the elderly population most at risk, no benefit to the younger population not at risk, and much potential for harm from the inoculations to both populations. It is unclear why this mass inoculation for all groups is being done, being allowed, and being promoted.

5. Overall conclusions

The people with myriad comorbidities in the age range where most deaths with COVID-19 occurred were in very poor health. Their deaths did not seem to increase all-cause mortality as shown in several studies. If they hadn't died with COVID-19, they probably would have died from the flu or many of the other comorbidities they had. We can't say for sure that many/most died from COVID-19 because of: 1) how the PCR tests were manipulated to give copious false positives and 2) how deaths were arbitrarily attributed to COVID-19 in the presence of myriad comorbidities.

The graphs presented in this paper indicate that the frail injection recipients receive minimal benefit from the inoculation. Their basic problem is a dysfunctional immune system, resulting in part or in whole from a lifetime of toxic exposures and toxic behaviors. They are susceptible to either the wild virus triggering the dysfunctional immune system into over-reacting or under-reacting, leading to poor outcomes or the injection doing the same.

This can be illustrated by the following analogy. A person stands in a bare metal enclosure. What happens when the person lights a match and drops it on the floor depends on what is on the floor. If the floor remains bare metal, the match burns for a few seconds until extinguished. If there is a sheet of paper on the floor under the match, the match and the paper will burn for a short time until both are extinguished. If, however, the floor is covered with ammonium nitrate and similar combustible/explosive materials, a major explosion will result! For COVID-19, the wild virus is the match. The combustible materials are the toxic exposures and toxic behaviors. If there are no biomarker 'footprints' from toxic exposures and toxic behaviors, nothing happens. If there are significant biomarker 'footprints' from toxic exposures and toxic behaviors, bad outcomes result.

Adequate safety testing of the COVID-19 inoculations would have provided a distribution of the outcomes to be expected from 'lighting the match'. Since adequate testing was not performed, we have no idea how many combustible materials are on the floor, and what the expected outcomes will be from 'lighting the match'.

The injection goes two steps further than the wild virus because 1) it contains the instructions for making the spike protein, which several experiments are showing can cause vascular and other forms of damage, and 2) it bypasses many front-line defenses of the innate immune system to enter the bloodstream directly in part. Unlike the virus example, the injection ensures there will always be some combustible materials on the

floor, even if there are no other toxic exposures or behaviors. In other words, the spike protein and the surrounding LNP are toxins with the potential to cause myriad short-, mid-, and long-term adverse health effects even in the absence of other contributing factors! Where and when these effects occur will depend on the biodistribution of the injected material. Pfizer's own biodistribution studies have shown the injected material can be found in myriad critical organs throughout the body, leading to the possibility of multi-organ failure. And these studies were from a single injection. Multiple injections and booster shots may have cumulative effects on organ distributions of inoculant!

The COVID-19 reported deaths are people who died **with** COVID-19, not necessarily **from** COVID-19. Likewise, the VAERS deaths are people who have died **following** inoculation, not necessarily **from** inoculation.

As stated before, CDC showed that 94 % of the reported deaths had multiple comorbidities, thereby reducing the CDC's numbers attributed strictly to COVID-19 to about 35,000 for all age groups. Given the number of high false positives from the high amplification cycle PCR tests, and the willingness of healthcare professionals to attribute death to COVID-19 in the absence of tests or sometimes even with negative PCR tests, this 35,000 number is probably highly inflated as well.

On the latter issue, both Virginia Stoner [85] and Jessica Rose [86] have shown independently that the deaths **following** inoculation are not coincidental and are **strongly related to** inoculation through strong clustering around the time of injection. Our independent analyses of the VAERS database reported in Appendix 1 confirmed these clustering findings.

Additionally, VAERS historically has under-reported adverse events by about two orders-of-magnitude, so COVID-19 inoculation deaths ***in the short-term*** could be in the hundreds of thousands for the USA for the period mid-December 2020 to the end of May 2021, potentially swamping the *real* COVID-19 deaths. Finally, the VAERS deaths reported so far are for the very short term. We have no idea what the death numbers will be in the intermediate and long-term; the clinical trials did not test for those.

The clinical trials used a non-representative younger and healthier sample to get EUA for the injection. Following EUA, the mass inoculations were administered to the very sick (and first responders) initially, and many died quite rapidly. However, because the elderly who died following COVID-19 inoculation were very frail with multiple comorbidities, their deaths could easily be attributed to causes other than the injection (as should have been the case for COVID-19 deaths as well).

Now the objective is the inoculation of the total USA population. Since many of these potential serious adverse effects have built-in lag times of at least six months or more, we won't know what they are until most of the population has been inoculated, and corrective action may be too late.

All the authors contributed equally and approved the final version of the manuscript.

Author's contribution

Kostoff RN contributed to this paper with conception, data analysis, and writing the manuscript; Calina D contributed to data analysis, writing the manuscript, and editing; Kanduc D participated in data analysis and writing the manuscript; Briggs MB participated in data analysis, results validation, and graphics development; Vlachoyiannopoulos P participated in writing the manuscript; Svistunov AA participated in editing and reviewing the manuscript; Tsatsakis A participated in editing and reviewing the manuscript; all the authors contributed equally and approved the final version of the manuscript.

Ethical approval

Not applicable.

Declaration of Competing Interest

The authors declare that they have no competing interests

Acknowledgement

Not applicable.

Appendix A

EXPECTED DEATHS IN 65+ DEMOGRAPHIC VS COVID-19 INOCULATION DEATHS

The goal of this appendix is to estimate the number of actual deaths from the COVID-19 inoculation based on the number of deaths following inoculation reported in VAERS [93,94,101]. The approach used will:

1) identify the number of deaths following COVID-19 inoculation that would have been **expected** without COVID-19 inoculation (i.e., pre-COVID-19 death statistics);
2) relate the VAERS **expected** death data to the actual number of deaths **expected** based on historical death statistics; and
3) apply this ratio to scale-up the deaths attributed to COVID-19 inoculation reported in VAERS to arrive at actual deaths attributable to COVID-19 inoculation.

For example, if ten deaths could be shown in VAERS to reflect expected pre-COVID-19 deaths, and the actual number of expected pre-COVID-19 deaths from historical data was 100, the scaling factor of deaths would be ten to translate VAERS-reported deaths to actual deaths. Then, the deaths reported in VAERS that can be attributed to the COVID-19 inoculation will be multiplied by the expected deaths scaling factor, ten, to arrive at the actual number of deaths resulting from the COVID-19 inoculation. Thus, if VAERS shows fifty deaths that can be attributed to the COVID-19 inoculation, then the actual number of deaths attributed to COVID-19 will be 500 with these assumptions [3].

The basis for our approach is the following statement from the USA Federal government: "Healthcare providers are required to report to VAERS the following adverse events after COVID-19 vaccination [33] and other adverse events if later revised by FDA" [96,102,103]. "Serious AEs regardless of causality.", including death [3,95].

If there had been full compliance with this requirement in VAERS, then the VAERS-reported deaths would have equaled the sum of

1) actual expected deaths (based on past statistics)
2) actual deaths over and above expected deaths that could be attributed to the COVID-19 inoculations.

Based on this requirement, we will generate a rough estimate (in the simplest form possible) of the number of deaths that would have occurred in the 65+ demographic if there had been no COVID-19 "pandemic". Then, we will relate this number to the number of deaths reported to VAERS following COVID-19 inoculations in the 65+demographic. This would provide a "floor" for estimating the fraction of actual deaths reported to VAERS. This will be followed by parameterizing potential deaths attributable to the COVID-19 inoculations and displaying the effects on ratio of reported deaths to actual deaths. We will perform a global analysis and a local analysis, to see whether major or minor differences occur. The local analysis (Section A1-a2) may be somewhat easier to comprehend than the global analysis, but both come to similar conclusions.

A1-a Deaths Following COVID-19 Inoculations Reported to VAERS Compared to Expected Deaths

A1-a . Problems with VAERS

Before we discuss numbers of adverse events reported by VAERS, we need to identify potential shortcomings of, and problems with, VAERS, so these numbers of adverse events can be understood in their proper context. As stated previously, VAERS is a passive surveillance system managed jointly by the CDC and FDA, and historically has been shown to report about 1% of actual vaccine/inoculation adverse events (confirmed by the first principles analysis that follows in this appendix). There is no evidence that even the 1% reported have been selected randomly.

Some of this gross underreporting of adverse events reflects a major conflict-of-interest of CDC with respect to VAERS. CDC provides funding for administration of many vaccines, including the COVID-19 inoculations. Prior to COVID-19, the CDC provided about five billion dollars annually to the Vaccines for Children Program alone [102].

For COVID-19, the CDC has received many billions of dollars in supplemental funding for myriad activities, including vaccine distribution. It is difficult to separate out the CDC funding available for vaccine distribution from other CDC COVID-19 related activities, but one budget item (of many) should illustrate the magnitude of the effort: "Coronavirus Response and Relief Supplemental Appropriations Act, 2021 (P.L. 116–260): P.L. 116–260 provided $8.75 billion to CDC to plan, prepare for, promote, distribute, administer, monitor, and track coronavirus vaccines to ensure broad-based distribution, access, and vaccine coverage." [3]. Low reporting rates of actual adverse events in VAERS should not be surprising, since the same organization that receives multi-billions of dollars in funding annually for promoting and administering vaccines also has responsibility for monitoring the safety of these products (whose liability has been waived).

In addition, the 1% reporting rates came from a thirty-day tracking study [22], and therefore are strictly applicable to *very near-term* adverse events. For mid-term and especially long-term events, the reporting rates would be much lower, since the links between inoculation and adverse events would be less obvious. That doesn't mean these non-very-short-term adverse events don't exist; it just means they haven't been tracked. Absence of evidence is not evidence of absence. Thus, the VAERS numbers should be viewed as a very low "floor' of the numbers and types of adverse events from COVID-19 inoculations that exist in the real-world.

A1-a2 Global analysis

We used 2019 death statistics from CDC to start the analysis. According to search results from CDC Wonder [104] obtained 11 June 2021, there were 2,117,332 deaths from all causes for people aged 65+ in the United States in 2019. Assuming uniformity throughout the year, there would have been~882,000 deaths occurring the first five months of the year, and that number will be used as the expected deaths for the first five months of 2021. From the same source, the population estimate is~54,000,000 for the 65+ age range. From CDC COVID-19 data tracker, the number of people 65+ vaccinated with at least one dose is~44,000,000 [24]

For those who were inoculated somewhere in the time frame 1 January 2021 to 31 May 2021, the number who would have been expected to die in the period from inoculation to 31 May will be a function of the duration of this period. For example, if all 44,000,000 people had been fully inoculated on 1 January 2021, then the number expected to die post-inoculation from non-COVID-19 inoculation causes would be simply (44,000,000/54,000,000) x 882,000, or~723,000 deaths. Conversely, if all 44,000,000 people had been fully inoculated on 31 May 2021, then the number expected to die post-inoculation from non-COVID-19 inoculation causes would be extremely small [24].

For an accurate estimation of the number expected to die post-inoculation from non-COVID-19 causes, one would need to integrate the time between inoculation and 31 May over the inoculation temporal distribution function. For present purposes, we will do a very rough approximation by modeling the inoculation distribution function as a delta function occurring at a mean temporal location. In other words, we compress all inoculations an individual receives into one, identify the mean temporal location from the actual inoculation distribution function, and compute the expected deaths based on the distance from 31 May to the temporal mean point.

From a graph of inoculation trends in the CDC data tracker [101] the distribution appears to be non-symmetrical pyramidal, rising to a peak in mid-April. This is slightly over the 2/3 point in the five-month range of interest. We will approximate the mean time point as 2/3 of the distance.

Table A1 displays the mean time normalized to the five-month study window vs potential deaths from COVID-19 inoculation (not expected from prior census data) normalized to the deaths expected from prior census data. Each cell represents the percent of deaths reported in VAERS following inoculation relative to total deaths (number of deaths expected from prior census data plus number of deaths following COVID-19 inoculation not contained in the expected death group). The model on which the table is based is as follows: there are two classes of deaths for the period following COVID-19 inoculation. One is the deaths expected from prior census data, and the other is deaths attributable mainly to COVID-19 inoculation. There would be potentially substantial overlap between the two in this age group (and perhaps other age groups as well). We assume that we can tag those individuals who would be expected to die based on prior census data. The remaining deaths attributable to COVID-19 inoculation not contained within the tagged group are classified as potential COVID deaths in Table A1.

Consider the cell (2/3,0). The mean time is about mid-April 2021 and the only deaths occurring are those expected (some may have died because of the inoculation, but they were sufficiently ill that they would have died during that period without the inoculation). There were 723,000 expected deaths and~3560 reported, yielding a ratio of deaths reported in VAERS to actual deaths of ½%.

Consider the cell (1/2,1). The mean time would have been about mid-March 2021 and the inoculation distribution would have resembled an isosceles triangle. The total deaths occurring are those expected and an equal number whose deaths were attributed to COVID-19 inoculation but did not overlap with those in the tagged expected group (there still could have been some/many in the latter group that may have died because of the inoculation, but they were sufficiently ill that they would have died during that period without the inoculation). There were 724,000 total deaths that occurred during that period and~3560 reported, yielding a ratio of deaths reported in VAERS to actual deaths of ½%. [3]

So, according to Table A1, focusing on the parameter most closely reflecting the actual inoculation distribution (2/3), the reporting percentages of actual to total are about 1%. This mirrors the Harvard Pilgrim study results (referenced in our vaccine safety study) which were obtained through an entirely different empirical approach [4]. At least for deaths reporting, there appears to be an approximately two order of magnitude difference between actual and reported deaths in VAERS.

Table A1 used two parameters to examine a broad spectrum of possible results, the mean time and the number of deaths solely attributable to COVID-19 inoculation. The mean time parameter was fairly well known and constrained in interpretation, because it was based on an empirical inoculation distribution function. The number of deaths solely attributable to COVID-19 inoculation is completely unknown.

As will be shown in the next section, the numbers of deaths reported in VAERS are strongly related to the inoculation date by clustering, but those who died might also have been those who would have died anyway because they were expected to die. There were probably some of each in that group reported. But we have no idea of the total number whose death could be directly attributed to COVID-19 inoculation and who were not in the group expected to die. For all we know, there could have been ten million people in that group, and only an extremely small fraction of that total group was reported in VAERS.

Suppose, for example, that the actual number of deaths reported in VAERS came from two groups: 90 % were from the inoculation-attributable death group and 10 % were from the expected death group. Assume there is no overlap between the two groups. In that case, what VAERS shows is not that 1% of actual expected deaths were reported, but rather that 1/10 of one percent of the expected deaths were reported. If that metric is used as the standard to scale up to total deaths, then the number in the actual inoculation-attributable death group is not 100 times the VAERS reported deaths, but rather 1000 times the VAERS-reported deaths! The point is we can't "reverse-engineer" the reported VAERS death numbers to get the actual inoculation-attributable deaths because it depends on the unknown contribution of each of the two groups (expected deaths and inoculation-attributable deaths) to the VAERS reported deaths, and we can't separate those out.

All this analysis shows is that, at best, only about 1% of the number expected to die was reported, and because the number reported in VAERS included deaths from both groups, the fraction from each actual group of deaths could not be determined. Realistically, we may have to wait until mid-2022, when the 2021 total deaths for each age group are finalized, to ascertain whether we can see increases in all-cause mortality that could have come from the inoculation-attributable deaths.

A1-a3 Local Analysis

Another way of estimating VAERS reporting efficiency is to perform a local analysis, focused on clustering about date of COVID-19 inoculation. For the 65+demographic, the post-inoculation deaths cluster near the vaccination date, providing evidence of a ***strong link to the inoculation***.

Following the approach in the first section of this appendix, we calculate the deaths expected in any ten-day period based on 2019 pre-COVID-19 death statistics. For the inoculated group, the number of deaths expected for any ten-day period are (2,117, 332 deaths/per year) x (44,000,000/54,000,000 fraction of population in age range inoculated) x (10/365 fraction of year), or ~47,270 deaths.

BEST-CASE SCENARIO

Consider the ten days following inoculation (including day of inoculation). Approximately 2,000 deaths were reported in VAERS. Assume hypothetically that all these deaths were in the expected category; this can be viewed as a *best-case scenario*. In this *best-case scenario*, where the concentration of deaths is the highest and is normalized to the expected number of non-COVID-19 inoculation deaths (excluding deaths due solely to COVID-19 inoculation), 2,000/47,270 % of actual deaths (inoculation-related or not), or 4.23%, are reported in VAERS. Thus, at best, VAERS is underreporting by a factor of ~20.

Suppose in that ten-day interval there had been 10,000 deaths that could be directly attributed to COVID-19 inoculation in addition to the expected deaths. This would have given a ratio of 2,000/57,270 actual total deaths, or 3.5 % reported in VAERS. This latter approach requires less assumptions than the former approach, but still yields results of only a few percent actual deaths reported in VAERS.

The Harvard Pilgrim electronic tracking study of post-vaccination events reported to VAERS performed in 2010 [4] showed a 1 % reporting rate for a thirty-day period. In the present case, ~2900 post-inoculation deaths were reported to VAERS within thirty days of inoculation, or ~82 % of total deaths for the 65+demographic. Substituting thirty days for ten in the above computation yields 141,810 expected non-COVID-19 post-inoculation deaths for the thirty-day period, or 2% that are reported in VAERS. The Harvard study used an electronic system that automatically tracked every event that occurred, no matter how small. Because of the effort (time and cost) required to submit event reports to VAERS, we suspect that only the more serious events, such as death, would be reported, and even in this case, the numbers reported are miniscule.

We also did an analysis for sixty days post-inoculation. In the present case, ~3300 post-inoculation deaths were reported to VAERS within sixty days of inoculation, or ~93 % of total deaths for the 65+demographic. Substituting sixty days for ten in the above computation yields 283620 expected non-COVID-19 post-inoculation deaths for the thirty-day period, or 1.2 % that are reported in VAERS. Remember, this normalization is based only on expected deaths. If 100,000 deaths attributable mainly to the COVID-19 inoculation beyond those that overlapped with the expected group occurred during this period, then the denominator would have to be increased by 100,000, yielding a VAERS reporting rate of 0.86 %.

Thus, both the global and local analyses, and the Harvard Pilgrim empirical analysis, are converging on the same two orders-of-magnitude difference between the actual number of deaths that occurred in the USA and those reported in VAERS. Depending on how many people have really died as a result of the COVID-19 inoculation, this reporting rate could well be a fraction of a percent!

A1-a3a Local Clustering Analysis

We end this appendix with one more example from the local analysis. Some background perspective is required. In the buildup to the pandemic (putting aside the issue of high false positives from PCR tests run at high numbers of amplification cycles), almost anyone who died **with** COVID-19 was assumed to have died **from** COVID-19, irrespective of the number of potentially lethal comorbidities they had. The CDC admitted later that about 94 % of the deaths attributed to COVID-19 would ordinarily have been attributed to one of the comorbidities.

For this example, we adopt a similar philosophy for the COVID-19 inoculations. People in the 65+ demographic who have died following

inoculation are divided into two groups: those who died **from** the inoculation and those who died as **expected** based on pre-COVID-19 death data. The two groups range from being entirely separate to completely overlapping. We will examine two cases: entirely separate and completely overlapping.

How are the members of each group determined? The death **from** inoculation group consists of those whose deaths cluster significantly around the date of inoculation. The deaths expected group are the number who would have died in the absence of COVID-19. We allow for overlap, where each person who died can be double-valued (a member of both groups), but not double-counted.

To obtain a relatively precise estimate of expected deaths, we would want to select a region of time where the distribution function has substantially leveled off. From Fig. A1, the thirty-sixty-day range appears reasonable. However, there is a time issue here. Given the lag time in data reported by VAERS, most of the data in this range will probably have come from inoculations in January and February, and early-mid March, approximately 35 percent of the total inoculations. Therefore, we could multiply the thirty-sixty-day average number of deaths by ~3 to obtain ~40 expected deaths per day. An even simpler way to estimate the expected deaths reported in VAERS is to use the 15−30-day average shown, which will represent most of the range. This value is ~37, which is close to the ~40 obtained with the above approximation. This analysis should be re-run in three-four months, when more of the long-range data has been filled in.

Table A2 shows the results of our analysis. As stated previously, two separate cases were analyzed: completely separate groups and completely overlapping groups. Two values of daily expected deaths were used: the 37 as described above, and 20 to account for potentially lower expected death reporting when the VAERS data has filled in more completely.

Thus, based on the deaths reported in VAERS following COVID-19 inoculation, and assuming the inoculation-related deaths are reported in the same ratio as expected deaths, the actual number of deaths strongly related to the COVID-19 inoculation should be scaled up by factors of 100−200. For the broadest definition of VAERS coverage provided by CDC Wonder, which includes the USA and all territories, protectorates, and possessions, the total deaths following COVID-19 were ~5200 in early June 2021. Using our scaling factors, this translates into somewhere between one-half million and one-million deaths, and this has not taken into account the lag times associated with entering data into VAERS. Compared with the ~28,000 deaths the CDC stated were due to COVID-19 and not associated morbidities for the 65+ age range, the ***inoculation-based deaths are an order-of-magnitude greater than the COVID-19 deaths!*** It should be remembered these are only the **very-short-term inoculation-based deaths**, and could increase dramatically if mid- and long-term adverse effects come to fruition.

We end this appendix with an even more unsettling possibility. The main assumption upon which the results in Table A2 were based is that the post-inoculation temporal distribution function shown in Fig. A1 could be divided into two regions. The strongly varying region originating from the inoculation date reflected deaths from the inoculation, and the essentially flat region that followed reflected expected deaths (that flat region also started at the inoculation date, and formed the base on which the highly varying region is positioned). This model excludes the possibility that deaths from the inoculation extend well beyond the limits of the highly varying region.

We know in general this is not true. There can be lag effects such as ADE in the Fall viral season, and longer-term effects such as autoimmune diseases. We postulate that there are other effects from the inoculation that could result in the same flat death profile as that for expected deaths.

Consider the following. Some of the damage we have seen following the inoculations in VAERS includes coagulation/clotting effects and neurological effects of all types [63]. If these effects are not lethal initially, they raise the level of dysfunction. Thus, platelet aggregation has increased to a new base level, and micro-clots have raised the probability of serious clots forming from other lifestyle factors [105]. Death of specific neurons can increase the risk of Alzheimer's disease or Parkinson's disease, and can accelerate the onset of these and many other diseases. Thus, the adverse impacts of the COVID-19 inoculations could be viewed as raising the level of expected deaths in the future. Any deaths of this nature reported in VAERS would need to be viewed as inoculation-driven, and the expected deaths used in the computations would be reduced accordingly.

Consider Table A3 below. The "expected deaths reported" have been reduced below their counterparts in Table A2 to illustrate parametrically how the total inoculation-based deaths would change from VAERS reporting if this baseline effect is operable. While Table A2 used values of 37 and 20 for expected deaths, Table A3 uses values of 10 and 15.

Thus, if the baseline of the host for coagulation/clotting, inflammation, hypoxia, neurodegeneration, etc., has been raised by the inoculations, translating into an increase in expected deaths and accelerated deaths, then it is entirely plausible that the VAERS death numbers reflect over a million deaths from COVID-19 inoculations so far. These are very short-term-effects only, and time will tell whether the large potential waves of ADE-driven deaths and autoimmune-driven deaths come to pass.

Appendix B

DETAILED ANALYSIS OF MAJOR COVID-19 INOCULANT CLINICAL TRIALS

A2-a Clinical Trials in the Mainly Adult Population

Definitions. *Efficacy* is the degree to which a vaccine prevents disease, and possibly also transmission, under ideal and controlled circumstances – comparing a vaccinated group with a placebo group [106].

Effectiveness refers to how well a vaccine performs in the real world [107]

Relative Risk (RR) is computed by dividing the percentage of patients that contracted disease in the vaccine arm by the percentage of patients that contracted disease in the placebo arm.

Relative Risk Reduction (RRR) is computed by subtracting the RR from 1.

Absolute Risk Reduction (ARR) is computed by subtracting the percentage that contracted disease in the vaccine arm from the percentage that contracted disease in the placebo arm.

Absolute Risk = probability = incidence.

Cumulative Incidence represents the number of new cases in a period of time / population at risk.

Incidence Density is the number of new cases of a given disease during a given period in specified population; also, the rate at which new events occur in a defined population.

Immunogenicity is the ability of a molecule or substance to provoke an immune response or the strength or magnitude of an immune response. It can be a positive (wanted) or negative (unwanted) effect, depending on the context.

Immune Response is an integrated systemic response to an antigen (Ag), especially one mediated by lymphocytes and involving recognition of Ags by specific antibodies (Abs) or previously sensitized lymphocytes [108]

Safety data for Pfizer and Moderna trials:

There were two major COVID-19 inoculant clinical trials: Pfizer/BioNTech and Moderna.

The Pfizer clinical trials were titled officially "a phase 1/2/3, placebo-controlled, randomized, observer-blind, dose-finding study to evaluate the safety, tolerability, immunogenicity, and efficacy of sars-cov-2 rna vaccine candidates against covid-19 in healthy individuals" [98]. The "Actual Study Start Date" was 29 April 2020, the "Estimated Primary Completion Date" was 2 November 2020, and the "Estimated Study Completion Date" is 2 May 2023. Thus, the mass inoculation rollout so far has been conducted in parallel with the Pfizer Phase III Clinical Trial. For all practical purposes, the mass global inoculation of the Pfizer inoculant recipients can be considered Phase III 2.0 of the Clinical Trials! The inclusion criteria for the official Phase III Clinical Trials incorporated (as stated in the title and in the protocol document) healthy individuals, while the criteria for mass inoculation went well beyond healthy individuals. In essence, we have an official Phase III Clinical Trial with ~43,000+ healthy individuals, and an unofficial Phase III Clinical Trial with billions of individuals covering a wide spectrum of health levels [98].

The Pfizer Phase III trials were initiated July 2020, the efficacy data were submitted to the FDA for EUA approval in November 2020, and FDA approval was granted in December 2020. Six deaths occurred in the Pfizer trial, two in the inoculated group and four in the placebo group (which received saline) [33]. The two inoculated, both over the age of 55, died of cardiovascular causes. One died three days after inoculation and the other died 62 days after inoculation [109]. These two deaths were comparable (in frequency and cause) to placebo group deaths and perhaps more importantly, similar to the general population at that age. In the case of Moderna, there were 13 deaths, six in the inoculated group, seven in the placebo group (normal saline placebo, a mixture of sodium chloride in water 0.90 % w/v) at 21–57 days after the inoculation ([103]b).

In a report by the Norwegian National Medicines Association, published on 15 January 2021, there were 23 elderly people (all over the age of 75 and frail) in nursing homes, who died at various intervals from the time of inoculation with mRNA inoculant The report then suggested that, following the assessment, 13 of the 23 deaths would have been a direct result of the side effects of inoculation. It is possible that the other 10 deaths were post-inoculation, but not directly related to side effects, so not necessarily related to the inoculant itself [109].

It is no surprise that frail elderly people can be fatally destabilized by adverse reactions associated with post-inoculation inflammation, which in a young adult would have been considered minor. It is also no surprise that frail elderly people with comorbidities can be fatally destabilized from COVID-19 infection, which in a young adult or child would have been considered minor. A frail elderly person can be fatally destabilized by a simple coughing fit! This does not mean that these deaths are not events that need to be taken very seriously; on the contrary, if confirmed, they should guide inoculation policies in this category of patients from now on. Specifically, each case should be carefully assessed and an inoculation decision made based on the risk-benefit ratio [110].

In light of these data, the question may arise as to why there were no inoculant-attributed deaths in clinical testing of inoculants. The answer is that neither Pfizer nor Moderna included frail patients and included only a small number of very elderly patients - those over 75 accounted for 4.4 % of the total tested for Pfizer and 4.1 % for Moderna. While they could not in fact determine a causal relationship between inoculation and death, they also could not rule out that the inoculations had accelerated the deterioration of the condition of those patients [33].

Effectiveness data

As defined previously, the effectiveness of a vaccine lies in its ability to prevent a particular disease. If designed, tested, and administered correctly, authorized vaccines are effective in preventing disease and protecting the population. Like medicines, vaccines are not 100 % effective in all vaccinated people. Their effectiveness in a person depends on several factors. These include: age; other possible diseases or conditions; time elapsed since vaccination; previous contact with the disease.

To be declared safe and effective, a vaccine against COVID-19 infection must pass a series of tests and must meet regulatory standards, like any other vaccine or drug approved on the pharmaceutical market [111].

Regarding Pfizer and Moderna trials:

The first important note is that maximum efficiency does not come immediately, because the immune response needs time.

In the case of Pfizer, the chance of developing COVID-19 becoming virtually the same between the inoculated and placebo groups increases up to 12 days after the first inoculation, then gradually decreases for those inoculated. The inoculum efficiency between the first and second doses is 52 % [106], but it is unclear what long-term protection a single dose provides. After the second dose, the effectiveness rises to 91 % and only beyond 7 days after the second dose is 95 % reached. However, the ARR for the latter case is only 0.7 % [112]. In other words, within 12 days after the first dose we can get COVID-19 as if we had not been inoculated. Another important aspect is that we still do not know if the Pfizer inoculant prevents severe cases. Seven days after the second dose, there were four severe cases of COVID-19, one in the inoculated group and three in the placebo group, which is far too low for us to make a statistical assessment. There are as yet no data on the inoculant's ability to prevent community transmission. Realistically, the effectiveness of the inoculant in preventing asymptomatic cases has not been tested.

For Moderna, the effectiveness is only 50 % in the first 14 days after the first dose and reaches a maximum of 92.1 % on the edge of the second dose (ARR of 1.1 %, which is 28 days, not 21 as in the case of Pfizer) [46]. Moderna also did not test the long-term efficacy of a single dose. Then, 14 days after the second dose, the effectiveness rises to 94.1 %, with the amendment being an average. Thus, in people over 65 it was 86.4 %, compared to 95.6 % in the 18–65 age range ([103]). It is a minor difference from Pfizer, which declares equal efficiency in all age groups. An important observation is the statement by Moderna that their inoculant prevents severe cases, but only more than 14 days after both doses [126]. All 30 severe cases were in the placebo group, suggesting 100 % efficacy. After a single dose, there were two severe cases among those inoculated and four in the placebo group [33]. Last, but not least, unlike Pfizer, Moderna tested the presence of asymptomatic infection by RT-PCR before the second dose: there were 39 asymptomatic cases in the placebo group and 15 in the inoculated group. It is difficult to draw definitive conclusions due to the small number of cases. These data suggest that the inoculant reduces, but does not prevent, asymptomatic transmission [126].

A2-b Ongoing Clinical Trials in the Pediatric Population

In a recent Phase III study performed in the pediatric population, Comirnaty (Pfizer) was tested on a group of 2,260 children, aged 12–15, years who had no previous clinical signs of SARS-CoV-2 infection. They were divided into two groups, one placebo (978 children) and the other with Comirnaty (1005 children). In the Comirnaty group, of the 1005 children in whom the serum was administered, none developed COVID-19 disease, compared with the placebo group in which 16 children in 978 had clinical signs of the disease. The Pfizer study showed that the children's immune response was comparable to the immune response in the 16–25 age group (measured by the level of antibodies against SARS-CoV-2). It could be

concluded that in this study, Comirnaty was 100 % effective in preventing SARS-CoV-2 infection, although the actual rate could be between 75 % and 100 %. [63]. The results will be evaluated by the FDA and EMA.

The predictive value (for mass inoculation results) of the Comirnaty trial for the children aged 12–15 years is questionable. There were 1005 children who were inoculated with Comirnaty. Using the rule of three in statistics, where to obtain a predictive result of 1/x with high confidence (e.g., 1 in a thousand), 3x participants are required for the test sample. For the Comirnaty test sample of 1005, an adverse event of about 1/340 could be detected with high confidence.

What does this mean in the real world? In the USA, there are approximately 4,000,000 children in each age year for adolescents. Thus, there are 16,000,000 children in the 12–15 age band. A serious adverse event, including death, that occurred at a 1/800 rate would not be detectable with high confidence in a sample of 1005 people. Thus, the results of the trials for 1005 children would allow for 20,000 children to suffer a non-trial-detected serious adverse event, including death, when extrapolated to potential inoculation of all children in the 12–15 age group! Given that the risk of contracting COVID-19 with serious outcomes is negligible in this population, ***proceeding with mass inoculation of children 12–15 years old based on the trials that were conducted cannot be justified on any cost-benefit ratio findings***.

Also, the evaluation of efficacy in children aged 6 months to 11 years has recently begun and continues [24]. Pfizer began enrolling children under 12 to evaluate the COVID-19 mRNA inoculant. Also, Comirnaty will be evaluated in a new clinical trial for children aged 6 months to 11 years. In the first phase, the study will enroll 144 people and will identify the required dose for 3 age groups (6 months - 2 years, 2–5 years and 5–11 years). After a 6-month follow-up period, the parents/guardians of children in the placebo group will have the option of allowing their children to receive the inoculation. The results are expected in the second half of 2021.

Moderna also began a study to evaluate the mRNA inoculation in children aged 6 months to 12 years. Both companies have already started testing vaccines in 14-year-olds. In the US, children make up 23 % of the population [113].

Data on the risks and benefits of possible inoculation in children and adolescents are currently insufficient and no recommendation can be made. Specifically, mass child inoculations cannot be recommended until the benefits and minimal projected risks have been demonstrated in a sufficiently large trial to provide confidence that mass inoculation will have an acceptable level of adverse effects relative to the demonstrated benefits. On the other hand, children often experience COVID-19 asymptomatically, and the SARS-CoV-2 infection progresses harmlessly. Currently, in the context of limited inoculation capacities, there is no indication of urgent inoculation of children. In the context of declining incidences of SARS-CoV-2 infections and demonstrated low serious adverse effects from COVID-19 infections for children and adolescents, the issue of inoculating children and adolescents is no longer paramount. Authorized forums must calculate what prevails for children and adolescents: the benefits or risks.

A2-c Clinical Trial Issues for Other Categories

Although people with severe comorbidities such as obesity or oncological conditions were not initially included in the clinical trials that led to obtaining EUA, they were included in subsequent studies, some even ongoing. In their case, it seems that the efficacy was lower compared to the results obtained initially with healthy adults.

The interim analysis of data from a prospective observational study indicates the need to prioritize cancer patients for timely (respectively 21-day) booster administration in the case of administration against COVID-19 with Comirnaty. According to the study, the effectiveness of a single dose of Comirnaty among cancer patients is low, but the immunogenicity of patients with solid cancers increased at 2 weeks after receiving the second dose of inoculant 21 days after the first dose. Because the study was conducted in the UK, participants inoculated before December 29, 2020 received two doses of Comirnaty 21 days apart, and those who started the regimen after this date were scheduled to receive a second dose of Comirnaty 12 weeks apart. first administration. Thus, the study continues to collect data from participants receiving Comirnaty 12 weeks after the first dose.

Approximately 21 days after a single dose of Comirnaty, the proportion of study participants who tested positive for anti-S IgG antibodies was [114]:

94 % among healthy participants;

38 % among patients with solid cancers;

18 % among patients with hematological cancers.

Among participants who received the 21-day booster and for whom biological samples were available two weeks after the second dose, the following proportions of confirmation as seropositive for anti-S IgG antibodies were reported [114].

100 % of healthy participants, compared to 86 % of the same group of participants who did not receive the second dose;

95 % of patients with solid cancers, compared with 30 % of the same group of participants who did not receive the second dose;

60 % of patients with hematological cancers, compared with 11 % of the same group of participants who did not receive the second dose.

Two other studies suggest low immunogenicity in the context of Comirnaty administration in patients with hematological cancers. In one study, patients with chronic lymphocytic leukemia (CLL) had significantly reduced immune response rates to COVID-19 inoculation compared to healthy participants of the same age. Considerable variations in post-administration immune response have been reported among patients with CLL depending on their stage of treatment

The effectiveness of Comirnaty administration was also evaluated in elderly patients with multiple myeloma [115]. 21 days after administration of the first dose of Comirnaty inoculation (before receiving the second dose), 20.5 % of patients with multiple myeloma compared to 32.5 % of control participants had neutralizing antibodies against SARS-CoV-2. One possible explanation could be that the therapy negatively affects the production of antibodies. However, the administration of the second dose is important for the development of the immune response in these patients [115].

Preliminary data from the v-safe surveillance system, the v-safe pregnancy registry and the Vaccine Adverse Event Reporting System (VAERS) do not indicate obvious safety signals regarding pregnancy or the associated neonatal implications with mRNA injections against COVID-19 *in the third trimester of pregnancy* [3]. The study included 35,691 pregnant women [116]. Compared to non-pregnant women, pregnant women reported more frequent pain at the injection site as an adverse event associated with mRNA COVID-19 vaccination, and headache, myalgia, chills, and fever were reported less frequently. In the context where initial clinical trials of messenger RNA-based inoculants have not evaluated the efficacy and safety of innovative technology among pregnant women, these preliminary data *from the third trimester only* help to inform both pregnant women and health professionals in making the inoculation decision. However, continuous monitoring through large-scale longitudinal studies remains necessary to investigate the effects associated with maternal anti-COVID-19 inoculation on mothers, pregnancies, the neonatal period and childhood.

On the other hand, the inoculation landscape has become even more complex due to new circulating viral variants. Authorities recommend genomic surveillance and adaptation in order to be effective against new variants (different from the initial strain that was detected at the end of

2019). The efficacy data of Comirnaty against circulating viral variants are highlighted in a very recent study in Israel which showed that the protection offered by the Pfizer inoculant against variant B.1.351 (first identified in South Africa) is lower [112].

The results have not yet been submitted to the expertise of specialists. The study compared nearly 400 adults who were diagnosed with COVID-19 at least 14 days after receiving one or two doses of the inoculant to the same number of uninoculated people. It was found that B.1.351 represents approximately 1 % of the COVID-19 cases studied. But among patients who received two doses of inoculant, the prevalence rate of the variant was eight times higher than in those not inoculated - 5.4 % compared to 0.7 %. This suggests that Comirnaty is less effective against variant B.1.351, compared to the original variant and variant B.1.1.7. The limitation of the study comes from the small number of adult people studied, but it is an alarm signal for a closer study of these cases. In addition, it seems that at present, the prevalence of this variant is low. On the other hand, in early April, Pfizer announced that according to the results of the Phase III study in the adult population, Comirnaty also demonstrated 100 % efficacy in the prevention of Covid-19 disease caused by SARS-CoV-2 variant B.1.351 (9 cases of Covid-19 were recorded, all in the placebo group, and after sequencing it was found that 6 had been determined by B.1.351) [117].

Appendix C

MID- AND LONG-TERM ADVERSE EFFECTS FROM PRIOR VACCINES

A 2020 study emphasizing mid- and long-term adverse effects from prior vaccines [4] identified the following sixteen mid- and longer-term potential issues concerning vaccines. These include:

3.1. Antibody-Dependent Enhancement (where enhanced virus entry and replication in a number of cell types is enabled by antibodies);

-1a. *Intrinsic Antibody-Dependent Enhancement* (where non-neutralizing antibodies raised by natural infection with one virus may enhance infection with a different virus);

-1b. *Immune Enhancement* (enhancement of secondary infections via immune interactions);

-1c. *Cross-Reactivity* (an antibody raised against one specific antigen has a competing high affinity toward a different antigen.);

-1d. *Cross-Infection Enhancement* (infection enhancement of one virus by antibodies from another virus);

3. 2. Vaccine-Associated Virus Interference (where vaccinated individuals may be at increased risk for other respiratory viruses because they do not receive the non-specific immunity associated with natural infection);

3. *Vaccine-Associated Imprinting Reduction* (where vaccinations could also reduce the benefits of 'imprinting', a protection conferred upon children who experienced infection at an early age)

4. *Non-Specific Vaccine Effects on Immune System* (where previous infections can alter an individual's susceptibility to unrelated diseases);

5. *Impact of Infection Route on Immune System* (where immune protection can be influenced by the route of exposure/delivery);

6. *Impact of Combinations of Toxic Stimuli* (where people are exposed over their lifetime to myriad toxic stimuli that may impact the influence of any vaccine);

7. *Antigenic Distance Hypothesis* (negative interference from prior season's influenza vaccine (v1) on the current season's vaccine (v2) protection may occur when the antigenic distance is small between v1 and v2 ($v1 \approx v2$) but large between v1 and the current epidemic (e) strain ($v1 \neq e$).);

8. *Bystander Activation* (activation of T cells specific for an antigen X during an immune response against antigen Y);

9. *Gut Microbiota* (Impact of gut microbial composition on vaccine response);

10. *Homologous Challenge Infection Enhancement* (the strain of challenge virus used in the testing assay is very closely related to the seed virus strain used to produce the vaccine that a subject received);

11. *Immune Evasion* (evasion of host response to viral infection);

12. *Immune Interference* (interference from circulating antibody to the vaccine virus);

-12a. *Original Antigenic Sin* (propensity of the body's immune system to preferentially utilize immunological memory based on a previous infection when a second slightly different version of that foreign entity (e.g. a virus or bacterium) is encountered.);

13. *Prior Influenza Infection/Vaccination* (effects of prior influenza infection/vaccination on severity of future disease symptoms);

14. *Timing between Viral Exposures* (elapsed time between viral exposures);

15. *Vaccine-Associated Enhanced Respiratory Disease* (where vaccination enhances respiratory disease); and

16. *Chronic Immune Activation* (continuous innate immune responses).

Most of these events are not predictable, and most, if not all, would be possible for the COVID-19 inoculant in the mid- and long-term for adults and children.

3.3. Mid- and Long-Term Serious Illnesses for Adults and Children from Past Vaccines

As stated in the aforementioned 2020 study on vaccine safety: "The biomedical literature is very sparse with studies on long-term vaccine effects, especially long-term adverse effects. Large numbers of people and long periods of time are required to identify such adverse events, and draw statistically-valid connections between vaccinations and disease. These efforts would be very resource-intensive, and there appears to be little motivation among the vaccine producers and regulators to make these resources available for such studies. Thus, the following examples reflect the extremely small tip of an extremely large iceberg of long-term adverse vaccine effects." [4]

"The two main categories of diseases reported in the biomedical literature triggered by past vaccinations are "Autoimmune (e.g., Systemic Lupus Erythematosus, Psoriasis, Arthritis, Multiple Sclerosis, Hepatitis, Uveitis, Pseudolymphoma, Guillain-Barre Syndrome, Thrombocytopenic Purpura, etc.) and Neurological (e.g., Central Demyelinating Diseases, Developmental Disability, Febrile seizures, Narcolepsy, Encephalomyelitis, Autonomic Dysfunction, etc.). Others include Diabetes, Gastrointestinal, Joint-related, Necrobiotic Granuloma, Neutropenia, Pulmonary Fibrosis, etc."

"Vaccinations may also contribute to the mosaic of autoimmunity [118]. Infrequently reported post-vaccination autoimmune diseases include systemic lupus erythematosus, rheumatoid arthritis, inflammatory myopathies, multiple sclerosis, Guillain-Barre syndrome, and vasculitis".

"Studies have demonstrated a latency period of years between HiB vaccination and diabetes mellitus, and between HBV vaccination and demyelinating events [118] latency periods can range from days to years for postinfection and postvaccination autoimmunity".

"Most of the extra cases of IDDM appeared in statistically significant clusters that occurred in periods starting approximately 38 months after immunization and lasting approximately 6–8 months. Immunization with pediatric vaccines increased the risk of insulin diabetes in NOD mice. Exposure to HiB immunization is associated with an increased risk of IDDM." [4]

Thus, even the sparse past vaccine studies that went beyond the short-term showed latency effects of serious diseases occurring ***three years or more*** post-vaccination.

Appendix D

COST-BENEFIT ANALYSIS OF COVID-19 INOCULATIONS

This appendix presents a non-traditional *best-case scenario* pseudo-cost-benefit analysis of the COVID-19 inoculations for the 65+ demographic in the USA. In this incarnation of a cost-benefit analysis, the costs are the number of deaths resulting from the inoculations, and the benefits are the lives saved by the inoculations. The time range used was from December 2019 to end-of-May 2021.

It is assumed, in this best-case scenario, that all the deaths truly attributable to COVID-19 only could have been eliminated by the inoculations given (about half the USA population has been inoculated at this time) [88,119]. It can be conceptualized as the vaccines having been available in Summer 2019, and subsequent administration having eliminated all the deaths experienced that were truly attributable to COVID-19. If the cost-benefit ratio is ***poor*** for this *best-case scenario*, it will be ***very poor*** for any real-world scenario [120].

We will use Figs. 1 and 2 as starting points to conduct a cost-benefit analysis of COVID-19 inoculations for the most vulnerable demographic, those 65 + . We start with the official government numbers for COVID-19 and post-inoculation deaths, and modify them to arrive at actual deaths resulting from COVID-19 and the inoculations. We compare the two numbers (appropriately normalized) to ascertain costs vs benefits .

As Fig. 1 shows, there are three age bands that comprise the 65+ demographic. We weight the COVID-19 deaths per capita in each band by the band's population, and divide the sum of these three products by the total 65+ population to arrive at an average COVID-19 deaths per capita of 0.0087 for the total 65+ demographic.

Fig. 2 contains two normalizations. First, the deaths were normalized by total inoculations given, not by people inoculated or people who had completed the full series of inoculations. We will retain the normalization by total inoculations given, since it will provide the ***most conservative results*** (largest denominator) for estimation purposes. Second, the deaths were normalized/restricted to those occurring within seven days post-inoculation. This normalization was done to compare across age bands, where the inoculations started at very different points in time. For the present cost-benefit purpose, where we are concentrating on the 65+ band, we remove this latter normalization, and include all post-inoculation deaths. Removing this normalization increases deaths per inoculation by about 40 % to a value of 0.000032, and offers a more credible comparison to the numbers from Fig. 1.

Thus, based on the CDC's official numbers, there are an average COVID-19 deaths per capita of 0.0087 and an average deaths per inoculation of 0.000032 for the 65+ demographic. The chances of a person 65+ dying from an inoculation relative to their chances of dying from COVID-19 are approximately 0.0037, or about 1/270, based on these official CDC figures.

However, as we have shown previously, three corrections to these numbers are required to convert them to real-world effects. First, as the Harvard Pilgrim study has shown and as our results in Appendix 1 confirm, VAERS is underreporting actual deaths by about two orders of magnitude. Applying this correction alone to the above 1/270 ratio changes the risk benefit to about 1/3., Second, as the CDC has stated, approximately 94 % of the COVID-19 deaths could have been attributed to any of the comorbidities these patients had, and only 6% of the deaths could actually be attributed to COVID-19. As we pointed out, if pre-clinical comorbidities had been included, this number of 6% would probably be decreased further. For ***conservative*** purposes, we will remain with the 6%. Applying this correction to the 1/3 risk-benefit ratio changes it to 5/1! Third, as a comprehensive survey of false positives from RT-PCR tests concluded: "evidence from external quality assessments and real-world data indicate enough a high enough false positive rate to make positive results highly unreliable over a broad range of scenarios" [127]. Because of the myriad RT-PCR tests performed in the USA to screen for/diagnose COVID-19 using different values for Ct and different procedures, a specific number for false positives cannot be obtained at this point in time. Again, these false positives would reduce the 6% number, perhaps substantially. And again, for ***conservative*** purposes, we will remain with the 6% number.

Thus, our ***extremely conservative*** estimate for risk-benefit ratio is about 5/1. In plain English, people in the 65+ demographic are five times as likely to die from the inoculation as from COVID-19 under the most favorable assumptions! This demographic is the most vulnerable to adverse effects from COVID-19. As the age demographics go below about 35 years old, the chances of death from COVID-19 become very small, and when they go below 18, become negligible.

It should be remembered that the deaths from the inoculations shown in VAERS are short-term only (six months for those inoculated initially), and for children, extremely short-term (one month) [3]. Intermediate and long-term deaths remain to be identified, and are possible from ADE, auto-immune effects, further clotting and vascular diseases, etc., that take time to develop. Thus, the long-term cost-benefit ratio under the *best-case scenario* could well be on the order of 10/1, 20/1, or more for all the demographics, increasing with decreasing age, and an order-of-magnitude higher under real-world scenarios! In summary, the value of these COVID-19 inoculations is not obvious from a cost-benefit perspective for the most vulnerable age demographic, and is not obvious from any perspective for the least vulnerable age demographic.

Appendix Da

PROBLEMS WITH TEST CRITERIA FOR DETERMINING COVID-19

Consider the criteria for determining whether an RT-PCR test result is positive for SARS-CoV-2. The CDC instruction (until 1 May 2021) specifies running the RT-PCR tests for 45 amplification cycles. Then, to interpret the data: when all controls exhibit the expected performance, a specimen is considered positive for SARS-CoV-2 if all SARS-CoV-2 marker (N1, N2) cycle threshold growth curves cross the threshold line within 40.00 cycles (< 40.00 Ct). The RNase P may or may not be positive as described above, but the SARS-CoV-2 result is still valid ([103]a).

Many false positives are possible in the upper part of this cycle threshold range, especially in areas of low prevalence. In particular, virus culture has been found to be unfeasible in cases with a Ct value exceeding 33. A prospective cohort study involving the first 100 COVID-19 patients in Singapore also showed that attempts to culture the virus failed in all PCR-positive samples with a Ct value >30" [121]. During mass testing in Germany, it was found "that more than half of individuals with positive PCR test results are unlikely to have been infectious" [122]. Another study found that tests with low specificity (deriving from use of many cycles) cannot provide strong evidence for the presence of an infection [123]. A systematic review of PCR testing concluded "Complete live viruses are necessary for transmission, not the fragments identified by PCR. Prospective

routine testing of reference and culture specimens and their relationship to symptoms, signs and patient co-factors should be used to define the reliability of PCR for assessing infectious potential. Those with high cycle threshold are unlikely to have infectious potential." [89].

As skeptics have argued, in the buildup of the pandemic, the rapid increase in numbers of COVID-19 cases was due in part to the high values of cycle threshold used in the tests. Unfortunately, the true numbers of false positives will probably be unobtainable if an audit were performed, since these values are not reported with the test results: all currently-available nucleic acid tests for SARS-CoV-2 are FDA-authorized as qualitative tests, and Ct values from qualitative tests should never be used to direct or inform patient management decisions. Therefore, it is not good for laboratories to include Ct values on patient reports [124].

After mass inoculations started, a large number of "breakthrough" cases emerged, and a total of 10,262 SARS-CoV-2 vaccine breakthrough infections had been reported from 46 U.S. states and territories as of April 30, 2021 [18]; the number of reported COVID-19 vaccine breakthrough cases is likely a substantial undercount of all SARS-CoV-2 infections among fully vaccinated persons. The national surveillance system relies on passive and voluntary reporting, and data might not be complete or representative. Many persons with vaccine breakthrough infections, especially those who are asymptomatic or who experience mild illness, might not seek testing [18].

This negative outcome of increased "breakthrough" cases motivated the CDC to change a number of reporting and test procedures and issue new regulations for identifying and investigating hospitalized or fatal vaccine breakthrough cases starting 1 May 2021, stating: "For cases with a known RT-PCR cycle threshold (Ct) value, submit only specimens with Ct value ≤28 to CDC for sequencing. (Sequencing is not feasible with higher Ct values.)". Thus, the Ct values for sequencing were lowered from the high false positive range allowed during the pandemic buildup to a limit that would eliminate many of these false positives in the 'breakthrough case' identification phase [101].

References

[1] D. Calina, T. Hartung, I. Mardare, M. Mitroi, K. Poulas, A. Tsatsakis, I. Rogoveanu, A.O. Docea, COVID-19 pandemic and alcohol consumption: impacts and interconnections, Toxicol. Rep. 8 (2021) 529–535.

[2] Coronavirus (COVID-19) Vaccinations. https://ourworldindata.org/covid-vaccinations [Accessed 2021].

[3] CDC, Vaccine Adverse Event Reporting System (VAERS) [Online]. Available: Vaccine Adverse Event Reporting System (VAERS) [Accessed 2021], 2021.

[4] R.N. Kostoff, D. Kanduc, A.L. Porter, Y. Shoenfeld, D. Calina, M.B. Briggs, D. A. Spandidos, A. Tsatsakis, Vaccine- and natural infection-induced mechanisms that could modulate vaccine safety, Toxicol. Rep. 7 (2020) 1448–1458.

[5] CORNELL, Definitions Relating to Taxable Vaccines [Online]. Available: https://www.law.cornell.edu/uscode/text/26/4132#a_2 [Accessed 4.06.2021], 2021.

[6] D.E. Martin, The Fauci/COVID-19 Dossier [Online]. Available: https://f.hubspotusercontent10.net/hubfs/8079569/The%20FauciCOVID-19%20Dossier.pdf [Accessed July 12, 2021], 2021.

[7] H. Levine, When Will Babies and Children Get the COVID-19 Vaccine? [Online]. Available: https://www.whattoexpect.com/news/first-year/covid19-vaccine-babies-children [Accessed 12 June 2021], 2021.

[8] A.O. Docea, A. Tsatsakis, D. Albulescu, O. Cristea, O. Zlatian, M. Vinceti, S. A. Moschos, D. Tsoukalas, M. Goumenou, N. Drakoulis, J.M. Dumanov, V. A. Tutelyan, G.G. Onischenko, M. Aschner, D.A. Spandidos, D. Calina, A new threat from an old enemy: Re-emergence of coronavirus (Review), Int. J. Mol. Med. 45 (2020) 1631–1643.

[9] A.L. Arsene, I.B. Dumitrescu, C.M. Dragoi, D.I. Udeanu, D. Lupuliasa, V. Jinga, D. Draganescu, C.E. Dinu-Pirvu, G. Dragomiroiu, I.E. Blejan, R.E. Moisi, A. C. Nicolae, H. Moldovan, D.E. Popa, B.S. Velescu, S. Ruta, A new era for the therapeutic management of the ongoing COVID-19 pandemic, Farmacia 68 (2020) 185–196.

[10] M. Goumenou, D. Sarigiannis, A. Tsatsakis, O. Anesti, A.O. Docea, D. Petrakis, D. Tsoukalas, R. Kostoff, V. Rakitskii, D.A. Spandidos, M. Aschner, D. Calina, COVID-19 in Northern Italy: an integrative overview of factors possibly influencing the sharp increase of the outbreak (Review), Mol. Med. Rep. 22 (2020) 20–32.

[11] M.T. Islam, M. Hossen, Z. Kamaz, A. Zali, M. Kumar, A.O. Docea, A.L. Arsene, D. Calina, J. Sharifi-Rad, The role of HMGB1 in the immune response to SARS-COV-2 infection: From pathogenesis towards A new potential therapeutic target, Farmacia 69 (2021) 621–634.

[12] P. Sidiropoulou, A.O. Docea, V. Nikolaou, M.S. Katsarou, D.A. Spandidos, A. Tsatsakis, D. Calina, N. Drakoulis, Unraveling the roles of vitamin D status and melanin during COVID-19 (Review), Int. J. Mol. Med. 47 (2021) 92–100.

[13] K. Farsalinos, K. Poulas, D. Kouretas, A. Vantarakis, M. Leotsinidis, D. Kouvelas, A.O. Docea, R. Kostoff, G.T. Gerotziafas, M.N. Antoniou, R. Polosa, A. Barbouni, V. Yiakoumaki, T.V. Giannouchos, P.G. Bagos, G. Lazopoulos, B.N. Izotov, V. A. Tutelyan, M. Aschner, T. Hartung, H.M. Wallace, F. Carvalho, J.L. Domingo, A. Tsatsakis, Improved strategies to counter the COVID-19 pandemic: lockdowns vs. Primary and community healthcare, Toxicol. Rep. 8 (2021) 1–9.

[14] A. Tsatsakis, D. Petrakis, T.K. Nikolouzakis, A.O. Docea, D. Calina, M. Vinceti, M. Goumenou, R.N. Kostoff, C. Mamoulakis, M. Aschner, A.F. Hernández, COVID-19, an opportunity to reevaluate the correlation between long-term effects of anthropogenic pollutants on viral epidemic/pandemic events and prevalence, Food Chem. Toxicol. 141 (2020) 111418.

[15] D. Calina, C. Sarkar, A.L. Arsene, B. Salehi, A.O. Docea, M. Mondal, M.T. Islam, A. Zali, J. Sharifi-Rad, Recent advances, approaches and challenges in targeting pathways for potential COVID-19 vaccines development, Immunol. Res. 68 (2020) 315–324.

[16] M.T. Islam, C. Quispe, M. Martorell, A.O. Docea, B. Salehi, D. Calina, Ž. Reiner, J. Sharifi-Rad, Dietary supplements, vitamins and minerals as potential interventions against viruses: perspectives for COVID-19, Int. J. Vitam. Nutr. Res. (2021) 1–18.

[17] J. Sharifi-Rad, C.F. Rodrigues, Z. Stojanovic-Radic, M. Dimitrijevic, A. Aleksic, K. Neffe-Skocinska, D. Zielinska, D. Kolozyn-Krajewska, B. Salehi, S.M. Prabu, F. Schutz, A.O. Docea, N. Martins, D. Calina, Probiotics: versatile bioactive components in promoting human health, Medicina-Lithuania 56 (2020) 30.

[18] CDC, COVID-19 Vaccine Breakthrough Case Investigation and Reporting [Online]. Available: https://www.cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html [Accessed 2021], 2021.

[19] M. Neagu, D. Calina, A.O. Docea, C. Constantin, T. Filippini, M. Vinceti, N. Drakoulis, K. Poulas, T.K. Nikolouzakis, D.A. Spandidos, A. Tsatsakis, Back to basics in COVID-19: antigens and antibodies-completing the puzzle, J. Cell. Mol. Med. 25 (2021) 4523–4533.

[20] A. Mandavilli, Your Coronavirus Test Is Positive. Maybe It Shouldn't Be [Online]. Available: https://www.nytimes.com/2020/08/29/health/coronavirus-testing.html [Accessed 11 May 2021], 2020.

[21] J. Mercola, Asymptomatic 'Casedemic' Is a Perpetuation of Needless Fear [Online]. Available: https://articles.mercola.com/sites/articles/archive/2020/11/19/covid-testing-fraud-fuels-casedemic.aspx?eType=EmailBlastContent&eId=0b802463-f128-49db-83f8-ecb922534dc4 [Accessed 22 March 2021], 2020.

[22] R.N. Kostoff, M.B. Briggs, A.L. Porter, A.F. Hernández, M. Abdollahi, M. Aschner, A. Tsatsakis, The under-reported role of toxic substance exposures in the COVID-19 pandemic, Food Chem. Toxicol. 145 (2020) 111687.

[23] R.N. Kostoff, M. Goumenou, A. Tsatsakis, The role of toxic stimuli combinations in determining safe exposure limits, Toxicol. Rep. 5 (2018) 1169–1172.

[24] Weekly Updates by Select Demographic and Geographic Characteristics. https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm?fbclid=IwAR3-wrg3tTKK5-9tOHPGAHWFVO3DfslkJ0KsDEPQpWmPbKtp6EsoVV2Qs1Q.

[25] M. Torequl Islam, M. Nasiruddin, I.N. Khan, S.K. Mishra, E.Z.M. Kudrat, T. Alam Riaz, E.S. Ali, M.S. Rahman, M.S. Mubarak, M. Martorell, W.C. Cho, D. Calina, A. O. Docea, J. Sharifi-Rad, A perspective on emerging therapeutic interventions for COVID-19, Front. Public Health 8 (2020) 281.

[26] H. Pott-Junior, M.M.B. Paoliello, A.D.Q.C. Miguel, A.F. Da Cunha, C.C. De Melo Freire, F.F. Neves, L.R. Da Silva De Avó, M.G. Roscani, S.D.S. Dos Santos, S.G. F. Chachá, Use of ivermectin in the treatment of Covid-19: a pilot trial, Toxicol. Rep. 8 (2021) 505–510.

[27] D. Calina, A.O. Docea, D. Petrakis, A.M. Egorov, A.A. Ishmukhametov, A. G. Gabibov, M.I. Shtilman, R. Kostoff, F. Carvalho, M. Vinceti, D.A. Spandidos, A. Tsatsakis, Towards effective COVID-19 vaccines: updates, perspectives and challenges (Review), Int. J. Mol. Med. 46 (2020) 3–16.

[28] C. Sarkar, M. Mondal, M. Torequl Islam, M. Martorell, A.O. Docea, A. Maroyi, J. Sharifi-Rad, D. Calina, Potential therapeutic options for COVID-19: current status, challenges, and future perspectives, Front. Pharmacol. 11 (2020) 572870.

[29] D. Calina, T. Hartung, A.O. Docea, D.A. Spandidos, A.M. Egorov, M.I. Shtilman, F. Carvalho, A. Tsatsakis, COVID-19 vaccines: ethical framework concerning human challenge studies, Daru 28 (2020) 807–812.

[30] D. Calina, A.F. Hernández, T. Hartung, A.M. Egorov, B.N. Izotov, T. K. Nikolouzakis, A. Tsatsakis, P.G. Vlachoyiannopoulos, A.O. Docea, Challenges and scientific prospects of the newest generation of mRNA-Based vaccines against SARS-CoV-2, Life 11 (2021) 907.

[31] A.F. Hernández, D. Calina, K. Poulas, A.O. Docea, A.M. Tsatsakis, Safety of COVID-19 vaccines administered in the EU: Should we be concerned? Toxicol. Rep. 8 (2021) 871–879.

[32] C. Wang, X. Zhou, M. Wang, X. Chen, The impact of SARS-CoV-2 on the human immune system and microbiome, Infect. Microbes Dis. 3 (2020) 14–21.

[33] FDA, Pfizer-BioNTech COVID-19 Vaccine [Online]. Available: https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine [Accessed 19 June 2021], 2021.

[34] E.E. Walsh, R.W. Frenck Jr., A.R. Falsey, N. Kitchin, J. Absalon, A. Gurtman, S. Lockhart, K. Neuzil, M.J. Mulligan, R. Bailey, K.A. Swanson, P. Li, K. Koury,

W. Kalina, D. Cooper, C. Fontes-Garfias, P.Y. Shi, Ö. Türeci, K.R. Tompkins, K. E. Lyke, V. Raabe, P.R. Dormitzer, K.U. Jansen, U. Şahin, W.C. Gruber, Safety and immunogenicity of two RNA-Based Covid-19 vaccine candidates, N. Engl. J. Med. 383 (2020) 2439–2450.
[35] R. Sahelian, Covid Vaccine Side Effects [Online]. Available: https://www.raysahelian.com/covidvaccinesideeffects.html [Accessed 15 July 2021], 2021.
[36] S. Seneff, G. Nigh, Worse than the disease? Reviewing some possible unintended consequences of the mRNA vaccines against COVID-19, Int. J. Vacc. Theory Practice Res. 2 (1) (2021) 38–79.
[37] Y. Lei, J. Zhang, Schiavon Cr, M. He, L. Chen, H. Shen, Y. Zhang, Q. Yin, Y. Cho, L. Andrade, Shadel Gs, M. Hepokoski, T. Lei, H. Wang, J. Zhang, Yuan Jx, A. Malhotra, U. Manor, S. Wang, Yuan Zy, Shyy Jy, SARS-CoV-2 spike protein impairs endothelial function via downregulation of ACE 2, Circ. Res. 128 (April (9)) (2021) 1323–1326, https://doi.org/10.1161/CIRCRESAHA.121.318902.
[38] G.J. Nuovo, C. Magro, T. Shaffer, H. Awad, D. Suster, S. Mikhail, B. He, J. J. Michaille, B. Liechty, E. Tili, Endothelial cell damage is the central part of COVID-19 and a mouse model induced by injection of the S1 subunit of the spike protein, Ann. Diagn. Pathol. 51 (2021) 151682.
[39] Y.J. Suzuki, S.G. Gychka, SARS-CoV-2 spike protein elicits cell signaling in human host cells: implications for possible consequences of COVID-19 vaccines, Vaccines 9 (2021) 36.
[40] E. Avolio, M. Gamez, K. Gupta, R. Foster, I. Berger, M. Caputo, A. Davidson, D. Hill, P. Madeddu, The SARS-CoV-2 Spike Protein Disrupts the Cooperative Function of Human Cardiac Pericytes - Endothelial Cells Through CD147 Receptor-mediated Signalling: a Potential Non-infective Mechanism of COVID-19 Microvascular Disease, bioRxiv, 2020.12.21.423721, 2020.
[41] S. Ndeupen, Z. Qin, S. Jacobsen, H. Estanbouli, A. Bouteau, B.Z. Igyártó, The mRNA-LNP Platform's Lipid Nanoparticle Component Used in Preclinical Vaccine Studies Is Highly Inflammatory, bioRxiv, 2021.
[42] P. Sellaturay, S. Nasser, S. Islam, P. Gurugama, P.W. Ewan, Polyethylene glycol (PEG) is a cause of anaphylaxis to the Pfizer/BioNTech mRNA COVID-19 vaccine, Clin. Exp. Allergy 51 (2021) 861–863.
[43] B.Z. Igyártó, S. Jacobsen, S. Ndeupen, Future considerations for the mRNA-lipid nanoparticle vaccine platform, Curr. Opin. Virol. 48 (2021) 65–72.
[44] O. Vera-Lastra, A. Ordinola Navarro, M.P. Cruz Domiguez, G. Medina, T. I. Sánchez Valadez, L.J. Jara, Two cases of graves' disease following SARS-CoV-2 vaccination: an Autoimmune/Inflammatory syndrome induced by adjuvants, Thyroid (2021).
[45] B.G. İremli, S.N. Şendur, U. Ünlütürk, Three cases of subacute thyroiditis following SARS-CoV-2 vaccine: postvaccination ASIA syndrome, J. Clin. Endocrinol. Metab. (2021).
[46] A.F. Ogata, C.A. Cheng, M. Desjardins, Y. Senussi, A.C. Sherman, M. Powell, L. Novack, S. Von, X. Li, L.R. Baden, D.R. Walt, Circulating SARS-CoV-2 vaccine antigen detected in the plasma of mRNA-1273 vaccine recipients, Clin. Infect. Dis. (2021).
[47] E.M. Rhea, A.F. Logsdon, K.M. Hansen, L.M. Williams, M.J. Reed, K.K. Baumann, S.J. Holden, J. Raber, W.A. Banks, M.A. Erickson, The S1 protein of SARS-CoV-2 crosses the blood–brain barrier in mice, Nat. Neurosci. 24 (2021) 368–378.
[48] T.P. Buzhdygan, B.J. Deore, A. Baldwin-Leclair, T.A. Bullock, H.M. Mcgary, J. A. Khan, R. Razmpour, J.F. Hale, P.A. Galie, R. Potula, A.M. Andrews, S. H. Ramirez, The SARS-CoV-2 spike protein alters barrier function in 2D static and 3D microfluidic in-vitro models of the human blood-brain barrier, Neurobiol. Dis. 146 (2020) 105131.
[49] A. Vojdani, E. Vojdani, D. Kharrazian, Reaction of human monoclonal antibodies to SARS-CoV-2 proteins with tissue antigens: implications for autoimmune diseases, Front. Immunol. 11 (2020), 617089.
[50] EMA, Signal Assessment Report on Embolic and Thrombotic Events (SMQ) With COVID-19 Vaccine (ChAdOx1-S [recombinant]) – Vaxzevria (previously COVID-19, 2021.
[51] P.R. Hunter, Thrombosis after covid-19 vaccination, BMJ 373 (2021) n958.
[52] H.A. Merchant, CoViD vaccines and thrombotic events: EMA issued warning to patients and healthcare professionals, J. Pharm. Policy Pract. 14 (2021) 32.
[53] Pfizer, SARS-CoV-2 mRNA Vaccine (BNT162, PF-07302048) [Online]. Available: https://www.pmda.go.jp/drugs/2021/P20210212001/672212000_30300AMX00231_I100_1.pdf [Accessed], 2021.
[54] S.M. Moghimi, Allergic reactions and anaphylaxis to LNP-Based COVID-19 vaccines, Mol. Ther. 29 (2021) 898–900.
[55] E. Shepherd, Injection Technique 1: Administering Drugs via the Intramuscular Route [Online]. Available: https://www.nursingtimes.net/clinical-archive/assessment-skills/injection-technique-1-administering-drugs-via-the-intramuscular-route-23-07-2018/ [Accessed 12 March 2021], 2018.
[56] J.J. Polania Gutierrez, S. Munakomi, Intramuscular injection. StatPearls, StatPearls Publishing LLC, Treasure Island (FL), 2021. StatPearls Publishing Copyright © 2021.
[57] J.S. Suk, Q. Xu, N. Kim, J. Hanes, L.M. Ensign, PEGylation as a strategy for improving nanoparticle-based drug and gene delivery, Adv. Drug Deliv. Rev. 99 (2016) 28–51.
[58] G. Vogel, Mixing vaccines may boost immune responses, Science 372 (2021) 1138.
[59] J. Sharifi-Rad, C.F. Rodrigues, F. Sharopov, A.O. Docea, A.C. Karaca, M. Sharifi-Rad, D. Kahveci Karincaoglu, G. Gulseren, E. Senol, E. Demircan, Y. Taheri, H.A. R. Suleria, B. Ozcelik, K.N. Kasapoglu, M. Gultekin-Ozguven, C. Daskaya-Dikmen, W.C. Cho, N. Martins, D. Calina, Diet, lifestyle and cardiovascular diseases: linking pathophysiology to cardioprotective effects of natural bioactive compounds, Int. J. Environ. Res. Public Health 17 (2020) 31.
[60] M. Sharifi-Rad, N.V.A. Kumar, P. Zucca, E.M. Varoni, L. Dini, E. Panzarini, J. Rajkovic, P.V.T. Fokou, E. Azzini, I. Peluso, A.P. Mishra, M. Nigam, Y. El Rayess, M. El Beyrouthy, L. Polito, M. Iriti, N. Martins, M. Martorell, A.O. Docea, W.N. Setzer, D. Calina, W.C. Cho, J. Sharifi-Rad, Lifestyle, oxidative stress, and antioxidants: back and forth in the pathophysiology of chronic diseases, Front. Physiol. 11 (2020) 21.
[61] S. Kuipers, S.C. Cannegieter, S. Middeldorp, L. Robyn, H.R. Büller, F. R. Rosendaal, The absolute risk of venous thrombosis after air travel: a cohort study of 8,755 employees of international organisations, PLoS Med. 4 (2007) e290-e290.
[62] R. Yang, Y. Deng, B. Huang, L. Huang, A. Lin, Y. Li, W. Wang, J. Liu, S. Lu, Z. Zhan, Y. Wang, A, R, W. Wang, P. Niu, L. Zhao, S. Li, X. Ma, L. Zhang, Y. Zhang, W. Yao, X. Liang, J. Zhao, Z. Liu, X. Peng, H. Li, W. Tan, A core-shell structured COVID-19 mRNA vaccine with favorable biodistribution pattern and promising immunity, Signal Transduct. Target. Ther. 6 (2021) 213.
[63] Novel coronavirus (COVID-19) https://www.cdc.gov/budget/fact-sheets/covid-19/index.html.
[64] C.C.E. Lee, K. Ali, D. Connell, I.R. Mordi, J. George, E.M. Lang, C.C. Lang, COVID-19-associated cardiovascular complications, Diseases (2021) 9.
[65] C. Matucci-Cerinic, R. Caorsi, A. Consolaro, S. Rosina, A. Civino, A. Ravelli, Multisystem inflammatory syndrome in children: unique disease or part of the Kawasaki disease spectrum? Front. Pediatr. (2021) 9.
[66] N.A. Nakra, D.A. Blumberg, A. Herrera-Guerra, S. Lakshminrusimha, Multi-system inflammatory syndrome in children (MIS-C) following SARS-CoV-2 infection: review of clinical presentation, hypothetical pathogenesis, and proposed management, Children (Basel, Switzerland) 7 (2020) 69.
[67] A. Farooq, F. Alam, A. Saeed, F. Butt, M.A. Khaliq, A. Malik, M. Chaudhry, M. Abdullah, Multisystem inflammatory syndrome in children and adolescents (MIS-C) under the setting of COVID-19: a review of clinical presentation, workup and management, Infect. Dis. (Auckl) 14 (2021), 11786337211026642.
[68] T.P. Vogel, K.A. Top, C. Karatzios, D.C. Hilmers, L.I. Tapia, P. Moceri, L. Giovannini-Chami, N. Wood, R.E. Chandler, N.P. Klein, E.P. Schlaudecker, M. C. Poli, E. Muscal, F.M. Munoz, Multisystem inflammatory syndrome in children and adults (MIS-C/A): case definition & guidelines for data collection, analysis, and presentation of immunization safety data, Vaccine 39 (2021) 3037–3049.
[69] R.K. Pilania, S. Singh, Kawasaki Disease. Periodic and Non-Periodic Fevers, 2019, pp. 45–63.
[70] R.P. Sundel, R.E. Petty, KAWASAKI DISEASE. Textbook of Pediatric Rheumatology, 2011, pp. 505–520.
[71] T.M. Nielsen, N.H. Andersen, C. Torp-Pedersen, P. Søgaard, K.H. Kragholm, Kawasaki disease, autoimmune disorders, and cancer: a register-based study, Eur. J. Pediatr. 180 (2021) 717–723.
[72] M.D. Hicar, Antibodies and immunity during Kawasaki disease, Front. Cardiovasc. Med. 7 (2020) 94.
[73] D. Kanduc, Y. Shoenfeld, Molecular mimicry between SARS-CoV-2 spike glycoprotein and mammalian proteomes: implications for the vaccine, Immunol. Res. 68 (2020) 310–313.
[74] K. Roe, Potential new treatments for Kawasaki disease, its variations, and multisystem inflammatory syndrome. SN Comprehensive Clinical Medicine, 2021, pp. 1–5.
[75] J. Kabeerdoss, R.K. Pilania, R. Karkhele, T.S. Kumar, D. Danda, S. Singh, Severe COVID-19, multisystem inflammatory syndrome in children, and Kawasaki disease: immunological mechanisms, clinical manifestations and management, Rheumatol. Int. 41 (2021) 19–32.
[76] Y. Wu, F.F. Liu, Y. Xu, J.J. Wang, S. Samadli, Y.F. Wu, H.H. Liu, W.X. Chen, H. H. Luo, D.D. Zhang, W. Wei, P. Hu, Interleukin-6 is prone to be a candidate biomarker for predicting incomplete and IVIG nonresponsive Kawasaki disease rather than coronary artery aneurysm, Clin. Exp. Med. 19 (2019) 173–181.
[77] H. Chaudhary, J. Nameirakpam, R. Kumrah, V. Pandiarajan, D. Suri, A. Rawat, S. Singh, Biomarkers for Kawasaki disease: clinical utility and the challenges ahead, Front. Pediatr. (2019) 7.
[78] K.J. Denby, D.E. Clark, L.W. Markham, Management of Kawasaki disease in adults, Heart 103 (2017) 1760–1769.
[79] ECDC, COVID-19 in Children and the Role of School Settings in Transmission - Second Update [Online]. Available: https://www.ecdc.europa.eu/sites/default/files/documents/COVID-19-in-children-and-the-role-of-school-settings-in-transmission-second-update.pdf [Accessed 10 July 2021], 2021.
[80] F. Busa, F. Bardanzellu, M.C. Pintus, V. Fanos, M.A. Marcialis, COVID-19 and school: to open or not to open, that is the question. the first review on current knowledge, Pediatr. Rep. 13 (2021) 257–278.
[81] J. Jung, M.J. Hong, E.O. Kim, J. Lee, M.N. Kim, S.H. Kim, Investigation of a nosocomial outbreak of coronavirus disease 2019 in a paediatric ward in South Korea: successful control by early detection and extensive contact tracing with testing, Clin. Microbiol. Infect. 26 (2020) 1574–1575.
[82] J. Lopez Bernal, N. Andrews, C. Gower, C. Robertson, J. Stowe, E. Tessier, R. Simmons, S. Cottrell, R. Roberts, M. O'doherty, K. Brown, C. Cameron, D. Stockton, J. Mcmenamin, M. Ramsay, Effectiveness of the Pfizer-BioNTech and Oxford-AstraZeneca vaccines on covid-19 related symptoms, hospital admissions, and mortality in older adults in England: test negative case-control study, BMJ (Clin. Res. Ed.) 373 (2021) n1088-n1088.
[83] T. Powell, E. Bellin, A.R. Ehrlich, Older adults and Covid-19: the most vulnerable, the hardest hit, Hastings Cent. Rep. 50 (2020) 61–63.
[84] CDC Wonder https://wonder.cdc.gov/controller/datarequest/D8;jsessionid=9B19C44D4E84BCEF41D794D1A6DF.

[85] V. Stoner, The Deadly COVID-19 Vaccine Coverup [Online]. Available: https://www.virginiastoner.com/writing/2021/5/4/the-deadly-covid-19-vaccine-coverup [Accessed June 4th 2021], 2021.

[86] J. Rose, A report on the US Vaccine Adverse Events Reporting System (VAERS) of the COVID-19 messenger ribonucleic acid (mRNA) biologicals, Sci. Publ. Health Pol. Law 2 (2021) 59–80.

[88] M.T. Islam, B. Salehi, O. Karampelas, J. Sharifi-Rad, A.O. Docea, M. Martorell, D. Calina, HIGH SKIN MELANIN CONTENT, VITAMIN D DEFICIENCY AND IMMUNITY: POTENTIAL INTERFERENCE FOR SEVERITY OF COVID-19, Farmacia 68 (2020) 970–983.

[89] T. Jefferson, E.A. Spencer, J. Brassey, C. Heneghan, Viral cultures for COVID-19 infectious potential assessment – a systematic review, Clin. Infect. Dis. (2020), https://doi.org/10.1093/cid/ciaa1764 ciaa1764.

[92] CDC, About The Vaccine Adverse Event Reporting System (VAERS) [Online]. Available: https://wonder.cdc.gov/vaers.html [Accessed 12 April, 2021], 2021.

[93] CDC, COVID-19 Vaccine Safety Updates [Online], Available: https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-06/03-COVID-Shimabukuro-508.pdf [Accessed 2 July 2021], 2021.

[94] CDC, COVID-19 Vaccine Breakthrough Infections Reported to CDC — United States, January 1–April 30, 2021 [Online]. Available: https://www.cdc.gov/mmwr/volumes/70/wr/mm7021e3.htm [Accessed May 29, 2021], 2021.

[95] CDC, COVID Data Tracker [Online]. Available: https://covid.cdc.gov/covid-data-tracker/#datatracker-home [Accessed], 2021.

[96] FDA, Vaccines and related biological products advisory committee December 10, 2020 Meeting Announcement [Online] (2020). Available: https://www.fda.gov/advisory-committees/advisory-committee-calendar/vaccines-and-related-biological-products-advisory-committee-december-10-2020-meeting-announcementVaccines [Accessed 3.05.2021].

[98] Clinicaltrials.Gov, Study to Describe the Safety, Tolerability, Immunogenicity, and Efficacy of RNA Vaccine Candidates Against COVID-19 in Healthy Individuals [Online]. Available: https://clinicaltrials.gov/ct2/show/NCT04368728 [Accessed June 12, 2021], 2021.

[100] Eric Kowarz, L.K. Jenny Reis, Silvia Bracharz, Stefan Kochanek, Rolf Marschalek, Vaccine-Induced Covid-19 Mimicry" Syndrome: splice reactions within the SARS-CoV-2 Spike open reading frame result in Spike protein variants that may cause thromboembolic events in patients immunized with vector-based vaccines. Research Square, 2021, https://doi.org/10.21203/rs.3.rs-558954/v1.

[101] CDC, Demographic Characteristics of People Receiving COVID-19 Vaccinations in the United States [Online]. Available: https://covid.cdc.gov/covid-data-tracker/#vaccination-demographic [Accessed July 11, 2021], 2021.

[102] CDC, Selected Adverse Events Reported After COVID-19 Vaccination [Online]. Available: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html [Accessed 5.06.2021], 2021.

[103] FDA, CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel [Online]. Available: https://www.fda.gov/media/134922/download [Accessed 21 May 2021], 2020.

[104] CDC, Clinical Questions about COVID-19: Questions and Answers [Online]. Available: https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html [Accessed 14.04.2021], 2021.

[105] V.V. Wojciechowski, D. Calina, K. Tsarouhas, A.V. Pivnik, A.A. Sergievich, V. V. Kodintsev, E.A. Filatova, E. Ozcagli, A.O. Docea, A.L. Arsene, E. Gofita, C. Tsitsimpikou, A.M. Tsatsakis, K.S. Golokhvast, A guide to acquired vitamin K coagulopathy diagnosis and treatment: the Russian perspective, Daru 25 (2017) 10.

[106] F.P. Polack, S.J. Thomas, N. Kitchin, J. Absalon, A. Gurtman, S. Lockhart, J. L. Perez, G. Pérez Marc, E.D. Moreira, C. Zerbini, R. Bailey, K.A. Swanson, S. Roychoudhury, K. Koury, P. Li, W.V. Kalina, D. Cooper, R.W. Frenck Jr., L. L. Hammitt, Ö. Türeci, H. Nell, A. Schaefer, S. Ünal, D.B. Tresnan, S. Mather, P. R. Dormitzer, U. Şahin, K.U. Jansen, W.C. Gruber, Safety and efficacy of the BNT162b2 mRNA Covid-19 vaccine, N. Engl. J. Med. 383 (2020) 2603–2615.

[107] S.H. Hodgson, K. Mansatta, G. Mallett, V. Harris, K.R.W. Emary, A.J. Pollard, What defines an efficacious COVID-19 vaccine? A review of the challenges assessing the clinical efficacy of vaccines against SARS-CoV-2, Lancet Infect. Dis. 21 (2021) e26–e35.

[108] C. Melenotte, A. Silvin, A.-G. Goubet, I. Lahmar, A. Dubuisson, A. Zumla, D. Raoult, M. Merad, B. Gachot, C. Hénon, E. Solary, M. Fontenay, F. André, M. Maeurer, G. Ippolito, M. Piacentini, F.-S. Wang, F. Ginhoux, A. Marabelle, G. Kroemer, L. Derosa, L. Zitvogel, Immune responses during COVID-19 infection, Oncoimmunology 9 (2020) 1807836.

[109] E.M. Agency, Assessment Report COVID-19 Vaccine Moderna. Procedure No. EMEA/H/C/005791/0000 [Online]. Available:, 2021 https://www.ema.europa.eu/en/documents/assessment-report/covid-19-vaccine-moderna-.

[110] W.E. Beyer, J. Mcelhaney, D.J. Smith, A.S. Monto, J.S. Nguyen-Van-Tam, A. D. Osterhaus, Cochrane re-arranged: support for policies to vaccinate elderly people against influenza, Vaccine 31 (2013) 6030–6033.

[111] S.P. Kaur, V. Gupta, COVID-19 vaccine: a comprehensive status report, Virus Res. 288 (2020) 198114.

[112] S.A. Madhi, V. Baillie, C.L. Cutland, M. Voysey, A.L. Koen, L. Fairlie, S. D. Padayachee, K. Dheda, S.L. Barnabas, Q.E. Bhorat, C. Briner, G. Kwatra, K. Ahmed, P. Aley, S. Bhikha, J.N. Bhiman, A.E. Bhorat, J. Du Plessis, A. Esmail, M. Groenewald, E. Horne, S.H. Hwa, A. Jose, T. Lambe, M. Laubscher, M. Malahleha, M. Masenya, M. Masilela, S. Mckenzie, K. Molapo, A. Moultrie, S. Oelofse, F. Patel, S. Pillay, S. Rhead, H. Rodel, L. Rossouw, C. Taoushanis, H. Tegally, A. Thombrayil, S. Van Eck, C.K. Wibmer, N.M. Durham, E.J. Kelly, T. L. Villafana, S. Gilbert, A.J. Pollard, T. De Oliveira, P.L. Moore, A. Sigal, A. Izu, Efficacy of the ChAdOx1 nCoV-19 Covid-19 vaccine against the B.1.351 variant, N. Engl. J. Med. 384 (2021) 1885–1898.

[113] A.T. Mccarty, Child poverty in the United States: a tale of devastation and the promise of hope, Sociol. Compass 10 (2016) 623–639.

[114] L. Monin, A.G. Laing, M. Muñoz-Ruiz, D.R. Mckenzie, I. Del Molino Del Barrio, T. Alaguthurai, C. Domingo-Vila, T.S. Hayday, C. Graham, J. Seow, S. Abdul-Jawad, S. Kamdar, E. Harvey-Jones, R. Graham, J. Cooper, M. Khan, J. Vidler, H. Kakkassery, S. Sinha, R. Davis, L. Dupont, I. Francos Quijorna, C. O'brien-Gore, P.L. Lee, J. Eum, M. Conde Poole, M. Joseph, D. Davies, Y. Wu, A. Swampillai, B. V. North, A. Montes, M. Harries, A. Rigg, J. Spicer, M.H. Malim, P. Fields, P. Patten, F. Di Rosa, S. Papa, T. Tree, K.J. Doores, A.C. Hayday, S. Irshad, Safety and immunogenicity of one versus two doses of the COVID-19 vaccine BNT162b2 for patients with cancer: interim analysis of a prospective observational study, Lancet Oncol. 22 (2021) 765–778.

[115] M. Gavriatopoulou, I. Ntanasis-Stathopoulos, E. Korompoki, E. Terpos, M. A. Dimopoulos, SARS-CoV-2 vaccines in patients with multiple myeloma, HemaSphere 5 (2021) e547-e547.

[116] T.T. Shimabukuro, S.Y. Kim, T.R. Myers, P.L. Moro, T. Oduyebo, L. Panagiotakopoulos, P.L. Marquez, C.K. Olson, R. Liu, K.T. Chang, S. R. Ellington, V.K. Burkel, A.N. Smoots, C.J. Green, C. Licata, B.C. Zhang, M. Alimchandani, A. Mba-Jonas, S.W. Martin, J.M. Gee, D.M. Meaney-Delman, Preliminary findings of mRNA Covid-19 vaccine safety in pregnant persons, N. Engl. J. Med. 384 (2021) 2273–2282.

[117] Y. Yan, Y. Pang, Z. Lyu, R. Wang, X. Wu, C. You, H. Zhao, S. Manickam, E. Lester, T. Wu, C.H. Pang, The COVID-19 vaccines: recent development, challenges and prospects, Vaccines 9 (2021) 349.

[118] M. Vadalà, D. Poddighe, C. Laurino, B. Palmieri, Vaccination and autoimmune diseases: is prevention of adverse health effects on the horizon? EPMA J. 8 (2017) 295–311.

[119] M.S. Islam, A.M. Kamal, A. Kabir, D.L. Southern, S.H. Khan, S.M.M. Hasan, T. Sarkar, S. Sharmin, S. Das, T. Roy, M.G.D. Harun, A.A. Chughtai, N. Homaira, H. Seale, COVID-19 vaccine rumors and conspiracy theories: the need for cognitive inoculation against misinformation to improve vaccine adherence, PLoS One 16 (2021), e0251605.

[120] M.S. Islam, T. Sarkar, S.H. Khan, A.H. Mostofa Kamal, S.M.M. Hasan, A. Kabir, D. Yeasmin, M.A. Islam, K.I. Amin Chowdhury, K.S. Anwar, A.A. Chughtai, H. Seale, COVID-19-Related infodemic and its impact on public health: a global social media analysis, Am. J. Trop. Med. Hyg. 103 (2020) 1621–1629.

[121] T.P. Velavan, C.G. Meyer, COVID-19: a PCR-defined pandemic, Int. J. Infect. Dis.: IJID 103 (2021) 278–279.

[122] A. Stang, J. Robers, B. Schonert, K.H. Jöckel, A. Spelsberg, U. Keil, P. Cullen, The performance of the SARS-CoV-2 RT-PCR test as a tool for detecting SARS-CoV-2 infection in the population, J. Infect. 83 (2021) 237–279.

[123] R.J. Klement, P.S. Bandyopadhyay, The epistemology of a positive SARS-CoV-2 test, Acta Biotheor. (2020) 1–17.

[124] D. Romero-Alvarez, D. Garzon-Chavez, F. Espinosa, E. Ligña, E. Teran, F. Mora, E. Espin, C. Albán, J.M. Galarza, J. Reyes, Cycle threshold values in the context of multiple RT-PCR testing for SARS-CoV-2, Risk Manag. Healthc. Policy 14 (2021) 1311–1317.

[125] A. Asandei, L. Mereuta, I. Schiopu, J. Park, C.H. Seo, Y. Park, et al., Non-receptor-mediated lipid membrane permeabilization by the SARS-CoV-2 spike protein S1 subunit, ACS Appl. Mater. Interfaces 12 (50) (2020) 55649–55658.

[126] L.R. Baden, H.M. ElSahly, B. Essink, K. Kotloff, S. Frey, R. Novak, et al., Efficacy and safety of the mRNA-1273 SARS-CoV-2 vaccine, N. Engl. J. Med. 384 (5) (2021) 403–416.

[127] A.N. Cohen, B. Kessel, M.G. Milgroom, Diagnosing SARS-CoV-2 infection: the danger of over-reliance on positive test results (2021), https://doi.org/10.1101/2020.04.26.20080911.