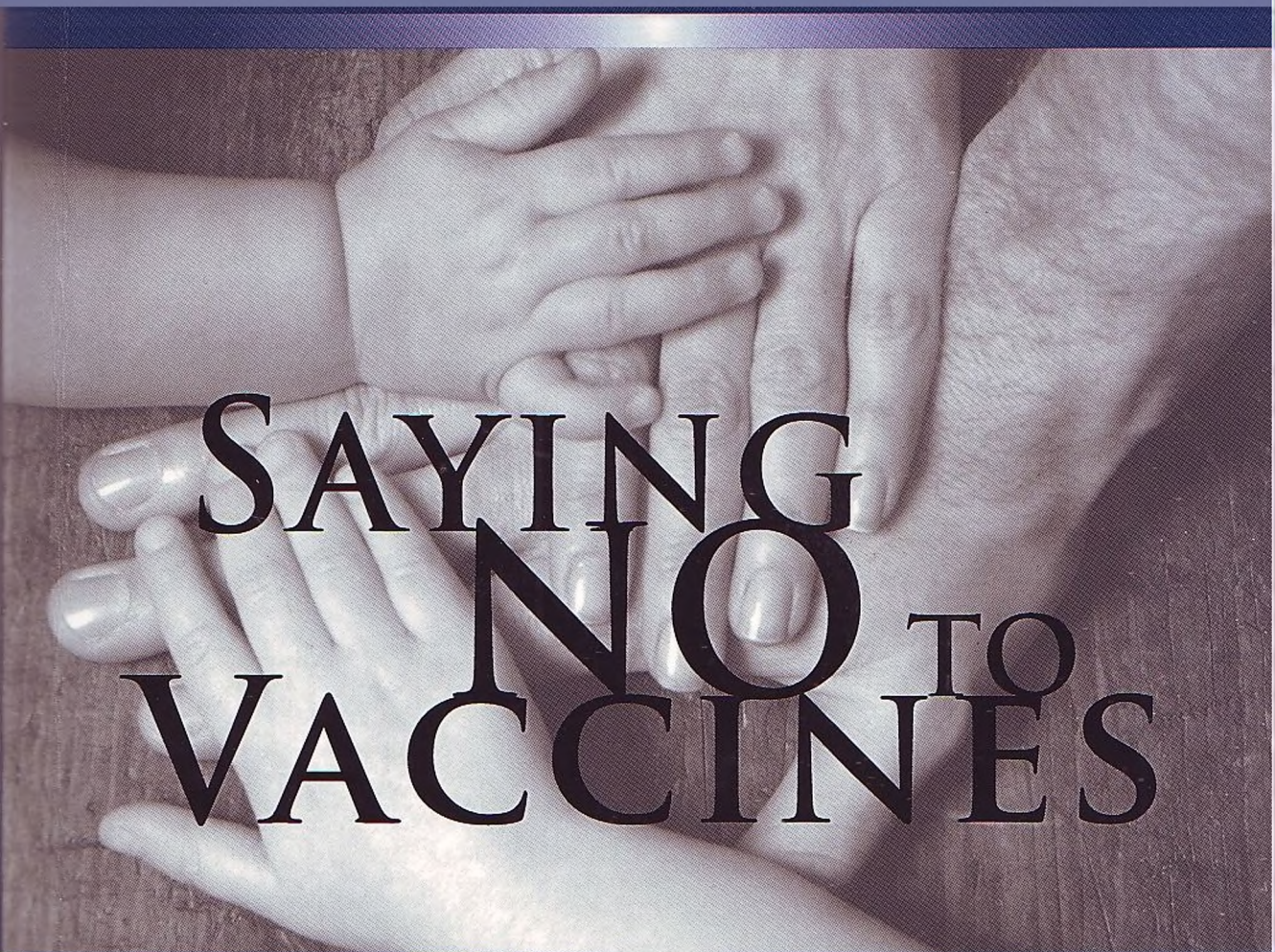

SAYING NO TO VACCINES

A RESOURCE GUIDE FOR ALL AGES

DR. SHERRI TENPENNY

Also includes:

- A (Short) History of Mandatory Vaccination
- Vaccine Exemptions for Schools, Healthcare, Military & Other Special Circumstances
- Vaccine Ingredients and Schedules
- 350+ Medical References Documenting Vaccine Problems…and more!

Saying No to Vaccines
A Resource Guide for All Ages

Dr. Sherri J. Tenpenny

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The decision of whether or not to vaccinate is an important and complex issue. The decision should be made by the patient or by the parent(s) of a minor in consultation with a health care provider and one's own conscience. The decision to vaccinate or not to vaccinate is yours alone, and Dr. Tenpenny is not responsible for any consequence of those decisions.

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A Note to Readers

Dear Friends,

Have you ever heard the expression, "Some things you pick...and some things pick you"?

I was drawn into the ever-changing, emotionally-charged vaccine debate after attending a meeting presented by the National Vaccine Information Center (NVIC), a 22-year-old non-profit organization dedicated to preventing vaccine injuries and deaths through public education and defending the right to informed consent to vaccination. The meeting was held in Washington, DC, in September 2000. At the close of the three-day meeting, I was troubled by what I had heard and decided to research vaccines by going straight to the leading vaccine authority in the country: the Centers for Disease Control (CDC). Imagine my surprise—and dismay—when I discovered that most of what I had accepted as the truth about vaccines really wasn't the truth at all. Here are a few examples of what the CDC had to say:

- Vaccines are not responsible for the eradication of diseases, such as polio and smallpox.
- Vaccines have not been proven to be safe for the individual.
- When a vaccine is called "effective," it's not the same as being "protective."
- During a research study, a second vaccine is used as a "placebo" instead of an inert substance, such as sterile water or normal saline.
- Vaccines are not "relatively harmless." Many thousands have been injured and many hundreds have died as a result of vaccination.

And the list goes on. From the first NVIC meeting to the present, I have invested more than 8,000 hours into my research. Every day, I commit several hours to reading and researching vaccine-related information. That level of commitment is required to keep abreast of the "vaccine issue." It is a big topic that includes at least the following:

1- **Pediatric vaccine recommendations:** The current vaccination schedule continues to change. As of 2007, there are 14 vaccines given to children before they start school.

2- **Adolescent vaccine recommendations:** The newly released adolescent vaccination schedule went into effect January 2007 and is subject to change frequently as more vaccines are developed for adolescents.

3- **Adult vaccine recommendations:** Some vaccines on the pediatric schedule are also recommended as boosters for adults. There are at least nine separate vaccines for adults and several others recommended for travel.

4- **New vaccines under development:** At least 20 vaccines are in development including vaccines for sexually transmitted diseases, nicotine addiction, elevated cholesterol and periodontal disease. New vaccine ingredients, adjuvants, additives, delivery systems and culture media (including the use of dog kidney cells and retinal tissue from an aborted fetus) are being produced and require investigation.

5- **Bio-terrorism vaccines:** A long list of vaccines is being considered for both military and civilian application. As of 2005, at least 95 U.S. companies were working on vaccines or therapeutics to combat bioweapons. Funding for biodefense by the National Institute of Allergy and Infectious Diseases (NIAID) increased from $3.2 million in fiscal year 2001 to an estimated $561.5 million in fiscal year 2005. Project

Bioshield legislation, enacted in 2006, provided $5.6 billion over the next 10 years to help generate medical countermeasures. Vaccines are under development for plague, botulism, pandemic influenza, tularemia, Venezuelan equine encephalitis and the Ebola virus, as well as genetically engineered threats.

6- **Vaccination politics:** State and national governments frequently engage in the topic of vaccination. Exemption laws are discussed in each state in nearly every legislative session. National mandates, such as the attempt at national mass smallpox vaccination after 9-11, are surfacing on a regular basis.

7- **Medical issues associated with vaccination:** The skyrocketing autism epidemic, controversy surrounding mercury and thimerosal, and the rampant childhood epidemics—asthma, allergies, eczema, attention deficit disorders (ADD), attention deficit hyperactivity disorders (ADHD) and cancer—have been linked to vaccines. Unearthing documentation from the medical literature to prove the association is part of my daily research.

Ongoing determination is required to become an expert in problems surrounding vaccines, but I welcome the challenge. I am passionate about getting solid, well-documented information into the hands of the public so I can help prevent the lifelong tragedy of vaccine injury. It seems my devotion to this task is part of my life purpose: Every time I try to walk away from the issues, something deep inside summons my return. This mission picked me, and I'm doing my best to serve it well.

When asked if I am "anti-vaccine," I prefer a different, more complex description:

- I oppose the one-size-fits-all public health policy imposed by state rules and enforced by physicians and public health employees.

- I oppose a system that forces parents to make decisions based on fear. A physician who forces a parent to vaccinate by using threats, such as reporting the parent to Children's Services for medical neglect or threatening to discharge a family from the medical practice for not vaccinating, is not the physician you want to care for your family. I am opposed to those behaviors.
- I oppose public health policy that demands the rights of the individual must become secondary to injecting a product that can have deadly consequences. Public health officials credit vaccination alone for low infection rates and use persuasion and coercion to enforce vaccination policy.
- I support the freedom to refuse any medical procedure, including the right to refuse a vaccination. Once a person understands the real risks of vaccine-preventable infections and the real risks of vaccines designed to prevent them, I support the person's right to make a choice regarding which risk they are willing to accept.
- I am in favor of fully informed consent, which means giving a person the full range of pros and cons about a medical option and then allowing the option to refuse.
- I am pro-information. Most information distributed to the general public by government organizations about the benefits of vaccination is incomplete at best and, at worst, deceptive. However, those that challenge the official stance about vaccination are marginalized as "anti-vaccine eccentrics" or "conspiracy theorists." The premises behind vaccination need to be challenged. A debate cannot occur if questioning is not allowed.
- I believe that vaccines can cause more harm to the health of the individual—and subsequently to the community as a whole—than the good claimed by doctors and public health officials.

I am determined to share the information I have discovered because I have witnessed firsthand the destruction vaccines can cause children and their families. I have seen the pain in the eyes of parents, desperate

to get their baby back to the way he was the day before he received multiple vaccines. I have cried with broken-hearted parents who wished they had taken time to investigate the risks of vaccines before they were forced to make an on-the-spot decision about vaccinating. With a little more information, they would have chosen differently.

My education and publishing company, NMA Media Press, is dedicated to uncovering and sharing little-known information about problems associated with vaccines and other health controversies. The company creates educational material including books, DVDs, CDs, articles, and manuals. Our small but committed team works tirelessly to produce information that is well-documented and as timely as possible.

This book is not intended to be a balanced view of the vaccination literature. Pro-vaccine information abounds and is readily accessible in books published by the American Academy of Pediatrics, the Centers for Disease Control and many other government-sponsored organizations. Books that challenge the benefit of vaccines and expose evidence of harm are much more difficult to find. This book does much of the research for you. It has been written to balance the debate.

Writing material that is not in support of vaccinating opens one to a wide range of criticisms from strident parents who defend vaccinating to belittling medical doctors and public health officials who believe that questioning vaccines is akin to chasing conspiracy theories. But the thousands of supportive emails and letters that I have received over the last seven years confirms that parents who choose not to vaccinate need a voice and documented support for the decisions that they have made. Supporting their freedom to choose was the impetus for writing *Saying No to Vaccines*.

This resource guide contains hundreds of references to problems with vaccines. The references for each section are embedded into the text,

for ease of use, instead of appearing as endnotes or footnotes. If several paragraphs of text precede a reference, all of the material is based on that source. The pro-vaccine contingent is very strong and heavily funded by vaccine manufacturers. I anticipate a backlash from naysayers who will respond to my vaccination references with an even larger number of articles reporting vaccines to be safe, effective and, as stated by the CDC, "the most important medical advance in history." In research, you can't find what you are not looking for, so if the starting premise is to prove vaccine safety, efficacy, or cost effectiveness, epidemiological studies can make the numbers large enough to consistently prove those premises to be true and make the number of injuries seem inconsequential. Little attention is given to the scope of vaccine injuries. This book is the evidence that problems exist and are being ignored.

While vaccination exemptions for a broad number of situations have been included, undoubtedly there will be special circumstances that have been missed. Please contact me through **www.SayingNo ToVaccines.com.** Your questions will spur updates to the current release of this book.

Many of the forms mentioned throughout the text and listed at the end of the book are also available to download at **www.SayingNoTo Vaccines.com.** The website also has an ever increasing selection of products to enhance your immune system and boost your health.

Deciding whether or not to vaccinate is an important decision that can substantially affect your health and the health of your child. My hope is that the information provided in this manual and other materials will help you to be more confident with your decision if you choose to not vaccinate.

Sincerely,

Sherri J. Tenpenny, D.O.

Acknowledgments

This book has taken 18 months to write, but has been eight years and more than 8,000 hours of research in the making. Writing a book is both a daunting task and a pleasurable experience. When the project is complete, reflecting on the help of others who helped put it all together is the icing on the cake.

I want to especially thank Cindy Stolten, my tremendous researcher and internet sleuth. If you can't find it, it's not there. It is such fun to work with you and without you, there's no way this book would have come together.

To Annette Sylvester, my appreciation for your loyalty and dedication to me and this project would require another book to express. Your creativity and expertise in layout and text design are outstanding. Thank you for your dogged determination to get it ready for print.

Thanks to Norm Friedman, my editor, for taking on this project in spite of your other pressing projects. Plowing through technical material about vaccines was an arduous task and I most appreciate your comments for clarity. Many thanks to Alan Phillips for your help on the section regarding religious exemptions. Your depth of knowledge is far greater than mine and I hope that all who need legal services to help with this type of exemption will be directed to your capable hands. To Joyce Riley, thank you for your commitment to our men and women in military service. Your support and comments on military exemptions is most appreciated.

The love from my friends, Bonnie Shaker, Ingri Cassel, Don Harkins, Dawn Richardson, Lou Paget and Robban Sicca, M.D., have kept me going and of course, I want to give a very special thanks to all the fantastic employees at OsteoMed II. We've been through the incredible storms together; thanks for your love and loyalty. You are a wonderful team.

A special thanks to my mother-in-law, "Gini" Carey-Tokar. Your support and admiration mean a lot to me.

Most importantly, thanks to my wonderful husband, Kevin. You took care of everything while I spent long days and late nights perched in front of my computer. Your love supports my life.

DEDICATION

This book is dedicated to:

The hundreds of thousands of persons—children and adults—who are living with vaccine injuries and vaccine-induced illnesses. You have suffered through the hand of unknowing, under-educated medical practitioners. Your misery has been silenced by the vaccine industry for the benefit of the pharmaceutical industry.

The thousands of family members who are caring for or who have lost loved ones to vaccine injuries.

The hundreds of health care practitioners who work tirelessly to restore health and hope to those who have become ill from what came through that needle.

Special Dedication

To My Mom, my #1 fan.
I know you know the book is complete.

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FOREWORD

"First they ignore you, then they ridicule you,
then they fight you, then you win." ~ Mahatma Gandhi

The soul of this book is centered around choice: your freedom to choose in health care decisions and, specifically, the freedom to choose to not vaccinate. When I was writing *Hot Mamas*, my message was about the impact pregnancy and the first six months postpartum had on the strength and stability of sexuality in the marriage. I expected to hear about health concerns for mother and baby. What I did not expect was the large number of queries I received about vaccines.

In your hands is a guidebook for those who want to know they have the right to make choices about their most personal possession, their bodies. *Saying No to Vaccines* is a user-friendly guide, written from a physician's mind using layperson's language, so you can speak with ease and confidence about a very complex topic.

Imagine you are on stage with people questioning your choice to not vaccinate your child. This book is like having your worldwide expert and friend, Dr. Sherri, just off stage prompting and supporting you with extensively researched documentation. You can discuss with the audience reasons for not vaccinating and why they should choose to not vaccinate. Note I did not say argue. This book is not about arguing. It is about delivering documentation to substantiate your right to not vaccinate. Dr. Sherri has done your homework for you.

At no time in history have we held such a focused interest in our bodies and our health. We want to make informed health care choices for ourselves and our families. The general population today is

exceedingly knowledgeable about health, and maintaining it has become hugely important. For example, we annually spend $1.7 billion on vitamins and supplements and $15 billion on health clubs. We prize our health and for good reason: We're living longer. And we want to do so in good shape, guided by accurate, non-judgmental information.

Furthermore, for the first time in our history, we are calling the medical profession onto the responsibility carpet to answer questions and give explanations to never-before-questioned practices, such as the escalating use of vaccines and pharmaceuticals and the integrity of manufacturing practices. For example, in one ten-day period in April 2008, three articles were published in the *Wall Street Journal* alone that jumped out at me: "Why You Can't Tell Where Your Medication Was Made" (4/8/08); "Merck's Publishing Ethics Are Questioned by Studies" (4/16/08); and "Economic Fraud Suspected in Heparin Contamination" (4/16/08). We want straight answers and accountability that are not always forthcoming from our doctors.

I am not a medical professional. Yet I want accurate and full disclosure from medical professionals when I make health decisions. So it is understandable, given the current cultural and philosophical environment, that people are challenging the use of vaccines. Why so many vaccines? Why has autism skyrocketed? And how did we end up with a population of children who all seem to have ADHD, asthma and allergies that require the use of multiple medications? Do we really need a flu shot every year?

As a consumer, I understand the profound and lifelong impact vaccines can have on one's life and health. As a best-selling author in the area of sexuality and sex education, I have concerns about the hepatitis B vaccine and the new Gardasil (human papilloma virus) vaccine. Dr. Sherri's research validated that my concerns are real. Her explanation of Army Regulations 40-562, giving persons in the military an option

to refuse vaccination, was a surprise, as most military personnel think they have no option except to be vaccinated. You will find many more eye-opening surprises throughout *Saying No to Vaccines*.

Delivered in simple subject segments and bite-sized chunks, this book walks you through all the typical – and not-so-typical – variations of the 25 Most Common Arguments for Vaccination with fact-based rebuttals. Then, in the Frequently Asked Questions section of the book, Dr. Sherri gives you helpful answers and suggests people and organizations you may want to contact. Her recommendations have been honed by years of wading through the minefields and barriers that prohibit people from having free choice. The end result? You know you have the power to choose.

Saying No to Vaccines was not prompted by experiences in Dr. Sherri's personal life; she does not have a vaccine-damaged child or relative. Her motivation came from observations of the wrenchingly tragic results of vaccinations as she cared for vaccine-injured children and adults in her medical practice. However, her personal opinions about vaccine-injury are not mingled with her well-researched facts. Her delivery is clear, egoless and unemotional, while so well organized you can easily find answers to very specific questions or go with an easy flow browsing from subject to subject.

This has not been an easy journey. I have watched Dr. Sherri for eight years maintain an unwavering focus to deliver meticulously researched and documented resources to people who want to exercise vaccination choice. She brought this book to life while running two businesses, getting married, losing her entire office to a fire and losing her beloved mother. She is a woman on a mission and this book is part of that mission.

Nor will it likely be an easy journey for you. Whenever we step outside

party-line thinking, we can be subjected to isolation and censure. But Dr. Sherri's evidence will make you feel you are not alone when you question vaccination. Her well-written, concise text and extremely well-documented references will help you make informed choices. You will feel more confident when speaking about vaccine problems and more likely to seize "teaching moments" when you have the opportunity to share what you have discovered.

In health and love, I wish Dr. Sherri the best for this seminal book.

Lou Paget

Lou Paget is an AASECT Certified Sex Educator, best-selling author of five books: How to Be A Great Lover (Broadway 1999); How to Give Her Absolute Pleasure (Broadway 2000); The Big O (Broadway 2001); The Great Lover Playbook (Gotham 2004); and Hot Mamas (Gotham 2005).

Foreword by Dr. Russell L. Blaylock, MD

Dr. Sherri Tenpenny has written a book that should be read by anyone truly interested in knowing the truth about vaccine safety and efficacy. My wife and I met Dr. Tenpenny at a medical meeting and found her to not only be a delightful person but a storehouse of knowledge and understanding concerning the vaccine issue.

In today's modern world we are obsessed with finding data and "facts", but more important is the need for understanding. To truly understand an issue goes far beyond collecting and arranging data. Understanding comes only after years of wrestling with an issue--dissecting it, analyzing it and considering all aspects in great depth. Dr. Tenpenny has done just that and shares what she has found in this wonderful book.

What I found intriguing about her work is that she goes right to the source of the controversies involved in this issue, reading and searching for documentation on everything related to vaccination. She has invested thousands of hours churning through complex CDC documents and original studies, and speaking with CDC scientists, virologists and experts of infectious diseases. She has appeared before a number of Centers for Disease Control (CDC) hearings, special committees and lectured before wide audiences in the U.S and abroad. She has also supported vaccine-injured parties as an expert witness as the US Federal Court of Claims, commonly referred to as the "vaccine court." In a word: she knows her stuff and has the documentation to prove her points.

I am often asked how all this material – documentation and proof that vaccines can and do cause harm – could have been covered up for so many years. I have spent a lifetime dealing with that very issue. I have discovered that the government, at all levels, has spent an inordinate amount of time, effort and money doing just that: covering up problems caused by vaccination. When you enter this controversial area, you

quickly learn that your naïve worldview goes out the window. The essence of collectivism is that the elite of society devise plans to control large segments of the population. They intend for their mass vaccination plans to be followed and use every ruse, deviser and method they can conjure up to ensure their plan is implemented and their products are injected into every child.

Those who see major problems with their plan are enemies and they are definitely treated as such. The greatest fear of this elite group is that the weaknesses or dangers within their plan will be discovered and implementation will be incomplete. The vaccine program has grown in scope beyond anyone's imagination, as Dr. Tenpenny demonstrates throughout her book. What began as a simple program, with restricted goals and agreed upon objectives has grown, in a piecemeal fashion, into a monstrosity. The vaccine program includes compulsion, political maneuvers, personal attacks, legal restrains and mandatory enforcements. Parents who resist are treated as criminals and enemies of society and safety, and professionals who challenge the plan have had their reputations destroyed. Dr. Tenpenny has risked a lot to write this book and get this information into your hands.

The pressures applied to those who oppose the plan for mass vaccination are not limited to those who step outside the system. There are a significant number of CDC scientists, public health officials and independent research scientists who agree with Dr. Tenpenny's position, in part or whole, but are afraid to speak out because they risk losing their reputations and subsequent access to research grants. They fear they would be fired from their university positions or denied access to major scientific journals and meetings. Evidence of this is abundant to anyone who will look.

This book makes several critical points—such as, freedom of the individual to protect their health and their family's health, the right to

refuse medical treatments that they deem harmful and the right to free access to information concerning complications, efficacy and need for these vaccines. This book is the tool to help you defend your rights.

One of the major claims by the vaccine defenders is that those who oppose vaccines have no scientific explanations for their proposed vaccine injuries. This, of course, is not true, which this book clearly documents. Dr. Tenpenny's analysis dovetails into my areas of research: the effects of vaccination on the brain, especially the developing child's brain.

My findings have been published in several peer-reviewed journals. My work has discovered that when the systemic immune system is over-activated—such as giving five to nine vaccines during a single office visit—the brain's special immune cells, called microglia, become activated. When activated, the microglia cells secrete a number of molecules that are harmful to the brain, including inflammatory cytokines, chemokines, free radicals, lipid peroxidation products and two different excitotoxins.

Stimulating the brain's immune system with sequential vaccination, such as giving a series of "routine" vaccinations every two months, can cause an intense, over-activation of the microglia, that can persist for years, and *even decades*. A recent study in which the brains of autistic people were examined at autopsy, found widespread microglia activation even four decades into life. This means that the brain was in a state of constant inflammation.

The same thing happens in all vaccinated children, but with different manifestations. The inflammation caused by vaccination can result in childhood seizures, sudden infant death, learning difficulties, behavioral difficulties, language difficulties and other subtle neurological problems. Physicians, because they are totally unaware of the physiological

mechanism of vaccination, do not connect the outcome to the vaccines, even when a perfectly healthy child suddenly deteriorates before their eyes after a series of shots. Even though tens of thousands of adverse events are documented every year through the Vaccine Adverse Event Reporting System (VAERS), many thousand more reactions most likely go unreported. The American Academy of Pediatrics, AMA and other political/medical societies assure the physician that there is no link to the injected substances. If the proponents of vaccination were truly interested in the truth and truly interested in the health of children, why have they hidden so many documents that question the "wisdom" of giving vaccines? Why have they refused to do, and even actively blocked, studies that would compare the health of the unvaccinated children to the health of vaccinated children? Why has it taken more than 80 years to do *any* studies to demonstrate the effects of thimerosal (mercury) on the brain? These questions demand answers.

One of the absolutely critical sections of the book is the chapter covering vaccine contaminations. A number of studies have shown that most, if not all of the common vaccines are contaminated with viruses, viral fragments, and fragments of animal DNA and RNA. Virologists *know* that these contaminants can produce a number of hybrids that can be associated with a host of new diseases. It has been scientifically proven that viruses and viral fragments can be absorbed into the brain's microglia and trigger neurodegeneration. Once this occurs, all subsequent vaccinations greatly magnify the damage going on within the brain. This is a proven fact and has been reported in prestigious, peer-reviewed research journals. Yet, the vaccine defenders tell us that such contaminants have no safety concerns and the vaccination "plan" continues.

Few realize that many vaccines used in the United States are manufactured in China where FDA inspections are allowed only *once*

every 12 years. FDA inspectors are not allowed in the facility and they must take the word of the Chinese communist rulers that safety precautions and procedures are being followed.

It is telling that so many physicians and nurses refuse the take the s a m e vaccines they strongly promote to their patients and to the public. All vaccine proponents, including public health officials, politicians *and their families*, should be forced to take every vaccination they recommend. It is interesting to note that when the governor of Maryland, who forced over a thousand young people to be vaccinated, was asked if his children had been fully vaccinated, he refused to answer the question. Not only should he have been impeached, his entire family should have also been forcibly vaccinated.

This book is a valuable addition to Dr. Tenpenny's other works and will be an important tool for all those who have stood up to the vaccine juggernaut.

Russell L. Blaylock, MD
Retired Neurosurgeon
Visiting professor of Biology, Belhaven College in Jackson, Mississippi

(Those interested in more information on the link between vaccines and neurological disorders can download free copies of Dr. Blaylock's papers at www.RussellBlaylockMD.com)

Chapter 1

Decisions About Vaccination: Whom Should You Trust?

Parents want to trust their pediatrician. We no longer live in extended families. Moms and grandmas often live far away so when Johnny or Jenna gets sick, instead of consulting with those close to us who know how to take care of sick kids, we confer with our doctor.

Most pediatricians are well-meaning and do what they feel is in the best interest of their little patients. However, when it comes to vaccination, pediatricians often go beyond helpful suggestions; they resort to fear tactics. Parents are told frightening, "worst-case scenario" stories of a child who had serious complications from an illness such as measles, mumps or chickenpox. The children who recovered uneventfully are never mentioned. The pressure to vaccinate escalates each visit and sometimes results in threats. Intimidated into believing that "the doctor knows best," parents reluctantly give in.

Then, you begin to read articles and books by doctors, including me, who have uncovered problems associated with vaccines. Reports of vaccine dangers are not based on opinion. They represent thousands of hours of research, exposing important facts unfamiliar to most pediatricians. The information tackles mainstream thinking about vaccines head-on with new-found detailed references.

But two sets of divergent, compelling data create a sense of confusion. You spend hours researching both sides of the argument to determine which doctor is telling the truth, which information is correct. You struggle, argue and feel conflicted. Both doctors are convincing. Both speak with authority and present foreign information you grapple to understand. Which guidelines should you follow? Which doctor should you trust?

You shouldn't wholly trust either.

Take a moment to trust your own intuition, your gut feeling. Trust what has been called your own internal guidance system. Sit quietly and see how it feels when you consider vaccination. What does it feel like when you look at your precious baby, knowing injections are planned at the next doctor visit? How does it feel when you consider the future without vaccines? If both considerations—vaccinating vs. not vaccinating—generate equally negative feelings, examine your fears. Do you understand the real risks of the childhood diseases you are trying to prevent? Do you understand the risks of the vaccine? When one feeling is definitely stronger than the other, your intuition is whispering to you. Trust that it is guiding you to the correct decision.

Moms know when something is not right with their child, even when the child is out of sight. That's intuition. On the other hand, mothers have cried while their child was being vaccinated, praying that nothing will go wrong. That's going against your intuitive sense. Adults experience the same conflict when it comes to vaccinations. Whether it is a hepatitis B vaccine required by an employer or the decision about travel vaccines, adults frequently disregard their intuitive sense when it comes to vaccination. We have abdicated our personal power to professionals, particularly to doctors, even though the medical industry has failed us miserably in many ways.

It's time to take back control over what we will allow to be injected into our bodies. Have confidence that if you are questioning and researching problems associated with vaccines, you are capable of learning and understanding the risks vs. the benefits. The more you listen to that "inner voice," the clearer it becomes. It is the best test of the medical information about vaccines.

Much of the material in this book is provided to support those who

have investigated the information about vaccines and have made a firm decision to refuse. Once you have made that first decision, more decisions are necessary. While vaccination decisions used to end after children started school, recommendations for more vaccines are being developed for adolescents and adults. Vaccines are being promoted for incoming college freshmen, office workers, medical professionals—even for bellmen at hotels. Understand what you are up against and know you have a legal right to refuse.

Immunization:
The Reality Behind the Myth

By Walene James

1. Vaccinations are forced.
2. Vaccinations are toxic.
3. Vaccinations are part of only one model of health care—the allopathic (treatment by conventional means, i.e., with drugs and surgery) medical model.
4. Vaccinations are promoted through fear, guilt and creative statistics.
5. Vaccinations are represented as safe and effective; evidence suggests they are neither.
6. Vaccinations are aggressively pushed by government agencies as though they were the only issue important to public health.

Ten Reasons to Say "No Thank You" to Vaccination

1. Vaccinations are promoted through fear, intimidation—and often—coercion.
2. Vaccine manufacturers are protected from liability by the government when their products cause injuries.
3. Those who administer vaccines are protected from liability if an injury or death occurs.
4. Vaccinations can damage the immune system and the nervous system. Vaccine mandates ignore biochemical individuality and family genetics.
5. Vaccinations contain many toxic substances.

6. Vaccinations are aggressively promoted by those who have a financial interest in their use: drug companies and physicians.

7. Vaccinations are misrepresented by government agencies and public health officials as safe and effective when they can cause harm and can fail to protect.

8. Vaccinations are heavily subsidized by tax dollars and injuries are compensated through taxes paid by parents for each vaccine a child receives.

9. Vaccine production is a $12 billion per year business, and growing.

10. Vaccines are the economic loss-leader of the pharmaceutical industry. Vaccines are relatively inexpensive but the medications necessary to treat injuries generate billions for drug companies.

Chapter 2

A (Short) History of Mandatory Vaccination

"It is revolting, to say the least, to think I must have diseased animal matter injected into the blood of my child before he can receive an education."
Charles Hoppe, Brooklyn theosophist, 1931

The vaccine industry evolved from surprisingly modest origins. When smallpox outbreaks were marching across much of Europe, Englishman Edward Jenner noticed that many milkmaids seemed to escape its ravages. His was a straightforward observation: Milkmaids boasted blemish-free complexions, while smallpox survivors had conspicuous, disfiguring pockmarks. This led to Jenner's deduction that the milkmaids were somehow protected from the disease, perhaps because they had contracted a milder version of the illness, known as cowpox, from milking the cows.

In 1796, Jenner tested his theory by injecting cowpox from a pustule on the arm of Sarah Nelmes, a milkmaid, into James Phipps, a healthy eight-year-old boy. Phipps was injected over several days, gradually increasing the dosage of each inoculation. Phipps was later exposed to smallpox and, although he became ill, his illness was mild and he made a full recovery. The experiment was considered a success and the seeds of the industry were sown. Down through history, Jenner has been credited as the Father of Vaccination.

The first regulations requiring smallpox vaccination were passed in 1806 in Piombino and Lucca, former Napoleonic principalities now part of Italy. Throughout the 19th century, many European countries passed laws requiring smallpox vaccination. In France, the laws were

first applied to university students in 1810; by 1902, laws were passed to include the entire country. Anti-vaccination movements, present in nearly all European countries, tended to be strongest in countries where at least some vaccinations were compulsory. However, enforcement was lax and varied between localities. **REF: Salmon DA, et al. Compulsory vaccination and conscientious or philosophical exemptions: past, present, and future. Lancet. 2006 Feb 4;367(9508):436-42.**

When mandatory vaccination was implemented in the United Kingdom in the mid-1800s, British Parliament formed the Epidemiological Society of London in 1850 to investigate the effectiveness of vaccination throughout the country. Statistics was an evolving science at the time and numbers added weighty persuasion to arguments. The Society was assigned the task to prove the premise that more unvaccinated persons died from smallpox than those who were vaccinated.

Given the bias of the premise, the results were bound to be skewed and data was substantially distorted to reach the desired conclusion. For example, if a vaccinated person contracted smallpox, the patient was considered unvaccinated. If a vaccinated person died during a bout of smallpox, he was considered "improperly vaccinated" and was counted among the unvaccinated. Mortality rates were derived from patients who died in hospitals; all who died were considered to be unvaccinated, whether they were vaccinated or not. Most important, persons with mild cases of smallpox who recovered uneventfully—more than 90 percent of those infected—were not included in any of the statistics. As a result, the numbers were slanted in favor of those who had been vaccinated and the conclusions were used to pass mandatory vaccination requirements.

To gain a sense of the mid-1800s, when infectious diseases including typhoid, cholera and yellow fever were the leading causes of death, one

also needs to understand the deplorable fragmentation and ineffectiveness of the practice of medicine at the time. Governments had comparatively little involvement in health matters, hospitals were filthy death wards and few tools existed to combat disease until antibiotics were developed in the 1930s. No standardized medical education was in place, and at least 19 different licensing bodies offered the designation of "physician." One could become a medical doctor by attending university, becoming an apprentice or purchasing the title.

Furthermore, treatments were often barbaric. Common practices included the use of leeches, (called blood letting), purges (to induce vomiting) and cold water dousing, remedies that often worsened – or killed – the patient. Against this backdrop of chaos and futility, the advent of vaccines offered a rallying point for the medical profession. Vaccine proponents argued solely from empirical evidence that inoculation with cowpox protected against smallpox and should be made mandatory for the entire nation. The procedure was promoted as "the promise of scientific medicine," the first method to offer a true benefit to patients by stopping the spread of disease.

During the first 50 years of vaccine use, vaccinators were mostly lay persons: clergy, druggists and midwives. But physicians, seeing vaccination as an opportunity to gain financial benefits and professional status, argued that vaccination was a medical procedure that should be delivered only through the hands of medical doctors. Physicians in Parliament pushed for government regulations and advocated that vaccination should become a mandatory service of the state. Requiring vaccinations would allow the procedure to become the domain of medical professionals. The first Compulsory Vaccination Act, passed in 1853, became the underpinning upon which the medical profession has been built. **REF: Durbach, Nadia. "Bodily Matters: The Anti-Vaccination Movement in England. 1853 to 1907." Duke University Press. 2005. pg. 25.**

The procedure physicians wanted to take control of was offensive. It involved cutting lines in the skin with a surgical instrument and smearing the wound with lymph extracted from cows infected with cowpox. Because person-to-person (also called "arm-to-arm") vaccination was considered the best way to promote immunity, a mother was instructed to return to the vaccinator several days after the procedure so that matter from oozing sores could be inserted directly into the arm of her waiting infant. Parents who refused to inoculate their infants could be fined and be required to sell their property at auction if they did not have the funds to pay. If they did not have assets to sell, one parent, generally the father, could be jailed for up to two weeks. **REF: Durbach. pg. 3.**

It was during this period that medical doctors became the biggest proponents of vaccination. They insisted that mandatory vaccination was the best protection for society and the only means to stop the spread of smallpox. Every unvaccinated person was stigmatized as a potential spreader of disease. The government created registries to ensure that entire communities were vaccinated. No one was allowed to jeopardize the lives of others by refusing to be vaccinated. Parents who refused the vaccine for their children could be fined repeatedly for as long as the children remained unvaccinated. Laws contained language that vaccination was necessary to "protect children from negligent parents." **REF: Durbach. pg. 33-34.**

What was unrecognized then and still little known today is that smallpox infections occurred in varying degrees of severity. The most common form, called "ordinary discrete smallpox," occurred in more than 40 percent of cases. This type of outbreak manifested as a small scattering of pustules distributed across the body. The person was marginally ill and required minimal medical care other than adequate hydration and fever control for comfort. Often maintaining a temperature below 102°F (38.8°C) was all that was necessary for full recovery.

In response to the often draconian enforcement measures, a grassroots movement coalesced to resist. The British Anti-Vaccination Movement became what is considered by many historians to be the largest medical-resistance campaign ever mounted. At the core of the debate were two highly charged, yet fundamental questions: To what extent should government be allowed to intervene in the health of its citizens? Who actually controls the body? These cornerstone arguments between public health and personal health care choices continue to the present day.

Pro- and anti-vaccinators had very different ideas about how human bodies worked and how best to safeguard them from disease. Intelligent, devoted and determined proponents of the anti-vaccination movement succeeded in establishing that opposition to vaccination was not a passing fad. In 1880, J.H. Levy, professor of logic and economics at London's Birkbeck College and editor of the Personal Rights Journal, maintained that compulsory vaccination was a "gross and cruel invasion of personal liberty." The laws interfered with the individual's choices for self-governance, eliminated self determination and impinged upon personal liberty. **REF: Bodily Matters. p. 87.**

Resistance involved rallies, hiding children and acts of civil disobedience. In 1865, more than 20,000 citizens took to the streets of Leicester for an anti-vaccine demonstration. A wide variety of newsletters and pamphlets provoked heated discussions in the pages of the press. Vaccinators were accused of contaminating the blood with animal material, spreading diseases such as tuberculosis and syphilis. Resistors charged doctors with "producing a sicklier population for their own financial gain." **REF: Bodily Matters. p. 34.**

Not all clinicians supported vaccination and the practice of alternative medicine evolved in tandem with the vaccination resistance movement. Holistic practitioners viewed the body as a whole and recognized that

health came from within. Naturalists were unyielding in their position that injecting the body with viruses, bacteria and animal matter would not keep humans healthy. It was evident to early alternative practitioners that many died as a result of the contamination. The shared beliefs of anti-vaccinators and holistic practitioners created a synergy that advanced both groups. **REF: Durbach. pg. 23.**

Resistance to vaccination and the debate over compulsory requirements for work and schools escalated throughout a seven-year debate. In an attempt to resolve the dispute between vaccinators and vaccine resistors, Parliament introduced the Royal Commission on Vaccination in 1889. The Commission was charged with investigating the usefulness of vaccination to control the spread of smallpox and was asked to determine if there were other means that could be used to control the infection. Additional tasks included looking into the safety of the vaccine to determine if any changes should be made to compulsory vaccination laws.

In seven years, the 13-member Commission met 136 times and questioned 187 witnesses, including many supporters and opponents of mandatory vaccination. In the final report, issued in 1896, the Commission admitted the decreased incidence of smallpox was only partially attributed to vaccination, being careful not to dismiss the contribution of improved sanitation. The Commission acknowledged that, despite reports to the contrary, the use of arm-to-arm lymph (serum) inoculation did contribute to the spread of syphilis.

As a result of the Commission's report, a conscience objection clause was introduced into new legislation that allowed parents to obtain exemption certificates by applying to the local magistrate. As described by Durbach:

> "The conscientious objector was prepared to suffer for his honest belief. The conscientious objector was not

someone who merely reasoned that vaccination was wrong, or one who rejected it because it was incompatible with religious beliefs. The conscientious objector had thoroughly investigated the issue and was neither irrational nor negligent. The conscientious objector was intelligent, loving and devoted to protecting his children." **REF: Bodily Matters. p. 175.**

It was hoped that the new 1898 Compulsory Vaccination Act would resolve the conflict once and for all. However, it proved to be a poor compromise and none were satisfied with the result. Fines were limited, but not eliminated, for late vaccination. Conscientious objection status was allowed only for a parent or guardian who could prove, in front of two justices or two magistrates, that his objections were from his conscience. Because the term "conscientious objection" had not been clearly defined in the Act, magistrates could set their own standards, refuse petitions at will and use the application as a weapon of persecution. **REF: Bodily Matters. p. 188.**

By the turn of the century, it was clear that the 1898 Act had not in any way mitigated the opposition to vaccination. Defaulters continued to be prosecuted and fees for exemption certificates were marginally different from the fines issued for not vaccinating. As a result, the government again responded with a compromise to the vaccination mandates rather than abolishing them. The 1907 Vaccination Act repealed the requirement that a parent must satisfy a magistrate. Instead, a parent could obtain the exemption certificate by declaring a conscientious objection to vaccination without being questioned or refused. According to the Registrar General's reports, the number of certificates of conscientious objection almost tripled in the first year after the passage of the legislation. **REF: Bodily Matters. p. 196.**

The campaign to repeal the vaccination acts declined as the number of

conscientious objection certificates grew. By 1908, anti-vaccination rhetoric had been mostly silenced by the ability to obtain exemptions. The British government repealed vaccination requirements for smallpox altogether in 1946 because nearly half of parents throughout the country were claiming conscientious exemptions. Vaccination rates fell, and to the dismay of pro-vaccinators, so did the number of smallpox outbreaks. **REF: Anon. Public Health Act, 1961. Sec 38. Prevention and Notification of Disease. London: HM Stationery Office, 1961: 1335-36.**

The National Anti-Vaccination League, the leading voice of the movement in England, continued to claim more than 1,000 members through the 1970s. At one point, it lobbied the United Nations to include the right to refuse vaccination in the charter on human rights and the group mounted campaigns against each new vaccine that was developed. The organization eventually dissolved to form the Howey Foundation, an environmental group that officially folded in 1982. With its termination, the historical anti-vaccination movement in the U.K. officially collapsed. **REF: Durbach, p. 201.**

Mandatory Vaccination in the United States

In 1809, Massachusetts passed the first mandatory vaccination law in the U.S. and was the first state to require vaccination as a school requirement, in 1850. Smallpox outbreaks seemed to be well contained until 1901, when Boston experienced the last major epidemic in the country, leading to 1,596 cases and 270 reported deaths (17 percent). A state statute at that time granted city boards of health the authority to require vaccination "when necessary for public health or safety." For example, the Cambridge Board of Health adopted an ordinance requiring all residents to be vaccinated or to pay a hefty fine of five dollars, the equivalent of $118 today. During the 1901-02 outbreaks, Boston public health officials dispatched teams of physicians and police officers

to administer vaccinations, by force if necessary. Even though outbreaks occurred across all ethnic and economic classes, efforts were concentrated on neighborhoods populated by immigrants and ethnic minorities. **REF: Lawrence H. Officer and Samuel H. Williamson, "Purchasing Power of Money in the United States from 1774 to 2006," MeasuringWorth.Com, 2007.**

One of only four Massachusetts residents who resisted the ordinance was Rev. Henning Jacobson, who asserted that he and his son had developed serious reactions to previous vaccinations and refused to be revaccinated during the epidemic. State law permitted a medical exemption for children at risk from vaccination but held no exclusions for adults. Jacobson argued that the compulsory vaccination law was "...unreasonable, arbitrary and oppressive, and therefore, hostile to the inherent right of every freeman to care for his own body and health in such a way as to him seems best; and that the execution of such a law against one who objects to vaccination, for whatever reason, is nothing short of an assault upon his person." **REF: Jacobson v Commonwealth of Massachusetts, 197 US 11 (1905).**

Failing three times in the lower courts, Jacobson took his case to the U.S. Supreme Court in 1905. The question before the Court was whether the state had overstepped its authority and whether the sphere of personal liberty was protected by the due process clause of the 14th Amendment. In making their ruling, the justices no doubt took into account the difficulty Boston had experienced containing the smallpox outbreak in 1901-02. Perhaps the justices had family members who had been vaccinated or had experienced smallpox. Perhaps they considered the lack of standardized public health programs. Whatever criteria were used, the Supreme Court handed down its landmark ruling in 1905: States were given the right to force vaccinations on their citizens if they deemed vaccination to be the best way to protect the community from disease. As a result, the Jacobson decision has defined

the central relationship between the rights of the individual vs. the role of the government to protect its citizens against infectious diseases and epidemics to the present day.

Jacobson is the first case in U.S. history to deal with the right of self-determination regarding one's own body. The Court affirmed that it was the prerogative of each state legislature to determine how to control an epidemic, including the use of police powers if deemed necessary. Because the federal judiciary could not usurp the role and powers of the states, each state was given the right to decide its own vaccination laws and mandates. The only stipulation given by the Court was that states were to ensure that enforcement must not be "unreasonable, arbitrary or oppressive." The Court clearly stated that protection of the public would supersede individual interests for the "greater good." **REF: Mariner, Wendy K. JD, LLM, MPH, et al. Jacobson v Massachusetts It's Not Your Great-Great-Grandfather's Public Health Law. American Journal of Public Health. April 2005, Vol 95, No. 4.**

The issues in Jacobson are enduring because they arose from the fabric of American democracy and our Constitution. Jacobson was one of the few Supreme Court cases before 1960 in which a citizen challenged the state's authority to impose mandatory restrictions on personal liberty for public health purposes. Jacobson laid the foundation for U.S. public health officials to mandate vaccination by law. **REF: Jacobson v. Massachusetts and Public Health Law: Perspectives in 2005. http://www2.cdc.gov/phlp/jacobson/pdfs/public_health_guide.pdf**

Despite the Supreme Court's emphasis on protecting the "greater good," some states moved toward protecting individual rights when laws were put in place. For example, Utah (1907) and North Dakota (1919) enacted laws expressly forbidding the passage of any mandatory vaccination requirements. Washington and Wisconsin repealed mandatory requirements and replaced them with personal belief

exemptions in 1919 and 1920, respectively. Massachusetts legislators, however, boasting the most forceful laws in the country, rejected annual appeals from 1915 to 1918 to repeal mandatory requirements. **REF: "State of Immunity," by James Colgrove. University of California Press, 2006. p. 64.**

Throughout the twentieth century, public education became widespread and cities quickly realized that the schoolhouse served as a locus of prevention. James Colgrove, author of State of Immunity: The Politics of Vaccination in Twentieth-Century America, defined the evolution this way:

> "Although controversy over public health regulations was not uncommon during this period, vaccination provoked an especially vociferous response. Other regulations that limited individual liberty in order to protect the common good generally required that people refrain from an action or behavior. Vaccination, in contrast, required people to submit to a procedure, one that involved discomfort and whose safety and efficacy remained uncertain in the minds of many." **REF: Colgrove. p. 10.**

The balance between the right of the individual and the good of the whole has long been a difficult dance. Since the beginning of mandatory vaccination programs, health officials have pressed individuals to participate through the use of several scripted arguments. These have included: Promoting the concept of "herd immunity" (an entire community will be protected if everyone is vaccinated); citing large epidemiological studies to minimize the number of injured in proportion to the numbers who have been vaccinated; and framing vaccination as a necessary act of a good citizen. Sometimes the arguments have been presented civilly, encouraging compliance through cooperation. But far

too often, the approach has been coercive.

At the turn of the twentieth century, medical education began to shift toward an emphasis on sickness. The belief was fostered that only experts could legitimately make health decisions and physicians were positioned as better qualified than parents to judge the well-being of children. One of the best opportunities for the state to intervene and assess children was prior to attending school, and by 1912 most states had passed laws permitting or requiring medical examinations before school matriculation. **REF: Colgrove, p 49.**

Perhaps the earliest example of the use of medical examinations to usurp the judgement and care of parents occurred around the turn of the century when "pre-tubercular children"—children who were discovered through laboratory testing to be infected with TB but who had no symptoms—were removed from their homes and placed in a medical sanatorium. According to Colgrove:

> "Separation of endangered children from their parents was the cornerstone of an overall plan to protect them from the unhealthy influences [of their parents]. Although the transfer of a child to a sanatorium was ostensibly voluntary, coercion by charitable organizations and health officials of the poor, often immigrant, families was sometimes applied." **REF: Colgrove, pg. 51.**

By the 1920s, health officials began to use newly developed marketing techniques to promote the importance of vaccination and encourage cooperation. Vaccination programs appealed to the emotions of parents to motivate them to comply. Fear and guilt were used to characterize parents who did not vaccinate as nonconformists and neglectful. Charged language emphasized, and often magnified, the risk of the illness to portray the benefit of vaccines. These techniques were

successful: During this period, roughly 80 percent of all students received all doses of recommended vaccines prior to school entry—an all-time high. **REF: CDC. Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series. US, National Immunization Survey, 2006.**

The use of coercion to compel parents to vaccinate their children became particularly prevalent in the 1960s. A 1963 publication by the federal Communicable Disease Center, the original name for the CDC, contended that "the use of the word epidemic itself in public statements is the most effective single means of simulating the public to action." That same year, the measles vaccine was approved for use in children. Shortly thereafter, a nationwide campaign to eradicate a national measles "epidemic" was spearheaded by the president of the Joseph P. Kennedy Foundation, Massachusetts Senator Ted Kennedy. To implement the vaccination strategy, a mixture of cooperative appeals and coercive school mandates were set in motion. **REF: Achieving Public Response to Immunization Programs. Referenced by Colgrove, pg 12.**

As recently as 1968, about half of the states had laws requiring vaccination for school attendance, but they were inconsistently enforced. By 1981, all 50 states had enacted legislation demanding measles vaccination as a prerequisite for enrolling in school. During that 13-year period, legislators characterized their sweeping changes regarding vaccination requirements as giving parents "helpful prompts to action."

The belief by public health officials that parents needed a push toward social responsibility provided the justification for increasingly coercive measures to force vaccination. Since the 1980s, regulations for daycare and health care institutions and recommendations for colleges regarding "vaccine-preventable diseases" have been added. In fact, more than

200 vaccination laws, appropriations bills and policies are considered during each state legislative session across the nation. Funding for vaccination programs is a substantial part of every state's annual budget.

As the number of mandates increased, every state retained clauses within their statutes to exempt children from vaccination for medical reasons. Every state, except West Virginia and Mississippi, currently allows parents to refuse vaccinations if they have significant religious objections to the procedure. As of January 2008, 18 states allow an exemption to the procedure based on philosophical opposition to vaccination: Arizona, Arkansas, California, Colorado, Idaho, Louisiana, Maine, Michigan, Minnesota, New Mexico, North Dakota, Ohio, Oklahoma, Texas, Utah, Vermont, Washington and Wisconsin. Mississippi, which has only a medical exemption for the public school system, allows an automatic exemption for home-schooled students.
REF: Home School Legal Defense Association.
http://www.hslda.org/Legislation/State/wv/2007/WVSB91/default.asp

Even with exemptions in place, parents have begun to question the necessity of the number of required vaccines. In 1900 the only vaccine given to schoolchildren was smallpox; by 1971, smallpox had been eradicated and the vaccine was no longer required for school. As recently as 1985, the only vaccines required for school were polio, diphtheria-tetanus-pertussis (DTP) and measles-mumps-rubella (MMR). But the landscape started to change in 1991 with the rapid addition of many more vaccines. By 2007, 113 vaccine antigens from at least 10 different vaccines had been added as school requirements. Many parents are asking: How many more vaccines are going to be forced on children in order to obtain tax-funded, public education? Now, more than ever, parents are starting to say no.

Many parents blame the health problems of their children on the sheer number of vaccines and additives they receive. Tens of thousands of

parents have watched their children regress into poor health after vaccinations. They believe their children are at high risk and may suffer reactions from further doses. Parents who barely questioned their doctors' decisions in the past are now becoming informed and challenging vaccination recommendations. Many are choosing the risk of the infection over the risk of the vaccine.

Legitimate concerns have been met by steely resistance from the medical profession and public health officials. A flurry of articles, closed-door meetings, congressional hearings and position papers from the Institutes of Medicine defend the national vaccination program and attempt to protect vaccines from all culpability. Officials position vaccination as widely accepted, an economic necessity and a small personal sacrifice for the good of the community. Resisters are marginalized as "wackos who believe in conspiracy theories." This tactic is not new. As far back as 1894, those who opposed vaccination were blasted in the New York Times as engaging "in a futile attempt to head off human progress and to reopen a question about which pretty much all of the world has made up its mind." **REF: Cited in Brooklyn Medical Journal. 8(1894):576 and reference in Colgrove, p.14.**

It has been almost 150 years since the first compulsory vaccination laws were passed and anti-vaccination sentiment is again on the rise. Officials dismiss objections to vaccination as ignorance rather than appreciating that resistance is most often based on extensive research of scientific information. Paternalistic posturing that the "doctor knows best" remains imbedded within the medical industry, and parents are strong-armed into vaccinating against their better judgment through the same emotional bullying that was first used in the 1920s.

The battle between pro-vaccination forces and those opposed to vaccines in the late 1800s is strikingly similar today:

• Physicians are the biggest proponents of vaccines. Injections are said to be the only way to keep children healthy, and unvaccinated children are thought to put entire communities at risk. Hardcore promotion by pediatricians creates a distinct conflict of interest as reimbursement for vaccination is a sizable portion of their income.

• Modern-day alternative medicine practitioners, acting in the same good conscience as their 1850s predecessors, oppose vaccines that retain washed sheep red blood cells, cells from chickens, and proteins from cows and monkeys. Holistic providers express grave concerns about the measurable amounts of formaldehyde, glycerol, monosodium glutamate (MSG) and phenoxyethanol (antifreeze)—traces of more than 100 chemicals in all. The contamination of the blood in the name of health continues today.

• Nationwide vaccination databases are under construction in all states as a means to ensure that every child is vaccinated, although these are being contested by many who are aware of them.

• Significantly more skepticism about government intervention has escalated due, in part, to bad decisions about required vaccines. This includes the decision in November 2007 by Maryland public health officials to remove children from the custody of their "neglectful parents" for refusing to have them vaccinated. Forced to appear in court for failure to comply with vaccination laws that required chickenpox and hepatitis B vaccines for middle school, parents of more than 1,100 children

were threatened with criminal charges, fines and up to 10 days in jail for "noncompliance."

- Over the last several years, a growing number of papers have been published in public health journals by government officials and pro-vaccine medical doctors calling for the removal of all vaccine exemption laws, which would eliminate all rights to refuse.

Philosopher George Santayana famously stated, "Those who cannot remember the past are condemned to repeat it." **REF: Reason in Common Sense, p. 284.** Although much in the struggle between pro-vaccination and anti-vaccination forces is timeless, the issue has grown more complex. Today, the clout of the immense pharmaceutical giants is used to persuade and coerce state and national government officials to embrace massive, expensive vaccination programs. For example, over the last seven years, the industry has contributed more than $800 million in federal and state lobbying and campaign donations. No other industry has spent more money to sway public policy to use their products: drugs and vaccines. **REF: "Drug Lobby Second to None." Center for Public Integrity. July 7, 2007.**

In response, grass roots movements that question and refuse vaccinations are gaining strength and momentum. Television, print ads, books and videos are educating the masses about the connection between vaccines, autism and other childhood illnesses. Vaccine information available through the Internet is no longer just opinion; well-documented, highly-researched articles are available at lightning speed, and viral marketing is spreading the word around the world.

Meanwhile, dozens of vaccines are in the manufacturing pipeline, destined to become mandates for children, adolescents and adults in the next few years. Protecting the right to refuse vaccination will

require political vigilance and active participation on the part of all who want their right to choose.

In his written dissent to the majority's 1905 decision on Jacobson, Justice Robert Jackson wrote that the Court's ruling would "lie around like a loaded weapon" waiting to be fired inappropriately. Our modern world is complicated and rapidly changing, but the core issues in the vaccination debate are relatively unchanged. As stated by Walter Robert Hadwen, MD, a vocal, late nineteenth century anti-vaccination reformer:

> "The very moment you take a medical prescription and you incorporate it into an act of Parliament, it passes beyond the confines of a purely medical question and becomes essentially a social and political one." **REF: Hadwen, W.R. "The Case Against Vaccination." Gloucester: Gloucester Anti-vaccination League, 1896. p 5.**

Chapter 3

Refuting the 25 Most Common Arguments Supporting Vaccination

When parents question vaccination, they often face strong opposition. Here are 25 of the most common arguments used to promote vaccination balanced against information supporting another view. I gleaned the list of arguments from the Centers for Disease Control website, from an article published by the South Australian Health Commissioner called, "Responding to Arguments Against Immunization," and various articles published in the "Pediatric Infectious Disease Journal."

My rebuttals are based on years of observation as a medical practitioner, a deep commitment to shedding light on the problems with vaccination, and a great deal of research undertaken to write this book. You will note that the rebuttals are heavily documented, but this was not done to impress you with scholarship. The references—while in no way exhaustive—are included within each section to facilitate access to important articles and issues most important to you and your family.

The sections below are independent and are not intended to be read in any particular order. Refer to the table of contents to find specific arguments.

KEY:
Assertion by pro-vaccine advocates
TRUTH: Information supporting another view
REF: References for preceding information

1. Vaccines are safe.

TRUTH: Contrary to claims by government officials and the pharmaceutical industry, vaccines have not been proven to be safe by

the same standards applied to other procedures or drugs: a double-blind, placebo-controlled investigation. In a placebo-controlled study, the safety of a medication is determined by comparing it to a neutral substance, such as a sugar pill. In vaccine safety trials, a new vaccine is not compared to an inert substance, such as a shot of sterile saline. Instead, the designated inert substance, the placebo, is another vaccine with a "known safety profile." If the number of side effects caused by the new, experimental vaccine is found to be the same as the number of reactions caused by the placebo vaccine, manufacturers declare the new vaccine to be as safe as the placebo. In actuality, this is true: It is as safe as the older, existing vaccine. That does not mean it is as safe as a true, inert placebo.

Another method used by vaccine investigators to claim safety for a new vaccine is to discount any part of the data that suggests a problem. The following excerpt is from a clinical trial that used another vaccine as the placebo and then eliminated the negative data. The investigation was designed to determine the safety of Comvax®, a vaccine combining the Haemophilus influenza vaccine (HiB) and the hepatitis B vaccine into one shot. The placebo in this study consisted of giving the HiB and the hepatitis B vaccine as two separate shots.

> "During the study, 17 children (1.9%) had an event within 14 days of vaccination that met one of the defining criteria of a serious adverse experience. These experiences included seizure, asthma, diarrhea, apnea (stopped breathing) and several others. Virtually all of these adverse experiences were classified as serious because they involved a hospitalization. None were judged by the study investigators to be caused by Comvax® or the placebo, the two vaccines given separately. In addition, three deaths among participants in this study were attributed to sudden infant death

syndrome [SIDS] that occurred more than 14 days after administration of a dose of vaccine (on days 29, 31, and 38, respectively). Again, none of the deaths were judged by the investigators to be related to vaccination." **REF: Ped. Inf. Dis. J 1997; 16:593-599. "Safety and immunogenicity of bivalent H. influenza type b/hepatitis B vaccine in healthy infants."**

Because the number of side effects from the single shot was similar to the number of side effects induced by the separate shots, Comvax® was declared to be "as safe as a placebo." Investigators eliminated the association between the vaccines and SIDS deaths with a stroke of the pen. Comvax® was declared to be "safe and well-tolerated."

Other issues with vaccine safety:

1. Studies generally include pooled data from only a few thousand healthy children. Children are excluded from studies if they have an underlying disease such as neurological disorders, seizures, asthma, eczema, or altered immune function. Once approved, the new vaccine is recommended for all children, including those who are chronically ill, premature or with neurological disorders, populations untested in pre-market studies.

2. Side effects during a study are followed, on average, for five to 15 days. The development of an autoimmune reaction can take months or years to appear. If an adverse response occurs more than two weeks after a vaccine is administered, no connection is presumed and proving a connection is difficult.

2. Vaccines are effective and save millions of lives per year around the world.

TRUTH: Webster's defines the word "effective" as "the power to

produce intended results." During vaccine research, vaccines are deemed effective if they induce antibodies. However, parents and the medical community interpret the word "effective" to be a synonym for "protective" even though vaccines have not clearly demonstrated that they keep children from getting sick. Therefore, saying that vaccines are effective is misleading. **(See TRUTH 5 for more detail.)** It is difficult to prove that vaccines save lives, and extrapolating the positive effects of vaccination worldwide is a guess. How can researchers prove that a vaccine saved a life? The assumption of those who promote vaccination is that all persons will be exposed, and when exposed, every person will become ill unless the person has been vaccinated. This is a false premise.

An example is an outbreak of mononucleosis (mono) or other respiratory infection in a classroom. Not all children contract the illness. If this is true for illnesses for which there are no vaccines, it is certainly true for the so-called vaccine-preventable infections.

3. Serious adverse events following vaccination are rare.

TRUTH: An estimated 11,000 to 12,000 reports of vaccine reactions are filed with Vaccine Adverse Event Reporting System (VAERS) each year. Of these, 15 percent are considered "serious" because they necessitated a trip to the emergency room, required hospitalization, or resulted in a permanent disability. But these figures are likely only a drop in the bucket because this "passive" system relies on voluntary reporting. (A similar limited voluntary system exists, for example, in Canada.) Self-reported data does not prove an association between vaccine injuries and death. In many instances, there is too little information in the VAERS report to reach any firm conclusions. However, the magnitude of reported reactions suggests that there may be many more injuries than recognized, and the sheer number of adverse reactions and deaths from a single class of medication takes

exception with the notion that adverse vaccine events are "rare."

Between mid-1999 and January 4, 2004, a total of 128,035 adverse reactions were reported to VAERS. Because it is estimated that only 1 percent of all adverse drug reactions are voluntarily reported, this figure may actually represent 1.28 million adverse reactions. During that same period, 2,093 deaths that occurred soon after vaccinations were reported to VAERS. This may actually represent between 20,930 (10 percent) and 209,300 (1 percent) of all deaths possibly associated with vaccines. **REF: JAMA 269 (1993): 2765–2768. Kessler, D. A. "Introducing MEDWatch. A new approach to reporting medication and device adverse effects and product problems."**

Between 1990 and August 2007, 4,421 cases of persons who were injured by a vaccine were heard by the appointed judges, referred to as Special Masters, presiding over a civil district court commonly referred to as the Vaccine Court. Even though more than $1 billion has been paid to vaccine-injured victims, only 20 percent of persons who apply receive compensation and, as of this publication, all cases involving autism have been dismissed without compensation for injuries sustained from vaccinations. **REF: National Vaccine Injury Compensation Program Pre-1988 monthly Statistics Report. August 2007. ftp://ftp.hrsa.gov/vaccinecompensation/Statistics_report.htm REF: National Vaccine Injury Compensation Program Post-1988 Statistics Report. August 31, 2007. ftp://ftp.hrsa.gov/vaccinecompensation/ Post1988_ StatisticsReport.pdf**

4. Vaccination has been demonstrated to be one of the most effective medical interventions known to mankind. The eradication of smallpox demonstrates this accomplishment.

TRUTH: Most discussions about vaccination start by pointing out the success of the smallpox and polio eradication programs. **(See TRUTH**

18 for more detail) A full discussion about smallpox is far beyond the scope of this text, but a brief overview is in order.

In 1717, Lady Mary Wortley Montague, wife of the British ambassador to the Ottoman Court, was hailed as the person who introduced inoculation to Europe. However, it was the Englishman Edward Jenner who first noticed that most milkmaids seemed to escape its ravages. (Jenner, a country apothecary, had purchased his medical degree from St. Andrews University in Scotland for the sum of 15 pounds.) His was an easy observation: Milkmaids boasted blemish-free complexions, while smallpox survivors were conspicuous with their facial pockmarks. This led to Jenner's deduction that the milkmaids were somehow protected from the disease, perhaps because they had contracted a milder version of the illness, known as cowpox, from milking the cows.

As previously discussed, Jenner tested his theory by injecting cowpox pus from Sarah Nelmes, a milkmaid, into James Phipps, a healthy 8-year-old boy. Jenner repeatedly injected Phipps with cowpox pus over several days, gradually increasing the dosage. He then injected Phipps with smallpox and the boy became ill. After a few days, he made a full recovery with no apparent effects from the smallpox or side effects from the vaccine. The experiment was considered a success and the seeds of an industry were sown. Down through history, Jenner has been given credit as the "Father of Vaccination."

What is not generally discussed about this discovery is that Phipps had been re-vaccinated more than 20 times and died at the age of 20. Jenner also experimented with his own son by inoculation, and his son died at the age of 21. Before their deaths, these boys acquired tuberculosis, which some researchers have linked to the smallpox vaccine.

The global smallpox vaccination program is not nearly as successful as it is touted to be. If the science of vaccination worked, it should have

prevented epidemics. But instead, while the population of England increased 16 percent during the years of compulsory vaccination, smallpox deaths increased 160 percent, a figure that does not include the deaths from the procedure. The only complete series of official records in Europe revealed that the decrease in smallpox mortality paralleled the decreased use of the vaccination. Moreover, some of the most severe epidemics on the continent occurred after the onset of compulsory vaccination.

In a report published in an early edition of The British Medical Journal, Dr. L. Parry analyzed vaccination statistics from the 19th century and asked the following questions:

> "How is it that smallpox is five times as likely to be fatal in the vaccinated as in the unvaccinated? How is it that in some of our highest vaccinated towns—for example, Bombay and Calcutta—smallpox is rife, whilst in some of our most poorly vaccinated towns, such as Leicester, it is almost unknown? How is it that something like 80 percent of the cases admitted into the Metropolitan Asylums Board smallpox hospitals have been vaccinated, whilst only 20 percent have not been vaccinated?"
> **REF: The British Medical Journal. 1-21-1928, p. 116.**

By 1897, a weaker form of smallpox, variola minor, became the dominant strain in the U.S. Although the rash was similar to classic smallpox (variola major), the new form was a mild disease, left little scarring and only rarely caused death. The illness was considered an inconvenience more than a danger—especially compared to the risks of serious harm from vaccination, which included infection, gangrene and even a tetanus or syphilis infection. Nevertheless, pro-vaccination publications issued by health departments often used gruesome photos of the worst cases of variola major-type smallpox to

generate fear. This coercion technique allowed vaccination to continue in the U.S. until 1971, even though the last reported case of smallpox in this country was in Texas in 1949. **REF: MMWR. 25th Anniversary of the Last Case of Acquired Smallpox.**
http://archderm.amaassn.org/cgi/reprint/139/2/240-a.pdf

Dr. Tom Mack, smallpox expert with the CDC and affiliated with the University of Southern California School of Medicine, reported at a July 2001 meeting of the CDC on the estimated death rate from smallpox. He stated that the fatality rate among adults was "much lower than generally advertised," closer to 10 to 15 percent instead of the publicized 30 percent. He went on to say, "Even without mass vaccination, smallpox would have died out anyway. It just would have taken longer." **REF: Dr. Tom Mack, of USC, reported at the CDC meeting June 20, 2002. From the verbatim transcript of the meeting of the Advisory Committee on Immunization Practices (ACIP) June 19 and 20, 2002. (unavailable online).**

5. Vaccine-induced antibodies provide protection against infection, disability and death caused by vaccine-preventable diseases. Antibodies are a sign of protection.

TRUTH: The role of vaccine-induced antibodies in disease prevention is unclear. A new vaccine is developed with the intent of stimulating the immune system to produce a "protective antibody." Physicians believe that the presence of an antibody is proof of immunity and protection from illness. However, even the medical journal *Vaccine* reported in 2001, "It is known that, in many instances, antigen-specific antibody titers do not correlate with protection." **REF: Vaccine. 2001 Oct 15;20 Suppl 1:S38-41.**

Many who have been vaccinated, and develop antibodies, contract the disease, and those who do not develop post-vaccination antibodies

(called seroconversion) do not become ill. Is it the presence of an antibody that defines the state of a person's resistance to an infectious disease?

The following verbatim references from a broad spectrum of publications are presented as documentation that the presence of an antibody does not guarantee that a vaccinated person will not contract the infection. Some language in the references is quite technical but will be understood by medical practitioners.

Pertussis (whooping cough)

"Pertussis continues to cause significant morbidity (i.e. the incidence of illness in a population) and mortality in infants and children throughout the world, even in well-immunized populations. Laboratory measurement of antibodies has not demonstrated a level that corresponds to protection." **REF: Clin Diagn Lab Immunol. 1999 Jul;6(4):464-70. "Protective effects of pertussis immunoglobulin (P-IGIV) in the aerosol challenge model."** NOTE: *Therefore, a vaccinated person with a high antibody titer can still contract the illness. ~ST*

"Determining the correlation between the level of antibodies in the blood and immunity to pertussis has been difficult. It is unlikely that the association can be ascertained. There is no direct association between antibody levels that ensures protection from pertussis." **REF: Infect Immun. 2004 Jan;72(1):615-20. "Antibody-mediated neutralization of pertussis toxin-induced mitogenicity of human peripheral blood mononuclear cells."** NOTE: *Therefore, is a pertussis antibody necessary if it cannot reliably confer protection?~ST*

"There is no known direct correlation between levels of specific pertussis antibodies and protection against pertussis." **REF: Canada Communicable Disease Report. Vol. 23 (ACS-3) 15 July 1997. "Statement on the Pertussis Vaccine."**

"The findings of efficacy studies have not demonstrated a direct correlation between antibody response and protection against pertussis disease." **REF: MMWR. March 28, 1997/Vol. 46/No.RR-7, p4.**

Tetanus

"Severe (grade III) tetanus occurred in four patients who had been vaccinated and had a high level of tetanus antibody. The disease was fatal in one patient who was fully vaccinated. One patient who contracted tetanus had received multiple tetanus shots close together to produce commercial tetanus immune globulin. Two patients had received a tetanus vaccination within one year before contracting the disease. Antibody titers in those who contracted the illness ranged from 0.15 IU/ml to 25 IU/ml. **REF: Neurology. 1992; 42:761-764. "Severe tetanus in immunized patients with high anti-tetanus titers."** ***NOTE:*** *A level of 0.01 IU/ml is considered to be sufficient to protect against infection. ~ST*

"A diagnosis of cephalic tetanus (involving only the muscles of the face and scalp) was made in a man who had a tetanus antibody level of 3.37 IU/ml, which was far above levels considered to be protective (0.01 IU/ml). The patient was treated with tetanus toxoid, tetanus immune globulin, metronidazole (Flagyl), and benzodiazepines (a medication such as Valium, a potent muscle relaxer). His neurological symptoms improved slowly but did not resolve completely. Tetanus can occur in patients who have adequate antibody levels." **REF: BMJ. 2003;326:117-118. "Response to: Tetanus with protective serum immunity," by Yumiko Kanei, Manuel Revuelta, Division of Infectious Diseases, Beth Israel Medical Center. New York City.**

"Seven neonates with tetanus were found to have antibody levels 4 to 13 times higher than the presumed protective level of 0.01 IU/ml. In two of the seven children whose mothers had received multiple tetanus toxoid boosters during pregnancy "had antibody levels that were 100- and 400-times higher than the presumed protective level." **REF:**

Microbiol Immunol. 1991 Jun;3(3):171-5. "Neonatal tetanus despite protective serum antitoxin concentration."

Mumps

"Little is known about the correlation of mumps titers and protection from mumps."

REF: J Clin Microbiol. 2005 September; 43(9): 4847–4851. "Mumps Virus-Specific Antibody Titers from Pre-Vaccine Era Sera: Comparison of the Plaque Reduction Neutralization Assay and Enzyme Immunoassays."

Haemophilus influenza b

NOTE: Haemophilus influenza b is the bacteria the HiB vaccine (HibTITER) was designed to neutralize. "Antibodies generated by HibTITER vaccine have been found to have high ability to bind to antigen (the cell wall of the bacteria) in vitro (in a laboratory). However, the amount of clinical protection provided by H.influenza b antibodies in vivo (in a human) is unknown. **REF: HiB TITER package insert.** ***NOTE:*** *In other words, what happens in a test tube does not correlate to protection in the individual.~ST*

Pneumococcus (adult pneumonia vaccine)

"The results from several randomized studies show that the polysaccharide pneumococcal vaccine does not appear to reduce the incidence of pneumonia or death in adults with or without chronic lung disease or in adults that have other chronic illnesses. Neither does the vaccine reduce the incidence of pneumonia or death in persons 55 years and above." **REF: The Cochrane Library, Issue 4, 2003. Chichester, UK: John Wiley & Sons, Ltd. "Vaccines for preventing pneumococcal infection in adults." Cochrane Methodology Review.**

Cholera

"The antibody titer for the cholera vaccine did not correlate with protection from infection with V. cholerae O139. One-quarter of

contacts developed symptomatic or asymptomatic cholera even though they had high antibody titers." **REF: J of Inf Dis. 2004:189 (15 June). "Incomplete Correlation of Serum Vibriocidal Antibody Titer with Protection from Vibrio cholerae Infection in Urban Bangladesh."**

Rotavirus

"No correlation between antibody titer and immunity against rotavirus infection was identifiable when serum antibodies were measured. No consistent relationship was found between the titers of any of the six antibodies to the six viruses in the vaccine and clinical protection against developing rotavirus infection." **REF: Vaccine. Volume 13, Issue 13, 1995, Pages 1226-1232. "Lack of correlation between serum rotavirus antibody titers and protection following vaccination with reassortant RRV vaccines."**

Seasonal influenza

"A serum antibody titer of 1:40 does not guarantee protection from influenza infection. People with lower titers show protection against influenza, and people with higher titers can have symptomatic infection. Moreover, the assumption that a titer value of 1:40 or greater will protect an individual from infection is valid only if the virus causing the increased titer is the same virus that is in circulation during the flu season." **REF: NEJM. 2006 Mar 30;354(13):1343-51. "Safety and Immunogenicity of an Inactivated Subvirion Influenza A (H5N1) Vaccine."**

6. Arguments against vaccination are irrational, based on fear and resistance to authority (In other words, persons who make these arguments don't want the government telling them what to do). Many are conspiracy theorists and believe the government is knowingly harming them.

TRUTH: Contrary to this often-used accusation, arguments promoting vaccinations are the ones based on fear. Doctors scare parents with stories of rare, serious complications and death from childhood

infections that most adults over 40 years old experienced without consequence. Arguments opposing vaccination are often based on a studious review of the medical literature that reports complications soon after vaccination, including autoimmune disease, allergy and death. They are not based on fear-mongering.

The line between coercion and persuasion can be razor-thin and the rights of parents to decide what is best for their child has been at odds with recommendations pushed by public health officials since the first smallpox vaccination was given in the U.S. in 1803. A recent example is from a 1963 guide published by the federal Communicable Disease Center (former name for the CDC) contended that "the full use of the word epidemic in public statements is the most effective single means of stimulating the public to action."

People who resist fear-based arguments from doctors and the government and then decide not to vaccinate have often evaluated the risks. No medical procedure is guaranteed to be safe for every child, and there is no way to determine in advance who will react and who will not. Parents often struggle in their decision to vaccinate, not because they are concerned about "resisting authority," but because arguments both for and against vaccination can be compelling. Those who refuse have concluded that the risk of a particular vaccine is more substantial than the hype about the infection. **REF: Coercion vs. persuasion information from "State of Immunity," by James Colgrove. University of California Press. 2006. p. 11-12.**

7. Vaccine-preventable diseases of childhood can be serious. If your child is not vaccinated, they could contract one of these illnesses and die.

TRUTH: This is a typical example of fear-mongering tactics used to coerce parents into vaccinating. Certainly, childhood illnesses can be

serious in some children. However, the vast majority of children who contract a "vaccine-preventable disease" experience a week or two of discomfort, fever, vomiting and a rash. They pass through the childhood illnesses and recover uneventfully. While rare complications can occur in any child, the underlying health of a child who experienced a complication is unknown. For example, was the child immune-compromised by drugs, such as steroids? Was the complication associated with other illnesses, such as congenital heart disease or cancer? Data generated from the CDC documents that the mortality rate from pediatric infectious diseases declined to low levels before vaccines for those diseases were introduced. (See graphs at Addendum I.)

8. Parents who believe chickenpox is a benign disease and that the vaccine is not necessary are putting their children at considerable risk.

TRUTH: Rarely mentioned by medical personnel are the serious complications that can arise from the vaccines. For example, an assessment of the chickenpox vaccine (Varivax®) demonstrates the possibility of sustaining a serious reaction from the vaccine is greater than the small risk of a serious complication from this benign childhood disease.

Between March 1995 and July 1998, VAERS received 6,574 reports of adverse events related to Varivax, including 262 serious reactions, 30 episodes of anaphylaxis (shock) and 14 deaths. Fourteen persons developed a shingles outbreak caused by the virus in the chickenpox vaccine. These are the known reactions; thousands more could have occurred in persons who were not familiar with filing an adverse event report with VAERS. **REF: JAMA. Vol. 284 No. 10, September 13, 2000. "Post-licensure Safety Surveillance for Varicella Vaccine."**

In contrast, the CDC reported that during the same period 5,900 children experienced serious complications from chickenpox. Before the vaccine was available, the number of deaths from chickenpox complications in all age groups was about 17 per year. After the vaccine was released, about 14 people died per year from complications of chickenpox, essentially the same as the number of reported deaths from the vaccine. In other words, little has been gained in preventing deaths from chickenpox through mass use of the vaccine. **REF: Prevention of Varicella: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR. July 12, 1996/ 45(RR11);1-25.**

FACTS ABOUT CHICKENPOX AND THE CHICKENPOX VACCINE:

1989: According to American Medical Association's Encyclopedia of Medicine, chickenpox is a "common and mild infectious disease of childhood" and "all healthy children should be exposed to chickenpox ...at an age at which it is no more than an inconvenience."

1995: The chickenpox vaccine was approved for use.

1996: The American Academy of Pediatrics stated in a 1996 brochure on chickenpox, "Most children who are otherwise healthy and get chickenpox won't have any complications from the disease."

1996: Studies have shown that vaccine recipients can contract chickenpox from the vaccine, and persons have contracted chickenpox from recently vaccinated children. **REF: Prevention of Varicella: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR. July 12, 1996 / 45(RR11);1-25.**

1996: The incidence for children developing shingles within 10 years after the vaccination has been reported to be 18 in 100,000—or nearly 1 in 5,000—a high risk. Shingles is an extremely painful rash most commonly seen in adults who are diabetic, on steroids or immuno-compromised. **REF: Prevention of Varicella: Recommendations of**

the Advisory Committee on Immunization Practices (ACIP). MMWR. July 12, 1996 / 45(RR11);1-25.

1998: Only 42 percent of Washington state pediatricians recommended universal chickenpox vaccination. Many of the doctors surveyed felt that complications of the disease were rare, the vaccine was not cost effective, and the vaccine would not provide lifelong immunity. **REF: Arch Pediatr Adolesc Med. 1998; 152:792-796. "Reactions of Pediatricians to the Recommendation for Universal Varicella Vaccination."**

2002: Adults need to be exposed to the natural chickenpox virus to prevent the development of shingles. Mass vaccination of children against chickenpox is anticipated to contribute to future epidemics of shingles in more than 50 percent of Americans. **REF: Varicella vaccine and shingles. JAMA May 1, 2002;287(17):2211.**

2003: Children are now experiencing an unprecedented incidence of shingles. It has been predicted that a large-scale shingles epidemic will soon be seen among adults and an estimated 50 million adults will experience shingles over the next 10 to 15 years due to the widespread use of the vaccine. **REF: Vaccine. Vol.21, Issue 27/28. Oct. 2003. [This issue devoted 18 pages and three reports to this topic.]**

2007: Studies have shown that antibodies from the chickenpox vaccines wane over time; by 5 years of age, 58 percent of children who were vaccinated no longer have a residual antibody. **REF: NEJM. 2007 Mar 15;356(11):1121-9. "Loss of Vaccine-Induced Immunity to Varicella over Time."**

The average failure rate of the vaccine ranges from 24 to 38 percent, meaning more than 30 percent of vaccinated children contract chickenpox. The National Institutes of Health reported that the vaccine is effective at reducing the severity of an outbreak, but it does not actually prevent an outbreak of the disease. **REF: Varivax package insert.**

9. No child should be denied the benefits of vaccination.

TRUTH: No child should be forcibly vaccinated with a product that can cause serious health complications, including death. Physicians and government officials must be willing to have open and honest discussions about the risks of vaccination instead of only touting their supposed benefits. Denying the risks that have been described by first-hand accounts drives a wedge through the core of the doctor-patient relationship. Adults have a right to know the risk of what is being injected into their body and into the bodies of their children. Doctors have a responsibility to be forthcoming about known side effects. The choice between the risk of the disease and the risk of the vaccine should be a decision between the doctor and the patient, and not a mandate from an appointed, unaccountable politician or bureaucrat.

10. Vaccination is one of the most cost-effective interventions in all of health care.

TRUTH: The national vaccination programs are costing the country billions in tax dollars and health care costs. The known, direct costs of vaccination include the following:

1990s: Global vaccine sales doubled from $2.9 billion in 1992 to more than $6 billion in 2000.

2005: The global vaccine market is generating between $10 billion and $16 billion dollars per year. The global vaccine business is projected to grow 18 percent a year to $30 billion by 2011, well above the 4.4 percent annual growth expected for the drug industry overall. A new adult and adolescent vaccine market is anticipated to comprise the largest portion of that growth.

2006: More than $4 billion in international assistance had been given by the U.S. in an attempt to eradicate polio. It has been estimated that complete eradication could cost the U.S. another $1.2 billion over the next three years. **REF: Science (Washington). Vol. 312, no. 5775, pp. 852-854.12 May 2006. "Is Polio Eradication Realistic?" NOTE:** *The eradication of polio will not eradicate paralysis.~ST*

2007: Nearly 32 percent of the CDC's $8.2 billion total budget—$2.6 billion—was allocated to the National Immunization Program, which includes the following:

- $2.1 billion to support the Vaccine for Children fund, a program that purchases 40 percent of all childhood vaccines in the U.S.
- $507 million for the Section 317 Immunization Grants Program.
- $300 million to establish a six-month stockpile of all routinely recommended pediatric vaccines.
- $188 million to enhance pandemic preparedness.

Federal wholesale purchase price for vaccines has escalated with each additional mandate and the cost to taxpayers to purchase vaccines for children has increased:

- 1985: DTP (5 doses), polio (4 doses) and MMR (1 dose) cost the government **US$45 per child.**
- 1995: With the addition of HiB (4 doses) and Hepatitis B (3 doses), the government paid **US$155 per child** for full vaccination.
- 2007: Multiple doses of nine more vaccines were added to the requirements: the flu shot, chickenpox, Prevnar (streptococcal vaccine), hepatitis A, rotavirus, a second dose of MMR, teen tetanus booster, Gardasil (HPV vaccine), and Menactra (college meningitis vaccine). The government (our tax dollars)

pays **more than $1200 per child** for all doses of vaccines given to children by 11 years of age. Doctors pay more to purchase inventory for their offices: **$1500 per child.**

REF: National Vaccine Finance Working Group Update. Sept. 26, 2006. Indirect Costs of Vaccines.

At the September 26, 2006 meeting of the NVAC, it was reported that a 10-doctor pediatric group typically has allocated more than $100,000 to vaccine inventory. Is it any wonder that doctors want to recoup those costs by pushing vaccines on every child? **REF: National Vaccine Finance Working Group Update. Sept. 26, 2006. Indirect cost of vaccines.**

The National Vaccine Injury Compensation Program (NVICP) was signed into law in 1986. Injury claims began to be filed on October 1, 1988. Since that time (through October 2007), 11,351 injury claims have been filed seeking compensation, with only 2,122 persons (18.6 percent) being awarded compensation.

The total amount paid to claimants by the government is just over $699 million. The amount rewarded for a vaccine-related death is limited to $250,000 plus attorneys' fees and expert witness costs. Awards are paid from the Vaccine Injury Compensation Trust Fund, arising from an excise tax on every dose of vaccine purchased by the government from the manufacturers. For example, the excise tax on every flu shot is $0.75 because it prevents one disease. On the other hand, the excise tax imposed on a dose of measles-mumps-rubella vaccine is $2.25 because it is given to prevent three diseases. **REF: National Vaccine Injury Compensation Program, Statistics and Reports. http://www.hrsa.gov/vaccinecompensation/statistics_report.htm**

National Vaccine Injury Compensation Program (VICP)

Claims Filed and Compensated or Dismissed by Vaccine[1]
October 1, 2007

Vaccines Listed in Claims as Reported by Petitioners

Vaccine(s)	Filed			Compensated	Dismissed
	Injury	Death	Total		
DT (diphtheria-tetanus)	61	9	70	18	47
DTP (diphtheria-tetanus-whole cell pertussis)	3,280	694	3,974	1,262	2,672
DTP-HIB	16	8	24	3	19
DTaP (diphtheria-tetanus-acellular pertussis)	226	58	284	61	86
DTaP-Hep B-IPV	13	5	18	2	2
DTaP-HIB	5	1	6	3	0
Td (tetanus-diphtheria)	111	1	112	45	50
Tetanus	55	2	57	20	29
Hepatitis A (Hep A)	10	0	10	0	2
Hepatitis B (Hep B)	515	43	558	82	224
Hep A-Hep B	3	0	3	0	1
Hep B-HIB	3	0	3	1	1
HIB (*Haemophilus influenzae* type b)	15	3	18	6	5
HPV (human papillomarvirus)	0	0	0	0	0
Influenza (Trivalent)	172	12	184	13	15
IPV (Inactivated Polio)	259	14	273	4	264
OPV (Oral Polio)	279	26	305	157	146
Measles	142	19	161	54	107
Meningococcal	2	0	2	0	0
MMR (measles-mumps-rubella)	724	50	774	271	323
MMR-Varicella	3	0	3	0	0
MR	15	0	15	6	9
Mumps	10	0	10	1	9
Pertussis	5	3	8	2	6
Pneumococcal Conjugate	20	3	23	5	12
Rotavirus	30	1	31	20	11
Rubella	189	4	193	68	123
Varicella	35	2	37	18	12
Nonqualified[2]	57	7	64	0	63
Unspecified[3]	5,094	5	5,099	0	370
TOTAL	**11,351**	**970**	**12,321**	**2,122**	**4,608**

[1] The number of claims filed by vaccine as reported by petitioners in claims since the VICP began on October 1, 1988, which have been compensated or dismissed by the U.S. Court of Federal Claims (Court). Claims can be compensated by a settlement between parties or a decision by the Court.
[2] Claims filed for vaccines which are not covered under the VICP.
[3] Insufficient information submitted to make a determination

From: Government Vaccine Compensation Claims.
ftp://ftp.hrsa.gov/vaccinecompensation/Claims_Filed_Compen_Dismiss.pdf

Beyond the awards for the injury, the total dollars spent on the health care for all vaccine-injured persons is unknown and can only be painstakingly calculated, one injury at a time and one vaccine at a time, through the examination of multiple databases. These costs need to be determined and added to the cost of the national vaccination program.

The costs incurred by vaccine injuries are hidden costs that negate the "cost effectiveness" tauted by pro-vaccine sources. The following is one vivid example of vaccine injury, representing the costs of vaccination:

The relationship between the influenza vaccine and Guillain-Barré Syndrome (GBS) has been documented. GBS is an inflammatory disorder of the peripheral nerves (those outside the brain and spinal cord) characterized by an acute onset of weakness and paralysis. Called "ascending paralysis," it starts in the legs and moves gradually up the body, eventually attacking the muscles that aid in breathing. Weakness may have an abrupt onset but typically has a gradual onset over a two-week period of time. Treatment often involves long-term hospitalization, including many weeks in the intensive care unit, as most patients need the assistance of a respirator. Neurological deficits remain in up to 40 percent of people who recover from GBS and mortality from GBS ranges from five to 10 percent. **REF: Fanion, David. "Guillain-Barré Syndrome," found at eMedicine on WebMD.**

> A story published November 19, 2002, in the Canadian Public Health Reporter gives an example of the suffering incurred by GBS after an influenza vaccine:
>
> > A 47-year-old executive, Brian Claman, thought he was too busy to bother with the flu, so when his company offered the shots on site, he was one of the first in line. Two weeks later, he woke up with a severe headache and leg weakness, and by that same afternoon, he was placed in the intensive

care unit and on a respirator, completely paralyzed. After eight months in the hospital, he had to relearn to walk. Claman said, "Never in my wildest dreams—or maybe I should say nightmares—could I have imagined almost losing my life to the flu shot." **REF: "Flu shot left executive paralyzed," by Andre Picard. Public Health Reporter. Monday, November 18, 2002, (page A1).**

According to Health Canada, 37 cases of GBS exhibited suspicious links to the flu vaccine in 1987 alone. Health Canada cautioned that because reporting of cases of GBS is not mandatory, the actual number was probably higher.

The CDC estimates that the risk of contracting GBS following an influenza vaccine is approximately one or two cases per one million persons vaccinated. In 2006, the actual number who received the flu shot was 70.4 million, so using CDC estimates, between 70 and 140 persons could contract vaccine-induced GBS each year after receiving a flu shot. **REF: Estimates of Influenza Vaccination Target Population Sizes in 2006 and Recent Vaccine Uptake Levels.**
http://www.cdc.gov/flu/professionals/vaccination/pdf/targetpopchart.pdf.

The health care costs associated with Guillain-Barré can be significant. Based on 2005 data obtained from the Healthcare Cost and Utilization Project (HCCUP), GBS patients accumulate charges of nearly $73,800 per person. If between 70 and 140 persons contracted GBS from the flu shot, the costs to the healthcare system would be burdened with between $5.16 and $10.3 million in costs associated with this vaccine injury.

Moreover, long-term hospital stays place patients at risk for significant complications. The risk for contracting hospital-acquired, or "nosocomial" pneumonia ranges from 10 to 65 percent. Within days of being placed on a ventilator, patients can acquire ventilator-associated pneumonia,

or VAP. The fatality rate from either type of pneumonia can be more than 25 percent. **REF: Chest. 2001, 120:2059-2093. "Infection control in the ICU."** The costs of complications often associated with GBS can be substantial. Longer hospital stays, repeated blood tests and sputum cultures, x-rays, antibiotics and other drugs, IV tubing, urinary catheters, a wide variety of costly invasive monitoring devices, and even extra surgical procedures can make the costs soar for patients with GBS.

This example represents only one complication, from one vaccine. The costs associated with each injury needs to be calculated, multiplied by the number of persons who sustained the injury and added to the full cost of the national vaccine program. Vaccine injuries are no doubt costing the health care system hundreds of millions of additional dollars, making the vaccine program not effective after all.

11. There is no evidence that vaccination harms the immune system.

TRUTH: The immune system is the body's intricate regulatory system. Composed of cells, tissues, mediators and antibodies, it plays a role in destroying tumors; eliminating viruses, bacteria and other microbes; neutralizing toxins; and performing other defense functions. It has a memory system capable of recalling previous encounters with infectants and can mount a strong response upon re-challenge. For example, when you have had measles or chickenpox, your immune system "remembers" and eliminates the virus upon re-exposure without once again experiencing the infection. This function is called lifetime immunity.

Any substance that leads to an antibody response is called an immunogen. For a molecule to be immunogenic, it must be seen as foreign by the host. Vaccines are called effective because they are immunogenic,

foreign particles in the blood. They are considered "antigens" because they lead to the production of an antibody. While antibodies are considered markers of immunity, they do not guarantee protection from infection.

An antibody is a molecule that produces its effect while circulating in the bloodstream. There are five distinct classes of antibodies: IgG, IgM, IgA, IgE and IgD, easily remembered by the word GAMED. The most abundant type of antibody found in the blood is IgG, a protein shaped like a capital letter Y. It is the upper tips of the Y that bind with a specific foreign antigen, creating a complex that neutralizes and eliminates a foreign particle such as a virus or bacteria. The presence of IgG means the person has responded to a vaccination.

Two different types of IgG responses occur after vaccination. The first injection stimulates the immune system to respond and causes an initial IgG spike detected about six days after the shot. The spike levels off in 12 to 14 days and then settles to a lower level. When the second shot is given, a strikingly large IgG response quickly occurs and lasts for several years. Because blood tests (called titers) are not routinely ordered, a third dose of vaccine is administered to children who may not need it.

Overall, the immune response is categorized into two general areas: humoral, which involves the production of antibodies; and cell-mediated, which includes different types of white blood cells, including macrophages and several different lymphocytes. Active immunity and lifetime protection is gained when a person experiences and recovers from an infection. The interplay between the humoral and cell-mediated divisions locks the event into the long-term memory of the immune system.

Alternatively, vaccination introduces passive, temporary immunity. By

engaging primarily the humoral immune system and producing antibodies, no lifelong protection is conferred as vaccine-induced antibodies disappear within a few years. In other words, a person's immune system and overall, long-term health are more robust if an illness such as chickenpox or measles is contracted and resolved naturally, as opposed to trying to avoid the infection through vaccination.

Scientific evidence of this truth has been published in the medical literature. The immune system of an infant is uncommitted, or "naive." Lymphocytes can differentiate into either TH1 cells, representing a predominance of cell-mediated immunity, or TH2 cells, a preponderance of humeral antibody immunity. A healthy immune system has a "bias" toward the TH1 system. When vaccines are introduced, the immune system is shifted heavily toward TH2 dominance. Persons with a TH2-skewed immune response tend to have allergies and asthma. The increased TH2 pattern has also been associated with increases in autoimmune disorders, type 1 diabetes, inflammatory bowel disease and autism. **REF: NEJM. 1992; 326:298-304. "Predominant TH2-like broncheoalveolar T-lymphocyte population in atopic asthma." REF: Thorax. 1997; 52: 1-4. "Allergic respiratory disease: Strategic targets for primary prevention during childhood."**

Despite all we know about the intricacies of the adult immune system, an investigation of the immune system of infants and small children has only recently begun and is minimally understood. At the First International Neonatal Vaccination Conference held in Washington, D.C. (March 2-4, 2004), Professor Claire-Ann Siegrist, from France, delivered a detailed presentation on the complexities of a newborn's immune system. Within the first moments of life, the infant is bombarded with millions of antigens. Both the humeral and cell-mediated immune system begin the process of developing resistance to the exposures and helpful protection is passed to the newborn through breast feeding. According to researchers, the process continues

exponentially throughout the first few months of life. Injections—such as hepatitis B vaccine and the vitamin K shot—during the initial moments of life disrupt the rapidly developing, delicate communication system within the newborn. When cytokines and interleukins, complex messenger molecules, lose their connection, immune system dysfunction can develop later in life. **REF: "Neonatal Vaccination and Autoimmunity," presentation by Paul-Henri Lambert, 1st International Neonatal Vaccination Conference, Washington DC. March 2-4, 2004. http://www.hhs.gov/nvpo/meetings/neonatal/Lambert-two.pdf**

In addition to immediate description of the immune system, the brain is at high risk of injury by vaccinations introduced during the first few months of life. Myelin, the fatty coating that surrounds nerve cells and over the surface of the brain, does not begin to form until 14 weeks *after birth*. Myelin and brain cells grow rapidly throughout the first year of life. During these early delicate stages of neurological development, 60 vaccine antigens and measurable amounts of chemicals are injected, risking cellular damage and death. **REF: J of Neurology. 2005; 484:156-167. "Axonal development in the cerebral white matter of the human fetus and infant."**

Evidence of serious health consequences was recently confirmed in the Journal of Pediatrics in which CRP levels were measured after vaccination. CRP, short for C-reactive protein, is a blood marker indicating a heightened state of inflammation throughout the body.

The study involved 239 infants in a neonatal intensive care unit who were given two or more vaccines on the same day. A separate group of infants were given one shot at a time, every three days. The vaccines administered were DTaP, HiB, polio [IPV], hepatitis B and Prevnar. The findings were disturbing:

- An abnormally elevated CRP occurred in 85 percent of infants who received simultaneous vaccines and

nearly 70 percent of infants who received the shots one at a time.

- Gastroesophageal reflux (GERD) and severe intraventricular hemorrhage (bleeding in the brain) occurred in infants who received multiple vaccines at the same time.
- Cardiorespiratory events (stopped breathing) occurred in 16 percent of all infants within 48 hours
- Infants who received DTaP, Prevnar and HiB as single injections experienced the largest number of respiratory events.

REF: J of Pediatrics. Vol. 51, Issue 2, pgs. 167-172. August, 2007. "Primary Immunization of Premature Infants with Gestational Age <35 weeks."

There are further concerns about elevated CRP levels. In a study of 62 children who were part of the Diabetes Autoimmunity Study, infants and young children who had an elevated CRP level had an increased risk of developing Type 1 (insulin-dependent) diabetes later in childhood. **REF: Diabetes. 2004 Oct; 53 (10): 2569-73. Elevated C-reactive protein levels in the development of type 1 diabetes. Diabetes. 2004 Oct;53(10):2569-73.**

It is difficult to imagine that the introduction of viruses, bits of bacteria, mercury, aluminum and more than 100 additional chemicals into the body of an infant can be considered harmless. In truth, the long-term consequences of vaccines on the immune system of a child under two years of age cannot be predicted even though the risk is substantial.

12. There is no evidence that vaccination can lead to chronic disease.

TRUTH: Vaccines and vaccine components are associated with

chronic diseases. Tetanus toxoid, influenza vaccines, polio vaccine, rubella vaccines and others have been related to phenomena ranging from auto-antibody production to full-blown illness (such as rheumatoid arthritis). **REF: J. Autoimmune. 2000 Feb; 14(1): 1-10. Shoenfeld Y. "Vaccination and autoimmunity –'vaccinosis': a dangerous liaison?"**

If a child develops an autoimmune disorder, such as rheumatoid arthritis or insulin-dependent diabetes, vaccines are rarely, if ever, suspected as the inciting event even though evidence points to vaccines as a source of immune system disruption. In 2005, the journal, Vaccine, reported a study in which all relevant publications between 1966 and June 2004 were reviewed to determine if there was a published association between autoimmune diseases and vaccination. The most frequently reported autoimmune manifestations for the various vaccinations were:

Hepatitis B virus (HBV)–rheumatoid arthritis, reactive arthritis, vasculitis, encephalitis, neuropathy, thrombocytopenia;
MMR–acute arthritis or arthralgia, chronic arthritis, thrombocytopenia, hearing loss;
Influenza–Guillain-Barré syndrome (GBS), vasculitis;
Polio–GBS;
Varicella–mainly neurological syndromes.

REF: Vaccine. 2005 Jun 10;23(30):3876-86. Epub 2005 Apr 7. "Consequence or coincidence? The occurrence, pathogenesis and significance of autoimmune manifestations after viral vaccines."

The hepatitis B vaccine has been particularly troublesome, with at least 200 reports in the medical literature of harm caused by the vaccine. Injuries have occurred in infants, children and adults. A representative list of injuries reported after vaccination with hepatitis B is contained in Addendum J. **REF: For a complete list, compiled by Dr. Burton Waisbren, MD of Milwaukee, Wisconsin, go to "New Yorkers for Vaccination Information**

and Choice" at http://ffitz.com/nyvic/health/hep-b/autoimun.htm

13. There is no evidence that vaccination is linked with the development of asthma.

TRUTH: This is simply not true. The information is skewed when epidemiological studies make the thousands of children who have developed asthma after vaccinations "statistically insignificant" in comparison to the millions of shots given. The larger the denominator, the easier it is to discount the size of the numerator. For example, 231 injured in a study that involved 679,900 persons makes the percentage of those injured (0.034 percent) appear extremely small.

Pediatricians point to the abundance of epidemiological studies to reassure parents that there is no association between vaccines and asthma. Nonetheless, evidence of the connection exists and individual experiences affirm the connection. Here are four examples:

1. Persons who were fully vaccinated as children were found to have a higher risk of asthma as adults. **REF: Aust N Z J Public Health. 2004 Aug;28(4):336-8. "Asthma and vaccination history in a young adult cohort."**

2. In a study of 450 children, 11 percent who had received the pertussis vaccination suffered from asthma, as compared with only 2 percent of the children who had not been vaccinated. **REF: JAMA. Aug 24-31; 272(8): 592-3. 1994. "Pertussis vaccination and asthma: is there a link?"**

3. A small study published in 2000 uncovered the association between the DTaP or tetanus vaccine with allergies and allergy-related respiratory symptoms. The results showed that the odds of developing asthma were

twice as great among vaccinated subjects than among unvaccinated subjects. In addition, the odds of developing allergy-related symptoms within 12 months of a vaccine were 63 percent greater among vaccinated subjects than unvaccinated subjects. This association was greatest among children ages 5 through 10 years of age. **REF: J Manipulative Physiol Ther. 2000 Feb;23(2):81-90. "Effects of diphtheria-tetanus-pertussis or tetanus vaccination on allergies and allergy-related respiratory symptoms among children and adolescents in the United States."**

4. Persons with a TH2-skewed immune response tend to have allergies and asthma. **REF: NEJM. 1992; 826:298-304. "Predominant TH2-like bronchoa/veolas T-lymphocyte population in atopic asthma."**

Drugs are prescribed when symptoms develop. Severe disruptions after vaccination, such as asthma, allergies, ADD/ADHD, seizure disorders, diabetes and cancer create customers for life for the pharmaceutical industry.

14. There is no evidence that vaccination can lead to allergies.

TRUTH: The following vaccines and vaccine additives have been associated with an increase of serum IgE, the antibody present in most persons with allergies:

NOTE: *This is not an exhaustive list; it is meant to be representative of research articles published to confirm the association between vaccines and allergies.~ST*

Aluminum

- **REF:** Rocz Panstw Zakl Hig. 1993;44(1):73-80. (Polish). "Aluminum as an adjuvant in vaccines and post-vaccine reactions."

CONCLUSION: Vaccine nodules persisting more than 6 weeks may indicate development of aluminum hypersensitivity. Aluminum adjuvants induce the production of IgE antibodies.

- **REF:** Vaccine.Volume 22, Issue 1, 8 December 2003, Pages 64-69. **CONCLUSION:** The itching in aluminum-related nodules after vaccination was intense and long-lasting; 75 percent had symptoms after a median of four years.
- **REF:** Pediatrics. Volume 97, Number 3 March, 1996, pp. 413-416. **CONCLUSION:** Aluminum is being implicated as interfering with a variety of cellular and metabolic processes in the nervous system and in other tissues.
- **REF:** Zatta PF, Alfrey AC. (Eds). "Aluminium Toxicity in Infants' Health and Disease." 1997, World Scientific Publishing. **CONCLUSION:** Aluminum is eliminated from the body primarily through the kidneys. Infant kidney function (glomerular filtration rate) is low at birth and doesn't reach full capacity until 1-2 years of age. Infants may not be able to effectively excrete aluminum, contributing to heavy metal toxicity.
- **REF:** Vaccine. 1991 Oct;9(10):699-702. **CONCLUSION:** Reactions to DPT may be due to factors such as sensitization induced by aluminum adjuvants.
- **REF:** "Vaccines Show Sinister Side," by Pieta Woolley. **CONCLUSION:** New research by Vancouver neuroscientist Chris Shaw shows a link between the aluminum hydroxide used in vaccines and symptoms associated with Parkinson's, amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease), and Alzheimer's.

DT vaccine (diphtheria and tetanus)

- **REF:** Vaccine. 2002 Sep 10;20 (27-28):3409-12.

CONCLUSION: The study showed simultaneous development of IgE antibodies to both toxoids.

Gelatin

NOTE: Vaccines that contain gelatin are Boostrix, Fluzone, JE-Vax, MMR, ProQuad, Rabies, Varivax, Tripedia (DTaP), yellow fever, Zostavax.

- **REF:** Ann Allergy Asthma Immunol. 2000 Mar; 84 (3):341-4.

CONCLUSION: IgE reactions to the chickenpox vaccine are most likely caused by a reaction to gelatin.

• **REF:** Int Arch Allergy Immuol 2007 Dec 14;146 (1):85-88. **CONCLUSION:** Based on clinical symptoms, skin testing, Immunocap testing and immunoblot evaluation, we feel that our patient developed anaphylaxis due to an allergy to the infectious agent in the influenza vaccine as well as gelatin and ovalbumin in egg.

• **REF:** J Allergy Clin Immunol. 1993 Apr; 91(4):867-72. Anaphylaxis to measles, mumps, and rubella vaccine mediated by IgE to gelatin. **CONCLUSION:** Anaphylaxis to MMR vaccine was caused by the gelatin component.

• **REF:** J Allergy Clin Immunol. 1999; Feb103:321–5. **CONCLUSION:** The vaccine reactions to gelatin were categorized as follows: 34 had anaphylaxis, 76 had urticaria (hives), 215 had a rash, and 41 had local reactions. Serum was available for 206 children, revealing IgE antibodies against gelatin. Of children with anaphylaxis, 93 percent (25 of 27) had IgE antibodies to gelatin; 56 percent (27 of 48) had urticaria, 9 percent (8 of 90) had a rash. No children who had only local reactions had antibodies to gelatin.

• **REF:** Ped Asthma, Allergy & Immunology. 2007, 20(3): 201-205. **CONCLUSION:** Anaphylaxis to gelatin is the most common identifiable cause of severe allergic reaction to vaccines.

• **REF:** Pediatrics. 2002 Dec;110 (6):e71. **CONCLUSION:** Almost one fourth of patients with reported anaphylaxis after MMR seem to have hypersensitivity to gelatin in the vaccine. They may be at higher risk of developing anaphylaxis to subsequent doses of other gelatin-containing vaccines.

• **REF:** Vaccine. Volume 17, Issue 4, February 1999, Pages 327-329. **CONCLUSION:** Generalized urticaria (hives) occurred from gelatin in the chickenpox vaccine. Children known to be allergic to gelatin should not receive Oka/Merck varicella vaccine (VARIVAX®).

• **REF:** Vaccine. Volume 18, Issue 15, 14-February-2000 pp. 1555-1561 **CONCLUSION:** Gelatin-containing diphtheria--tetanus--pertussis (DTP) vaccine causes sensitization and allergy to the recipients.

Influenza vaccine

• **REF:** Int Arch Allergy Immunol. 2007 Dec 14;146(1):85-88. **CONCLUSION:** Based on clinical symptoms, skin testing, and Immunocap testing and immunoblot evaluation (blood tests), we

feel that our patient developed anaphylaxis due to an allergy to the infectious agent in the influenza vaccine (the virus) as well as gelatin and ovalbumin in egg.

Pertussis vaccine

- **REF:** Pediatr Allergy Immunol. 1994 May;5 (2):118-23.
CONCLUSION: The correlation between total IgE and pertussis (pertactin)-IgE indicates that immunizations play a role in the development of allergy and merits further study.
- **REF:** Vaccine.1997 Oct;15 (14):1558-61. **CONCLUSION:** The high rates of pertussis (pertactin)-IgE responses have been noted after both acellular and whole cell pertussis vaccine. Studies have shown that the IgE response is due to the vaccine.

Mercury (thimerosal)

- **REF:** A J Contact Dermat. 2003 Sep;14 (3):138-43
CONCLUSION: Mercury was the 5th most common allergen in this clinic of more than 2,500 patients.
- **REF:** AltMedReview. Aug, 2003. Kidd, Parris.
CONCLUSION: Mercury depletes glutathione, polarizing theTH2 dominance.
- **REF:** Australas J Dermatol. 2003 Aug;44 (3):199-202.
CONCLUSION: Well's syndrome was determined to be caused by the thimerosal in the vaccines.
- **REF:** Cl & Exp. Immunology. Vol. 134, Issue 2, pg 202. Nov. 2003. **CONCLUSION:** Mercury can induce a strong increase of IgE.
- **REF:** J of Immunology. 2003, 171: 1596-1601. **CONCLUSION:** After exposure to subtoxic doses of mercury, mice developed an autoimmune syndrome consisting of serum IgG1 and IgE.

MMR vaccine

- **REF:** Allergy. 1980 Oct;35 (7):581-7. **CONCLUSION:** Severe hypersensitive reaction due to the measles vaccines in six children due to neomycin or gelatin.
- **REF:** Clin Immunol. 01-Sep-2001; 100(3): 355-61.
CONCLUSION: MMR vaccine can induce IgE class switching in human B cells. Evidence exists that childhood viral immunizations can induce atopic reactions (allergies). ***NOTE: IgE antibodies and the possibility of allergies are associated with the rubella portion***

of the MMR vaccine in this study.
• **REF:** J Allergy Clin Immunol. 1993 Apr; 91(4):867-72. **CONCLUSION:** Anaphylaxis to measles, mumps, and rubella vaccine mediated by IgE to gelatin.
• **REF:** Vaccine. Jan. 2008. **CONCLUSION:** VAERS reports identified 44 cases of likely idiopathic sensorineural hearing loss after MMR administration.

15. The traces of additives found in vaccines are inconsequential and non-toxic.

TRUTH: All of the vaccines together contain measurable amounts of more than 100 different additives, preservatives, chemicals, medications and antibiotics added during the manufacturing process. One vaccine does not contain all of these substances, but every vaccine contains at least several. For example, the DTaP vaccine is produced using formaldehyde, aluminum hydroxide, aluminum phosphate, polysorbate 80 and gelatin. Another example, the polio vaccine, is produced using three different viruses and can contain measurable amounts of formaldehyde or phenoxyethanol; sucrose (table sugar); and the antibiotics neomycin, streptomycin and polymyxin B. Every one of the chemicals has a toxicity profile. The combined effects when these substances are injected into infants are unknown. Manufacturers claim that giving the DTaP and the polio vaccines together is acceptable and causes little damage, but the long-term health consequences of the injected chemicals is unknown. (see Addendums F, G and H.)

The injection of these chemical and animal virus slurries into children has been challenged. On January 29, 2001, Jack Doubleday, CEO of the California non-profit, Natural Woman, Natural Man, Inc., offered $20,000 to the first U.S.-licensed medical doctor or pharmaceutical company CEO who would publicly drink a standard mixture of vaccine additive ingredients. On August 1, 2007, the offer was increased to

$90,000 and will increase $5,000 per month, in perpetuity, until a medical doctor, a pharmaceutical executive, or any of the 15 current members of the ACIP agrees to drink a dose of chemicals that would be equivalent to the dose given to an infant. It should be no surprise that no adult has been willing to swallow what is routinely injected into children. **REF: Spontaneous Creation Press Release. http://www.spontaneouscreation.org/SC/$75,000VaccineOffer.htm**

16. The stray viruses sometimes found in vaccines are harmless.

TRUTH: Vaccines contain bovine cells and viruses (from cow serum), avian cells and viruses (from chickens), immortalized cells (from aborted fetal tissue), viruses from monkey kidneys, and stray bacteria that enter due to lax sterility standards. The following is specific information about animal tissues and the stray viruses they contain.

Bovine (cow) serum: Polio, hepatitis A, rubella, mumps, rotavirus, chickenpox and the shingles vaccines are made using bovine serum. The most common contaminant virus found in bovine serum is a member of the pestivirus family called bovine diarrhea virus (BVDV). All commercially available bovine serum is thought to be contaminated with this virus. Vaccines grown on contaminated cells may, in turn, have viral contaminants in the final product. The animal viruses can combine with viruses in the vaccine and become an active, unique disease. **REF: J Infect Dis. 1996 Dec;174(6):1324-7. Contamination of commercially available fetal bovine sera with bovine viral diarrhea virus genomes: implications for the study of hepatitis C virus in cell cultures.**

The medical literature indicates BVDV can cause diarrhea in humans. One revealing study states, "...feces from children under two years of age who had gastroenteritis (diarrhea) that could not be attributed to

a recognized (normal) pathogen were examined for pestivirus antigens. These antigens were detected in 30 of 128 stool samples. The children who excreted pestivirus also had respiratory inflammation (asthma)." The most probable source for the pestiviruses is from vaccines. **REF: Lancet. 1989 Mar 11;1(8637):517-20. "Infantile gastroenteritis associated with excretion of pestivirus antigens."**

How much BVDV has trickled into humans? In spite of reassurances from manufacturers and regulatory agencies, a study published in 2001 found that 13 percent of MMR, polio or streptococcus pneumonia vaccines (Prenar and adult pneumonia shot) were contaminated with pestivirus. One researcher observed, "Antibodies identifying BVDV have been detected in approximately 30 percent of the human population who have had no contact with potentially infected animals," meaning that the only possible way animal viruses could have gotten into the blood of these people was through a vaccine. Many other references confirm that bovine viruses are entering the human genome through vaccines. **REF: Harasawa R. "Latent Risk in Bovine Serums Used for Biopharmaceutic Production." http://www.asmusa.org/pcsrc/ sum02.htm**

Bovine viruses grow rapidly in the human cell cultures WI-38 and MRC-5, cells originating from aborted fetal tissue. These cells, in turn, are used to manufacture the rubella and chickenpox vaccines. Rapid replication of BVDV increases the amount of animal virus that ends up in the final vaccine product.

REF: Dev Biol Stand. 1991;75:177-81. "Bovine viral diarrhea virus contamination of nutrient serum, cell cultures and viral vaccines."

REF: J Vet Med Sci. 2001 Jul;63(7):723-33. "Genotypes of pestivirus RNA detected in live virus vaccines for human use."

Avian (chicken) cells: The influenza, measles, rabies and yellow fever vaccines are produced using chicken cells and eggs. The vaccine industry has known since the 1960s that human vaccines have been contaminated

with avian leukemia virus (ALV), a retrovirus that infects most commercially raised poultry. Vaccines made using eggs repeatedly expose humans to an avian virus that can easily activate the human cancer-causing genes called erbB and myc. Once these genes are "turned on," erbB and myc have been associated with the development of human breast cancer. It seems the issue of ALV vaccine contamination deserves an extremely high level of attention—not the passive oversight it has been given by the Center for Biologics Evaluation and Research (CBER) and the FDA. **REF: "Tumor Viruses," by Joklik WK et al, 1992. Zinsser Microbiology (20th ed.), Chapter 59, p.889. Appleton & Lange.**

VERO (monkey kidney) cells: Monkey kidney cells, similar to WI-38 and MRC-5 cells, are called "immortal cell lines" because they have no limit to the number of times they can divide. A cell that divides indefinitely is, by definition, a cancer cell. The FDA is concerned about the number of adventitious (extra, outside) viruses that contaminate the monkey cells and are then passed on through polio vaccines. Scientists have determined that it takes only one "functional unit" of viral DNA to be incorporated into the DNA of a human cell to transform the cell into cancer. The current standards within vaccine manufacturing allow up to 100 million "functional units" of viral DNA in each dose of vaccine. The risk of developing cancer from a vaccine contaminated with animal viruses is apparently real. **REF: "What Is Coming Through That Needle? The Problem of Pathogenic Vaccine Contamination," a research paper by Benjamin McRearden.**

In 1999, a workshop co-sponsored by the FDA and CBER titled "Evolving Scientific and Regulatory Perspectives on Cell Substrates for Vaccine Development," gathered experts from government and industry to discuss the problems of animal viral contaminants found in vaccines. Dr. Walid Heneine, a CDC virologist, voiced the importance of not assuming that viral contaminants are harmless. She mentioned research conducted in 1997 that demonstrated viral contaminants

from animal tissues are capable of replicating and, therefore, are capable of causing disease in humans. Dr. Heneine suggested that simply ignoring rogue animal viruses in vaccines may be "imprudent." She warned that while the presence of some viruses is known, the disease-causing capability of viruses that have yet to be detected is unknown. In other words, we may be causing diseases, including cancer, from viral contaminants in vaccines that have not yet been identified. **REF: J of Virology. 71 (1997): 3005–3012. "Reverse transcriptase activity in chicken embryo fibroblast culture supernatants is associated with particles containing endogenous avian retrovirus EAV-0 RNA."**

Bacterial contaminants: In 2004, Chiron, a vaccine manufacturer headquartered near San Francisco, was warned by the FDA that its plant had failed to follow production procedures and had produced a contaminated influenza vaccine. The citations included bacteria found in sterile rooms, failure to maintain proper storage temperatures for its vaccines, improper cleaning and equipment maintenance, inaccurate production records, and lack of corrective actions after warnings about contamination. Ultimately, the bacteria *Serratia marcescens* was found in nine of its 100 flu vaccine lots. Because the plant had failed to keep adequate records of each vaccine batch, it could not trace where the problem started, nor determine if the other 91 lots were contaminated. As a result, none of the batches were safe for use and Chiron's flu vaccine production was suspended for the season. **REF: "Early flu-shot contamination revealed," The San Francisco Chronicle, by Sabin Russell. From SFgate.com**

In December, 2007, more than 1 million doses of the HiB vaccine were recalled due to the discovery of bacterial contaminate in the vaccine. Merck & Co. and the FDA informed health care professionals and consumers of a voluntary recall of 13 lots of PedvaxHiB and two lots of COMVAX vaccines. (See Table page 63)

TABLE: HIB vaccine recalled by FDA from http://www.fda.gov/consumer/updates/hib121307.html

Vaccine	Lot Number	Expiration Date
Pedvax HIB	0677U	January 11, 2010
Pedvax HIB	0820U	January 12, 2010
Pedvax HIB	0995U	January 16, 2010
Pedvax HIB	1164U	January 18, 2010
Pedvax HIB	0259U	October 17, 2009
Pedvax HIB	0435U	October 18, 2009
Pedvax HIB	0436U	October 19, 2009
Pedvax HIB	0437U	October 19, 2009
Pedvax HIB	0819U	January 9, 2010
Pedvax HIB	1167U	January 10, 2010
Pedvax HIB	J2438	October 24, 2009
COMVAX	0376U	January 5, 2010
COMVAX	0377U	January 8, 2010

The vaccines were recalled because the manufacturer could not guarantee the sterility of the lots. Routine testing of manufacturing equipment used to produce PedvaxHIB and COMVAX identified the presence of the bacteria, *Bacillus cereus*. Sterility tests on recalled lots did not find any contamination. However, vials have been distributed since April, 2007. Health care professionals were instructed to immediately discontinue use of any of the affected lots and follow the manufacturer's instructions for returning recalled vaccines.

Bacillus cereus is most commonly associated with food poisoning. However, in 2005, three neonates were confirmed to have hemorrhagic meningitis caused by *B. cereus*. All three had the same clinical course that started with an uncomplicated delivery and an uneventful first few days of life. Within an average of nine days, infants developed signs and symptoms of meningitis and had downhill clinical courses: All died within five days after the onset of full-blown infection. Injecting a

vaccine contaminated with this bacteria has the potential of causing a blood infection, local abcess or deadly meninigitis. **REF: Am J Neuroradiol. 2005 Sep;26(8):2137-43. "Bacillus cereus meningoencephalitis in preterm infants: neuroimaging characteristics."**

17. Vaccines cannot cause the diseases they are designed to prevent.

TRUTH: The following examples attest to the fact that this is not true.

***Haemophilus influenza b meningitis vaccine* (HiB)**
The first HiB vaccine, licensed in the U.S. in 1985, was a polysaccharide vaccine. Between May 1985 and September 1987, 228 cases of H. influenza b meningitis were reported in children who had been vaccinated with this vaccine. Most cases occurred within the first two months after vaccination. Ten developed meningitis within 72 hours of vaccination and one child developed a fatal episode of HiB5 meningitis within 48 hours of vaccination. Breast feeding confers natural protection against H. influenza and the vaccine eliminated that protection, increasing the risk of meningitis. This HiB vaccine was removed from the U.S. market when the currently used cell-wall vaccine was released in 1991. **REF: J Infect Dis. 1988 Aug;158 (2):343-8."Spectrum of disease due to Haemophilus influenzae type b occurring in vaccinated children."**
REF: Pediatr Infect Dis J. 1990 Aug;9 (8):555-61. "Safety evaluation of PRP-D Haemophilus influenzae type b conjugate vaccine in children."

Chickenpox vaccine (Varivax)
Those vaccinated with the chickenpox vaccine can pass vaccine-strain chickenpox to others, causing an outbreak of chickenpox. **REF: Prevention of Varicella: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR. July 12, 1996/ 45(RR11);1-25.**

Rabies (IMOVAX)
In 2004, a rabies vaccine intended for humans was recalled in the U.S.

and 23 other countries because a live strain of the virus was found in the vaccine. Testing of the IMOVAX vaccine discovered the presence of a live strain of the rabies virus when the shot was supposed to contain only attenuated viruses. While no one contracted rabies from the vaccine, the risk was real. **REF: CDC. Rabies vaccine recall. April 8, 2004.**

Rubella

The MMR vaccine is a live virus vaccine and the viruses can theoretically shed through the respiratory tract for several weeks after a child has been vaccinated. If a pregnant woman comes in contact with a child who has recently been vaccinated with the MMR, she can be exposed to the rubella virus. During the first 16 weeks of pregnancy, there is a small risk that the fetus could develop congenital rubella, a syndrome characterized by congenital glaucoma, deafness, mental retardation, and heart defects as a result of the MMR vaccine. **REF: Lancet. 1982;781-784. "Consequences of confirmed maternal rubella at successive stages of pregnancy."**

Rubella exposure during pregnancy requires a "significant contact," defined as being in the same room for over 15 minutes or having close face-to-face contact for at least five minutes, to be a concern to the fetus. **REF: Infection and Pregnancy - study group recommendations http://www.rcog. org.uk/index.asp?PageID=1737**

Zostrix (adult shingles vaccine)

Adults who had chickenpox during childhood maintain their lifetime immunity when they come in contact with children who have chickenpox. With the introduction of the chickenpox vaccine in 1991, fewer children contract chickenpox, causing adults to lose long-term immunity to the virus. Under certain circumstances, such as emotional stress, immune deficiency (from AIDS, steroid medication or chemotherapy) or illness with cancer, the varicella virus can reactivate, causing a condition referred to as shingles.

Shingles is a visible rash that appears several days to a week after the onset of burning pain and sensitive skin. The blisters follow the path of individual nerves from the spinal cord (called dermatomes). Eventually, the blisters rupture and ooze, with crusting over and healing within 3 to 4 weeks. Shingles can be extremely painful and can persist indefinitely as a condition referred to as post-herpetic neuralgia. With the elimination of the wild chickenpox virus, vaccines are now being created to address problems caused by vaccines.

Zostrix, approved for use in May 2006, contains the same virus that is used in the chickenpox vaccine but at a much larger concentration. The chickenpox vaccine (Varivax) contains 1,350 viral particles, called PFUs, while Zostrix contains 19,400 viral particles. Within one year of its release, 590 adverse events have been reported to VAERS about Zostrix. Of those, 315 events were considered "serious," including 145 adults who had developed shingles shortly after being vaccinated with Zostrix. Several children developed chickenpox after coming in contact with an adult who had received Zostrix a few days earlier. Five adults developed shingles after exposure to a spouse who had received Zostrix. Two elderly persons died within a few days of receiving the vaccine. Notably, Zostrix is causing the illness it is supposed to be preventing. **REF: "Update on Safety of Herpes Zoster Vaccination," by Sandra Chaves, MD. ACIP Committee Presentation, June 27-28, 2007. http://www.cdc.gov/vaccines/recs/acip/downloads/mtg-slides-jun07/12-zoster-chavez.pdf**

Polio (Vaccine-Associated Paralytic Polio (VAPP))

The last case of wild-strain polio in the U.S. occured in 1979; the last case in the Western Hemisphere was in Peru, in 1991. Between 1987 and 2001, the oral polio vaccine (OPV) was the only cause of paralyitic polio in the U.S., and 156 persons have received compensation from the National Vaccine Compensation Program because they were paralyzed after exposure to the vaccine. **REF: National Vaccine Injury**

Compensation Program, Claims Filed, Compensated or Dismissed. ftp://ftp.hrsa.gov/vaccinecompensation/VICPClaimsFiled_ Compen_Dismiss-6-9-06.pdf

While the U.S. stopped using the OPV in 2001, it is still used during massive global immunization campaigns. During National Immunization Days (NIDs), more than 430 million children worldwide are vaccinated over the course of a few weeks with the oral drops. Armies of vaccinators comb the streets in countries ranging from India to Nigeria, determined to inoculate every child under the age of five.

Five NIDs were orchestrated in 2004 that spanned 23 African countries, resulting in some children being forced to swallow up to 20 doses of vaccine as there were no records of previous vaccination. **REF: "Drives in 6 nations aim to treat every child under age 5," Ken Moritsugu. Knight Ridder Newspapers. Oct. 19, 2004.**

The long-term ramifications of this action will remain unknown even though there are well-documented episodes of vaccine-induced paralytic polio (VAPP) occurring after NIDs.

- In 2000-2001, 13 cases of VAPP occurred in the Dominican Republic and 8 occurred in Haiti after a vaccine-strain virus reverted to its active form. Similar outbreaks occurred that year in the Philippines, Madagascar, China and Indonesia. **REF: WHO Bulletin. "Circulating polio-derived vaccination viruses." Vol. 82. No. 1. Jan. 2004.**
- From 1998 through 2005, 91 cases of VAPP were registered in Russian Federation; 66 had received the OPV and 25 contracted VAPP through contact with a person who had been vaccinated. **REF: Zh Mikrobiolol Immunobiol. (5):37.44. Paralytic poliomyelitis in Russian Federation in 1998-2005.**
- In 2007, 69 Nigerian children and two from Niger experienced VAPP after a mass campaign. **REF: "Polio outbreak in Nigeria sparked by vaccine." Associated Press. October 5, 2007.**

During each NID, more than 400 million children are given doses of oral polio vaccine. As a result, 800 persons (2 per million doses of vaccine according to the WHO) could develop VAPP during a campaign. The WHO no longer tracks the actual number of persons paralyzed during NIDs, sending a message that policy makers are more concerned that all are vaccinated regardless of the consequences. Campaigns could be creating three times more paralysis than the wild poliovirus. Sadly, the National Institutes of Infectious Disease admits that "paralysis associated with OPV is unavoidable as long as the oral polio vaccine is used for eradication of paralysis caused by poliovirus." **REF: Jpn. J. Infect. Dis. 55, 57-58, 2002. "Surveillance of Poliovirus-Isolates in Japan, 2001."**

If the reason organizations such as UNICEF and the International Rotary Club are spending billions of dollars to drive polioviruses into extinction is to eliminate childhood paralysis, their goal is unattainable. An astonishing number of non-polio viruses can cause acute flaccid paralysis (AFP) including coxsackie viruses, Japanese encephalitis viruses, echoviruses and enteroviruses. **REF: Am. J. Neuroradiol. Jan 2001; 22: 200-205. "Acute Flaccid Paralysis in Infants and Young Children with Enterovirus 71 Infection: MR Imaging Findings and Clinical Correlates."**

Given this information, the WHO is engaging in double-speak when it insists that "the polio virus must be eradicated to prevent paralysis." As an example, in 1999, Egypt had only 9 cases of polio-related paralysis. The WHO declared the country was "on the threshold of eradicating poliovirus," implying that with the elimination of the poliovirus, paralysis would be eliminated from the country. In contrast, that same year the country documented 276 cases of "non-polio AFP," meaning the paralysis was caused by a virus other than the poliovirus. Paralysis in poverty-stricken areas with poor hygienic controls will not be eliminated by eradication of the poliovirus.

Other examples abound similar to the scenario in Egypt. In 1986, an outbreak of acute flaccid paralysis occurred in Jamaica that was associated with echovirus 22. Six patients developed severe acute flaccid paralysis with inability to walk. Three cases had facial weakness, four required hospitalization and breathing assistance from a ventilator, and two died. There was no evidence of infection by a poliovirus in any of these patients, most were fully vaccinated. Among the four who survived, three had residual weakness in their lower limbs and walked with an abnormal gait for three years after the attack. **REF: J Med Virol 1989. Dec;29(4):315-9. "An outbreak of acute flaccid paralysis in Jamaica associated with echovirus 22."**

A recent 10-year study (1996 to 2005) conducted in Belarus reviewed 456 cases of acute flaccid paralysis. Among those, 11 were caused by the polio vaccine (VAPP), and 445 were caused by viruses other than the poliovirus (non-polio AFP). The predominant number of those who contracted non-polio AFP had previously been vaccinated with the OPV, posing an interesting and unanswered question: Does the OPV make persons more susceptible to paralysis caused by non-polio viruses? Three serotypes of coxsackie B viruses (B1, B4, B6) and six serotypes of echoviruses (6, 7, 11, 14, 24, 25) were the cause of the non-polio paralysis. **REF: Mikrobiol Epidemiol Immunobiol. (2):24-31. "Surveillance of acute flaccid paralysis in Belarus." Sept. 27, 2007.**

When wild polio viruses are no longer detected among paralyzed victims, the WHO, UNICEF, International Rotary Clubs, The Bill & Melinda Gates Foundation and other pro-vaccine organizations will celebrate the eradication of another "killer virus" through massive vaccination. Unfortunately, paralysis will continue and that explanation will not be told. **Polio eradication will not eradicate paralysis.**

The WHO claims repeated administration of the OPV vaccine is harmless. However, the live viruses in the vaccine have the ability to

spontaneously combine with other viruses. There is a very real possibility that massive NIDs could lead to the creation of new, potentially more aggressive viral strains within the intestinal tract of the vaccine recipient. The more doses that are given, the greater the likelihood a new virus will form. **REF: Science Daily (Apr. 28, 2003). "Human interference can cause SARS virus to mutate."**

The WHO tracks cases of wild polio through weekly updates. In 2007, only 1,088 cases of polio were documented in the entire world. Nigeria reported 278 cases and India 756, with the rest scattered across nine other countries: Pakistan, DRC, Afghanistan, Niger, Sudan, Chad, Angola, Somalia and Mynanmar (Burma). **REF: Weekly Polio Update. http://www.polioeradication.org/casecount.asp**

The U.S. spends $2.5 billion annually to vaccinate the poorest countries in the world in a futile attempt to eliminate paralysis. It has been estimated that an additional US$7.5 billion will be required to eradicate the poliovirus by 2015. Is it worth the money? What if all those billions were spent instead to provide sewage systems, clean water, education, books and eyeglasses to read them? Wouldn't that be a greater benefit where the average wage can be as little as US$1 per day? **REF: "Extra $1 Billion Immunization Funding Could Save 1 Billion Lives In Ten Years," from MedicalNewsToday.com, Dec 12, 2005.**

The best protection against viral paralysis – from wild polio or other types of viruses – when traveling throughout Third World countries is to use common sense. Since these viruses start as gastrointestinal infections, the best protection is to use only purified water and eat only foods that can be cooked or peeled. Iodine is frequently recommended as a simple, cost-efficient means to disinfect water during travel or for work in areas where municipal water is not reliable. The generally recommended 2 mg per day dose of iodine with three weeks maximum does not have a firm basis. An occasional unmasking of underlying

thyroid disease can occur. However, most people can use iodine for water treatment in excess of recommended daily dietary consumption over a prolonged period without concern. Iodine treated water has a foul taste. It has been reported that adding one teaspoon of activated charcoal per liter of water will remove most of the taste. **REF: Backer, H., Hollowell J. Use of iodine for water disinfection: iodine toxicity and maximum recommended dose. Environ Health Perspect. 2000 August; 108(8): 679–684.**

18. We must continue to vaccinate against polio until the WHO declares the virus is eradicated. After all, polio is just a plane ride away.

TRUTH: The last case of wild-strain polio was documented in the U.S. in 1991; in 1994, the WHO confirmed the Western Hemisphere was "polio-free."

As of December 31, 2007, only 11 countries—among the poorest and most hygienically deprived in the world—continued to report laboratory-confirmed cases of wild-strain polio, with the most cases occurring in India (756) and Nigeria (278). In addition to keeping the unhealthy environments of these countries in mind, consider that in a country like India, with a population of more than 1 billion, the number of confirmed infections is a miniscule percent of the population. Furthermore, the data does not mean that 756 persons remained permanently paralyzed.

Polio and paralysis are not at all synonymous. According to the CDC, polio has four distinct presentations:

1. Up to 95 percent of all polio infections are completely asymptomatic.
2. Between 4 and 8 percent of polio infections consist of a minor illness, indistinguishable from an influenza-

like illness: sore throat, fever, nausea, vomiting, and/or stomach pain. This clinical presentation is known as abortive poliomyelitis, and is characterized by complete recovery in less than a week.

3. The third presentation of polio occurs in 1 or 2 percent of infections and is called nonparalytic aseptic meningitis. Symptoms present as stiffness in the neck, back and/or legs, usually following several days after a flu-like syndrome. Complete recovery occurs within 2 to 10 days of the illness.
4. Fewer than 1 percent of all polio infections result in paralysis. Many persons with paralytic polio recover completely and, in most others, muscle function returns to some degree. Any weakness or paralysis still present 12 months after onset is usually permanent. **REF: Epidemiology and Prevention of Vaccine-Preventable Diseases, Chapter 8 "Poliomyelitis." The Pink Book, published by the Centers for Disease Control.**

In 2007, the world had only 1,088 confirmed cases of wild polio that resulted in acute flaccid paralysis. And yet, U.S. children continue to receive five polio injections, each containing three inactivated viruses ostensibly to protect them from contracting polio. The argument that "polio is only a plane ride away" has been used to rationalize the vaccination of all children with five doses of vaccine prior to entering kindergarten even though the real threat of contracting polio from importation is negligible. In the 18 years between 1980 and 1998 only six cases of imported polio were documented, the last being in New York City in 1993. **REF: Poliomyelitis Prevention in the United States. MMWR May 19, 2000/49(RR05); 1-22.**

19. Everyone must be vaccinated to protect everyone else.

TRUTH: This argument is based on a concept referred to as herd immunity, meaning that if a certain portion of a population has become immune to a disease, then the rest of the community will be protected from the infection. The term 'herd immunity' was coined by A.W. Hedrich in 1933 after he had studied the dynamics of measles outbreaks in the Boston area between 1900 and 1930. Through observation, he established that when 68 percent of children contracted measles, the outbreaks stopped. This protection persisted until the number who had contracted or had been exposed to measles once again fell below 68 percent of the community. **REF: Am J Hyg. 17:613- 630. "Estimates of the child population susceptible to measles, 1900-1931."**

Notably, the concept of herd immunity was intended to be applied to a population that had become immune through the natural course of an infection. However, herd immunity was conveniently applied to vaccination by assuming that vaccination confers the same type of protection as natural infection. However, vaccine-induced antibodies wane quickly. In fact, most are gone within 12 years or less of the vaccination. Lifetime immunity is only conferred through an engagement with the real virus. The assumption that the presence of antibodies will protect a person from illness is flawed. (See TRUTH #5). **REF: Vaccine. 2001 Oct 15;20 Suppl 1:S38-41. "What are the limits of adjuvanticity?"**

If vaccinations were as effective as natural immunity, then an overall vaccination rate of 68 percent would be enough to stop outbreaks. However, even when the vaccination coverage approaches 100 percent, large outbreaks have occurred. Here are a few examples:

- **Chickenpox: REF: Pediatrics. Vol. 113 No. 3 March 2004, pp. 455-459. "Chickenpox Outbreak in a Highly Vaccinated (97%) School Population."**

- **Measles:** REF: NEJM. 3216: 771-774. 1987. "Measles outbreak in a fully immunized (100 percent) secondary-school population. NOTE: *[In this case report, 99 percent of students had been vaccinated and 95 percent had vaccine-induced measles antibody.~ST]*
- **Measles:** REF: Am J Pub Health. 77:434-438.1987. "Measles outbreak in a vaccinated (70 percent) school population: epidemiology, chains of transmission and the role of vaccine failure."
- **Mumps:** REF: Arch Pediatr Adolesc Med. 149: 774-778, 1995. "Between October 3 and November 23, 1990, clinical mumps developed in 54 students; 53 had been vaccinated."
- **Pertussis:** REF: J Trop Pediatr. Mar 1991, 37(2): 71-76. "An Outbreak of Whooping Cough (pertussis) in a Highly Vaccinated Urban Community."
- **Influenza:** REF: J Am Ger Sociologist. Jun 1992, 40(6):589-592. "An Outbreak of Influenza A (H3N2) in a Well-Immunized Nursing home Population."
- **Hepatitis B:** REF: Dtsch Med Wochenschr. Oct 12, 1990, 115(41):1545-1548. "Inoculation Failure following Hepatitis B Vaccination."
- **Hepatitis B:** REF: Dtsch Med Wochenschr. May 17, 1991, 116(20): 797. "Unsuccessful Inoculation against Hepatitis B."

20. Pertussis (whooping cough) is serious and children are at risk of dying from this infection.

TRUTH: Pertussis is caused by the bacteria, *Bordatella pertussis*. It attaches to the lining of the respiratory tract and produces toxins that paralyze the cilia (hairs that sweep mucus from the lungs). The bacteria releases a toxin that causes inflammation and leads to excess mucus in the bronchial tubes. The combination of profuse secretions and the difficulty clearing them from the lungs is typical of pertussis infection.

Not all cases of pertussis are dangerous, in fact, a pertussis infection may be asymptomatic. The definition of pertussis used by the WHO is a spasmodic cough that lasts for at least 21 days, accompanied by a positive culture. The course of the infection can range from a mild congestion to a harsh, persistent cough that lasts for weeks. The classic "whoop" that occurs during a forced inspiration is not common. Persons who have been vaccinated can still contract the illness, and anyone who has a persistent, barking cough should be suspected of having whooping cough.

A pertussis infection typically involves three stages of illness. The first stage, the catarrhal stage, appears similar to the common cold: runny nose, sneezing and an occasional cough. If the cough becomes more severe over about two weeks, the suspicion that pertussis may be the cause of the illness should be raised. Coughing bursts during the paroxysmal stage occur in an attempt to expel thick mucus. During the cough, the patient may turn blue and vomit. At the end of the cough, some patients experience a long inspiratory phase, leading to the characteristic high-pitched whoop that gives whooping cough its name. Coughing typically occurs more frequently at night, with episodes every two to three hours. Between coughing episodes, the person does not appear ill and there is little fever associated with pertussis infection; the presence of a fever usually represents an additional bacterial infection. Recovery is gradual. It can take up to 10 weeks before the cough is completely resolved and occasional coughing spells can occur many months after the infection has clinically resolved. **REF: Epidemiology and Prevention of Vaccine-Preventable Diseases. Chapter 6 "Pertussis," The Pink Book, Published by the Centers for Disease Control.**

Pertussis can be life-threatening in infants under 3 months of age because their windpipe is too small to expel the secretions. The most common complication and most common cause of pertussis-related

TABLE: Pertussis Death Rates

	Incidence of pertussis	Deaths from pertussis^	Death Rate
1992	4,083	5	0.23%
1993	6,586	7	0.10%
1994	4,617	8	0.17%
1995	5,137	6	0.11%
1996	7,796	4	0.05%
1997	6,564	6	0.09%
1998	7,405	5	0.06%
1999	7,298	7	0.09%
2000	7,867	12	0.15%
2001	7,580	17	0.22%
2002	9,771	18	0.18%
2003	11,647	11	0.09%
2004	25,807	27	0.10%
	Most hospitalizations and nearly all deaths are in infants <6 months	^info from CDC Summaries of Notifiable Diseases, United States	

deaths is pneumonia caused by a co-infection with another bacteria, such as pneumoccoccus. Other serious complications from pertussis can include seizures and high pitched crying or encephalopathy (brain swelling and inflammation). Approximately one-third who develop encephalopathy from pertussis are left with neurological deficits, including learning disabilities. The majority who contact pertussis recover and are normal. **REF: J Am Board Fam Med. Nov-Dec;19(6):603-11.2006. "Pertussis infection in the United States: Role for vaccination of adolescents and adults."**

REF: Neuropediatrics. 1990 Nov;21(4):171-6. "Workshop on neurologic complications of pertussis and pertussis vaccination."

Pertussis continues to circulate in the community causing periodic

outbreaks in spite of high vaccination rates. Although it can be serious, whooping cough is not as "deadly" as the CDC, the media, health officials and medical professionals would have us believe. Parents are frequently told, "If your child gets pertussis, your child could die." However, the fear of contracting pertussis has more hype than substance. The CDC collects data every year tracking the national incidence and death rate from pertussis. The table on the previous page describes the likelihood of death from pertussis.

Note from this table that the death rate from pertussis, on average, is approximately 10 per year or 0.11% of all children who contract the disease. Putting the number of deaths in perspective, 112 children died from falls in 1997 and in 1999, 53 children died in bathtub drowning accidents in the state of Georgia (stats from Childwelfare.net). Nationwide, the risk of complication and death from pertussis is rarer than accidental deaths from normal daily activities.

21. The pertussis vaccine is safe. After all, it has been FDA-approved for use since the 1940s.

TRUTH: The search for a pertussis vaccine began in 1906, when two French bacteriologists isolated *Bordetella pertussis*, the bacterium that causes infection. In the 1930s, it was determined that a protein called pertussis toxin was the cause of the infection. The first vaccines (1948) were produced by growing the bacteria in a slurry and then separating the toxin from bacterial cells in a centrifuge. The final product, called a "whole cell" vaccine, contained variable amounts of pertussis toxin and bacterial cells. The whole cell vaccine varied from batch to batch and from manufacturer to manufacturer, making toxicity and potency unpredictable. All of the early vaccines contained 1.7 times more bacteria than recommended by the WHO. **REF: Neuropediatrics. 1990 Nov;21(4):171-6. "Workshop on neurologic complications of pertussis and pertussis vaccination."**

The whole-cell pertussis vaccine

Whole-cell pertussis vaccines contain a mixture of five proteins extracted from the bacteria: filamentous hemagglutin (FHA), pertactin (PERT), two fimbrial proteins (FIM types 2 and 3, formerly called agglutinogens) and pertussis toxin (PT). The intended effect of the injection was to stimulate the body to produce antibodies toward the pertussis toxin (PT), thought to be the most important factor for immunity to whooping cough.

Problems associated with the whole-cell pertussis vaccine

By the late 1960s, problems started to come to light. Papers were published reporting brain inflammation in infants within hours of vaccination. In the 1970s and 1980s, the whole-cell pertussis vaccine was implicated in causing permanent brain injury. At an FDA symposium in 1982, Dr. John Cameron, from the Institute Armand Frappier in Laval, Quebec, warned scientists that the vaccine had not been tested adequately and the risks of side effects had not been discussed:

> "As far as the whole-cell vaccine is concerned, the only standard it has to meet is the mouse protection test and the mouse weight gain test. That is all. Nothing about humans. Nobody is talking about cell content; nobody is talking about the toxic potential of pertussis toxin, or anything like that...all we are talking about is the amount of purified antigen in solution....If this data is put before an ethical committee, how will they respond? I don't think they would be necessarily as sympathetic as this audience."

In response, Dr. John Robbins, from the Bureau of Biologics (now CBER), responded, "Well, to give a personal opinion, I think it is unethical not to try the new vaccine." In other words, it was ethical to experiment on children with a vaccine of questionable safety. **REF: "A Shot in the Dark," by Harold Coulter and Barbara Loe Fisher. Penguin Books. 1985. pg 210.**

Investigators throughout the 1980s worked feverishly to determine whether or not pertussis toxin (PT) was capable of causing brain damage. Investigations concluded that PT could lead to:

1. The release of islet activating factor from the pancreas, a protein that increases the amount of insulin in the blood, leading to a fall in blood sugar (hypoglycemia). In infants, a sudden decrease in the amount of sugar in the bloodstream can cause brain damage.
2. PT can cause an elevated white blood cell count. When coupled with a low-grade fever, doctors can misinterpret the elevated white blood cell count as a sign of infection, leading to blood tests, a spinal tap and other extensive hospital evaluations, when the two symptoms are direct side effects (complications) of the vaccine.
3. PT can punch holes in the protective coating of the brain called the blood brain barrier. Once disrupted, viruses and other toxins can enter the brain and lead to the most serious side effects of the vaccine: encephalopathy, an inflammation of the brain, and seizures.
4. PT increases the production of a molecule called adenyl cyclase, which can alter the function of neurotransmitters in the brain, leading to brain damage. **REF: Neuropediatrics. 1990 Nov;21(4):171-6. "Workshop on neurologic complications of pertussis and pertussis vaccination."**

The whole-cell pertussis vaccine induced pertussis antibodies in nearly 85 percent of children who were tested shortly after completion of the three-dose series (at two, four and six months). However, the antibodies (and their perceived protection) waned quickly and disappeared after only two years. The risk of infection by conventional medical standards

returned but the damage had been done. **REF: Pediatrics. 1997 Feb;99(2):282-8. American Academy of Pediatrics Committee on Infectious Diseases. "Acellular pertussis vaccine: Recommendations for use as the initial series in infants and children."**

In 1977, researcher G.T. Stewart from the U.K. published an important study documenting problems associated with the whole-cell pertussis vaccine. He reported the mortality (death) rate from whooping cough had greatly declined after the turn of the century and the number of deaths from whooping cough could not be credited to the "small-scale vaccination program that began in 1948 or by the nationwide vaccination campaign that began in the U.K. in 1957." He stated unequivocally that "no protection by this vaccine can be demonstrated in infants." In addition, he uncovered a strong association between vaccination and adverse reactions, including brain inflammation. In a study of 160 children who had received the whole-cell pertussis vaccine, 19 out of 160 had severe reactions including 14 who experienced shock and brain disturbances. Another 65 experienced convulsions, hyperkinesis (jerking movements), and severe mental and behavior changes. Stewart concluded by saying, "The claim by officials that the risk of whooping cough exceeds the risks of vaccination is at best, questionable." **REF: Lancet. Jan 29;1(8005):234-7. 1977. "Vaccination against whooping-cough. Efficacy versus risks."**

In support of Stewart's findings, Great Britain's National Childhood Encephalopathy Study, completed in 1979, also suggested a causal relationship between the whole-cell pertussis vaccine and the risk of permanent brain damage. Ignoring warnings from these studies, the U.S. continued to administer the whole-cell vaccine instead of placing a moratorium on its use. Public health clinics were required only to have parents sign a release (now called a VIS, Vaccine Information Statement) before vaccinating their child with the whole-cell vaccine. By 1985, 219 lawsuits had been filed in U.S. courts alleging harm to

children from whole-cell pertussis vaccination. The average amount of compensation, when specified, was $26 million dollars. **REF: J Hist Med Allied Sci. 2002 Jul;57(3):249-84. "The true story of pertussis vaccination: a sordid legacy."**

A clinician-researcher evaluated 20 children who received the whole-cell pertussis vaccine and published his results as a case report. Seventy-five percent had developed neurological complications within 12 hours of vaccination and 80 percent within 24 hours, a pattern often reflected in the medical literature and not compatible with a mere "chance" association. **REF: Ann. Neurol. 28 (1990). "Neurologic complications of pertussis vaccination."**

The growing number of lawsuits throughout the 1980s forced the IOM to begin a series of hearings on whole-cell DTP vaccination. Deliberations about the possible association between the vaccine and brain damage dragged on without changes in the recommendations even though virtually every year, from 1933 to the early 1980s, at least one paper had been published describing the adverse effects from whole-cell pertussis vaccine on the brains of children. For normal children, the risk of permanent brain injury from the whole-cell pertussis vaccine (called DTP or DTwP) was estimated at one in 310,000 vaccinations. In the U.S., most children receive five doses, so millions of children may be suffering from some degree of permanent brain injury from the whole-cell vaccine used between 1948 and 2001. **REF: Neuropediatrics. 1990 Nov;21(4):171-6. "Workshop on neurologic complications of pertussis and pertussis vaccination." REF: J Hist Med Allied Sci. 2002 Jul;57(3):249-84."The true story of pertussis vaccination: a sordid legacy."**
Here are excerpts from annual IOM reports regarding the use of whole-cell pertussis vaccines:

- In 1985: Discussion was held to consider changing to acellular pertussis vaccine.
- In 1990: Sufficient evidence demonstrated that the whole-

cell pertussis vaccine could cause acute encephalopathy. Still no change in recommendations for use.

- In 1991: A new, safer acellular pertussis vaccine was licensed for use. Still no change in recommendations for use of the whole-cell vaccine.
- In 1993: Evidence existed that whole-cell pertussis vaccine can cause permanent brain damage. Still no change in recommendations for use.
- In 1994: Whole-cell pertussis vaccine is "more likely than not" responsible for encephalitis-like reactions up to 7 days after vaccination resulting in brain damage in previously normal children. Still no change in recommendations for use.
- In 2001: The whole-cell pertussis vaccine was finally removed from the U.S market even though a safer vaccine—the acellular pertussis vaccine—had been advised since 1937.

The damaging whole-cell pertussis vaccine was used on American children for 64 years longer than necessary. **REF: J Hist Med Allied Sci. 2002 Jul;57(3):249-84. "The true story of pertussis vaccination: a sordid legacy."**

NOTE: *While the whole-cell vaccine is no longer routinely used in the U.S., it is still used in many countries around the world because it is less expensive to manufacture. The number of children worldwide suffering from brain damage as a result of this practice is unknown.~ST*

Because the incidence of pertussis is thought to be increasing, the whole-cell vaccine is once again under consideration, this time, for newborn infants. The medical community appears to be more concerned about vaccinating to prevent pertussis than it is about the possibility of causing vaccine-induced brain damage.

22. Due to concerns about the whole-cell pertussis vaccine, a new, acellular pertussis vaccine was licensed in 1991. The DTaP vaccine is safe and effective.

TRUTH: It was first demonstrated in 1937 that acellular pertussis vaccines were safer and caused less brain irritation than vaccines containing the whole bacteria. Dozens of clinical trials over the ensuing years consistently demonstrated that acellular vaccines were associated with a lower incidence of fever, had fewer local adverse reactions (redness, swelling, pain or tenderness) and a reduced rate of serious adverse events, including hypotonic-hyporesponsive episodes (discussed below.) Nonetheless, the first acellular vaccine was not made available for commercial use until 1981 and the FDA did not license an acellular vaccine for use in the U.S. until 1991.

Similar to whole-cell vaccines, acellular vaccines contain a combination of four purified *B. pertussis* antigens. However, acellular vaccines use only a small snip of the germ's capsule instead of the entire bacterium. The PT antigen in the acellular vaccine is weakened by treatment with formaldehyde. Several acellular pertussis vaccines are available and each contains a different concentration of inactivated PT (see Table 1 page 84). While no DTaP is consistently safer than another, it is thought that the most serious side effects are associated with large doses of pertussis toxin (PT).

Table 1. Types of acellular pertussis vaccines (DTaP) available in the U.S. Pertussis toxin is the fraction of the vaccine most likely to cause encephalopathy.

DTaP PRODUCT	Pertusis Toxin PT	FHA	PERTACTIN Pert	FIM
Tripedia	23 mcg	23 mcg	---	---
Infranrix	25 mcg	25 mcg	8 mcg	---
Daptacel	10 mcg	5 mcg	3 mcg	5 mcg
Boostrix (teens)	8 mcg	8 mcg	2.5 mcg	---
Adacel (teens)	2.5 mcg	5 mcg	3.0 mcg	5.0 mcg

Pertussis vaccines vary considerably between manufacturers. Assessing the possibility of a reaction is difficult because:

- The amount of antigen within different vaccine brands is not standardized between manufacturers (see Table 1).
- Unless the vaccine is properly prepared and refrigerated, potency of the vaccine and risk of reactions can vary from one batch to the next.
- Genetic individuality and the health status an individual receiving the vaccine are not taken into consideration before the vaccine is given.
- For a given manufacturer, pertussis vaccines are not standardized from one batch to the next. Because of the disparity between production lines, reports of vaccine "hot lots," those that appear to be associated with more injuries and deaths than others, have been reported in the U.S. and Europe. Hot lot reports were most common with the whole-cell pertussis vaccine but continue to occur for all vaccines, including the acellular pertussis vaccine. **REF: Neuropediatrics. 1990 Nov;21(4):171-6. "Workshop on neurologic complications of pertussis and pertussis vaccination."**

Even though the acellular pertussis vaccine (DTaP) is presented as safer and less toxic than whole-cell vaccines, it is estimated that at least 50 percent of infants receiving the DTaP will experience a reaction: soreness at the injection site, fever, vomiting, fussiness, reduced appetite and excess sleeping. Studies have documented that at least 2 percent of children experience excessive local reactivity—including swelling of an entire limb—after booster doses of DTaP. **REF: Pediatrics. 2000. Jan; 105(1):e12. "Extensive swelling after booster doses of acellular pertussis-tetanus-diphtheria vaccines."**

Approximately 1 percent of all children who receive a DTaP vaccine develop significant or serious side effects including fever of 105°F or higher, experience a seizure, have prolonged, high-pitched crying (encephalopathy), or experience what is called hypotensive/hyporesponsive episode, or HHE. First described in 1979, researchers observed infants turning pale then becoming limp and unresponsive within four to 10 hours after vaccination and called this HHE. The unresponsiveness lasted at least a few minutes or could persist for at least 48 hours, requiring hospitalization. Although most HHE events have been associated with whole-cell pertussis vaccines, HHE has been observed after acellular pertussis and several other vaccines. **REF: Pediatrics. 2000 Oct;106(4):E52. "Hypotonic-hyporesponsive episodes reported to the Vaccine Adverse Event Reporting System (VAERS), 1996-1998."**

NOTE: *When questioned, pediatricians and their nurses call an HHE reaction a "normal side effect" of the vaccine. There is nothing normal about inducing a near-death event in an infant. Nearly 4 million children per year receive up to five DTaP shots. If 1 percent of vaccinees have a "significant or serious reaction," that equates to 40,000 children per year. ~ST.*

According to the National Immunization Information Network, about 4 out of every 50,000 pertussis vaccinations will result in a serious reaction that can include breathing difficulty, shock or severe brain

reaction (brain inflammation, long seizure, coma or lowered consciousness) or death. **REF: National Network of Immunization Information. http://www.immunizationinfo.org**

After an extensive and difficult examination of reports filed to VAERS in 1998, researcher Sandy (Mintz) Gottstein identified 57 deaths that were reported following DTaP vaccination. Of those, 23 expired the day following vaccination. It is significant that 57 infant deaths is more than ten times the number of deaths (5) reported that same year from a pertussis infection. **REF: MMWR. July 19, 2002 / Vol. 51 / No. 28.**

NOTE: *Physicians are quick to point out that pertussis can be "deadly" as a means of frightening parents into vaccinating. The preceding discussion in this section documents that the risk from the vaccine is far greater than the rare risk of death from a pertussis infection. ~ST*

23. There is no treatment for pertussis.

TRUTH: The CDC recommends testing all patients who have had a cough that persists more than two weeks and treating as "probable pertussis" regardless of culture results. Medical management includes rest, fluids and cough medication. The CDC recommends that all household contacts, regardless of age and vaccination status, be given a 7-day course of antibiotics if one person in the household is diagnosed with a culture-confirmed pertussis infection. Erythromycin is the drug of choice, although other antibiotics (e.g., azithromycin [Zithromax], clarithromycin [Biaxin] and trimethoprim-sulfamethoxazole [Bactrim]) are sometimes prescribed. Antibiotics do not treat a pertussis infection; they are given austensibly to shorten the course of the infection and protect others in the family from becoming sick. There are better choices for prevention than prophylactic antibiotics (discussed below.) **REF: J Fam Pract 2005;54:74-6. "Clinical inquiries. What are the indications for evaluating a patient with cough for pertussis?"**

While all children less than one year of age suspected of having pertussis need to be under the care of a physician, a variety of natural remedies are available to support the immune system and help older children and adults recover. Even though the infection just needs to run its course, here are some suggestions for help and comfort:

1. Avoid all dairy products. Dairy can increase mucus and make secretions more difficult to expel.
2. Drink plenty of fluids to thin secretions. Squeeze and freeze natural fruit juices, particularly cherry juice, into popsicles. Avoid products that contain refined white sugar such as soda pop.
3. Make nourishing soups from broth and pureed fresh vegetables. Garlic, onions, cabbage and water chestnuts have infection-fighting properties.
4. Use a humidifier in the bedroom at night with a few drops of lavender oil. Be sure that the mist does not dampen bed clothing.
5. Mix 5 drops of almond oil, 10 drops of fresh white onion juice and 1 teaspoon of colloidal silver into 2 oz. of ginger juice. All of these can be readily obtained at health food stores or through herbal vendors on the Internet. Dilute as necessary for taste. Sip 8 ounces over the course of the day to loosen secretions and build resistance.
6. Add a tablespoon of raw, organic honey to a glass of boiling water and drink as needed. This will soothe the throat and give a few calories.
7. A safe, non-toxic product made from an extract of brewer's yeast called Epicor is available through **www.SayingNoToVaccines.com.** It is a much better option for prevention of recurrent ear infections in children over 5 years of age and adults than prophylactic antibiotics.

24. The incidence of pertussis is on the rise. Adolescents need to be revaccinated to prevent outbreaks of pertussis.

TRUTH: Physicians in the U.S., Guam and Puerto Rico are required by law to report cases of pertussis to state health departments whenever it is suspected, not only upon laboratory confirmation. The CDC will accept a reported case of pertussis if the person has had a prolonged cough or if they developed a cough after being exposed to a person who has culture-confirmed pertussis. Without laboratory confirmations of the person being diagnosed, the actual incidence of pertussis may be substantially distorted. **REF: JAMA. 1999;282:164-70."Mandatory reporting of diseases and conditions by health care professionals and laboratories." REF: Inf Dis in Children. "Building a better pertussis vaccine." June, 2005. http://www.idinchildren. com/200506/philed.asp**

Pertussis appears to be on the rise, but the statistics could be influenced by a phenomenon known as the "Hawthorne effect." First described in the 1920s during a study on workplace behavior, the central idea of the Hawthorne effect is that a subject's awareness of participating in an experiment can change the outcome of the study. In the case of pertussis surveillance, a Hawthorne-like effect refers to those who seek cases in order to report them. If a doctor looks for cases of pertussis by performing more cultures, the incidence rate will go up, even if the actual number of persons with pertussis is the same as in previous years. **REF: Inf Dis in Children. "Building a better pertussis vaccine." June, 2005. http://www.idinchildren.com/200506/philed.asp**

In a commentary about the troubling increased incidence of pertussis, Phillip A. Brunell, Chief Medical Editor for the Journal Infectious Diseases in Children, commented on the possible role of the Hawthorne effect:

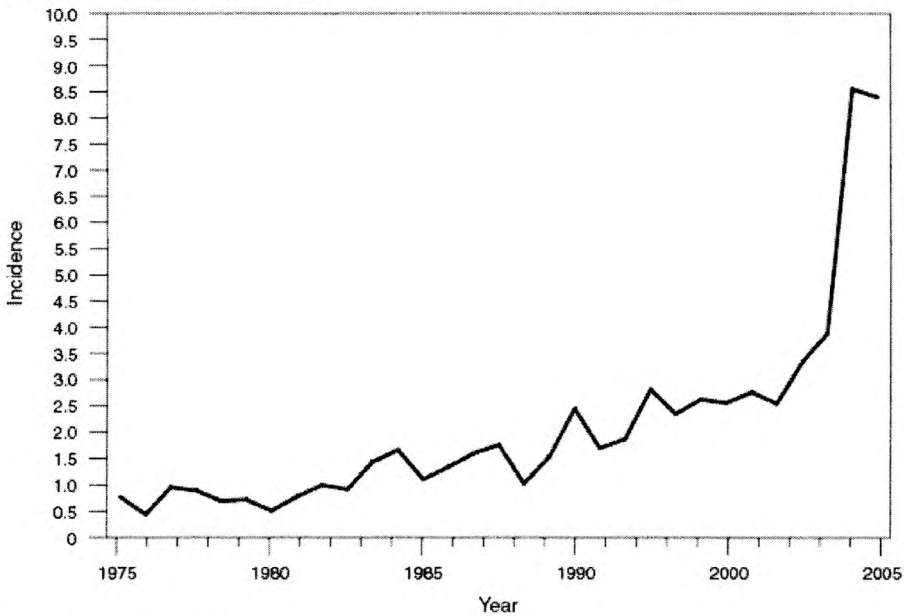
"The state of Massachusetts has the best serologic laboratory for the diagnosis of pertussis. Its test was reported to detect 65 percent of culture-proven cases. Within two years after the introduction of serologic testing in 1987, the number of cases in Massachusetts increased more than threefold, the vast majority of the increase based on the newly introduced serologic test. Coincident with this increase was a rise in the number of cultures submitted to the State Laboratory Institute. As the number increased, the proportion that was positive decreased, reflecting the intensified effort to find cases.

"At a recent ACIP meeting, data were presented which indicated that the rate of pertussis in Massachusetts in recent years was six to 90 times the teenage rate for the rest of the United States....Massachusetts and a handful of other states contribute the bulk of reported cases in the 10- to 20-year age group in the United States." **REF: Inf Dis in Children. "Building a better pertussis vaccine." June, 2005. http://www.idinchildren.com/200506/philed.asp."**

Between 1994 and 2004, thousands of confirmed and "probable" pertussis infections among teenagers were reported to the CDC. A probable case was defined as someone who had a cough lasting at least two weeks, *without laboratory confirmation* of the infection. Increasing the prevalence paved the way for approval of two teen pertussis booster vaccines that had been in the development pipeline, Adacel and Boostrix, released in 2005.

Were these vaccines developed out of the clinician's and manufacturer's concern that the incidence of pertussis was increasing, or was the need for the vaccines artificially created by the increasing the number of cultures?

PERTUSSIS. Incidence,* by year — United States, 1975–2005



* Per 100,000 population.

In 2005, incidence of reported pertussis remained stable after doubling during 2003–2004. Increased availability of sensitive diagnostic tests and improved case recognition and reporting account for an unknown fraction of this increase.

SOURCE: CDC pg 64. http://www.cdc.gov/mmwr/PDF/wk/mm5453.pdf

25. There is no relationship between the MMR vaccine and autism. The MMR is completely safe and should be given to all children.

TRUTH: Serious side effects can occur after the MMR vaccine. The Vaccine Court has ruled that evidence of a causal relationship exists and that the MMR can cause acute encephalopathy followed by permanent brain injury or death. The following is an excerpt from a 1998 review of the VAERS database about the MMR vaccine:

> "Following the MMR, 34 children developed seizures, coma and/or behavior changes that could not be attributed to a side effect of a medication. Seizures were associated with fever in 32 children, and a measles-like rash occurred in nine. Twenty-nine of the 34 rapidly progressed to coma after the vaccine, and five experienced a changed level of consciousness. A mixture of chronic encephalopathy with mental retardation, seizure disorders and residual spastic paresis (similar to cerebral palsy) remained in these children. Three deaths among the 34 injured occurred 3 months to 4 years later.
>
> "Two apparently normal and healthy children received the MMR vaccine and died two and 12 days later. Autopsy findings revealed cerebral edema (brain swelling) in one, and viral encephalitis with hemorrhagic infarctions (bleeding in the brain) in the other.
>
> "VAERS contained a specific case report of a normal 16-month-old female who received a measles vaccine. Seven days later, she developed a fever and a measles-like rash. Ten days after the vaccination, she was

hospitalized with status epilepticus (continual grand mal seizure) and a temperature of 106°F. The day after she was admitted to the hospital, she continued to have intermittent seizures, developed a coma and became paralyzed on her left side. An EEG (brainwave test) was extremely abnormal. At age 10 years, she had residual left-sided paralysis and severe learning disabilities."
REF: Pediatrics.101:383-387. 1998. "Acute encephalopathy followed by permanent brain injury or death associated with further attenuated measles vaccines: A review of claims submitted to the National Vaccine Injury Compensation Program."

While the introduction of the measles vaccine appeared to play a role in decreasing the incidence of measles in the U.S., the trade-off has had significant consequences. A new neurodegenerative condition, Measles-Induced Neuroautistic Encephalopathy, or MINE syndrome, has been suggested to be related to, and possibly caused by, the MMR vaccination. MINE syndrome has a constellation of symptoms similar to autism.

MINE is a variant of Subacute Sclerosing Panencephalitis (SSPE), an extremely rare, serious complication of a measles infection. SSPE develops for unknown reasons in an individual who is unable to clear the measles virus from the body, resulting in a persistent, low-grade infection. The virus can remain quiescent for years prior to erupting in the central nervous system as complications of SSPE. Prior to 1963, when the measles vaccine was put into use, more than 500,000 cases of measles were reported each year. During that time, approximately 60 cases of SSPE occurred annually. By 1975, the number of reports of SSPE had dropped to about 41 cases per year. Only 80 cases of SSPE have been reported in the U.S. over the last 15 years—roughly 5 per year. However, since the late 1990s, more than 2,000 children have been diagnosed with MINE syndrome and many thousands more have been diagnosed with autism.

MINE consists of a troubling constellation of symptoms with a similarity to the signs and symptoms seen in children with autism:

- All children diagnosed with MINE syndrome had the MMR vaccine between 12 and 21 months of age. There are no reported cases of MINE in children who have not been vaccinated with the MMR.
- Prior to vaccination, none of the children showed any features of autism or any signs of enterocolitis (intestinal problems).
- In a subset of children whose blood and spinal fluid were examined, vaccine-strain measles virus was found in the specimens.
- All autistic symptoms developed many months after the measles vaccine, an interval characteristic of diseases cased by "slow viruses," such as the measles virus.
- Prior to vaccination, the affected children had a history of severe, recurrent infection or significant allergies and eczema, suggesting that each had a pre-existing immunological problem.
- A preponderance of children who demonstrate MINE syndrome or SSPE are male.

For both MINE syndrome and SSPE, a specific condition is required: The child must have an immature, defective or damaged immune system that is unable to eliminate the measles virus from the body. Can there be any doubt that the 60 vaccine antigens and multiple doses of chemicals injected at two, four and six months prior to administering the MMR are a contributing factor? The risk of SSPE from measles infection is real; the risk of developing MINE syndrome from MMR appears to be equally as real. **REF: J Ped Neurology. 2004; 2(3): 121-124. "Some aspects about the clinical and pathogenic characteristics of the presumed persistent measles infections; SSPE and MINE."**

In 1998, Dr. Andrew Wakefield published a paper in The Lancet that identified a possible connection between the MMR vaccine and enterocolitis, a severe bowel disruption. Wakefield, a pediatric gastroenterologist, had performed colonoscopies on 12 children whose history included an onset of abnormal behavioral symptoms and irritable bowel disease shortly after receiving an MMR vaccine. All 12 children had intestinal abnormalities, ranging from lymphoid nodular hyperplasia (enlarged and inflamed lymph nodes in the lining of the intestine) to bloody ulceration of the mucosal lining of the colon. At the end of his report, Wakefield concluded the following:

> "We did not prove an association between measles, mumps and rubella vaccine and the syndrome described....Further investigations are needed to examine this syndrome and its possible relation to this vaccine."
> **REF: Lancet. 351:637-641.(1998). "Ileal-lymphoid-nodular hyperplasia,non-specific colitis, and pervasive developmental disorder in children."**

As a result of this case report, Wakefield has become the target of Britain's medical establishment. Framed as a villain, he is in the center of a lengthy controversy over whether the MMR given to toddlers is capable of causing autism, other types of brain damage and the painful new form of intestinal disease called MINE syndrome.

An interview with Wakefield's wife, Carmel, published online at "On The Mail" (October 15, 2006) reveals the following:

> "In the early nineties Andy made some important discoveries about the causes of inflammatory bowel disease and it was this that led him to look at the measles virus, which is known to linger in the bowel....He started voicing his concerns to the Department of Health in 1992, assuming they'd order

> urgent clinical research. He assumed public safety would be of paramount concern to health officials. He thought they would want to rule out any possibility that MMR could cause gut damage, particularly as worrying evidence was starting to emerge that the live mumps and measles viruses in the vaccine could interact to suppress the body's natural immune response. But no one wanted to know."

Mrs. Wakefield went on to say that she clearly remembered the day in 1997 when her husband warned her, shortly before the Lancet published one of many academic papers to his name, that "there could be a bit of a problem with this one. This [finding] could be rather unpopular." Familiar with the paper's content, she thought he was being melodramatic. Why would there be any problem? The paper was nothing more than a report of medical histories and clinical findings in a group of children. "Obviously," she says now, "I was very naive."

What the Wakefield's learned was that only the very bravest, or most foolhardy, of medical researchers would dare publicly express doubts about any childhood vaccine, let alone raise the question that it might cause something as serious as autism. **REF: "VILIFIED by the MMR zealots," MAIL ON SUNDAY, October 15, 2006. Susan Corrigan.**

On May 18, 2005, the Immunization Safety Review Committee of the IOM issued a report on immunizations and autism. After reviewing the published and unpublished epidemiological studies regarding the possible connection between vaccinations and autism, the committee concluded that the body of epidemiological evidence favored rejection of a causal relationship between the MMR vaccine and autism. The committee also concluded that the body of epidemiological evidence favored rejection of a causal relationship between thimerosal-containing vaccines and autism. The committee further found that potential

biological mechanisms for vaccine-induced autism are only theoretical. **REF: Immunization Safety Review: "Vaccines and Autism." National Academies Press. 2004.**

NOTE: *If an academic panel reviewed 25 papers all concluding the world was flat, then the only possible conclusion the panel could return is "the evidence favors rejection of a theory that the world is round." The IOM reviewed studies that all concluded there was no connection between autism and thimerosal and no connection between autism and the MMR. The only possible conclusion was to reject the connection. ~ST*

Shortly after the release of the IOM report, Rep. Dave Weldon, M.D. (FL) fired back a reply that the conclusions were hastily drawn:

> "In my 10 years of service in the U.S. Congress, I have never seen a report so badly miss the mark. I have heard some weak arguments here in Washington, D.C., and I can tell my colleagues that the arguments put forward in this IOM report are indeed very weak.
>
> For too long, those who run our national vaccination program have viewed those who have adverse reactions, including those with severe adverse reactions, as the cost of doing business. Furthermore, the vaccine compensation program, which was designed to be a no-fault compensation system, has become so adversarial that only the most obvious cases receive compensation, and too many parents feel that the program is not worth the difficulty of going through it.
>
> The IOM conclusions are premature and hastily drawn, raising suspicions that this IOM exercise might be more about drawing pre-designed conclusions aimed at restor-

ing public confidence in vaccines rather than conducting a complete and thorough inquiry into whether or not thimerosal might cause neurodevelopmental disorders. Many of the authors have conflicts of interest including funding from vaccine manufacturers, employment by manufacturers, or conflicts in that they implemented vaccine policies that are now being investigated. Relying on these studies to draw conclusions is based on shaky ground. I am also troubled by the lack of liability or accountability by these decision-makers should they be proved wrong."
REF: Press Release: "Institute of Medicine Report Stuns Scientific Community and Parents," Uninformed Consent.Thursday, May 20, 2004 6:00PM http://www.university-ofhealth.net/Press_release_2005_03.html

Weldon is correct in his concerns about the lack of accountability by decision-makers of the committee. While medical experts who presented scientific evidence to the IOM were required to disclose any potential conflicts of interest, the members of the Immunization Safety Review Committee were not held to the same requirements. The selection procedure for IOM committee members consisted of self disclosures about conflicts of interest with a 20-day public notification period posted in medical journals. The IOM selection committee merely stated that "if something substantial came up" about the candidate, the committee would take the information under consideration. When pressed further, the committee disclosed that no independent background checks were completed on any of the Immunization Safety Review Committee members who issued the final report in 2005.

TO DATE: The American Medical Association, The American Academy of Pediatrics, the CDC, the FDA, the IOM, the Department of Health and Human Services (HHS), all pharmaceutical companies

and the U.S. Congress have all maintained that there is absolutely no connection between thimerosal and autism, and that the onset of autism around the time of an MMR vaccine is purely coincidental.

Chapter 4

Vaccine Exemptions: How to Legally Avoid Vaccinations*

**These are standard exemptions available in the U.S. and may not appy to your specific country*

The decision to refuse vaccines is weighty, medically and legally. On the one hand, parents have a legal obligation to refrain from actions that may harm their child. On the other, the U.S. Supreme Court has long upheld the right of parents to make decisions for their children based on religious grounds, but it is much more difficult for courts to justify parental refusal of medical treatment for reasons based on non-religious objections. Therefore, with choice comes responsibility.

There are many issues to examine before deciding to exercise your right to refuse vaccinations:

- Learn about each of the childhood "vaccine-preventable" infections, including measles, chickenpox, rubella and pertussis, and know what to do if your child becomes sick. This is not difficult. Your mother and grandmother took care of ill children during their childhood diseases; you can do it too. Learn how to recognize them and what to do while your child is recovering. You will find that these illnesses are mostly mild and only rarely do children become seriously affected by them.
- Dr. Stephanie Cave's book, *What Your Doctor May Not Tell You About Children's Vaccinations* describes these illnesses in detail and gives suggestions on how to care for your child if he or she becomes ill. Another excellent resource is *Child Health Guide: Holistic Pediatrics for Parents*, by naturopathic physician Randall Neustaedter, has excellent recommendations on how to keep your child healthy without vaccines.

- In the event of an outbreak in your neighborhood, school or daycare, you need to have a plan. You may be required to keep your child home until the outbreak is over. That means planning ahead for days missed from work or for childcare arrangements.
- Many parents are under-informed about the importance of fever and nearly panic if their child has an elevated temperature. (See article,"The Importance of Fever," page 165.)
- Knowledge is power and once you are no longer afraid of the infection, you can make a fearless choice about refusing vaccines.

There is a common misconception that children must be vaccinated to attend public school. Parents frequently get letters before school starts, warning them that their children need up-to-date shots. However, schools are required to have either a completed vaccination record **OR** a signed exemption letter on file in the event the school is audited by the state health department. Rarely do schools offer exemption forms. Many school administrators, and even pediatricians, are not aware exemptions exist for school attendance because so few parents request them.

Four types of exemptions are available that allow you to refuse public school vaccination requirements: philosophical, religious, medical and proof of immunity. Each state has its own specifically worded laws and requirements. It is important to be familiar with the rules of the state in which you intend to send your child to school. A copy of the state law can be obtained from **www.NVIC.org** or at **www.vaclib.org.**

For those who do not have access to the Internet, request that a copy of your state law be sent by mail from your local health department. Libraries will have a book of state statutes; vaccine regulations are listed under the section entitled "Public Health Law, Immunizations."

Philosophical Exemptions

Exercising the right to a philosophical exemption means that you simply do not want your child to be vaccinated. You have decided to keep your child healthy by other means, including diet, exercise, supplements, clean hands and plenty of sleep. As of October 2007, 18 states allow an exemption to vaccination based on philosophical beliefs. Those states are: Arizona, Arkansas, California, Colorado, Idaho, Louisiana, Maine, Michigan, Minnesota, New Mexico, North Dakota, Ohio, Oklahoma, Texas, Utah, Vermont, Washington and Wisconsin.

States differ in what is required when this exemption is exercised.

- Some states stipulate that individuals must object to all vaccines;
- Some states require a notarized statement;
- Some require the signature of both parents;
- Some states require a one-time submission to cover all school years; some require an annual submission;
- Some require a personal letter in addition to the signed exemption form.

A sample personal philosophical refusal (exemption) letter is available. See Addendum M or download a sample letter at **www.SayingNoToVaccines.com.** Please modify the language of the letter to fit your individual needs.

Religious Exemptions

A religious exemption is available in all states except West Virginia, which only has a medical exemption and Mississippi, which only allows a medical exemption but has an automatic exemption for

home-schooled students. **REF: Home School Legal Defense Association. http://www.hslda.org/Legislation/State/wv/2007/WVSB91/default.asp**

In general, the religious exemption is intended for people who hold sincere religious beliefs that are in opposition to vaccination requirements. This belief needs to be so strong that if the state forced vaccination on you or your family, it would be an infringement upon your religious convictions.

Even though there is nothing in the U.S. Constitution that specifically guarantees the right to refuse vaccination, the First Amendment provides broad support for religious exemptions. As a result, several types of religious exemptions are available and are generally catergorized as broad vs. restrictive. While the distinction is somewhat arbitrary, it generally means that in some states, the state can't challenge the claim—if a claim is made, it has to be accepted; in other states, the state has the authority to challenge exemption claims and exercise discretion to deny exemptions.

Some states have laws written in what is called "restrictive language", meaning, the state may require a person to be a member of an organized religion that has, as part of its written tenets, an opposition to invasive medical procedures such as vaccination. Examples include, The First Church of Christ and the Christian Scientist Church. When addressing the specific language issues in restrictive states, it is particularly advisable that you seek legal assistance to write your exemption letter to assure that you meet state requirements. Pro-active steps should also include working with state legislators to modify the exemption.

In Arkansas, the requirement to be part of a "recognized religion" that was opposed to vaccination was declared unconstitutional in 2002 when exemption cases were challenged in the state federal district courts. The Court ruled that the language of this mandate violated the

Equal Protection Clause of the Fourteenth Amendment. Members of a "recognized church" were able to enjoy the benefit of a religious exemption that was denied to people who also had sincere religious beliefs against vaccination, but didn't belong to a recognized church. This preferential treatment was considered to be discriminatory. Accordingly, the provision requiring church membership was found to be unconstitutional. The state now has both a religious and philosophical exemption.

The "recognized church" requirement has been challenged in other state courts; only in New York did the federal court direct the state to rewrite the exemption to make it Constitutional. The Court held that religion need not "be founded upon a belief in the fundamental premise of a 'God' as commonly understood in Western Theology." This ruling is only binding in New York courts; other states are not bound by this decision and until the premise is legally challenged, it can't be assumed that an individual state would rule in the same way.

The U.S. Supreme Court ruled that the "test of a belief" in a Supreme Being is defined as "whether a given belief is sincere, meaningful, occupies an important place of ultimate concern in the life of the individual and parallels practices of orthodox belief systems." **REF: Sherr v. Northport-East Northport U. Free, 672 Fed. Supp.81, (quoting United States v. Seeger, 380 U.S. 163, 165-66, 85 S.Ct. 850, 854, 13 L.Ed.2d 733 (1965)]**

Many different beliefs and practices may qualify for a vaccine religious exemption under the U.S. Constitution that may not have the same jurisdiction within state rules. The technicalities of what is an acceptable religion go beyond the narrow range that come to mind with the phrase "religious exemption." This concept , however, does not prohibit states and school districts from enforcing a state's church-membership rule to force vaccination compliance.

As you can see, exercising a religious exemption can be tricky business. For example, parents may need to be prepared to defend their position, possibly in front of a judge. This has happened very recently in New York, despite updated rulings. The proposed exemption must be written in the person's own words; form letters are ill-advised. If a state regulation requires membership in a church that opposes vaccination, the family needs to be a bone fide member of a qualifying church. The parent may be asked to state the beliefs of the church, how often the family attends services, what the actual involvement with the church is and why that particular church was chosen over another. Carefully worded exemptions that follow every detail of the state's law are important.

A reason often cited for exercising the religious exemption is the belief that the body is the temple of the Holy Spirit and should not be intentionally defiled with biological substances. Another argument is that several vaccines (hepatitis A, rabies, rubella, and chickenpox vaccines) are manufactured from cells originating from aborted fetal tissue. If a person is morally opposed to abortion, this can be a starting place to explain the religious reason to refuse at least these vaccinations. These premises have not been legally challenged and upheld; there is no guarantee that the arguments will be accepted. If your family belongs to a particular religious denomination, written support attesting to your religious conviction from your pastor, priest, rabbi or spiritual advisor may be helpful. Once again, carefully adhering to the state law is key to a successful religious exemption.

Although not part of state statutes, states usually allow you to exercise your right to a religious or philosophical exemption even if a child has received a few vaccines. The parent may have vaccinated before he was aware that an exemption was available. However, it is important to understand that after the exemption has been exercised, all future

vaccines must be refused, including annual flu shots, or the exemption could be denied or lost.

There are a number of situations in which a consultation with an attorney who is knowledgeable in the area of exemption law is advisable, including:

1. A situation that involves going to court for any reason.
2. A situation in which a person has been threatened (in any way) by a health official, a physician, a school administrator or a social worker.
3. When vaccination has become an issue during child custody proceedings.
4. When accusations of medical neglect or child abuse have arisen or are anticipated for not vaccinating.
5. When proactive steps need to be taken with employment, immigration, the military or adoption, and discussions about avoidance require legal oversight.

These are just a few of the most common reasons to consider consulting with an attorney who is knowledgeable in the area of religious exemptions. The fee is a small price to pay for the long-term security of knowing how best to proceed.

Medical Exemptions

All 50 states allow medical exemptions from vaccination. A medical exemption is a signed statement, usually written by a medical doctor (M.D.) or doctor of osteopathic medicine (D.O.), stating that in the opinion of the physician, the administration of one or more vaccines would be detrimental to the health of an individual. Most states accept a private physician's written exemption without question. However, in some states, medical exemptions are reviewed by the state

medical director of the local health department who has the authority to revoke the exemption if she or he does not feel the exemption is justified. Seldom are medical exemptions accepted by schools or health departments when written by doctors of chiropractic (D.C.), naturopathic physicians (N.D.) or doctors of Oriental medicine (D.O.M.).

Proof of Immunity Exemption

The final type of exemption, rarely discussed, is called the "proof of immunity" exemption. This type of exemption can be used if: 1) the child has previously had the infection, such as chickenpox or measles; 2) the child has been exposed to another child but didn't manifest the illness or 3) the child has had a few vaccines and you want to refuse the rest of the series. Acceptance of this type of exemption varies by state. To see a full list of all exemptions for all states, go to **www.SayingNoToVaccines.com** and download the CDC's 2005-2006 reference guide called "Childcare and School Immunization Requirements." The information is self-explanatory and requirements for each state can be viewed.

Establishing proof of immunity involves getting a blood test called a titer level (pronounced with a long "i"). If the results demonstrate the presence of an antibody, this serves as "proof of immunity"; no further vaccines for that disease are required. (See Addendum P for acceptable titer levels.)

Care of Your Exemption Papers

Once your decision has been made to exercise a vaccination exemption, create a personal paper trail. When the documents and letters are submitted to the local school authorities, retain a copy for your records.

Sign and date it when it is delivered to the school authority. Likewise, have the person who accepts the form sign and date the record. Keep your copy in a safe, handy place in the event that the school misplaces your documents.

Chapter 5

VACCINE EXEMPTIONS FOR SPECIAL CIRCUMSTANCES*

**These are standard exemptions available in the U.S. and may not appy to your specific country*

I. Exemptions for Health Care Workers

Vaccination laws for health care workers can be written as state statutes or public health regulations. Both vary widely from state-to-state in terms of which vaccines are required, the type of healthcare settings regulated, and roles of persons covered. States do not necessarily offer exemptions along the same lines of school requirements. In addition, the documentation required to exercise an exemption varies between states, settings and populations.

The CDC guidelines define health care workers as "persons who provide medical care to patients or work in institutions that provide patient care, e.g., physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, hospital volunteers, and administrative support staff in healthcare institutions." All regulations governing these groups of workers fall into two categories: assessment and administrative. **Assessment** statutes are rules that require a facility to document and keep up-to-date records on the vaccination status of their employees. Assessment statutes include activities such as offering a hepatitis B vaccine after a dirty needle puncture or tetanus shot after an on-the-job laceration.

Administration statutes are divided into "offer" and "ensure" categories. An *offer law* means that vaccination is optional; however, the facility is required to offer, or make available, specific vaccines for its employees. An *ensure law* indicates that vaccination is mandatory unless the person has refused the vaccine and/or exercises a vaccine exemption. The facility is required to arrange for vaccination or make certain that an

employee has been vaccinated for a vaccine-preventable disease. In settings that have ensure laws, medical, religious or philosophical exemptions are available, but vary widely between states. The vaccines generally included within these statutes are influenza, pneumococcal (pneumonia shot), hepatitis B and, in some circumstances, MMR and chickenpox.

First responders and those in private physician's offices, nursing homes, schools, and laboratories are considered health care workers. **REF: MMWR. Immunization of Health Care Workers. December 26, 1997 / 46(RR-18);1-42**

Question: Is there an exemption for the annual TB test for healthcare workers?

Answer: Tuberculosis is caused by the bacteria *Mycobacteruim tuberculosis*. Most persons who are infected are asymptomatic and non-infectious. The only evidence of infection may be a complex reaction that can occur using a Mantoux test, the injection of 0.1 cc purified protein derivative (PPD) under the skin routinely called a "TB test." It is becoming increasingly difficult to refuse the annual TB test as a health care worker, even with a physician's exemption letter. However, the following information may help win the argument against the test and offer another option for screening.

The tuberculin skin test is non-specific. A positive response, identified as a red area measuring from 5 to 15 mm in diameter, is interpreted to mean that at some point in time, the person has become infected with *Mycobacterium tuberculosis*, the germ that causes TB. Without symptoms, a positive TB test represents a dormant infection, commonly referred to as a latent infection. Even though more than 90 percent of persons who have a positive TB skin test will not develop active disease, it is not possible to predict which 10 percent will become sick and start to spread the disease. Therefore, all persons with a positive TB test are

treated with an antibiotic, Isoniazid, (also called INH), for nine months. Unfortunately, once a person has a positive TB test, all subsequent tests will be positive. The only assurance that the test does not represent active disease is extensive antibiotic treatment.

Treatment with INH is not without concern. Side effects can include skin rashes, nausea and significant, even fatal, hepatitis. A variety of animal studies have demonstrated that INH can cause death in liver cells and disrupt DNA strands. In a study of 83 healthcare workers who received a 6-month course of INH, 34 (41%) developed adverse side effects, including hepatitis. **REF: Isoniazid Toxicity. eMedicine. http://www.emedicine.com/emerg/topic287.htm**

Most disturbing is that a TB test does not distinguish between infections by M. *tuberculosis* and other types of benign mycoplasma species. A person can have a false positive TB test if they have had previous TB (BCG) vaccine, derived from *Mycobacterium bovis*, a vaccine commonly used in countries around the world.

Conversely, between 10 and 25 percent of patients who have active tuberculosis can have a negative skin test. The CDC admits that there is no reliable way to distinguish with a tuberculin skin reaction the difference between an infection with M. *Tuberculosis* and a reaction due to previous BCG vaccine or other mycobacterium infection. **REF: CDC. Association of Professionals in Infection Control and Epidemiology (APIC) position paper: "Responsibility for interpretation of the PPD tuberculin skin test." APIC Guidelines Committee, 1998.**

A little-known, rarely-used blood test is available to determine if a person is actively infected with M. tuberculosis. Called QuantiFERON-TB (QFT). The test was approved for use by the FDA in 2001 to identify active tuberculosis infections. It involves drawing a blood sample, mixing it with PPD and incubating the solution for up to 24 hours. If the

patient's sample releases a larger proportion of IFN-g (interferon gamma) than the control sample, this is a marker of active disease. As of December 2005, CDC guidelines approved the use of the QuantiFERON TB Gold test (QFT-G) to screen for active tuberculosis. **REF: MMWR. 2005;54(RR- 15):49-55.**

In February 2008, a landmark study published in the American Journal of Respiratory and Critical Care Medicine documented that the QuantiFERON-TB test was six times more accurate than the conventional TB skin test for predicting which individuals needed treatment to prevent active disease. It is likely that more than 75 percent of individuals thought to be positive by the skin test will be negative by the Quanti-FERON-TB. **REF: Am. J. Respir. Crit. Care Med. 2008. Feb. 14 "Predictive value of a wholeblood IFN-gamma assay for the development of active TB disease."**

QFT-G can be used in all circumstances in which the tuberculin skin test is currently used including recent immigrants who have had BCG vaccination and for TB screening of health care workers. Before the QFT-G is conducted, arrangements should be made with a qualified laboratory and courier service, if needed, prompt and proper processing of blood to insure accurate results. **REF: QuantiFERON-TB Gold Test Fact Sheet. CDC. http://www.cdc. gov/tb/pubs/tbfactsheets/QFT.htm**

Discuss this information with the laboratory director of your hospital or the office manager in your doctor's office. Request that the QFT-G test be used to screen for TB; after all, the real purpose of the TB test is to be sure that you do not have the infection that could be spread to others. A QFT-G blood test is much less invasive and much more accurate than a non-specific skin test that injects mycoplasma proteins into your body. You may want to go so far as to demand an explanation as to why your facility does not allow the QFT-G test as a screen when the CDC approves it for finding active disease. One note: This test may

not be covered by your hospital or your insurance carrier. To find out more, go to **http://www.quantiferon.com/**

Question: Is there an exemption for the annual flu shot for those who work in hospitals?

Answer: The definition of a health care worker includes any employee who comes into contact with patients in a health care setting. In 2003, the the National Foundation for Infectious Diseases (NFID) documented that only 36 percent of healthcare employees were vaccinated with the influenza vaccine, prompting the development of stringent, new national strategies to increase vaccination rates.

The new measures drafted by the NFID for employers helped to ensure health care workers were provided with convenient access to influenza vaccines. Health care organizations were encouraged to develop strong, written policies regarding employee flu shots. The recommendations clearly stated that "top management and administration must become strong advocates to ensure health care workers get vaccinated to achieve better infection control, reduce absenteeism and increase cost savings." Recommendations began to include the threat of loss of employment if the employee refused the vaccine. **REF: CDC Monograph. "Improving Influenza Vaccination Rates in Health Care Workers." 2004. p9. http://www.cpha.com/links/HCW_Monograph.pdf**

The NFID recommendations stopped just short of suggesting that flu shots be made mandatory, but every conceivable marketing tool and technique has been developed by the government—from posters and stickers to free screensavers—to encourage all health care personnel to be vaccinated. Programs crafted by the CDC have been provided free of charge to hospital administrators to demonstrate the adverse consequences of influenza on employees, including the number of days lost from work and the risk unvaccinated employees pose to patients.

Subsequently, in mid-2006, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) announced a new standard for hospitals, critical access hospitals, and long-term care facilities, effective January 2007. Under this standard, JCAHO- accredited facilities are required to offer annual influenza vaccination to staff, volunteers, and others with direct patient contact. National policies regulating health care worker vaccination are likely to significantly affect vaccination coverage and could encourage enforcement of state laws that promote compliance and mandatory vaccination requirements. **REF: Am J Prev Med. 2007;32(6):459–465). "Assessing State Immunization Requirements for Healthcare Workers and Patients."**

Getting a flu shot has always been a matter of personal choice. However, thanks to major government initiatives, refusing a flu shot has become an issue of "patient safety," and employees who refuse the flu shot are thought to put patients at risk. As a consequence, some employers are beginning to demand that workers receive the vaccine as a requirement for continued employment. Public health policy is once again shifting from cooperation to coercion, forcing injections on health care workers against their will.

However, vaccination as a requirement for employment has been challenged in District Court. An announcement made January 7, 2006, upheld a nurse's right to refuse. The ruling, made by the United States District Court, would not allow Virginia Mason Medical Center to make flu shots a condition of employment and would not allow the Center to fire nurses who did not comply. The ruling paralleled an earlier objection filed by the Washington State Nurses Association (WSNA), representing more than 600 registered nurses. The WSNA stated that the organization was "absolutely supportive of flu vaccines and encourages nurses to get them," but opposed any health care facility requirement that threatened to fire people if they did not submit to mandatory vaccination. **REF: Press release. "Nurses Win Federal Court**

Decision on Virginia Mason's Mandatory Flu Vaccination Policy." January 7, 2006. http://www.conscienceIaws.org/

Hospital systems are taking a stronger stand with their requirements. Currently, there are only a few states with ensure requirements for vaccination of health care workers (recall that an ensure law indicates that vaccination is mandatory unless the person has refused the vaccine or exercises a vaccine exemption). The decision to implement mandatory vaccination policies has ultimately been left to individual states and health care facilities.

Use the information in this book to educate HR directors, nursing directors, the hospital administrator and perhaps even the hospital board of directors that the flu shot is no more effective than a placebo for preventing the flu. Point out that the risk of side effects from the flu shot can be considerable. Ask the person who insists that you submit to a flu shot to take personal and/or corporate responsibility in the event you sustain a serious reaction from a vaccine you were forced to take against your will. Find like-minded, educated co-workers to support your decision. **REF: See Addendum Q, Influenza Vaccine Requirements for Hospital Employees, by State. Also see "State Immunization Laws for Healthcare Workers and Patients at Risk" on www.SayingNoToVaccines.com. This is a large, searchable database where you can find exemptions and requirements specific to your needs.**

Question: Is there an exemption for the annual flu shot for those who work in a nursing home?

Answer: In 1999, there were approximately 18,000 nursing homes in the United States with approximately 1.6 million residents. In 2003, it was reported that only 36 percent of all persons who work in these settings received an annual flu shot. This resulted in a public health initiative to increase the vaccination rate among nursing home employees. Legislative and regulatory policies came under scrutiny at

both state and federal levels.

As of the spring 2004, 28 states and the District of Columbia had laws regarding vaccination requirements for long-term care facilities. Of those, seven states have regulations and four states have both laws and regulations primarily addressing influenza and pneumonia vaccines for employees and residents. Of those, twelve states have specifically written regulations that provide employees with a mechanism for refusing influenza and pneumonia vaccines.

	Religious	Philosophical or Refusal	Medical	Proof of Immunity
Alabama	x	x	x	
Arkansas	x		x	
Kentucky	x	x	x	
Maine	x	x	x	x
Maryland	x	x	x	
New Hampshire		x	x	
New York	x	x	x	
Oklahoma		x	x	
Oregon		x		
Rhode Island	x		x	
Texas		x	x	
Utah		x	x	

TABLE: States with Specific Statutes Regarding Vaccination Exemptions for Employees of Long-Term Care Facilities

Florida regulations state that a facility may "adopt and enforce any rules necessary to comply with implementation of vaccination." Pennsylvania statutes insist that "facilities require documentation of

annual immunization against influenza for each employee, which includes written evidence from a health care provider indicating the vaccine has been administered." No exemptions are specifically in place for these two states.

The only state that appears to require additional vaccines by statute for nursing home employees is Maine. Requirements include proof of immunization or documented immunity against: (1) rubeola (measles); (2) mumps; (3) rubella (German measles); (4) varicella (chicken pox); (5) hepatitis B. Employees have the right to exercise a religious and philosophical exemption for each vaccine if the reasons are clearly stated in writing and in the person's own words. **Reference for this section: Dept. of Public Health Policy. "The Epidemiology of U.S. Immunization Law: Immunization Requirements for Staff and Residents of Long-Term Care Facilities Under State Laws/ Regulations," by Alexandra Stewart, J.D., Marisa Cox, M.A., and Sara Rosenbaum, J.D. http://www.gwhealthpolicy.org.**

Question: What is the risk of contracting hepatitis B? Is there an exemption for the hepatitis B vaccine for those who handle or are potentially exposed to blood and blood products?

Answer: When deciding whether to accept the hepatitis B vaccine series, it is important to know the risk and potential seriousness of a hepatitis B infection.

Hepatitis B is an infection caused by a virus with the same name. Symptoms include nausea, vomiting, fever and malaise, followed by a period of jaundice that lasts three to 10 days. The treatment is supportive and symptomatic; importantly, recovery from the infection usually occurs within four to eight weeks. More than 50 percent of persons who are exposed to the virus have no symptoms at all. The virus is expelled from the body, and the person develops lifetime immunity after exposure. Approximately 30 percent of those who are exposed

develop only flu-like symptoms, recovery is complete and the result is lifetime immunity.

About 20 percent of persons who are exposed to the hepatitis B virus actually develop the most common symptom that leads to diagnosis of hepatitis B infection: jaundice. Importantly, even 95 percent of persons who become significantly ill from hepatitis B recover fully and have lifetime immunity.

Only about 3 percent of all persons who develop a full-blown hepatitis B infection become a chronic carrier of the virus. A person is considered a "chronic carrier" when tests show the virus is still present in the blood six months after an acute episode of the illness. As a carrier, the person may unknowingly pass the virus to others. Those who have been positively diagnosed with hepatitis B should be tested within six months to determine if they have become a carrier.

A truly small number of persons who have been exposed to hepatitis B virus, only about 1.25 percent of persons who become active carriers, progress to liver disease and liver cancer. According to CDC data, the actual number of cancer deaths from hepatitis B annually can range from 175 to 3,700 annually. Of note, liver cancer is thought to develop 10 to 30 years after an acute episode of infection. **REF: Clin. Infect. Dis. 20, 992-1000. 1995. "Risks of chronicity following acute hepatitis B virus infection: A review."**

In the U.S., more than 70 percent of all cases of hepatitis B occur in high-risk persons—chronic alcoholics, male homosexuals and intravenous drug users. It is likely that advanced liver disease and liver cancer have not developed solely as a result of a previous hepatitis B infection.

Federal Occupational Safety and Health Administration (OSHA)

standards requiring employers to offer hepatitis B vaccination to staff with occupational exposure risk became effective in 1992. OSHA provides an exemption form called the "Statement of Declination of Hepatitis B Vaccination" for persons who wish to refuse the vaccine (See Addendum K). **REF: OSHA Regulations (Standards - 29 CFR) Hepatitis B Vaccine Declination (Mandatory) - 1910.1030 App A.**

OSHA requires that the employee be given appropriate training about the risks of a hepatitis B infection and the potential risks, benefits, efficacy, safety, and method of administration of the vaccination. The statement is not a permanent waiver; an employee can receive the hepatitis B vaccination at a later date should they so desire. When using the waiver, no words may be added to or deleted from the form.

Conversely, employees choosing to receive the vaccine must sign an informed consent release. Some employers have tried to add language to the consent form to relieve them from responsibility in the event an adverse reaction occurs. This is a violation of OSHA regulations.

If you have previously received the hepatitis B vaccination series and wish to refuse it with a new employer, the best way is to show records from your previous employer. Another option is to obtain a hepatitis B antibody (titer) test. OSHA allows a blood titer value of at least 10 IU/ml to be used as proof of immunity.

However, serum testing to establish proof of immunity may not be all that helpful. Vaccine-induced antibodies to hepatitis B decline over approximately seven years, and nearly 60 percent of persons who initially respond will lose detectable antibodies within 12 years of the three-shot series. **REF: MMWR. December 26, 1997, 46(RR-18);1-42.**

OSHA admits that antibody testing more than six months after completion of the hepatitis B series is "an unreliable measure of

immunity." It is difficult to differentiate if the hepatitis B antibody is present in the bloodstream from the vaccine or if it is present because the person has had a recent hepatitis B infection or exposure. In essence, the vaccine is neither long lasting nor protective. **REF: OSHA Regulations (Standards - 29 CFR) Hepatitis B Vaccine Declination (Mandatory) - 1910.1030 App A.**

If you are unable to show proof of immunity through a previous certificate, the next best option for refusing the vaccine is signing the hepatitis B declination statement. (See Addendum K).

In the event of a blood exposure, the worker should immediately file an incident report with their supervisor. If that worker later contracts hepatitis B, the person would not be excluded from Worker's Compensation benefits because they had refused the vaccine. Apparently, the Bureau of Workers' Compensation understands that receiving the vaccine does not protect the person from getting sick.

Special Categories with Hepatitis B Vaccination Requirements:

1. *Police, fire fighters, accident investigators:* OSHA clearly states that employees of state and local governments, such as police and firefighters, are covered by state, not Federal, OSHA standards. **REF: 29 USC 652 (5) and (6)]. Refer to your state and city regulations for requirements and declination forms.**
2. *Airport police and firefighters:* These employees are considered health care workers, according to CDC guidelines, because they may have contact with blood. Thus, hepatitis B vaccine series may be recommended for employment. Refer to your state and city regulations for declination forms.

Question: Who is at risk of contracting hepatitis A? Is the vaccine necessary?

Answer: Hepatitis A is a mild infection that lasts approximately two to three weeks. Symptoms include fatigue, diarrhea and jaundice. After the acute phase is over, life-long immunity remains. The mortality rate of the infection is less than one percent (actually 0.6 percent). There are no long-term complications and it is not a life-threatening illness. Hepatitis A virus is spread from person-to-person by the fecal-oral route, meaning, through poor sanitation and personal hygiene. According to the CDC, child-to-child disease transmission of hepatitis A within a school setting is uncommon. Therefore, the necessity of this vaccine is truly unclear.

Hepatitis A vaccines are made from human fetal diploid (lung) cells. Havrix, manufactured by GlaxoSmithKlein, contains aluminum, phenoxyethanol, traces of formalin and residual fetal human diploid cellular proteins. Vaqta, a Merck & Co. product, also contains aluminum. In addition, Vaqta contains viral DNA, bovine albumin and formaldehyde. Neither Havrix nor Vaqta have been evaluated for carcinogenic (ability to cause cancer) or mutagenic (ability to change a person's DNA) potential, or for the potential to impair fertility. Neither have been evaluated to determine if they are associated with chronic illness or disability, such as diabetes, asthma, seizure disorders, learning disabilities, ADHD, or autism. Vaqta's package insert includes the statement that, "Subjects were [only] observed for a 5-day period for fever and local complaints and for a 14-day period for systemic complaints." **REF: Package inserts of Havrix and Vaqta.**

Reactions and side effects from the vaccine are relatively common. In clinical trials between 9 and 14 percent of adults and children reported headache after vaccination and between 21 and 56 percent had local reactions. Up to 10 percent had fever, fatigue, malaise, nausea and loss

of appetite. Other reported reactions included stomach pain, diarrhea, vomiting, and joint pain. Post marketing vaccine reaction reports have included anaphylaxis, jaundice, convulsions (seizures), multiple sclerosis, Guillain-Barré syndrome, and neuropathy. Since the vaccine was licensed in 1996, there have been more than 9,000 reports of adverse events made to VAERS, including 476 serious events and 18 deaths. Interestingly, even though hepatitis A is spread through stool, the hepatitis A vaccine is not routinely recommended for sewage handlers. The vaccine is also not recommended for health care workers. The CDC states if a patient with hepatitis A is admitted to the hospital, routine infection control precautions will prevent transmission to hospital staff. One could easily extrapolate those recommendations to all others—hand-washing and caution with stool—completely eliminates the need for this vaccine. **REF: CDC. National Centers for Infectious Disease; Hepatitis A Infections. http://www.cdc.gov/ncidod/diseases/hepatitis/a/faqa.htm**

II. Vaccine Exemptions and Divorce

Question: Is there a way to ensure that my spouse and I will not have a disagreement over vaccines—especially if we divorce?

Answer: Agreeing on topics such as religious preferences and educational programs are important discussions prospective parents should engage in before starting a family. Unfortunately, the topic of vaccination is rarely discussed and often leads to strong disagreements after the baby is born.

Recently, a nurse midwife shared that she is requiring all of her patients to sign a form stating that they have discussed vaccination and are in agreement—either both for vaccination, or both against it—before she agrees to care for the family. She also suggested that if the parents are

in agreement to not vaccinate their children, that they sign a binding agreement—a contract—at the time the child is born stating that vaccination will not be used during divorce proceedings, should the situation arise.

This is a very novel, but good idea. Horror stories about one parent spitefully vaccinating a child with 10 or more vaccines at a time in retribution have had devestating results to the child's health. A prenuptial agreement concerning the health of your children may be a very reasonable course of action. If you choose to do this, have an attorney review the document, have it notarized and keep two copies in safe, separate places. Like any contract, its purpose is to settle future disputes. With the divorce rate at 50 percent or greater, this idea may start a new trend.

Question: I am getting divorced. My spouse and I disagree over the need for vaccines for our children. How do I avoid court-ordered vaccines during divorce proceedings?

Answer: Unfortunately, this situation is all too common. One parent uses vaccination in a custody dispute to "prove" that the other parent is unfit. It is appalling that one parent would force potentially dangerous injections into a child to, in effect, punish the other parent. Compounding the problem, an overreaching judge could rule one parent is not fit to care for the children if he or she is against vaccination.

A judge should not be determining what is in the best interest of the health of your child. Use every available negotiating skill to keep vaccination out of divorce proceedings and away from the administrative judge. Request or hire an arbitrator to help negotiate with your spouse. Show all parties the vaccine injury data from VAERS and documentation in this book as supporting evidence of the harm that can come from vaccines.

Before the divorce is finalized, make sure your attorney adds a clause to your divorce agreement stating that all medical expenses, in the event of a vaccine injury, will be paid by the parent forcing the vaccines. Add a clause that if the child gets sick from the vaccine, the parent forcing the vaccines will be required to miss work, stay home with the ill child and take financial responsibility for future therapies needed for recovery. In fairness, agree to stay home from work and assume medical expenses if your child becomes ill with chickenpox or another vaccine-preventable disease.

Question: My divorce is final and the judge has ordered vaccines for my children. Is there a safe way to vaccinate?

Answer: Unfortunately, there is no way to ensure any vaccine will be harmless. An injury can occur at any time, in any age group and from any vaccine. For example, I know adults who have become totally disabled after a hepatitis B vaccine and a 15-year-old who sustained permanent neurological damage from a flu shot. But there are things that can be done to minimize the risk.

1. For babies and infants, delay all vaccines as long as possible, even if it means extra office visits and additional expense. The decision to administer vaccines at two, four and six months has been arbitrarily assigned and is based on physician convenience and insurance reimbursement. There is nothing critical about vaccinating on that schedule. If possible, do not administer vaccines during the first two years of life while the immune system and the myelin sheath are undergoing rapid development and maturation.
2. Insist on giving one type of shot at a time and at least one month apart. If finances are a significant issue, get the shots from the local health department.

Don't be fooled by combination vaccines such as Pediarix®, which has DTaP, Hepatitis B and polio combined. Yes, it is one shot, but it is five vaccines in one injection.

3. For the viral vaccines—MMR, chickenpox, and polio—pre-treat with vitamin C powder and vitamin A drops. These two vitamins are the best way to protect your immune system from the effects of these vaccines. The doses and protocol for using these are available in Addendum T.

III. Other Special Circumstances:

Question: Can exemptions used for primary school be used as exemptions for college?

Answer: This is a growing area for public health law, as adolescents and college students are new customers for the pharmaceutical industry. State vaccination requirements were written many years ago and most only cite requirements for entry into elementary and high school. College requirements are under development and many of the new vaccines are not explicitly listed in the educational requirements. However, it appears that colleges, universities and professional schools, such as medical, law and dental schools, are going to be the next opportunity to promote required vaccination.

Here's a sample from Georgia of the new type of legislation being passed. In 2003, the state passed requirements for the college meningitis vaccines (HB 521). The law, which provides an exemption, states:

> "Students who are 18 years of age or older shall be required to sign a document provided by the post-secondary educational institution stating that he has received a vaccination against meningococcal disease

> **OR** has reviewed the information provided as required by subsection (a) of this Code section. If a student is a minor, only a parent or guardian may sign such document." [***NOTE:*** The "or" in this requirement is significant.~*ST*]

Many states have similar language in their laws. Notably, most states provide an exemption as part of the admission policy. (See Addendum R for a list of college requirements). **REF: A few examples include: Mississippi (2003: HB1087), Nebraska (2003: LB513), North Carolina (2003: HB 825), Oklahoma (2003: SB 787), and Tennessee (2003: SB 185).**

Vaccines suggested for college include boosters for MMR, pertussis, hepatitis B and tetanus. In 1969, a New England Journal of Medicine article advised against routine tetanus boosters, stating, "...tetanus boosters on admission to camps, schools, colleges and at times of injury should be abandoned, to minimize toxoid reactions." **REF: NEJM. 1969; 280/11:575-81. "Tetanus-toxoid emergency boosters. A reappraisal."**

Brachial-plexus neuropathy, an acute syndrome of the shoulder girdle marked by pain, weakness and mild sensory loss, has been shown to occur almost exclusively in adults who have received multiple injections of tetanus toxoid. **REF: NEJM. 1995; 333/9:599. "Protection against tetanus."**

There are many reports in the medical literature of severe side effects after routine tetanus shots including allergic reactions, pericarditis, serum sickness, painful neuropathies and even severe, transient Parkinsonism. Other side effects, listed on the package insert, include headache; nausea; vomiting; arthralgias; tachycardia (racing heart); syncope (fainting); cranial nerve paralysis; and a variety of neurological complications including EEG disturbances, seizures and encephalopathy; anaphylaxis; and Gullian-Barré syndrome. **REF: J Neurol Neurosurg Psychiatry. 1997;63:258-259."Severe but transient Parkinsonism after tetanus vaccination."**

Reports of suppression of the immune system, with T-cell counts as low as those seen in patients who have HIV, have occurred after tetanus boosters. The same types of reactions can occur by over-vaccinating your child. **REF: NEJM. 1984; 310/3:198-9. "Abnormal T-Lymphocyte subpopulations in healthy subjects after tetanus booster immunization."**

In addition, the college meningitis vaccine, Menactra, is now being highly recommended, and the new HPV vaccine, Gardasil, will be advocated shortly. Many new vaccines are under development for sexually transmitted disease, including chlamydia and Group B streptococcal vaginal infections. Vaccines are planned for cocaine addiction, for gingivitis, for lowering cholesterol, and to stop smoking. There will be a very big push to require all adolescents to receive the HIV vaccine when it is available. In fact, more than 20 vaccines are under development for the 13- to 18-year-olds over the next 10 years.

If a college or university writes that vaccinations are required, show the administrator a copy of the table in Addendum R. Meet with the high level administrator with a copy of your state's law. Challenge the school's position and ask for the school bylaws. Point out that the school is asking you to medicate your child, using a procedure with potentially harmful (even deadly) complications, in exchange for an education you are paying a hefty sum to obtain. You may want to go as far as politely asking the administrator if he is willing to accept the risk and be responsible for any medical bills that may result from an injury caused by the vaccine. Perhaps the institution and the administrator have never been exposed to a broader view of vaccines, making this an educational opportunity. You may be in a position to protect others by requiring that the language regarding vaccine "requirements" be changed explicitly to "recommendations."

Many administrators are simply uninformed. Unfortunately, few know that exemptions exist even though injuries occur. Recently, I received

a request to write an exemption letter for a person who was employed by a large university in Tennessee and had no direct contact with students. When she requested an exemption, she was told she was the first person in the history of the school to ask for one. She took the opportunity to educate the head of her department on the problems associated with vaccines and was promptly granted the right to refuse.

Question: What vaccine exemptions are available for daycare or for private schools?

Answer: Philosophical, religious, medical and proof of immunity exemptions are available to attend public school. These exemptions may apply to day care centers and private schools, particularly if they receive state funding, no matter how small the sum. Perhaps they receive money for a lunch program or even for school milk. If they receive state funds—and are licensed by the state—they are required to comply with state law. In some states, such as Montana, requirements are set by public health policy instead of through state statutes. Go to **www.SayingNoToVaccines.com** and download the CDC's "Childcare and School Immunization Requirements Manual." It is a very large document and is a thorough review of current daycare requirements by state. A short summary is included in Addendum C.

If the facility is completely private, investigate its policies. First, ask to see the bylaws and policies requiring vaccination. Read the language carefully. Then, politely ask to see the policy on discrimination. Have a meeting with the daycare administrator, suggesting that the existing polices disallowing your right to refuse vaccines for your child may be discriminatory, particularly if you are refusing vaccines on religious grounds.

Use the conversation as an educational opportunity; the administrator may not be aware of state-recognized vaccine exemptions. Point

out that if vaccines work, your child is the only one at risk. Your unvaccinated child is not putting the vaccinated children at risk. The administrator may not be aware that most of the day care outbreaks have occurred in fully vaccinated children (cited in other sections of this book.)

A polite yet firm negotiation may win the right for your child to be in their facility without vaccines. You will most likely be required to keep your child home in the event of an outbreak. This could be difficult for working parents, but a small price to pay if you are choosing to not vaccinate.

If the administrator is unbending, perhaps your assurance that you intend to vaccinate when your child is older will make the difference. The administrator may not know that the myelin sheath, the fatty coating that surrounds the brain and shields it from injury, doesn't become fully protective until at least two years of age. He may not be aware of the contents in vaccines. He may not be aware that a fully licensed facility needs to adhere to state laws and public health regulations. He may be grateful for the discussion and information. You might be pleasantly surprised by the response. While these efforts cannot insure that your child will be allowed into a particular daycare, making the efforts is in the best interest of your child.

Question: Is there an exemption for the annual flu and pneumonia shot for nursing home residents?

Answer: Only 21 states that have laws pertaining to vaccinations for those residing in long-term care facilities. The clear majority of the regulations apply to requirements surrounding influenza and pneumococcal vaccines. For states not specifically listed, its facilities will have policies and requirements, which should include exemption provisions.

Table. States with Laws or Regulations for Nursing Home Residents

STATE	Religious	Philosophical or Refusal	Medical		STATE	Religious	Philosophical or Refusal	Medical
AL	x	x	x		NH	x		x
AZ		x			NJ		x	x
AR	x	x	x		NY	x	x	x
CA			x		NC	x	x	x
CT	x		x		OK		x	x
FL	x		x		RI	x	x	x
GA			x		TN			x
IL		x	x		TX			x
IN	x	x	x		UT			x
KY	x	x	x		VA			x
MD	x	x	x					

Question: Does the law provide for exemptions for those in correctional centers?

Answer: Similar to health care facilities, correctional institutions and detention centers have administration statutes that are divided into "offer" and "ensure" categories. An offer law means that vaccination is optional; however, the facility is required to offer, or make available, specific vaccines for its residents and resident health care workers. An ensure law indicates that vaccination is mandatory unless the person has refused the vaccine or exercises a vaccine exemption. The facility is required to arrange for vaccination or make certain that all detainees have been vaccinated for vaccine-preventable diseases. In settings that have ensure laws, medical, religious or philosophical exemptions are available, but vary by state.

Currently, 19 states have laws for inmates in correctional facilities; Three states require vaccination of all residents regardless of age. The vaccines generally included within these statutes are influenza, pneumococcal, hepatitis B and, in some circumstances, MMR, chickenpox and TB testing. **REF: See "State Immunization Laws for**

Healthcare Workers and Patients at Risk" on www.SayingNoToVaccines.com This is a large, searchable database where you can find exemptions and requirements specific to your needs.

Question: Does the law provide for exemptions for developmentally disabled residents?

Answer: As for group homes, the laws are specific in 39 states. Age-appropriate vaccination requirements vary from state to state. For example, Arizona requires residential group care facilities to arrange for a resident to receive any routine immunizations and booster shots within 30 days of admission. However, most are "ensure laws," necessitating vaccination unless the resident has a specific medical reason to not be vaccinated. Only eight states provide exemptions:

a) Medical: DE, KS, KY, LA, NC, SD, TX and WI
b) Religious: KS, KY, NC, SD and TX
c) Philosophical: TX

These exemptions are subject to change by statute and requirements may change without notice in the event of an outbreak. **REF: See "State Immunization Laws for Healthcare Workers and Patients at Risk" on www.SayingNoToVaccines.com." This is a large, searchable database where you can find exemptions and requirements specific to your needs.**

Question: I am required to travel overseas for my job. Do I have rights to refuse travel vaccinations that are suggested / recommended / required by my employer?

Answer: At the beginning of your assignment, have an open and honest discussion regarding your position on vaccines with your employer. Many may not have considered an exemption or may not be familiar with the possibility of vaccine injury. Your right to refuse may be granted simply by raising the objection. However, the right to legally refuse for religious reasons has support from federal statutes. Title VII of the Federal Civil Rights Act of 1964 requires employers to reasonably

accommodate their employees' religious beliefs and practices. This applies to employers with more than 15 employees.

Question: There are many recommended travel vaccines. Are these required or can I avoid them?

Answer: All travel vaccines are recommendations only and rarely necessary (See Article, "Vaccines and Overseas Travel", page 191). The primary exception is the yellow fever vaccine which can be required by International Health Regulations when traveling to some sub-Saharan African countries and in countries in tropical South America. One other, the meningococcal vaccination, is required by the government of Saudi Arabia for annual travel during the Hajj.

Yellow fever, a viral disease transmitted between humans by a mosquito, is a very rare cause of illness in travelers. General precautions to avoid mosquito bites should be followed including the use of insect repellent, protective clothing and mosquito netting. In South America, sporadic infections occur almost exclusively in forestry and agricultural workers from occupational exposure in or near forests. In Africa, the virus is transmitted in three geographic regions:

- Foremost, in the moist savanna zones of West and Central Africa during the rainy season
- Occasional outbreaks in urban locations and villages
- Rare cases in jungle regions

The yellow fever vaccine is administered only at designated vaccination centers which can be recommended by local health departments. However, the vaccine can have serious, and even fatal, side effects. Since 1992, six cases of encephalitis among adult recipients of the yellow fever vaccine have been reported to VAERS. In addition, 10 cases of autoimmune neurologic disease have been

reported to VAERS, including patients with Guillian-Barré syndrome and acute disseminated encephalomyelitis.

A serious adverse reaction syndrome, called Vaccine-Associated Viscerotropic Disease, has been reported over the last 10 years among recipients of yellow fever vaccines. Since 1996, 12 cases of the disease—very similar to naturally acquired yellow fever—have been reported in the United States; an additional 24 suspected cases have been identified worldwide as of August 2006. Patients became seriously ill with fever, shock, hypotension, respiratory failure, elevated liver enzymes, lymphocytopenia (low white blood cell count), and thrombocytopenia (low platelet count) and required hospitalization in the intensive care unit. Seven of the 12 U.S. cases (58 percent) were fatal.

If a physician concludes that a yellow fever vaccine should not be administered for medical reasons, the traveler should take with them a signed and dated exemption letter on the physician's letterhead stationary, which may be acceptable to some governments. Ideally, the letter should also bear the stamp of a U.S. health department or an official immunization center. Reasons other than medical contraindications are not acceptable for exemption from this vaccination. While it is a rare occurrence, the traveler should be advised that issuance of a waiver does not guarantee that the destination country will accept it and on arrival, the traveler may be faced with quarantine, refusal of entry or vaccination on site.

While another type of travel vaccine, the typhoid vaccination, is not required, it is often recommended for travel in Third World countries. Typhoid is relatively common in areas where hand-washing is less frequent and water is contaminated with sewage. Typhoid fever is an illness caused by the bacterium *Salmonella typhi*. In the United States, only about 400 cases occur each year, and 75 percent of those are acquired while traveling internationally. Typhoid fever is characterized

by a fever as high as 103° to 104° F (39° to 40°C), stomach pain, headache, diarrhea, malaise and loss of appetite. Some patients develop a rash of flat, rose-colored spots. The only way to know for sure if an illness is typhoid fever is to have samples of stool or blood tested for the presence of *S. typhi*. Many other gastrointestinal microbes can cause a similar constellation of symptoms.

The CDC acknowledges that none of the available typhoid vaccines are 100 percent effective and they do not provide cross-protection against other common causes of gastrointestinal infections that cause traveler diarrhea. Food-borne pathogen precautions and hand-washing are recommended rather than the vaccine.

Question: Are vaccine exemptions available for foreign adults who want to immigrate to the U.S.?

Answer: Aliens who are immigrating into this country can apply for a religious exemption. According to federal law, "The Attorney General will authorize an INA 212(g)(2)(c) waiver when the alien establishes that compliance with the vaccination requirements would be contrary to his or her religious beliefs or moral convictions." Seek the assistance of an attorney knowledgeable in immigration law as you proceed as these are administrative decisions and can vary widely per individual.

Question: Are there exemptions for children who are being adopted?

Answer: Parents are strongly encouraged to work closely with the adoption agency to obtain the vaccines that they want—or don't want—for their adopted child born in the United States. If parents have unvaccinated children currently living in their home, adoption agencies often view this unfavorably. Some parents have even been denied adoption as the agencies perceive non-vaccination as a form of "medical endangerment" and/or "child abuse." Quiet caution is advised

for all parents in these circumstances.

Question: Are there exemptions for children being adopted from outside the country?

Answer: When working through an international adoption agency, it can be difficult to receive a child who has not been vaccinated in the country of origin. Some agencies recommend complete revaccination even if the country of origin provides a vaccination record. The CDC supports obtaining vaccination titers under these circumstances:

> "...multiple approaches [are available] if a question exists regarding whether vaccines administered to an international adoptee were immunogenic.... If avoiding unnecessary injections is desired, judicious use of serologic testing might be helpful in determining which immunizations are needed." **REF: MMWR. February 8, 2002/Vol. 51/No. RR-2. pg. 19.**

To order vaccine titers, to go **www.SayingNoToVaccines.com** and see Addendum P for vaccine titer table.

U.S. immigration law allows entry of the child without vaccines. Section 212(a)(1)(A)(ii) of the United States Immigration and Nationality Act requires that any person who seeks admission as an immigrant is required to show documentation of having received all vaccinations, but the subsection specifically exempts the immunization requirement for children under 10 years of age if the adoptive parents execute an affidavit stating that the parent will ensure that, within 30 days of the child's admission, or "*at the earliest time that is medically appropriate*," the child will receive the vaccinations. This puts the timing in the hands of the parents who could delay the injections for a long time.

Your adoption agency may not be familiar with this provision. Show them a copy of this law as you work with your representative. See Addendum L to review the affidavit and go to **www.SayingNoToVaccines.com** to download an exemption form for your internationally- born child.

Question: Are there vaccination exemptions for persons in the military?

Answer: Military recruits may receive up to five vaccines simultaneously. Unfortunately, this threshold can be exceeded in the event of immediate deployment. Many adverse events have been documented from vaccines given to military members. For example, after reinstitution of the smallpox vaccination program for military personnel in 2002, there were more than 50 cases of probable myocarditis (inflammation of the heart muscle) that were reported as a complication of the vaccine. **REF: J Am Coll Cardiol. 2004;43:1503–1510. Cassimatis DC, et al. Smallpox vaccination and myopericarditis: a clinical review.**

A Finnish study in 1989 identified electrocardiogram (ECG) changes suggestive of myocarditis in 3 percent of military recruits after being vaccinated against mumps, polio, tetanus, smallpox, diphtheria, and type A meningococcus. The mycarditis was documented in persons who had no previous evidence of cardiac disease. **REF: Ann Clin Res. 1978;10:280–287. "Myocardial complications of immunizations."**

There are three types of exemptions from vaccinations: medical, administrative and religious. Medical exemptions can only be granted by a physician or other military health care professional. Administrative and religious exemptions are non–medical functions and approval is controlled by the individual's unit commander.

Medical exemptions can be granted under the following circumstances:

1. The vaccine candidate is currently taking an

immunosuppressive medication, is undergoing radiation therapy, has had a severe adverse response to a previous vaccine, has an acute illness, has recently had surgery or is pregnant.

2. The vaccine candidate has evidence of immunity based on serologic tests (vaccine titer) or documentation that proves the candidate had the infection (vaccination record or medical record documenting a physician-diagnosed disease.)

3. The vaccine candidate has a complex medical condition. In such cases, consulting the appropriate military medical specialist is required.

Individuals with previously documented adverse reaction to a vaccine component, such as egg, gelatin, preservatives or latex, are deferred from vaccination. The member will be referred to an appropriate medical specialist for evaluation unless health records are available that document a previous adverse reaction or allergy to the component. The military allows serologic (titer) tests to identify preexisting immunity from prior infection or previous vaccination to eliminate the need for unnecessary immunization. (See Addendum P for vaccine titer table.) **REF: Army Regulations 40-562. 9 Sept 2006. Vaccine and Chemoprophylaxis. Chapter 2: Program Elements and Clinical Considerations. 2-1: Standards, (4) f, pg. 2-3.**

The service member's primary care provider or a physician specialist may grant a temporary medical exemption. Temporary exemptions can be revoked by the unit commander if he feels the exemption is no longer warranted. Permanent medical exemptions can be issued only by military physicians. For the Air Force, permanent exemptions can be issued only by the Air Force Surgeon General.

Administrative Exemptions:
A member in the Army, Navy or Air Force may refuse vaccines if he or she has been approved for retirement or has received a separation order within 180 days of being required to receive the vaccinations. A service member may be exempt from pre-deployment vaccines if he is not currently assigned or scheduled to perform duties in a geographic area where a vaccination is indicated, or if the commander has not directly ordered vaccinations because of overriding mission requirements. Administrative exemptions also apply to civilian employees and contractors who will leave a position within 30 days or less of the vaccination requirement. Active duty personnel continuing in the Reserve Component (RC) are not exempted on this basis. **REF: Army Regulations 40-562. 9 Sept 2006. Vaccine and Chemoprophylaxis. Section 2-6. Exemptions. b. Administrative exemptions.**

Military Religious Exemptions:
Vaccination exemptions for religious reasons may be granted according to service–specific policies to accommodate religious beliefs. This is a command decision made with advice from medical personnel and the unit chaplain. Requests for a religious exemption must include occupational specialty code or branch, and a description of the religious tenet or belief contrary to vaccination. A military physician and commander are required to counsel the individual with information about the vaccine and the vaccine-preventable disease. The commander must counsel that noncompliance with immunization requirements may adversely impact deployability and other elements of the members' career.

The military applicant must express a medical or religious objection to vaccination at the time of enlisting. Appropriate paperwork to document the waiver must be provided. If the waiver is refused by the recruiter, do not sign the paper work and take the matter up with the recruiter's supervisor. Do not allow the recruiter to convince you that there are no vaccination waivers for military personnel. However,

permanent exemptions for religious reasons are not granted for the Air Force.

Air Force:
Medical: Active duty members who can demonstrate direct proof of immunity through serology (titer testing), an age-appropriate vaccination record or a provider-documented history of the illness will not be required to be vaccinated against measles, mumps, rubella or chickenpox. Herpes zoster (shingles), diagnosed by a physician, will also preclude the necessity for a chickenpox vaccination. **REF: US Department of Air Force Memorandum. June 7, 2006. http://www.vaccines.mil/documents/951AFSGOJune2006.pdf**

Authority to grant temporary medical waivers can only be exercised by the major command (MAJCOM) surgeon generals, and a permanent waiver may only be granted by the Air Force surgeon general. Air Force members with permanent medical exemptions require a medical evaluation board and/or a flying waiver in accordance with medical evaluations stated in AFI 48–123 before permission to fly will be granted.

Anthrax and smallpox vaccinations are required for some, but not all, deployments. If an individual must be deployed to a location requiring either or both of these vaccines and is unable to take them, a waiver for deployment without these immunizations can be obtained from the theater commander if the individual agrees to accept the increased potential risk of the illness. **REF: Air Force Instruction 48-123 Volume 2. Medical Examinations and Standards. June 5, 2006. Section A2.21.14. http://www.e-publishing.af.mil/shared/media/epubs/AFI48-123v2.pdf**

Only units specifically identified by the MAJCOM require initial and subsequent vaccination against Japanese encephalitis, meningococcal disease, typhoid fever and yellow fever. **REF: Army Regulations 40-562. 9 Sept 2006. Vaccine and Chemoprophylaxis. Several sections in document.**

Religious exemption: Legitimate religious objections to vaccination will be accommodated when possible, but will be revoked if necessary to "ensure the accomplishment of the military mission." Permanent religious exemptions are not granted for personnel in the Air Force. **REF: Army Regulations. 40-562. 9 Sept 2006. Vaccine and Chemoprophylaxis. Section 2-6. Exemptions. Religious. Section (3)(a)1.**

Army:

The U.S. Department of Defense provides for a religious-based waiver for vaccination of army military personnel and civilian personnel employed by the military or training under military sponsorship. A religious exemption is granted "only in the case of legitimate religious objections" and may be revoked if necessary to ensure the accomplishments of the military mission. An application for such a waiver must include, among other things, the name of the "recognized religious group and the date of the applicant's affiliation," and a supporting certification signed by an authorized personal religious counselor. **REF: From the Army Publishing Directorate, Multi-Service Administrative Publications, http://www.apd.army.mil/multiservice.asp, Army Regulations 40-562, AFJI 48-110, BUMEDISNT 6230.15, or CG CMDTINST M6230.4E, Paragraph 13. Waivers.**

Coast Guard:

The Coast Guard is administered by the U.S. Department of Transportation. The Coast Guard allows exemptions to accommodate religious beliefs, but will not allow an exemption about how the vaccine was made. The Coast Guard's medical manual states, "All active duty and reserve unit commanding officers are responsible for immunizing all individuals under their purview and maintaining appropriate records of these immunizations. If local conditions warrant and pertinent justification supports, the Maintenance and Logistic Commands, designated MLC (k), may grant authority to deviate from specified immunization procedures on request." **REF: U.S. Coast Guard Medical Manual. Chapter 7, "Preventive Medicine." Section B: Immunizations. http://www.uscg.mil/hq/g-w/g-wk/wkh/pubs/index.htm**

Other than previously stated, no specifically written exemptions are listed for the Navy or the Marines in the most recent regulations published by the Department of Defense.

Question: Is there an exemption for the anthrax vaccine?

Answer: The anthrax vaccine, which was licensed by the FDA in 1970, is manufactured under contract by the Michigan Biologic Products Institute. The vaccine schedule consists of three subcutaneous injections, given two weeks apart, followed by three more injections given 6, 12 and 18 months later. Booster injections are given at one-year intervals following the initial series.

In 2003, Congress upheld the refusal of some military personnel regarding the anthrax vaccine. In October 2004, Judge Emmet Sullivan issued an injunction against the use of the anthrax vaccine on military personnel because there was no true informed consent, the vaccine had been declared "safe and effective" without proper studies, and expiration dates of the doses currently in stock had been illegally altered without the approval of the FDA.

Unfortunately, on Oct. 16, 2006, the anthrax vaccine was once again declared mandatory for military personnel; exemption arguments may not be possible at this time. On February 8, 2007, the Assistant Secretary of Defense for Health Affairs approved the Army Anthrax Vaccine Immunization Plan (AVIP), directing mandatory anthrax vaccinations for designated military and civilian personnel serving in the Central Command and Korean Peninsula area for 15 or more consecutive days. Anthrax and smallpox vaccinations are required for some, but not all deployments. If an individual must deploy to a location requiring either or both of these vaccinations and is unable to take them, a waiver for deployment without these shots can be obtained from the theater commander. **REF: Department of Defense Memorandum. Implementation of the Anthrax Vaccine Immunization Program (AVIP). Dec. 6, 2006.**

Coast Guard:
Temporary or permanent medical exemptions for the anthrax vaccine may be authorized for individuals who have a compromised immune system, have a history of severe local and systemic adverse reactions to the vaccine, or are pregnant. Health care providers within the service branch will determine if an individual with a medical condition can continue with the anthrax vaccine or be exempt for a specified duration. A medical officer may authorize temporary medical exemptions. Permanent medical exemptions may be authorized only by the Commandant (G-WK). Commanders may exempt personnel who are retiring or separating from the Coast Guard no more than 180 days prior to the issue of a vaccine requirement. If a Coast Guard member refuses vaccination, he or she remains deployable. However, the member may be subject to administrative or disciplinary action, or both, at the discretion of the commander, for disobeying a lawful order.
REF: U.S. Department of Transportation. United States Coast Guard. Coast Guard Anthrax Vaccine Immunization Program (CG-AVIP).

Question: What is the military punishment for refusing the anthrax vaccine?

Answer: Anthrax vaccine waivers have been established for certain medical conditions, such as hypersensitivity to vaccines and pregnancy, on a case-by-case determined by the commander.

Refusing this vaccine is difficult. If the member does not have a valid basis for requesting a waiver, the member's commander may give the member a direct order to submit to the vaccination. If the member refuses, the commander has a full range of options, from taking no action to administrative action (letters of counseling, letters of reprimand, referral OPR/EPR, etc.) to punitive action under the Uniform Code of Military Justice. Punishments, ranging from nothing to court-martial, have included fines, docked pay, reduction in rank, and a less-than-honorable discharge. Some who have refused were

charged with a felony and forced to serve jail time. Some were allowed to leave the military; some were allowed to continue to serve. For reservists, reprimands may be taken only if the refusal to submit to the vaccination occurs while the member is in active duty training status.

For those wanting to refuse the anthrax vaccine, suggestions include using all available resources throughout the appropriate military chain of command. Contact your state's members of Congress, the Senate and your state's Attorney General to request an exemption attempt using these routes to dissuade an attempt by your commanders to pursue a court martial.

Question: Are there vaccination exemptions for military assessions?

Answer: Service assessions are defined as persons who are training prior to entering full-time military service. This includes Reserve Officers' Training Corps (ROTC); Officers Candidate School (Marines); military academy preparatory schools; the five service academies (Air Force, Coast Guard, Merchant Marine, Military Academy and the Naval Academy); Naval Officer Indoctrination School; and officers who have been directly commissioned. A medical childhood vaccination record or a vaccine titer are accepted as proof of vaccination. When called to active duty, the recruit must provide documentation of vaccination or immunity through blood tests or all vaccines will most likely be repeated. Members in the Reserves are required to be vaccinated with the same vaccines as active duty personnel and similar exemptions apply. (See Addendum P for titer table.) **REF: Army Regulations 40-562. 9 Sept 2006. Vaccine and Chemoprophylaxis. Military personnel. Section 3-1. pg. 10-11.**

Question: Are there vaccination exemptions for civilian employees, military contract workers and their family members?

Answer: Civilian employees and contracted workers are deployed to support the Armed Forces. Persons may be required to take vaccinations as a condition of employment. Failure to voluntarily receive the immunizations may result in counseling or loss of employment opportunity, but in no case will vaccinations be involuntarily administered. **REF: Army Regulations 40-562. 9 Sept 2006. Vaccine and Chemoprophylaxis. Chapter 4, pg.12.**

While no exemption policies are specifically written for civilian employees and contract workers or for their family members, persons refusing vaccinations are required to have a review with an appropriate military authority for counseling. The counseling is to be documented in the person's health record with a note that states "refusal of country-specific vaccinations may subject the worker to adverse action according to host country policies, which could include compulsory immunization, detention, quarantine, or denial of entry." Since there are few country-specific requirements—only recommendations—it is unclear how strictly this warning would apply.

Civilian health care employees and volunteers are exempt from vaccinations if they have a positive vaccine titer (see Addendum P for titer table) or have received a medical exemption. This policy applies to all health care settings, regardless of age or sex of the health care employee. Administrative exemptions may apply to civilian employees and contractor personnel who will be in a position for 30 days or less. **REF: Army Regulations 40-562. 9 Sept 2006. Vaccine and Chemoprophylaxis. Civilian employees and contracted workers. Section 3-2, (2) and (3). pg. 10.**

Question: Are there vaccination exemptions for military

school teachers and daycare workers?

Answer: Vaccines are required for all groups. An exemption can be granted with a completed vaccination record, a medical record documenting a physician-diagnosed illness or positive vaccination titer. The person can also be medically or administratively exempted. Administrative exemptions may apply to personnel who will leave or be in a position for 30 days or less. For rubella, immunity is based only on documentation of vaccination or positive serology (titer). (see Addendum P for titer table.) **REF: Army Regulations 40-562. 9 Sept 2006. Vaccine and Chemoprophylaxis. Civilian employees and contracted workers. Section 3-2, (4). pg. 10.**

Question: Are there vaccination exemptions for military children and other family members of military personnel?

Answer: Age-appropriate, recommended vaccines are required for children whose parents are in the military. Exemptions are allowed with documentation of previous vaccination, for medical contraindications or for religious reasons. A positive titer test may be acceptable as proof of immunity. **REF: Army Regulations 40-562. 9 Sept 2006. Vaccine and Chemoprophylaxis. Civilian employees and contracted workers. Section 3-2,b (4). pg. 10.**

Family members may be subject to country-specific vaccinations. While no specifically written exemptions policies are written, neither are the regulations written that vaccination is required. The family member is to be counseled and the session documented with a note that states "refusal of country-specific vaccinations may subject the worker to adverse action according to host country policies, which could include compulsory immunization, detention, quarantine, or denial of entry." Since there are few country-specific requirements—only recommendations—it is unclear how strictly this warning would apply. **REF: Army Regulations 40-562. 9 Sept 2006. Vaccine and Chemoprophylaxis. Other populations. Section 3-3, a, pg. 11.**

Chapter 6

FREQUENTLY ASKED QUESTIONS ABOUT VACCINATIONS

QUESTION: My daughter is now 4 months old and we haven't had her vaccinated. At her 2-month appointment, the physician told us that she is going to keep pushing us to vaccinate until we follow through. Her appointment is this week and I'm afraid that we are going to get reprimanded again by our pediatrician. What should we do?

ANSWER: Remember the doctor is not your parent, so reprimands should not be tolerated. Your doctor is a paid consultant...and if your doctor doesn't treat you with respect, I suggest you find someone who will. The purpose of the check-up visit is for education and information. You want to be assured that your child does not have a birth defect (congenital problem) and is making milestones on the growth chart. Tolerating verbal battery should not be part of the contract between you and your doctor.

There is a public speaking trick that helps with nervousness: Pretend your audience is either all naked or wearing purple polka dotted underwear. (i.e. they look silly.) The same technique can be used when meeting with your doctor. Your physician holds no power over you; you just think he does. If you are being put on the spot and you don't want to vaccinate or you are not ready to make that decision, just say no. Don't allow your doctor to be a bully; would you put up with that from a colleague or coworker? Don't tolerate it from your health care provider.

QUESTION: I would not be so opposed to vaccinating my 2-year-old against the measles if the vaccine could be administered alone. I don't want the MMR because of all the controversy surrounding it. If my child gets the measles, what are the dangers and what can I expect?

ANSWER: Merck & Co., the manufacturer of the MMR, is no longer producing separate measles, mumps and rubella vaccines. That means when it comes to being vaccinated with the MMR, it is "all or nothing."

There is no doubt that measles can be a serious infection in some children. However, in the vast majority, measles presents as an acute febrile illness lasting for 7 to ten days. Nearly all healthy children fully recover—and have lifetime immunity—after a bout with the measles.

Even if your child is vaccinated, he can contract measles. Here are key points about the infection:

1. Measles, also called rubeola, is primarily a respiratory infection. The first symptoms are irritability, runny nose, eyes that are red and sensitive to light, hacking cough, and a fever that can be as high as 105°F (40.6°C).
2. After three or four days of fever, a rash appears which typically begins on the forehead, and spreads downward over the face, neck and body. The rash looks like, flat red to brown blotches and often cover the entire body, especially on the face and shoulders. The child can appear particularly ill during the first days of the rash. Don't panic!
3. The rash fades in the same order that it appeared, forehead first and feet last. The total time for the rash, from beginning to end, head to toe, is usually six days. As the rash disappears, the skin may temporarily look brown and usually peels from the palms and the soles. This is normal. When the rash is gone, most children will have lifetime immunity to the infection.
4. Support your child with ample fluids, Vitamin A, Vitamin C and cooling baths for the fever. Don't worry if your child doesn't have an appetite; it is more

important to consume adequate fluids than to eat. Keep track of the amount of fluids that are consumed. Every sip counts and a teaspoon of ice chips every hour is usually enough to keep a child hydrated. As long as your child is urinating every few hours and has a moist tongue, he is adequately hydrated. Consider seeking the assistance of a knowledgeable homeopathic practitioner to support your child's immune system. One of the best natural supports for viral infections, particularly measles, is vitamin A drops. Recommended dosages are available through homeopathic section on **www.SayingNoToVaccines.com** and in Addendum T.

If you choose to vaccinate, here are some recommendations:

1. Wait until your child is at least 2 years old. The only reason that the vaccine is given around one year of age is that is the time of a scheduled annual checkup.
2. Give only the MMR. Do not allow any other vaccines to be given at the same time.
3. Be sure that your child has not taken an antibiotic or a steroid medication within three to four weeks of getting the vaccine. If your child has had one of these medications, give him a probiotic daily in organic yogurt for a month before proceeding with vaccination. (Probiotics called acidophillus are the "good bacteria" in the intestines that need to be replenished after an antibiotic or steroid medication.)
4. Do not allow the MMR to be given to your child if he has received another viral vaccine (polio, chickenpox, influenza, rotavirus) within the preceeding six weeks.
5. Since the 1920s, children in Third World countries who received vitamin A drops when they contracted

measles had greatly improved survival rates. Globally, it is estimated that as many as 250 million children under five years of age are affected by vitamin A deficiency. These children suffer a dramatically increased risk of death, blindness and illness from measles. In 1987, the WHO began advocating the combined administration of vitamin A with the measles vaccine. **REF: WHO. "Vitamin A Supplementation." http://www.who.int/ vaccines/en/ vitamina.shtml**

6. When a single large dose of vitamin A (100,000 IU) is given at the same time the vaccine is administered, fewer complications occurred. There is no risk of side effects from the vitamin A (even at this dose) when given only once. Therefore, be sure to give your child vitamin A drops on the day he receives the MMR vaccine. (See Addendum T and the homeopathic section **www.SayingNoToVaccines.com** for information about vitamin A.)

7. Powdered vitamin C can be given before any vaccine. Vitamin C is a powerful antioxidant and can help to decrease the adverse effects of the vaccine. (See Addendum T and the homeopathic section **www.SayingNoToVaccines.com** for information on vitamin C.)

Vaccinated children can still get measles. Ask your parents or grandparents about their experience with the illness. Most adults over 40 years had measles during their childhood. Most will tell you that measles is nothing to be feared.

Even though some children still contract measles, few die. In fact, the death rate from measles in 1955 was less than 3 per 10 million; that was eight years before the measles vaccination campaign began in 1963.

REF: MMWR. Achievements in Public Health, 1900-1999. Impact of Vaccines Universally Recommended for Children in the United States, 1990-1998. April 02, 1999 / 48(12); 243-248.

QUESTION: We have chosen not to vaccinate our 1-year-old son. He plays with children who have been vaccinated. Is there any chance he can get sick from playing with a recently vaccinated child?

Answer: Varivax (chickenpox), Zostrix (adult shingles vaccine), FluMist (the nasal influenza vaccine), the oral polio vaccine (no longer used in the U.S.) and the MMR vaccine contain live, attenuated virues. Children who have been vaccinated with these products can shed viruses for up to 21 days after the vaccine has been administered. There is a small chance your child can contract a mild form of the illness from a recently vaccinated playmate although the risk is mostly theoretical, except for Varivax and Zostrix. Many persons have contracted chickenpox after being exposed to someone recently vaccinated by these two vaccines.

To reduce susceptibility, make sure your child washes his hands in warm soapy water frequently and try to keep him from sharing toys with a recently vaccinated child. Another way to support his immune system and develop a resistance is through the use of homeopathy, vitamin C powder and vitamin A drops.

QUESTION: Our 8-year-old has the opportunity to go to Ecuador with his grandparents. He is a healthy child and has not been vaccinated. Should we be concerned about measles?

Answer: There are no required travel vaccines for Ecuador or, for that matter, most countries in the world. Most vaccines are only recommended. Here's an important statistic: In 1955, the death rate

from measles was less than 3 in 10,000,000. Mass vaccination with the MMR did not begin until 1963. In other words, the death rate from measles was negligible even before wide use of the vaccine. **REF: MMWR. Achievements in Public Health, 1900-1999 Impact of Vaccines Universally Recommended for Children -- United States, 1990-1998. April 02, 1999 / 48(12);243-248.**

While on the trip, make sure that he avoids the immune suppressing effects of white sugar, drinks only sealed bottled water and frequently washes his hands. In addition, give him extra vitamin A, vitamin C and Epicor during your trip. (See **www.SayingNoToVaccines.com** for information on these products and homeopathic sprays, Travel-DFC and Liver-DFC. These two products improve resistance against hepatitis a, hepatitis b and a variety of other pathogens that may be encountered while traveling abroad.)

QUESTION: My 15-month-old daughter has had her two- and four-month shots. Her doctor is saying she is not protected if she doesn't receive the third shot in the series. Is there a way to know if she needs the third dose?

ANSWER: The theory behind the three-dose schedule is that the first shot exposes the immune system to the antigen in the vaccine; the second locks in the initial response. The third is to boost the level of those who did not attain a high antibody level after the second shot. Up to 60 percent of children acquire an antibody after the first shot. For most children, the third shot is not necessary to develop what is referred to as "protective antibodies." To determine the needs for the third shot, obtain a blood test (titer) to assess the level of antibodies she has developed. This can be done from your computer and without a doctor's order. Go to **www.SayingNoToVaccines.com**, click on "order antibody titers" and follow the simple instructions. A table of normal values considered protective can be found in Addendum P.

QUESTION: I am a new mother of a four-month-old daughter. She was born premature and spent almost six weeks in the intensive care unit. She weighed less than three pounds at birth and now weighs a hefty 10 pounds which I contribute to breastfeeding. I was just beginning to research vaccinations when I went into labor, and I am trying to decide the best course of action since she is a preemie.

I first became concerned when we were in the hospital and I was being pressured to give her the hepatitis B vaccine. This was my first red flag. I am a dental hygienist and I could not understand why this vaccination was being recommended for my small infant who was in the sterile environment of the neonatal unit. I was still concerned about this vaccine at her two month visit. This has made me question all the vaccination recommendations. Of course my baby's pediatrician assured me that vaccinations are safe... but I find myself feeling uneasy about injecting my small, healthy baby with vaccines to protect her against a diseases rarely seen. Call it motherly instinct, but I don't feel the CDC is looking out for my child, and I'm worried that my pediatrician will want to give her even more vaccinations because of her early arrival. What should I do?

ANSWER: Decisions about vaccines are important and parents have been led to believe that injections are the only way to keep a child from getting sick. Have a discussion with any parent who has not vaccinated: Their kids are healthy and well without vaccines. Vaccines are given at two, four and six-months because those are scheduled appointments for "well baby checks." Vaccines are given at that time because it is convenient. Take your time deciding. If you decide to vaccinate, you can wait until two years of age (or older) for even the first shots.

Question: My four-month-old daughter contracted whooping cough from our guests during Christmas. I am taking her to the doctor

tommorow morning. Should vaccinate her with the DTaP vaccine? What else can I do?

ANSWER: Whooping cough can be serious in children under three months of age, but it can also be no more significant than a bad cold. Since she already has the infection, the vaccine will not provide any benefit and could make her very sick. Please do not be bullied into vaccinating her; do not be belittled into submission.

Your doctor will probably give her an antibiotic. Go to the health food store (or online) and purchase a probiotic. Open one capsule and put it in her formula daily. If you are breast feeding, make a little paste of the powder and put it on your nipple. That will protect her from the side effects of the antibiotic and help her immune system fight off the pertussis infection. To help your baby remove the secretions, sit with her in a steamy shower. This moistens the mucus and helps it to be expelled. She will most likely recover uneventfully, but keep her doctor informed of her condition.

QUESTION: I am 36 weeks pregnant and trying to find a doctor for my baby once she gets here. My husband and I have chosen not to vaccinate our daughter. We are having a very difficult time finding a doctor who will accept our baby as a patient because of our decision. I know I'm making the right choice by not vaccinating her...now I just need some support from a doctor.

ANSWER: It can be difficult to find a pediatrician who is not insistent about vaccines. Giving physicians the benefit of the doubt, most are doing what they believe is in the best interest of their little patients. But they are often embarrassingly uninformed on the topic of vaccines beyond what they were taught in medical school. Trying to share information about what you have learned is a difficult task you may not want to undertake.

Instead, let your fingers do the walking. Go through your insurance book and first call the pediatricians covered by your plan. You may want to ask the receptionist:

> "Hello...I'm looking for a new pediatrician. Is your practice currently accepting new patients? Can you tell me if your doctor is willing to work with me and respect my wishes to not vaccinate (or selectively vaccinate) my child?"

The receptionist will know the answer to that question. If the doctor is not willing to work with you, politely thank the receptionist and move on to the next call. If you have exhausted all of the pediatricians, try the family practitioners next. You may want to focus on the osteopathic family practitioners first as they sometimes have a more holistic approach to health. In addition, a family physician can take care of your entire family, not just your child.

There are other ways to obtain health care for your child. In my opinion, the skills of a pediatrician are necessary if your child has specialized health needs arising from serious health conditions, such as a congenital birth defect, a complex seizure disorder, insulin-dependent diabetes or a cardiac condition requiring specialized medications. Well-baby checks can certainly be handled by a family doctor or other trained health professional. Ask other mothers who do not vaccinate who they use for their family's healthcare. You may want to consider the care of a holistic nurse practitioner, a naturopathic physician, a doctor of Oriental medicine, or pediatric chiropractor. Many parents find that their unvaccinated children are very healthy and require very little medical attention.

For additional support, connect with the local and National Holistic Mom's Network (www.holisticmoms.org.) You will find many like-

minded parents across the country who have made the same decision about vaccination that you have.

QUESTION: My child has had a few vaccines and I don't want him to have any more. At this point, can I still claim the right to refuse?

ANSWER: At any time, you can become informed about the possible risks associated with vaccines, change your mind about vaccination and exercise your right to refuse. Your decision can come because you recently learned about exemptions, your child has had a serious reaction or you did your homework and don't want any more shots.

However, once you have declared that you are opposed to vaccines and vaccination, from that point forward, you must refuse all further vaccines for your child, including the annual flu shot, or your right to refuse vaccines required for school may be revoked.

QUESTION: Are there times when children should receive vaccines?

ANSWER: It is my opinion that no time is right or safe for any of the vaccines that the medical establishment promotes. I would caution that the CDC guidelines for timing of vaccinations are based on convenience, not on the well-being of the child. The CDC and the American Academy of Pediatrics give very broad support to vaccination of all children, regardless of their underlying health condition. Parents of children with cancer, organ transplants and other serious illnesses are often encouraged the most to vaccinate. However, vaccines may not prevent the infection and vaccine-induced antibodies are temporary. Vaccinating a child that already has a compromised health profile could be even more detrimental to his health.

According to the CDC's new guidelines for vaccination, released in December, 2006, "All vaccines can be administered to all persons with

minor acute illness. Inappropriate reasons to withhold a vaccine are diarrhea, minor upper-respiratory tract illnesses with or without fever (including otitis media), mild-to-moderate local reactions to a previous dose of vaccine, current antimicrobial therapy, and recovering from an acute illness." In other words, there is no medical reason to withhold a vaccine in the eyes of the pro-vaccinators. This defies common sense. **REF: MMWR. General Recommendation of Vaccination. December 1, 2006 / Vol. 55 / No. RR-15.**

Most doctors and nurses, particularly those who work in public health, view vaccines as completely safe, effective and necessary. They believe that minimal, if any, harm comes from vaccination and that the good from vaccination far outweigh the risks. The unwavering position is that the "sacrifice of a few" through a rare vaccine injury—an injury which could include death—is acceptable for the "good of the whole."

QUESTION: My doctor says thimerosal (mercury) is out of the vaccines. Does that make them safe?

ANSWER: Mercury is only one ingredient in vaccines. Mercury is not, and never has been, the only concern. While removing large quantities of a neurotoxic substance from a vaccine certainly lowers the risk of a serious reaction, thimerosal- free vaccines still contain dozens of chemicals. (See Addendum H for a complete list.)

QUESTION: How do I explain to my neighbors and other family members that I have chosen not to vaccinate?

ANSWER: The decision to not vaccinate—and all other health care decisions regarding your children—is a private matter between you, your spouse and your child. A good, standard answer is to say, "Yes, he has had all the vaccines that he needs." The answer is simple and truthful. The answer should satisfy most inquiries.

QUESTION: What if my child has an injury or illness that requires a visit to the emergency room?

Answer: An emergency department is a very busy place. One of the questions asked by the triage (intake) nurse includes, "Is your child up to date on his vaccines?" It is best not to engage in a debate about your position on vaccines. Depending on the belief system of the nurse, you could be challenged and possibly be reported to Children's Services for neglecting the care of your child.

If your child is being seen for an illness or injury that does not require a tetanus shot or TIG injection, the best answer is, "Yes...he is up to date with all the vaccines he needs." It would be extremely rare for the nurse, or doctor, to question your answer and request additional information. However, if a copy of your child's vaccination record is requested, mention that you have, unfortunately, left it at home. If your child has received a serious puncture, crush injury or other type of wound, a determination needs to be made on a case-by-case basis about a tetanus shot, booster or TIG injection. That determination is beyond the scope of this text.

QUESTION: Does a person really need a tetanus booster with every cut?

ANSWER: As an adult, you can refuse any procedure, including being injected with a medication (a vaccine). As a general rule, the recommended shot can be given within three days of an injury if it is deemed necessary. If you have received a tetanus booster within the last 10 years, you do not need an additional injection. Tell the emergency room personnel that you will check your records or check with your family doctor, stating that you are uncertain when you received your last booster. Medical evidence indicates that routine boosters every 10 years are not cost-effective and have marginal value. When given without

knowing of the person's tetanus titer level, routine vaccinations can markedly increase the risks of side effects. **REF: J Gen Intern Med. 1993;8:405-412. "Should adult tetanus immunization be given as a single vaccination at age 65? A cost-effectiveness analysis."**

In 1969, a New England Journal of Medicine article advised against routine tetanus boosters, stating, "...tetanus boosters on admission to camps, schools, colleges and at times of injury should be abandoned, to minimize toxoid reactions." **REF: NEJM. 1969; 280/11:575-81. "Tetanus-toxoid emergency boosters. A reappraisal."**

Brachial-plexus neuropathy, an acute syndrome of the shoulder girdle marked by pain, weakness and mild sensory loss, has been shown to occur almost exclusively in adults who have received multiple injections of tetanus toxoid. **REF: NEJM. 1995; 333/9:599. "Protection against tetanus."**

There are many reports in the medical literature of severe side effects after routine tetanus shots including allergic reactions, pericarditis, serum sickness, painful neuropathies and even severe, transient Parkinsonism. Other side effects, listed on the package insert, include headache; nausea; vomiting; arthralgias; tachycardia (racing heart); syncope (fainting); cranial nerve paralysis; and a variety of neurological complications including EEG disturbances, seizures and encephalopathy; anaphylaxis; and Gullian-Barré syndrome. **REF: J Neurol Neurosurg Psychiatry. 1997;63:258-259."Severe but transient Parkinsonism after tetanus vaccination."**

Reports of suppression of the immune system, with T-cell counts as low as those seen in patients who have HIV, have occurred after tetanus boosters. The same types of reactions can occur by over-vaccinating your child. **REF: NEJM. 1984; 310/3:198-9. "Abnormal T-Lymphocyte sub-populations in healthy subjects after tetanus booster immunization."**

If the injury is minor, good wound hygiene (through cleaning) is the best prevention of tetanus or other type of infection. At home, wash the wound for several minutes with warm, soapy water. Let the cut bleed for several minutes. This washes dirt particles out of the area and allows infection-fighting white blood cells to flood the tissue. Use hydrogen peroxide to irrigate the area; the extra oxygen in the peroxide can kill anarobic tetanus spores. Use an antibiotic ointment and change the dressing daily. With these precautions, the risk of infection, including tetanus, will be extremely low.

QUESTION: I stepped on a dirty piece of metal and I could be pregnant. Should I get a tetanus shot?

ANSWER: Standard care would advocate a tetanus booster. The medical literature states that boosters are safe. However, there are things you should know while when making this decision:

1. If you have had a tetanus shot within the last 10 years, a booster is not necessary. Some studies have shown that tetanus antibodies exceeded the protective level for up to 20 to 25 years.
2. Many articles in the medical literature document that tetanus antibodies cross the placenta and are found in the baby when the baby is born.
3. A few articles suggest that tetanus antibodies are passed through breast-feeding. Here's one: **"Serum and breast milk antibodies to food antigens in African mothers and relation to their diet." Adv-Exp-Med-Biol. 1991; 310201-6.**
4. It is important to understand that there is not an absolutely protective level of antibody. The level of neutralizing antibody currently considered protective (0.01 antitoxin unit/ml), is based on animal studies that correlated levels with symptoms from tetanus vs.

death from tetanus. The level suggested to be "protective" was proposed by researcher P.H.A. Sneath in 1937. This level has been accepted by most investigators without further proof that the level is actually beneficial. **REF: JAMA. 1988; (25)519:1171-3. "Clinical tetanus despite a protective level of toxin-neutralizing antibody."**

Here are some things to know about dirty wounds:

1. Profuse wound cleaning is the most important tool. Every wound should be allowed to bleed freely, since this helps to eliminate bacteria and supplies oxygen.
2. Apply copious amounts of hydrogen peroxide to the wound. It is cheap, easy, very efficacious. Peroxide is a product that should be in every household. To remain potent, the bottle should be replaced every six months.
3. Homeopathic remedies Ledum and Hypericum, administered when a wound looks suspicious, have had a track record for the prevention of tetanus for more than a century. Keep these in your medicine cabinet.

QUESTION: Can I use homeopathy instead of vaccines for keeping healthy?

ANSWER: The science of "homeoprophylaxis," i.e., using homeopathic medications to prevent illness instead of only treating illness, has been known for more than 150 years. However, homeopathy is not accepted by the state health departments or by conventional medicine as a "real vaccination" process. If you choose to work with a homeopathic physician for prevention, it is wise to comply with your state exemption laws and use the homeopathy for your own private use.

QUESTION: How does homeopathy work? Is there such a thing as "homeopathic vaccination"?

ANSWER: Vaccines stimulate the production of antibodies through the TH2 pathway in the immune system. Homeopathy is thought to strengthen resistance by enhancing the TH1 pathways of the immune system. Because of the differing mechanisms of action, homeopathic vaccination is not a term that should be used. Some very effective homeopathic sprays that work on the principle of supporting the immune system are available through **www.SayingNoTo Vaccines.com.**

Chapter 7

Selected Articles by Dr Tenpenny

The Importance of Fever

Childhood fevers can be frightening, mostly because they are misunderstood.

A fever is an increase in body temperature above the "normal range." But the definition of "normal" can vary from person to person. Body temperature also varies with different levels of activity and at different times of the day. Medical texts differ in their definition of the highest "normal" body temperature, which can range from 98.2 to 100.4°F. It is generally accepted that a fever is defined as an "early morning temperature greater than 99°F or a temperature greater than 100°F at any time of the day." **REF: Harvard Medical School's Intelihealth. http://www.intelihealth.com**

There are several causes of fever, but it is most commonly associated with dozens of different viruses, bacteria and parasites that cause upper respiratory infections, pneumonia, diarrhea, and urinary tract infections.

When infectious organisms invade the body, it is fever that gets our attention. Yet, despite its universal recognition, little is known about how fever occurs. The currently held view is that when a microbe enters the body, the body activates its innate immune responses, which include the release of complex mediators with equally complex names: cytokines, tumor necrosis factor alpha (TNFα), interleukin (IL-1) and interleukin 6(IL-6). These substances signal the part of the brain called the hypothalamus to raise the body's thermostat, which in turn leads to chills and shivering to increase the metabolic rate. Heat loss is minimized by restricting blood flow to the skin, giving it a pale appearance. Fever sufferers generally lose their appetite and feel lethargic and achy requiring the body to rest and take care of business: eliminate the invader.

Contrary to signaling the need to give an aspirin, an elevated temperature is expressing that the immune system is working at its best. The number of white blood cells is increased and a cascade of mediators flood the blood stream, in rapid pursuit of the host's invaders. Fever impairs the ability of bacteria and viruses to replicate, creating an inhospitable environment for the invading organisms. The heat makes it impossible for invading microbes to replicate and, by definition, die off. Fever helps win the war against wayward microbes.

Fever phobia

Fever is certainly one of the most common reasons that parents seek medical attention for their children. In 1980, a paper published by Barton Schmitt, MD contained the results of a survey in which 81 parents were asked their understanding of fever. All parents were inappropriately worried about low-grade fever, temperatures of 102°F (38.9°C) or less. Most parents (52 percent) believed that a temperature of 104°F (40°C) *or less* could cause serious neurological side-effects. As a result, almost all parents in the study treated fever aggressively: 85 percent gave anti-fever medications and 68 percent sponged the child with cool water at fever temperatures far below 102°F (39.5°C). Their over-concern was designated by Schmitt as "fever phobia." **REF: Am J Dis Child. 1980 Feb;134(2):176-81. "Fever phobia: misconceptions of parents about fevers."**

In 2001, a follow-up study was conducted to see if the trends in "fever phobia" had changed. The study sought to explore current parental attitudes toward fever and to compare these attitudes with those described by Schmitt in 1980. The results of the study were disturbingly worse than the fever phobia reported by Schmitt 20 years earlier.

Of the 340 caregivers who were interviewed, 56 percent reported that they were "very worried" about the potential harm that fever could cause to their children. Compared with 20 years earlier, more

caregivers listed seizure as a potential harm of fever, woke their children and checked temperatures more often during febrile illnesses, and gave anti-fever medications or initiated sponging more frequently to achieve normal temperatures. Forty-four percent considered 102°F (38.9°C) to be a high fever, and 7 percent thought that climbing temperatures could spiral out of control and reach temperatures greater than 110°F (43.4°C) if left untreated. Almost all of the caregivers (91 percent) believed that even a low-grade fever could cause harmful effects. The worst concerns listed were brain damage (21 percent) and death (14 percent).

Strikingly, 25 percent of parents admitted giving anti-fever medications for fevers less than 100°F (37.8°C), and a full 85 percent would awaken their child to give fever medications. The survey revealed that 14 percent chose acetaminophen, and 44 percent opted for ibuprofen; however, both were given at too frequent dosing intervals. When it came to baths to cool children, 73 percent stated that they sponged their child to treat a fever. However, 24 percent sponged at temperatures less than 100°F (37.8°C), and nearly 20 percent used alcohol in a cool bath. Alcohol has been used to assist with cooling as it evaporates from the skin quickly. However, alcohol is also absorbed through the skin, potentially leading to toxicity, especially in very young children. **REF: Pediatrics. Vol. 107 No. 6 June 2001, pp. 1241-1246. "Fever Phobia Revisited: Have Parental Misconceptions About Fever Changed in 20 Years?"**

The study revealed that nearly one quarter of those surveyed alternated the use of acetaminophen and ibuprofen during their child's febrile illness. This is a common practice despite a lack of evidence to support the efficacy and safety of this practice. A study by Clara A. Mayoral et al. in May, 2000 reported that 50 percent of pediatricians surveyed stated that they advised parents to alternate acetaminophen and ibuprofen using various regimens despite there being no evidence to support this protocol. **REF: Pediatrics. Vol. 105 No. 5. May 2000, pp. 1009-1012. "Alternating Antipyretics: Is This an Alternative?"**

Troubling, yet not surprising, was that 46 percent of caregivers who aggressively addressed even minor temperature elevations, listed doctors as their primary resource for information about fever. When obtaining a history about a child's illness, pediatric health care providers are often quick to ask about the importance and value of an elevated temperature. Discharge instructions to parents after a visit with the physician include calling or returning if the child's temperature rises beyond a certain level or if a fever persists more than 2 to 3 days. But placing emphasis on the child's temperature without explaining when a fever should be of concern or without explaining when a fever can be good, heightens parental anxiety and serves to perpetuate fever phobia.

Caregivers need to understand the importance of fever for healing. Unfortunately, fever phobia is fostered by the medical community itself. When doctors tell parents to give medication when a temperature rises above a certain level, say 101°F, many parents automatically assume that a fever is "dangerous" at that level. In reality, the purpose of anti-fever methods is to provide comfort as the body fights off the infection. If doctors were clear about this, there would be a lot less fever phobia.

Confirming the problem of misinformation about fever, May and Baucher published a study in Pediatrics revealing that instructions given to parents about the management of fever are often dismally incomplete and lack consistency. The study, which reviewed information given to parents during sick-child visits, found that 10 percent of providers almost never discussed the definition of a "high fever"; 25 percent almost never discussed the dangers of fever, and sadly, a full 15 percent almost never discussed the reasons for fever, assuming that parents understood the importance of fever. **REF: Pediatrics. Vol 90. Issue 6, pp. 851-854, 12/01/1992. "Fever phobia: the pediatrician's contribution."**

If parents understood how to appropriately support their child during a fever, parents would acquire a comfort level with caring for an ill child. They would rid themselves of unnecessary stress, unnecessary doctor and emergency room visits, and most importantly, their child would benefit from infection-fighting fevers. The concerns about fever are often not justified but are understandable without appropriate information. Health education to counteract fever phobia should be a part of routine medical care for children at the two, four and six month office visits. New parent education should be paramount over vaccinations during these exams.

When is fever harmful?

The body has a way to protect itself from excessively high temperatures. Many parents are unaware of this process and believe that temperatures will continue to rise to lethal levels if left untreated. In the absence of overwhelming factors, such as extreme dehydration or unsafe circumstances, like being locked in a hot closed automobile, a normal child's temperature will not rise out of control. Therefore, it is exceedingly rare for a temperature to exceed 107°F (41.7°C) during an infection. Under normal circumstances, it is best to seek medical care if your child has a fever greater than 101°F *and* is less than six months of age, or if an older child has had a fever of 103.5°F or more for longer than four days.

The fear most parents have about a high fever—defined as a sustained temperature of greater than 104°F for several days—is that it will cause seizures. A febrile seizure manifests as abnormal jerking movements all over the body without evidence of central nervous system infection. Febrile seizures occur most commonly in children between the ages of three months and five years of age and usually last five minutes or less. About 3 percent of all children experience a febrile seizure sometime during childhood. Febrile seizures occur most commonly due to a sudden rise in temperature and not due to a prolonged fever, unless the child is severely dehydrated.

Of those children who have a first-time febrile seizure, about one-third will experience more than one episode. Risks for recurrence are increased when the first seizure occurs at age 16 months or younger, and who have a family history of febrile seizures. If a child has had two febrile seizures, there is a 50 percent chance that additional episodes will occur at some time in the future. Although frightening, febrile seizures are almost always benign.

How to treat a fever: Home management

1. Encourage lots of water. Fever increases fluid loss, and dehydration causes fevers to remain high. Often, children with fevers do not feel thirsty, or by the time they do want something to drink, they're already dehydrated. Keep offering water or an electrolyte-based drink such as Pedialyte or Gatorade. Every teaspoon counts. Small, frequent sips are often best, especially if the child feels nauseated. If necessary, use a medicine dropper that can be readily purchased at the drug store to gently insert water into your child's mouth. The measurements on the dropper help you keep track of the number of cc's per hour your child is consuming.

2. To dress lightly or bundle up? The answer depends on your children's perception of temperature; follow her cues. If your child looks pale, shivers, or complains of feeling chilled, bundle her in layers of breathable fabrics but be sure that the layers can be easily removed. If the fever is low-grade, dress her snuggly and give warm liquids to assist the body's fever production. If she complains of being too hot, use light clothes and sheets for comfort.

3. Starve a fever? Children with fevers generally don't have much appetite, but it is much more important to remain hydrated than to consume foods. Let your child determine when and what she wants to eat. Try light foods such as chicken broth or Cream of Wheat cereal for calories and easy digestion.

4. Avoid white, refined sugar. It has been documented that refined white sugar can suppress the activity of the immune system. A study published in the American Journal of Clinical Nutrition as far back as 1977 reported the adverse effect that sugar has on the immune system. By drawing blood from subjects, the activity of the white blood cells was observed and calculated before and after subjects were given various doses of sugar: 6, 12, 18 and 24 teaspoons. Each subsequently higher dose of sugar created a corresponding decrease in the activity of the subject's white blood cells. The group that had consumed the largest amount of sugar had essentially immobilized white blood cells within an hour after consuming the sugar. The immunosuppression occurred for up to two hours, but the adverse effects of blood cell activity persisted in some instances for up to five hours. **REF: Am J Clin Nut. 1977;30:613 "Depression of lymphocyte transformation following oral glucose ingestion."**

Why is this important? White blood cells eliminate viruses and bacteria that invade our defenses. Without the efforts of these cells, susceptibility to infection is increased and recovery from infection can be stalled. Therefore, do not offer children with fevers corn-syrup drinks such as Coca-Cola, 7-Up, or ginger ale for an upset tummy or ice cream to soothe a sore throat. These hefty doses of sugar can further drag down the immune system at a time when it needs to be at its strongest.

5. To medicate or not to medicate? A rule of thumb when treating a fever "First, do nothing," meaning that observation is a better choice than running for the medicine cabinet. Is your child drinking fluids well? Urinating at least once every four hours or wetting at least eight diapers per day? Does your touch console her? Is she attempting to play? If the answer to these questions is yes, this is probably not a serious illness, despite the number on the thermometer.

Medications such as acetaminophen should be used for comfort. If your

child feels miserable because of a fever, a trial of one or two doses can be given as a "screening test." If you child looks and acts much better within a short time, it is likely that the infection is not serious. He may be more likely to drink fluids, nibble food, and sleep if he is a little more comfortable. This means keeping the fever around 100 or 101°F.

The not-so-good news: Several studies have shown that by suppressing the fever, the body needs a longer time to recover.

- In a study of children with chickenpox, acetaminophen prolonged itching and the time to scabbing compared to placebo treatment. **REF: J Pediatr. 1989; 114:1045-1048. "Acetaminophen: more harm than good for chickenpox?"**

- A study of adults found that aspirin and acetaminophen suppressed production of the patient's antibodies and increased cold symptoms, with a trend toward longer viral shedding and prolonged symptoms. **REF: J Infect Dis. 1990; 162:1277-1282. "Adverse effects of aspirin, acetaminophen, and ibuprofen on immune function, viral shedding, and clinical status in rhinovirus-infected volunteers."**

The bottom line

Use anti-fever medicines sparingly when your child suffers discomfort from a fever up to 104°F (40°C). Ask yourself whether you are administering the fever-reducing medicine to make your child more comfortable or to decrease your own anxiety. If the situation does not seem urgent, consider a trial of echinacea tea, lavender oil and vitamin C before you pull out the fever drugs. Drug-free approaches can go a long way toward helping your child feel better.

A Brief Overview of The Flu: Past and Present

Excerpted from "FOWL! Bird Flu: It's Not What You Think"

The flu is conventionally defined as a "highly-contagious illness caused by viruses that infect the respiratory tract." Compared with adenovirus, which causes the common cold, influenza viruses are often associated with more severe symptoms. Viruses are thought to spread from person-to-person via respiratory droplets released by coughing and sneezing. The viral particles bind to mucous on the surface of the respiratory tract and then bury themselves into the cells that line the lungs. Following an incubation period of about 48 hours, flu symptoms abruptly appear.

Of course, a textbook list of symptoms does not quite capture the suffering endured by those who contract the flu in any given year. There's an old joke about the "24-hour bug" that goes something like this: The first 12 hours you're afraid you're going to die, and then for the next 12 hours you feel so uncomfortable you're afraid you might not. As the body goes through the complex physiological process to expel the virus and the contaminated mucous of the lungs, the symptoms can be miserable.

While no one wants to get the flu—even with the quasi-perk of a couple of days off from work or school—the fact remains that most adults and children recover completely within two weeks. Most overtly healthy individuals do not contract the flu at all.

Influenza viruses

Influenza viruses are identified as three distinct immunogenic types—A, B, and C—and a large number of subtypes. Type C viruses are associated with either a very mild respiratory illness or no symptoms at all. They are not associated with epidemics and do not have a public health impact. Influenza type B viruses also tend to be part of minor illnesses. Having a propensity for older persons, influenza type B viruses are most often identified in nursing home outbreaks. Influenza types C and B have not been identified in any species except humans.

Influenza viruses in category "A," known to affect many different species, are divided into subtypes based on different combinations of two surface "crunched" proteins called antigens. Any foreign substance that enters the blood stream and stimulates the immune system to produce antibodies is defined as an antigen. The outer shell of influenza A viruses is covered with two types of antigens: One is called hemagglutinin, signified by the abbreviation (H) or (HA), the other is called neuraminidase, identified as (N) or (NA). The differences between the H and the N antigens provide the basis for classifying and naming all the many subtypes of influenza type A viruses.

Fifteen different H antigens (referred to as H1 to H15) and nine different N proteins (referred to as N1 to N9) are commonly known to exist. Another antigenic type, H16, has been identified in some scientific papers, but is not universally accepted. The various combinations of these antigens are the basis for sub-typing. Notably, every possible combination of H and N can be found in wild and domestic birds. **REF: Fouchier, R.A. "Characterization of a novel influenza A virus hemagglutinin subtype (H16) obtained from black-headed gulls," J. of Virology. 79 (2005): 14-22.**

A virus is not a living organism, but it can make copies of itself that can be passed on to other hosts. The ability to replicate is what gives the impression that a virus is "alive". There are only five groups in

which influenza A viruses can replicate: large land mammals, sea mammals, wild birds, domestic birds, and humans. Land mammals associated with influenza A viruses include swine and horses. Sea mammals encompass seals, dolphins, and whales.

Since 1977, only a few influenza A viruses, specifically H1N1, H1N2, and H3N2, have been associated with humans. Even though the official nomenclature for identifying individual viruses is cumbersome and long, the naming system serves as a code for virologists and other researchers to identify different characteristics. For example, the official name of one H5N1 viral subtype is A/chicken/Vietnam/HauGiang /178 /2004 (H5N1). Breaking it down, the code identifies the virus as an influenza type A virus, isolated from a chicken in Vietnam, in the city of HauGiang. It was the 178th virus isolated in 2004 of serotype H5N1. **REF: Duke University PowerPoint presentation available online at http://duke.usask.ca/~misra/virology/slides/flu.ppt#272, 11, Nomenclature slide #11.**

The number of different serotypes for H5N1, the viral type thought to cause the next panedmic, is in the hundreds; The number of antigenically distinct influenza A viruses is in the tens of thousands. **REF: "Taxonomy Browser." National Center for Biotechnology Information. (http://www.ncbi.nlm.nih.gov/Taxonomy/Browser).** The fact that hundreds of subtypes exist for H5N1 influenza virus is more than just a scientific curiosity. As stated by Nancy Cox, PhD, chief of the Influenza Branch, National Center for Infectious Diseases at the CDC, "If we don't get a close match, the [bird flu and flu] vaccine will be less effective, producing illness, hospitalizations, and death." For those who purport the importance of getting a vaccine to protect a person from getting the flu, how can a "close match" be good enough?

Just because a virus is present doesn't mean that it is causing a problem. In fact, influenza A viruses can be completely benign, silent passengers

in the intestinal tracts of waterfowl. During trans-global seasonal migration, thousands of ducks and geese congregate in available lakes and ponds along their journey. An examination of the lake water after the flocks have converged would reveal tens of billions of influenza A particles. As many as 130 viral subtypes have been identified in the viral soup. It is this free exchange of genetic material between viruses that has scientists concerned.

Influenza A subtypes have been delineated as either "mildly pathogenic," meaning they cause minimal or no disease, or "highly pathogenic," meaning their presence has been associated with widespread death among all types of birds. All outbreaks of Highly Pathogenic Avian Influenza (HPAI) viruses since the 1980s have been caused by antigen subtypes H5, H7, and H9. For this discussion, these three antigenic types are important to remember. **REF: Sen, Sumit K. "Avian Influenza (or Bird Flu) and India," The Birds of Kolkata. http://www.kolkatabirds.com/birdflu.htm.**

The bird flu virus that was in the news in 2005 was a highly pathogenic subtype referred to as H5N1. Unlike what was portrayed by the media, outbreaks of highly pathogenic viruses are not new. These viruses have been causing problems in bird populations for a very long time. In fact, records show that since 1959 there have been 21 reported outbreaks of highly pathogenic avian influenza worldwide. While the majority have occurred in Europe, a few emerged in Mexico, Canada and even the U.S. Of the 21 incidents, five resulted in significant losses to regional economies. Past experiences with H5N1 and other HPAI outbreaks have a striking similarity to the recent bird flu hysteria: Reports of human deaths have been exceedingly rare.

If an outbreak of highly pathogenic H5N1 is ever detected in U.S. flocks, the financial consequences to the poultry sector could be dire. However, the nation and the economy have weathered HPAI outbreaks

in the past. Keep that in mind—and don't panic—if and when the media starts once again to hawk that an H5N1 outbreak occurred in this country.

Drifting and shifting: How viruses change

For symptoms to occur, a virus must undergo replication. Only when a virus bypasses several layers of immune system protection can it proliferate and trigger the cascade of symptoms associated with the flu. Viral replication is a complex task and defects can occur during the process, resulting in offspring that are not exact copies of its parent. If a small alteration in the genetic makeup of an influenza virus is repeated, it is said to become a permanent change in the genes of the virus, creating a new strain.

Even though the new strain is related to the parent virus, subtle differences make it "antigenically distinct," to the immune system. This change, called an antigenic "drift," accounts for the differences in each year's influenza viruses. The CDC takes advantage of this drift, using it to justify the production of a new flu shot each season. When major changes in the surface for antigens of viruses occur, it is called an "antigenic shift."

Conditions favorable for the development of an antigenic shift have long been blamed on humans who live in close proximity to domestic poultry and pigs. For example, if the human influenza virus H3N2 infects a pig that is simultaneously harboring any one of the avian influenza viruses (say, H6N4 from a chicken), the two viruses have an opportunity to exchange genes. The new "recombinant" virus will contain genetic material from both parent viruses. This process—the blending of two different viruses—is called reassortment. Mixing of surface antigens can lead to a new virus that the human immune system has had no previous exposure, potentially sparking a global pandemic.

Reassortment and antigenic shifts are what scientists are worried about. They fear that a new "super influenza virus" could emerge and be particularly dangerous to humans, depending on which gene or genes are acquired during the swap. Antigenic shifts have been blamed for all three influenza pandemics. For example, it is thought that the reassortment of a human H2 antigen with the avian H3 antigen was the origin of the new H3N2 virus outbreak that caused the pandemic of 1968. And antigenic shift is the most widely accepted theory for the start of the 1918 influenza pandemic. **REF: Wong, Derek. "Influenza Viruses," Virology-Online. (http://virology-online.com/viruses/Influenza.htm)**

Antigenic Shift

Monitoring the tendency of influenza viruses to undergo antigenic drifts and shifts has been the work of the World Health Organization Global Influenza Program since its inception in 1947. Minor drifts occur annually and are the basis for adjusting the composition of each year's influenza vaccine. The concern is that a major change in the (H) and/or (N) viral surface proteins will occur, igniting the next global pandemic.

A pandemic, by definition, is an outbreak of a disease occurring over a very wide area, crossing international boundaries and usually affecting a large number of people. It has been long held that the 1918 pandemic virus emerged through the combination of an influenza virus from a bird and an influenza virus from a pig combined, resulting in a new virus that massively infected humans.

Even though bird flu is no longer discussed in the popular press or national television networks, the CDC and WHO continue to warn we that we are overdue for the next pandemic, similar to the Great Influenza Pandemic of 1918 in which tens of millions reportedly died from the flu. Three major pandemics have occurred in this past century. It is the pattern of these outbreaks that keep global authorities and the international media concerned.

Spanish Flu (1918–1919)

The most notorious outbreak is the global influenza pandemic of 1918. It has been reported that more than 200 million people were ill due to the virus, but death estimates range from 30 to 100 million, an ever-changing and escalating number. Called the Spanish flu, it gained its name from the press in politically neutral Spain, where some of the earliest printed reports of the flu's impact were not censored during World War I.

The highest mortality rate occurred among those who developed a rapidly progressing pneumonia. Because penicillin was not discovered until 1928, many deaths were most likely due to secondary bacterial infections and could have been preventable today. As pointed out in a letter published in the Wall Street Journal on November 1, 2005, by Dr. Edward H. Livingston, chairman of gastrointestinal and endocrine surgery at the University of Texas Southwestern School of Medicine, hospitalization at the turn of the century didn't have much to offer. Even the use of intravenous therapy, routine today, was virtually non-existent in 1918. His astute comments included, "In 1918, care of the flu patient was limited to rest, providing aspirin, oxygen, and other supportive measures. The primary cause of death was pneumonia resulting from bacterial infection of lungs injured as a result of the flu. Lacking antibiotics, there was no effective way of treating the pneumonia."
Milloy, Steven. "Flu Proposal Misguided," Nov.3, 2005. Fox News Report.

Asian Flu (1957–1958)

The new influenza virus, H2N2, was isolated in Singapore in February 1957, arriving in Hong Kong later that year. The new flu strain that had circulated throughout the southern hemisphere arrived in the U.S. during June 1957. Ultimately blamed for the deaths of nearly 70,000 Americans, the H2N2 virus was thought to have originated from the reassortment of genes from wild ducks. Notably different from the 1918 pandemic, the highest mortality rates occurred among the elderly. Worldwide, one million people reportedly died during the 1957 flu pandemic.

Hong Kong Flu (1968–1969)

When the novel subtype virus, H3N2, was first identified in Hong Kong on August 16, 1968, the WHO rapidly issued a warning: Another worldwide outbreak was looming. It was predicted that the outbreak pattern would be similar to that seen in 1957, but this pandemic was different. Nearly everywhere, the clinical symptoms were mild and the mortality was low. The disease seemed to spread slowly rather than explosively. In some countries, absentee rates and increased deaths rates were slight or non-existent. Canada, for example, experienced practically no deaths from the flu. In the U.K., deaths from influenza-like illness and pneumonia were *actually lower* than in the year preceding the new outbreak. A similar picture was seen in most of Europe, where flu symptoms were mild and increase numbers of deaths over previous years were negligible. In striking contrast, the influenza outbreaks across the U.S. were the global exceptions. Nearly 34,000 deaths were attributed to the H3N2influenza virus,, mostly in the elderly. **REF: "Avian influenza: assessing the pandemic threat," World Health Organization, January 2005. (http//www.who.int/csr/disease/influenza/H5N1-9reduit.pdf.)**

Researchers suggest that the death rate may have been lower worldwide because the strain had a shift in the (H) antigen only—from H2 to H3—and the (N) antigen remained the same as the virus that was associated with the 1957 outbreak. People who had been exposed to that virus 10 years earlier had an intrinsic resistance, resulting in far fewer casualties. However convenient this explanation appears to be, it doesn't explain the skew toward the elderly only in the U.S. Most in that age group would also have been exposed to the 1957 viruses that supposedly made this pandemic less severe.

Lessons From Past Pandemics

A critical view of the three historical global influenza outbreaks can lead to some interesting observations about past pandemics:

1. Malnutrition played a role in the 1918 pandemic.
Whereas fit and healthy persons are resistant to infections under ordinary circumstances, wars, chemical exposures, and other natural disasters can lead to increased susceptibility. During wartime, malnutrition due to shortages of fresh food and an absence of clean water can lead to widespread immunocompromise. In 1985, the director of the National Institute of Allergy and Infectious Disease (NIAID), Dr. Anthony Fauci, declared that malnutrition was the most prevalent cause of immune deficiency diseases throughout the world in humans. Malnutrition undoubtedly played a hefty role in the large number of deaths during the 1918 pandemic. **"If It's Not HIV, What Can Cause AIDS?" Alive & Well AIDS Alternatives.**

2. Two of the three pandemics were directly associated with wars.
Global outbreaks of influenza occurred around the time of American-involved wars: World War I and Vietnam. In fact, the WHO attributed the 1968 outbreak to the return of U.S. troops to California from Southeast Asia. Poor hygiene, emotional stress, pre-deployment vaccines, and chemical exposure contributed to the weakening of immune systems and outbreak of influenza. **REF: "Avian influenza: assessing the pandemic threat," World Health Organization, January 2005. http//www.who.int/csr/disease/influenza/H5N1-9reduit.pdf p.32.**

3. The general health of those who contracted influenza, particularly the elderly, is unknown.
During the global outbreaks, the underlying health conditions of those who died are unknown. Influenza could have been blamed for deaths that were really caused by something else, such as congestive heart failure or bacterial pneumonia.

4. Healthcare technology has advanced, leading to increased chances of survival.
Dramatic advances in medicine, medications, public sanitation, personal

hygiene, and food preparation make it much less likely that a naturally occurring pandemic of global proportion will ever happen again.

5. Vaccination could have contributed to influenza deaths.
Before going to war in 1918, troops received the smallpox and yellow fever vaccinations and possibly several more. Worldwide smallpox vaccination had been ongoing since the late 1800s. The Salk polio vaccination campaign began in 1955; the Asian flu outbreak occurred shortly thereafter (1957). The young men who served in Vietnam—and those who served stateside—received many vaccines, including an experimental plague vaccine, before deployment and the start of the 1968 pandemic. The impact of mass vaccination on the troops and within the civilian population could have led to immune system disruption, increasing susceptibility to the effects of influenza viruses.

Flu Shots: They Don't Work

The vaccination of "every man, woman and child" has been in the planning for at least the last several years. The concept originated in 2001 from former Health and Human Services Secretary Tommy Thompson and was advanced by his successor, Mike Leavitt, to vaccinate everyone with a flu shot. Thompson envisioned mass vaccination using the smallpox vaccine. But times have changed, and the flu shot, exalted by ongoing threats of a bird flu pandemic, now appears to be the instrument of choice for those pursuing the universal vaccination agenda.
REF: CIDRAP News. "US pledges smallpox vaccine for world stockpile." December 4, 2004. REF: Department of Health and Human Services FY 2007 Budget announcement. February 6, 2006. http://www.hhs.gov/news/speech/ 2006/ 060206.html

The fact that multiple studies presented in highly reputable publications have documented that flu shots are ineffective in all age groups hardly seems to matter to those who continually promote their use. For example, The Cochrane Collaboration produced a series of articles in 2005 reviewing the published literature to determine the effectiveness of the flu shot. Nothing substantiating its usefulness was found.

In a review of 51 studies including 17 papers translated from Russian, involving more than 260,000 children, researchers concluded that there was "no evidence that injecting children 6 to 23 months of age with flu vaccines is any more effective than placebo." Furthermore, the reviewers found no evidence to back claims that vaccines prevent deaths from influenza or other serious complications in this age group. As for "safety studies," there aren't any. "We were astonished to find only one safety study of inactivated vaccine in children under two years of age; that was carried out nearly 30 years ago and only in 35 children," stated Dr. Jefferson, head of Cochrane the influenza review panel. **REF: The Cochrane Database of Systematic Reviews. "Vaccines for preventing influenza in healthy children." 1-(2006).**

For healthy adults, the results were similar. A total of 25 studies were reviewed that included more than 60,000 study participants. Again, The Cochrane Group found that vaccination reduced the risk of influenza by a meager 6 percent and reduced the number of days missed from work by less than one (0.16) day. Researchers concluded, "Universal immunization of healthy adults was not supported by the results of this review." **REF: The Cochrane Database of Systematic Reviews "Vaccines for preventing influenza in healthy adults."1-(2006)**

For the elderly population, the prime target group for flu shots, The Cochrane Group reviewed 64 studies over 96 flu seasons and chided, "The effectiveness of the flu shot—particularly for the elderly—was wildly overstated and the runaway 100 percent effectiveness touted by proponents [of the flu shot] for the elderly was nowhere to be seen. What you see is that marketing rules the response to influenza, and scientific evidence comes fourth or fifth." Dr. Jefferson, the lead researcher, went on to say, "Vaccines may have a role, but they appear to have a modest effect. The best strategy to prevent the illness is to wash your hands." **REF: Rosenthal, Elisabeth. "Two Studies Question the Effectiveness of Flu Vaccines," The New York Times, 21 September 2005.**

With this much evidence that flu shots are ineffective, why would anyone proceed to inject three viruses and a load of toxic chemicals into his or her body to avoid the flu when vitamin C and hand-washing will be more effective?

Flu Shots: The Manipulation of Annual Campaigns

As predictable as the return of yellow school buses and football season, the arrival of fall also brings the first fearful chatter about the approaching flu season. But in 2004, the Centers for Disease Control (CDC) revealed its portentous blueprint to ensure the economic success of each flu season's vaccine.

Concerned over 2003 data documenting that almost 65 percent of people surveyed did not receive the flu shot—including nearly 47 percent with chronic illnesses and 78 percent of children aged 6-23 months—a new strategy was devised. The plan was fully disclosed in a 51-slide communiqué called **"Planning for the 2004-05 Influenza Vaccination Season: A Communication Situation Analysis,"** prepared by Glen Nowak, Ph.D., the Associate Director for Communications at the National Immunization Program.

The most important part of the program, "The Seven-Step Recipe for Generating Interest in, and Demand for, Flu (or any other) Vaccination," is designed to methodically manipulate the general public. Language within the presentation reveals the intent of the government and its drug company "partners" to use major news media (newswires, TV) to send scheduled, fear-based messages to convince the unsuspecting public that the flu shot is necessary and motivate them to demand it. This will amount to millions of dollars of free advertising for flu vaccine manufacturers. **REF: CDC. "Planning For The 2004-05 Influenza Vaccination Season. A Communication Analysis," by Glen Nowak.** Here is a synopsis of the CDC's annual promotion plan:

Step 1: Start discussing the flu at the beginning of the "immunization

season." Posters, fliers and media campaign materials are generally mailed to public health departments and health care provider offices in mid-August, "planting the seeds" in the minds of patients so that they request the flu vaccine when it arrives.

Step 2: The media will begin to make pronouncements that the "new" influenza strains anticipated this year "will be associated with severe illness and serious outcomes."

Step 3: The buildup will continue throughout the early fall, as local and national "medical experts and public health authorities publicly (e.g., via media) state concern and alarm (by predicting dire outcomes)– and urge influenza vaccination."

Here's an example that will sound familiar:

> "We know we're going to have a pandemic because, historically, we're overdue for one," said Neil Pascoe, epidemiologist in the infectious disease division of the Texas Department of Health. "When it happens, it's going to be huge. It will be global, and everyone is going to be affected...it could be terribly fatal. Imagine 4 million Texans [becoming] infected, and 20 percent of them die."

Step 4: Reports from medical experts will be used to "frame the flu season in terms [that will] motivate behavior." Language to be used includes, "very severe," "more severe than last or past years," and "deadly." Each year, flu season promotions include phrases such as, "this could be the worst flu season ever," "the flu kills 36,000 people per year," "don't be fooled, the flu can be deadlyl" and "the flu shot is the best way to prevent the flu." The use of this language and these messages is systematically planned.

Step 5: Continue to release reports from health officials through the

media that influenza is causing severe illness and/or affecting lots of people, ***"helping to foster the perception that many people are susceptible to a bad case of influenza."***

Step 6: Give visible and tangible examples of the seriousness of influenza by showing pictures of ill children and affected families who are willing to come forward with their stories. "Show pictures of people being vaccinated, ***the first to motivate, the latter to reinforce."***

Step 7: List references to, and have discussions regarding, the influenza pandemic. "Make continued reference to the importance of vaccination."

The language used to describe Steps 5, 6, and 7 was taken directly from Nowak's presentation. This should leave little doubt that the government intends to use the media to create hysteria that will increase the demand for a pharmacuetical product.

Health officials expect that a carefully planned and implemented strategy will create record demands for vaccination each year. Understanding the tactical maneuvers that go on between the CDC-Big Pharma-Media partnership will result in continual "bust" years for the flu vaccines.

Flu Shots: Beware of Toxic Additives

In April 2006, *The Washington Post* ran a story that not only extolled the use of the influenza vaccines but also pushed for a new and improved version by saying, "Why wait for the pandemic to benefit from better flu vaccines?" The story went on to say that the National Institutes of Health (NIH) is planning to strengthen the flu shot "destined for the elderly" by adding an immune-boosting compound to the shot called an adjuvant. **REF: Neergaard, Lauren. "Experts Say Elderly Need Better Flu Shot." The Washington Post. April 17, 2006.**

An adjuvant is a substance added to produce a high antibody response using the smallest amount of virus (antigen) possible. By definition, adjuvants are considered to be pharmacologically active drugs. They are designed to be inert without inherent activity or toxicity and yet they are required to "potently augment effects of the other compounds" in the vaccines. It is difficult to explain how a substance can be defined as "pharmacologically active" and at the same time be described as "inert and have no activity or toxicity." **REF: Expert Review of Vaccines 2 (2) (2003): 167–188. "Survey of human-use adjuvants."**

The limiting factor for approval of new adjuvants has been that most are far too toxic for use in humans. However, one adjuvant has been approved in Europe and its approval is on the way for use in the U.S. It is an oil-based adjuvant called MF-59, a compound primarily composed of squalene.

On first blush, squalene—manufactured naturally in the liver—seems like a good choice for an adjuvant. In addition, squalene can be purchased at health food stores in its more commonly known form, "shark liver oil." However, ingested squalene has a completely different effect on the body than injected squalene. When molecules of squalene

enter the body through an injection, even at concentrations as small as 10 to 20 parts per billion, it can lead to self-destructive immune responses, such as autoimmune arthritis and lupus. **REF: Scan J of Immunology 54 (2001): 599–605. "Responses of the rat immune system to arthritogenic adjuvant oil."**

Several mechanisms have been proposed to explain this reaction. Metabolically, squalene stimulates an immune response both excessively and nonspecifically. More than two dozen peer-reviewed scientific papers from ten different laboratories throughout the U.S., Europe, Asia and Australia have been published documenting the development of autoimmune disease in animals subjected to squalene-based adjuvants. A convincing proposal for why this occurs includes the concept of "molecular mimicry" in which an antibody created against the squalene in MF59 can cross-react with the body's squalene on the surface of human cells. The destruction of the body's own squalene can lead to debilitating autoimmune and central nervous system diseases. **REF: Vaccine A: The Covert Government Experiment That's Killing Our Soldiers and Why GIs Are Only the First Victims Vaccine. Gary Matsumoto. (New York: Basic Books).**

The squalene in MF59 is not the only cause for concern. One of its components, Tween80 (polysorbate 80), is considered by vaccine manufacturers to be inert but is far from it. A study published in December 2005 discovered that Tween80 can cause anaphylaxis, a sometimes fatal reaction characterized by a sharp drop in blood pressure, hives and breathing difficulties. Researchers concluded that the severe reaction was not a typical allergic response characterized by the combination of IgE antibodies and the release of histamines; it was caused by a serious disruption that had occurred within the immune system. **REF: Annals of Allergy, Asthma and Immunology. 95 (2005): 593–599. "Polysorbate 80 in medical products and nonimmunologic anaphylactoid reactions."**

Vaccine manufacturer Chiron is already using MF59 in its European influenza vaccine for seniors called Fluad™. It remains to be seen if Chiron will gain approval for using this adjuvant-containing vaccine in the U.S. In the meantime—and for the first time—all children from age 6 months to 5 years became targets for the flu shot in the fall of 2006. Expect even more children to be on the vaccine list. Discussions are underway to mandatorily vaccinate the healthy 5- to 9-year-old group as a school requirement and has been implemented in New Jersey. Be prepared for an ongoing push to get everyone vaccinated each fall. Consider it to be psychological pre-conditioning. The plan is to get each person ready—and eager—to roll up a sleeve for an injection of the "pandemic" flu vaccine when it becomes available.

Retaining freedom of choice will become increasingly important for those who want to refuse. Get politically active by joining the Coaltion Against Mandatory Vaccination, an initiative of the American Association for Health Freedom (AAHF). AAHF is the only organization on Capitol Hill that lobbies for a person's right to choose and the practitioner's right to practice. Self-appointed experts at the WHO and the CDC really believe the only way to survive is to be inoculated with viruses and chemicals, and the pressure is mounting to get everyone to comply. Resistance is a grass-roots phenomenon, and changing laws to allow vaccination exemptions is a priority of this initiative. Please join at **www.DrTenpenny.com** or **www.HealthFreedom.net.**

When the media begins to, once again, shriek about a coming pandemic and using coercion to get everyone to comply, remember that a new pandemic vaccine will be largely untested. Worse, it will be no more effective than the annual flu shot, and there is a high probability it will contain a toxic adjuvant such as MF-59.

Vaccinations and Overseas Travel

The time has finally arrived for the highly anticipated trip out of the country. The plans began long ago: airplane tickets, hotel reservations, rental car, sightseeing itinerary. The bags are being pulled from the attic to be packed, and the excitement mounts with each passing day. Everything is a go.

But wait! What about vaccines? Is this one more preparation that needs to be added to the "to do" list? Traveling out of the country can feel like a venture to another planet. Pictures of exotic destinations coupled with new, curious foods dance off the pages of the travel brochures. Anticipating the unexpected can be a challenge for even the most seasoned traveler. However, traveling with children adds an extra dimension to the anxiety—the thought of your child becoming ill in a foreign country is extremely frightening. Your doctor is recommending a variety of vaccines. Are they necessary? How do you evaluate the risks?

U.S. Standards for Overseas Protection.
Currently, 11 different vaccines are recommended for children in the US: Hepatitis B, Hepatitis A, Rotavirus, polio, diphtheria-tetanus-pertussis (DTaP), measles-mumps-rubella (MMR), chickenpox, HiB, Prevnar, influenza vaccine and, most recently, Gardasil, for the prevention of cervical cancer. The HiB and Prevnar are given to prevent bacterial infections caused by H. influenza b and Strep. pneumonia, respectively. Some of these vaccines are also recommended for international travel. But are the risks of getting these diseases any greater when traveling than they are at home? Let's take a closer look at the more worrisome infections that might be encountered while traveling abroad.

Hepatitis B is a viral infection that is spread through contact with

blood. In the U.S., hepatitis B is primarily a disease of adults and is spread through sexual contact or shared needles used with illicit drugs. Hepatitis B is more common in the general population in East and Southeast Asia and in Sub-Saharan Africa. Even in these areas, the risk for contracting the infection is exceptionally low unless blood products or close intimate contact is anticipated. If you contract hepatitis B, you can become very ill for a few weeks or a few months but the risk of long-term complications is much less than generally believed. More than 95 percent of those who contract hepatitis B fully recover, resulting in lifetime immunity. Unless you plan to spend extended periods in close contact with infected persons, the risk of contracting hepatitis B while traveling is negligible.

Polio is an infectious disease caused by a virus that enters the body through the gastrointestinal track and inflames the nerves within the spinal cord. The disease occurs primarily in children under 5 years of age. The initial symptoms include fever, fatigue, headache, vomiting, diarrhea and stiffness in the neck. More than 95 percent of persons who contract polio recover uneventfully from what is perceived to be the stomach flu. Transient paralysis results in approximately 2 percent of children who contract the viral infection; of those, more than 98 percent completely recover. Polio is not a synonym for paralysis. Very few polio infections result in a permanent lifetime disability.

While polio was once common throughout the undeveloped world, only a few countries continue to have polio outbreaks. Although the Western Hemisphere was certified "polio-free" by the World Health Organization in 1994 and there have been no cases of wild polio in this region since 1991, the U.S. pediatric vaccination schedule continues to include five doses of the polio vaccine. The reason given is that until polio is eradicated around the world, the risk of reintroducing polio into this country is "only a plane ride away." However, examination of the data reveals only six cases of imported polio documented between

1980 and 1998, the last in New York City in 1993. The risk for contracting polio is negligible.

Tetanus is an acute, spastic paralytic illness caused by a toxin released from the bacterium clostridium tetani. The bacterium is found in soils and animal feces throughout the world. In infants, neonatal tetanus is the most common and is frequently deadly. However, the vast majority of these cases occur following childbirth as a result of using nonsterile equipment to cut the umbilical cord. Cephalic tetanus, the least common, causes muscle spasms in the face, leading to the classic case of "lockjaw." Localized tetanus is recurring muscle spasms near the original site of the infection. Recovery from each of these infections is usually complete, but can take many weeks and often requires extended hospitalization.

While it is commonly accepted that a tetanus shot will prevent the onset of tetanus, the data shows that even if a person has three or more tetanus shots, it is still possible to contract the disease. A recent issue of the British Medical Journal reported that tetanus can occur "despite adequate immunization and [adequate] levels of neutralizing antibodies." **REF: Letter to the Editor, British Medical Journal 320 (5 February 2000): 383.**

Frequent tetanus shots may give a false sense of security. The best way to protect from the infection is to thoroughly clean the wound with copious amounts of warm, soapy water and to encourage the injury to bleed profusely. Wash the wound with hydrogen peroxide, as the extra oxygen in the solution can kill organisms that cause tetanus. Prophylactic antibiotics such as metronidazole (Flagyl) and penicillin are effective against the clostridium bacteria that release tetanus toxin into the bloodstream. It might be a good idea to carry these antibiotics and peroxide if you are going to offbeat places. If you have access to medical care when traveling, a shot of tetanus immune globulin (TIG) can be given for severe injuries. Equivalent to a "dose of antibodies,"

TIG continues to circulate in the body for up to three weeks and can effectively neutralize any toxin that might be released by the tetanus-causing bacterium.

What About Exotic Diseases?
When traveling overseas, it is possible to encounter some illnesses not generally seen in the U.S. The CDC lists the following infections as possible concerns for travelers to any destination around the globe.

Typhoid Fever, an acute, febrile illness caused by the bacterium Salmonella typhi, is characterized by fever, headache and enlargement of the spleen. The greatest risk is for travelers to the Indian subcontinent and to developing countries in Asia, Africa and Central and South America who will have prolonged exposure to potentially contaminated food and drink. Eating food you have prepared and only food that can be cooked is the best way to avoid typhoid infections.

Yellow Fever is a mosquito-borne viral illness that can vary in severity from a flu-like syndrome to severe hepatitis and hemorrhagic fever. The disease occurs only in sub-Saharan Africa and rural, tropical South America. Some African countries require this vaccination unless a specific waiver has been signed by a physician. Please see the CDC website and travel advisories as this list changes frequently.

Japanese Encephalitis, another mosquito-borne viral infection, is found throughout Asia, particularly in rural or agricultural areas of the temperate regions of China, Japan, Korea and eastern Russia. The risk to short-term travelers and those who confine their travel to urban centers is low. Use effective mosquito repellants to avoid all mosquito-borne illnesses.

Tick-borne Encephalitis, also known as spring-summer encephalitis, is a tick-borne viral infection that causes inflammation of the central

nervous system. Although the disease is common throughout Europe, travelers are at low risk unless they visit forested areas and/or eat non-pasteurized dairy products.

Hepatitis A is a viral disease that has an onset of fever, malaise, nausea and diarrhea, followed within a few days by jaundice. The disease ranges in clinical severity from no symptoms at all to a mild illness lasting one to two weeks. Although endemic throughout the world, hepatitis A can be prevented by carefully following the hygiene and food recommendations listed in the table below called "Minimizing Risks."

What's recommended? What's required?
Although the CDC recommends that all travelers obtain all available vaccines when traveling abroad, it is important to realize that, with one exception, very few vaccines are required, before you travel anywhere in the world: The vast majority are only "recommended." You will not be required to obtain vaccines to return home. Individual countries can post requirements from time to time and the best way to know them for sure is to check the sections on "Travel Vaccines" on the CDC website. If you do not wish to be vaccinated, ask your physician to write a short letter for documentation.

The primary exception is the yellow fever vaccine, which may be required if you travel to or from a South American or African country infected with yellow fever. The recommendations can vary from country to country; if such a destination is part of your travel plans, you should look up the yellow fever requirements for that specific country on the CDC website and read about yellow fever vaccine in other sections of this book.

I have been a globe-trotter for most of my adult life. In the past 25 years, I have had the good fortune to have traveled to more than 50

countries. I have never been asked for a vaccine record, nor have I ever felt the need for any vaccines, even when traveling to remote, exotic destinations. U.S. customs does not require a vaccination record to reenter the county.

What are the other health considerations?
Vaccines are available for all diseases mentioned above, should you choose to vaccinate. Infections that are a concern worldwide, and for which there are no vaccines, include malaria and traveler's diarrhea.

Malaria is a serious, sometimes fatal disease caused by a parasite that is injected into the body by an infected mosquito. The parasite grows in the liver, then infects circulating red blood cells. Symptoms of malaria include fever, shaking chills, headache, muscle aches, vomiting, diarrhea and extreme fatigue. If untreated, death from malaria can occur due to dehydration and kidney failure.

For most people, the symptoms of malaria begin 10 days to four weeks after they become infected, although the symptoms may not develop until as much as a year later. Anyone who begins to have recurring, shaking chills up to one year after returning home should seek professional medical care. Be sure to tell your health care provider that you have visited a malaria-risk area.

Prescription drugs for the prevention of malaria are sometimes recommended for those traveling to malaria-endemic countries. Some antimalarial drugs are more effective in some parts of the world than others, but all of them have side effects and potential complications. In addition, a medical condition may prevent your child from taking certain drugs.

An alternative to taking drugs is to use mosquito precautions (see below). It is important to obtain a natural mosquito repellant, one that

is free of DEET, the toxic additive found in most insect repellants. My favorite is Natural Mosquito Repellant, made by Royal Neem. It is free of chemicals and contains many natural ingredients: aloe vera; the oils of coconut, neem, lemongrass, citronella, cedarwood and rhodiumwood; plus extracts of myrrh, barberry, thyme, goldenseal and chamomile.

If you contract malaria, a natural treatment is available that is perhaps even more effective than pharmaceuticals and is certainly less toxic. During an archeological dig in the 1970s, instructions for treating malaria with an herb called wormwood, or artemisia, were found in a 2000-year-old Chinese tomb. Shortly thereafter, Western scientists isolated the herb's active component and called it "artemisinin." Studies in China and Vietnam have confirmed that artemisinin is a highly effective compound, with a close to 100 percent response rate in the treatment of malaria. Outside the U.S., artemisinin is the most commonly used herb to treat malaria. The WHO is investigating the use of this herb worldwide for malaria treatments. Because there can be a wide variation in quality, it is important that artemisinin be purchased from a reputable source, such as Allergy Research Group, (www.allergyresearchgroup.com). It should be noted that this company sells only to licensed health care practitioners.

Traveler's diarrhea is, by far, the most common illness affecting those traveling outside the U.S. It is estimated that between 20 and 50 percent of travelers—nearly 10 million people each year—develop diarrhea. Although a variety of viral and parasitic pathogens can be the cause, by far the most common source of traveler's diarrhea is the bacteria E. coli. Symptoms usually begin abruptly and increase over several days. The typical experience includes four or more watery bowel movements each day, associated with nausea, vomiting, abdominal cramping, fever and malaise. Most cases are benign and resolve in one to two days without treatment. Although rarely life-threatening, traveler's diarrhea can bring a sudden halt to the fun and mystique of international travel.

The best way to avoid traveler's diarrhea is by strict adherence to food and water precautions. In addition, studies have shown that taking two tablespoons of Pepto-Bismol four times a day (for adults) can decrease the incidence of traveler's diarrhea. The dosage for children 9 to 12 is one tablespoon four times a day; children 6 to 8, two teaspoonfuls; 3 to 6, one teaspoonful; under 3, consult a physician before taking. (PRECAUTION: People allergic to aspirin, pregnant women and those on the blood thinner Coumadin should not take Pepto-Bismol. Also, large doses of Pepto-Bismol can temporarily blacken the tongue and stool.)

The most important treatment for traveler's diarrhea is oral rehydration to replace lost fluids and electrolytes. Clear liquids are routinely recommended for adults, and, for children, electrolyte-based liquids such as Gatorade. On rare occasions, antibiotics may be required if the symptoms persist for more than a few days.

Another option for prevention is to support the immune system and boost resistance before and during travel. Homeopathic formulations are available through **www.SayingNoToVaccines.com** to boost resistance against traveler's diarrhea, malaria, hepatitis A and B, influenza and pesky colds.

The Best Medicine

The best medicine for any type of infectious disease is always prevention. For most diseases around the world, common-sense precautions are the best way to stay healthy. With vaccinations only recommended, not required, for nearly every destination in the world, a trip to your doctor for vaccines is one item you can cross off your pre-trip "to do" list. Weigh the risk of the infection against the risk of a vaccine reaction that may prevent travel. Then go and have fun!

MINIMIZING FOOD-BORNE RISKS:

1. Eat only cooked foods hot to the touch. Avoid eating food from street vendors.
2. Avoid eating raw fruits and vegetables unless you peel them yourself.
3. Drink only "safe" beverages: sealed bottled water, carbonated beverages, hot tea, coffee, beer, wine and boiled water.
4. Don't drink beverages with ice.
5. Avoid eating raw or undercooked meat and seafood.
6. Avoid all tap water, and be careful of getting shower water in your mouth. When dining in restaurants, ask whether the salad greens have been washed in boiled or distilled or bottled water.
7. Avoid nonpasteurized milk and dairy products.

PROTECT AGAINST MOSQUITO RISKS:

1. Pay special attention to mosquito protection between dusk and dawn.
2. Wear long-sleeved shirts, long pants, and hats.
3. Frequently apply natural insect repellant, particularly after swimming.

Chapter 8
GLOSSARY

ACIP (Advisory Committee for Immunization Practices): The ACIP consists of 15 physicians who are considered to be experts in fields associated with immunization. They are appointed by the secretary of the U. S. Department of Health and Human Services to provide advice and guidance to the secretary, the assistant secretary for health, and the CDC to control vaccine-preventable diseases.

The ACIP develops written recommendations for the routine administration of vaccines given to children and adults in the civilian population. Recommendations include age for vaccine administration, the number of doses, the dosing interval, precautions, and contraindications. The ACIP is the only entity in the federal government that makes such recommendations. The goals of the ACIP are: 1) to provide advice that will lead to a reduction in the incidence of vaccine-preventable diseases in the U.S. and 2) to increase the use of vaccines and related biological products. **REF: CDC website. Advisory Committee on Immunization Practices (ACIP). http://www.cdc.gov/vaccines/ recs/ acip/default.htm**

Adjuvant: A substance considered to be a stimulator that is added to a vaccine to increase the immune response so that less vaccine antigen is needed to produce an antibody.

Antigen: An antigen is any substance that causes the immune system to produce an antibody against it. Antigens are foreign substances including chemicals, pollen, bacteria, or viruses.

CBER (Center for Biologics Evaluation and Research): A division of the FDA. CBER regulates the licensing of vaccines and other biological products. CBER and the CDC jointly manage the VAERS.

CDC (Centers for Disease Control): The CDC is one of the major operating components of the Department of Health and Human Services. The CDC's mission is "To promote health and quality of life by preventing and controlling disease, injury and disability." A subdivision within the CDC, the National Immunization Program, was replaced spring of 2007 with The National Center for Immunization and Respiratory Diseases (NCIRD). NCIRD is the interdisciplinary vaccination program that brings together all national and government program activities for the prevention of vaccine- preventable diseases.
REF: CDC website. http://www.cdc.gov/vaccines/about/default.htm

FDA (Food and Drug Administration): The FDA is responsible for protecting the public health by ensuring the safety, efficacy and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA is also responsible for quickly advancing innovations that make medicines and foods safer, more effective, and more affordable. The FDA's Center for Biologics Evaluation and Research (CBER) is responsible for regulating vaccines in the United States.

IOM (Institute of Medicine): The Institute of Medicine was chartered in 1970 as a component of the National Academy of Sciences. It is a nonprofit organization specifically created to serve as an adviser to the national government. The institute's charter directs members to provide "unbiased, evidence-based, and authoritative information and advice concerning health and science policy to policy-makers, professionals, leaders in every sector of society, and the public at large." The institute's members are elected on the basis of their professional achievement and commitment to service. They serve without compensation. Election to active membership is both an honor and a commitment to serve in institute affairs. The bylaws of IOM specify that no more than 65 new members shall be elected

annually; announcements of new members are made at the Annual Meeting in October. The number of regular members plus foreign associates and emeritus members is currently about 1,600. The charter stipulates that at least one-fourth of the members be selected from outside the health professions, from such fields as the natural, social, and behavioral sciences, as well as law, administration, engineering, and the humanities.

NVAC (National Vaccine Advisory Committee): The National Vaccine Advisory Committee was established to comply with Section 2105 of the Public Health Service Act (42 U.S. Code 300aa-5). The NVAC is made up of 17 members appointed by the director of the National Vaccine Program. Each member serves a four-year rotating term, with one-fourth of the committee members' terms ending each year. A member is generally engaged in vaccine research or vaccine manufacturing, but can be a physician, a member of a parent organization concerned with immunizations, or a representative of a state or local health agency or public health organization.

The functions of NVAC are 1) to recommend ways to encourage the availability of an adequate supply of safe and effective vaccination products and 2) to recommend research priorities that enhance the safety and efficacy of vaccines.

NVP (National Vaccine Program): The National Vaccine Program is responsible for coordinating and ensuring collaboration among the many federal agencies involved in vaccine and immunization activities. The office of the NVP also 1) ensures that national agencies collaborate, so that immunization activities are carried out in an efficient, consistent, and timely manner; 2) develops and implements strategies for achieving the highest possible use of vaccines; 3) works to prevent adverse reactions to vaccines; and 4) ensures that minimal gaps

occur in federal planning of vaccination programs. **REF: CDC website. National Vaccine Program Office. http://www.hhs.gov/nvpo/about.html**

Thimerosal: Thimerosal is a preservative that has been used in some vaccines since the 1930s, when it was first introduced by the Eli Lilly Company. It contains 49.6% mercury by weight and is metabolized or degraded into ethylmercury and thiosalicylate. It was added to vaccines to kill organisms found in growth media. Prior to its introduction in the 1930s, data were available in several animal species and human studies questioning its safety and effectiveness as a preservative. As a vaccine preservative, thimerosal is used in concentrations of 0.003% to 0.01%. A vaccine containing 0.01% thimerosal contains 50 micrograms of thimerosal per 0.5 ml dose, or approximately 25 micrograms of mercury per 0.5 ml dose. Most thimerosal was removed from vaccines in 2001; however, mercury is still present in many vaccines.

Vaccine Abbreviations:

Hep B: Hepatitis B vaccine
Hep A: Hepatitis a vaccine
dT, TT: Adult tetanus booster; dT contains diptheria toxoid
DTaP: Diphtheria, Tetanus, acellular Pertussis
DTP: Whole-cell pertussis vaccine (also DTwP)
Flu shot: Influenza vaccine
HiB: H. influenza vaccine (childhood meningitis)
HPV: Human papilloma virus vaccine (Gardasil)
IPV: Injectable, inactivated polio
OPV: Oral polio vaccine
MCV4: Neisseria meningitis vaccine (Menactra)
MMR: Measles, Mumps and Rubella vaccine
Prevnar: Strep pneumococcal vaccine for children
Rotateq: Rotavirus vaccine (diarrhea); also Rotarix
Varicella: Chickenpox vaccine
Zostrix: Adult shingles vaccine

Vaccine Manufacturing

1. Attenuation Process: The attenuated form of a bacteria or virus is obtained by serial passage of the active organism through a culture media or animal cells. Chemicals, antibiotics and adjuvants are then added. Animal RNA/DNA can be combined with the viral RNA/DNA during the process. According to the WHO, the molecular basis for how attenuation occurs is unknown. The following are live, attenuated vaccines:

a. Oral polio (passed through monkey kidney cells)
b. Chickenpox vaccine (passed through human diploid cells MRC-5)
c. Measles (passed through chicken embryos)
d. Rubella (passed through aborted human embryo fibroblast cells called WI-38 and MRC-5)
e. Influenza (historically grown on eggs; some now on dog kidney cells and retinal cells of aborted fetal tissue)
f. Zoztrix (passed through human diploid cells MRC-5)

Problems associated with live, attenuated virus vaccines:

a. Mutations can cause the virus to revert to active form.
b. Preparations are unstable and sensitive to heat.
c. Animal tissues are contaminated with animal viruses and mycoplasma. These can become part of the vaccine.

2. Inactivation Process: Viruses or bacteria are treated with heat and radiation. The chemicals most commonly used to inactivate organisms are formaldehyde, 2-phenoxyethanol or betapropiolactone. Inactivated vaccines include annual influenza, injectable polio, and rabies vaccines.

Vaccine Terminology

Immunization: The process of inducing artificial immunity.

Inoculation: The introduction of a disease agent to cause disease.

Vaccination: The physical act of administering a vaccine; giving a shot.

NOTE: Vaccination does not insure immunity. The act of sticking a needle and marking a vaccination record does not guarantee the recipient is protected from a disease. Even measuring antibody titers does not insure protection. Vaccination is nothing more than an assumption of protection. **REF: ImmunoFacts, published by Facts and Comparisons. 2002. pg. 13.**

Vaccine Titer: A titer (pronounced with a long "I" sound) is a test that measures the concentration of antibodies in the blood induced by vaccination. The concentration, called a titer level, is determined by making a number of dilutions of the blood and then measuring the amount of antibody that reacts to a reagent. For example, a titer of 1:8 (one to eight) means the blood has been diluted in a ratio of one part blood and seven parts saline and still reacts positively to a reagent. The higher the titer level (1:32 is higher than 1:8), the more antibody is present.

VAERS (Vaccine Adverse Event Reporting System): The Vaccine Adverse Event Reporting System is a national vaccine safety surveillance program co-sponsored by the CDC and the FDA. VAERS collects information and the data is analyzed by employees of the CDC and the FDA. VAERS was created from the National Vaccine Injury Compensation Act, signed into law in 1988 by former President

Ronald Reagan. Since 1990, VAERS has received more than 130,000 reports, ranging from mild reactions to deaths. Approximately 15 percent of the reports reflect serious adverse events involving life-threatening conditions, hospitalization, permanent disability, or death. Both the CDC and the FDA review data reported to VAERS. The FDA also closely monitors reporting trends caused by individual vaccine lots.

Even though anyone can file a VAERS report, the majority of reports are submitted by vaccine manufacturers (42%) and health care providers (30%). The remaining reports are obtained from state vaccination programs (12%), vaccine recipients or their parent or guardian (7%), and other sources (9%). **REF: VAERS information. http://www.vaers.hhs.gov/vaers.htm**

VRBPAC (The Vaccines and Related Biological Products Advisory Committee): The division within the FDA that first reviews new vaccines and new vaccine applications.

WHO (World Health Organization): The WHO is the directing and coordinating authority for health and makes recommendations to all member states of the United Nations. It is responsible for "providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries, and monitoring and assessing health trends."

The World Health Assembly at the U.N. is the supreme decision-making body for WHO. It generally meets in Geneva in May of each year and is attended by delegations from all 193 member states. Its principal function is to determine the policies of the organization. The Health Assembly appoints the director-general, supervises the financial

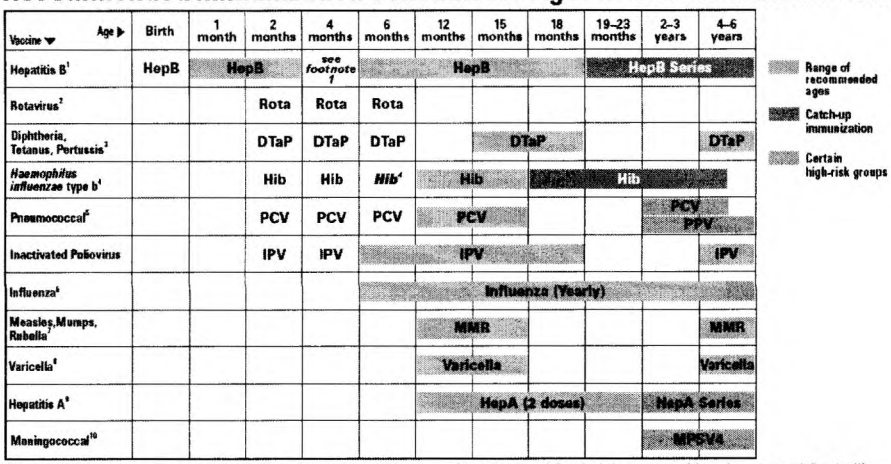
policies of the organization, and reviews and approves the global budget. The organization is headed by the director-general, who is appointed by the Health Assembly after being nominated by the Executive Board. Dr Margaret Chan, from the People's Republic of China, is the current director-general of WHO, appointed by the World Health Assembly on November 9, 2006. Her term will run through June 2012. **REF: The WHO website. http://www.who.int/about/en/**

Addendum A

Recommended Childhood Immunization Schedule 2007-2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommended Immunization Schedule for Ages 0–6 Years UNITED STATES • 2007



This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children through age 6 years. For additional information see www.cdc.gov/nip/recs/child-schedule.htm. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective ACIP statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). *(Minimum age: birth)*

At birth:

- Administer monovalent HepB to all newborns prior to hospital discharge.
- If mother is HBsAg-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG (no later than age 1 week).
- If mother is HBsAg-negative, the birth dose can only be delayed with physician's order and mothers' negative HBsAg laboratory report documented in the infant's medical record.

Following the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered at age ≥24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of 3 or more doses in a licensed HepB series, at age 9–18 months (generally at the next well-child visit).

4-month dose of HepB:

- It is permissible to administer 4 doses of HepB when combination vaccines are given after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.

2. Rotavirus vaccine (Rota). *(Minimum age: 6 weeks)*

- Administer the first dose between 6 and 12 weeks of age. Do not start the series later than age 12 weeks.
- Administer the final dose in the series by 32 weeks of age. Do not administer a dose later than age 32 weeks.
- There are insufficient data on safety and efficacy outside of these age ranges.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). *(Minimum age: 6 weeks)*

- The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4–6 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). *(Minimum age: 6 weeks)*

- If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.
- TriHiBit® (DTaP/Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in ≥12 months olds.

5. Pneumococcal vaccine. *(Minimum age: 6 weeks for Pneumococcal Conjugate Vaccine (PCV); 2 years for Pneumococcal Polysaccharide Vaccine (PPV))*

- Administer PCV at ages 24-59 months in certain high-risk groups. Administer PPV to certain high-risk groups aged ≥2 years. See *MMWR* 2000; 49(RR-9):1-35.

6. Influenza vaccine. *(Minimum age: 6 months for trivalent inactivated influenza vaccine (TIV); 5 years for live, attenuated influenza vaccine (LAIV)*

- All children aged 6–59 months and close contacts of all children aged 0–59 months are recommended to receive influenza vaccine.
- Influenza vaccine is recommended annually for children aged ≥59 months with certain risk factors, healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006; 55(RR-10);1-41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children receiving TIV should receive 0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

7. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*

- Administer the second dose of MMR at age 4–6 years. MMR may be administered prior to age 4–6 years, provided ≥4 weeks have elapsed since the first dose and both doses are administered at age ≥12 months.

8. Varicella vaccine. *(Minimum age: 12 months)*

- Administer the second dose of varicella vaccine at age 4–6 years. Varicella vaccine may be administered prior to age 4–6 years, provided that ≥3 months have elapsed since the first dose and both doses are administered at age ≥12 months. If second dose was administered ≥28 days following the first dose, the second dose does not need to be repeated.

9. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*

- HepA is recommended for all children at 1 year of age (i.e., 12–23 months). The 2 doses in the series should be administered at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA is recommended for certain other groups of children including in areas where vaccination programs target older children. See *MMWR* 2006; 55(RR-7):1-23.

10. Meningococcal polysaccharide vaccine (MPSV4). *(Minimum age: 2 years)*

- Administer MPSV4 to children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high risk groups. See *MMWR* 2005;54 (RR-7):1-21.

The Childhood and Adolescent Immunization Schedule is approved by:

Advisory Committee on Immunization Practices www.cdc.gov/nip/acip • American Academy of Pediatrics www.aap.org • American Academy of Family Physicians www.aafp.org

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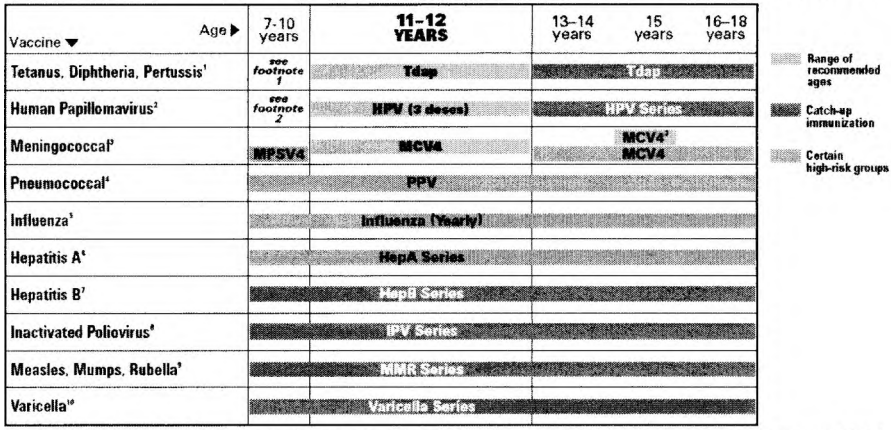
Addendum B

Recommended Adolescent Immunization Schedule 2007-2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommended Immunization Schedule for Ages 7–18 Years UNITED STATES • 2007



This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 7–18 years. For additional information see www.cdc.gov/nip/recs/child-schedule.htm. Any dose not administered at the recommended earlier age should be administered at any subsequent visit when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective ACIP statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

FOOTNOTES

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).
(Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL™)
- Administer at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a Td booster dose.
- Adolescents 13–18 years who missed the 11–12 year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series.

2. Human papillomavirus vaccine (HPV). *(Minimum age: 9 years)*
- Administer the first dose of the HPV vaccine series to females at age 11–12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

3. Meningococcal vaccine. *(Minimum age: 11 years for meningococcal conjugate vaccine (MCV4); 2 years for meningococcal polysaccharide vaccine (MPSV4))*
- Administer MCV4 at age 11–12-years and to previously unvaccinated adolescents at high school entry (~ 15 years of age).
- Administer MCV4 to previously unvaccinated college freshmen living in dormitories; MPSV4 is an acceptable alternative.
- Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high risk groups. See *MMWR* 2005;54 (RR-7):1-21. Use MPSV4 for children aged 2–10 years and MCV4 or MPSV4 for older children.

4. Pneumococcal polysaccharide vaccine (PPV).
(Minimum age: 2 years)
- Administer for certain high-risk groups. See *MMWR* 1997; 46(RR-08): 1–24 and *MMWR* 2000; 49(RR-9):1-35.

5. Influenza vaccine. *(Minimum age: 6 months for trivalent inactivated influenza vaccine (TIV); 5 years for live, attenuated influenza vaccine (LAIV)*
- Influenza vaccine is recommended annually for persons with certain risk factors, healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006; 55(RR-10);1-41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

6. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*
- The 2 doses in the series should be administered at least 6 months apart.
- HepA is recommended for certain other groups of children including in areas where vaccination programs target older children. See *MMWR* 2006; 55(RR-7):1-23.

7. Hepatitis B vaccine (HepB). *(Minimum age: birth)*
- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for 11–15 year olds.

8. Inactivated poliovirus vaccine (IPV). *(Minimum age: 6 weeks)*
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age ≥ 4 years.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be given, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR).
(Minimum age: 12 months)
- If not previously vaccinated, administer 2 doses of MMR during any visit with ≥ 4 weeks between the doses.

10. Varicella vaccine. *(Minimum age: 12 months)*
- Administer 2 doses of varicella vaccine to persons without evidence of immunity.
- Administer 2 doses of varicella vaccine to persons aged ≤13 years at least 3 months apart. Do not repeat the second dose, if administered ≥28 days following the first dose.
- Administer 2 doses of varicella vaccine to persons aged ≥13 years at least 4 weeks apart.

The Childhood and Adolescent Immunization Schedule is approved by:
Advisory Committee on Immunization Practices www.cdc.gov/nip/acip • American Academy of Pediatrics www.aap.org • American Academy of Family Physicians www.aafp.org

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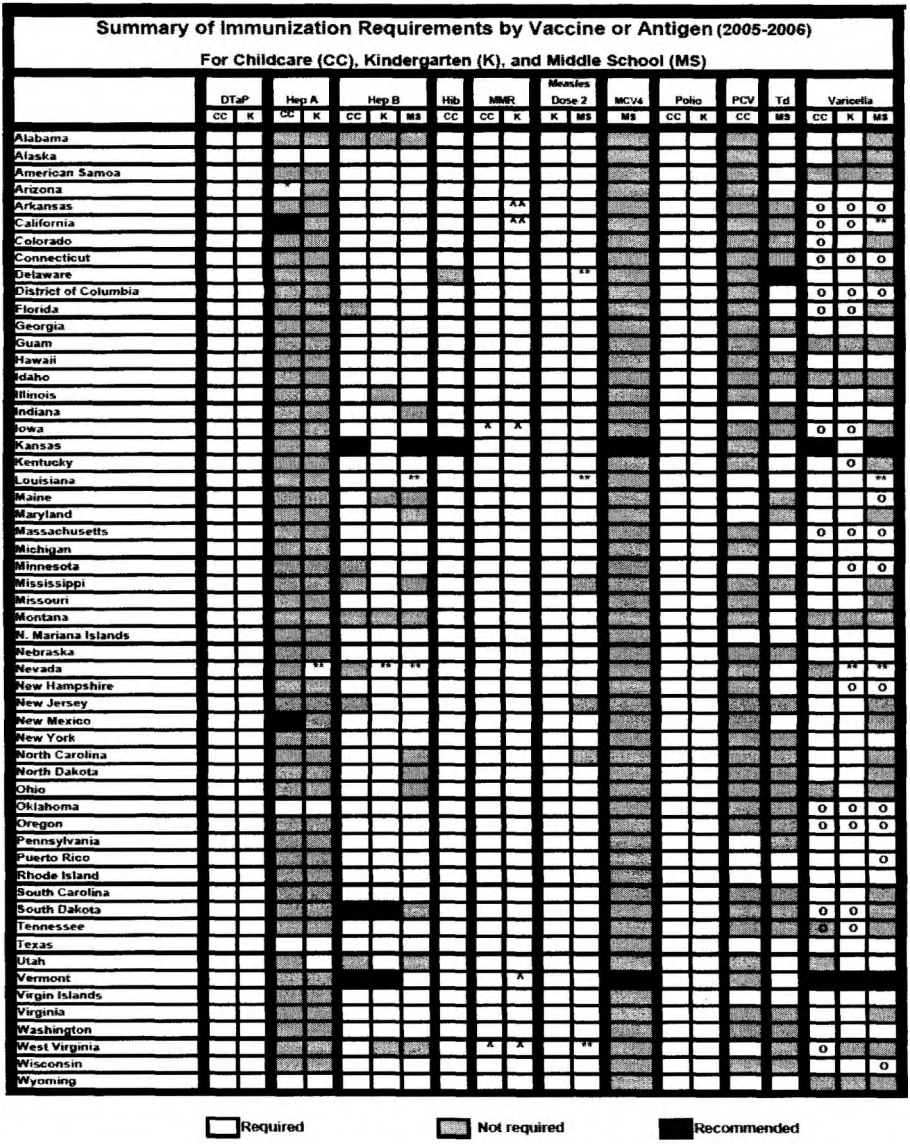
Addendum C

School Requirements, by State



*Required for specific geographic area(s) only
**Required for new entrants only
^Mumps not required
^^Measles containing vaccine accepted
oDocumented history of disease acceptable

Addendum D

Recommended International Childhood EU Vaccination Schedules

Vaccination schedules can be obtained for the following countries by going to **www.EUVAC.net.** Since vaccine requirements can change often, start with this reference and then proceed to vaccination schedules for each country.

- Austria
- Belgium
- Croatia
- Cyprus
- Czech Republic
- Denmark
- Estonia
- Finland
- France
- Germany
- Greece
- Hungry
- Iceland
- Ireland
- Italy
- Latvia
- Lithuania
- Luxembourg
- Malta
- The Netherlands
- Norway
- Poland
- Portugal
- Romania
- Slovakia
- Slovenia
- Spain
- Sweden
- Switzerland
- Turkey
- United Kingdom

Addendum E

Recommended Vaccine Price Lists

Pediatric, as of July 2007

Pediatric Vaccine/Vaccine For Children (VFC) Price List	Manufacturer	Brandname/ Tradename	CDC/Public clinics wholesale cost per dose* ^	Physicians/private sector wholesale cost per dose* ^
DTaP	Sanofi Pasteur	Tripedia	$ 12.65	$ 21.40
DTaP	Sanofi Pasteur	DAPTACEL	$ 13.25	$ 22.04
DTaP	GlaxoSmithKline	Infanrix	$ 13.25	$ 20.96
DTaP-Hep B-IPV	GlaxoSmithKline	Pediarix	$ 47.25	$ 70.72
DTaP-Hib	Sanofi Pasteur	TriHiBit	$ 25.91	$ 42.89
IPV (injectable polio)	Sanofi Pasteur	IPOL	$ 11.06	$ 22.80
Hepatitis B-HiB	Merck	COMVAX	$ 27.75	$ 43.56
Hepatitis A, pediatric	Merck	Vaqta	$ 12.25	$ 30.37
Hepatitis A, adult	Merck	Havrix	$ 12.25	$ 28.74
Hep A + Hep B	GlaxoSmithKline	Twinrix	$ 37.64	$ 78.16
Hepatitis B, pediatric-adolescent	GlaxoSmithKline	Energix b	$ 9.10	$ 21.37
Hepatitis B, pediatric-adolescent	Merck	Recombivax HB	$ 24.25	$ 59.09
HiB	Merck	PedvaxHiB	$ 10.83	$ 22.77
HiB	Sanofi Pasteur	ActHiB	$ 8.12	$ 21.78
HPV	Merck	Gardasil	$ 96.75	$ 120.50
MMR-V	Merck	Pro-Quad	$ 77.75	$ 124.37
Meningococcal	Sanofi Pasteur	Menactra	$ 73.09	$ 89.43
MMR-V	Merck	MMR-II	$ 17.60	$ 44.84
Pneumococcal 7-valent, peds	Wyeth-Lederle	Prevnar	$ 62.14	$ 78.44
Rotaviru	Merck	RotaTeq	$ 55.05	$ 66.94
Tetanus and Diphtheria toxoid	Sanofi Pasteur	DECAVAC	$ 17.38	$ 19.14
Tetanus and reduced Diphtheria toxoids, Acellular pertussis	GlaxoSmithKline	BOOSTRIX	$ 30.75	$ 36.25
Tetanus and reduced Diphtheria toxoids, Acellular pertussis	Sanofi Pasteur	ADACEL	$ 30.75	$ 37.43
Varicella	Merck	Varivax	$ 59.14	$ 74.56
* All vaccines include Federal Excise Tax ranging from $0.75 per dose to $3.75 per dose (each included vaccine) for funding the National Vaccine Injury Compensation Program				
^ Contracts and fees change in March of each year and are subject to change during the year				

Recommended Vaccine Price Lists
Adult, as of July, 2007

Adults Vaccine Price List, as of March, 2008	Manufacturer	Brandname/ Tradename	CDC/Public clinics wholesale cost per dose* ^	Physicians/private sector wholesale cost per dose* ^
Hepatitis A	Merck	Vaqta	$ 18.85	$ 63.51
Hepatitis A	GlaxoSmithKline	Havrix	$ 18.86	$ 52.28
Hepatitis A and B	GlaxoSmithKline	Twinrix	$ 37.64	$ 83.10
Hepatitis B	Merck	Recombivax	$ 23.78	$ 59.70
Hepatitis B	GlaxoSmithKline	Energix B	$ 24.73	$ 50.35
Pneumococcal, 23-strain (adult pneumonia shot)	Merck	Pneumovax	$ 14.86	$ 26.08
Tetanus-Diphtheria Toxiods	Mass. Biological Labs	dT	$ 10.36	$ 15.95
Zoster Vaccine	Merck	Zostavax	$ 107.93	$ 145.35

*all vaccines include Federal Excise Tax ranging from $0.75 per dose to $3.75 per dose (each included vaccine) for funding the National Vaccine Compensation Program.

^ Contracts and fees can vary slightly based on packaging, change each year per contract and are subject to change during the year

Influenza Contracts
as of October, 2007

Influenza Vaccine/Vaccine For Children (VFC) Price List through March, 2008	Manufacturer	Brandname/ Tradename	CDC/Public clinics wholesale cost per dose* ^	Physicians/private sector wholesale cost per dose* ^
Influenza, 6 mon and older	Sanofi Pasteur	Fluzone	$ 10.15	$ 11.72
Influenza, 6 to 35 mon	Sanofi Pasteur	Fluzone, peds	$ 12.77	$ 14.26
Influenza, 36 mon+	Sanofi Pasteur	Fluzone, preservative free	$ 13.75	$ 15.36
Influenza, Age 4+	Novartis	FluViron	$ 10.16	$ 12.48
Influenza, 18 yrs +	GlaxoSmithKline	Fluarix	$ 12.00	$ 13.25
Influenza, Live 6-49yrs	MedImmune	FluMist	$ 17.65	$ 17.95

*all vaccines include Federal Excise Tax ranging from $0.75 per dose to $3.75 per dose (each included vaccine) for funding the National Vaccine Compensation Program.

^ Contracts and fees can vary slightly based on packaging, change each year per contract and are subject to change

Addendum F

VACCINE INGREDIENT LIST

Traces of these ingredients are in all of the vaccines. Each vaccine contains a different combination; all ingredients are not in any one vaccine.

Adjuvant: Aluminum
Adjuvant: Marcol 82 (A mixture of liquid saturated hydrocarbons)
Adjuvant: **MF59:** This is an adjuvant composed of squalene and two emulsifying agents, called Tween80 (a.k.a polysorbate 80) and Span85. Mixed together, these compounds form an oil in-water emulsion with uniform droplets. Found in Anthrax vaccine and has been implicated in Gulf War Illness.
Adjuvant: Mineral oil
Adjuvant: Montanide 80 (oil based)
Adjuvant: Squalene (oil based)
Adjuvant: Polyoxidonium (polymer)

Amino acids: Glutamate, Glycine, Histidine, Alanine

Animal cells: African green monkey kidney cells
Animal cells: Bovine (cow) serum. Bovine blood products can be contaminated with viruses. Bovine viral diarrhea virus (BVDV) is the one most often contaminating fetal bovine serum. **REF: European Commission on Health and Consumer Protection Directorate-General. Scientific Committed on Animal Health and Animal Welfare. Adopted 25 October, 2000. http://europa.eu.int/comm/food/fs/sc/scah/out50_en.pdf**
Animal cells: Chick embryo cells
Animal cells: Chinese hamster ovary cells
Animal cells: Dog kidney cells
Animal cells: Egg protein

Animal cells: Fetuin (calf blood proteins)
Animal cells: Hemin chloride (porcine source)
Animal cells: Human albumin
Animal cells: Human cell line: PER C6
Animal cells: Human diploid cells: WI-38
Animal cells: Human diploid cells: MRC5
Animal cells: Mouse brain cells
Animal cells: Ovalbumin (egg)
Animal cells: Protein contaminants

Antibiotic: Amphotericin B
Antibiotic: Cephalin
Antibiotic: Erythromycin
Antibiotic: Gentamicin
Antibiotic: Kanamycin
Antibiotic: Chlortetracycline hydrochloride
Antibiotic: Neomycin
Antibiotic: Polymyxin B
Antibiotic: Streptomycin

Carriers: Dextran, silicone, polydimethylsiloxane (silcon), polyribosyribitol phosphate

Chemicals: 2 – **Phenoxyethanol.** Used as a fixative for perfumes, a bactericide, an insect repellent, a topical antiseptic, solvent in dyes, inks, resins, plasticizers. Classed as "Very Toxic Material". May lead to kidney, liver, blood and central nervous system (CNS) disorders. Harmful or fatal if swallowed. Effects include behavioral disorders. May cause reproductive defects. ***Also known as "antifreeze".*** **VACCINES: DTaP, HiB, IPV, Hep A, Hep B, Typhoid, Adacel**
Chemicals: 2 – Ethylmercurithio-benzoic acid
Chemicals: Acetic acid

Chemicals: Alcohol
Chemicals: Ammonium sulfate
Chemicals: Arum triphyllum
Chemicals: Aspartame
Chemicals: Benzethonium chloride
Chemicals: **Beta-propiolactone:** Vapor is very irritating and the liquid form is carcinogenic. Propiolactone is "reasonably expected to be a human carcinogen." **VACCINES: Rabies, Fluviron.**
Chemicals: **Dibutyl phthalate:** A commonly used plasticizer used as an additive to adhesives and printing inks. It was added to a list of suspected teratogens (cause birth defects) in November of 2006. It is a suspected endocrine disrupter. **VACCINES: Typhoid Oral vaccines.**
Chemicals: **Diethyl phthalate:** A plasticizer suspected to be toxic to the liver, GI tract, endocrine system, immune system, reproductive tract, respiratory system, skin and neurological system.
Chemicals: Diethylether
Chemicals: Ethylene glycol (another name for 2-Phenoxyethanol)
Chemicals: **Formaldehyde:** Australian National Research Council reported that between 10 and 20 percent of the general population may be susceptible to formaldehyde and may react acutely at any exposure level. Ranked as one of the most hazardous compounds (worst 10 percent) to ecosystems and human health. Formaldehyde has caused cancer in laboratory animals and may cause cancer in humans. There is no known threshold level below which cancer risk does not exist. The World Health Organization recommends that exposure should not exceed 0.05 ppm. **REF: IAQ fact sheet: formaldehyde. http://www.nsc.org/ehc/indoor/formald.htm**
VACCINES: Boostrix, Comvax (HiB+HepB); Twinrix, DTaP, DTP, dT, Flu Lavel, Fluzone, Infanrix, IPOL, Hepatitis A, Pediarix, Recombivax (HepB), TriHiBit (DTaP+Hib), Vaqta.

Chemicals: **Formalin:** Derivative of formaldehyde. Mixture of 40% formaldehyde, 10% methanol and water.
Chemicals: Hexadecyltrimethylammonium bromide
Chemicals: Hydrochloric acid
Chemicals: Monophosphoryl lipid A
Chemicals: **MSG:** Monopotassium glutamate, Monopotassium phosphate, monosodium Glutamate (MSG), glutamic acid, potassium glutamate. **VACCINES: ProQuad, Varivax (chickenpox), Typhoid, RotaShield (recalled), FluMist**
Chemicals: Phenol. **VACCINES: Dryvax, Pneumovax, TyphimVi**

Culture Medium: Ascorbic acid
Culture Medium: Acid hydrolysate (casein)
Culture Medium: Casamino acids (casein)
Culture Medium: Dextrose
Culture Medium: Disodium dehydrogenate phosphate
Culture Medium: Dulbecco's Modified Eagle Medium
Culture Medium: Galactose
Culture Medium: Medium 199
Culture Medium: Minimum Essential Medium
Culture Medium: Protein hydrolysate
Culture Medium: Sucrose
Culture Medium: Soy peptone
Culture Medium: Soy protein
Culture Medium: Tryspin
Culture Medium: Yeast extract

Detergent: Anhydrous disodium phosphate
Detergent: Glycol p-isooctylphenyl ether (same as Triton X-100)
Detergent: Octoxynol-10
Detergent: Sodium borate (borax)
Detergent: Sodium deoxycholate
Detergent: Sodium hydroxide

Detergent: Sodium tetraborate decahydrate (borax)
Detergent: Triton X-100 (some forms manufactured for experimental use only and not for human use."
Detergent: Triton N-101

Emulsifier: Fatty-acid ester-based antifoam
Emulsifier: Liquid light paraffin
Emulsifier: **Polysorbate 80.** An emulsifying agent used in ice cream to prevent milk proteins from completely coating the fat droplets, providing a firmer texture and holding its shape as the ice cream melts. Polysorbate 80 is a ubiquitously used solubilizing agent that can cause severe nonimmunologic anaphylactoid reactions. **VACCINES: Japanese encephalitis, Pediarix, hepatitis A, FluShield, Boostrix, Gardasil, Rotateq**
Emulsifier: **Polysorbate 20.** Used to combine oils and water. Used to make body or room sprays, creams, lotions and other formulations
Emulsifier: Potassium dihydrogen phosphate, potassium diphosphate, potassium monophosphate, potassium phosphate, potassium phosphate- monobasic.
Emulsifier: **Sorbitan monooleate:** Used in foods. Medical Conditions Aggravated by exposure: Nausea, headache and vomiting. Target Organs: Central nervous system, cardiovascular system and thyroid.

(An excipient is an inactive substance used as a carrier)
Excipient: Hydroxypropyl methycellulose phthalate
Excipient: Iron oxide yellow dye ci77492 (Typhoid vaccine)
Excipient: Lactose
Excipient: Lecithin (holds ingredients together)
Excipient: Mineral salts
Excipient: Phospholipids lecithin

Excipient: Sorbitol
Excipient: Sodium acetate
Excipient: Sodium bicarbonate
Excipient: Sodium carbonate
Excipient: Sodium citrate
Excipient: Sodium hydrogen carbonate
Excipient: Sodium phosphate- dibasic anhydrous
Excipient: Sodium phosphate-dibasic dodecahydrate
Excipient: Sodium phosphate-monobasic
Excipient: Titanium dioxide

Filler: **Gelatin:** Bovine-derived products in vaccine manufacture. Has been shown to cause severe allergic reaction in vaccines. **VACCINES: Yellow fever, Chickenpox, DTaP, Rabies, ProQuad, MMR, Rubella, JE-Vax**
Filler: Glycerine
Filler: **Latex from stopper**: Essentially in every vaccine
Filler: Polygeline (a blood expander that can cause shock)
Filler: Xanthan gum
Filler: Sodium taurodeoxycholate

Medication: Belladonna
Medication: Hydrocortisone (flu shots)
Medication: Hydrogen succinate (flu shots)
Medication: Potassium chloride
Medication: Synthetic alpha-tocopheryl (flu shot)
Medication: Trometamol. Generic name for Torodol, an injectable anti-inflammatory—used to extract Hep b antigens, in Hepatyrix®, a combination of Hepatitis A and typhoid vaccine.

Preservative: Ethylenediaminetetraacetic acid (EDTA)
Preservative: Disodium edentate (EDTA)

Preservative: **Glutaraldehyde:** A toxic chemical used for cold sterilization of medical and dental equipment. There is no Occupational Safety and Health Administration (OSHA) permissible exposure limit. The National Institute for Occupational Safety and Health (NIOSH) recommends that exposure to glutaraldehyde be under 0.2 ppm (parts per million). **REF: FMSCME Fact sheet: glutaraldehyde. http://www.afscme.org/health/faq-glut.htm VACCINES: Adacel, Daptacl, Infarix, Pediarix**

Preservative: Mercurius, solubilis, etc **VACCINES: TT, dT, Energix B, Fluarix, Fluvirin, FluLavel, Menomune, TriHiBit, Tripedia, Twinrix,**

Reagent: Disodium dehydrogenate phosphate
Reagent: Disodium phosphate dehydrate

Reagent: Isotonic phosphate buffered saline
Reagent: Monosodium phosphate
Reagent: M phosphate- buffered saline

Solvent: Mannitol
Solvent: Polyalcohols
Solvent: Sodium chloride
Solvent: Tri(n)butylphosphate

For more information, see **www.NoVaccine.com**

Addendum G

INDIVIDUAL INGREDIENTS, SORTED BY VACCINE

This list identifies wish ingredients are in each vaccine. Manufacturer and individual ingredients in each vaccine subject to change. Please check current package inserts for most current information.

Correct as of September, 2007

SOURCE: IMMUNOFACTS, FDA website and **www.VaccineSafety.edu**

SUBSTANCE	MANUF.	VACCINE	AMOUNT
Albumin, Human			
MMRII	Merck	MMR	0.30 mg
Attenuvax	Merck	Measles	0.30 mg
Meruvax II	Merck	Rubella	0.30 mg
ProQuad	Merck	MMR + Chickenpox	0.31 mg
RabAvert	Chiron	Rabies	<0.30 mg
Aluminum hydroxide			
Boosterix	GSK	Teen pertussis	0.390 mg
Comvax	Merck	Hib + Hep b	0.225 mg
Energix B	GSK	Hepatitis b	0.500 mg
Havrix	GSK	Hep A, peds	0.250 mg
Havrix	GSK	Hep A, adult	0.500 mg
Infanrix	GSK	DTaP	0.625 mg
Pediarix	GSK	DTaP + HepB +IPV	0.625 mg
Recombivax	Merck	Hep B	0.500 mg
Twinrix	GSK	Hep A+B	0.450 mg
Vaqta	Merck	Hep A, peds	0.225 mg
Vaqta	Merck	Hep A, adult	0.450 mg
Aluminum sulfate			
Gardasil	Merck	HPV	0.225 mg
dT	S-Pasteur	Tetanus booster	0.280 mg
TriHiBit	S-Pasteur	DTaP + HiB	0.170 mg
Tripedia	S-Pasteur	DTaP	0.170 mg
Vaqta	Merck	Hep A	0.225 mg
Ammonium sulfate			
ActHiB	Aventis	Hib + tet toxoid	??
Daptacel	S-Pasteur	DTaP	??
Tripedia	S-Pasteur	DTaP	??

SUBSTANCE	MANUF.	VACCINE	AMOUNT
Aluminum Phosphate			
Adacel	S-Pasteur	Teen pertussis	1.500 mg
Daptacel	S-Pasteur	DTaP	0.330 mg
Prenvar	Wyeth	Pneumococcal	0.125 mg
Recombivax	Merck	Hep B	0.500 mg
Twinrix	GSK	Hepatitis A+ B	0.450 mg
Amphotericin B			
RabAvert	Chiron	Chiron	< 2 ng
Bovine products (including bovine serum)			
Attenuvax	Merck	Measles	< 1ppm
Boostrix	GSK	Teen pertussis	in medium
Dryvax	Wyeth	Smallpox	in medium
DT	S-Pastuer	Tetanus booster	25 mcg
Infanrix	GSK	DTaP	trace amts
IPOL	S-Pasteur	Polio	trace amts
Havrix	GSK	Hepatitis A	<0.1mg
Meruvax II	Merck	Rubella	< 1ppm
MMR II	Merck	MMR	< 1ppm
ProQuad	Merck	MMR + Chickenpox	0.05 mg
Pediarix	GSK	DTaP+HepB+IPV	trace amts
Pnemovax 23	Merck	Adult pneumonia	trace amts
RabAvert	Chiron	Rabies	trace amts
Rotateq/Rotarix	Merck	Rotavirus	trace amts
TriHiBit	S-Pasteur	DTaP + HiB	trace amts
Tripedia	S-Pasteur	DTaP	trace amts
Vaqta	Merck	Hepatitis A	<0.5mg
Varivax	Merck	Chickenpox	in medium
Zostavax	Merck	Zoster (shingles)	in medium

SUBSTANCE	MANUF.	VACCINE	AMOUNT
Disodium phosphate			
Typhim Vi	S-Pasteur	Typhoid	0.13mg/ml
EnergixB	Merck	Hep B	0.98 mg
DNA from animal cells*			
Havrix (MRC-5)	GSK	Hep A	5 mcg
IPOL (VERO cells)	S-Pasteur	Polio	IN VAX
MMR II (WI-38)	Merck	MMR	IN VAX
Meruvax II (WI-38)	Merck	Rubella	IN VAX
ProQuad (MRC-5 + WI-38)	Merck	**MMR + chickenpox**	IN VAX
RabAvert (MRC-5)	S-Pasteur	Rabies	IN VAX
Twinrix (MRC-5)	GSK	Hep A + B	2.5mcg/ml
Vaqta (MRC-5)	Merck	Hep A	trace
Varivax (MRC-5, bovine)	Merck	Chickenpox	IN VAX
Zostavax (MRC-5, bovine)	Merck	Zoster (shingles)	IN VAX
Egg/Ovalbumen/Chicken products			
Attenuvax	Merck	Measles	IN VAX
Fluarix	GSK	Influenza	IN VAX
FluLaval	GSK	Influenza	IN VAX
FluMist	MedImmune	Influenza	IN VAX
Fluvirin	S-Pasteur	Influenza	IN VAX
Fluzone	S-Pasteur	Influenza	IN VAX
MMR II	Merck	MMR	IN VAX
Mumpsvax	Merck	Mumps	IN VAX
ProQuad	Merck	**MMR + chickenpox**	IN VAX
RabAvert	Chiron	Rabies	IN VAX
YF-Vax	S-Pasteur	Yellow Fever	IN VAX

* The FDA has concern over the amount of viral contaminantion in these cell lines. Scientists have determined that it takes only one "functional unit" (one that can replicate) of foreign DNA to integrate into the host cell genome and transform that cell into cancer. Current lax standards allow up to 100,000,000 "functional units" of viral DNA in a dose of vaccine. **REF:** "What's Coming Through That Needle? The Problem of Pathogenic Vaccine Contamination," a research paper by Benjamin McReardon.

SUBSTANCE	MANUF.	VACCINE	AMOUNT
Formaldehyde: Recognized carcinogen			
Adacel	S-Pasteur	Teen pertussis	≤ 0.005mg
Boostrix	Merck	Teen pertussis	≤ 0.100mg
Comvax	Merck	Hib + Hep B	0.04 mg
Daptacel	S-Pasteur	DTaP	≤ 0.100mg
DT	S-Pasteur	Adult tetanus	≤ 0.20 mg
Fluarix	GSK	Influenza	≤ 0.050mg
FluLaval	GSK	Influnza	≤ 0.025mg
Fluzone	S-Pasteur	Influenza	≤ 0.20 mg
Infanrix	GSK	Influenza	≤ 0.100mg
IPOL	S-Pasteur	Polio	≤ 0.20 mg
JE-Vax	S-Pasteur	Jap. Encephalitis	≤ 0.100mg
Pediarix	GSK	DTaP + Hep b + IPV	≤ 0.100mg
Recombivax	Merck	Hep B	≤ 0.20 mg
Td	S-Pasteur	Tetanus booster	≤ 0.20 mg
TriHIBit	S-Pasteur	DTaP + HiB	≤ 0.100mg
Tripedia	S-Pasteur	DTaP	≤ 0.100mg
Vaqta	Merck	Hepatitis A	≤ 0.008mg
Formalin			
ActHIB	S-Pasteur	HiB	≤0.001mg
Daptacel	S-Pasteur	DTaP	≤0.001mg
Harivax	GSK	Hepatitis A	≤0.001mg
Twinrix	GSK	Hepatitis A+B	≤0.001mg
Gentamycin Sulfate			
FluMist	MedImmune	Influenza	<0.0015 mg
Fluarix	GSK	Influenza	<0.0150 mg
Glycerin			
Dryvax	Wyeth	Smallpox	50% of diluent

SUBSTANCE	MANUF.	VACCINE	AMOUNT
Gelatin, porcine			
Attenuvax	Merck	Measles	14.5 mg
Boostrix	GSK	Teen pertussis	<0.1 mg
Fluzone	Aventis	Influenza	0.50 mg
JE-Vax	S-Pasteur	Jap. Encephalitis	0.50 mg
Meruvax II	Merck	Rubella	14.5 mg
MMR II	Merck	MMR	14.5 mg
Mumpsvax	Merck	Mumps	14.5 mg
ProQuad	Merck	MMR + chickenpox	11.0 mg
RabAvert (bovine)	Chiron	Rabies	12.0 mg
TriHiBit	S-Pasteur	DTaP+HiB	trace
Tripedia	S-Pasteur	DTaP	trace
Varivax	Merck	Chickenpox	12.5 mg
YF Vax	S-Pasteur	Yellow Fever	stabilizer
Zostavax	Merck	Zoster (shingles)	15.58 mg
Gentamycin Sulfate			
FluMist	MedImmune	Influenza	<0.0015 mg
Fluarix	GSK	Influenza	<0.0150 mg
Glutaraldehyde			
Adacel	S-Pasteur	Teen pertussis	<50 ng
Daptacel	S-Pasteur	DTaP	<50 ng
Infanrix	GSK	DTaP	trace
Pediarix	GSK	DTaP + HepB + IPV	trace
Glycol p-isooctyophenyl ether			
Fluzone	S-Pasteur	Influenza	
Lactose			
Menomune	S-Pasteur	Meningitis	2.5-5.0 mg
Vivotif	Berna	Typhoid	100-180 mg

SUBSTANCE	MANUF.	VACCINE	AMOUNT
Latex			
ActHiB	Aventis	HiB	rubber stopper
Adacel	S-Pasteur	DTaP	rubber stopper
Boostrix	GSK	Teen pertussis	rubber stopper
Comvax	Merck	Hib-HepB	rubber stopper
Daptacel	S-Pasteur	DTaP	rubber stopper
DT	Aventis	Tetanus booster	rubber stopper
Energix B	GSK	Hep B	rubber stopper
Fluarix	GSK	Influenza	rubber stopper
Harivax	GSK	Hep A	rubber stopper
HiBTITER	Wyeth	HiB	rubber stopper
Infanrix	GSK	DTaP	rubber stopper
IPOL	S-Pasteur	Polio	rubber stopper
Menactra	S-Pasteur	Meningitis	rubber stopper
Menomune	S-Pasteur	Meningitis	rubber stopper
Pediarix	GSK	**DTaP + Hep B + IPV**	rubber stopper
Prevnar	Wyeth	Peds pneumococcal	rubber stopper
Td	S-Pasteur	Tetanus booster	rubber stopper
TriHiBit	S-Pasteur	DTaP+ HiB	rubber stopper
Tripedia	S-Pasteur	DTaP	rubber stopper
Twinrix	GSK	Hep A+ B	rubber stopper
YF-Vax	S-Pasteur	Yellow fever	rubber stopper
Monosodium or Potassium Glutamate (MSG)			
Flumist	MedImmune	Influenza	0.47 mg/dose
ProQuad	Merck	MMR + chickenpox	0.40 mg
RabAvert	Chiron	Rabies	0.40 mg
Varivax	Merck	Chickenpox	0.50 mg
Zostavax	Merck	Zoster (shingles)	0.62 mg

SUBSTANCE	MANUF.	VACCINE	AMOUNT
Magnesium stearate			
Vivotif	Berna	Typhoid	3.6-4.4 mg
Neomycin/Neomycin sulfate; tetracycline			
Attenuvax	Merck	Measles	0.025 mg
Dryvax	Wyeth	Smallpox	100 units/ml
Fluvirin	Chiron	Influenza	trace
Havrix	GSK	Hep A + B	40 ng/ml
Imovax	S-Pasteur	Rabies	150 mcg
IPOL	S-Pasteur	Polio	<5 ng/ml
Meruvax II	Merck	Rubella	0.025 mg
MMR II	Merck	MMR	<5 ng/ml
Mumpsvax	Merck	Mumps	0.025 mg
Pediarix	GSK	DTaP + Hep B + IPV	≤0.05 ng
ProQuad	Merck	MMR + Chickenpox	0.016 mg
RabAvert	Chiron	Rabies	≤ 20 ng
Twinrix	GSK	Hep A + B	≤ 20 ng
Varivax	Merck	Chickenpox	trace
Zostavax	Merck	Zoster (shingles)	trace
Phenol			
Dryvax	Wyeth	Smallpox	2.5 mg/ml
Typhim Vi	S-Pasteur	Typhoid	2.5 mg/ml
Pneumovax 23	Merck	Adult pneumonia	2.5 mg/ml
Polymyxin B			
Dryvax	Wyeth	Smallpox	100 units/ml
Fluvirin	Chiron	Influenza	trace
IPOL	S-Pasteur	Polio	25 ng
Pediarix	Merck	DTaP + Hep B + IPV	<0.01 ng

SUBSTANCE	MANUF.	VACCINE	AMOUNT
2-phenoxyethanol			
Adacel	S-Pasteur	Teen pertussis	3.3 mg
Daptacel	S-Pasteur	DTaP	3.3 mg
Harivax	GSK	Hep A	5 mg
Infanrix	GSK	DTaP	2.5 mg
IPOL	S-Pasteur	Polio	5 mg (0.5%)
Twinrix	GSK	Hep A + B	5 mg/ml
Polygeline			
RabAvert	Chiron	Rabies	12 mg
Polysorbate 20			
Havrix	SKB	Hep A	3 mg (0.3%)
Twinrix	SKB	Hep A + B	??
Polysorbate 80			
Fluarix	GSK	Influenza	4.15 mg
Gardasil	Merck	HPV	0.50 mg
Infanrix	GSK	DTaP	0.10 mg
Pediarix	GSK	DTaP + Hep B + IPV	0.10 mg
RotaTeq/Rotarix	Merck	Rotavirus	??
TriHiBit	S-Pasteur	DTaP + HiB	??
Tripedia	S-Pasteur	DTaP	??
Potassium chloride			
Varivax	Merck	Chickenpox	0.08 mg
Zostavax	Merck	Zoster (shingles)	0.10 mg
Potassium phosphate			
Flumist	**MedImmune**	Influenza	in buffer
ProQuad	Merck	MMR + Chickenpox	0.072 mg
Varivax	Merck	Chickenpox	0.08 mg
Zostavax	Merck	Zoster (shingles)	0.10 mg

SUBSTANCE	MANUF.	VACCINE	AMOUNT
Sodium borate (borax)			
Comvax	Merck	HiB + Hep B	35 mcg
Gardasil	Merck	HPV	35 mcg
Vaqta	Merck	Hep A, peds	35 mcg
Vaqta	Merck	Hep A, adult	70 mcg
Sodium chloride			
Attenuvax	Merck	Measles	trace
Comvax	Merck	Hib-HepB	9.0 mg
Fluarix	GSK	Influenza	trace
Gardasil	Merck	HPV	9.56mg
Infanrix	GSK	Influenza	4.5 mg
Meruvax II	Merck	Rubella	trace
MMR II	Merck	MMR	trace
Mumpsvax	Merck	Mumps	trace
Pediarix	GSK	DTaP + Hep b + IPV	4.5 mg
ProQuad	Merck	MMR + chickenpox	2.4 mg
Typhim Vi	S-Pasteur	Typhoid	8.3 mg
Varivax	Merck	Chickenpox	3.2 mg
Vaqta	S-Pasteur	Hep A, ped & adult	9.0 mg
YF-Vax	S-Pasteur	Yellow Fever	0.6 mg
Zostavax	Merck	Zoster (shingles)	4.0 mg
Sodium deoxycholate			
FluLaval	GSK	Influenza	0.05 mg
Sodium dihydrogen phosphate			
Energix-B	GSK	Hep B	0.71 mg
Sodium EDTA			
RabAvert	Chiron	Rabies	0.30 mg
Sodium hydroxide			
RotaTeq/Rotarix		Rotavirus	trace

SUBSTANCE	MANUF.	VACCINE	AMOUNT
Sodium phosphate dibasic/monobasic			
Attenuvax	Merck	Measles	0.34 mg
MMR II	Merck	MMR	0.34 mg
ProQuad	Merck	MMR + chickenpox	0.34 mg
Varivax	Merck	Chickenpox	0.45 mg
Zostavax	Merck	Zoster (shingles)	0.57 mg
Sucrose			
ActHiB	S-Pasteur	HiB	85 mg (8.5%)
Attenuvax	Merck	Measles	1.9 mg
Fluarix	Merck	Influenza	trace
FluMist	MedImmune	Influenza	in buffer
Fluzone	S-Pasteur	Influenza	trace
Meruvax II	Merck	Rubella	1.9 mg
MMR II	Merck	MMR	1.9 mg
Mumpsvax	Merck	Mumps	1.9 mg
OmniHiB	GSK	HiB	85 mg
ProQuad	Merck	MMR + Chickenpox	≤21 mg
RotaTeq/Rotarix		Rotavirus	trace
Varivax	Merck	Varicella	25 mg
Vivotif	Berna	Typhoid	26-130 mg
Zostavax	Merck	Zoster (shingles)	31.16 mg
Sorbitol			
Attenuvax	Merck	Measles	14.5 mg
Meruvax II	Merck	Rubella	14.5 mg
MMR II	Merck	MMR	14.5 mg
Mumpsvax	Merck	Mumps	14.5 mg
ProQuad	Merck	MMR + Chickenpox	1.8 mg
YF Vax	S-Pasteur	Yellow fever	stabilizer

SUBSTANCE	MANUF.	VACCINE	AMOUNT
Yeast			
Comvax	Merck	HepB + HiB	≤ 10 mg/cc
Energix B	GSK	Hep B	50 mg
Gardasil	Merck	HPV	trace
HiBTITER	Wyeth	HiB	large amts
Pediarix	GSK	DTaP + Hep B + IPV	≤ 50 mg/cc
Prevnar	Wyeth	Pneumococcal	large amts
Recombivax	Merck	Hep B	≤ 10 mg/cc
Twinrix	GSK	Hep A + B	≤ 50 mg/cc
Vivotif	Berna	Typhoid	large amts
Thimerosal containing (as of 9-07)			
Decavac	Mass Pub Health	dT booster	<0.3 mcg/dose
DT, dT, TT	(several)	Tetanus boosters	25 mcg/dose
Energix-B	GSK	Teen pertussis	<0.50 mcg/dose
Energix-B	GSK	Adult formulation	<1.0 mcg/dose
Fluarix	GSK	Influenza	< 1.0 mcg/dose
FluLaval	GSK	Influenza	25 mcg/dose
Fluvirin	Novartis	Influenza	<1.0 mcg/dose
Fluzone	S-Pasteur	Flu (multi dose)	25 mcg/dose
JE Vax	S-Pasteur	Jap. Encephalitis	35 mcg/dose
Menomune	S-Pasteur	Meningitis	25 mcg/dose
TriHiBit	S-Pasteur	DTaP + HiB	<0.3mcg/dose
Tripedia	S-Pasteur	DTaP	<0.3 mcg/dose
Twinrix	GSK	Hep A+ B	<1.0 mcg/dose

SUBSTANCE	MANUF.	VACCINE	AMOUNT
Thimerosal-free formulations (as of 9-07)			
ActHIB	S-Pasteur	HiB	never contained
Anthrax	BioPort	Anthrax	never contained
Boostrix	GSK	Teen pertussis	never contained
Comvax	Merck	Hib + Hep B	never contained
Daptacel	S-Pasteur	DTaP	never contained
Energix B	GSK	Hep B	**as of 1-30-2007**
Fluzone **SINGLE**	S-Pasteur	Influenza	**as 12-23-2004**
FluMist	MedImmune	Influenza	never contained
Harivax	GSK	Hep A	**as of 6-29-2007**
HibTITER	Wyeth	HiB	never contained
Infanrix	GSK	DTaP	**as of 9-29-2000**
IPOL	S-Pasteur	Polio	never contained
Imovax	S-Pasteur	Rabies	never contained
Menactra	S-Pasteur	Meningitis	never contained
MMR II	Merck	MMR	never contained
OmniHiB	GSK	HiB	never contained
Pediarix	GSK	DTaP + Hep B + IPV	**as of 1-29-2007**
PedVax HiB	Merck	HiB	**as of 8-1999**
Pneuovax 23	Merck	Adult pneumonia	never contained
PolioVax	S-Pasteur	Polio	never contained
Prevnar	Wyeth	Peds pneumococcal	never contained
RabAvert	Novartis	Rabies	never contained
Recombivax HB	Merck	Hep B	**as of 8-27-1999**
Typhim Vi	S-Pasteur	Typhoid	never contained
Vivotif	Berna	Typhoid (oral)	never contained
Varivax	Merck	Chickenpox	never contained
Y-F Vax	S-Pasteur	Yellow fever	never contained

Addendum H

Common Vaccines and Their Ingredients

Vaccine availability, ingredients and
manufacturers change frequently.
Correct as of November, 2007.

ActHiB

Haemphilus Influenza Type B (HiB) Tetanus Toxoid Conjugate
S-Pasteur
Contents: Ammonium sulfate, formalin, Muller medium, sucrose (85 mg/cc), tetanus toxoid

Adacel (Adolescent Pertussis Booster)

Reduced diphtheria toxoid, reduced acellular pertussis, tetanus
Sanofi-Pasteur
Licensed: 1-23-2006
COMMENT: Pertussis booster vaccine for 11- to 64-year-olds
Contents: Tetanus toxoid , Diphtheria toxoid, Pertussis toxoid (PT), FHA, pertactin (PRN), FIM, aluminum phosphate, formaldehyde, glutaraldehyde, 2-phenoxyethanol, Muller's media, latex

Attenuvax

Individual Measles Virus Vaccine – Live
Not available in the U.S.
Merck
Contents: Sorbitol, sodium phosphate, sucrose, sodium chloride, gelatin, human albumin, fetal bovine serum, neomycin, residual egg proteins, chicken embryo culture

Boostrix

Toxoids from B. pertussis, C. tetani, C. diphtheria

GlaxoSmithKline (GSK)
Licensed: 12-29-2005
RECOMMENDATION: Pertussis booster for 10- to 18- year-olds
Contents: Diphtheria toxoid, Tetanus toxoid, Pertacin (PRN), FHA, pertussis toxin (PT), sodium chloride, aluminum adjuvant, formaldehyde, polysorbate 80, latex from stopper, Latham medium derived from bovine extract

Comvax

Vaccination for H.influenza b (HiB) and hepatitis B in a combination vaccine
Merck
Contents: Aluminum hydroxide, sodium borate decahydrate, yeast protein, formaldehyde

Daptacel (DTaP)

Toxoids from B. pertussis, C. tetani, C. diphtheria
Sanofi-Pasteur
Licensed: 2002
Contents: Formaldehyde, glutaraldehyde, formalin, latex from rubber stopper, 2-phenoxyethanol, pertussis toxoid, pertactin (PRN), aluminum phosphate, diphtheria toxoid, tetanus toxoid, filamentous hemagglutinin (FHA), pertactin, Stainer-Scholte medium, modified casamino acids, modified Mueller's medium, ammonium sulfate

Dryvax

Live, attenuated vaccine for smallpox; administered with bifurcated needle
Wyeth
COMMENT: One vial and diluent will create 100 vaccinations
Contents: Phenol, calf lymph, polymyxin B, dihydro-streptomycin, chlortetracycline, neomycin, skin of vaccinated bovine calves

DTP

Diphtheria and Tetanus Toxoids and whole cell Pertussis Vaccine Adsorbed
SmithKline Beecham Pharmaceuticals
No longer used in the U.S.
Contents: Aluminum phosphate, formaldehyde, ammonium sulfate, washed sheep red blood cells, glycerol, sodium chloride, thimerosal, medium of porcine pancreatic hydrolysate of casein

dT Vaccine

For active immunity to tetanus and diphtheria, booster
Sanofi-Pasteur
Contents: Diphtheria toxoid, tetanus toxoid, aluminum potassium sulfate, formaldehyde, latex stopper, amino acid peptone medium, Mueller and modified Miller medium, **thimerosal 25 mcg/dose**

Energix-B

Inactiated Hepatitis B Vaccine
GlaxoSmithKlein (GSK)
COMMENT: Adult = 20 mcg/cc injection is twice the dose of Recombivax; Pediatric = 10 mcg/0.5cc injection
Contents: Aluminum hydroxide, Disodium phosphate, sodium dihydrogen phosphate, yeast protein (50 mg), **trace thimerosal**

Fluarix

Influenza Inactivated Virus Vaccine
GlaxoSmithKlein (GSK)
Contents: 15mcg each of influenza A, H1N1 virus, influenza A, H3N2 virus and influenza B; Triton X100 detergent, a-tocopherol hydrogen succinate, polysorbate 80, residual egg proteins, latex, **thimerosal**

Fluvirin

Influenza Inactivated Virus Vaccine
Novartis
Contents: 15mcg each of influenza A, H1N1 virus, influenza A, H3N2 virus and influenza B; phosphate buffer, residual egg proteins, neomycin, polymyxin B, **thimerosal**

FluLaval

Influenza Virus Vaccine, Trivalent, Types A& B
GlaxoSmithKlein (GSK)
COMMENT: For persons 18 years of age and older only
Contents: 15mcg each of influenza A, H1N1 virus, influenza A, H3N2 virus and influenza B; formaldehyde, residual egg proteins, sodium deoxycholate, **thimerosal**

FluMist

Live, intranasal Influenza Vaccine
MedImmune
Contents: One million viral particles of influenza A H1N1, influenza A H3N2, and influenza B; sucrose, MSG, gentamycin, residual egg protein from SPF chickens

Fluvirin

Influenza Inactivated Virus Vaccine
Novartis, U.K.
Contents: Embryonated chicken eggs, neomycin, polymyxin b, beta-propiolactone, nonylphenol ethoxylate, phosphate buffered saline, 15mcg each 15mcg each of influenza A, H1N1 virus, influenza A, H3N2 virus and influenza B; **thimerosal** 24.5 mcg mercury per 0.5 mL dose

Fluzone

Influenza Inactivated Virus Vaccine
Sanofi-Pasteur
Contents: 15mcg of influenza H1N1 virus, influenza H3N2 virus, and influenza B; gelatin, formaldehyde, residual egg proteins, **thimerosal** in multidose vials

Gardasil

Recombinant Vaccine for Human Papilloma Virus
Merck
Licensed June, 2006
Contents: Viral-like particles from HPV types 6, 11, 16 and 18, yeast, aluminum sulfate, sodium chloride, L-histidine, polysorbate 80, sodium borate

Havrix

Hepatitis A Inactivate Virus
GlaxoSmithKlein (GSK)
Contents: 2-phenoxyethanol, aluminum hydroxide, polysorbate 20, formalin, bovine albumin, MRC-5 cells, neomycin sulfate, latex from stopper

HiB TITER

Haemophilus Influenza Type B (HiB)
Wyeth
Contents: CRM 197 Diphtheria toxoid, casaminoacids, "yeast extract-based medium that is ultrafiltered before use"

Imovax Rabies

Inactivated Rabies virus, either before or after exposure
S-Pasteur
Contents: Rabies antigen < 2.5 IU, albumin, neomycin sulfate, MRC-5 human diploid cells

Infanrix

Toxins from B. pertussis, C. tetani, C. diphtheria (DTaP)
GlaxoSmithKline (GSK)
Contents: Diphtheria, tetanus and pertussis toxoids, 2-phenoxyethanol, aluminum hydroxide, formaldehyde, polysorbate 80, sodium chloride, latex from stopper, Modifed Stainer-Scholte medium, Fenton bovine extract, glutaraldehyde, FHA, pertactin

IPOL

Inactivated Polio Vaccine (Injectable)
Sanofi-Pasteur
For protection against 3 strains of polio virus
Contents: Type 1 antigen 40IU, Type 2 antigen 8IU, Type 3 32IU, formaldehyde, 2-phenoxyethanol (5mg), newborn calf serum, neomycin, streptomycin or polymyxin b, latex rubber from stopper, VERO cells from African green monkeys, Eagle modified medium, M-199 medium without calf serum

JE-Vax

Inactivated vaccine for Japanese encephalitis virus; used for travel and military
S-Pasteur
COMMENTS: Vaccine is prepared by inoculating mice brains
Contents: Nitrogen 2-3 mcg/dose, mouse serum protein, formaldehyde, gelatin. **Thimerosal** 35 mcg/dose

Menactra

Meningococcal Vaccine for Neiseria meningitidis serotypes A,C,Y W-135
Sanofi-Pasteur
COMMENTS: College meningitis vaccine
Contents: 4 mcg of cell wall from each Neiseria meningitidis serotypes: A,C,Y and W-135; diphtheria 48 mcg, sodium phosphate,

latex from stopper, cultured on Mueller-Hinton agar and grown in Watson Scherp Medium

Menomune

Meningococcal Polysaccharide Vaccine
S-Pasteur
Contents: 50 mcg each of each antigen from Neiseria meningitidis serotypes A,C,Y and W-135, lactose, latex from stopper, Medium 199 amino acids, cultured on Mueller-Hinton agar and grown on Watson Scherp2 Medium, **thimerosal** 25 mcg/dose

> The origination of the new "superbugs":
> **1999:** "Following the widespread use of Haemophilus influenza type b vaccines, S pneumoniae has become the most common cause of bacterial meningitis in the United States." **REF: Infect Med 16(9):596-612, 1999. "Advances in Pneumococcal Vaccines."**
>
> **2005:** "Neisseria meningitidis has become a leading cause of bacterial meningitis in the United States after dramatic reductions in the incidence of Streptococcus pneumoniae and Haemophilus influenzae type b (HiB) infections have been achieved as a result of using conjugate vaccines." **REF: MMWR. Control of Meningococcal Disease, May 27, 2005 / 54(RR07);1-21 http://www.cdc.gov/MMWR/PREVIEW/MMWRHTML/rr5407a1.htm**

Meruvax II

Rubella Live Virus Vaccine
Merck
Contents: Sorbitol, sodium phosphate, sucrose, sodium chloride, gelatin, human albumin, fetal bovine serum, neomycin, human diploid cells WI-38

MMR II

Measles, Mumps, Rubella Live Virus Vaccine
Merck
Contents: Sorbitol, sodium phosphate, sucrose, sodium chloride, gelatin, human albumin, fetal bovine serum, neomycin, residual egg proteins, chicken-embryo cell culture, Medium 199, Human diploid cells, WI-38 for rubella

Mumpsvax

Mumps Live Virus Vaccine
Merck
Contents: Sorbitol, sodium phosphate, sucrose, sodium chloride, gelatin, human albumin, fetal bovine serum, neomycin, residual egg proteins, chicken embryo culture

Orimune (OPV)

Poliovirus Vaccine Live Oral Trivalent
Wyeth-Lederle
Contents: Type 1 800,000 particles, Type 2 100,000 particles, Type 3 500,000 particles, VERO cells from African green monkeys, Eagle MEM modified mediurm, M-199 medium without bovine serum

Pediarix

Combination vaccine for DTaP, Hep B, and IPV vaccine (7 vaccine antigens per shot)
GlaxoSmithKlein
Contents: Toxids of diphtheria and tetanus; pertussis antigens toxin (PT); filamentous hemagglutinin (FHA), and pertactin; polysorbate 80, aluminum hydroxide, sodium chloride, neomycin, polymyxin b, yeast, latex from stopper, glutaraldehyde, bovine serum, formaldehyde, Modified Stainer-Scholte liquid medium

Pneumovax 23

Pneumococcal Vaccine Polyvalent for adults, referred to as the "pneumonia vaccine."
Merck
COMMENT: This vaccine contains 575 mcg of antigen; for comparison, Prevnar is 16 mcg of antigen
Contents: 25 mcg of antigen of 23 different strains of Streptococcal bacteria: strains 1,2,3,4,5,6B,7F, 8,9N,9V,10A,11A, 12F, 14,15b,17F,18C,19F,19A,20,22F,23F,3F; phenol 2.5mg, bovine serum

Prevnar

Cell-wall antigen vaccine for infants and children against 7 strain of Strep pneumonia
Wyethe
COMMENT: This vaccine contains 16 mcg of antigen
Contents: 2 mcg each of strains 4, 9V, 14, 18C, 19F and 23F, 4 mcg of strain 6B, diphtheria toxoid 20 mcg, latex rubber stopper, aluminum phosphate, soy peptone broth

ProQUAD

Combination of attenuated live viruses of Measles, Mumps, Rubella and Varicella
Licensed 9-6-2005
Merck
Contents: Attenuated live measles, mumps, rubella and varicella viruses; chick embryo cells, WI-38 human diploid cells, MRC-5 human diploid cells, bovine serum, human albumin, sucrose, gelatin, sodium chloride, sorbitol, MSG, sodium phosphate dibasic, sodium bicarbonate, potassium phosphate monobasic, potassium chloride, potassium phosphate dibasic, neomycin,

RabAvert

Inactivated injectable rabies vaccine, for before or after viral exposure
Chiron
Contents: Rabies antigen <2.5IU, potassium glutamate (MSG), polygeline protein, human serum albumin, sodium EDTA, neomycin, egg albumin, bovine serum, trace chicken protein, MRC-5 human diploid cells

Recombivax

Hepatitis B Vaccine
Merck
Adult 10mcg/cc injection; Pediatric 5 mcg/cc injection
Contents: Hepatitis B surface antigen (HBsAg), aluminum hydroxide, recombined with Saccharomyces cerevisiae yeast (10mg/cc), soy peptone, dextrose, amino acids, phosphate buffer, formaldehyde, potassium aluminum sulfate

RotaTeq/Rotarix

Rotavirus Vaccine, 5 live viruses in oral suspension
Merck
COMMENT: Four rotaviruses from human parent strain and one rotavirus from bovine strain
Contents: Fetal bovine serum, polysorbate 80, sodium citrate, sodium phosphate monobasic monohydrate, sodium hydroxide, sucrose

TriHiBit

Combination vaccine DTaP plus HiB for H. influenza B
Sanofi-Pasteur
Contents: Diphtheria and tetanus toxoids; pertussis toxin and filamentous hemagglutinin; HiB antigen, aluminum sulfate, formaldehyde, gelatin, polysorbate 80, latex from stopper, Stainer-Scholte casamino acids, Modified Mueller medium, peptone-based

bovine extract, ammonium sulfate, **thimerosal**

Tripedia

For pediatric prevention of diphtheria, tetanus and pertussis
Sanofi -Pasteur
Contents: Toxoids of diphtheria, tetanus and pertussis, aluminum sulfate, formaldehyde, gelatin, polysorbate 80, latex from stopper, Stainer-Scholte casamino acids, Modified Mueller medium, ammonium sulfate, peptone bovine extract, **trace thimerosal**

Twinrix

Inactivated Hepatitis A and B
GlaxoSmithKlein (GSK)
Contents: 2-phenoxyethanol, aluminum phosphate and aluminum hydroxide, polysorbate 20, formalin, MRC-5 cells, yeast, neomycin sulfate, latex from stopper, **thimerosal**

Typhim Vi

Active immunity against typhoid fever
Sanofi-Pasteur
Inactivated bacteria, IM injection
Contents: Purified Vi polysaccharide, phenol 0.25% (2.5mg), sodium chloride, disodium phosphate, monosodium phosphate, anti-foam agent, semi synthetic medium

Vaqta

Hepatitis A
Merck
Contents: Inactivated hepatitis A virus (50 units), human MRC-5 cells, aluminum sulfate, bovine albumin, formaldehyde, sodium borate, sodium chloride

Varivax

Varicella Vaccine for prevention of chickenpox
Merck
COMMENT: Must remain frozen at -15C (5UF) up to 72 hours before reconstitution, then stored at 35-46F for 72 hrs before use.
Contents: Live, attenuated varicella virus (1,350), sucrose, hydrolyzed gelatin, sodium chloride, MSG (0.5mg), sodium phosphate dibasic, potassium phosphate monobasic, potassium chloride, trace EDTA, neomycin, bovine serum, MRC-5 human diploid cells

Vitamin K (AquaMephyton)

Aqueous Collodial Solution of Vitamin K
FDA BLACK LABEL WARNING

> "Severe reactions, including fatalities, have occurred during and immediately after the parental administration of AquaMEPHYTON. Typically these severe reactions have resembled hypersensitivity and/or anaphylaxis, including shock and cardiac and/or respiratory arrest. Some patients have exhibited these severe reactions on receiving AquaMEPHYTON for the first time. The majority of these reported events occurred following intravenous administration, even when precautions were taken to dilute the AquaMEPHYTON and to avoid rapid infusion. Therefore, the INTRAVENOUS route should be restricted to those situations where another route is not feasible and the increased risk involved is considered justified."

Contents: phytonadione 2 mg or 10 mg, polyoxyethylated fatty acid derivative, dextrose, benzyl alcohol (9mg/cc)

Vivotif Berna

Active immunity against typhoid fever
Berna, Switzerland
COMMENT: Live, attenuated oral enteric-coated capsule with Salmonella typhi colony-forming units
Contents: Between 26 and 130 mg of sucrose, ascorbic acid, amino acid mixture, magnesium sterate, lactose, yeast extract, casoamino acids, dextrose and galactose

YF-VAX

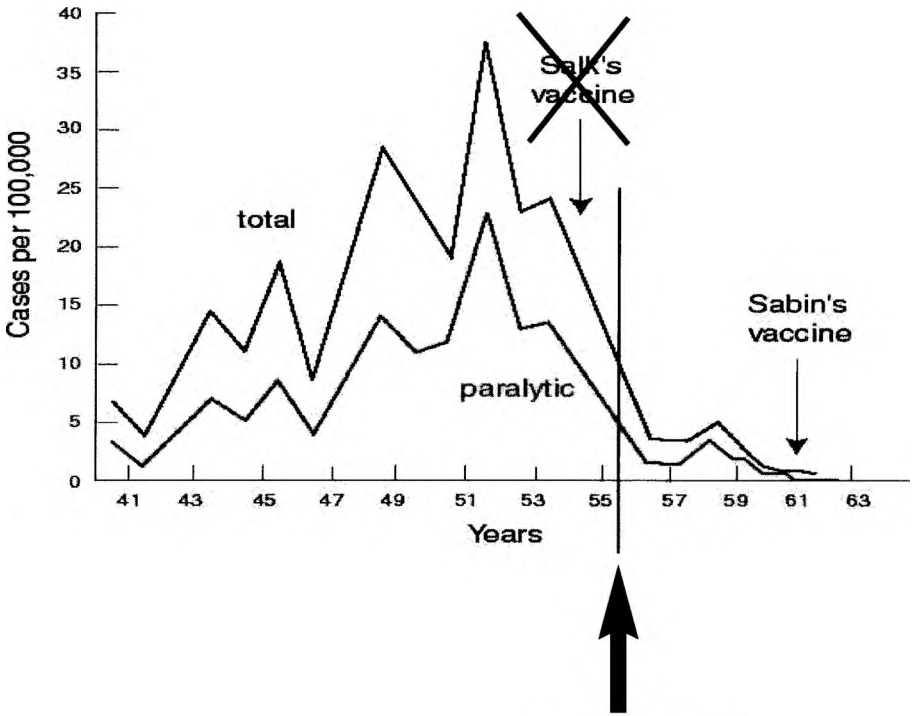
Yellow Fever, subcutaneous use
Berna, Switzerland
Contents: Two yellow fever viruses, chicken protein, sorbitol, gelatin, sodium chloride

Zostrix

Varicella virus for the prevention of shingles
Merck
COMMENT: Must remain frozen -15°C (5°F) until immediately before use
Contents: Live, attenuated Oka/Merck strain virus (19,400 PFU*), sucrose, porcine hydrolyzed gelatin, sodium chloride, MSG, sodium phosphate dibasic, potassium phosphate monobasic, potassium chloride, neomycin, fetal bovine serum, residual MRC-5 cells
*NOTE: There are 1.350 PFU in the chickenpox vaccine.

Addendum I
GRAPHS OF INFECTIOUS DISEASE DECLINE

Decline of Polio
Incidence of poliomyelitis in the USA
(from the Centers for Disease Controls, 1972)

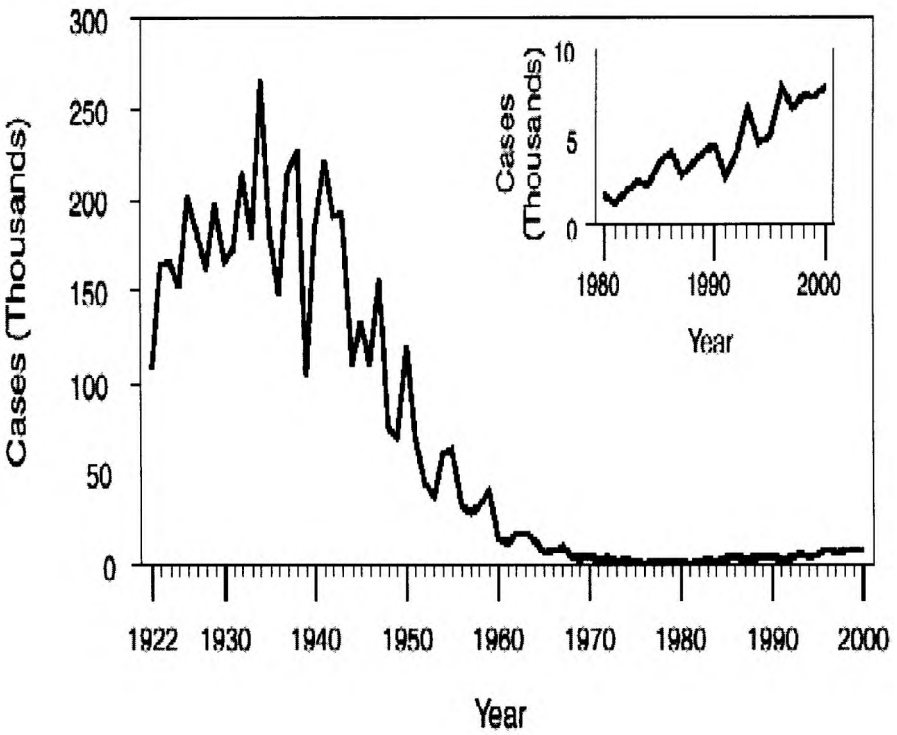


Actual Release of
Salk Vaccine

April 12, 1955

Decline of Pertussis

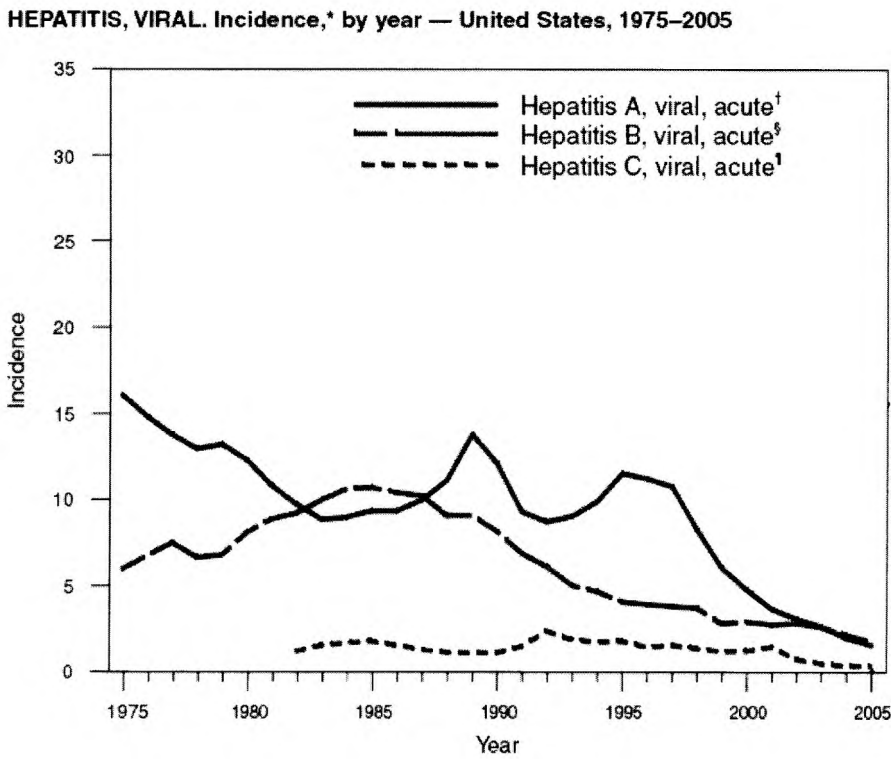
FIGURE 1. Number of reported pertussis cases, by year — United States, 1922–2000



SOURCE: CDC.
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5104a1.htm#fig1

NOTE: Whole-cell pertussis vaccine combined with diphtheria and tetanus toxoids (DTP) was licensed for use in the U.S. in 1949. In 1996, acellular pertussis vaccines (DTaP) were licensed and recommended for routine use among infants in the U.S. ~ST

Decline of Hepatitis

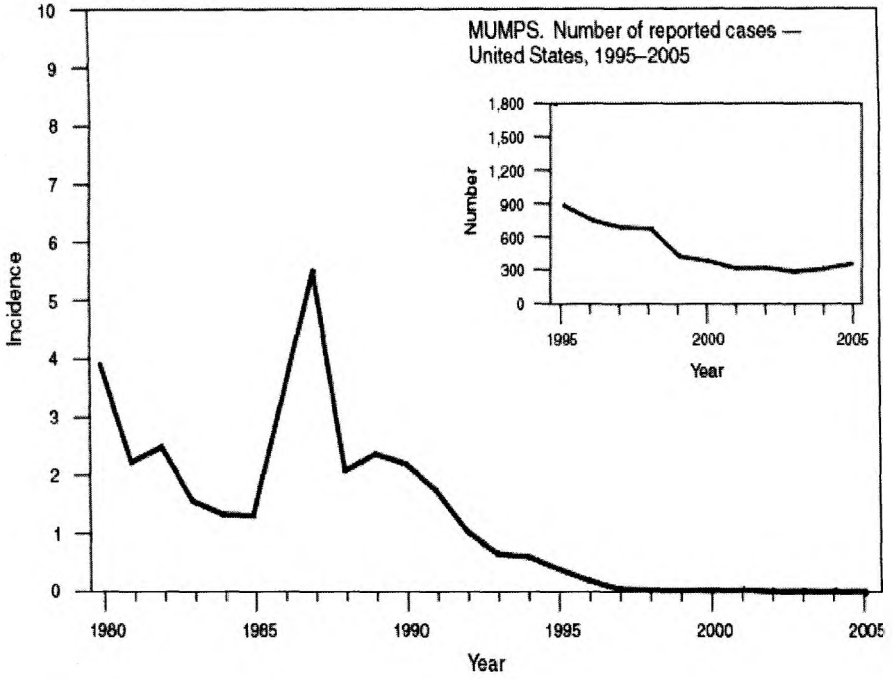


SOURCE: CDC. http://www.cdc.gov/mmwr/PDF/wk/mm5453.pdf

Hepatitis A vaccine was first licensed in 1995.
Hepatitis B vaccine was first licensed for infants in 1991.
Note the low incidence overall.

Decline of Mumps

MUMPS. Incidence,* by year — United States, 1980–2005

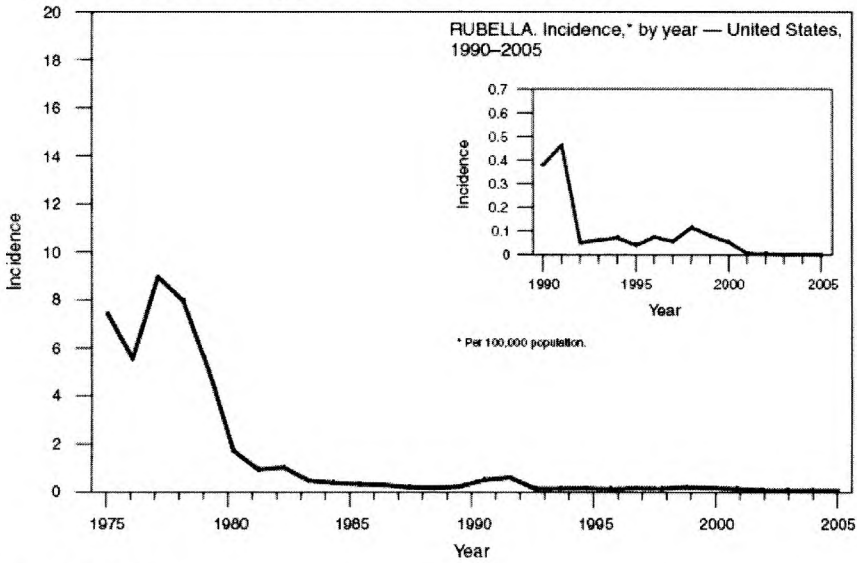


*Per 100,000 population. Mumps vaccine was licensed in 1967.

SOURCE: CDC. pg 63 http://www.cdc.gov/mmwr/PDF/wk/mm5453.pdf

Decline of Rubella

RUBELLA. Incidence,* by year — United States, 1975–2005



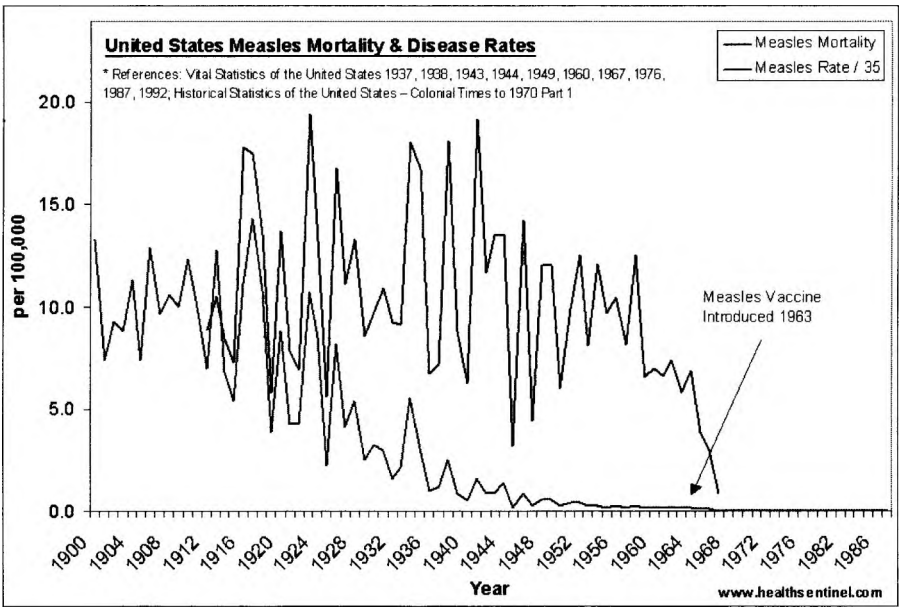
* Per 100,000 population.

Rubella vaccine was licensed in 1969. Evidence suggests that rubella is no longer endemic in the United States (CDC. Elimination of rubella and congenital rubella syndrome—United States, 1969–2004. MMWR 2005;54:279–82).

SOURCE: CDC. pg 66 http://www.cdc.gov/mmwr/PDF/wk/mm5453.pdf

Note the very low incidence overall.

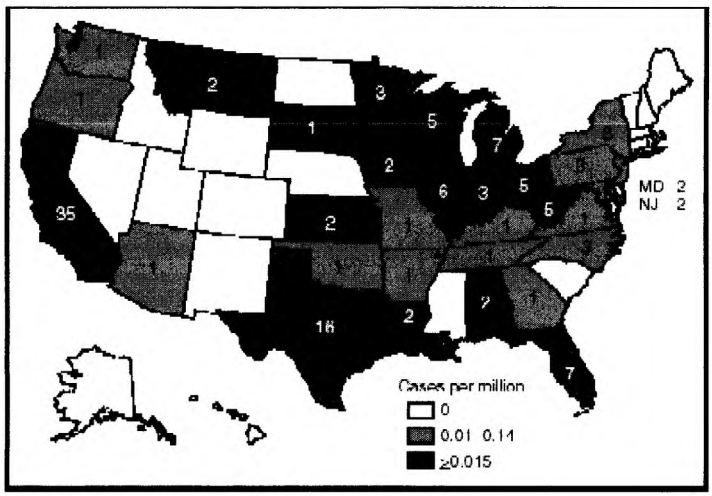
Decline of Measles



This graph was obtained at www.healthsentinel.com, a site highly recommended for research and information. Information presented on Health Sentinel is from well-respected scientific and medical journals and well-known news sources. The data that was used to generate the graphs comes from a large number of sources with those references displayed on the graph itself.

Incidence of tetanus in the U.S.

FIGURE 2. Number of tetanus cases reported and average annual incidence rates, by state — United States, 1998–2000



SOURCE: CDC.

Addendum J

References for Disorders Related to Hepatitis B

NOTE: While not all of these articles conclude that Hepatitis B vaccination has a causal relationship with the disorder, the number and type of reactions is significant. When using these references, refer to the entire article, not just the conclusion of the abstract. ~ST

Autoimmune Reactions:

- **REF:** Aaron-Maor, Shoenfeld Y. "Vaccination and systemic lupus erythematosis: the bidirectional dilemma." Lupus 2001;10:237-240.
- **REF:** Arkachaisri T. " **Serum sickness** and hepatitis B vaccine including review of the literature." J Med Assoc Thai. 2002 Aug;85 Suppl 2:S607-12. Review.
- **REF:** Cohen AD, Shoenfeld Y. "Vaccine-induced **autoimmunity**." J Autoimmune. 1996 Dec; 9(6): 699-703. PMID: 9115571. **CONCLUSION: "There is no doubt that the new recombinant hepatitis B vaccine has the ability to trigger autoimmunity."**
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Addendum K

OSHA Hepatitis B Declination Statement

When the waiver is signed, no words may be added or deleted to the exemption. IT MUST BE EXACTLY AS WORDED BELOW. Copy the form, print, sign and turn in to your employee. Found at: **http://www.osha.gov/SLTC/etools/hospital/hazards/bbp/declination.html**

The following statement of declination of hepatitis B vaccination must be signed by an employee who chooses not to accept the vaccine. The statement can only be signed by the employee following appropriate training regarding hepatitis B, hepatitis B vaccination, the efficacy, safety, method of administration, and benefits of vaccination, and that the vaccine and vaccination are provided free of charge to the employee. The statement is not a permanent waiver; employees can request and receive the hepatitis B vaccination at a later date if they remain occupationally at risk for hepatitis B.

Declination Statement: 1910.1030 App A
I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature:_____
Date:_____

Employer Signature:_____
Date: _____

Addendum L

Foreign Adoption Affidavit

(Please seek the advice of an attorney trained in vaccine exemptions for specific advice.)

Affidavit Concerning Exemption from Immigrant Vaccination Requirements for a Foreign Adopted Child

Statement for Parent(s): Section 212(a)(1)(A)(ii) of the Immigration and Nationality Act requires that any person who seeks admission as an immigrant, or adjustment of status to the status of an alien lawfully admitted for permanent residence, shall present documentation of having received vaccination against vaccine-preventable diseases, specifically: mumps, measles, rubella, polio, tetanus and diphtheria toxoids, pertussis, influenza type B, hepatitis B, varicella and pneumoccocal. This section exempts from the immunization requirement a child who:

(i) is 10 years of age or younger;
(ii) is described in Section 101(b)(1)(F), and
(iii) is seeking an immigrant visa as an immediate relative under section 201(b),

provided that the adoptive parent or prospective adoptive parent, prior to the child's admission, executes an affidavit stating that the parent is aware of the provisions of subparagraph (A)(ii) and will ensure that, within 30 days of the child's admission, **or at the earliest time that is medically appropriate, the child will receive the vaccinations identified in such subparagraph.**

Section 101(b)(1) defines the term "child" as an unmarried person under 21 years of age. Subparagraph (F) refers to a child, under the age of 16 at the time a petition is filed on his behalf to accord

classification as an immediate relative under section 201(b), who is an orphan because of the death or disappearance of, abandonment or desertion by, or separation or loss from, both parents, or for whom the sole surviving parent is incapable of providing the proper care and has in writing irrevocably released the child for emigration and adoption; who has been adopted abroad by a United States citizen and spouse jointly, or by an unmarried United States citizen at least 25 years of age, who personally saw and observed the child prior to or during the adoption proceedings; or who is coming to the United States for adoption by a United States citizen and spouse jointly, or by an unmarried United States citizen at least 25 years of age, who have or has complied with the pre-adoption requirements, if any, of the child's proposed residence: Provided, That the Attorney General is satisfied that proper care will be furnished the child if admitted to the United States: Provided further, That no natural parent or prior adoptive parent of any such child shall thereafter, by virtue of such parentage, be accorded any right, privilege, or status under this Act.

Affidavit by Adoptive Parent or Prospective Adoptive Parent

I, _____, certify that I am the adoptive parent /prospective adoptive parent of a child, _____, on whose behalf I have filed or will file an I-600 (petition to classify orphan as immediate relative) according said child status as an orphan as defined by Section 101(b)(1)(F).

I have read the statement above and I am aware of the vaccination requirement set forth in Section 212(a)(1)(A)(ii) of the Immigration and Nationality Act. In accordance with Section 212(a)(1)(A)(ii), I will ensure that my foreign adopted child receives the required and medically appropriate vaccinations within 30 days after his or her admission into the U.S., or at the earliest time that is medically appropriate.

Signed this _____ day of _____, _____, at _____.

_____ _____

(Signature of Parent) (Signature of Parent)

Subscribed and sworn to (or affirmed) before me this _____ day of _____, _____at _____.

My commission expires on _____.

_____

(Signature of Notary Public or Officer Administering Oath)

Addendum M

Sample Philosphical Exemption Refusal Form

I/We_____, hereby state that we have chosen to not vaccinated our child _____ because we are philosophically opposed to vaccination.

We maintain that we have investigated by the reported risks and benefits of vaccination and the reported risks of the so-called "vaccine preventable diseases." We maintain we are making a responsible and ethical choice for the following reasons:
1. vaccination is a medical intervention performed on a healthy child that has the ability to injure or cause the death of the child;
2. the fact that there cannot be a guarantee that the deliberate introduction of live or killed microorganisms into the body of a healthy child will not compromise the health or cause the death of that child, either immediately or in the future;
3. there are no predictors in science that can give advance warning that injury or death may occur in any particular child;
4. there are no proven assurances that the vaccine will protect the child from contracting the disease;
5. there is an absence of adequate acientific knowledge regarding the way vaccines interact with the human body on a molecular level.
Therefore, we believe that vaccination is a medical procedure that could reasonably be termed as experimental each time it is admistered to a healthy child.

The law in the State of _____ makes provision for non-vaccination of children whose parents object to vaccines for religious and/or philosophical reasons. We accept full responsibility for the health of our child. Our child will not be vaccinatated against our will.

In the event any of "vaccine-preventable" disease outbreak in our community, our child is the one at risk,our child will remain home. We understand your facility would exclude our child and we will gladly make arrangements for our child stay home.

Attached is a copy of our state law (YOU CAN FIND THE LAW AT **WWW.NVIC.ORG** OR **WWW.VACLIB.ORG**) We expect that the school system will comply with the law.

Sincerely,

_____ _____

DATE

Person who received this document:

_____ _____

DATE

Addendum N

Sample Hepatitis B Refusal Form for Newborns for Hospital Deliveries

(Rewrite this form in your own words)

DATE:_____
(The day you go to the hospital...take this form with you.)

To All Doctors and hospital personnel:
This is to inform you that we are refusing the hepatitis B shot for our new born baby.

This letter is intended to supersede any consent, implied or otherwise, to papers signed at the time of, or before, hospital admission for the birth of our child.

The administration of the hepatitis b vaccine is not a medical emergency. The legal position on this is clear: however convinced a doctor—or nurse—may be that a certain treatment is in a child's best interest, no medical treatment may be given to a child without the consent of the parent.

We want to be very clearly understood: We do NOT give consent for the vaccine to be given. If our child is vaccinated, we will take legal action.

Sincerely,
_____, mother
_____, father

_____ _____
Name of person who accepts letter Date

Addendum O

National Childhood Vaccine Injury Act

Vaccine Injury Table

ftp://ftp.hrsa.gov/vaccinecompensation/vaccineinjurytable.pdf

Vaccine	Adverse Event	Time Interval
I. Tetanus toxoid-containing vaccines (e.g., DTaP, Tdap, DTP-Hib, DT, Td, TT)	A. Anaphylaxis or anaphylactic shock B. Brachial neuritis C. Any acute complication or sequela (including death) of above events	0-4 hours 2-28 days Not applicable
II. Pertussis antigen-containing vaccines (e.g., DTaP, Tdap, DTP, P, DTP-Hib)	A. Anaphylaxis or anaphylactic shock B. Encephalopathy (or encephalitis) C. Any acute complication or sequela (including death) of above events	0-4 hours 0-72 hours Not applicable
III. Measles, mumps and rubella virus-containing vaccines in any combination (e.g., MMR, MR, M, R)	A. Anaphylaxis or anaphylactic shock B. Encephalopathy (or encephalitis) C. Any acute complication or sequela (including death) of above events	0-4 hours 5-15 days Not applicable
IV. Rubella virus-containing vaccines (e.g., MMR, MR, R)	A. Chronic arthritis B Any acute complication or sequela (including death) of above event	7-42 days Not applicable
V. Measles virus-containing vaccines (e.g., MMR, MR, M)	A Thrombocytopenic purpura B. Vaccine-Strain Measles Viral Infection in an immunodeficient recipient C Any acute complication or sequela (including death) of above events	7-30 days 0-6 months Not applicable

VI. Polio live virus-containing vaccines (OPV)	A. Paralytic polio --- in a non-immunodeficient recipient --- in an immunodeficient recipient --- in a vaccine assoc. community case B. Vaccine-strain polio viral infection --- in a non-immunodeficient recipient --- in an immunodeficient recipient --- in a vaccine assoc. community case C. Any acute complication or sequela (including death) of above events	0-30 days 0-6 months Not applicable 0-30 days 0-6 months Not applicable Not applicable
VII. Polio inactivated-virus containing vaccines (e.g., IPV)	A Anaphylaxis or anaphylactic shock B. Any acute complication or sequela (including death) of above event	0-4 hours Not applicable
VIII. Hepatitis B antigen-containing vaccines	A. Anaphylaxis or anaphylactic shock B. Any acute complication or sequela (including death) of above event	0-4 hours Not applicable
IX. Hemophilus influenzae type b polysaccharide conjugate vaccines)	A. No condition specified for compensation	Not applicable
X. Varicella vaccine	A. No condition specified for compensation	Not applicable
XI. Rotavirus vaccine	A. No condition specified for compensation	Not applicable
XII. Vaccines containing live, oral, rhesus-based rotavirus	A. Intussusception B. Any acute complication or sequela (including death) of above event	0-30 days Not applicable
XIII. Pneumococcal conjugate vaccines	A. No condition specified for compensation	Not applicable
XIV. Any new vaccine recommended by the Centers for Disease Control and Prevention for routine administration to children, after publication by Secretary,	A. No condition specified for compensation	Not applicable

a) Effective date: February 1, 2007

b) As of December 1, 2004, hepatitis A vaccines have been added to the Vaccine Injury Table (Table) under this Category. As of July 1, 2005, trivalent influenza vaccines have been added to the Table under this Category. Trivalent influenza vaccines are given annually during the flu season either by needle and syringe or in a nasal spray. All influenza vaccines routinely administered in the U.S. are trivalent vaccines covered under this Category.

c)As of February 1, 2007, meningococcal (conjugate and polysaccharide) and human papillomavirus (HPV) vaccines have been added to the Table under this Category.

See News on the VICP website for more information (www.hrsa.gov/osp/vaccinecompensation).

Qualifications and Aids to Interpretation

(1) Anaphylaxis and anaphylactic shock mean an acute, severe, and potentially lethal systemic allergic reaction. Most cases resolve without sequelae. Signs and symptoms begin minutes to a few hours after exposure. Death, if it occurs, usually results from airway obstruction caused by laryngeal edema or bronchospasm and may be associated with cardiovascular collapse. Other significant clinical signs and symptoms may include the following: Cyanosis, hypotension, bradycardia, tachycardia, arrhythmia, edema of the pharynx and/or trachea and/or larynx with stridor and dyspnea. Autopsy findings may include acute emphysema which results from lower respiratory tract obstruction, edema of the hypopharynx, epiglottis, larynx, or trachea and minimal findings of eosinophilia in the liver, spleen and lungs. When death occurs within minutes of exposure and without signs ofrespiratory distress, there may not be significant pathologic findings.

(2) Encephalopathy. For purposes of the Vaccine Injury Table, a vaccine recipient shall be considered to have suffered an encephalopathy only if such recipient manifests, within the applicable period, an injury meeting the description below of an acute encephalopathy, and then a

chronic encephalopathy persists in such person for more than 6 months beyond the date of vaccination.

(i) An acute encephalopathy is one that is sufficiently severe so as to require hospitalization (whether or not hospitalization occurred).

(A) For children less than 18 months of age who present without an associated seizure event, an acute encephalopathy is indicated by a "significantly decreased level of consciousness" (see "D" below) lasting for at least 24 hours. Those children less than 18 months of age who present following a seizure shall be viewed as having an acute encephalopathy if their significantly decreased level of consciousness persists beyond 24 hours and cannot be attributed to a postictal state (seizure) or medication.

(B) For adults and children 18 months of age or older, an acute encephalopathy is one that persists for at least 24 hours and characterized by at least two of the following:

(1) A significant change in mental status that is not medication related; specifically a confusional state, or a delirium, or a psychosis;

(2) A significantly decreased level of consciousness, which is independent of a seizure and cannot be attributed to the effects of medication; and

(3) A seizure associated with loss of consciousness.

(C) Increased intracranial pressure may be a clinical feature of acute encephalopathy in any age group.

(D) A "significantly decreased level of consciousness" is indicated by the presence of at least one of the following clinical signs for at least 24 hours or greater (see paragraphs (2)(I)(A) and (2)(I)(B) of this section for applicable timeframes):

(1) Decreased or absent response to environment (responds, if at all, only to loud voice or painful stimuli);

(2) Decreased or absent eye contact (does not fix gaze upon family members or other individuals); or

(3) Inconsistent or absent responses to external stimuli (does

not recognize familiar people or things).

(E) The following clinical features alone, or in combination, do not demonstrate an acute encephalopathy or a significant change in either mental status or level of consciousness as described above:

(i) Sleepiness, irritability (fussiness), high-pitched and unusual screaming, persistent inconsolable crying, and bulging fontanelle. Seizures in themselves are not sufficient to constitute a diagnosis of encephalopathy. In the absence of other evidence of an acute encephalopathy, seizures shall not be viewed as the first symptom or manifestation of the onset of an acute encephalopathy.

(ii) Chronic encephalopathy occurs when a change in mental or neurologic status, first manifested during the applicable time period, persists for a period of at least 6 months from the date of vaccination. Individuals who return to a normal neurologic state after the acute encephalopathy shall not be presumed to have suffered residual neurologic damage from that event; any subsequent chronic encephalopathy shall not be presumed to be a sequela of the acute encephalopathy. If a preponderance of the evidence indicates that a child's chronic encephalopathy is secondary to genetic, prenatal or perinatal factors, that chronic encephalopathy shall not be considered to be a condition set forth in the Table.

(iii) An encephalopathy shall not be considered to be a condition set forth in the Table if in a proceeding on a petition, it is shown by a preponderance of the evidence that the encephalopathy was caused by an infection, a toxin, a metabolic disturbance, a structural lesion, a genetic disorder or trauma (without regard to whether the cause of the infection, toxin, trauma, metabolic disturbance, structural lesion or genetic disorder is known). If at the time a decision is made on a petition filed under section 2111(b) of the Act for a vaccine-related injury or death, it is not possible to determine the cause by a preponderance of the evidence of an encephalopathy, the encephalopathy shall be considered to be a condition set forth in the Table.

(iv) In determining whether or not an encephalopathy is a condition set forth in the Table, the Court shall consider the entire medical record.

(3) Seizure and convulsion. For purposes of paragraphs (b)(2) of this section, the terms, "seizure" and "convulsion" include myoclonic, generalized tonic-clonic (grand mal), and simple and complex partial seizures. Absence (petit mal) seizures shall not be considered to be a condition set forth in the Table. Jerking movements or staring episodes alone are not necessarily an indication of seizure activity.

(4) Sequela. The term "sequela" means a condition or event which was actually caused by a condition listed in the Vaccine Injury Table.

(5) Chronic Arthritis. For purposes of the Vaccine Injury Table, chronic arthritis may be found in a person with no history in the 3 years prior to vaccination of arthropathy (joint disease) on the basis of:

A) Medical documentation, recorded within 30 days after the onset, of objective signs of acute arthritis (joint swelling) that occurred between 7 and 42 days after a rubella vaccination;

(B) Medical documentation (recorded within 3 years after the onset of acute arthritis) of the persistence of objective signs of intermittent or continuous arthritis for more than 6 months following vaccination:

(C) Medical documentation of an antibody response to the rubella virus.

For purposes of the Vaccine Injury Table, the following shall not be considered as chronic arthritis: Musculoskeletal disorders such as diffuse connective tissue diseases (including but not limited to rheumatoid arthritis, juvenile rheumatoid arthritis, systemic lupus erythematosus, systemic sclerosis,

mixed connective tissue disease, polymyositis/dermatomyositis, fibromyalgia, necrotizing vasculitis and vasculopathies and Sjogren's Syndrome), degenerative joint disease, infectious agents other than rubella (whether by direct invasion or as an immune reaction), metabolic and endocrine diseases, trauma, neoplasms, neuropathic disorders, bone and cartilage disorders and arthritis associated with ankylosing spondylitis, psoriasis, inflammatory bowel disease, Reiter's syndrome, or blood disorders. Arthralgia (joint pain) or stiffness without joint swelling shall not be viewed as chronic arthritis for purposes of the Vaccine Injury Table.

(6) Brachial neuritis is defined as dysfunction limited to the upper extremity nerve plexus (i.e., its trunks, divisions, or cords) without involvement of other peripheral (e.g., nerve roots or a single peripheral nerve) or central (e.g., spinal cord) nervous system structures. A deep, steady, often severe aching pain in the shoulder and upper arm usually heralds onset of the condition. The pain is followed in days or weeks by weakness and atrophy in upper extremity muscle groups. Sensory loss may accompany the motor deficits, but is generally a less notable clinical feature. The neuritis, or plexopathy, may be present on the same side as or the opposite side of the injection; it is sometimes bilateral, affecting both upper extremities. Weakness is required before the diagnosis can be made. Motor, sensory, and reflex findings on physical examination and the results of nerve conduction and electromyographic studies must be consistent in confirming that dysfunction is attributable to the brachial plexus. The condition should thereby be distinguishable from conditions that may give rise to dysfunction of nerve roots (i.e., radiculopathies) and peripheral nerves (i.e., including multiple mononeuropathies), as well as other peripheral and central nervous system structures (e.g., cranial neuropathies and myelopathies).

(7) Thrombocytopenic purpura is defined by a serum platelet count less than 50,000/mm3. Thrombocytopenic purpura does not include cases of thrombocytopenia associated with other causes such as hypersplenism, autoimmune disorders (including alloantibodies from previous transfusions) myelodysplasias, lymphoproliferative disorders, congenital thrombocytopenia or hemolytic uremic syndrome. This does not include cases of immune (formerly called idiopathic) thrombocytopenic purpura (ITP) that are mediated, for example, by viral or fungal infections, toxins or drugs. Thrombocytopenic purpura does not include cases of thrombocytopenia associated with disseminated intravascular coagulation, as observed with bacterial and viral infections. Viral infections include, for example, those infections secondary to Epstein Barr virus, cytomegalovirus, hepatitis A and B, rhinovirus, human immunodeficiency virus (HIV), adenovirus, and dengue virus. An antecedent viral infection may be demonstrated by clinical signs and symptoms and need not be confirmed by culture or serologic testing. Bone marrow examination, if performed, must reveal a normal or an increased number of megakaryocytes in an otherwise normal marrow.

(8) Vaccine-strain measles viral infection is defined as a disease caused by the vaccine-strain that should be determined by vaccine-specific monoclonal antibody or polymerase chain reaction tests.

(9) Vaccine-strain polio viral infection is defined as a disease caused by poliovirus that is isolated from the affected tissue and should be determined to be the vaccine-strain by oligonucleotide or polymerase chain reaction. Isolation of poliovirus from the stool is not sufficient to establish a tissue specific infection or disease caused by vaccine-strain poliovirus.

Addendum P

Vaccine Titer Table

Hepatitis B	10 IU/L or greater	Accepted as positive immunity to hepatitis B
	Less than 0.89 IU	Negative
Measles (Rubeola)	0.90-1.09 IU	Equivocal
	1.10 IU or greater	**Positive** In absence of active infection, is accepted as positive immunity to measles
	Less than 0.89 IU	Negative
Mumps	0.90-1.09 IU	Equivocal
	1.10 IU or greater	**Positive** In absence of active infection, is considered to be positive correlation with immunity to mumps
	Less than 4 IU/mL	Negative
Rubella	5-9 IU/mL	Equivocal
	10 IU/mL or greater	**Positive:** In absence of active infection, is considered to be positive correlation with immunity to rubella
	Poliovirus 1	Titers $\geq$ 1:10 IU/ml is accepted as positive immunity to polio virus 1
Polio (IPV or OPV)	Poliovirus 2	Titers $\geq$ 1:10 IU/ml is accepted as positive immunity to polio virus 2
	Poliovirus 3: $\geq$ 1:10*	Titers > 1:10 IU/ml is accepted as positive immunity to polio virus 3. In vaccinated individuals, the significance of a low antibody titer to poliovirus 3 (the least immunogenic vaccine serotype) is unclear.

H. influenza B (HiB vaccine)	1.0 μmg/ml or greater	**Positive**: Accepted as positive immunity to H.influenza b
Tetanus	0.1 IU/mL or greater	**Positive**: Accepted as positive immunity to tetanus
Diphtheria	0.1 IU/mL or greater	**Positive**: Accepted as positive immunity to diphtheria
	Less than 8 units	Negative
Pertussis	9-11 units	Equivocal
	12 units or greater	**Positive** In absence of active infection, can be considered as a positive immunity to pertussis
	Less than 0.89 IU	Negative
Varicella (Chickenpox)	0.90-1.09 IU	Equivocal
	1.10 IU or greater:	**Positive** In absence of active infection, is considered to be positive correlation with immunity to varicella
Prevnar & Adult Pnuemonia Vaccine	Response of 1 μg/mL or greater one month post-vaccine is a long-term protective response in both children and adults.	A positive titer to >50% of the antigens in the vaccine is considered positive immunity to strains of strep
Rabies vaccine	presence of antibody considered to represent immunity	**Testing through links available at www.SayingNoToVaccines.com and www.DrTenpenny.com**

Addendum Q

Influenza Vaccine Requirements for Hospial Employees, by State

Laws change frequently and information on this table varies somewhat by source.Go to CDC website, "State Immunization Laws for Healthcare Workers and Patients," for updates and most recent information.

States	Hospital Employees	Medical (M), Religious (R), Philosophical (P) Exemptions	States	Hospital Employees	Medical (M), Religious (R), Philosophical (P) Exemptions
AL	ENSURE*	No	MT	No	No
AK	No	No	NE	No	No
AZ	No	No	NH	ENSURE*	YES (M)(R)
AR	No	No	NJ	No	No
CA	No	No	NM	No	No
CO	No	No	NY	No	YES (M)
CT	No	No	NV	No	No
DC	No	No	NC	No	No
DE	No	No	ND	No	No
FL	No	No	OH	No	No
GA	No	No	OK	No	No
HI	No	No	OR	No	No
ID	No	No	PA	No	No
IL	No	No	RI	OFFER*	YES (M)
IN	No	No	SC	No	No
IA	No	No	SD	No	No
KS	No	No	TN	No	No
KY	No	No	TX	No	No
LA	No	No	UT	No	No
ME	OFFER*	YES (M)(R)(P)	VT	No	No
MD	No	YES (M)(R)	VA	No	No
MA	No	No	WA	No	No
MI	No	No	WV	No	No
MN	No	No	WI	No	No
MS	No	No	WY	No	No
MO	No	No	WY	No	No

Addendum R

College Meningitis Vaccine Requirements, by State

Correct as of 11-07

Subject to change each legislative session

Source: National Conference State Legislatures, November 2007.
Note: List may not be comprehensive, but is representative of state laws that exist. NCSL appreciates additions and corrections.

State	No Requirement	Requires Vaccine or Waiver	Allows Exemptions (M)(R)(P)	Requires Information Be Given
AL	X			
AK		X		
AZ	X			
AR				X
CA		X		
CO		X		
CT			(M)(R)	
DE		X		
DC	X			
FL		X		
GA		X		
HI	X			
ID	X			
IL				X
IN			(M)(R)	
IA		X		
KS		X		
KY		X		X
LA		X		
ME				X
MD		X		
MA		X		X
MI				X
MN				X
MS				X
MO		X		

State	No Require-ment	Requires Vaccine or Waiver	Allows Exemptions (M)(R)(P)	Requires Information Be Given
MT	X			
NE				X
NH	X			
NH	X			
NJ			(M)(R)	
NM	X			
NY		X		X
NC		X		X
ND	X			
OH		X		
OK		X		
OR	X			
PA		X		
RI				X
SC				X
SD	X			
TN		X		
TX				X
UT	X			
VT	X			
VA		X		
WA				X
WV	X			X
WI		X		
WY	X			

Addendum S

Some Parent Support Resources, by State

Because websites are continually under development and revision, we can ensure only that these sites and contacts were active as of March, 2008.

Arizona
VIAL - Arizona Chapter
Kimberly Medlin, Director
4640 S. Deer Trail
Prescott, AZ 86503
www.knowshots.com

California
Vaccine Information and Awareness (VIA)
Karin Schumacher
12799 La Tortola
San Diego, CA 92129
kschumacher@san.rr.com
http://home.san.rr.com

Connecticut
Connecticut Vaccine Information Alliance
www.ctvia.org
info@ctvia.org

Florida
V.I.A.L.
Wendy Callahan, Director
PO Box 1693
Hawthorne, FL 32640
www.vaccinationtruth.org

Vaccine Injured Children
April Reneé
4371 Northlake Blvd, #337
Palm Beach Gardens, FL 33410
www.vacinfo.org
800-939-8227

K.N.O.W. Vaccines
Toni Krehal, Director
Jacksonville, FL
www.know-vaccines.org
knowing@know-vaccines.org

Idaho
Vaccination Liberation of Northern Idaho
Ingri Cassel or Tanya Turner
PO Box 457
Spirit Lake, ID 83869
888-249-1421
(208) 255-2307
www.vaccinetruth.com
vaclib@coldreams.com

Illinois
Eagle Forum
Barbara Skurnowicz
National Leader for Vaccine Information
PO Box 68
Alton, IL 62002
skurnowb@aol.com

Maryland
Vaccine Information and Action in Maryland (VIAM)
Amanda Buxbaum, Director
8632 Garfield Street
Bethesda, MD 20817
(301) 897-8962
amandabuxbaum@verizon.net

Massachusetts
Massachusetts Citizens for Vaccination Choice
Peter and Debbie Bermudes
PO Box 1033
East Arlington, MA 02474
(781) 646-4797
info@vaccinechoice.org
www.vaccinechoice.org

Michigan
Childhood Shots
Mary Tocco, Executive Director
www.childhoodshots.com
mary@marytocco.com
(231) 642-7984

Minnesota
Vaccine Awareness Minnesota
Christina Abel
3411 Winnetka Ave. N
Crystal, MN 55427
(763) 546-1708
ChristinaSAble@hotmail.com
www.vaccineawarenessminnesota.org

Missouri
Missouri Citizen's Coalition for Freedom in Healthcare (MCC-FHC)
PO Box 190138
St. Louis, MO 63119
(208) 485-1182
info@mcc-fhc.org
http://hometown.aol.com/MCCFHC

Nebraska
Inoculation Discussion Group of Omaha
Carla Ann Mowry
Omaha, NE 68104
(402) 455-6339
pcrc_mow@ix.netcom.com

New Mexico
Vaccine Resources
Think Twice Global Vaccine Institute
Nathan Wright
PO Box 9638
Santa Fe, NM 87504
(505) 983-1856
glogal@thinktwice.com
www.thinktwice.com

New Jersey
New Jersey Alliance for Informed Choice in Vaccination
Founder, Sue Collins, Dr. Renee Foster, Executive Director
PO Box 243
Gillette, NJ 07933
(800) 613-9925
www.njaicv.org
njaicv@aol.com

New York

Coalition for Informed Choice
Gary Krasner
188-34 87th Drive, Suite 4B
Holliswood, NY 11423
(718) 470-2939
cfic@nytc.net
www.cfic.us

Vaccine Information Network of Central New York
Cheryl T. Rigas, Chairman
18 Beechnut Terrace
Ithaca, NY 14850
(607) 277-4007

Consumers Health Freedom Coalition
Arnold Gore
720 Fort Washington Ave
New York, NY 10040
(212) 795-6460
Arnoldgore@aol.com

Andrew Baumann
NY Families of Autistic Children (NYFAC)
95-16 Pitkin Avenue
Ozone Park, NY 11414
(718) 641-3441 ext. 102
fax: (718) 641-4452
cell: (917) 416-3540
www.NYFAC.org

The Autism Autoimmunity Project
Barbara H. Labreque
306 Mid Ave
Elmira, NY 14904
(607) 734-0036
cell: (607) 731-0925
Barbara@TAAP.info
http://www.TAAP.info/

Vaccination Liberation - New York Chapter
Coutney Sullivan
PO Box 135
Spencer, NY 14883
(607) 589-6149
yvonne@clarityconnect.com
rick@itacahemp.com

Ohio
NMA Media Press
7271 Engle Road, Ste 115
Middleburg Heights, OH 44130
(440) 239-1878
info@drtenpenny.com
drtenpenny@gmail.com
www.SayingNoToVaccines.com
www.DrTenpenny.com
www.osteomed2.com

Texas
PROVE (Parents Requesting Open Vaccine Education)
Dawn Richardson, President
PO Box 91566
Austin, TX 78709
(512) 288-3999 (for media inquiries only)
prove@vaccineinfo.net
www.vaccineinfo.net

Utah
Utah Vaccine Awareness Coalition
Robin Goffe, Director
6337 Highland Drive, Suite 135
Salt Lake City, UT 84121
(801) 243-3526
goffe5@msn.com

Virginia
National Vaccine Information Center (NVIC)
Barbara Loe Fisher and Kathy Williams
421 E. Church Street
Vienna, VA 22180
(703) 938-0342
(703) 938-5768 -- fax

Wyoming
Wyoming Vaccine Information Network
PO Box 615
Buffalo, WY 82834
Jaque Jones (307) 684-2969
Jfj@bresnan.net
Susan Pierce (307) 655-2574
Spearce@vcn.com
Vaclib.org/chapter/myhome.htm

Government Resources

Recommendations of the Advisory Committee on Immunization Practices (ACIP)
www.cdc.gov/nip/publications/ACIP-list.htm

Epidemiology and Prevention of Vacine-Preventable Diseases
The Pink Book, Course Textbook 6th Edition (2nd Printing, January 2001)
www.cdc.gov/nip/publications/pink

A government site that offers a guide to locating vaccine safety
www.cdc.gov/nip/vacsafe/research/resourceguide.htm

Vaccine Informational Sites

Whale To:
An extensive and best organized set of links and categories available for research
www.whale.to/vaccines.html or www.vacinewebsite.com

PROVE www.vaccineinfo.net
Parents Requesting Open Vaccine Information. This site, managed by Dawn Richardson, primarily involves Texas laws on vaccination. However, there are many letters to school boards, congressmen, etc., that are excellent examples.

National Vaccine Information Center: www.nvic.org Organization for parents managed by Barbara Lowe-Fisher.

Vaccine Liberation www.vaclib.org
Offers vaccine resources and information. Hundreds of links to vaccine sites for research and information. Managed by Ingri Cassel, President

Vaccine Safety www.vaccines.net

VaccinationNews: www.vaccinationnews.com Daily updates and large database of daily information about vaccines, both for and against. Wonderful resource for reference material.

WAVE- World Authority on Vaccine Education
www.novaccine.com

Recommended Attorneys

Dr. Meryl Nass is an internist who uncovered the use of anthrax as a biological weapon in Rhodesia. She has shown that anthrax vaccine is one cause of Gulf War Illness, and that recently vaccinated service members have developed similar illnesses. She has provided testimony to seven Congressional hearings on anthrax vaccine and bioterrorism. She evaluates soldiers and veterans with vaccine-related injuries.

Meryl Nass, MD
Mount Desert Island Hospital
Bar Harbor, Maine 04609
207 288-5081 ext. 220
http://anthraxvaccine.blogspot.com
http://www.anthraxvaccine.org

Alan Phillips, author of "The Authoritative Guide to Vaccine Legal Exemptions," the internationally published "Dispelling Vaccination Myths" and other articles on vaccine legal exemption concerns, is a co-founder of North Carolina's Citizens for Healthcare Freedom, a public presenter on vaccine health and legal issues, and one of the nation's few attorneys with a focus on vaccine exemption law. Alan assists clients and attorneys throughout the U.S. in obtaining vaccine exemptions.

Alan G. Phillips, J.D.
Attorney and Counselor at Law
P.O. Box 3473
Chapel Hill, NC 27515-3473
919-960-5172
attorney@vaccinerights.com
www.vaccinerights.com

Thomas P. Gallagher has been representing vaccine injured clients throughout the United Sates since 1989. Carol L. Gallagher also represents vaccine injured clients. They are both admitted and qualified as attorneys and counsellors of the United /states Court of Federal Claims. The firm has successfully litigated and/or settled vaccine claims on behalf of their clients throughout the United States. In February 2002, Thomas Gallagher was appointed by the Department of Health and Human Services to the Advisory Committee on Childhood Vaccines, (ACCV) for a three year term. The firm's primary practice is representing injured vaccine victims under the National Childhood Vaccine Injury Compensation program.

Thomas P. Gallagher
Carol L. Gallagher
Gallagher and Gallagher
822 Shore Road
Somers Point, NJ 08244
Telephone: 609-926-6450
Fax: 609-926-6455
E-Mail: GandGLawFirm@aol.com

The law firm of Conway, Homer & Chin-Caplan, P.C. specializes in obtaining compensation for persons injured by vaccines. This firm presently represents over 1000 adults and children, located in all 50 states who have filed for compensation under the National Childhood

Vaccine Injury Program within the Federal Claims Court.

Kevin P. Conway and Ronald C. Homer
Conway, Homer and Chin-Caplan, P.C.
16 Shawmut Street
Boston, MA 02116
Telephone: 617-695-1990
Fax:617-695-0880
Website: www.ccandh.com

Recommended Books

"(The) Authoritative Guide to Vaccine Legal Exemptions", by Alan G. Phillips, J.D

"Cell Cultures for Virus Vaccine Production", National Cancer Institute Monograph 29, December 1968.

"(The) Chickenpox Vaccine: A New Epidemic of Disease And Corruption", by Mark, Orrin and Gary, S. Goldman Ph.D., Virtualbookworm.com, 2006.

"Childhood Vaccinations: Questions all Parents Should Ask", by Tedd Koren, DC.

"DPT: A Shot in the Dark", by Harris L. Coulter, Ph.D., and Barbara Loe Fisher, Warner Books, 1985.

"Evidence of Harm: Mercury in Vaccines and the Autism Epidemic: A Medical Controversy", by David Kirby, St. Martin's Griffin, 2006.

"Immunization: History, Ethics, Law and Health", Catherine J.M.

Diadati, M.A., Integral Aspects Incorporated, 1999.

"Injection! A fictional account based on a Researcher's 8-year experience on a project funded by the Centers for Disease Control and Prevention (CDC)", by Carol Givner based on research by Gary S. Goldman, PhD, Booklocker.com, Inc., 2006.

"Just a Little Prick", by Peter and Hilary Butler, Robert Reisinger Memorial Trust, 2006.

"(The) Medical Mafia", by Guylaine Lanctot, M.D., Here's the Key, Inc., 1995.

"(The) Parents' Concise Guide to Childhood Vaccinations: From Newborns to Teens, Practical Medical and Natural Ways to Protect Your Child", by Lauren Feder, Hatherleigh Press, 2007

"Raising a Vaccine Free Child", by Wendy Lydall, AuthorHouse, 2005.

"(The) Parents' Concise Guide to Childhood Vaccinations: From Newborns to Teens, Practical Medical and Natural Ways to Protect Your Child", by Lauren Feder, Hatherleigh Press, 2007.

"(The) Sanctity of Human Blood: Vaccination Is Not Immunization", by Tim O'Shea, Two Trees, 2004.

"State of Immunity: The Politics of Vaccination in Twentieth-Century America", by James Colgrove, University of California Press, 2006.

"(A) Stolen Life", by Marge Grant.

"(The) Truth About Vaccines: How We Are Used as Guinea Pigs Without Knowing It", by Richard Halvorsen, Gibson Square Books

Ltd. (UK), 2007.

"(The) Virus and the Vaccine: Contaminated Vaccine, Deadly Cancers, and Government Neglect", by Debbie Bookchin and Jim Schumacher, St. Martin's Griffin, 2005.

"Vaccination Deception: How Vaccines Prevent Optimal Health!", by Teddy H. Spence, DDS, ND, Truth Seekers Press, 2000.

"Vaccine Guide: Risks and Benefits for Children and Adults", by Randall Neustaedter, North Atlantic Books, 2002.

"When Your Doctor is Wrong, Hepatitis B Vaccine and Autism", by Judy Converse, Xlibris Corporation, 2002.

"White Lies: A Tale of Babies, Vaccines, and Deception", by Sarah Collins Honenberger, Cedar Creek Publishing, 2006.

Health Resources

At www.SayingNoToVaccines.com you will find homeopathic remedies for increasing resistance to a variety of viruses and bacteria including upper respiratory infections (colds), influenza, hepatitis viruses, strep bacteria and several others. Please check the website for more information or call 440-239-1878.
It is now possible to have your blood drawn to determine your antibody titer levels for most vaccines without obtaining an order from your doctor. Go to the link below and follow the menu. You can also find the link of www.DrTenpenny.com and www.SNTU.com.

Addendum T

Pre-Vaccine Preparation

Reduce the possibility of vaccine reactions, particularly to viral vaccines (ie polio, MMR, chickenpox, hepatitis A, hepatitis B and influenza).

DISCLAIMER: *Using this protocol does not guarantee or ensure that a reaction will not occur.*

a. Infants and toddlers up to 30 pounds:

Vitamin C: (give in divided doses)

- o 5 mg per pound orally in juice for 3 days before;
- o 10 mg per pound orally in juice the day of the vaccine and
- o 5 mg per pound orally in juice for 3 days after the vaccine.

Vitamin A:

- o 5, 000 IU (one drops) in juice for 3 days before the vaccines;
- o 10,000 IU (two drops) in juice the day of the vaccine; and
- o 5,000 IU (one drop) in juice for 3 days following the vaccine

b. Toddlers from 31 to 50 pounds:

Vitamin C: (give in divided doses)

- o 15 mg per pound orally in juice for 3 days before;
- o 30 mg per pound orally in juice the day of the vaccine and
- o 15 mg per pound orally in juice for 3 days after the vaccine.

Vitamin A:

- o 10,000 IU (two drop) in juice for 3 days before the vaccines;
- o 15,000 IU (three drops) in juice the day of the vaccine; and
- o 10,000 IU (two drop) in juice for 3 days following the vaccine.

c. Children from 51 to 100 pounds:

Vitamin C: (give in divided doses)

- o 30 mg per pound orally in juice for 3 days before;

o 50 mg per pound orally in juice the day of the vaccine and
o 30 mg per pound orally in juice for 3 days after the vaccine.
Vitamin A: (give in divided doses)
o 15,000 IU (three drops) in juice for 3 days before the vaccines;
o 25,000 IU (five drops) in juice the day of the vaccine; and
o 15,000 IU (three drops) in juice for 3 days following the vaccine

d. Adults: 100 pound and up
Vitamin C: (give in divided doses)
o 1000 mg orally 4 times/day for 3 days before;
o 1500 mg orally 4 times/day the day of the vaccine and
o 1000 mg orally 4 times/day for 3 days following the vaccine.
Vitamin A:
o 20,000 IU (four drops) orally in juice for 3 days before;
o 50,000 IU (ten drops) orally in juice the day of the vaccine and
o 20,000 IU (four drops) orally in juice for 3 days after the vaccine.

I recommend using powdered vitamin for accurate dosing. For example, if each teaspoon contains 4000 mg of Vitamin C. The math to calculate the correct dosage can easily be determined.
For example, 1000 mg = 1/4 teaspoon;
500 mg = 1/8 teaspoon
250 mg = 1/16 teaspoon

A sign of too much vitamin C is loose stools. Although unlikely, if you or your child experiences loose stools, decrease the vitamin C dose by 50%.

Micel Vitamin A Dosages for Immune Support

To improve resistance against viral infections and reduce the possibility of vaccine reactions, particularly to viral vaccines (ie polio, MMR,

chickenpox, hepatitis A, hepatitis B and influenza).

Micel A drops have 5000IU of Vitamin a per drop and can be found at www.SNTV.com and

Infants and toddlers up to 30 pounds: One drop three times per week in juice
Toddlers and children from 31 to 100 pounds: One drop daily in juice
Adults: 100 pound and up: Two to three drops daily in juice

DISCLAIMER: These statements have not been evaluated by the Food and Drug Administration. These products are not intended to diagnose, treat, cure, or prevent any disease.

OVER CONCERN ABOUT VITAMIN A TOXICITY:

According to the Merck Manual, vitamin A toxicity was reported in arctic explorers who developed drowsiness, irritability, headaches and vomiting, with subsequent peeling of the skin, within a few hours of ingesting several million units of vitamin A from polar bear or seal liver. These symptoms cleared up with discontinuation of the vitamin-A rich food. The only other reference to vitamin A toxicity resulted from taking megavitamin tablets more than 100,000IU/day of synthetic vitamin A every day for many months.

Unless you are an arctic explorer or indulging in huge doses of vitamin A or taking more than 3 tablespoons of cod liver oil per day, it is virtually impossible to develop vitamin A toxicity.

As for children, a study carried out in Rome, Italy found no congenital malformations among 120 infants whose mother consumed more than 50,000 IU of vitamin A per day. A study from Switzerland looked at

blood levels of vitamin A in pregnant women and found that a dose of 30,000 IU per day resulted in blood levels that had no association with birth defects.

For more information, see information from the Weston Price Organization,
http://www.westonaprice.org/basicnutrition/vitaminasaga.html

Addendum U

Quick List References From Text
(Includes Additional References Beyond Text)

A. History of Vaccination

- Durbach, Nadia. "Bodily Matters: The Anti-Vaccination Movement in England. 1853 to 1907." Duke University Press. 2005.
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Index

There is an almost desperate need to defend the current belief - and trust - in vaccines. The public's view of childhood disease seems similar to our current view on terrorism: random attacks that are potentially deadly. After nearly 200 years of use, fear still sells vaccines.

Saying No to Vaccines is not intended to be a balanced view of vaccination literature. Pro-vaccine information is readily accessible through the American Academy of Pediatrics, the CDC, healthcare and government-sponsored organizations. This book balances the debate.

"*Saying No to Vaccines* is an absolute must-read for any parent or individual who is interested in optimal health for their children and themselves. Dr. Sherri Tenpenny is a brave, heroic, and honorable physician."
~Christiane Northrup, MD, best-selling author of Mother-Daughter Wisdom (Bantam, 2005), The Wisdom of Menopause (Bantam, revised 2006), and Women's Bodies, Women's Wisdom (Bantam, revised 2006).

"Of the Talmudic saying, 'He who saves one life, it is as if he saves the whole world,' Dr. Tenpenny's well-written, brilliant book, says it all. *Saying No to Vaccines* is recommended for all professionals involved with the treatment of children, all parents and grandparents concerned about mandated vaccines and all politicians, members of administrative bodies and medical societies who have the responsibility of passing vaccine legislation that impact our children."
~Mayer Eisenstein, MD, JD, MPH. Under his medical leadership, doctors with Homefirst Health Service in metro Chicago have delivered more that 15,000 babies at home. Eisenstein said, "We don't have a single case of autism in an unvaccinated child."