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Friday, 28 November 2014

On 23 November 2014, Paul G. King, PhD, downloaded an on-line New York City Health Department "Frequently Asked Questions" document titled "**Influenza Vaccination Requirements for Children in Daycare or Preschool: Frequently Asked Questions for Parents**", from http://www.nyc.gov/html/doh/downloads/pdf/imm/day-care-flu-faq.pdf.

Dr. King's responses to that article follows these introductory remarks and a "table of contents" page.

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This assessment is titled, "**Responses to 'Influenza Vaccination Requirements for Children in Daycare or Preschool: Frequently Asked Questions for Parents'".**

Introductory Remarks

First, each portion of the article's text is quoted in a grayed "Calibri" font.

Second, Dr. King's responses follow in a "DejaVu Sherif" font and are indented.

Third, when quoting from the article's text, the quoted portions of the text are in an *italicized* "*Times New Roman*" font.

Fourth, when quoting/referencing other sources, the quoted text/references are in an "Arial Narrow" font.

Finally, should anyone find any significant factual error in these responses for which they have independent[a], scientifically sound, peer-reviewed, published, substantiating documents, please submit that information to Dr. King so that he can improve his understanding of factual reality and, where appropriate, revise his views and these responses.

Respectfully,

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[To whom all responses should be directed]

[a] To qualify as an independent document, the article should be published by researchers who have no direct or indirect conflicts of interest from their ties to either those commercial entities who profit from the sale of any product or practice addressed in this response or those entities, academic, commercial or governmental, who directly or indirectly, actively promote any product or practice, the development of any product or practice, and/or programs using any product or practice covered in this assessment.

Table of Contents for:

Responses to "Influenza Vaccination Requirements for Children in Daycare or Preschool: Frequently Asked Questions for Parents"

Response to "Influenza Vaccination Requirements for Children in Daycare or Preschool: Frequently Asked Questions for Parents"

"Why does the Board of Health require my daycare and preschool-aged child to be vaccinated against influenza?

Each year, many children get sick with seasonal influenza, and some die. The highest infection rates are in children under 5 years old; in fact, *10 to 40%* of children under 5 years old will get influenza each year."

First, based on the reports in VAERS, some children also get sick and die shortly after an influenza vaccine inoculation.

Second, based on the basis document's unsubstantiated "*10 to 40%*" claim for "*seasonal influenza*" cases and Dr. Peter Doshi's published study[1], somewhere between 1.5 % and 7.5% of those "*children under 5 years old*" may actually contract a viral infection caused by an influenza virus each year.

Moreover, in children less than two (2) years of age, the recommended influenza vaccines are no more effective than a placebo injection in preventing influenza[2].

Furthermore, for "*children under 5 years old*", there are no independent randomized double-blind, true-placebo controlled studies with adequate post-inoculation follow-up to establish that the influenza vaccines are effective in preventing those receiving each manufacturer's influenza vaccine from subsequently being infected by even the strains of the influenza viruses used to manufacture the influenza vaccines administered.

The only published, peer-reviewed, randomized, double-blind, placebo-controlled study (the "gold standard" for a clinical vaccine-effectiveness study), of which Dr. King is aware is a 2012 study[3] in children six (6) to 15 years of age, which followed the study's subjects for nine (9) months after each child was inoculated.

In that study, compared to the double-blinded controls given sterile saline injections, those in the treatment arm who received the inactivated-influenza vaccine were only moderately more "protected" from subsequently being infected by an influenza virus than the controls were.

Also, those who received an inactivated-influenza vaccine inoculation had three-plus-fold higher rates of non-influenza viral respiratory infections (which are also "flu" cases) than the controls injected with sterile saline.

Based on the studies cited in this response, the inactivated-influenza vaccines provide no protection from influenza infection to any child less than two years of age and little protection to those who are 2 to 5 years of age.

Finally, those children given the inactivated-influenza vaccine resulted

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1 Doshi P, Influenza: marketing vaccine by marketing disease. ***British Med J. [BMJ]*** 2013; 346 doi: http://dx.doi.org/10.1136/bmj.f3037 (Published 16 May 2013). This paper shows that less than 20% of all "flu" cases are influenza.

2 Jefferson T, Rivetti A, Di Pietrantonj C, Demicheli V, Ferroni E. Vaccines for preventing influenza in healthy children (Review). The Cochrane Library 2012, Issue 8. This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in http://www.thecochranelibrary.com. Abstract at http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004879.pub4/abstract; full article available at http://www.update-software.com/pdf/CD004879.pdf.

3 Cowling BJ, Fang VJ, Nishiura H, et al. Increased Risk of Noninfluenza Respiratory Virus Infections Associated with Receipt of Inactivated Influenza Vaccine. *Clin Infect Dis.* 2012 June 15; 54(12): 1778-1783.

in their being three-plus times as likely as the controls to contract the some non-influenza viral respiratory infection ("flu"), which has the same symptoms as influenza (e.g., common cold viruses, parainfluenza viruses, coxsackie viruses, and the respiratory syncytial virus [RSV]).

Therefore, any inactivated-influenza vaccine program both causes and spreads the "flu" and provides no (in children 2 years of age or younger) or little (in children 2 to 5 years of age) protection from influenza infection to those who have been vaccinated with an inactivated-influenza vaccine.

Turning to the live, genetically engineered, cold-adapted influenza vaccines, their first problem is that they are neither approved by the U.S. Food and Drug Administration (FDA) nor recommended by the U.S. Centers for Disease Control and Prevention (CDC) to be given to children under 2 years of age – which this "***Frequently Asked Questions for Parents***" (FAQ) document fails to disclose.

The second problem is that, to develop protective levels of antibodies, the live viruses must infect the recipient so that the live influenza vaccines does give most of those who are inoculated with it "concurrent", if not "simultaneous" multiple viral influenza infections — one for each strain of the live viruses in the live-virus vaccine, which now contains four (4) strains of influenza viruses.

The third problem is that those children who are inoculated with the live-virus influenza vaccine can and do shed live viruses, which, for a period of three weeks to a month, may infect and have infected others according to the manufacturer's package insert[4].

Thus, if the NY City Health Department were truly concerned about the health of the children and the public, it would ban the administration of the live-virus vaccine to any New Yorker or require that all individuals receiving the MedImmune FluMist® Quadrivalent vaccine to be quarantined at home for at least three (3) weeks.

Fourth, if, shortly before or after inoculation, a live-virus inoculated child has been, or is exposed to, other strains of influenza, the vaccine's viruses may exchange genetic material (a process called resortment) with the "other" influenza virus and create a hybridized invasive influenza virus that may be more virulent than the vaccine's influenza viruses with which the child was inoculated.

Finally, for those children who have a nasal membrane defect where the olfactory nerves enter the brain, spraying the live-virus solution up each nostril risks a fatal brain infection by one or more of the live-virus vaccine's strains. [**Note:** The distribution of an intranasally administered radiolabeled placebo in healthy adults showed that, on average, 2.4% of the introduced radioactivity ended up in the recipients' brain[5].]

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4 http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM294307.pdf, in section "12 CLINICAL PHARMACOLOGY".

5 Ibid., "Page 15 of 25", "12.3 Pharmacokinetics
Biodistribution

Thus, the administration of the inactivated-influenza vaccines and/or the live-virus vaccine increases the risk of "flu" (any influenza-like infection [ILI]) in New York City (NYC) daycares and preschools.

Therefore, unless the intent of the NYC Department of Health is to increase the cases of the "flu" in those who attend and work in City-regulated daycares and preschools as well as in their direct contacts that those flu-infected children will have, the NYC Health Department should immediately cancel this influenza vaccination program for City-regulated daycares and preschools.

"Conditions at daycares and preschools allow influenza to spread. At these locations, many children are in close contact, and children may not cover their coughs. Many daycare-aged children haven't been vaccinated against influenza. Vaccination is the best way to protect your children from infection."

First, Dr. King agrees that "*[c]onditions at daycares and preschools*" may "*allow influenza to spread*".

However, given the disease-causing nature of the current influenza vaccines, the fact that "*[m]any daycare-aged children haven't been vaccinated against influenza*" is a positive health factor that the NY City Health Department is inexplicably trying to reduce.

Furthermore, independent studies have found that inactivated-influenza-vaccine inoculations do <u>not</u> protect our young "*children from infection*" but rather increase their risk of a "flu" infection and, *when a live-virus influenza vaccine is used to inoculate those over two years of age*, actually infects those inoculees as well as may, and does, spread influenza to others.

Given the findings of peer-reviewed published studies cited, it is clear that the mandated influenza vaccination program for daycares and preschools is a disease causing and disease spreading program – and certainly <u>not</u> the "*the best way to protect … children from infection*".

Based on Dr. King's studies, a nutritional supplementation program in which the vitamins and minerals (e.g., vitamin A as beta-carotene, vitamin B-12, vitamin C, vitamin D-3, vitamin K-2, magnesium, iodine, potassium, and selenium) that strengthen the immune system's ability to ward off disease would be a better approach than a vaccination program that causes disease.

In addition to supplementation with those vitamins and minerals with which NYC's children tend to be deficient, that program might include a probiotic to promote a healthy gastrointestinal microbiome as well as the removal of all GMO items from the foods provided by those institutions.

"Young children can also spread influenza throughout the entire community, passing it to other children and their family members, who then spread infection to others. Immunizing your children against influenza protects the rest of the population, including vulnerable populations, like the elderly and pregnant women."

Here, Dr. King finds that the NYC Health Department makes another

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A biodistribution study of intranasally administered radiolabeled placebo was conducted in 7 healthy adult volunteers. The mean percentages of the delivered doses detected were as follows: nasal cavity 89.7%, stomach 2.6%, brain 2.4%, and lung 0.4%. The clinical significance of these findings is unknown"

specious argument which ignores the reality that, if "*[y]oung children can also spread influenza*", it is the young vaccinated children who are, and will, be disproportionately contracting, *either directly from the live-virus vaccine or indirectly when they are inoculated with the inactivated-influenza vaccines*, the "flu" and spreading those cases of the "flu" (non-vaccine-strain-influenza and other ILIs) throughout the community to the "*vulnerable populations, like the elderly and pregnant women*" about whom the department has expressed its "concern".

Similarly, given the outcomes observed by Cowling et al (2012)[6] and Kelly et al (2011)[7], influenza-vaccinated older children, adults and elderly will be at increased risk of contracting and spreading "flu" (any ILI) through the community.

In addition, Dr. King is appalled at the concept that an agency would propose a disease-causing "health" practice that it knows will sacrifice the health and lives of some percentage of NYC's infants and young children on the altar of influenza vaccination to protect "*vulnerable populations*".

Besides the CDC[8], what "ethical" agency would knowingly recommend vaccinating young children with a vaccine that provides them no, or little, protection from contracting a disease in order to purportedly protect some other at-risk population?

Such practices border on societal suicide — knowingly risking the health and lives of healthy children who will receive no or little benefit from influenza vaccination and may be harmed by that vaccination to some degree to purportedly protect some small percentage of the sick, infirm and elderly from contracting influenza (less than 20% of those who annually contract the "flu").

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6 Cowling BJ, Fang VJ, Nishiura H, et al. Increased Risk of Noninfluenza Respiratory Virus Infections Associated with Receipt of Inactivated Influenza Vaccine. *Clin Infect Dis.* 2012 June 15; 54(12): 1778-1783.

7 Kelly H, Jacoby P, Dixon GA, Carcione D, et al. Vaccine Effectiveness against laboratory-confirmed influenza in healthy young children: a case-control study. *Pediatr Infect Dis J* 2011; 30: 107–111.

8 The CDC, through its industry-led "Advisory Committee for Immunization Practice" (ACIP), has long recommended the universal administration three (3) doses of the hepatitis B vaccine beginning "at birth" when, except in rare instances in the United States of America (USA) these infants have no real population risk of contracting hepatitis B. Moreover, for those infants who have been exposed to hepatitis B from their infected mothers, neither vaccination nor vaccination plus antiserum treatments have been shown to be effective in preventing the developing hepatitis B disease in these "hepatitis B"-exposed infants and the vaccine is known to damage these infants' livers. Moreover, the CDC's justification for this program is that it recommends vaccinating our infants because it cannot get those adults who are intravenous drug users and actively engage in unsafe sex with multiple partners to get the hepatitis B vaccine. In addition, without any proof of safety and effectiveness in infants, it is the CDC's ACIP that, in April of 2002 when all approved influenza vaccines were Thimerosal (organic mercury) preserved, made a recommendation to vaccinate all infants 6 to 23 months of age in the "flu" season with those Thimerosal-preserved vaccines "*when feasible*" (Carolyn B. Bridges CB, Fukuda K, Uyeki TM, Cox NJ, Singleton JA. Prevention and Control of Influenza Recommendations of the Advisory Committee on Immunization Practices (ACIP). *Morbidity and Mortality Weekly Report* (*MMWR*) 2002 April 12; 51(RR03): 1-31). Clearly, the CDC thinks that it is ethical to risk literally sacrificing infants for, in their view, the "greater good" even when such policies appear to be a form of societal suicide based on the observed outcomes where more than one in two of our children have at least on chronic medical condition in childhood and more than 25% are projected to have at least one lifetime chronic medical condition.

"Does the New York City Health Department have the authority to require this immunization?

Yes, the City Charter gives the Health Department authority over all matters concerning health in New York City."

From Dr. King's reading of the online NEW YORK CITY CHARTER, City of New York, As Amended Through July 2004, the city charter requires the consent of an appointed NYC Board of Health and the approval of the mayor of New York City for actions regarding the city's mandated vaccination requirements.

Thus, since the mayor's approval is required, the mayor, former Mayor Bloomberg, and not the "Department of Health and Mental Hygiene", had and used his questionable authority to require this vaccination program for children in daycares and preschools, which the current mayor or a future mayor may revoke or otherwise modify.

Therefore, to be accurate, the former mayor authorized an early childhood influenza-vaccination program that an administrative board approved and the NYC Department of Health supported.

Based on the proven actuality that the mandated early childhood influenza-vaccination program provides no or little influenza-protection benefit to these children and actually increases the risk of their contracting and spreading the "flu", clearly this mandated influenza vaccination program is a "flu" causing and "flu" spreading vaccination program.

As such, the mayor, the board, and the NYC Department of Health apparently engaged in defrauding the people of NYC by falsely claiming that this influenza vaccination program protects against the "flu".

Actually, for less than 70% of those vaccinated each year, the influenza vaccines provide, at best, only limited-duration protection from influenza infection by the three (3) or four (4) vaccine strains of the many circulating influenza strains to which New Yorkers may be exposed and no protection from the other organisms that cause the "flu" (any ILI).

Moreover, since the State of New York has declined to enact similar legislation, it would seem that, like the overturned "Bloomberg" ban on selling large-size containers of sugar-sweetened sodas, the NYC is again exceeding its health regulation authority.

This is the case because the courts have ruled that the NYC Mayor, the board and the NYC Health Department do not have the authority to legislate a vaccination mandate, much less to legislate outside of the legal bounds for such mandates established by the State of New York.

To the extent that the preceding applies, no administrative branch of the government of NYC has the authority to institute this vaccination mandate and, as such, this influenza vaccination mandate appears to be an extralegal action.

Finally, there is a growing evidence that repeatedly inoculating anyone with a given vaccine greatly increases the inoculee's risk for autoimmune reactions[9].

[9] Tsumiyama K, Miyazaki Y, Shiozawa S. Self-Organized Criticality Theory of Autoimmunity. *PLoS ONE* 2012 December 31; 4(12): e8382 (9 pages).

Thus, unless one of the objectives of the NYC Department of Health and Mental Hygiene is to also increase the risk of and/or increase the severity of chronic immune-system dysregulation in children, this clearly disease causing, disease spreading, and apparently extralegal, early childhood influenza vaccination mandate should be immediately revoked.

"When will the vaccination requirement begin, and how will it be enforced?

The requirement went into effect in January 2014 and requires parents and child care facility operators to take these steps:

- **Parents Must Vaccinate Children**: Children between 6 months and 5 years old who attend City-regulated daycares and preschools must be vaccinated annually. That means each child must receive at least one dose of the influenza vaccine between July 1 and December 31 each year.
- **Child Care Facilities Must Document Vaccinations:** Child care facilities must track whether all students have received the influenza vaccination."

Here, Dr. King simply notes that the Department of Health influenza mandate does not cover those children who do not "*attend City-regulated daycares and preschools*".

In addition, Dr. King questions whether the NYC Department of Health can require "*[c]hild care facilities*" that are not City-regulated[10] to track the influenza vaccination status of their attendees.

Finally, as the FAQs admit later, the initial bullet is, *as written*, knowingly misleading and inaccurate, and should be revised to correct its errors by, for example, stating,

> "***Parents Must*"**: The parents of "*[c]hildren between 6 months and 5 years old who attend City-regulated daycares and preschools must*" elect to: **a)** have their children vaccinated annually with an influenza vaccine; **b)** appropriately provide or seek a medical or religious exemption from this requirement; or **c)** send their children elsewhere. "*That means*" that the parents of each child who is not exempt from this vaccination mandate must annually decide whether to: **1)** send their child to a City-regulated daycare or preschool, **2)** send them elsewhere, or **3)** provide their affected children daycare or schooling in their home. When parents elect to send their children who are 6 to 59 months of age to a City-regulated daycare or preschool, then the parents must ensure that their affected children: **a)** are given "*at least one dose of the influenza vaccine between July 1 and December 31 each year*" or **b)** have a valid medical or religious exemption to this influenza vaccination mandate.

Similarly, the second bullet should be revised to read, for example,

> **City-regulated** "***Child Care Facilities Must Document Vaccinations:***" City-regulated "*[c]hild care facilities must track whether all*" *attendees* "*have received*

[10] Perhaps, since the State of New York has no such disease causing, disease spreading influenza vaccination mandate for children 5 years old and younger, City-regulated daycares and preschools that truly care about the health of infants and young children should consider becoming State-regulated facilities exempt from complying with this influenza vaccination mandate if that is possible. Alternatively, concerned parent should band together and form childcare "cooperatives" and home schools that fall outside of the applicable City-regulations.

the influenza vaccination."

"Since the requirement is new, the Health Department will provide these resources to your community:

- Informative print and online materials sent to childcare facilities
- Promotional materials for childcare facilities that must follow the regulation
- Education for childcare facility staff provided by the Health Department's Bureau of Child Care

In 2015, the Health Department's Bureau of Child Care will enforce the requirement by educating childcare staff during routine inspections.

Beginning January 1, 2016, the Department will begin issuing notices of violation to childcare facilities that fail to follow the mandate."

Here, Dr. King first observes that the preceding statements address only how the influenza-vaccination program will be administered and enforced for the City-regulated "*childcare facilities*".

In that regard, there does not appear to be any suspension or postponement of the parents' mandate to have their child appropriately vaccinated or exempted if that child is to attend a City-regulated daycare or preschool in 2015 or beyond.

"**How is the influenza vaccine given?**

There are two types of vaccine:

1. The '**flu shot**' contains inactivated virus particles and is administered by injection.
2. The '**Flumist**,' also called '**nasal spray**' or '**LAIV**,' contains a weakened virus and is a nasal spray.

Most children can use either vaccine but may prefer one over the other. Talk to your pediatrician about the best vaccination method for your child."

Technically, there are several types of vaccines rather than just the two (2) presented by the Health Department here.

The first major division is in the culture system used to grow the viruses or viral fragments, whether live, inactivated or synthetic.

Currently, most influenza virus strains for vaccines are initially grown in embryonated chicken eggs and there are decades of history for the production of split-viron inactivated-influenza vaccines and more than a decade of experience for a genetically engineered, live-virus influenza vaccine, currently MedImmune's FluMist Quadrivalent, a nasal-spray vaccine.

However, Novartis has recently introduced Flucelvax®, a preservative free, antibiotic-free inactivated-influenza vaccine that is grown in a Madin Darby Canine Kidney (MDCK) cell line.

The disclosed concerning components in that influenza vaccine's formulation include Residual MDCK cell protein (≤ 8.4 µg), protein other than HA (≤ 120 µg), MDCK cell DNA (≤ 10 ng), polysorbate 80 (≤ 1125 µg), cetyltrimethly-ammonium bromide (≤ 13.5 µg), and β-propiolactone (≤ 0.5 µg). [**Note:** The population experience for this vaccine is limited and it is currently not approved for use in children but may be prescribed for them if they are very allergic to eggs.]

In addition, Protein Sciences Corporation has introduced a genetically engineered insect-cell-line process that directly produces the active compo-

nent hemagglutinins (HAs) for the selected strain of influenza without having to "grow" large quantities of the selected influenza virus strains.

That influenza HA-based vaccine, Flublok®, is a preservative-free inactivated-influenza vaccine that also contains residual amounts of baculovirus and host cell proteins (≦ 28.5 mcg), baculovirus and cellular DNA (≦ 10 ng), and Triton X-100 (≤ 100 mcg). [**Note:** The population experience for this vaccine is even more limited than that for Flucelvax and it is currently only approved for use in those 18 to 49 years of age, but, as with Flucelvax, it may be prescribed for children who are highly allergic to eggs.]

Currently, *for children under two years of age*, Sanofi's Fluzone vaccines are the only FDA-approved and CDC-recommended influenza vaccines.

As the children get older, there are other approved and/or recommended choices.

In addition to age, the parents of children who have serious respiratory problems, are on a daily aspirin therapy, or are immunocompromised should avoid FluMist and, because it can infect other than those inoculated with it, may want to request that their daycare or preschool not offer, and discourage the use of, this choice – especially if they or their children are immunocompromised.

For a condensed view of your choices and the nature of the all of the available influenza vaccines for the 2014-2015 "flu" season, see http://dr-king.com/docs/20140824_Influenza_Vaccine%20Choices_for_the_2014_2015_Flu_Season_final_b.pdf.

If you are only interested in those vaccines that do not contain any added Thimerosal, you may consult the companion document, http://mercury-freedrugs.org/docs/20140827_No_Thimerosal_Influenza_Vaccine_Choices_for_the_2014_2015_Flu_Season_final_b.pdf, posted on the CoMeD web site.

However, since **1)** supposedly only qualified healthcare providers give vaccines to a child after obtaining the parent's "informed consent" and appropriately reviewing that child's medical records, and **2)** children under three (3) years of age are only supposed to be given no-Thimerosal or trace-Thimerosal vaccines since these are readily available, the first statement,

"*Most children can use either vaccine but may prefer one over the other*,"

is highly inaccurate and should be revised to read, for example,

"**For children who are:**

a. ***Between six (6) months and two (2) years of age***, currently only the no-Thimerosal Sanofi Fluzone Quadrivalent, 0.25-mL-dose vaccine should be given;

b. ***Less than three years of age and have certain medical issues*** (e.g., asthma, chronic obstructive pulmonary disease [COPD], aspirin therapy, a compromised immune system), currently only the no-Thimerosal Sanofi Fluzone Quadrivalent 0.25-mL inactivated-influenza vaccine formulation should be given;

c. ***Between two (2) and three (3) years of age and have no contraindicating medical issues***, the Sanofi no-Thimerosal Quadrivalent 0.25-mL-dose vaccine and the MedImmune FluMist® Quadrivalent live-virus influenza vaccine can be given;

d. ***Between three (3) and four (4) years of age***, the current influenza vaccine choices are: Fluzone, Fluzone Quadrivalent, GlaxoSmithKline's Fluarix® Quadrivalent, IDC BioMedical of Quebec's FluLaval® Trivalent and Quadrivalent, and FluMist Quadrivalent; and

e. ***Between four (4) and five (5) years of age***, the current influenza vaccine choices are: Fluzone, Fluzone Quadrivalent, Novartis' Fluvirin®, Fluarix Quadrivalent, FluLaval Trivalent and Quadrivalent, and FluMist Quadrivalent."

Turning to the second statement,

"*Talk to your pediatrician about the best vaccination method for your child*",

because it is inaccurate and ignores the reality that not all children have pediatricians as their primary healthcare providers, Dr. King recommends changing this to read,

"When a child is old enough that there are CDC-recommended options, the parent should talk with his or her child's primary healthcare provider to choose the safest influenza vaccine for the child."

"**When should my child get the influenza vaccine?**

The new mandate requires that your child be vaccinated between July 1 and December 31 each year. (See above.) Your child should get the vaccine as soon as it's available within that timeframe so that he or she will be protected when influenza season starts."

Factually, the current influenza vaccines for each "flu" season are normally not available before late August of each year.

Thus, rather than hurrying to get your child vaccinated, you should carefully weigh your choices and, *if you choose to vaccinate*, make sure that the influenza vaccine that you have chosen as the safest for your child is available and, if at all possible, only allow that influenza vaccine to be given.

Since Thimerosal is a proven human carcinogen, mutagen, teratogen, reproductive toxin and autoimmune inducer at levels below 1 part-per-million, you may want to avoid vaccines that contain any level of Thimerosal.

Studies have shown that none of the influenza vaccines is effective in preventing children 5-years old or younger from subsequently getting the "flu".

Indeed, since they apparently increase the vaccinated child's overall risk for viral respiratory infections that cause influenza-like symptoms, you may also want to look into those supplements and practices that can bolster and protect your child's immune system before you allow your child to be given any influenza vaccine.

"**How long is the influenza vaccination good for?**

The influenza vaccine protects your child for one influenza season. Influenza activity is usually at its worst January through March, but it can start as early as November and extend as late as May. It's important that your child receive an influenza vaccine each year because influenza virus strains change annually. That's why the vaccine is updated each year."

Again, the Health Department's answer begins with a factual distortion.

At best, the influenza vaccine inoculation may provide some degree of protection from your child's being infected by one of the three or four strains of influenza included in the vaccine he or she receives, but there are no guarantees of any protection.

Moreover, based on the only "gold standard" clinical study of vaccinated versus sham-vaccinated children using an inactivated-influenza vaccine[11], the only FDA-approved influenza vaccines for children under two (2) years of age, an inactivated-influenza vaccination may significantly increase the risk of your child's contracting some non-influenza viral illness ("flu") during the "flu season".

Also, based on its package insert, the live-virus influenza vaccine must infect your child with now four (4) live viruses if he or she is to develop any antibody protection against subsequent re-infection.

Furthermore, after being inoculated with the live-virus influenza vaccine, your child may be able to infect others for about a month so that you may want to restrict your "*Flumist*"-inoculated child's interactions with other family members and the public for more than three (3) weeks.

"**Does the influenza vaccine work?**

The influenza vaccine is the best protection against seasonal influenza. Children who receive the influenza vaccine are 60% less likely to get sick and need medical attention for influenza. The vaccine also reduces the chance of death from influenza. It can help with other benefits, such as reducing illness, antibiotic use, hospitalizations and time lost from school and work."

Given that the currently available influenza vaccines for children under two (2) years of age provide them no protection from influenza and they and the live-virus influenza vaccines only provided minimal protection to children 2 to 5 years of age, Dr. King would suggest the NYC Health Department's initial "*best protection*" response should simply be ignored.

Moreover, though the second statement,

> "*Children who receive the influenza vaccine are 60% less likely to get sick and need medical attention for influenza*"

roughly matches the outcomes seen in older children for influenza infections, it ignores the three-plus-fold (340%) increase in non-influenza viral respiratory cases of the "flu" that were seen in the vaccinated arm of the "gold standard" study of vaccinated versus sham-vaccinated children 6 to 15 years of age.

When the two effects are factored together, the net result was that the vaccinated children had more than twice the cases of "flu" as those who received the sterile-saline, placebo injection.

In addition, lacking randomized, double-blind, true-placebo-controlled studies of vaccinated versus non-vaccinated children under 5 years of age with follow-up for at least nine (9) months after inoculation, Dr. King finds that there is no sound science that supports most of the "other benefits" claims.

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11 Cowling BJ, Fang VJ, Nishiura H, et al. Increased Risk of Noninfluenza Respiratory Virus Infections Associated with Receipt of Inactivated Influenza Vaccine. *Clin Infect Dis.* 2012 June 15; 54(12): 1778-1783.

However, there is sound science[12] that negates the general "*reducing illness*" claim in children five (5) years of age and younger as well as in a "gold standard" study[13] in children 6 to 15 years of age, where, *on a normalized group-size basis*, the vaccinated children had more than twice the "flu" cases as the children given a saline (sham influenza) injection.

"**Is the influenza vaccine safe?**

Influenza vaccines have been given for more than 50 years, and they have a very good safety track record. Influenza vaccines are made the same way each year, and their safety is closely monitored by the federal Centers for Disease Control and Prevention and the Food and Drug Administration.

Hundreds of millions of influenza vaccines have been given safely."

First, all FDA-approved influenza vaccines were Thimerosal-preserved inactivated-influenza vaccines until 2002.

Moreover, for more than 40 of those "*more than 50 years*", the vaccine makers have refused to prove that the level of Thimerosal in the vaccines is safe and the FDA has blatantly ignored their non-compliance since 1973.

In April of 2011, the FDA effectively removed the minimum requirement for influenza vaccine makers to prove their Thimerosal-preserved influenza vaccines are safe to the "sufficiently nontoxic" requirement minimum.

Based on the preceding facts, any rational scientist would logically conclude: Thimerosal-preserved inactivated-influenza vaccines do <u>not</u> meet the regulatory "sufficiently nontoxic"[14] safety requirement minimum.

Additionally, for some reason, the FDA has also refused to enforce the preclinical safety standards for any prophylactic vaccine product given to humans of any age.

This required preclinical toxicity testing is supposed to prove that a prophylactic (disease protective) drug, and influenza vaccines are such drugs, <u>cannot</u> cause cancer, mutations or reproductive toxicity to humans <u>before</u> any formulation of it is given to any human being.

Therefore, regardless of the touted years of use and the unsubstantiated generalizations made here (e.g., "*they have a very good safety track record*" and "*their safety is closely monitored by the federal Centers for Disease Control and Prevention and the Food and Drug Administration*"), <u>none</u> of the influenza vaccines meets the applicable prophylactic (disease protective) vaccine safety standards[15].

Moreover, with the advent of a live-virus vaccine, inactivated-influenza

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12 Jefferson T, Rivetti A, Di Pietrantonj C, Demicheli V, Ferroni E. Vaccines for preventing influenza in healthy children (Review). The Cochrane Library 2012, Issue 8. This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in http://www.thecochranelibrary.com. Abstract at http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004879.pub4/abstract; full article available at http://www.update-software.com/pdf/CD004879.pdf.

13 Cowling BJ, Fang VJ, Nishiura H, et al. Increased Risk of Noninfluenza Respiratory Virus Infections Associated with Receipt of Inactivated Influenza Vaccine. *Clin Infect Dis.* 2012 June 15; 54(12): 1778-1783.

14 In toxicology, the phrase "sufficiently nontoxic" *minimally* means that, for toxic bioaccumulative materials like organic mercury-containing compounds, the level of a toxic material in a dose of a vaccine is 10-fold or more <u>below</u> its scientifically sound, published, population-based estimate for the applicable NOAEL (no observed adverse-effect level) in humans.

15 <u>See</u> http://dr-king.com/docs/20130501_Vaccines_The_Safest_of_Medicines_or_the_Biggest_Liequstn_e_b_r1.pdf for a complete discussion of these realities.

vaccines grown in dog kidney cells and, more recently, the genetically engineered influenza-virus hemagglutinin particles grown in caterpillars infected by a baculovirus, the generalized claim that "*[i]nfluenza vaccines are made the same way each year*" obscures the reality that each of the now 19 available and 21 approved influenza vaccine formulations are made by processes that change from year to year and differ among the various vaccine makers, vaccine manufacturing sites, and vaccine formulations.

Finally, the outcomes (e.g., apparent in-use effectiveness and reported adverse reactions) observed for the various FDA-approved and CDC-recommended influenza vaccines are not constant but also differ from year to year, from vaccine maker to vaccine to vaccine[16]

"**Are there any side effects to the seasonal influenza vaccine?**

Common side effects include soreness, redness and swelling at the injection site, low fever and feeling achy and tired. Serious side effects are very rare. Ask your doctor if you have any concerns about side effects."

A more factual answer to the question,

"***Are there any side effects to the seasonal influenza vaccine?***"

would be:

> "Yes, there are side effects to the seasonal influenza vaccine. For the majority, the short-term adverse effects are not perceived as serious (e.g., '*soreness, redness and swelling at the injection site, low fever and feeling achy and tired*'). However, the serious short-term side effects to inoculation with the seasonal influenza vaccine depend, in part, upon the nature of the vaccine. Therefore, you should carefully read the package insert's sections that list those side effects that may be serious and, if you do not understand any term, then ask your child's healthcare provider to explain what that term means."

Based on the list provided in the package insert for Fluzone, the only influenza vaccine currently approved for children less than two (2) years of

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16 For example, at one time CSL, LTD., now bioCSL, had FDA approval for administration to children as young as 6 months of age, but the company had an undisclosed manufacturing problem that greatly increased the risk of seizures in children under five (5) years of age who received their influenza vaccines. The FDA then revised their approval to individuals 5 years of age and older. In a rare precautionary move, the CDC changed the recommended minimum age range for administering the now bioCSL Afluria® inactivated-influenza vaccine to nine (9) years of age. In addition, manufacturing sites that once only marketed no-Thimerosal influenza vaccines formulations in the USA have sought and received approval to market Thimerosal-preserved vaccines and vice versa, sites that only produced Thimerosal-preserved vaccines are now also producing no-Thimerosal formulated products. Furthermore, instead of vaccines which provide protection against 3 strains of influenza (2 influenza A strains and 1 influenza B strain), those firms have recently switched to or added vaccines that provide protection from 4 strains of influenza (2 influenza A strains and 2 influenza B strains). Finally, some of the vaccine makers have had periodic microbial contamination issues in both their preserved multi-dose products and their no-preservative single-dose products that, to some extent, the FDA has tolerated for some period of time before taking or being forced to take action against the vaccine maker and the vaccine doses so that some microbially contaminated vaccines doses may have been, and may again in the future be, administered. The products with known microbial contamination include some 2004 lots of now Novartis' Fluvirin and some current lots of FluLaval® produced by ID Biomedical Corporation of Quebec, a wholly owned subsidiary of GlaxoSmihKline.

age, the listed[17] side effects of the inactivated-influenza vaccines, many of which can be serious, life threatening, disabling and/or fatal, include but are not limited to,

- **Blood and Lymphatic System Disorders:** Thrombocytopenia [low blood-platelet levels], and lymphadenopathy [disease, disorder or enlargement of lymph nodes].
- **Cardiovascular Disorders:** Vasculitis [inflammation of blood and/or lymph vessels], vasodilatation/flushing.
- **Immune System Disorders:** Anaphylaxis, other allergic/hypersensitivity reactions (including urticaria [hives] and angioedema [rapid swelling of the dermis, subcutaneous tissue, mucosa and submucosal tissues]).
- **General Disorders and Administration Site Conditions:** Pruritus [intense feeling of itchiness], asthenia [loss of body strength] /fatigue [extreme tiredness], pain in extremities, and chest pain.
- **Nervous System Disorders:** Guillain-Barré syndrome (GBS) [a disorder in which the body's immune system attacks parts of the peripheral nervous system], convulsions [contortions of the body caused by violent, involuntary muscular contractions], febrile convulsions [a fit or seizure caused by fever], myelitis [inflammation of the spinal cord or bone marrow], including encephalomyelitis (brain inflammation) and transverse myelitis (inflammation across both sides of one level, or segment, of the spinal cord)]), facial palsy (Bell's palsy) [facial paralysis], optic neuritis [inflammation of the optic nerve] /neuropathy [nerve damage], brachial neuritis [inflammation of the nerves that control your shoulder, arm, and hand], syncope [fainting] (shortly after vaccination), dizziness, paresthesia [sensation of tingling, tickling, pricking, or burning of one's skin].
- **Respiratory, Thoracic and Mediastinal Disorders:** Dyspnea [shortness of breath or breathlessness], pharyngitis [inflammation of the back of the throat], rhinitis [irritation and inflammation of the mucous membrane inside the nose].

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17 More than a hundred million doses of seasonal influenza vaccines are administered each year in the USA each "flu season". In addition, the percentage of serious adverse events following inoculation that are reported to the VAERS (Vaccine Adverse Events Reporting System), jointly maintained by the CDC and the FDA, appears to generally be about 1 percent. Therefore, it is difficult to estimate the true frequencies of such adverse events. However, based on Dr. King's research into those adverse events where frequency estimates can be made, it would appear that a claimed rate of "1 in a million" for an adverse event is probably closer to a true rate of 1 in 10,000. In other words, the actual population risk for a serious adverse event is roughly 100 times higher than the risk level usually claimed by the CDC.

Moreover, there are currently no recognized metrics that can be used to estimate the individual child's or ward's risk. This is the case because science still does not know how the human immune system functions or what are the markers that collectively could be used to make such risk estimates because risk because, if these were known, among other things, the market for vaccines might be reduced rather than, as the Establishment wants, continually expanding.

- **Skin and Subcutaneous Tissue Disorders:** Stevens-Johnson syndrome [serious disorder of the skin and mucous membranes in which some percentage of the affected skin and mucous membranes die and the dead tissue sloughs off].

For the live-virus FluMist Quadrivalent influenza vaccine, the package insert's also lists certain side effects, many of which can be serious, life threatening, disabling and/or fatal.

These include but are <u>not</u> limited to,

- **Cardiac disorders:** Pericarditis [inflammation of the membrane enclosing the heart].
- **Congenital, familial, and genetic disorders:** Exacerbation of symptoms of mitochondrial encephalomyopathy (Leigh syndrome).
- **Gastrointestinal disorders:** Nausea, vomiting, diarrhea.
- **Immune system disorders:** Hypersensitivity reactions (including anaphylactic reaction, facial edema [facial swelling], and urticaria [hives]).
- **Nervous system disorders:** Guillain-Barré syndrome, Bell's Palsy, meningitis [inflammation of the membranes that surround the brain and spinal cord], eosinophilic meningitis [meningitis coupled with elevated levels of eosinophils (type of white blood cell with two-lobed nuclei that are part of the human immune system) in the body's cerebrospinal fluid], vaccine-associated encephalitis [vaccine-associated brain inflammation].
- **Respiratory, thoracic, and mediastinal disorders:** Epistaxis [nose bleed].
- **Skin and subcutaneous tissue disorders:** Rash.

Finally, there is <u>no</u> concerted effort upon the part of the vaccine makers and the governmental agencies that regulate these firms and their products to accurately ascertain either the population risks for these short-term "side effects", the factors that define the risk of those "side effects" for a given individual, or the long-term risks to the health of those developing children and others who are administered influenza vaccines multiple times.

"**Can the influenza vaccine cause the flu?**

No. Injected influenza vaccines do not contain a live virus and cannot cause influenza. The nasal vaccine contains weakened viruses that may cause a stuffy nose but will not cause influenza illness."

Here, the Health Department's initial statement is a response that might have been appropriate if the question "asked" were:

"*Can the influenza vaccine cause*" influenza?

Based on the outcomes in the previously cited "gold standard" treatment/placebo study[18] as well as the outcomes reported, and inappropriately dismissed, in an earlier study, inoculation with an inactivated-influenza vac-

[18] Cowling BJ, Fang VJ, Nishiura H, et al. Increased Risk of Noninfluenza Respiratory Virus Infections Associated with Receipt of Inactivated Influenza Vaccine. *Clin Infect Dis.* 2012 June 15; 54(12): 1778-1783.

cine did cause some of those who were vaccinated to get the "flu", any disease that causes an ILI, at a rate more than 3 times higher than those who were not vaccinated but rather given a placebo inoculation.

Moreover, the earlier study[19] also noticed a significant increase in "flu" (any ILI) in those vaccinated with an inactivated-influenza vaccine.

Furthermore, contrary to the Health Department's assertion,

> "*The nasal vaccine contains weakened viruses that may cause a stuffy nose but will not cause influenza illness.*"

a search of the VAERS database for live-virus-only reports found several reports of ILI following inoculation with only a live-virus influenza vaccine as well as other serious, life threatening, disabling and fatal effects associated with administration of a live-virus influenza vaccine.

Thus, the reality is that inoculation with the inactivated-influenza vaccines markedly increases the inoculated children's susceptibility to contracting the "flu" and inoculation with the live-virus vaccine does cause some children to contract influenza as well as to infect others with whom they have direct contact via live-virus shedding.

"**What are preservatives, and why are they sometimes used in vaccines?**

Preservatives have been used in vaccines for over 70 years. Preservatives are added to vaccines that are packaged in multi-dose vials and will be used more than once after opening. Preservatives prevent the growth of bacteria or fungi that could make the vaccine unsafe after opening. Single-dose influenza vaccines, which are used only once after opening, do not contain preservatives."

First, all of these statements are generalizations and the questions posed here are not the questions that parents want answered.

Second, when it comes to the inactivated-influenza vaccines, today's parents want to know what justifies the continued use of Thimerosal, a highly toxic chemical[20], as a preservative in some of today's influenza vaccine formulations when:

1. Most of these same inactivated-influenza vaccine makers (Sanofi, GlaxoSmithKline and its Canadian subsidiary, and bioCSL), sell no-Thimerosal formulations of these influenza vaccines, and
2. There are other, non-bioaccumulatively toxic compounds, like 2-phenoxyethanol, which are significantly less toxic than Thimerosal and its initial ethylmercury solvolysis products and methylmercury metabolites and which have been and are being used to make preserved vaccines for multi-dose vials of vaccines that are required to be preserved.

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19 Kelly H, Jacoby P, Dixon GA, Carcione D, et al. Vaccine Effectiveness against laboratory-confirmed influenza in healthy young children: a case-control study. *Pediatr Infect Dis J* 2011; 30: 107–111.

20 Thimerosal known to be a highly toxic human carcinogen, mutagen, teratogen, reproductive toxicant, immune system dysregulator with a strong propensity to induce autoimmune reactions, and systemic poison at tissue levels below 1 part-per-million whose final toxic metabolites, intracellular retained ionic mercury (Hg2+intracellular) species have been shown to bioaccumulate in the human body with half-lives of on the order of 5 to 20 years depending upon the organ in which these end-stage metabolites form. Unfortunately, the longest half-lives of these intracellular mercuric species are found in the human brain.

In addition, parents want to know whether the use of Thimerosal as a preservative has been proven to be safe in the appropriate toxicological studies that are supposedly required for preservatives in biological drug products, including vaccines, as set forth in 21 CFR § 610.15(a) [emphasis added],

> "Any preservative used shall be sufficiently nontoxic so that the amount present in the recommended dose of the product will not be toxic to the recipient, …".

If Thimerosal were safe to this standard, then there would be vaccine-maker published, toxicologically derived NOAELs (no observed adverse-effect levels) for Thimerosal in each Thimerosal-preserved vaccine.

Instead of publishing these NOAEL values and showing that the preservative levels of Thimerosal in inactivated-influenza and other Thimerosal-preserved vaccines were safe, the FDA, *in response to citizen petitions and law suits demanding the requisite proofs of safety*, extralegally changed 21 CFR § 610.15 by adding 21 CFR § 610.15(d) [see 76 FR 20518, Apr. 13, 2011], which simply states,

> "The Director of the Center for Biologics Evaluation and Research or the Director of the Center for Drug Evaluation and Research may approve an exception or alternative to any requirement in this section. Requests for such exceptions or alternatives must be in writing."

Moreover, if the years of usage or industry-conducted/influenced epidemiological studies truly proved safety, then cigarette smoking might still be considered "safe" and exposure to asbestos would not be a health concern.

Based on the FDA's action, to remove the absolute minimum CGMP (current good manufacturing practice) standards for the proof of safety requirements for biological products, the public should know that the level of Thimerosal in Thimerosal-preserved vaccines is not safe.

In addition, no level of Thimerosal has been proven to be toxicologically safe for repeated human exposures by injection in any scientifically sound, appropriate, peer-reviewed, published, toxicological study designed for that purpose (see footnote "**23**" for an upper-bound estimate of that toxicologically safe level).

Moreover, the parents should be aware that, while single-dose vaccines packaged by the vaccine manufacturers are not preserved, Novartis' single-dose Fluvirin inactivated-influenza vaccine, approved for children 4 years of age and older, does contain a trace of Thimerosal (up to 1 µg of Thimerosal-derived organic mercury/0.5-mL dose).

Additionally, some medical businesses have been known to "repackage" the contents of multi-dose Thimerosal-preserved inactivated-influenza vaccines into single-dose syringes and offer those at various walk-in influenza-vaccination clinics in grocery and other stores.

For vaccine-maker supplied and FDA-approved information about the influenza vaccine you are to be given or that is to be given to your child or ward, demand a copy of the package insert for that vaccine and carefully read it (with a magnifying glass if necessary).

Then, if you want to understand the reality of these risks, then you may want to visit www.MedAlerts.org and use its simple interface to locate the

adverse-event reports for the type of influenza vaccines that you are considering giving to yourself or to your children.

"**Does the influenza vaccine contain mercury?**

Some vaccines contain trace amounts of a chemical compound called thimerosal, which contains mercury.

Thimerosal prevents contamination of the vaccine. Multi-dose vials of influenza vaccine contain a small amount of thimerosal. Single-dose influenza vaccines do not contain thimerosal. If you are concerned about mercury, ask your provider for a single-dose vaccine that does not contain any mercury."

Here, the NYC Health Department begins with a misrepresentation,

"*Some vaccines contain trace amounts of a chemical compound called thimerosal, which contains mercury*",

when, *for the inactivated-influenza vaccines*, the truth is that currently only one (1) preservative-free inactivated-influenza vaccine formulation, Novartis' preservative-free, single dose Fluvirin®, actually contains "*trace amounts*" of Thimerosal[21].

Furthermore, while Thimerosal is utilized as a preservative to prevent "*contamination of the vaccine*" in the current multi-dose inactivated-influenza vaccine formulations, at least one study has established that Thimerosal is not an effective antibacterial preservative in multi-dose vaccines[22].

Moreover, all of the current multi-dose formulations of the inactivated-influenza vaccines contain a preservative level of Thimerosal nominally at about "50" micrograms (µg) of organic mercury per milliliter of vaccine or "25" times the FDA-recognized "trace level" of *not more than* 1 µg of mercury per 0.5-milliliter (mL) dose of vaccine or 2 µg of mercury per mL of vaccine – a dose that is anything but "*a small amount of thimerosal*".

Even if the reference dose (RfD), established as safe upper limit value for daily consumption of fish containing mercury by the U.S. Environmental Protection Agency (EPA) [0.1 µg of mercury/kilogram (kg) of body weight in a 24-hour period] were a safe limit for injected Thimerosal **(and it is not[23])**, the dose of Thimerosal in a Thimerosal-preserved inactivated-influenza vac-

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21 http://www.fda.gov/biologicsbloodvaccines/safetyavailability/vaccinesafety/ucm096228.htm, "Introduction", which states (emphasis added), "Vaccines with trace amounts of thimerosal contain 1 microgram or less of mercury per dose". This web page was last updated on "06/18/2014".

22 Stetler HC, Garbe PL, Dwyer DM, et al. Outbreaks of group A streptococcal abscesses following diphtheria-tetanus toxoid-pertussis vaccination. *Pediatrics* 1985; 75: 299-303.

23 See, http://dr-king.com/docs/090812_fnldrft_TheTruthAboutTheToxicityOfThimerosalr5b.pdf, where, in 2009, based on the findings in the only FDA-recognized long-term chronic Thimerosal-injection study, Mason MM, Cate CC, Baker. TOXICOLOGY AND CARCINOGENESIS OF VARIOUS CHEMICALS USED IN THE PREPARATION OF VACCINES. *J. Clin Toxicol*, 1971; 4(2): 185-204, a study in rats, Dr. King was able to establish that the safe level for Thimerosal in a vaccine intended to be given to developing children is some value that is less than 0.0086 µg of Thimerosal (0.0042 µg of mercury)/kg of body mass, which would require a child under 3 years of age to weigh more than 2,976.2 kg (> 6,561.4 pounds) and a child 3 to 5 years of age to weigh more than 5,952.4 kg (> 13,122.8 pounds). Since these weights are lower bound values that are impossible for human children to attain, clearly, Thimerosal-preserved inactivated-influenza vaccines are not safe to administer to children from 6 months to 5 years of age. [**Note:** Though this article was published in 2009 and has been repeatedly cited in subsequent articles addressing the toxicity of Thimerosal, no one in the federal government or elsewhere has come forward to provide proof that Dr. King's analysis was faulty or to provide more modern injected-Thimerosal chronic toxicity studies to show what the true NOAEL (no observed adverse-effect level) is for injected Thimerosal in developing humans.]

cine exceeds the EPA RfD unless the "infant" or toddler under three years of age, who is given nominally 12.5 µg of organic mercury in a 0.25-mL dose of a preserved inactivated-influenza vaccine, weighs significantly more than 125 kg (275+ pounds).

For an older child who nominally gets about "25" µg of organic mercury from Thimerosal in a 0.5-milliliter dose of vaccine, he or she would have to weigh significantly more than 250 kg (551+ pounds) for that dose to be "safe".

Since young children weigh closer to one-tenth of these crude "safe" weight limits, Thimerosal-preserved vaccines contain anything but "*a small amount of thimerosal*" from the viewpoint of toxicity.

"**Do seasonal influenza vaccines contain latex?**

The Fluzone® and Fluvirin® vaccines do not contain latex and can be given to people with a life-threatening latex allergy. Ask your doctor if you're concerned about an allergy.

Here, the answer provided is incomplete because both the Fluzone and Fluvirin single-dose syringes are capped with closures that may contain latex according to their 2014-2015 package insert or leaflet texts (available at: http://www.fda.gov/downloads/biologicsbloodvaccines/vaccines/approvedproducts/ucm195479.pdf, for Fluzone, where the applicable "latex" text can be found on "Page 24 of 34", and http://www.fda.gov/downloads/biologicsbloodvaccines/vaccines/approvedproducts/ucm123694.pdf, for Fluvirin, where the applicable "latex" text is located toward the bottom of "Page 13 of 20".

Since the responsibility for an adverse outcome rests with the parent, parents need to verify the facts from the vaccine's package insert and not rely on either the NYC Health Department or some "*doctor*" who may not know the facts or who, *perhaps unintentionally*, may misrepresent those facts to the questioning parent.

"**Can my child be excluded from daycare if he or she doesn't get an influenza vaccine?**

Yes. Children who have not provided proof that they received the influenza vaccine by December 31st of each year may be excluded from daycare and preschool."

Technically, this answer is only valid for daycares and preschools "regulated" by NYC.

It certainly does not apply to unregulated daycares and preschools, and may not apply to daycares and preschools "regulated" by the State of New York if there are such in NYC.

Furthermore, if this regulation is an extralegal action that exceeds the authority of NYC official to set regulations outside of those laws established by the State of New York, it may be that such exclusions are unlawful

However, like the "Bloomberg" extralegal regulation banning large sodas, this matter will need to be appropriately litigated by a parent or parents whose children have been excluded or are under imminent threat of being excluded if the children do not get a influenza vaccine inoculation.

Finally, as was the case in West Virginia[24], the City of New York may be obligated to provide in-home schooling in instances where a child, who is currently attending preschool, would, because of this new requirement, subsequently be excluded from a preschool that the State of New York recognizes as part of the required public schooling for its children.

"**Can my child be exempted from receiving the influenza vaccine?**

As with all immunizations requirements in New York City, children with a valid medical or religious objection will not be required to be vaccinated. If you wish to be exempted from the influenza vaccine requirement, please submit proper documentation to your child's daycare or preschool facility."

First, since, as the vaccines' package inserts attest, today's vaccines do not, and cannot, provide disease immunity and only provide some level of limited-duration protection from some influenza viruses to some percentage of those who are age-appropriately inoculated with these influenza vaccines, the answer to the question posed here should have used the singular form of the noun "vaccination" as the modifier to "*requirements*".

Second, Dr. King observes that the health department's response incorrectly characterizes the New York State legally permitted medical and religious exemptions to vaccination as if they were an "objection".

This apparently intentional mischaracterization is problematic because, based on an English Thesaurus, the acceptable English alternatives for the noun "exemption" are the nouns "*release, immunity, exclusion, freedom and discharge*" – but not the noun "*objection*".

Furthermore, the key word in this obviously nuanced response is the word "*valid*".

This is the case because there are significant obstacles to obtaining either a medical exemption or a religious exemption in the State of New York, with both exemptions being subject to review and scrutiny in what, to Dr. King and others, appears to be a non-uniform manner.

In addition, because exemptions are legal choices, the use of the phrase "*[i]f you wish*" is inappropriate.

Thus, Dr. King suggests that this response should be revised to read,

> "'*As with all*' *vaccination* '*requirements in New York City, children with a valid medical or religious*' *exemption are not* '*required to be vaccinated. If*'' *your child is exempt* '*from the influenza vaccine requirement, please submit proper documentation*' *of that exemption* '*to your child's daycare or preschool facility*' *or, if you are requesting an exemption, please submit a proper formal request for that exemption to the appropriate authorities.*

"**How will I afford my child's vaccine?**

All children in New York State have access to free or low-cost vaccines under the law. Also, the federal Affordable Care Act requires insurance to provide coverage for all major recommended vaccines, and co-pays for immunizations are not allowed. Currently, 75% of New York City children receive publically funded

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24 http://www.firstamendmentcenter.org/w-va-judge-county-must-educate-unvaccinated-student, "Monday, November 12, 2012", last accessed on 25 November 2014.

vaccines, and the rest have private insurance. Free vaccines are also directly given to New York City providers for children without insurance or whose insurance doesn't cover immunizations."

Here, Dr. King can only hope that, after reading his responses and verifying their accuracy, all of those who provide influenza vaccines to the children affected by this mandate will refuse to stock, market or dispense Thimerosal-containing inactivated-influenza vaccines for administration to NYC children who are less than five (5) years of age.

"**Where can my child get an influenza vaccine?**

You can contact your child's medical provider to receive the vaccine. Alternatively, to find a clinic, visit www.nyc.gov and search 'flu,' or call 311"

Here, Dr. King hopes that the information provided tells parents where they can get an age-appropriate no-Thimerosal inactivated-influenza vaccine for their children.

When that information is <u>not</u> available from the child's medical provider or www.nyc.gov, NYC parents should call 311 to seek this information.

If the 311 operators <u>cannot</u> provide the information, then you can file a 50-word or less "complaint", which Dr. King would suggest might read as follows,

"To comply with NYC mandate, I need to know where I can get a no-Thimerosal inactivated-influenza vaccine for my child because this information was not available elsewhere." [27 words]

Then, when you receive a complaint number from the 311 operator, you should record it and, after you have received and recorded that number, appropriately schedule a follow-up appointment with the NYC Public Advocate (http://pubadvocate.nyc.gov/) in case you do <u>not</u> receive a satisfactory response to your "complaint" within 15 days.

If, after reading Dr, King's responses and verifying their accuracy, you think that influenza vaccination is disease causing and provides insufficient protection to your child to justify the risk of harm inherent in influenza vaccines, then you may want to call 311, and file a complaint that states something like,

"Since the influenza vaccines have been found to be disease causing and/or disease spreading and provide <u>no</u> to little protection to those inoculated with them when they are 5 years of age or less, the City of New York should repeal its influenza vaccination mandate." [45 words]

Then, when you receive a complaint number from the 311 operator, you should record it and, after you have received and recorded that number, appropriately schedule a follow-up appointment with the NYC Public Advocate (http://pubadvocate.nyc.gov/) when you do <u>not</u> receive a satisfactory response to your "complaint" within 15 days.

Dr. King's Closing Remarks

Should the reader seek to find more information about the fundamental issues raised by Dr. King in his responses, then he or she can read the other pertinent articles posted on Dr. King's website.

His most recent cogent articles that focus on influenza vaccines include:

1. http://dr-king.com/docs/20140122_InfluenzaVaccines_VaccinationPrograms_Unsafe_NotEffective_IllnessCausing_Final_b.pdf,
2. http://dr-king.com/docs/20140205_PGK_sReality-basedResponsesTo_SettingTheRecordStraight_DebunkingALLTheFluVaccineMyths_b1.pdf,
3. http://dr-king.com/docs/20140308_RespnsTo_Opinion_MandatingFluShotsIsTheMoralChoice_fnl_b_r1.pdf, and
4. http://dr-king.com/docs/20140917_PGK_sRespnseTo_NYCHospitalsDon_tMakeHealthWorkersGetVaccinated_final_b1.pdf.

On the ongoing use of Thimerosal in vaccines, his recent articles include:

1. http://dr-king.com/docs/130130_DrftRevuOf_PoisonPill_NotAllMercuryIsToxic_b.pdf,
2. http://dr-king.com/docs/20140314_PGK_sRebuttalTo_IsTheCDCHidingDataAboutMercury_Vaccines_Autism_qustn_fnl_b1.pdf and
3. http://dr-king.com/docs/20141010_Thimerosal_organicmercury_InVaccines_CausalFactorForRegressive_Autism_InChildren_final_b.pdf.

On the issue of vaccine exemptions and vaccine safety, his recent articles are:

1. http://dr-king.com/docs/20130501_Vaccines_The_Safest_of_Medicines_or_the_Biggest_Liequstn_e_b_r1.pdf,
2. http://dr-king.com/docs/130306_DrftRevu_Of_ForegoingImmunization___final_b.pdf,
3. http://dr-king.com/docs/131016_AFormalScience-basedResponseTo_FailuretoVaccinateChldren%20AnUnconscionableTwistofFaith_finlr1_b.pdf,
4. http://dr-king.com/docs/131101_FormalResponseToLetter_MakeNoExemptionsForChildhoodVaccinations_fnl_br2.pdf,
5. http://dr-king.com/docs/131122_FormlRespnsTo_ExpertQ_A_ChildhoodVaccineSafety_fnl_b.pdf,
6. http://dr-king.com/docs/20140221_DrftResponseTo_Faith_Is_No_Excuse_for_Avoiding_Vaccinations_final_b.pdf,
7. http://dr-king.com/docs/20140416__Revu_ADoctor_sTakeOnTheAnti_VaccineMovement_final_b1.pdf,
8. http://dr-king.com/docs/20140716_Respnseto_ThankGodForVaccines_byDr_EmilyGibson_fnl_b_.pdf,
9. http://dr-king.com/docs/20140822_pgksrespnsto_SpacingOutKidsVaccinesCanHurtTheirHealthExpertsSay_final_b_.pdf,

Finally, for those seeking another researcher's views on vaccines, Dr. King recommends the current edition of "**VACCINE SAFETY MANUAL For Concerned Families and Health Practitioners**" by Neil Z. Miller (ISBN: 978-188121737-4) [which can be purchased from http://www.thinkchoice.com/vaccine.htm].

About Paul G. King, PhD, Author of the Responses

In addition to the information available on his web site, http://www.dr-king.com/, Dr. Paul G. King, PhD, an analytical chemist with an MS in inorganic chemistry, is Science Advisor to the Coalition for Mercury-Free Drugs (CoMeD, Inc., http://www.mercury-freedrugs.org/ as well as the Science Advisor to the National Coalition of Organized Women (NCOW).

More recently, Dr. King was the co-author of a review paper in the journal ***Vaccine*** with Gary S. Goldman, PhD, which evaluated the U.S. universal varicella vaccination program[25].

Moreover, Dr. King was also one of the authors of a paper in *Int. J. Environ. Res. Public Health*, where the lead author was Janet K. Kern, PhD.

That peer-reviewed paper reviewed Thimerosal exposure and the roles of sulfation chemistry and thiol availability in autism[26].

Also, Dr. King was one of the authors in a review chapter, "Mercury Induced Autism"[27] (pages

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[25] Goldman GS, King PG. Review of the United States universal varicella vaccination program: Herpes zoster incidence rates, cost effectiveness, and vaccine efficacy based primarily on the Antelope Valley Varicella Active Surveillance Project data. *Vaccine* 2013 March 25; 31(13): 1680-1684 (open access). [See, http://www.sciencedirect.com/science/journal/0264410X/31/13, article "6".]

[26] Kern JK, Haley BE, Geier DA, Sykes LK, King PG, Geier MR. Thimerosal Exposure and the Role of Sulfation Chemistry and Thiol Availability in Autism [Review]. *Int. J. Environ. Res. Public Health* 2013 Aug, 10, 3771-3800. OPEN ACCESS

[27] See, http://www.researchgate.net/publication/258009647_Mercury_Induced_Autism/file/60b7d526955a643330.pdf for the chapter.

1411-1432), in Comprehensive Guide to Autism Editors: Vinood B. Patel, Victor R. Preedy and Colin R. Martin. Springer New York (2014), where the lead author was Mark R. Geier, MD, PhD.

Additionally, Dr. King was one of the authors of the paper, "A two-phase study evaluating the relationship between Thimerosal-containing vaccine administration and the risk for an autism spectrum disorder diagnosis in the United States", in the journal, *Translational Neurodegeneration*, where the lead author was David A. Geier. That open-access paper contributed more evidence to the actuality of a causal relationship between the level of Thimerosal-preserved vaccine exposure and the subsequent risk of the inoculated children's receiving a diagnosis of "autism" in the USA[28].

Moreover, Dr. King is one of the authors of a paper titled, "Methodological Issues and Evidence of Malfeasance in Research Purporting to Show Thimerosal in Vaccines Is Safe"[29], where Dr. Brian Hooker was the lead author. That open-access paper established that the six (6) key epidemiological studies, which the CDC uses to support its assertion that Thimerosal-containing vaccines are safe to give to pregnant women and developing children, have significant methodological issues and evidence of intentional malfeasance that renders them scientifically unreliable.

Furthermore, Dr. King is the co-author of a paper with Dr. Gary S. Goldman that is titled, "Vaccination to prevent varicella: Goldman and King's response to Myers' interpretation of Varicella Active Surveillance Project data"[30], which, as the abstract's "Summary" states, clearly established that "[w]hen the costs of the booster dose for varicella and the increased shingles recurrences are included, the universal varicella vaccination program is neither effective nor cost-effective" in the USA.

Additionally, Dr. King is one of the authors of an in-press paper titled, "Thimerosal as discrimination: vaccine disparity in the UN Minamata Convention on mercury"[31], where Lisa K. Sykes was the lead author. That article addresses the discriminatory nature of the now internationally condoned disparity between the early childhood vaccination programs in the developed countries, where the use of Thimerosal-preserved vaccines has mostly been abandoned, and the developing countries, where several of the early childhood vaccines remain Thimerosal-preserved vaccines. Underscoring this dichotomy, the article's "Abstract" closes with,

> "Ultimately, the Minamata Convention on Hg has sanctioned the inequitable distribution of thimerosal by specifically exempting TCVs from regulation, condoning a two-tier standard of vaccine safety: a predominantly no-thimerosal and reduced-thimerosal standard for developed nations and a predominantly thimerosal-containing one for developing nations. This disparity must now be evaluated urgently as a potential form of institutionalised discrimination."

Finally, Dr. King is one of the authors of two papers where David A. Geier is the lead author, "A dose-response relationship between organic mercury exposure from thimerosal-containing vaccines and neurodevelopmental disorders"[32] and "A Case-Control Study Evaluating the Relationship Between Thimerosal-Containing Haemophilus influenzae Type b Vaccine Administration and the Risk for a Pervasive Developmental Disorder Diagnosis in the United States"[33], which clearly reinforce the causal linkages between injected Thimerosal-preserved vaccine exposures and subsequent risk of neurodevelopmental harm to the developing children who received then using MCO-generated records collected in the publicly accessible part of CDC's Vaccine Safety Datalink (VSD) database.

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28 Geier DA, Hooker BS, Kern JK, King PG, Sykes LK, Geier MR. A two-phase study evaluating the relationship between Thimerosal-containing vaccine administration and the risk for an autism spectrum disorder diagnosis in the United States. *Translational Neurodegeneration* 2013 Dec. 16; 2:25 (12 pages). [http://www.biomedcentral.com/content/pdf/2047-9158-2-25.pdf.

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30 Goldman Gs, King PG. Vaccination to prevent varicella: Goldman and King's response to Myers' interpretation of Varicella Active Surveillance Project data. *Hum Exp Toxicol* 2014 Aug; 33(8): 886-893. Abstract: http://het.sagepub.com/content/33/8/886.abstract.

31 Sykes LK, Geier DA, King PG, Kern JK, Haley BE, Chaigneau CG, Megson MN, Love JM, Reeves RE, Geier MR. Thimerosal as discrimination: vaccine disparity in the UN Minamata Convention on mercury. *Indian J Med Ethics*. 2014 Apr 11.

32 Geier DA, Hooker BS, Kern JK, King PG, Sykes LK, Geier MR. *Int J Environ Res Public Health*. 2014 Sep 5; 11(9): 9156-9170.

33 Geier DA, Kern JK, King PG, Sykes LK, Geier MR. *Biol Trace Elem Res.* 2014 Nov 11. [Epub ahead of print] <Abstract>