**Cover Letter for "Why I do not want to get the Covid-19 Vaccine" Report**

5/16/2021

In the report that follows, I explain why I do not want to get a Covid-19 vaccine at this time. I wrote this primarily for myself, and family members that had concerns about receiving the unapproved Covid-19 vaccines, especially when the vaccines might be mandated by an employer or school. I wanted to explore all aspects of this virus and vaccine, document my findings, and put together a report that could summarize my thoughts on why I did not want to receive the vaccine at this time. As family and friends helped me in the editing process, I realized others might want to see the information that I had compiled and consider for themselves whether or not they should get the vaccine at this time, so I've decided to put it out there for others to read.

To start, I want you to know that I am not an anti-vaxxer. I have received all my vaccines as a kid, I made sure my kids received their vaccines growing up, and I have also received the flu vaccine nearly every year. I'm a 60 year old male, in good health and close to normal weight. I have had a couple of serious adverse reactions to medications in the past. My current age and health, together with past personal and family medical concerns, along with many aspects of the Covid-19 vaccine that I will explore in this document, all played a part in me deciding not to get the vaccine, and I'll say it again: at this time.

While I am not a medical expert, I am college educated with a Bachelor of Science degree in Industrial Engineering. I've had a 36 year career in Engineering and Information Technology. Most important, I know how to read and study new and evolving issues with an open mind, looking at all viewpoints, and focusing on experts that speak with knowledge and experience. These days, many internet search and news sites, along with mainstream media, and even government entities do not make it easy to find information from experts that might contradict the popular narrative on many issues including Covid-19 and the vaccine. It takes some digging, but you can find legitimate and relevant information. I found reports from many medical experts including leading MD's and scientists that helped me to make my decision about the vaccine. These were legitimate and relevant voices that should be heard by everyone, so that they too can make a good decision regarding their own health.

When reading this, please understand I am NOT telling you "don't get the vaccine." Everyone needs to make their own decision on this, weighing their own risk factors for getting the virus along with the risks involved with the vaccine. Every person will be different. My hope is that everyone would do their own research, taking into account their own health, and then making an informed decision on whether or not to get the vaccine. If my document would help point you to some of the medical experts that would help you arrive at a decision, fantastic.

Sincerely,

Jim Watkins

8/27/21 - NOTE: I initially wrote this report in March/April 2021 and obviously the issues addressed have all evolved. I've updated numeric data occasionally, the last time being 8/7/21. There has been much more information released since the March/April time frame that solidifies my position even more. See the last couple of pages of this report for links to this information. Near the end of this document I've also included a couple of mini reports I wrote exploring these issues. Finally, on Monday 8/23/21 the FDA "fully approved" the Pfizer vaccine after only one year of testing. This is a rushed approval and my viewpoint on the vaccine has not changed. After three to five years of legitimate study, I might reconsider my opinion on this vaccine.

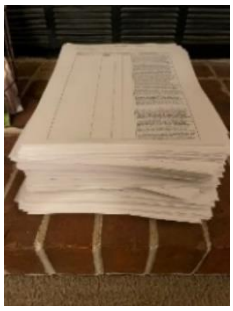
# Why I Choose to decline the Covid-19 Vaccine at this time

The first three pages of this document summarize the top reasons for my choice to decline the Covid-19 vaccine at this time. Starting on page five I give supporting information for many of these reasons. My decision is based upon personal medical experiences and on information from Medical Doctors, Juris Doctors (MD with Doctoral degree in Law), other PhD Scientists, experts, as well as from government, academic and other respected sources.

1. **Significant adverse events have been reported by many recipients of the Covid-19 vaccines.**

My primary reason for declining the Covid-19 vaccine is due to multiple severe adverse reactions I have experienced with past medical treatments, and a blood platelet disorder of an immediate family member which could be genetic and could be exacerbated by the vaccine. Because of these issues, it is very important that medical treatments I receive have been thoroughly tested and approved through the normal FDA drug approval process with side effects fully documented. That is not the case with these vaccines. They are not approved and not licensed by the FDA. Instead, they are *authorized* by the FDA under an EUA (Emergency Use Authorization), and as such they are still classified as experimental.

The fact that these vaccines are still experimental could explain the large number of adverse reactions being reported. On 8/7/21 the Vaccine Adverse Events Reporting System (VAERS) was reporting data submitted through 7/31/21 and showed 545,338 adverse events (up from nearly 191,774 on 5/14/21; 86,000 on 4/24/21 and 50,000 on 3/30/21). It also reported 12,366 deaths (up from 4434 on 5/10, 3487 on 4/24, 3005 on 4/12, and 2509 on 3/30). Prior to 5/14/21 the CDC stated on VAERS that *"there is no evidence that vaccination contributed to patient deaths."* When last checked on 5/14/21 their statement reads: "*A review of available clinical information, including death certificates, autopsy, and medical records has not established a causal link to COVID-19 vaccines. However, recent reports indicate a plausible causal relationship between the J&J/Janssen COVID-19 Vaccine and a rare and serious adverse event—blood clots with low platelets—which has caused deaths."* After reviewing these reports of adverse reactions including deaths, I believe that there is causal evidence of people dying after receiving a Covid-19 vaccine. With 12,366 deaths reported after approx. 191 million vaccinated with at least one dose (58% of US population), that equates to 1 death/15,406 vaccinated. That is a significant death rate, actually higher than the Covid-19 death rate for those under 17 years of age, of 1 death/50,000 infections. This number of deaths in the past would have surely resulted in the vaccine experiment being stopped, as the Swine Flu vaccine in 1976 was stopped after 25 deaths and 500+ Guillain-Barre syndrome cases. Clearly, this should be investigated and reported to the public. For a more recent comparison, my search of VAERS for Flu Vaccine deaths for 2020, 2019 and 2018 show: 25, 15 and 18 respectively, and total doses in millions for those years was 194, 168 and 155. This equates to a death rate for these recent Flu Vaccines of 1 death/7,760,000 vaccinated, 1/11,200,000 and 1/8,611,111 respectively. One death every: 15,406 Covid-19 shots vs. 7,760,000 Flu shots. That is significant. Why no red flags being raised on this issue for all to see?



Finally, to the right is a picture of a 900-page VAERS report of all Covid-19 adverse events for February and March 2021. This is a 5" thick report (nearly two reams of paper). My wife, an RN (BSN), printed and has been reading through this report. She is seeing that these are detailed and legitimate reports on significant adverse health events including death after receiving the vaccine. It includes cases of death within minutes or hours after vaccination. The events being logged in this system should be addressed, but they are being ignored or marginalized by the medical establishment and media. If you doubt this, google "Covid-19 VAERS" and see what the top results are. This concerns me and plays a big part in me declining the vaccine. See *#1 More info on Adverse Events* on page 5.

2. **Covid-19 has a low fatality rate for those less than 65.**

For someone my age, the risk of dying from Covid-19 is very low. I should be able to choose to risk getting the infection which my body will more than likely fight off, rather than get an experimental vaccine that has not undergone extensive long-term testing. Also see reference note #2 at end of report for supporting numeric info.

| | | | | |
|---|---|---|---|---|
| 0-17: | 20 deaths / 1,000,000 infections | =1 death / 50,000 infections | =0.002% chance of death | =99.998% survival rate |
| 18-49: | 500 deaths / 1,000,000 infections | =1 death / 2,000 infections | =0.05% chance of death | =99.95% survival rate |
| 50-64: | 6000 deaths / 1,000,000 infections | =1 death / 167 infections | =0.6% chance of death | =99.4% survival rate |
| 65+: | 90,000 deaths / 1,000,000 infections) | =1 death / 11 infections | =9.0% chance of death | =91.0% survival rate |

https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html *(dated 4/3/2021, see screen printed chart on last page)*

3. **These vaccines are investigational/experimental and should not be mandated to individuals.**
   As mentioned in #1 above, these Covid-19 vaccines have NOT been approved or licensed by the FDA. They have only been AUTHORIZED for emergency use. The FDA authorized the current Covid-19 vaccines under an Emergency Use Authorization (EUA) ruling, not under the normal FDA drug approval process. In doing so, the vaccines are specifically called investigational or experimental drugs and as such they cannot be mandated to individuals. Per the FDA guidelines, they can only be offered as a voluntary treatment, and that only after full disclosure of known issues with the treatment. This right of refusal stems from the Nuremburg Code which states that no one can be forced to take part in an experimental medical treatment. This was put in place after the Nazi medical experiments during World War 2. As the New England Journal of Medicine states: "The Nuremberg Code is the most important document in the history of the ethics of medical research." Additionally, standard drug testing typically takes at least two years or longer. These vaccines were released for widespread public distribution only seven months after their Phase 1 testing began. For example, Moderna supposedly started work on the Covid-19 vaccine in Jan 2020, then the 1st human trial in Mar 2020 (no legitimate animal trials), then the final Phase 3 trial began in Jul 2020 with the test conclusion and final report four months later in Nov 2020. I am not an anti-vaxxer, but I do not want something totally new and not fully tested put in my body. I trust past vaccines and medications because they went through the full FDA approval process. See *#3 More info on Drug Approval Process* page 11.
4. **mRNA is a new vaccine technique, and viral vector (i.e., DNA) method is very similar, both need more study.**
   Surprisingly both types of authorized vaccines utilize mRNA to produce the spike proteins found on the Covid-19 virus, they just do this in two different ways. The first two vaccines authorized were from Moderna and Pfizer. They each contain actual mRNA which finds its way into your cells and makes them produce the spike proteins of the Covid-19 virus. This mRNA method of treatment has been used to create proteins in the treatment of cancers and has shown promise, but it has never been used in a vaccine. The third vaccine authorized is from Johnson & Johnson and it is doing basically the same thing but is using the modified DNA from an adenovirus to make your cells produce the mRNA which then produces the same spike proteins inside your cells. Both methods result in an immune system response to those spike proteins. This should cause your immune system to attack the Covid-19 virus when encountered in the future. This is a new technique for coronavirus vaccines, getting your body to produce a part of the virus. There are concerns about your immune system attacking the cells of your body that are producing these spike proteins, which could explain the numerous different types of adverse reactions being reported. Now there is a report from the Salk Institute about how the spike proteins from the Covid-19 virus, and also created in your body from the vaccine, can lead to vascular damage, which could explain the stokes, heart attacks, and other adverse vascular events. Bottom line, there should have been more study of this new technique before being released into the general population. In addition, the age groups and those with no comorbidities that are not at high risk from this virus should not be pressured or forced into taking part in this vaccine experiment. See *#4 More info on the two types of vaccines* on page 15.
5. **Prior coronavirus vaccine attempts have failed – concerns about Immune Enhancement**
   Past Coronavirus vaccine attempts, and other disease vaccine attempts, have produced what is called Immune Enhancement. That term *Immune Enhancement* does not sound bad, but what it actually infers is concerning. There are concerns about two types of Immune Enhancement: Pathogenic Priming and Antibody-Dependent Enhancement (ADE). Pathogenic Priming occurs when you have previously had a disease or received a vaccination for the disease and you next encounter that virus in the wild. This next encounter can cause your immune system to overreact resulting in a massive and possibly fatal cytokine storm. ADE occurs when your immune system response actually helps the virus to attack your body. Picture the virus hidden amongst your own antibodies getting escorted by your immune system up to the doorstep of your cells. When this happens the infection is amplified and results in a much more severe illness. Reports suggest that the Phase 1 and Phase 2/3 studies conducted for these vaccines did not adequately study these potential issues, because there were not enough recipients studied that actually got the virus, and not enough time duration of study to see if these immune responses would happen. With the past history of these types of reactions from newly developed vaccines, more time and effort should've been spent to determine if these issues were a possible outcome. See *#5 More info on Pathogenic Priming and ADE* on page 17.
6. **Why do people that have had Covid-19 need the vaccine?**
   After experiencing a medical scare in April 2020, two of my doctors (primary care physician and cardiologist) believed that I may have had an early case of Covid-19 back in late January and early February, and the side effects of that infection could have caused the severe symptoms that I was experiencing at that time. Common medical understanding is that once you have had a viral infection your body's immune system keeps a "memory" of that

infection. It can then quickly "recreate" the immune defenses necessary to put the disease down if you ever encounter it again. However, with the Covid-19 infection many in the medical establishment are pushing for those that were infected and survived to now get the vaccine. Studies have determined that your body does keep a "memory" of the Covid-19 virus for at least eight months, and they believe that this memory will in fact last years. Bottom line, if you were infected with Covid-19 and survived, then your body now knows how to kill the Covid-19 virus and it will not forget this for quite some time. You do not need a vaccine on top of the immunity you already have. This push by the government and many in the medical establishment and media to vaccinate those that already survived the disease raises big red flags for me. See *#6 More info on Infection Immunity* on page 22.

7. **Information related to Covid-19 vaccine and alternative treatments is being censored.**
   The government entities, the drug companies, the media, and major social media are not allowing a fair and open discussion of these vaccines and other Covid related issues. Prominent doctors and scientists with alternative views are blocked on these major platforms from expressing their concerns. Top medical journals had to retract fraudulent published studies on alternative treatments. They are not only censoring, but actually attempting to destroy the careers and livelihoods of those with dissenting views. This creates a high degree of mistrust with many people, and is a disservice to the general public, depriving them of the opportunity to hear both sides of the story. See *#7 More info on Censoring* on page 24.
8. **If Coworkers, colleagues, patients, etc are already vaccinated, they should be safe.**
   First, the CDC is recommending employers handle Covid-19 workplace vaccination the same as for recent Flu vaccinations. They do not recommend mandating the vaccine. Second, the recent narrative for pressuring people to get the vaccine is that you should get it to protect others and if you don't, selfishness and carelessness is presumed. This narrative is amiss. The primary reason for getting a vaccine is to protect yourself. Those that are vaccinated should be safe from the virus. In the past with the flu vaccine, employers would offer (not mandate) flu vaccines to protect each individual employee from getting the flu and thus reduce the chance of those in the office getting the flu. However, you were not forced to get it, which shows it was directed more at an individual's protection thereby reducing that employee's chance of getting sick and missing work, and not protecting vaccinated employees from non-vaccinated. If it was meant to protect employees from one another, that narrative surely would have been clearly stated, but it never was in my 36 years in the corporate workforce. Finally, with these vaccines it is still possible to get the virus if you are exposed, but the manufacturers state that you will get a lessor case of the illness. Whether you are vaccinated or not, if you are exposed to the virus it is possible to spread the virus, but those that are vaccinated should be safe from a serious illness, so no need to force the vaccine. See *#8 More info on Vaccinated are Safe* on page 26.

The remaining points below do not necessarily relate to me and my decision but would be relevant to family and friends that may be considering the same need to decline the vaccine.

9. **Possible impact to existing and future pregnancies**
   There are legitimate concerns about existing pregnancies, and even the ability to have future pregnancies after this vaccine. There has not been enough time to study for a proper conclusion on this topic. See *#9 More info on Pregnancy Concerns* on page 27. (I included this reason for my three daughters also dealing with this issue.)
10. **Flu death rate is greater than the Covid-19 rate for ages <50yrs**
    The death rate for recent flu seasons was higher than that of Covid-19 for those under age 50. During those flu seasons, the flu vaccine was not mandated. Those at risk of complications from flu are encouraged to get the flu vaccine. Those that want to reduce the chances of getting the flu can also voluntarily get it. The same should be true for the Covid-19 vaccine. Instead of mandating the vaccine for everyone, attention should be focused on protection/prevention of those more vulnerable to this virus due to age or comorbidities. Also see reference note #2 at end of report for supporting numeric info.
    2019-2020: 22,000 deaths from 38,000,000 flu cases = 579 deaths / 1,000,000 infections =1 death / 1727 infections
    2018-2019: 34,000 deaths from 36,000,000 flu cases = 944 deaths / 1,000,000 infections =1 death / 1059 infections
    2017-2018: 61,000 deaths from 45,000,000 flu cases = 1356 deaths / 1,000,000 infections =1 death / 737 infections
    https://www.cdc.gov/flu/about/burden/past-seasons.html
11. **Possible consequences for entities that mandate the experimental vaccines authorized under an EUA:**
    As explained in #3 above, individuals have the right to refuse this experimental medical treatment. Those entities that mandate an EUA vaccination are breaking FDA recommendations, and will not have the legal protection afforded the pharmaceutical companies and medical centers involved in distribution of the vaccines. They could be held responsible for any complications the person experiences due to the forced vaccine. The LSU School of

Dentistry recently rescinded their mandate for students and faculty. See *#11 More info on Consequences* on page 28.

**The following pages contain more information on many of the bulleted items above. Much of this is relevant information copied from various online reports. This copied text is *italicized* with reference notes. I included the many excerpts from the online sources not only to make it easier on the reader to consider the relevant info from the sources, but also to protect from the possibility that this information might disappear from the web due to censoring.**

Note: I am very grateful for the MD's and JD's that wrote the America's Frontline Doctors report (AFDR) found here: *https://www.americasfrontlinedoctors.com/wp-content/uploads/Vaccine-PP.pdf*
These Doctors put their careers and reputations on the line, just to share many truths about this virus, therapeutic treatments and the vaccines. Many of these truths that they shared were contrary to what the political, medical, media and social media/tech establishments were forcing on the public as the only allowable narrative that could be heard. They have indeed paid the price for expressing their experiences and beliefs.

This report from AFD helped me early on, to understand the many issues related to Covid-19 and the vaccine. I will include many excerpts from this report and reports that it references. All excerpts and references taken from this report will be footnoted as "1" with page # to help in locating the info within their document. Example: [1 (p1)]

## #1 More info on Adverse Events

The CDC provides an online system VAERS (Vaccine Adverse Event Reporting System) for medical personnel as well as the general public to submit adverse events. This system has been likened to a canary in a mine. With VAERS, adverse events being quickly reported can help authorities to recognize a potential problem with a vaccine. The CDC allows the public to freely search this system. This is a powerful tool and many are using it during this pandemic to monitor the adverse reactions of the new vaccines. The CDC introduces this site as follows:

*Important things to know about VAERS*
*-VAERS is an early warning system used to monitor adverse events that happen after vaccination. VAERS is the frontline system of a comprehensive vaccine safety monitoring program in the United States. It is one of several systems CDC and the US Food and Drug Administration (FDA) use to help ensure all vaccines, including COVID-19 vaccines, are safe.*
*-VAERS gives vaccine safety experts valuable information so they can assess possible safety concerns related to vaccines, including new COVID-19 vaccines. It is especially useful for quickly detecting unusual or unexpected patterns of health problems (also called "adverse events") that might indicate a possible safety problem with a vaccine.*
*-If a health problem is reported to VAERS, that doesn't mean that the vaccine caused the problem. It warns vaccine safety experts of potential problems that may need investigation and alerts them to take further action, as needed.*
*-Millions of people in the United States have received COVID-19 vaccines. Other than rare reports of severe allergic reactions, analysis of VAERS reports has not detected any patterns that would indicate a safety problem with COVID-19 vaccines.*
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vaers.html

Okay, fair enough for them to present the system in this way. However, when you read through the individual reports of adverse reactions, it is clear that there are legitimate adverse reactions occurring with people after receiving this vaccine. In this section, I present examples of the adverse reactions being reported in VAERS, starting with those resulting in death, then some other important specific reactions, and near the end I show six individuals reports as an example of what is being reported.

In regard to reports of death after vaccine, the CDC reports the following:

### Reports of death after COVID-19 vaccination

**To date, Vaccine Adverse Event Reporting System (VAERS) has not detected patterns in cause of death that would indicate a safety problem with COVID-19 vaccines.**

- FDA requires vaccination providers to report any death after COVID-19 vaccination to VAERS.
- Reports of death to VAERS following vaccination do not necessarily mean the vaccine caused the death.
- CDC follows up on any report of death to request additional information and learn more about what occurred and to determine whether the death was a result of the vaccine or unrelated.
- CDC, FDA, and other federal partners will continue to monitor the safety of COVID-19 vaccines.

Over 211 million doses of COVID-19 vaccines were administered in the United States from December 14, 2020, through April 19, 2021. During this time, VAERS received 3,486 reports of death (0.0016%) among people who received a COVID-19 vaccine. CDC and FDA physicians review each case report of death as soon as notified and CDC requests medical records to further assess reports. **A review of available clinical information including death certificates, autopsy, and medical records revealed no evidence that vaccination contributed to patient deaths.** CDC and FDA will continue to investigate reports of adverse events, including deaths, reported to VAERS.

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html

Although they report 3486 deaths, they also state that there is "no evidence that vaccination contributed to patient deaths."

This report below presents interesting findings from the VAERS system as of 3-26-2021:

*Number of COVID Vaccine Injuries Reported to VAERS Surpasses 50,000, CDC Data Show*
*VAERS data released today showed 50,861 reports of adverse events following COVID vaccines, including 2,249 deaths and 7,726 serious injuries between Dec. 14, 2020 and March 26, 2021.*

*Data released today by the Centers for Disease Control and Prevention (CDC) on the number of injuries and deaths reported to the Vaccine Adverse Event Reporting System (VAERS) following COVID vaccines revealed steadily rising numbers, but no new trends. VAERS is the primary mechanism for reporting adverse vaccine reactions in the U.S. Reports submitted to VAERS require further investigation before a causal relationship can be confirmed.*

*Every Friday, VAERS makes public all vaccine injury reports received to the system as of Friday of the previous week. Today's data show that between Dec. 14, 2020, and March 26, a total of 50,861 total adverse events were reported to VAERS, including 2,249 deaths — an increase of 199 over the previous seven days — and 7,726 serious injuries, up 631 over the same time period.*

*Of the 2,249 deaths reported as of March 26, 28% occurred within 48 hours of vaccination, 19% occurred within 24 hours and 43% occurred in people who became ill within 48 hours of being vaccinated.In the U.S., 136.7 million COVID vaccine doses had been administered as of March 26.*
http://republicbroadcasting.org/news/cdc-data-show-covid-vaccine-injuries-reported-to-vaers-surpasses-50000/

This report had an interesting take on the Covid-19 deaths vs. all previous vaccine deaths from 2005-2020, here's an excerpt:

*The CDC announced this week that deaths reported to the Vaccine Adverse Event Reporting System (VAERS), a U.S. Government funded database that tracks injuries and deaths caused by vaccines, following experimental COVID injections, have now reached 3,486 deaths since December of 2020, when the Pfizer and Moderna mRNA COVID shots were given emergency use authorization (EUA) by the FDA.*

*To get a perspective on the magnitude of deaths following COVID shots that are being reported to the CDC, there were only 3,445 deaths reported to the CDC following all vaccines from 1/1/2005 through 11/30/2020, the 15-year period prior to the FDA issuing emergency use authorizations for experimental COVID injections in December of 2020.*
https://healthimpactnews.com/2021/mass-murder-3486-deaths-in-the-u-s-following-covid-injections-in-4-months-more-vaccine-deaths-recorded-than-the-past-15-years-combined/

Other adverse reactions mentioned in the America's Frontline Doctors Report from December 2020 (the numeric data is dated, I provide an update on these numbers immediately below it):

*Other known complications of vaccines include neurological diseases such as transverse myelitis, Bells' Palsy multiple sclerosis, autism, and Guillain-Barre… The extremely limited COVID-19 vaccine data already has at least two transverse myelitis cases and four Bell's Palsy cases that may be linked to vaccination.* [1 (p15)and:]
https://www.nature.com/articles/d41586-020-02706-6

Updated adverse reactions numeric data from VAERS 4/24/2021 http://wonder.cdc.gov/vaers.html

Anaphylactic Reactions: 466 cases
Guillain-Barre: 96 cases
Blood clotting issue: 208 cases
Bell's Palsy and Facial Paralysis: 253+550=803 cases
Transverse Myelitis (spinal cord inflammation): 32 cases

On 4/13, the FDA and CDC issued a recommendation to pause the Johnson & Johnson (Jannsen) vaccine due to a small number of cases of blood clotting in women aged 18-48. In a 4/24/21 search of VAERS for cases of thrombosis (blood clotting), the following is reported:

**Messages:**
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 200 total events.

| Symptoms | Vaccine | Events Reported | Percent (of 200) |
|---|---|---|---|
| THROMBOSIS | COVID19 (COVID19 (JANSSEN)) (1203) | 44 | 22.00% |
| | COVID19 (COVID19 (MODERNA)) (1201) | 68 | 34.00% |
| | COVID19 (COVID19 (PFIZER-BIONTECH)) (1200) | 95 | 47.50% |
| | COVID19 (COVID19 (UNKNOWN)) (1202) | 1 | 0.50% |
| | **Total** | **208** | **104.00%** |
| **Total** | | **208** | **104.00%** |

https://wonder.cdc.gov/vaers.html

It is interesting that all three vaccines are reporting blood clotting issues, but only the J&J had been recommended for a pause. CNBC and WSJ reports that Johnson & Johnson asked the other vaccine makers to join with them to investigate these blood clotting issues but they both declined.
*https://www.fda.gov/news-events/press-announcements/joint-cdc-and-fda-statement-johnson-johnson-covid-19-vaccine*
*https://www.cnbc.com/2021/04/16/jj-asked-pfizer-moderna-to-help-study-blood-clots-but-they-declined-wsj.html*

Regarding Anaphylactic Reactions (severe allergic reactions), the CDC says:

*Anaphylaxis after COVID-19 vaccination is rare and occurred in approximately 2 to 5 people per million vaccinated in the United States based on events reported to VAERS. If you have a history of allergic reactions to medications, etc, this could be problematic.*
*https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html*

The biggest concerns for severe allergic reactions are as follows:

*The mRNA vaccines from BioNTech/Pfizer contain polyethylene glycol (PEG). 70% of people develop antibodies against this substance – this means that many people can develop allergic, potentially fatal reactions to the vaccination.* [1 (p28)]

The Johnson & Johnson vaccine contains Polysorbate 80 which can also cause severe allergic reactions. The CDC recommends those with allergies to any ingredients in the three EUA vaccines, not get the vaccine.
*https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/janssen.html*

Bottom line on severe allergic reactions is, you need to look at all the ingredients in the vaccine to see if you might be susceptible to an allergic reaction. Links below provide information on vaccine ingredients.
*https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/specific-groups/allergies.html*
Pfizer vaccine general info and ingredients:
*https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/Pfizer-BioNTech.html*
*https://www.fda.gov/media/144414/download#page=2*
Moderna vaccine general info and ingredients:
*https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/Moderna.html*
*https://www.fda.gov/media/144638/download#page=2*
Johnson & Johnson (Janssen) vaccine general info and ingredients:
*https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/Janssen.html*
*https://www.fda.gov/media/146305/download#page=2*

## SOME REAL WORLD EXAMPLES OF VAERS REPORTS:

As explained on page 1, my wife printed out two months (February and March) of VAERS reports, and then read through them. When you read through these, you realize that the majority are legitimate adverse reports, and they each tell a story that should be heard. I thought it important to include a few in this report. Below are six actual individual reports of death from the VAERS system to give you an example of what is being reported in this system:

## Details for VAERS ID: 1098028-1

| Event Information | | | |
|---|---|---|---|
| **Patient Age** | 32.00 | **Sex** | Male |
| **State / Territory** | New York | **Date Report Completed** | 2021-03-14 |
| **Date Vaccinated** | 2021-03-13 | **Date Report Received** | 2021-03-14 |
| **Date of Onset** | 2021-03-14 | **Date Died** | 2021-03-14 |
| **Days to onset** | 1 | | |
| **Vaccine Administered By** | Unknown | **Vaccine Purchased By** | Not Applicable * |
| **Mfr/Imm Project Number** | NONE | **Report Form Version** | 2 |
| **Recovered** | No | **Serious** | Yes |

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"Not Applicable" will appear when information is not available on this report form version.

| Event Categories | |
|---|---|
| **Death** | Yes |
| **Life Threatening** | No |
| **Permanent Disability** | No |
| **Congenital Anomaly / Birth Defect *** | No |
| **Hospitalized** | No |
| **Days in Hospital** | None |
| **Existing Hospitalization Prolonged** | No |
| **Emergency Room / Office Visit **** | N/A |
| **Emergency Room *** | No |
| **Office Visit *** | No |

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"N/A" will appear when information is not available on this report form version.

| Vaccine Type | Vaccine | Manufacturer | Lot | Dose | Route | Site |
|---|---|---|---|---|---|---|
| COVID19 VACCINE | COVID19 (COVID19 (JANSSEN)) | JANSSEN | NONE | UNK | | |

| Symptom |
|---|
| CARDIAC ARREST |
| DEATH |

32 yr old, death 12 hrs after vaccine

| Adverse Event Description |
|---|
| Cardiac arrest, death approx 12 hours later |

## Details for VAERS ID: 1111683-1

| Event Information | | | |
|---|---|---|---|
| **Patient Age** | 73.00 | **Sex** | Male |
| **State / Territory** | Arkansas | **Date Report Completed** | 2021-03-18 |
| **Date Vaccinated** | 2021-03-15 | **Date Report Received** | 2021-03-18 |
| **Date of Onset** | 2021-03-16 | **Date Died** | 2021-03-17 |
| **Days to onset** | 1 | | |
| **Vaccine Administered By** | Pharmacy * | **Vaccine Purchased By** | Not Applicable * |
| **Mfr/Imm Project Number** | NONE | **Report Form Version** | 2 |
| **Recovered** | No | **Serious** | Yes |

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"Not Applicable" will appear when information is not available on this report form version.

| Event Categories | |
|---|---|
| **Death** | Yes |
| **Life Threatening** | No |
| **Permanent Disability** | No |
| **Congenital Anomaly / Birth Defect *** | No |
| **Hospitalized** | No |
| **Days in Hospital** | None |
| **Existing Hospitalization Prolonged** | No |
| **Emergency Room / Office Visit **** | N/A |
| **Emergency Room *** | No |
| **Office Visit *** | No |

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"N/A" will appear when information is not available on this report form version.

| Vaccine Type | Vaccine | Manufacturer | Lot | Dose | Route | Site |
|---|---|---|---|---|---|---|
| COVID19 VACCINE | COVID19 (COVID19 (MODERNA)) | MODERNA | 023M20A | 1 | IM | LA |

| Symptom |
|---|
| ABDOMINAL DISCOMFORT |
| DEATH |
| PAIN IN EXTREMITY |
| PYREXIA |

| Adverse Event Description |
|---|
| Patient's niece reported that the patient's arm became sore, had stomach upset, fever the day after the vaccine. The following day the patient died. |

## Details for VAERS ID: 1076188-1

| Event Information | | | |
|---|---|---|---|
| **Patient Age** | 65.00 | **Sex** | Male |
| **State / Territory** | North Carolina | **Date Report Completed** | 2021-03-05 |
| **Date Vaccinated** | 2021-02-20 | **Date Report Received** | 2021-03-05 |
| **Date of Onset** | 2021-02-20 | **Date Died** | 2021-02-21 |
| **Days to onset** | 0 | | |
| **Vaccine Administered By** | Private | **Vaccine Purchased By** | Not Applicable * |
| **Mfr/Imm Project Number** | NONE | **Report Form Version** | 2 |
| **Recovered** | No | **Serious** | Yes |

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"Not Applicable" will appear when information is not available on this report form version.

| Event Categories | |
|---|---|
| **Death** | Yes |
| **Life Threatening** | No |
| **Permanent Disability** | No |
| **Congenital Anomaly / Birth Defect *** | No |
| **Hospitalized** | Yes |
| **Days in Hospital** | 1 |
| **Existing Hospitalization Prolonged** | No |
| **Emergency Room / Office Visit **** | N/A |
| **Emergency Room *** | No |
| **Office Visit *** | No |

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"N/A" will appear when information is not available on this report form version.

| Vaccine Type | Vaccine | Manufacturer | Lot | Dose | Route | Site |
|---|---|---|---|---|---|---|
| COVID19 VACCINE | COVID19 (COVID19 (PFIZER-BIONTECH)) | PFIZER\BIONTECH | EN6203 | 1 | IM | RA |

| Symptom |
|---|
| ACUTE KIDNEY INJURY |
| CARDIAC ARREST |
| DEATH |
| ISCHAEMIC HEPATITIS |
| RESPIRATORY FAILURE |
| SHOCK |

| Adverse Event Description |
|---|
| Out of hospital cardiac arrest and refractory shock, acute kidney injury, shock liver, respiratory failure leading to death |

## Details for VAERS ID: 1040877-1

| Event Information | | | |
|---|---|---|---|
| **Patient Age** | 58.00 | **Sex** | Female |
| **State / Territory** | Hawaii | **Date Report Completed** | 2021-02-19 |
| **Date Vaccinated** | 2021-02-18 | **Date Report Received** | 2021-02-19 |
| **Date of Onset** | 2021-02-18 | **Date Died** | 2021-02-18 |
| **Days to onset** | 0 | | |
| **Vaccine Administered By** | Private | **Vaccine Purchased By** | Not Applicable * |
| **Mfr/Imm Project Number** | NONE | **Report Form Version** | 2 |
| **Recovered** | No | **Serious** | Yes |

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"Not Applicable" will appear when information is not available on this report form version.

| Event Categories | |
|---|---|
| **Death** | Yes |
| **Life Threatening** | No |
| **Permanent Disability** | No |
| **Congenital Anomaly / Birth Defect *** | No |
| **Hospitalized** | No |
| **Days in Hospital** | None |
| **Existing Hospitalization Prolonged** | No |
| **Emergency Room / Office Visit **** | N/A |
| **Emergency Room *** | No |
| **Office Visit *** | No |

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"N/A" will appear when information is not available on this report form version.

| Vaccine Type | Vaccine | Manufacturer | Lot | Dose | Route | Site |
|---|---|---|---|---|---|---|
| COVID19 VACCINE | COVID19 (COVID19 (MODERNA)) | MODERNA | NONE | UNK | | |

| Symptom |
|---|
| CARDIAC ARREST |
| DEATH |

Death 45 min after vaccine

| Adverse Event Description |
|---|
| unknown if related to vaccine. patient received 2nd vaccine at 0830, observed 15 minutes, discharged, arrested at 0915 upon entering her home. vaccine was administered by DOH at their community location. patient was pronounced lifeless in the ED. |

## Details for VAERS ID: 1127657-1

| Event Information | | | |
|---|---|---|---|
| **Patient Age** | 76.00 | **Sex** | Female |
| **State / Territory** | Rhode Island | **Date Report Completed** | 2021-03-23 |
| **Date Vaccinated** | 2021-03-22 | **Date Report Received** | 2021-03-23 |
| **Date of Onset** | 2021-03-22 | **Date Died** | 2021-03-23 |
| **Days to onset** | 0 | | |
| **Vaccine Administered By** | Public | **Vaccine Purchased By** | Not Applicable * |
| **Mfr/Imm Project Number** | NONE | **Report Form Version** | 2 |
| **Recovered** | No | **Serious** | Yes |

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"Not Applicable" will appear when information is not available on this report form version.

| Event Categories | |
|---|---|
| **Death** | Yes |
| **Life Threatening** | Yes |
| **Permanent Disability** | No |
| **Congenital Anomaly / Birth Defect *** | No |
| **Hospitalized** | Yes |
| **Days in Hospital** | 1 |
| **Existing Hospitalization Prolonged** | No |
| **Emergency Room / Office Visit **** | N/A |
| **Emergency Room *** | Yes |
| **Office Visit *** | No |

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"N/A" will appear when information is not available on this report form version.

| Vaccine Type | Vaccine | Manufacturer | Lot | Dose | Route | Site |
|---|---|---|---|---|---|---|
| COVID19 VACCINE | COVID19 (COVID19 (PFIZER-BIONTECH)) | PFIZER\BIONTECH | ER2613 | 2 | IM | RA |

| Symptom |
|---|
| CARDIAC ARREST |
| CARDIO-RESPIRATORY ARREST |
| ENDOTRACHEAL INTUBATION |
| RESUSCITATION |

Death 1hr after vaccine

| Adverse Event Description |
|---|
| Cardiopulmonary arrest at home @ 1 hour after vaccine administration. CPR by EMS to today hospital for asystolic cardiac arrest. Pt. Intubated then terminally extubated |

## Details for VAERS ID: 1121695-1

| Event Information | | | |
|---|---|---|---|
| **Patient Age** | 21.00 | **Sex** | Male |
| **State / Territory** | California | **Date Report Completed** | 2021-03-22 |
| **Date Vaccinated** | 2021-03-10 | **Date Report Received** | 2021-03-22 |
| **Date of Onset** | 2021-03-10 | **Date Died** | 2021-03-01 |
| **Days to onset** | 0 | | |
| **Vaccine Administered By** | Private | **Vaccine Purchased By** | Not Applicable * |
| **Mfr/Imm Project Number** | NONE | **Report Form Version** | 2 |
| **Recovered** | No | **Serious** | Yes |

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"Not Applicable" will appear when information is not available on this report form version.

21 yrs old

| Event Categories | |
|---|---|
| **Death** | Yes |
| **Life Threatening** | No |
| **Permanent Disability** | No |
| **Congenital Anomaly / Birth Defect *** | No |
| **Hospitalized** | Yes |
| **Days in Hospital** | 5 |
| **Existing Hospitalization Prolonged** | No |
| **Emergency Room / Office Visit **** | N/A |
| **Emergency Room *** | No |
| **Office Visit *** | No |

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"N/A" will appear when information is not available on this report form version.

| Vaccine Type | Vaccine | Manufacturer | Lot | Dose | Route | Site |
|---|---|---|---|---|---|---|
| COVID19 VACCINE | COVID19 (COVID19 (PFIZER-BIONTECH)) | PFIZER\BIONTECH | NONE | UNK | | |

| Adverse Event Description |
|---|
| The patient, who has no significant past medical history including diabetes, presented with very severe diabetic ketoacidosis one week after receiving the vaccine. He developed severe metabolic encephalopathy, aspiration pneumonia, and was placed on mechanical ventilation. At the time of this reporting, he is brain death (awaiting apnea test confirmation). He is expected not to survive. |

Finally, as alluded to in my initial summary, many in the media are trying to discount VAERS data, portraying it as being manipulated or abused by anti-vaxxers. I challenge these writers to read through a significant subset of these individual reports of adverse reactions. It is obvious when doing so that these reports are legitimate and should be taken seriously. They should not be ignored or discounted.
*https://sciencebasedmedicine.org/covid-19-vaccines-as-dangerous-continue-apace-vaers-edition/*
*https://www.newsweek.com/covid-vaccine-deaths-cause-pfizer-moderna-fact-check-966-died-1574447*

## #3 More info on Drug Approval Process

Three points will be covered here:

1. The FDA drug approval process explained.
2. The FDA authorized this under the Emergency Use Act (EUA) which means it is by definition an experimental medical product. It has NOT been approved or licensed by the FDA.
3. Modern Medical Ethics are based upon the Nuremburg Code, formulated after the horrific medical experiments the NAZI's committed on subjects in World War 2. In the Nuremburg Code, any medical experiments can be refused by an individual.

POINT #1: FDA Drug Approval Process Explained:

Per FDA guidelines, this is how testing of new drugs normally ensues:

*Most drugs that undergo preclinical (animal) testing never even make it to human testing and review by the FDA. The drugs that do must undergo the agency's rigorous evaluation process, which scrutinizes everything about the drug--from the design of clinical trials to the severity of side effects to the conditions under which the drug is manufactured.*

*Phase 1 studies are usually conducted in healthy volunteers. The goal here is to determine what the drug's most frequent side effects are and, often, how the drug is metabolized and excreted. The number of subjects typically ranges from 20 to 80.*

*Phase 2 studies begin if Phase 1 studies don't reveal unacceptable toxicity. While the emphasis in Phase 1 is on safety, the emphasis in Phase2 is on effectiveness. This phase aims to obtain preliminary data on whether the drug works in people who have a certain disease or condition. For controlled trials, patients receiving the drug are compared with similar patients receiving a different treatment--usually an inactive substance (placebo), or a different drug. Safety continues to be evaluated, and short-term side effects are studied. Typically, the number of subjects in Phase 2 studies ranges from a few dozen to about 300.*

*Phase 3 studies begin if evidence of effectiveness is shown in Phase 2. These studies gather more information about safety and effectiveness, studying different populations and different dosages and using the drug in combination with other drugs. The number of subjects usually ranges from several hundred to about 3,000 people.*

*"It's the clinical trials that take so long--usually several years," says Sandra Kweder, M.D., deputy director of the Office of New Drugs in the CDER. "The emphasis on speed for FDA mostly relates to review time and timelines of being able to meet with sponsors during a drug's development," she says.*
*https://www.fda.gov/drugs/information-consumers-and-patients-drugs/fdas-drug-review-process-ensuring-drugs-are-safe-and-effective*
*https://www.fda.gov/drugs/development-approval-process-drugs#FDA*

As explained in the America's Frontline Doctors report [1], this is our concern with the Covid-19 vaccines:

*According to the Food and Drug Administration, "An investigational drug can also be called an experimental drug and is being studied to see if your disease or medical condition improves while taking it." The Pfizer and Moderna and AstraZeneca applications properly identify their new agents as "investigational," which is normal at this very early stage of development.* [1 (p3)]

*…*

*Vaccine safety requires proper animal trials and peer-reviewed data, neither of which has occurred during operation warp speed.* [1 (p3)]

*…*

*Most other previous vaccines have performed and published results on animal studies prior to giving to humans. This is critical because deadly effects are often not seen until this step. Vaccines that have been given to humans prior to*

*animal trials have frequently resulted in deaths that caused the governments to yank the vaccines. Most scientists believe that human death is inevitable if there are no prior peer-reviewed animal studies.* [1 (p15)and: https://www.pfizer.com/news/press-release/press-release-detail/pfizer-and-biontech-announce-data-preclinical-studies-mrna]

This Pfizer report has a link to the actual animal study report: https://www.biorxiv.org/content/10.1101/2020.09.08.280818v1.full
I read through this complex report (click the "full text tab" to access it). While I can understand the basics of this study, there is much medical complexity in it that I am not able to wrap my head around in the quick read through that I did. That said, there are several things that concern me with this study and report.

First, in a bright yellow banner at the top of this report is the following statement:

> bioRxiv is receiving many new papers on coronavirus SARS-CoV-2. A reminder: these are preliminary reports that have not been peer-reviewed. They should not be regarded as conclusive, guide clinical practice/health-related behavior, or be reported in news media as established information.

Contrary to what they state in that banner, it is obvious that this information was used to guide clinical practice/health related behavior and was reported in the news media as established information.

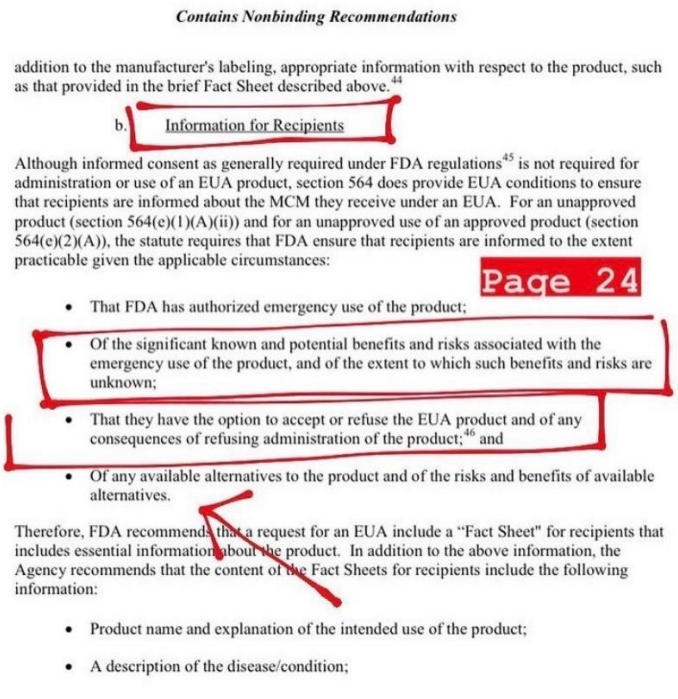
Second, the date of this report is 9/8/2020, which is one month AFTER the Phase 3 trials were started on approx. 30,000 humans. This begs the question, why did a large Phase 3 study begin one month prior to the report on the animal trial? It even begs the bigger question, why did this report come out six months AFTER the Phase 1 trial began?

Third, after reading through this report I do not see any data collected after day 56 of the trial, which means less than two months of animal trials. Don't our scientists conduct long-term and peer-reviewed animal studies prior to any human trials? I would think you would want much longer animal trials before even proceeding with Phase 1 trials with humans, especially with the past negative results of previous coronavirus vaccine trials. They had long finished the Phase 1 human trial and were one month into the Phase 2/3 human trial before this animal study report was released. This is very concerning to me.

<u>POINT #2: FDA authorized (not approved or licensed) this under the Emergency Use Act (EUA)</u>

Here's the document from the FDA entitled "Emergency Use Authorization of Medical Products and Related Authorities, Guidance for Industry and Other Stakeholders": *https://www.fda.gov/media/97321/download*
In this FDA document it clearly states: *"That they…*(the person receiving the vaccine)*…have the option to accept or refuse the EUA product…" and later "…that under an EUA, vaccines are not allowed to be mandatory. Therefore, early in the vaccination phase individuals will have to be consented and cannot be mandated to be vaccinated."*

On the next page I've included a couple of relevant snippets from this FDA report:



*Contains Nonbinding Recommendations*

addition to the manufacturer's labeling, appropriate information with respect to the product, such as that provided in the brief Fact Sheet described above.[44]

b. Information for Recipients

Although informed consent as generally required under FDA regulations[45] is not required for administration or use of an EUA product, section 564 does provide EUA conditions to ensure that recipients are informed about the MCM they receive under an EUA. For an unapproved product (section 564(e)(1)(A)(ii)) and for an unapproved use of an approved product (section 564(e)(2)(A)), the statute requires that FDA ensure that recipients are informed to the extent practicable given the applicable circumstances:

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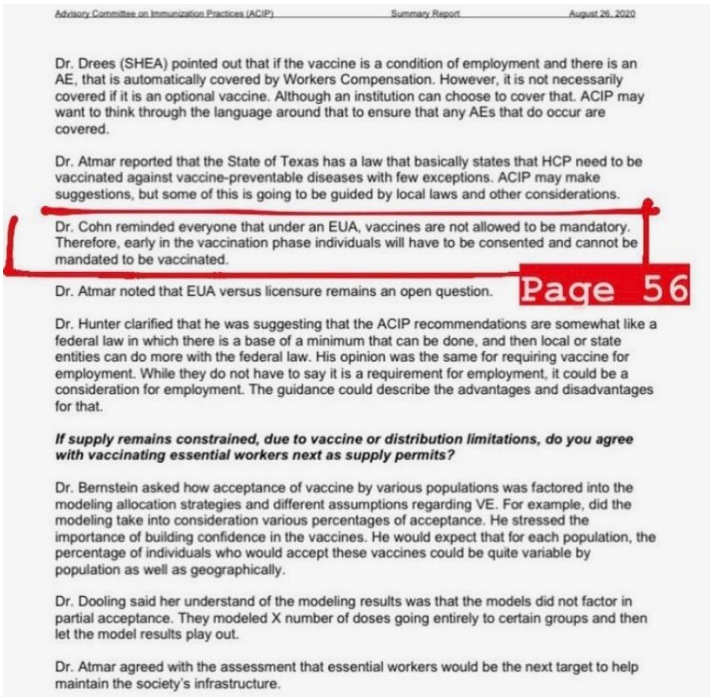
- That FDA has authorized emergency use of the product;
- Of the significant known and potential benefits and risks associated with the emergency use of the product, and of the extent to which such benefits and risks are unknown;
- That they have the option to accept or refuse the EUA product and of any consequences of refusing administration of the product;[46] and
- Of any available alternatives to the product and of the risks and benefits of available alternatives.

Therefore, FDA recommends that a request for an EUA include a "Fact Sheet" for recipients that includes essential information about the product. In addition to the above information, the Agency recommends that the content of the Fact Sheets for recipients include the following information:

- Product name and explanation of the intended use of the product;
- A description of the disease/condition;



Advisory Committee on Immunization Practices (ACIP) Summary Report August 26, 2020

Dr. Drees (SHEA) pointed out that if the vaccine is a condition of employment and there is an AE, that is automatically covered by Workers Compensation. However, it is not necessarily covered if it is an optional vaccine. Although an institution can choose to cover that. ACIP may want to think through the language around that to ensure that any AEs that do occur are covered.

Dr. Atmar reported that the State of Texas has a law that basically states that HCP need to be vaccinated against vaccine-preventable diseases with few exceptions. ACIP may make suggestions, but some of this is going to be guided by local laws and other considerations.

Dr. Cohn reminded everyone that under an EUA, vaccines are not allowed to be mandatory. Therefore, early in the vaccination phase individuals will have to be consented and cannot be mandated to be vaccinated.

Dr. Atmar noted that EUA versus licensure remains an open question.

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Dr. Hunter clarified that he was suggesting that the ACIP recommendations are somewhat like a federal law in which there is a base of a minimum that can be done, and then local or state entities can do more with the federal law. His opinion was the same for requiring vaccine for employment. While they do not have to say it is a requirement for employment, it could be a consideration for employment. The guidance could describe the advantages and disadvantages for that.

***If supply remains constrained, due to vaccine or distribution limitations, do you agree with vaccinating essential workers next as supply permits?***

Dr. Bernstein asked how acceptance of vaccine by various populations was factored into the modeling allocation strategies and different assumptions regarding VE. For example, did the modeling take into consideration various percentages of acceptance. He stressed the importance of building confidence in the vaccines. He would expect that for each population, the percentage of individuals who would accept these vaccines could be quite variable by population as well as geographically.

Dr. Dooling said her understand of the modeling results was that the models did not factor in partial acceptance. They modeled X number of doses going entirely to certain groups and then let the model results play out.

Dr. Atmar agreed with the assessment that essential workers would be the next target to help maintain the society's infrastructure.

If you go to the Moderna website (*https://www.modernatx.com/covid19vaccine-eua/*) this what you are presented with:

*The Moderna COVID-19 Vaccine has not been approved or licensed by the US Food and Drug Administration (FDA), but has been authorized for emergency use by FDA, under an Emergency Use Authorization (EUA), to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older. There is no FDA-approved vaccine to prevent COVID-19. The EUA for the Moderna COVID-19 Vaccine is in effect for the duration of the COVID-19 EUA declaration justifying emergency use of the product, unless the declaration is terminated or the authorization is revoked sooner.*

Here's the Pfizer vaccine EUA fact sheet: *https://www.fda.gov/media/144414/download*
And here's a snippet from this document:

*WHAT IS THE PFIZER-BIONTECH COVID-19 VACCINE?*
*The Pfizer-BioNTech COVID-19 Vaccine is an unapproved vaccine that may prevent COVID-19. There is no FDA-approved vaccine to prevent COVID-19. The FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine to prevent COVID-19 in individuals 16 years of age and older under an Emergency Use Authorization (EUA).*

Here's what the J&J website says (*https://www.janssenlabels.com/emergency-use-authorization/Janssen+COVID-19+Vaccine-HCP-fact-sheet.pdf*)

*The U.S. Food and Drug Administration (FDA) has issued an Emergency Use Authorization (EUA) to permit the emergency use of the unapproved product, Janssen COVID-19 Vaccine, for active immunization to prevent COVID-19 in individuals 18 years of age and older.*

Again, it is very hard for me to get my head around the fact that organizations are mandating a drug that **has not been approved or licensed by the FDA**.

Point #3: The Nuremberg Code is very clear about how medical experiments must be voluntary.
The Nuremberg Code, written by MD's during the Nuremberg trials after WW2, guides medical ethics for human medical experiments in our nation and the entire world, since those horrible medical experiments were inflicted on children, women and men by the Nazis. The full text of the Nuremberg Code is included below:

***The Nuremberg Code***

*Permissible Medical Experiments*

*The great weight of the evidence before us is to the effect that certain types of medical experiments on human beings, when kept within reasonably well-defined bounds, conform to the ethics of the medical profession generally. The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocurable by other methods or means of study. All agree, however, that certain basic principles must be observed in order to satisfy moral, ethical and legal concepts:*

1. *The voluntary consent of the human subject is absolutely essential.*

   *This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.*

   *The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.*
2. *The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.*
3. *The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.*
4. *The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.*
5. *No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.*
6. *The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.*
7. *Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.*
8. *The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.*
9. *During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.*
10. *During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill, and careful judgment required of him, that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.*

*https://ecfsapi.fcc.gov/file/10723227614219/The%20Nuremberg%20Code-British%20Medical%20Journal%20No%207070%20Volume%20313%20Page%201448%2C7%20December%201996.pdf*
*https://www.fhi360.org/sites/all/libraries/webpages/fhi-retc2/Resources/nuremburg_code.pdf*

The New England Journal of Medicine had a great article on the Nuremberg Code on its 50th anniversary in 1997. Here is an excerpt from that article, and then a link to the full article:

*The Nuremberg Code is the most important document in the history of the ethics of medical research. The Code was formulated 50 years ago, in August 1947, in Nuremberg, Germany, by American judges sitting in judgment of Nazi doctors accused of conducting murderous and torturous human experiments in the concentration camps (the so-called Doctors' Trial). It served as a blueprint for today's principles that ensure the rights of subjects in medical research. Because of its link with the horrors of World War II and the use of prisoners in Nazi concentration camps for medical experimentation, debate continues today about the authority of the Code, its applicability to modern medical research,*

*and even its authorship. The chief prosecutor at the Doctors' Trial, General Telford Taylor, believed that one of the three U.S. judges, Harold Sebring, was the author of the Code. Two American physicians who helped prosecute the Nazi doctors at Nuremberg, Leo Alexander and Andrew Ivy, have each been identified as the Code's author. A careful reading of the transcript of the Doctors' Trial, background documents, and the final judgment reveals that authorship was shared and that the famous 10 principles of the Code grew out of the trial itself.*

*In this article I will explain the important role that physicians had in the prosecution of the Nazi doctors and in the formulation of the Nuremberg Code and summarize how medical researchers have used the Code as a guide over the past five decades.*
*https://www.nejm.org/doi/full/10.1056/nejm199711133372006*

The bottom line: These vaccines are experimental, not approved, not licensed, and no one should be forced to get it.

## #4 More info on the two types of vaccines

As part of my process to come to a decision on receiving a Covid-19 vaccine, I wanted to understand how they worked. Here are explanations from the CDC on how the Moderna/Pfizer mRNA vaccines, and the J&J Viral Vector vaccine work:
*https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/how-they-work.html*
*https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/viralvector.html*

Point #1: Moderna and Pfizer mRNA Vaccines:

This NY Times article helped me understand how these new mRNA vaccines work:
https://www.nytimes.com/interactive/2020/health/moderna-covid-19-vaccine.html)

Here's my quick summary of the mRNA vaccines: This type of Covid-19 vaccine contains mRNA (picture step-by-step instructions, or a computer program) that create the spike proteins of the Covid-19 RNA virus. These small sections of mRNA are encapsulated in extremely small fat molecules (lipid nanoparticle) and injected into your arm. The fat molecules fuse to various cells in your body and allow the mRNA to enter into your cell. Mechanisms in your cell then read this mRNA and pass the instructions onto another mechanism that creates proteins, and this then results in the creation of the spike proteins common to Covid-19. These spike proteins "migrate" to the surface (I've also read how this is actually your cells recognizing these spike proteins as foreign objects and are actually ejecting them as waste). Then your body immune system (Helper T-cells) first identify these foreign spike proteins on your own cells and instruct other immune systems cells (Killer T-Cells, etc) to attack them. This is how your immune system learns to defend against Covid-19. When your immune system next encounters the Covid-19 virus with the same spikes, it should attack and kill the virus. One concern about this process, is since your own body's cells are making these Covid-19 spike proteins, then your immune system can recognize your own cells as the manufacturer of the "bad" spike proteins and will attack your own cells. This is a likely explanation for the many different types of adverse reactions being reported with this vaccine. There are also concerns for pathogenic priming that I'll go into in the next section.

As explained in the America's Frontline Doctors report [1]:

*This is the first time that an mRNA mechanism is being used in a vaccination. For the most part, mRNA technology is used in cancer therapy. It has had some success in producing various proteins to attack and disrupt certain cancer cells.* [1 (p12)]

*No vaccine based on messenger RNA has ever been approved for any disease, or even entered final-stage trials until now, so there's no peer-reviewed published human data to compare how mRNA stacks up against older technologies. How well mRNA vaccines will actually prevent COVID-19 remains unknown.* [1 (p14)and:
*https://www.bloomberg.com/features/2020-moderna-biontech-COVID-shot/*

*Despite trying for decades, scientists have never been able to create a successful coronavirus vaccine. Whenever they think they have, the experimental coronavirus vaccine has failed and animals who got the experimental vaccine died.* [1 (p15)and: *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3335060/*

Point 2: Johnson & Johnson (Jansen) Viral Vector Vaccine:

Another good article from the NY Times on how the Johnson & Johnson vaccine works:
*https://www.nytimes.com/interactive/2020/health/johnson-johnson-covid-19-vaccine.html*

After reading the above article, here is my take on the Johnson & Johnson Viral Vector vaccine. It is doing basically the same thing as the two mRNA vaccines. Instead of a single strand mRNA, they are using a double strand DNA inside an Adenovirus. Adenoviruses normally produce cold/flu symptoms, but in this case the virus cannot replicate itself inside your cells, so you will not get sick from it. This version of the adenovirus has had a gene added into its DNA that will allow for the manufacturing of the spike protein. Once injected into you, the adenovirus with a tough protein shell, bumps into your body's own cells, it latches onto your cell and then inserts itself into your cell. It then finds the nucleus of your cell and injects its DNA cargo into the nucleus. Now your cell's nucleus reads that injected DNA and produces a strand of mRNA, then ejects that mRNA from the nucleus, and the other mechanisms inside your cell that read mRNA do so here, and they produce the Covid-19 spike protein (the same as the mRNA vaccines do). From here on, the process with the different vaccines is identical. The spike proteins and fragments are pushed to the cell surface and your immune system detects the spike proteins and destroys them. Now your body's immune system knows to recognize the spike proteins of the Covid-19 virus and will destroy that virus too. I will reiterate the same thing as I did in the mRNA above: The concern I have about this process, is since your own body's cells are making these Covid-19 spike proteins, then your immune system can recognize your own cells as the manufacturer of the "bad" spike proteins and will attack your own cells. And again, this could be an explanation for the many different types of adverse reactions being reported with this vaccine. There are also concerns for pathogenic priming and Antibody-Dependent Enhancement (ADE) that I'll go into in the next section.

To conclude on this topic, both vaccines result in mRNA producing the spike proteins found in the Covid-19 virus…
On April 30, 2021 one of the top medical research organizations in the world, the Salk Institute released a report on how the spike proteins that are on the surface of the Covid-19 virus, and the same spike proteins produced in your body after receiving the vaccine, have been proven to cause damage to your vascular system. *https://www.salk.edu/news-release/the-novel-coronavirus-spike-protein-plays-additional-key-role-in-illness/*
Here are excerpts from this report:

*LA JOLLA—Scientists have known for a while that SARS-CoV-2's distinctive "spike" proteins help the virus infect its host by latching on to healthy cells. Now, a major new study shows that the virus spike proteins (which behave very differently than those safely encoded by vaccines) also play a key role in the disease itself.*

*The paper, published on April 30, 2021, in Circulation Research, also shows conclusively that COVID-19 is a vascular disease, demonstrating exactly how the SARS-CoV-2 virus damages and attacks the vascular system on a cellular level. The findings help explain COVID-19's wide variety of seemingly unconnected complications, and could open the door for new research into more effective therapies.*

*"A lot of people think of it as a respiratory disease, but it's really a vascular disease," says Assistant Research Professor Uri Manor, who is co-senior author of the study. "That could explain why some people have strokes, and why some people have issues in other parts of the body. The commonality between them is that they all have vascular underpinnings."*

*…*

*While the findings themselves aren't entirely a surprise, the paper provides clear confirmation and a detailed explanation of the mechanism through which the protein damages vascular cells for the first time. There's been a growing consensus that SARS-CoV-2 affects the vascular system, but exactly how it did so was not understood. Similarly, scientists studying other coronaviruses have long suspected that the spike protein contributed to damaging vascular endothelial cells, but this is the first time the process has been documented.*

*In the new study, the researchers created a "pseudovirus" that was surrounded by SARS-CoV-2 classic crown of spike proteins, but did not contain any actual virus. Exposure to this pseudovirus resulted in damage to the lungs and arteries of an animal model—proving that the spike protein alone was enough to cause disease. Tissue samples showed inflammation in endothelial cells lining the pulmonary artery walls.*

*The team then replicated this process in the lab, exposing healthy endothelial cells (which line arteries) to the spike protein. They showed that the spike protein damaged the cells by binding ACE2. This binding disrupted ACE2's*

*molecular signaling to mitochondria (organelles that generate energy for cells), causing the mitochondria to become damaged and fragmented.*

*Previous studies have shown a similar effect when cells were exposed to the SARS-CoV-2 virus, but this is the first study to show that the damage occurs when cells are exposed to the spike protein on its own.*

*"If you remove the replicating capabilities of the virus, it still has a major damaging effect on the vascular cells, simply by virtue of its ability to bind to this ACE2 receptor, the S protein receptor, now famous thanks to COVID," Manor explains. "Further studies with mutant spike proteins will also provide new insight towards the infectivity and severity of mutant SARS CoV-2 viruses."*

Here are links to the official study report:
*https://www.ahajournals.org/doi/10.1161/CIRCRESAHA.121.318902*
*https://www.ahajournals.org/doi/epub/10.1161/CIRCRESAHA.121.318902*
Why the silence in the mainstream media about this report, that the spike proteins themselves cause vascular damage, which could explain many of the adverse reactions with these vaccines?

## #5 More info on Pathogenic Priming and ADE

The coronavirus family of viruses include the common cold or more dangerous strains such as SARS, MERS and now Covid-19. Over the past couple of decades prior to the release of these experimental Covid-19 vaccines, there had been numerous vaccine candidates studied, but none were successful. They typically resulted in severe adverse reactions and/or death during the initial animal and phase 1 studies. These severe reactions include Immune Enhancement conditions such as Pathogenic Priming and Antibody-Dependent Enhancement (ADE). There are concerns that there has not been adequate time or effort to study these potential adverse reactions. I expand on each of these conditions in the two points below.

Point 1: Pathogenic Priming

The concern with this condition is that after you have been vaccinated, your immune system has been "primed" to recognize the spike protein as well as the building blocks (peptides) that make up the spike protein. Then when you encounter Covid-19 or one of the new variations (mutations), your immune system overreacts with a massive and possibly fatal cytokine storm. Info below from credible sources explore this condition further.

Here are several excerpts from the America's Frontline Doctors report [1] explaining Pathogenic Priming:

*Prior coronavirus (and other respiratory) vaccines have failed due to the scientific phenomena known as pathogenic priming that makes the vaccine recipient more likely to suffer a sudden fatal outcome due to massive cytokine storm when exposed to the wild virus. In addition to pathogenic priming there are three other potential safety issues that are being minimized. While we are hopeful that the vaccine is both effective and safe, hope is not science. Because these experimental vaccines have not been tested in accordance with the usual standards, we have serious concerns about safety.* [1 (p3)]

*…*

*Pathogenic priming includes the deleterious effect of antibody-dependent enhancement (ADE) whereby a vaccine or reinfection could result in a more severe or lethal disease, should the person become infected with SARS-CoV-2 in the wild. This phenomenon has been well-documented with prior vaccines. The most recent terrible headlines related to this was a vaccine for Dengue fever. Persons who received the vaccine and then encountered the virus in the wild suffered worse outcomes at an alarming rate. This is why the Dengue vaccine ("Dengvaxia") was only approved for very restricted use by the FDA—despite years of active research and development. In the Philippines, the former head of the Dengue department of the Research Institute for Tropical Medicine (RITM) was indicted in 2019 by the Department of Justice for "reckless imprudence resulting [in] homicide," because they "facilitated, with undue haste," Dengvaxia's approval and its rollout among Philippine schoolchildren. The antibody-dependent enhancement effect in the COVID-19 Experimental Vaccines will be further discussed in Section VI. But what is clear is that the Phase III trials from Pfizer, Moderna and AstraZeneca provide little to no insight into ADE and Vaccine-Associated Hypersensitivity (VAH). Not only is*

*the sample size of vaccinated participants who developed COVID-19 very small, but, based on the information publicly available, it is unknown which strains of SARS-CoV-2 afflicted the participants in the trials.* [1 (p14)]

*…*

*For example, in the Pfizer/BioNTech and Moderna trials,only 8 and 11 vaccinated participants, respectively, developed COVID-19. This is an alarmingly small number when taking into consideration the novelty of SARSCoV-2 and the possibility of the adverse effect known as pathogenic priming, which has been seen repeatedly with prior coronavirus vaccines.* [1 (p14)]

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7142689/

Here are excerpts from that National Institute of Health (NIH) report (referenced above in the America's Frontline Doctors report), that explains the concerns with coronavirus spike protein vaccines (full report available with link at end of excerpts):

*In SARS, a type of "priming" of the immune system was observed during animal studies of SARS spike protein-based vaccines leading to increased morbidity and mortality in vaccinated animals who were subsequently exposed to wild SARS virus. The problem, highlighted in two studies, became obvious following post-vaccination challenge with the SARS virus [2]. found that recombinant SARS spike-protein-based vaccines not only failed to provide protection from SARS-CoV infection, but also that the mice experienced increased immunopathology with eosinophilic infiltrates in their lungs. Similarly [3], found that ferrets previously vaccinated against SARS-CoV also developed a strong inflammatory response in liver tissue (hepatitis). Both studies suspected a "cellular immune response".*

*…*

*These types of unfortunate outcomes are sometimes referred to as "immune enhancement"; however, this nearly euphemistic phrase fails to convey the increased risk of illness and death due to prior exposure to the SARS spike protein. For this reason, I refer to the concept as "pathogen priming"; the peptides with pathogenic potential therefore are referred to as "putative pathogenic priming peptides".*

*…*

*Pathogenic priming may be more or less severe in vaccine or infection induced immune responses to some proteins than for others due to original antigenic sin; the immunologic reaction against self-antigens may be made less severe as fast-evolving viruses evolve away from the original vaccine type. Thus, the screening of immunogenic epitopes for pathogenic priming potential via homology may be augmented by studies of autoantibodies that cross-react with epitopes included in vaccines.*

*SARS-CoV-2 has some unexplained pathogenic features that might be related to the table of putative pathogenic priming peptides. Exposure to these specific peptides - via either infection or vaccination - might prime patients for increased risk of enhanced pathogenicity during future exposure due either to future pandemic or outbreaks or via universal vaccination programs. While the mechanisms pathogenesis of COVID-19 are still poorly understood, the morbidity and mortality of SARS has been extensively studied. Thus, the involvement of pathogenic priming in re-infection by COVID-19 is a theoretical possibility; of course no vaccine against SARS-CoV-2 has yet been tested in animals and therefore we do not yet know if pathogenic priming is in fact expected. Such studies should be undertaken before use of any vaccine against SARS-CoV-2 is used in humans.*

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7142689/

<u>Point 2: Antibody-Dependent Enhancement (ADE)</u>

With Antibody-Dependent Enhancement (ADE), the antibodies your body has produced after receiving the vaccine, help mask the virus the next time you encounter it. The virus actually hides within the mass of antibodies and is able to get access to your cells, similar to a Trojan horse hiding the soldiers as it is going through the gates of a city. When the virus is able to do this on a massive scale, using your immune system against itself, amplifying itself, you get a worse infection than you would've otherwise.

Here is the introduction to this condition from the America's Frontline Doctors report:

*One of the known complications of vaccines is something called immune enhancement. One type of immune enhancement is known as Antibody Dependent Enhancement (ADE). This is a process where a virus leverages antibodies*

*to aid infection. In short, the antiCOVID antibodies, stimulated by a vaccine, amplify the infection rather than prevent its damage. This paradoxical reaction has been seen repeatedly in other vaccines and animal development trials especially with coronavirus vaccine trials.* [1 (p15)and:]
https://academic.oup.com/jid/article/222/12/1946/5891764

America's Frontline Doctors report included this snippet from Wikipedia that actually did a pretty good job explaining ADE: (Note: I added the yellow highlight to this excerpt to draw attention to an interesting comment they make.) [1 (p20)and:]
*https://en.wikipedia.org/wiki/Antibody-dependent_enhancement*

> *Antibody-dependent enhancement (ADE), sometimes less precisely called immune enhancement or disease enhancement, is a phenomenon in which binding of a virus to suboptimal antibodies enhances its entry into host cells, followed by its replication.[1][2] Antiviral antibodies promote viral infection of target immune cells by exploiting the phagocytic FcγR or complement pathway.[3] After interaction with the virus the antibody binds Fc receptors (FcR) expressed on certain immune cells or some of the complement proteins. FcγR binds antibody via its fragment crystallizable region (Fc). Usually the process of phagocytosis is accompanied by the virus degradation, however, if the virus is not neutralized (either due to low affinity binding or targeting to a non-neutralizing epitope), antibody binding might result in a virus escape and therefore, enhanced infection. Thus, phagocytosis can cause viral replication, with the subsequent death of immune cells. The virus "deceives" the process of phagocytosis of immune cells and uses the host's antibodies as a Trojan horse. ADE may occur due to the non-neutralizing characteristic of the antibody, which bind viral epitopes other than those involved in a host cell attachment and entry. ADE may also happen due to the presence of sub-neutralizing concentrations of antibodies (binding to viral epitopes below the threshold for neutralization).[4] In addition ADE can be induced when the strength of antibody-antigen interaction is below the certain threshold.[5][6] This phenomenon might lead to both increased virus infectivity and virulence. The viruses that can cause ADE frequently share some common features such as antigenic diversity, abilities to replicate and establish persistence in immune cells.[1] ADE can occur during the development of a primary or secondary viral infection, as well as after vaccination with a subsequent virus challenge.[1][7][8] It has been observed mainly with positive-strand RNA viruses. Among them are Flaviviruses such as Dengue virus,[9] Yellow fever virus, Zika virus,[10][11] Coronaviruses, including alpha- and betacoronaviruses,[12] Orthomyxoviruses such as influenza,[13] Retroviruses such as HIV,[14][15][16] and Orthopneumoviruses such as RSV.[17][18][19]`
>
> *The mechanism that involves phagocytosis of immune complexes via FcγRII / CD32 receptor is better understood compared to the complement receptor pathway.[20][21][22] Cells that express this receptor are represented by monocytes, macrophages, some categories of dendritic cells and B-cells. ADE is mainly mediated by IgG antibodies,[21] however, IgM along with complement,[23] and IgA antibodies[15][16] have also been shown to be trigger ADE.*
>
> *ADE may cause enhanced respiratory disease and acute lung injury after respiratory virus infection (ERD) with symptoms of monocytic infiltration and an excess of eosinophils in respiratory tract.[24] ADE along with type 2 T helper cell-dependent mechanisms may contribute to a development of the vaccine associated disease enhancement (VADE), which is not limited to respiratory disease.[24] Some vaccine candidates that targeted coronaviruses, RSV virus and Dengue virus elicited VADE, and were terminated from further development or became approved for use only for patients who have had those viruses before.*

The America's Frontline Doctors report continues on ADE…

*ADE is especially tricky because it is a delayed reaction. Initially all seems well. The person seems to have a great immune response but then becomes deadly when the person is exposed to the virus in the wild. It is well known that you must do animal testing first to try to rule out ADE. Strong vaccine advocates Dr. Offit and Dr. Hotez, who would be expected to be enthusiastic about these experimental vaccines, have not really endorsed these new experimental vaccines, because previous coronavirus vaccines have a long history of failure due to "antibody dependent enhancement." Antibody Dependent Enhancement (ADE), is when anti-COVID antibodies, created by a vaccine, instead of protecting the person, cause a more severe or lethal disease when the person is later exposed to SARS-CoV-2 in the wild. The vaccine amplifies the infection rather than preventing damage. It may only be seen after months or years of use in populations around the world. This paradoxical reaction has been seen in other vaccines and animal trials. One well-documented example is with the Dengue fever vaccine, which resulted in avoidable deaths.* [1 (p20)and:]
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7642463/
https://www.nature.com/scitable/topicpage/host-response-to-the-dengue-virus-22402106/

*…*

*This has happened with other coronaviruses. SARS-CoV-1 had about 35 vaccine candidates, the best four were trialed in ferrets and it looked like it worked well. But when those ferrets were challenged in the wild they got very ill and died. Extremely concerning is that this antibody-dependent amplification, ADE, has long been known from experiments with corona vaccines in cats, for example. In the course of these studies all cats that initially tolerated the vaccination well died after catching the wild virus. The original SARS-CoV, a coronavirus 78% similar to the current SARS-CoV-2*

*causing COVID-19, caused an epidemic in 2003. Scientists attempted to create a vaccine. Initially it appeared promising, but ultimately it was abandoned because although the mice tolerated the vaccine and produced antibodies, when the mice were exposed to the actual virus in the wild, they died due to what we would think of as sudden severe cytokine storm.* [1 (p21)and:]

https://2020news.de/en/dr-wodarg-and-dr-yeadon-request-a-stop-of-all-corona-vaccination-studies-and-call-for-co-signing-the-petition/?fbclid=IwAR3yoj0SCIK8WaaS0-w1vIoi-g4qNYydTxT3aK01NJDwHut3jWpygtnnbNY
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3335060/

*…*

*CoV-2 varies so much from a large percentage of asymptomatic patients to rapid death in others. Science, Nature, Journal of Infectious diseases and others, have already documented ADE, or vaccine-associated hypersensitivity (VAH) risks in relation to the development of experimental COVID-19 vaccines. The Phase III trials from Pfizer, Moderna and AstraZeneca provide little insight into ADE and VAH. Not only is the sample size of vaccinated participants who developed COVID19 very small, but, based on the information publicly available, it is unknown which strains of SARS-CoV-2 afflicted the participants in the trials. This ADE response is so concerning that many scientists already agree the risk is much too high to release these experimental vaccines to the public at large. On December 1, 2020, the ex-Pfizer head of respiratory research Dr. Michael Yeadon and the lung specialist and former head of the public health department Dr. Wolfgang Wodarg filed an application with the European Medicine Agency responsible for approving drugs in the European Union, for the immediate suspension of all SARS CoV 2 vaccine studies, in particular the BioNtech/Pfizer study on BNT162b.* [1 (p22)and:]

https://2020news.de/en/dr-wodarg-and-dr-yeadon-request-a-stop-of-all-corona-vaccination-studies-and-call-for-co-signing-the-petition/?fbclid=IwAR3yoj0SCIK8WaaS0-w1vIoi-g4qNYydTxT3aK01NJDwHut3jWpygtnnbNY
*https://2020news.de/wpcontent/uploads/2020/12/Wodarg_Yeadon_EMA_Petition_Pfizer_Trial_FINAL_01DEC2020_EN_unsigned_with_Exhibits.pdf*

*One of the biggest reasons they cited was the formation of so-called "non-neutralizing antibodies" can lead to an exaggerated immune reaction, especially when the test person is confronted with the real, "wild" virus after vaccination. This so-called antibody-dependent amplification, ADE, has long been known from experiments with corona vaccines in cats, for example. In the course of these studies all cats that initially tolerated the vaccination well died after catching the wild virus. If these experimental coronavirus vaccines cause an ADE reaction and millions and millions of Americans have taken this vaccine, instead of a 99.98% cure rate for COVID19 we could face a 20-30% death rate when all these millions of Americans are exposed to COVID-19 in the wild.* [1 (p22)]

Below are excerpts from another report from National Institute of Health (NIH) in regard to concerns about ADE:

*Antibody-based drugs and vaccines against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) are being expedited through preclinical and clinical development. Data from the study of SARS-CoV and other respiratory viruses suggest that anti-SARS-CoV-2 antibodies could exacerbate COVID-19 through antibody-dependent enhancement (ADE). Previous respiratory syncytial virus and dengue virus vaccine studies revealed human clinical safety risks related to ADE, resulting in failed vaccine trials.*

*One potential hurdle for antibody-based vaccines and therapeutics is the risk of exacerbating COVID-19 severity via antibody-dependent enhancement (ADE). ADE can increase the severity of multiple viral infections, including other respiratory viruses such as respiratory syncytial virus (RSV)[9,10] and measles[11,12]. ADE in respiratory infections is included in a broader category named enhanced respiratory disease (ERD), which also includes non-antibody-based mechanisms such as cytokine cascades and cell-mediated immunopathology (Box 1). ADE caused by enhanced viral replication has been observed for other viruses that infect macrophages, including dengue virus[13,14] and feline infectious peritonitis virus (FIPV)[15]. Furthermore, ADE and ERD has been reported for SARS-CoV and MERS-CoV both in vitro and in vivo. The extent to which ADE contributes to COVID-19 immunopathology is being actively investigated.*

*…*

*ADE has been observed in SARS, MERS and other human respiratory virus infections including RSV and measles, which suggests a real risk of ADE for SARS-CoV-2 vaccines and antibody-based interventions. However, clinical data has not yet fully established a role for ADE in human COVID-19 pathology. Steps to reduce the risks of ADE from immunotherapies include the induction or delivery of high doses of potent neutralizing antibodies, rather than lower concentrations of non-neutralizing antibodies that would be more likely to cause ADE.*

*Going forwards, it will be crucial to evaluate animal and clinical datasets for signs of ADE, and to balance ADE-related safety risks against intervention efficacy if clinical ADE is observed. Ongoing animal and human clinical studies will provide important insights into the mechanisms of ADE in COVID-19. Such evidence is sorely needed to ensure product safety in the large-scale medical interventions that are likely required to reduce the global burden of COVID-19.*

NIH link for report: https://pubmed.ncbi.nlm.nih.gov/32908214/ Full text link of report: https://www.nature.com/articles/s41564-020-00789-5

Below are excerpts from another report from Oxford Academic – The Journal of Infectious Diseases. This article starts with the hypothesis that a Covid-19 vaccine should not cause ADE, but they do allude to ADE and similar issues with previous coronaviruses, and they conclude that much more study needs to be done, animal and voluntary human:

*It has proved difficult to achieve robust vaccine protection against avian, bovine, porcine, canine, and feline coronaviruses, failures sometimes attributed to antibody-dependent enhancement (ADE) [2]. The possibility that a SARS-CoV-2 vaccine may sensitize recipients to ADE has received considerable scrutiny [3]. On inspection, ADE is not 1 but 2 vaccine-related immunopathological phenomena: intrinsic ADE (iADE) and vaccine hypersensitivity (VAH). iADE describes interactions between microbial pathogen IgG antibody immune complexes that attach to Fc receptors to initiate infection but also enhance replication of the microbe by suppressing innate cellular defenses [4, 5]. VAH was first described in humans in the early 1960s, after formalin-inactivated measles vaccines were introduced in the United States and Europe. Within months, large numbers of vaccinated children developed a severe breakthrough disease, called atypical measles[6]. A similar outcome, vaccine-associated enhanced respiratory disease (VAERD), was observed in infants aged 4–12 months who were given formalin-inactivated respiratory syncytial virus (RSV) and a few months later infected by RSV[7]. The outcomes observed were attributed to delayed-type hypersensitivity and/or an Arthus reaction [8]. Lung lesions revealed damage to parenchymal tissue, a pulmonary neutrophilia with abundant macrophages and lymphocytes, and excess eosinophils. From studies in laboratory animals, it is thought that formalin-deconformed viral antigens raised nonprotective antibodies that led to a Th2 polarization of the immune response and a deficit of cytotoxic T cells. It was also the case that mice immunized with RSV inactivated with UV radiation, a purified fusion (F) protein, or a vaccinia-RSV replicative construct experienced similar pathology following challenge with wild-type virus. A similar pathological response has repeatedly accompanied live virus challenge in several species of laboratory animals vaccinated with SARS and Middle East respiratory syndrome (MERS) CoV constructs, with and without adjuvants [9, 10]. VAH may best be defined as a Coombs type III antigen hypersensitivity. It should be emphasized there is no formal proof that VAERD is antibody mediated. The mechanism(s) of the post measles vaccine disease enhancement and its similarity to VAERD are not known.*

*…A central challenge to SARS-CoV-2 vaccine development will be differentiating early from sustained protection and will be greatly aided by a SARS-CoV-2 model of VAH in laboratory animal models. Recognition of vaccine constructs that achieve solid protection in humans might be accelerated by challenge of vaccinated human volunteers with live SARS-CoV-2 [49]. Better understanding of the clinical and immunological behavior of SARSCoV-2 itself might be achieved through direct infections of human volunteers [50]. Given the magnitude of the repertoire of COVID-19 problems and the need for an effective vaccine, the full force of worldwide investigative resources should be directed at unraveling the pathogenesis of VAH.*

https://academic.oup.com/jid/article/222/12/1946/5891764 *NOTE: Click "PDF" on above site for full text of article.*

One more article regarding ADE. This is another report where they are not thinking that ADE will manifest in these new Covid-19 vaccines, but they agree more study needs to be done to make sure it doesn't.

*ADE is one form of immune enhancement, a poorly understood group of phenomena occurring when components of our immune system that usually protect against viral infections somehow end up backfiring. It's a concern in situations when people are continuously re-infected with particular pathogens, and with vaccines that work by injecting snippets of virus to mimic a first infection. Some immunizations, such as those against respiratory syncytial virus (RSV), have been observed in the past to make disease worse when vaccinated individuals contract the virus.*

*As far as researchers know, such cases are exceedingly rare across viruses. For SARS-CoV-2, it's unclear if any forms of immune enhancement could play a role in infections or vaccines under development, but there is no evidence so far.*

*"[It's just] a theoretical risk, but people are being extremely careful to make sure that this risk is not becoming a reality," notes Paul-Henri Lambert, an immunologist and vaccinologist retired from the University of Geneva who now advises the university's center of vaccinology and consults for a multinational collaborative project of researchers on safety evaluations of vaccine candidates. "With COVID-19, we have a disease which in eighty percent of people is selectively mild. So what you would not like is to give a vaccine that would not protect well and in a certain percentage of people make the disease worse."*

*Dengue remains the best-studied and one of the very few solid examples of ADE. It's thought to occur in communities where there are multiple viral strains of dengue circulating. While antibodies against one dengue strain will typically reliably protect against that strain, things can go awry when the antibodies encounter a different strain of dengue. Instead of neutralizing the virus—that is, binding to and blocking a protein the pathogen needs to enter host cells—the antibodies only bind to the virus without neutralizing it.*

*That can become a problem when immune cells, such as macrophages, dock onto the tail ends of antibodies using specialized receptors known as Fc receptors—which they often do to clear up antibody-virus debris. Because dengue viruses can use Fc receptors to infect cells, if the antibodies aren't disabling the pathogen, they actually end up helping the virus enter macrophages to infect the cells, Trojan horse–style, explains Dennis Burton, a microbiologist at the Scripps Research Institute in California. This amplifies viral replication, potentially pushing the immune system into over-drive and paving the way for severe disease. "That's the hallmark of ADE, basically . . . you make infection easier, you infect more cells, you get worse disease."*

*… Such experiments have found hints of ADE with viruses including Ebola virus, HIV, and coronaviruses such as SARS and MERS. However, it's still a mystery to what extent this occurs in live organisms in the presence of a functioning immune system. "The immune system typically modulates things to your benefit. I'm not saying that ADE does not occur in the body—I'm just saying it's difficult to bridge the results in the test tube to what happens in the body," Crowe says.*

*It's not yet clear if SARS-CoV-2 is capable of infecting macrophages. Although some scientists have reportedly spotted viral protein inside macrophages, whether it actually infects and replicates in macrophages in the body "is something investigators are trying to determine right now," Crowe says.*

*…*

*Of nearly 140 different COVID-19 vaccine candidates, 15 are already in human trials. "To date, I haven't seen any clear evidence to support ADE or ERD, but it's something you want to be aware of for sure," Burton says. "It may be that the vaccines that are already out there—Moderna, Janssen, and so on—they may turn out to be perfectly great, we just don't know at this point. I think it's good to have a plan B, where if there are some problems, you can start working it out quickly what they are, and re-engineering your vaccines based on knowledge about what's wrong."*
https://www.the-scientist.com/news-opinion/covid-19-vaccine-researchers-mindful-of-immune-enhancement-67576

Finally, for my conclusion on this topic, I think past occurrences of Immune Enhancement, both Pathogenic Priming and ADE, with various vaccines, and especially coronavirus vaccine tests, warrant further long term study before releasing an experimental vaccine on the general public.

## #6 More info on Infection Immunity

First, I want to cite a study conducted by the La Jolla Institute for Immunology. This study consisted of 188 persons that had Covid-19, and it showed that 95% of them had durable immune system memories of the virus up to eight months after infection. Here's a summary from this article with a link to the full article following:

*LA JOLLA—New data suggest that nearly all COVID-19 survivors have the immune cells necessary to fight re-infection.*

*The findings, based on analyses of blood samples from 188 COVID-19 patients, suggest that responses to the novel coronavirus, SARS-CoV-2, from all major players in the "adaptive" immune system, which learns to fight specific pathogens, can last for at least eight months after the onset of symptoms from the initial infection.*

*"Our data suggest that the immune response is there—and it stays," LJI Professor Alessandro Sette, Dr. Biol. Sci., who co-led the study with LJI Professor Shane Crotty, Ph.D., and LJI Research Assistant Professor Daniela Weiskopf, Ph.D.*

*"We measured antibodies, memory B cells, helper T cells and killer T cells all at the same time," says Crotty. "As far as we know, this is the largest study ever, for any acute infection, that has measured all four of those components of immune memory."*

*The findings, published in the January 6, 2021, online edition of Science, could mean that COVID-19 survivors have protective immunity against serious disease from the SARS-CoV-2 virus for months, perhaps years after infection.*

*The new study helps clarify some concerning COVID-19 data from other labs, which showed a dramatic drop-off of COVID-fighting antibodies in the months following infection. Some feared that this decline in antibodies meant that the body wouldn't be equipped to defend itself against reinfection.*

*Sette explains that a decline in antibodies is very normal. "Of course, the immune response decreases over time to a certain extent, but that's normal. That's what immune responses do. They have a first phase of ramping up, and after that fantastic expansion, eventually the immune response contracts somewhat and gets to a steady state," Sette says.*

*The researchers found that virus-specific antibodies do persist in the bloodstream months after infection. Importantly the body also has immune cells called memory B cells at the ready. If a person encounters SARS-CoV-2 again, these memory B cells could reactivate and produce SARS-CoV-2 antibodies to fight re-infection.*

*The SARS-CoV-2 virus uses its "spike" protein to initiate infection of human cells, so the researchers looked for memory B cells specific for the SARS-CoV-2 spike. They found that spike-specific memory B cells actually increased in the blood six months after infection.*

*COVID-19 survivors also had an army of T cells ready to fight reinfection. Memory CD4+ "helper" T cells lingered, ready to trigger an immune response if they saw SARS-CoV-2 again. Many memory CB8+ "killer" T cells also remained, ready to destroy infected cells and halt a reinfection.*

*The different parts of the adaptive immune system work together, so seeing COVID-fighting antibodies, memory B cells, memory CD4+ T cells and memory CD8+ T cells in the blood more than eight months following infection is a good sign.*

*"This implies that there's a good chance people would have protective immunity, at least against serious disease, for that period of time, and probably well beyond that," says Crotty.*
*https://www.lji.org/news-events/news/post/protective-immunity-against-sars-cov-2-could-last-eight-months-or-more/*

In this article, the National Institute of Health (NIH) speaks to lasting immunity after recovering from Covid-19:

*The researchers found durable immune responses in the majority of people studied. Antibodies against the spike protein of SARS-CoV-2, which the virus uses to get inside cells, were found in 98% of participants one month after symptom onset. As seen in previous studies, the number of antibodies ranged widely between individuals. But, promisingly, their levels remained fairly stable over time, declining only modestly at 6 to 8 months after infection.*

*Virus-specific B cells increased over time. People had more memory B cells six months after symptom onset than at one month afterwards. Although the number of these cells appeared to reach a plateau after a few months, levels didn't decline over the period studied.*

*Levels of T cells for the virus also remained high after infection. Six months after symptom onset, 92% of participants had CD4+ T cells that recognized the virus. These cells help coordinate the immune response. About half the participants had CD8+ T cells, which kill cells that are infected by the virus.*

*As with antibodies, the numbers of different immune cell types varied substantially between individuals. Neither gender nor differences in disease severity could account for this variability. However, 95% of the people had at least 3 out of 5 immune-system components that could recognize SARS-CoV-2 up to 8 months after infection.*

*"Several months ago, our studies showed that natural infection induced a strong response, and this study now shows that the responses last," Weiskopf says. "We are hopeful that a similar pattern of responses lasting over time will also emerge for the vaccine-induced responses."*
*https://www.nih.gov/news-events/nih-research-matters/lasting-immunity-found-after-recovery-covid-19*

Another UK study cited in "Nature":

*Most people who catch and recover from COVID-19 are likely to be immune for several months afterwards, a study of more than 20,000 health-care workers in the United Kingdom has found.*

*The study — called SARS-CoV-2 Immunity and Reinfection Evaluation (SIREN) and published on the preprint server medRxiv on 15 January1 — concluded that immune responses from past infection reduce the risk of catching the virus again by 83% for at least 5 months.*

*…*

*The data suggest that natural immunity might be as effective as vaccination, she added, at least over the five-month period the study has covered so far.*
*https://www.nature.com/articles/d41586-021-00071-6*

Another study reported in "Nature" showed that long term T-Cell immunity in both SARS and SARS-2 (Covid-19) are very similar and therefore they believe T-Cell immunity will probably last many years. Here's a clip from that report with links to the full report at the bottom:

*Thus, SARS-CoV-2 N-specific T cells are part of the T cell repertoire of individuals with a history of SARS-CoV infection and these T cells are able to robustly expand after encountering N peptides of SARS-CoV-2. These findings demonstrate that virus-specific T cells induced by infection with betacoronaviruses are long-lasting, supporting the notion that patients with COVID-19 will develop long-term T cell immunity. Our findings also raise the possibility that long-lasting T cells generated after infection with related viruses may be able to protect against, or modify the pathology caused by, infection with SARS-CoV-2.*
*https://www.nature.com/articles/s41586-020-2550-z*

This report references the above report in nature, and has additional interesting information on natural vs. vaccine immunity: *https://childrenshealthdefense.org/defender/scientists-challenge-health-officials-on-vaccinating-covid/*

To conclude this topic, it is common medical understanding that once you have had a viral infection your body develops an immunity that can last many years, even a lifetime. Vaccines are an attempt to teach your body to have that same immunity without having to experience the actual disease and without the extreme symptoms you would experience with that disease. Here is a couple of sites that explain this process:
*https://www.cdc.gov/vaccines/vac-gen/immunity-types.htm*
*https://www.hopkinsmedicine.org/health/conditions-and-diseases/the-immune-system*

Bottom line, if you have had the Covid-19 infection, you now have the same lasting immunity you would supposedly get from the vaccine, which begs the question: **Why do you need the vaccine if you have survived the infection?**

## #7 More info on Censoring

It is obvious to those of us that search for information on all sides of an issue, that social media, mainstream media and government authorities/institutions are doing everything they can to not allow dissenting views on various Covid-19 topics (and other topics in recent news), all in the name of protecting everyone from supposed dangerous un-truths. They have tried to silence and have lied about alternative treatments. This is wrong. We should be allowed to hear all sides of a story so that we can make an informed decision for ourselves. We should be allowed to share this information freely with others. Experts in their fields (MD's, PhD's, etc.), should all be heard. Not allowing the free flow of information, the covering of all sides of an issue is a disservice to us all. Below are references to the censoring taking place, as well as references to public mistrust, lying, and examples of censoring.

**The National Institute of Health (NIH) report on censoring:**

*Censorship on major social media platforms, such as Facebook, Twitter and YouTube, is not a new phenomenon. These companies regularly remove content that they consider as objectionable based on continually updated categories outlined in their policies. Examples of "objectionable content" include "hate speech", "glorification of violence" or "harmful and dangerous content". These categories are not only often broader than the exceptions to the freedom of speech entrenched in legislations of democratic countries, but also implicitly vague and leave plenty of room to interpretation. Indeed, an analysis of content banned on social networks suggests that the moderation is often politically biased (Stjernfelt & Lauritzen, 2020). Some very recent examples of moderation with apparent political ramifications include Twitter's labelling of US President Donald J. Trump's tweets as violating Twitter's policy about glorifying violence or abusive behaviour, or adding a warning suggesting that a post was factually inaccurate*

*A major question regarding the policies of the communication platforms is who exactly defines and how which information is deemed to be false or harmful? And can we rely on these judgements? One of the authoritative sources that all three major social media platforms mention in their policies on COVID-19 is the WHO. It is an established and influential organization, yet it may make mistakes, including in the context of handling epidemics. For example, concerns have been raised about influences of pharmaceutical companies on the guidelines related to the flu pandemic in 2009 (Cohen & Carter, 2010).*
*https://pubmed.ncbi.nlm.nih.gov/33103289/*

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7645258/

**Public believes information is being censored:**

*Pew Research Center survey conducted in June finds that roughly three-quarters of U.S. adults say it is very (37%) or somewhat (36%) likely that social media sites intentionally censor political viewpoints that they find objectionable. Just 25% believe this is not likely the case.*
https://www.pewresearch.org/internet/2020/08/19/most-americans-think-social-media-sites-censor-political-viewpoints/

**Two top medical journals in US had to retract reports on a potential Covid-19 treatment:**

*(CNN)Two influential medical journals retracted separate coronavirus studies Thursday over concerns about the data used in both studies -- data that came from the same international registry.*

*The authors of the studies, one published in The Lancet and another in The New England Journal of Medicine, requested the studies be retracted because independent auditors weren't able to access all the information needed to verify the data. Both studies used data from data analytics company Surgisphere Corporation.*

*The retracted Lancet study, published May 22, found Covid-19 patients treated with hydroxychloroquine and chloroquine were more likely to die or suffer dangerous side effects.*

*The study had provided a counterpoint to President Trump, who has called hydroxychloroquine a "game-changer" for Covid-19. Several countries and the World Health Organization paused ongoing studies looking at the efficacy of the drugs based on The Lancet study, although the WHO resumed its study on Wednesday.*
https://www.cnn.com/2020/06/04/health/retraction-coronavirus-studies-lancet-nejm/index.html
https://www.sciencemag.org/news/2020/06/two-elite-medical-journals-retract-coronavirus-papers-over-data-integrity-questions

**Example of Censoring: Analysis of a YouTube censorship event:**

*This video was censored on YouTube. …see link below for blog that contains censored video…*
*I am re-sharing it here so that I never forget that time the U.S. flirted with dystopia. John Ioannidis is a professor at Stanford who has made a career out of assessing evidence in medical research. Before the pandemic, he was glowingly covered by The Atlantic and The Economist, his research was written about extensively in The New York Times, and he was an invited speaker for the Talks at Google series. While credentials don't grant infallibility, the fact that a scientist with his expertise was censored for the statements he made in this video — positions that were/are held by other experts — should be deeply unsettling to us all.*

*In this blog post, I'm going to evaluate the accuracy of the most controversial points made by Ioannidis in the video. As a brief summary, in the interview (which was originally posted on March 23rd), Ioannidis argues the fatality risk of COVID-19 is most likely much lower than the numbers that were being presented at the time (because these numbers were being calculated from bad data). Based on this observation, he suggests that a more targeted response of protecting the most vulnerable might be a less harmful policy than full lockdowns (a position also held by other health professionals including David Katz at Yale and the Swedish government).*

…read rest of blog post analyzing points John Ioannidis made…blog concludes with:

*On close inspection, it appears Ioannidis was simply using his expertise to make reasonable and important arguments about the threat of COVID-19 and the costs and benefits of different responses. The video should never have been removed from YouTube, and we should be ashamed of ourselves for accepting such censorship. I hope we can all learn from this episode in history and that, the next time we face an unknown threat, we do not allow fear and panic to cloud our judgement, nor accept the silencing of alternative points of view.*
https://michaelaalcorn.medium.com/how-wrong-was-ioannidis-5940e49c9af6

**Example of Censoring: Analysis of a Facebook censorship event:**

*Journalist Glenn Greenwald is blasting Facebook for its decision to crackdown on users posting comments about the coronavirus vaccine that undermine official information being provided by "authorities."*

*Greenwald, a Pulitzer-prize winning reporter, said social media giants like Facebook are under immense pressure from mainstream media outlets to censor dissenting opinion.*

*"I think it's so important to recognize that Silicon Valley companies are not the ones who want to do this. They would rather stay as far away from censoring, and arbitrating, and intervening, and keeping people off their platforms, not because they're noble and nice, but because it's in their business self-interest not to do it. They're being pressured to do it," he told Fox News' Tucker Carlson on Tuesday evening.*

*"This is what's so amazing, by CNN, and NBC, and New York Times who are saying every time you allow information over your platform that we think is wrong, we're going to shame you, we're going to disgrace you," Greenwald continued.*

*"And they have their partners, who are the Democratic Party, who control the entire government now, who are right along with them saying, 'We demand that you censor more.' They're being pressured, led by journalists who are now the leading activists to destroy free discourse and free thought in the United States, that's the dynamic that we have to understand," he added.*

*Greenwald said he and his family will be vaccinated, a decision he said he reached by researching on the "free and open" internet, including seeking out dissenting opinions.*

*"But if the internet were a place where no dissent were allowed, I would have way less confidence in that ability because that would mean this is a profession that isn't confident enough to allow dissent, and if they're not confident enough to allow dissent, I think that they earn much less trust and faith in their pronouncements," he said.*
*https://nypost.com/2021/02/10/greenwald-blasts-facebook-for-censoring-covid-vaccine-opinions/*

## #8 More info on Vaccinated are Safe

The CDC is recommending the same conditions for implementing vaccines in the workplace, as has happened in the past for the flu vaccine:

*Can I require my employees to get the COVID-19 vaccine regardless of their medical conditions or religious beliefs?*

*The Equal Employment Opportunity Commission (EEOC) provides guidance on mandatory vaccination against H1N1 influenza. The EEOC guidance may be applicable to COVID-19 vaccination, which became available in December 2020.*

*For employers covered by the Americans with Disabilities Act (ADA), "…an employee may be entitled to an exemption based on an ADA disability that prevents him from taking the influenza vaccine." For employers covered under Title VII of the Civil Rights Act of 1964, "once an employer receives notice that an employee's sincerely held religious belief, practice, or observance prevents him from taking the influenza vaccine, the employer must provide a reasonable accommodation unless it would pose an undue hardship."*

*"Generally, ADA-covered employers should consider simply encouraging employees to get the influenza vaccine rather than requiring them to take it."*
*https://www.cdc.gov/coronavirus/2019-ncov/downloads/vaccines/toolkits/FAQs-for-Employers_EW-Toolkit_508.pdf*

*May an employer covered by the ADA and Title VII of the Civil Rights Act of 1964 compel all of its employees to take the influenza vaccine regardless of their medical conditions or their religious beliefs during a pandemic?*

*No. An employee may be entitled to an exemption from a mandatory vaccination requirement based on an ADA disability that prevents him from taking the influenza vaccine. This would be a reasonable accommodation barring undue hardship (significant difficulty or expense). Similarly, under Title VII of the Civil Rights Act of 1964, once an employer receives notice that an employee's sincerely held religious belief, practice, or observance prevents him from taking the influenza vaccine, the employer must provide a reasonable accommodation unless it would pose an undue hardship as defined by Title VII ("more than de minimis cost" to the operation of the employer's business, which is a lower standard than under the ADA).*

*Generally, ADA-covered employers should consider simply encouraging employees to get the influenza vaccine rather than requiring them to take it. As of the date this document is being issued, there is no vaccine available for COVID-19.*
*https://www.eeoc.gov/sites/default/files/2020-04/pandemic_flu.pdf*
*https://www.eeoc.gov/laws/guidance/your-employment-rights-individual-disability#:~:text=Under%20the%20ADA%20%2C%20you%20have,limits%20a%20major%20life%20activity.&text=To%20be%20protected%20under%20the,opposed%20to%20a%20minor%2C%20impairment.*
*https://www.eeoc.gov/laws/guidance/fact-sheet-disability-discrimination#:~:text=The%20ADA%20covers%20employers%20with,amended%2C%20and%20its%20implementing%20rules.*

Finally, I believe everyone in the workforce now knows to stay home if they are sick. If you are not exhibiting symptoms, you will not spread the virus. This is contrary to what we were told early in the pandemic. I think there is a good case to be made that if those exhibiting any symptoms of illness stay home, then vaccinated employees will be safe from unvaccinated employees, AND unvaccinated will be safe from vaccinated (because both can still get Covid-19).

CDC Report April 2021: Asymptomatic people do not spread Covid-19:
https://wwwnc.cdc.gov/eid/article/27/4/20-4576_article
CDC: Only 4% in Korean study were assymtomatic (vs. earlier estimates of 30%).
https://wwwnc.cdc.gov/eid/article/26/8/20-1274_article
China study: Primary method of transmission is at households (close proximity for long periods of time)
https://www.acpjournals.org/doi/10.7326/M20-2671

## #9 More info on Pregnancy Concerns

*According to VAERS data from 3/26/2021, 341 pregnant women had reported adverse reactions, including 104 reports of miscarriage or premature birth.*
*http://republicbroadcasting.org/news/cdc-data-show-covid-vaccine-injuries-reported-to-vaers-surpasses-50000/*

Additional details on how Covid-19 and the vaccine can impact pregnancy and fertility follow.

*Possible impact to existing and future pregnancies*

*The vaccinations are expected to produce antibodies against spike proteins of SARS-CoV-2. However, spike proteins also contain syncytin-homologous proteins, which are essential for the formation of the placenta in mammals such as humans. It must be absolutely ruled out that a vaccine against SARS-CoV-2 could trigger an immune reaction against syncytin-1, as otherwise infertility of indefinite duration could result in vaccinated women.*

*We do not know the effect on the pregnant or soon to be pregnant… The mechanism of action of the experimental mRNA vaccines includes a possible autoimmune rejection of the placenta. In layman's terms, the vaccine may permanently interfere with a woman's ability to maintain a pregnancy. The vaccine companies themselves acknowledge the possibility of ill effects on a pregnancy on the vaccine bottle, which says the following: "it is unknown whether COVID-19 mRNA VaccineBNT162b2 has an impact on fertility. And women of childbearing age are advised to avoid pregnancy for at least two months after their second dose."* 1 (p16)and:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/9414
https://2020news.de/wpcontent/uploads/2020/12/Wodarg_Yeadon_EMA_Petition_Pfizer_Trial_FINAL_01DEC2020_EN_unsi gned_with_Exhibits.pdf

*Placental inflammation resulting in stillbirths mid-pregnancy (second trimester) is seen with COVID-19 and with other similar coronaviruses. The way the experimental vaccines work, it is concerning that that deleterious effect on the placenta, which in the wild only lasts as long as the acute illness, would instead be lifelong.*

*There is a case report of a woman with a normally developing pregnancy who lost the otherwise healthy baby at five months during acute COVID-19. The mother's side of the placenta was very inflamed. This "infection of the maternal side of the placenta inducing acute or chronic placental insufficiency resulting in miscarriage or fetal growth restriction was observed in 40% of pregnant women with similar coronaviruses" Thus far SARS-CoV-2 appears to be similar. This issue has not been studied despite saying that "Additional studies of pregnant women with COVID-19 is warranted to determine if SARS-CoV-2 can cause similar adverse outcomes."*

*The purported mRNA vaccines may instigate a similar reaction as the virus. There is a component in the vaccine that could cause this same auto-immune rejection of the placenta but indefinitely. In layman's terms: getting COVID-19 has been associated with a high risk of mid-pregnancy miscarriage because the placenta fails – but the vaccine may do the exact same thing – but not for just the few weeks of being sick – but forever. Meaning repeated pregnancies would keep failing ~ mid-pregnancy. It is completely reckless to give this vaccine to millions of people who would otherwise all be expected to recover, until we know the answer to that question!*

*i. Here is the scientific theory/explanation for the effect on the placenta (and possibly on sperm): the spike protein of Sars-Cov-2, against which teams are competing to develop a vaccine, is highly homologous with a human HERV protein, syncytin1. Syncytin-1, which is a HERV derived protein, causes fusion of cells in the trophoblast and has a role in placentation. The vaccinations are expected to produce antibodies against spike proteins of SARS-CoV-2. However, spike proteins also contain syncytin-*

*homologous proteins, which are essential for the formation of the placenta in mammals such as humans. It must be absolutely ruled out that a vaccine against SARS-CoV-2 could trigger an immune reaction against syncytin-1, as otherwise infertility of indefinite duration could result in vaccinated women.*

*Alignment of the endogenous elements Syn1 found on human chromosome 7, or Syn2 found on chromosome 6, or HERV-K expressed from chromosome 6, all show a number of sequence motifs with significant similarity to nCoV2019 spike protein.*

*ii. As reported by Public Broadcasting Service, regarding placenta science: "The syncytiotrophoblast is the outermost layer of the placenta, the part that is pressed against the uterus. It's literally a layer of cells that have fused together, forming a wall….This wall of cells keeps mom and baby working in harmony and not killing each other. There's no other structure like this anywhere else in the body."*

*Many scientists already agree the risk is much too high to release these experimental vaccines to the public at large. On December 1, 2020, the ex-Pfizer head of respiratory research Dr. Michael Yeadon and the lung specialist and former head of the public health department Dr. Wolfgang Wodarg filed an application with the European Medicine Agency responsible for European approval, for the immediate suspension of all SARS CoV-2 vaccine studies, in particular the BioNtech/Pfizer study on BNT162b. One of the biggest reasons they cited was the possibility of lifelong infertility as described above and copied here.* [1 (p25)]

> ***XI.*** *Several vaccine candidates are expected to induce the formation of humoral antibodies against spike proteins of SARS-CoV-2. Syncytin-1 (see Gallaher, B., "Response to nCoV2019 Against Backdrop of Endogenous Retroviruses" – http://virological.org/t/response-to-ncov2019- against-backdrop-of-endogenous-retroviruses/396), which is derived from human endogenous retroviruses (HERV) and is responsible for the development of a placenta in mammals and humans and is therefore an essential prerequisite for a successful pregnancy, is also found in homologous form in the spike proteins of SARS viruses. There is no indication whether antibodies against spike proteins of SARS viruses would also act like anti-Syncytin-1 antibodies. However, if this were to be the case this would then also prevent the formation of a placenta which would result in vaccinated women essentially becoming infertile. To my knowledge, Pfizer/BioNTech has yet to release any samples of written materials provided to patients, so it is unclear what, if any, information regarding (potential) fertility-specific risks caused by antibodies is included.*
>
> *According to section 10.4.2 of the Pfizer/BioNTech trial protocol, a woman of childbearing potential (WOCBP) is eligible to participate if she is not pregnant or breastfeeding, and is using an acceptable contraceptive method as described in the trial protocol during the intervention period (for a minimum of 28 days after the last dose of study intervention).*
>
> *This means that it could take a relatively long time before a noticeable number of cases of post-vaccination infertility could be observed.*

1(p24)

Here's a link to a report written by an MD that includes the full text of above:
https://newsrescue.com/doctors-former-pfizer-respiratory-vp-chief-scientific-advisor-file-petition-covid-vaccine-could-be-linked-to-infertility/

## #11 More info on Consequences

Entities that mandate individuals to get the vaccine are not abiding by the FDA EUA guidelines and could be held responsible for any complications that come from the experimental vaccine.

Information for entities that Mandate the Vaccine:

*On March 10, 2020, the Secretary of HHS made a public health emergency declaration for COVID-19, which makes the PREP Act's protections applicable to the COVID-19 pandemic.*

*The PREP Act provides liability immunity to certain "covered persons" against any claim of loss caused by (or arising out of, relating to, or resulting from) the manufacture, distribution, administration, or use of medical countermeasures, which includes a COVID19 vaccine. This Act shields the pharmaceutical companies from liability,*

*making it difficult to hold them financially responsible. In other words, it is much more difficult than a regular products liability case. The pharmaceutical company can only be liable if there is "willful misconduct" as defined by the Act, which results in death or serious physical injury. AFLDS are putting the pharmaceutical companies on notice today, before the vaccine is distributed, administered, or used, that if they go forward now, with their intent to achieve a wrongful purpose and despite being informed of the serious potential risks as outlined herein, they are clearly engaging in willful misconduct and are, therefore, no longer protected under the PREP Act.*

*The PREP Act does not shield employers or businesses as "covered persons" and should they attempt to mandate vaccination, they may be liable for resulting harms. Pursuant to an EUA, each person has a right to decline a medication/biologic that is not fully licensed. The subject needs to be told the risks/benefits and of the right to decline. An experimental treatment cannot be forced. So, for example, if a teachers' union or an airline attempts to mandate a COVID-19 vaccine issued under an EUA, they may very well be liable for bad outcomes.* [1 (p27)]

**Interesting report about the LSU Dental School…**

*LSU Dental School Reverses "Vaccine" Policy*
*Mar 25, 2021*

*Liberty Counsel recently sent a letter to the dean of the Louisiana State University School of Dentistry, and now that school will no longer mandate that faculty, staff and students take the COVID-19 "vaccine."*

*A request regarding Chancellor Larry Hollier's vaccine mandate for attendance at graduation ("Anyone who is not vaccinated will not be allowed to participate in person, only virtually.") remains outstanding.*

*On March 16, Dentistry Dean Robert Laughlin notified faculty, staff and students at the dental school "involved in direct patient care will be required to show proof of having received full vaccination for COVID-19," effective March 22, 2021. Noncompliance would result in the student's inability to complete course requirements and graduate. Concerned students contacted Liberty Counsel.*

*Liberty Counsel's letter dated March 19 to Dean Robert Laughlin stated the mandate was a "violation of fundamental individual, economic and religious liberties. These include the rights of personal autonomy and bodily integrity, and the right to accept or reject the various COVID vaccines based on religious belief."*
*https://lc.org/newsroom/details/032521-lsu-dental-school-reverses-vaccine-policy-2?fbclid=IwAR0JKQmSHcK8yqpuu73CQznUdQ8iGaJLCr8a8dVH2K3ls9EGSyQmgjVFop8*

Other interesting reads on this topic:
*https://standforhealthfreedom.com/wp-content/uploads/2020/12/top-5-reasons.pdf*
*https://www.statnews.com/2021/02/23/federal-law-prohibits-employers-and-others-from-requiring-vaccination-with-a-covid-19-vaccine-distributed-under-an-eua/*

ADDITIONAL REFERENCE INFORMATION

1. America's Frontline Doctors Position Paper on Covid-19 Experimental Vaccines
   https://www.americasfrontlinedoctors.com/wp-content/uploads/Vaccine-PP.pdf
   https://assets.website-files.com/606d3a50c62e44338008303d/6076e4fd8bde421370729e47_Vaccine-PP.pdf
   Authors: -Simone Gold, MD, JD -James Todaro, MD -Lee Merritt, MD
   -Richard Urso, MD -Robin Armstrong, MD -Scott Barbour, MD
   -Jeff Barke, MD -Mark McDonald, MD -Teryn Clark, MD
   -Shelley Cole, MD -Geoff Mitchell, MD, JD
   Additional info from America's Frontline Doctors:
   https://www.americasfrontlinedoctors.org/covid-19/vaccine-information
   https://www.americasfrontlinedoctors.org/about-us/mission-statement

2: SOURCES FOR NUMERIC DATA/CALCULATIONS:
https://www.cdc.gov/mmwr/volumes/70/wr/mm7014e1.htm

**TABLE. Provisional* number and rate of total deaths and COVID-19–related deaths, by demographic characteristics — National Vital Statistics System, United States, 2020**

| Characteristic | No. (rate)† Total deaths | COVID-19 deaths§ |
|---|---|---|
| Total | 3,358,814 (828.7) | 377,883 (91.5) |
| Age group, yrs | | |
| <1 | 19,146 (506.0) | 43 (1.1) |
| 1–4 | 3,469 (22.2) | 24 (0.2) |
| 5–14 | 5,556 (13.6) | 67 (0.2) |
| 15–24 | 35,470 (83.2) | 587 (1.4) |
| 25–34 | 72,678 (157.9) | 2,527 (5.5) |
| 35–44 | 103,389 (246.2) | 6,617 (15.8) |
| 45–54 | 189,397 (467.8) | 17,905 (44.2) |
| 55–64 | 436,886 (1,028.5) | 44,631 (105.1) |
| 65–74 | 669,316 (2,068.8) | 80,617 (249.2) |
| 75–84 | 816,307 (4,980.2) | 104,212 (635.8) |
| ≥85 | 1,007,114 (15,007.4) | 120,648 (1,797.8) |

https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html (4/3/2021)

**Table 1. Parameter Values that vary among the five COVID-19 Pandemic Planning Scenarios.**
The scenarios are intended to advance public health preparedness and planning. They are **not** predictions or estimates of the expected impact of COVID-19.

| Parameter | Scenario 1 | Scenario 2 | Scenario 3 | Scenario 4 | Scenario 5: Current Best Estimate |
|---|---|---|---|---|---|
| $R_0$* | 2.0 | | 4.0 | | 2.5 |
| Infection fatality ratio (Estimated number of deaths per 1,000,000 infections)† | 0–17 years old: 6<br>18–49 years old: 150<br>50–64 years old: 1,800<br>65+ years old: 26,000 | | 0–17 years old: 80<br>18–49 years old: 1,700<br>50–64 years old: 20,000<br>65+ years old: 270,000 | | 0–17 years old: 20<br>18–49 years old: 500<br>50–64 years old: 6,000<br>65+ years old: 90,000 |

Total covid cases and deaths as of 12/31/2020
https://www.reuters.com/article/us-health-coronavirus-usa-cdc/u-s-cdc-reports-record-3764-coronavirus-deaths-in-a-day-idUSKBN2951RI

(Reuters) - The U.S. Centers for Disease Control and Prevention (CDC) on Thursday reported 341,199 deaths from the new coronavirus, a record rise of 3,764 deaths from its previous count.

The agency said the number of cases had risen by 230,337 to 19,663,976.

The CDC reported its tally of cases of the respiratory illness known as COVID-19, caused by a new coronavirus, as of 4 p.m. ET on Dec. 30 versus its previous report a day earlier. (bit.ly/33mTSJz)

The CDC figures do not necessarily reflect cases reported by individual states.

Reporting by Manojna Maddipatla in Bengaluru; Editing by Maju Samuel

# CDC Death rate doesn't "add up"

For latest reporting of data on 4/24/2021, CDC says 3486 deaths, and CNN states CDC reporting 93,000,000 fully vaccinated and 138,000,000 at least one dose. They report .0016% death rate. (see CDC and CNN reports below).
Using CDC death rate %...
138,000,000 x .0016/100 = 2208 deaths, which is not equal to the 3486 deaths reported
93,000,000 x .0016/100 = 1488 deaths, which is also not equal to the 3486 deaths reported
This doesn't add up to the 3486 deaths reported. So death rate should be:
3486 deaths / 138,000,000 vaccinated w/at least 1 dose or fully x 100% = .0025% death rate
This is nearly double the death rate being reported by CDC.
How many vaccines administered / death:
4/24: 138,000,000 vaccinated / 3486 deaths = 39,587 vaccinated / death … or … 1 death / 39,587 vaccinated
*https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html (4/24/2021)*
*Over 211 million doses of COVID-19 vaccines were administered in the United States from December 14, 2020, through April 19, 2021. During this time, VAERS received 3,486 reports of death (0.0016%) among people who received a COVID-19 vaccine.*
*https://www.cnn.com/world/live-news/coronavirus-pandemic-vaccine-updates-04-24-21*
*More than 225 million Covid-19 vaccine doses have been administered in the US, according to data published Saturday by the US Centers for Disease Control and Prevention (CDC).*
*The CDC reported 225,640,460 doses administered, nearly 78% of the 290,685,655 doses distributed.*
*More than 138 million people have now received at least one dose of Covid-19 vaccine and more than 93 million have been fully vaccinated.*

**How does this look with data from 5/10-12…**
CDC reporting 46.7% of US Population has received at least one dose of vaccine. With US Population of 328million, this equals 153million have received at least one dose, and also reporting 4434 deaths as of 5/10 now.
Using CDC published vaccine death rate % of .0017%...
153,000,000 x .0017/100 = 2601 deaths, which is not equal to the 4434 deaths reported
This doesn't add up to the 4434 deaths reported. So death rate should be:
4434 deaths / 153,000,000 vaccinated w/at least 1 dose or fully x 100% = .0029% death rate
Again, this is nearly double the death rate being reported by CDC.
How many vaccines administered / death:
7/30 data: 190,509,183 at least one dose/12,366 deaths=15,406 vaccinated/death …or… 1 death/15,406 vaccinated
5/10 data: 153,000,000 at least one dose/4434 deaths=34,506 vaccinated/death …or… 1 death / 34,506 vaccinated

**ADDITIONAL EXCERPTS FROM CDC VAERS SYSTEM THAT SUPPORT CALCULATIONS**
https://wonder.cdc.gov/vaers.html

SEARCH CRITERIA:

1. Symptoms, and by Vaccine
2. Symptoms: Death 10011906
3. Vaccine Characteristics: Ctrl-Click on each Flu vaccine type to select them all
4. All manufacturer, all doses
5. Location: The US, all ages, all genders
6. Event Characteristics: Death, All events, All days for all sub criteria
7. Search text fields: none
8. Select report completed dates: All
9. Select report received dates: All
10. Select vaccination dates: 2018 (then 2019, then 2020, then 2021)
11. Select adverse event onset dates: All
12. Select death dates: All

**FLU 2019**

## 2018-19 Seasonal Influenza Vaccine Total Doses Distributed

Español

Please note that 3/01/2019 is the final weekly update for the 2018-19 flu season.

**Influenza vaccine distribution information for the 2018-2019 season is posted here as CDC receives it, typically on Fridays. Please continue to check this page for the most up-to-date information.**

Flu vaccine is produced by private manufacturers, so supply depends on manufacturers. For the 2018-2019 season, manufacturers have projected they will provide as many as 163 to 168 million doses of injectable influenza vaccine for the U.S. market. (Projections may change as the season progresses.)

March 08, 2019 10:00 AM ET

### Table of 2018-19 Seasonal Influenza Vaccine—Total Doses Distributed

| Week | Total Doses Distributed |
|---|---|
| 03/01/2019 | ≈ 169.1 M |

**FLU 2018**

| Symptoms | Vaccine | Events Reported | Percent (of 15) |
|---|---|---|---|
| DEATH | INFLUENZA (SEASONAL) (NO BRAND NAME) (44) | 1 | 6.67% |
| DEATH | INFLUENZA (SEASONAL) (AFLURIA QUADRIVALENT) (1177) | 2 | 13.33% |
| DEATH | INFLUENZA (SEASONAL) (FLUARIX QUADRIVALENT) (1161) | 2 | 13.33% |
| DEATH | INFLUENZA (SEASONAL) (FLULAVAL QUADRIVALENT) (1166) | 1 | 6.67% |
| DEATH | INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE QUADRIVALENT) (1199) | 1 | 6.67% |
| DEATH | INFLUENZA (SEASONAL) (FLUZONE QUADRIVALENT) (1162) | 1 | 6.67% |
| DEATH | INFLUENZA (SEASONAL) (FLUBLOK QUADRIVALENT) (1176) | 2 | 13.33% |
| DEATH | INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE) (1145) | 4 | 26.67% |
| DEATH | INFLUENZA (SEASONAL) (FLUAD) (1173) | 1 | 6.67% |
| DEATH | Total | 15 | 100.00% |
| Total | | 15 | 100.00% |

2018

# 2017-18 Seasonal Influenza Vaccine Total Doses Distributed

Español

Please note that 2/23/2018 is the final weekly update for the 2017-18 flu season.

**Influenza vaccine distribution information for the 2017-2018 season is posted here as CDC receives it, typically on Fridays. Please continue to check this page for the most up-to-date information.**

Flu vaccine is produced by private manufacturers, so supply depends on manufacturers. For the 2017-2018 season, manufacturers have projected they will provide as many as 151 to 166 million doses of injectable influenza vaccine for the U.S. market. (Projections may change as the season progresses.)

May 3, 2018 4:00 PM ET

## Table of 2017-18 Seasonal Influenza Vaccine—Total Doses Distributed

| Week | Total Doses Distributed |
|---|---|
| 02/23/2018 | ≈ 155.3 million doses |

Flu 2019

**Messages:**
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 14 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

| Symptoms | Vaccine | Events Reported | Percent (of 14) |
|---|---|---|---|
| DEATH | INFLUENZA (SEASONAL) (NO BRAND NAME) (44) | 1 | 7.14% |
| DEATH | INFLUENZA (SEASONAL) (AFLURIA QUADRIVALENT) (1177) | 2 | 14.29% |
| DEATH | INFLUENZA (SEASONAL) (FLUARIX QUADRIVALENT) (1161) | 2 | 14.29% |
| DEATH | INFLUENZA (SEASONAL) (FLULAVAL QUADRIVALENT) (1166) | 1 | 7.14% |
| DEATH | INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE QUADRIVALENT) (1199) | 1 | 7.14% |
| DEATH | INFLUENZA (SEASONAL) (FLUZONE QUADRIVALENT) (1162) | 1 | 7.14% |
| DEATH | INFLUENZA (SEASONAL) (FLUBLOK QUADRIVALENT) (1176) | 2 | 14.29% |
| DEATH | INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE) (1145) | 3 | 21.43% |
| DEATH | INFLUENZA (SEASONAL) (FLUAD) (1173) | 1 | 7.14% |
| DEATH | Total | 14 | 100.00% |
| Total | | 14 | 100.00% |

Flu 2020

**Messages:**
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 24 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

| Symptoms | Vaccine | Events Reported | Percent (of 24) |
|---|---|---|---|
| DEATH | INFLUENZA (SEASONAL) (NO BRAND NAME) (44) | 1 | 4.17% |
| DEATH | INFLUENZA (SEASONAL) (FLUARIX QUADRIVALENT) (1161) | 3 | 12.50% |
| DEATH | INFLUENZA (SEASONAL) (FLULAVAL QUADRIVALENT) (1166) | 2 | 8.33% |
| DEATH | INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE QUADRIVALENT) (1199) | 8 | 33.33% |
| DEATH | INFLUENZA (SEASONAL) (FLUZONE QUADRIVALENT) (1162) | 5 | 20.83% |
| DEATH | INFLUENZA (SEASONAL) (FLUAD QUADRIVALENT) (1198) | 1 | 4.17% |
| DEATH | INFLUENZA (SEASONAL) (FLUCELVAX QUADRIVALENT) (1175) | 1 | 4.17% |
| DEATH | INFLUENZA (SEASONAL) (FLUBLOK QUADRIVALENT) (1176) | 1 | 4.17% |
| DEATH | INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE) (1145) | 1 | 4.17% |
| DEATH | INFLUENZA (SEASONAL) (FLUAD) (1173) | 1 | 4.17% |
| DEATH | Total | 24 | 100.00% |
| Total | | 24 | 100.00% |

Flu 2021

**Messages:**

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 3 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

| Symptoms | Vaccine | Events Reported | Percent (of 3) |
|---|---|---|---|
| DEATH | INFLUENZA (SEASONAL) (FLULAVAL QUADRIVALENT) (1166) | 1 | 33.33% |
| DEATH | INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE QUADRIVALENT) (1199) | 1 | 33.33% |
| DEATH | INFLUENZA (SEASONAL) (FLUZONE QUADRIVALENT) (1162) | 1 | 33.33% |
| DEATH | **Total** | **3** | **100.00%** |
| **Total** | | **3** | **100.00%** |

## Covid – 2021

**Messages:**

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 2,939 total events.

| Symptoms | Vaccine | Events Reported | Percent (of 2,939) |
|---|---|---|---|
| DEATH | COVID19 (COVID19 (JANSSEN)) (1203) | 202 | 6.87% |
| | COVID19 (COVID19 (MODERNA)) (1201) | 1,601 | 54.47% |
| | COVID19 (COVID19 (PFIZER-BIONTECH)) (1200) | 1,339 | 45.56% |
| | COVID19 (COVID19 (UNKNOWN)) (1202) | 13 | 0.44% |
| | **Total** | **3,155** | **107.35%** |
| **Total** | | **3,155** | **107.35%** |

## Covid – 2020

**Messages:**

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 179 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

| Symptoms | Vaccine | Events Reported | Percent (of 179) |
|---|---|---|---|
| DEATH | COVID19 (COVID19 (MODERNA)) (1201) | 77 | 43.02% |
| | COVID19 (COVID19 (PFIZER-BIONTECH)) (1200) | 107 | 59.78% |
| | **Total** | **184** | **102.79%** |
| **Total** | | **184** | **102.79%** |

## How many in US vaccinated with at least one dose: