ADDENDUM to DIV
(Declination of Influenza Vaccination)

The intent of this Addendum to the Declination of Influenza Vaccination (DIV) form is to educate my employer and to serve as a legal attachment.

I, _____ do NOT agree to the following fraudulent statements as contained in the DIV form. These statements are based on the forms provided by the Immunization Action Coalition (IAC)[1]. IAC is funded by pharmaceutical companies, including those who make and profit from influenza vaccines[2]. Because of the 1986 National Childhood Vaccine Injury Act, vaccine makers are not financially liable for injury or death due to flu (and other) vaccines, nor are those who administer them[3]. Additionally, Justices Sotomayor and Ginsberg dissented a 2011 Supreme Court decision that protected vaccine makers from liability even from flawed vaccine design, and they warned this created a "*regulatory vacuum in which no one ensures that vaccine manufacturers adequately take account of scientific and technological advancements when designing or distributing their products.*"[4] The statements in the DIV are not based on the actual capabilities of influenza vaccines and are intended to coerce and intimidate employees into vaccination. As evidenced below, in some instances, vaccinated employees may pose an increased risk of spreading influenza and other influenza-like-infections to patients.

STATEMENT #1: Influenza is a serious respiratory disease that kills 23,608 persons and hospitalizes more than 200,000 people in the United States each year.

- Fatality numbers such as the ones claimed above are derived from the CDC Pneumonia and Influenza (P-I) deaths and hospitalization reports, which are COMBINED estimates. CDC does not require lab confirmation of influenza of adults, therefore this category includes ALL pneumonia all "flu-like" respiratory deaths.[5]
- Bridges et al (2000) "In our study, as in most studies, only a minority of the respiratory illnesses among adults were due to influenza."[6]

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[1] http://www.immunize.org/catg.d/p4068.pdf
[2] http://www.immunize.org/aboutus/corporate-membership.asp
[3] https://www.hrsa.gov/vaccine-compensation/index.html
[4] https://www.law.cornell.edu/supct/html/09-152.ZD.html
[5] https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_05.pdf
[6] https://jamanetwork.com/journals/jama/fullarticle/193139

- Pediatric deaths are required to be lab confirmed and carefully tracked. In the 2017-18 flu season, there were 180 deaths. More than half were in those with underlying health conditions, and more than half had bacterial co-infections.[7]
- In WA State in 2016 per WA DOH, there were a total of 276 deaths. 45% (126) had gotten a flu vaccine, 23% (63) had not, 31% (88) had unknown vaccination status. 96% (266) had pre-existing conditions, and (88%) 242 were over age 65.[8]
- National fatality numbers includes upper respiratory infections *possibly caused by influenza vaccination*, as evidenced by:
    - Cowling et al (2012) "TIV recipients had an increased risk of virologically-confirmed non-influenza infections (**relative risk: 4.40**; 95% confidence interval: 1.31-14.8). Being protected against influenza, TIV recipients may lack temporary non-specific immunity that protected against other respiratory viruses."[9]
    - Dierig et al (2013) "Adeno- and rhinoviruses were the most common viruses causing ILI. Swabs taken by parents are an effective method for sample collection. Influenza-like illness was more common in children vaccinated against influenza in this observational study, but prior health-seeking behaviour may have contributed to this difference."[10]

- Data is unreliable. From the Cochrane ARI group: "However there is no reliable system to monitor and quantify the epidemiology and impact of ILI [Influenza Like Illness], the syndrome that presents clinically. Few states produce reliable data on the number of physician contacts or hospitalised cases due to ILI, and none tie these data to the proportion of ILI caused by influenza. We do not know for certain what the impact of ILI is, nor the impact of the proportion of ILI caused by influenza. Prospective studies apportioning positivity to the scores of viruses probably causing ILI are rare, as interest is focused on influenza. The standard quoted figure of 36,000 yearly deaths in the US is based on the "respiratory and circulatory deaths" category including all types of pneumonia, including secondary to meconium ingestion or bacterial causes. More recently, the US Centers for Disease Control and Prevention (CDC) have proposed estimates of impact ranging between 3,000 and 49,000 yearly deaths. When actual death certificates are tallied, influenza deaths on average are little more than 1,000 yearly. So, the actual threat is unknown (but likely to be small) and so is the estimation of the impact of vaccination".[11]

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[7] https://gis.cdc.gov/GRASP/Fluview/PedFluDeath.html
[8] https://www.doh.wa.gov/Portals/1/Documents/5100/420-100-FluUpdateSeason2017.pdf
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3404712/
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4181477/pdf/irv0008-0293.pdf
[11] https://community.cochrane.org/news/why-have-three-long-running-cochrane-reviews-influenza-vaccines-been-stabilised

STATEMENT #2: Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.

- Ohmit et al (2013) ". . . no evidence that vaccination prevented household transmission once influenza was introduced."[12]
- The 2016 Cochrane Review concluded that "[o]ffering influenza vaccination to HCWs [healthcare workers] based in long term care homes may have little or no effect on the number of residents who develop laboratory-proven influenza compared with those living in care homes where no vaccination is offered."
- Cox et al (2004) "The absence of immune response [to vaccination] in the nasal mucosa may indicate a lack of appropriate local influenza virus stimulation. An apparent drawback to traditional parenteral [i.e., intramuscular] vaccines is that they induce a weak and short-lived local mucosal immune response."[13]

STATEMENT #3: If I contract influenza, I can shed the virus for 24-48 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.

- Yan et al (2017) Vaccinated individuals may shed much more. "We observed 6.3 (95% CI 1.9–21.5) times more aerosol shedding among cases with vaccination in the current and previous season compared with having no vaccination in those two seasons."[14]

STATEMENT #4: If I become infected with influenza, even if symptoms ARE absent, minimal or resemble a cold, I can spread severe illness to others.

- The same is true for vaccinated individuals. In fact, because there is a chance vaccination will minimize symptoms without reducing mucosal infection, an infected vaccinated person is more likely to go to work, not knowing they are contagious. See #2 and #3.

STATEMENT #5: I understand that the strains of virus that cause influenza infection change almost every year which is why a different influenza vaccine is recommended each year.

- Skowronski et al (2010) Seasonal flu vaccination may increase risk of acquiring pandemic flu: "In late spring 2009, concern was raised in Canada that prior vaccination with the 2008–09 trivalent inactivated influenza vaccine (TIV) was

[12] http://europepmc.org/articles/PMC3693492
[13] https://onlinelibrary.wiley.com/doi/full/10.1111/j.0300-9475.2004.01382.x
[14] http://www.pnas.org/content/early/2018/01/17/1716561115.full

associated with increased risk of pandemic influenza A (H1N1) (pH1N1) illness."[15]

STATEMENT #6: I understand that I cannot get influenza from the influenza vaccine.

- The literal statement may be true, but the implied meaning is not. The shot is not a live vaccine so cannot infect me with a replicating virus, but because vaccination weakens my immune system for about two weeks, the vaccine increases my risk of succumbing to an infection, including with any influenza I was or will be exposed to, or from either an adverse reaction to the shot. See #1
- Talaat et al (2017) **Rapid changes in serum cytokines and chemokines in response to inactivated influenza vaccination.** "Serum cytokines changed rapidly following TIV and generally peaked at 24 hours. Trivalent influenza vaccine□induced reductions in IL□8 occurred later (44 hours) and were sustained for 2 weeks. An outlier response coincided with the only moderate side effects to the vaccine. These data suggest that early cytokine/chemokine responses may provide additional insight into the pathogenesis of adverse events and immune reactivity to vaccination."[16]
- Influenza vaccination injuries listed on the Federal Table of Vaccine Injuries[17], entitled to compensation under the Vaccine Injury Compensation Fund (see table for full list and descriptions):
    - Anaphylaxis
    - Shoulder Injury Related to Vaccine Administration
    - Vasovagal syncope
    - Guillain-Barré Syndrome
    - Any acute complication or sequela, including death, of the illness, disability, injury, or condition listed.
    - *Encephalopathy.* A vaccine recipient shall be considered to have suffered an encephalopathy if an injury meeting the description below of an acute encephalopathy occurs within the applicable time period and results in a chronic encephalopathy.
    - *Acute encephalopathy.* (A) For children less than 18 months of age who present:
        - (*1*) Without a seizure, an acute encephalopathy is indicated by a significantly decreased level of consciousness that lasts at least 24 hours.

[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2850386/
[16] https://onlinelibrary.wiley.com/doi/full/10.1111/irv.12509
[17] https://www.hrsa.gov/sites/default/files/vaccinecompensation/vaccineinjurytable.pdf

        - (*2*) Following a seizure, an acute encephalopathy is demonstrated by a significantly decreased level of consciousness that lasts at least 24 hours and cannot be attributed to a postictal state—from a seizure or a medication.
    - For adults and children 18 months of age or older, an acute encephalopathy is one that persists at least 24 hours and is characterized by at least two of the following:
        - (*1*) A significant change in mental status that is not medication related (such as a confusional state, delirium, or 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.Evidence of neurologic dysfunction consists of either:
    - One of the following neurologic findings referable to the CNS: Focal cortical signs (such as aphasia, alexia, agraphia, cortical blindness); cranial nerve abnormalities; visual field defects; abnormal presence of primitive reflexes (such as Babinski's sign or sucking reflex); or cerebellar dysfunction (such as ataxia, dysmetria, or nystagmus); or
    - An acute encephalopathy as set forth in paragraph (c)(2)(i) of this section.
    - Evidence of an inflammatory process in the brain (central nervous system or CNS inflammation) must include cerebrospinal fluid (CSF) pleocytosis (>5 white blood cells (WBC)/mm3 in children >2 months of age and adults; >15 WBC/mm3 in children <2 months of age); or at least two of the following:
        - (*1*) Fever (temperature ≥ 100.4 degrees Fahrenheit);
        - (*2*) Electroencephalogram findings consistent with encephalitis, such as diffuse or multifocal
        - nonspecific background slowing and periodic discharges; or
        - (*3*) Neuroimaging findings consistent with encephalitis, which include, but are not limited to brain/spine magnetic resonance imaging (MRI) displaying diffuse or multifocal areas of hyperintense signal on T2-weighted, diffusion-weighted image, or fluid-attenuation inversion recovery sequences.

- The Vaccine Adverse Event Reporting System captures just 1% of all adverse reactions according to a Harvard-Pilgrim study.[18] As of October 2018, there have been 153,742 influenza adverse reactions reported to VAERS. Cases heard in

[18] https://healthit.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf

the U.S. Court of Federal Claims Opinions can be found here: https://www.uscfc.uscourts.gov/opinion-search.

STATEMENT #7: The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients and my community.

- De Serres et al (2017) "RESULTS: In attributing patient benefit to increased HCW influenza vaccine coverage, each cRCT was found to violate the basic mathematical principle of dilution by reporting greater percentage reductions with less influenza-specific patient outcomes (i.e., all-cause mortality > ILI > laboratory-confirmed influenza) and/or patient mortality reductions exceeding even favourably-derived predicted values by at least 6- to 15-fold. If extrapolated to all LTCF and hospital staff in the United States, the prior cRCT-claimed NNV of 8 would implausibly mean >200,000 and >675,000 patient deaths, respectively, could be prevented annually by HCW influenza vaccination, inconceivably exceeding total US population mortality estimates due to seasonal influenza each year, or during the 1918 pandemic, respectively. More realistic recalibration based on actual patient data instead shows that at least 6000 to 32,000 hospital workers would need to be vaccinated before a single patient death could potentially be averted. CONCLUSIONS: The four cRCTs underpinning policies of enforced HCW influenza vaccination attribute implausibly large reductions in patient risk to HCW vaccination, casting serious doubts on their validity. The impression that unvaccinated HCWs place their patients at great influenza peril is exaggerated. Instead, the HCW-attributable risk and vaccine-preventable fraction both remain unknown and the NNV to achieve patient benefit still requires better understanding."[19]
- Ohmit et al (2013) "We found no evidence of vaccine effectiveness in preventing within-household transmission once influenza was introduced."[20]
- Also see #2 and #3

On Masking: "Unreasonable and Illogical"

September 7, 2018 "The Ontario Nurses' Association (ONA) has won a second decision on the controversial vaccinate or mask (VOM) policy, striking down the policy in effect at St. Michael's Hospital and several other hospitals that form the Toronto Academic Health Science Network (TAHSN). These policies force nurses and other health-care workers to wear an unfitted surgical mask for the entirety of their shift if they choose not to receive the influenza vaccine. . . .

[19] https://www.ncbi.nlm.nih.gov/pubmed/28129360
[20] https://academic.oup.com/cid/article/56/10/1363/404283

. . .ONA's well-regarded expert witnesses, including Toronto infection control expert Dr. Michael Gardam, Quebec epidemiologist Dr. Gaston De Serres, and Dr. Lisa Brosseau, an American expert on masks, testified that there was insufficient evidence to support the St. Michael's policy and no evidence that forcing healthy nurses to wear masks during the influenza season did anything to prevent transmission of influenza in hospitals. They further testified that nurses who have no symptoms are unlikely to be a real source of transmission and that it was not logical to force healthy unvaccinated nurses to mask. Arbitrator Kaplan accepted this expert evidence. In contrast, he noted the only fair words to describe the hospital's evidence in support of masking are "insufficient, inadequate and completely unpersuasive."[21]

Finally, I ask my employer to examine their approach to treating influenza. Current treatment protocols for influenza are increasing severity, duration, and fatalities.

- **The effect on mortality of antipyretics in the treatment of influenza infection: systematic review and meta-analyis** "In conclusion, this systematic review and meta-analysis has shown an increased mortality rate in animals treated with antipyretics during infection with influenza A or B, with no informative randomized placebo-controlled trials in humans. We propose that randomized placebo-controlled trials of antipyretic use in pandemic and seasonal influenza in humans are urgently needed in order to establish appropriate evidence-based management guidelines."[22]
- **Randomized controlled trial of the effect of regular paracetamol on influenza infection.** *"Regular paracetamol had no effect on viral shedding, temperature or clinical symptoms in patients with PCR□confirmed influenza. There remains an insufficient evidence base for paracetamol use in influenza infection."*[23]
- **Effect of Antipyretic Therapy on the Duration of Illness in Experimental Influenza A, *Shigella sonnei*, and *Rickettsia rickettsii*Infections.** "There was a striking correlation between antipyretic therapy and duration of illness in subjects infected with influenza A and *S. sonnei*, but not *R. rickettsii*."[24]
- Dr David Tovey, Editor-in-Chief of *The Cochrane Library*, commenting on the release of the updated Cochrane Review[25] on neuraminidase inhibitors [Tamiflu], said: "We now have the most robust, comprehensive review on neuraminidase

[21] https://www.ona.org/news-posts/ona-wins-vaccinate-or-mask-flu-policy/
[22] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2951171/
[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4738455/
[24] https://onlinelibrary.wiley.com/doi/abs/10.1592/phco.20.19.1417.34865
[25] https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD008965.pub4/abstract

inhibitors that exists. Initially thought to reduce hospitalisations and serious complications from influenza, the review highlights that [NIs are] not proven to do this, and it also seems to lead to harmful effects that were not fully reported in the original publications. This shows the importance of ensuring that trial data are transparent and accessible."[26]

[26] https://www.cochrane.org/news/tamiflu-and-relenza-getting-full-evidence-picture

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