

To all that have to vote this week:

You are tasked with voting to be on the right or wrong side of history this week. The **wrong** side of history, would be to impose any more laws on your constituents and their children regarding masks or covid mitigation strategies. The science is on our side. Anything less than an N95 mask does not work in stopping this virus. And N95 masks work one way, meaning, if you wear one you are protected, regardless of what anyone else does around you. Regardless of vaccination status of anyone around you, this access to N95s to anyone that wants one should now make any mask argument irrelevant.

Below I have included months worth of data about how masks are ineffective and also, how they are harming our children. The decision of whether or not to mask our children should be left up TO THE PARENTS. NOT to the governor, NOT to any politician, NOT to the DPH, NOT based on any politically or CDC man-made metrics. PARENTAL CHOICE. We will not accept another outcome.

Should parents not be allowed to have control of their lives and their children's lives back, I will make it my mission here in CT to ensure every seat is taken by a Republican. I will work tirelessly to turn CT red.

Do what is right. Be on the right side of history. Give parents back their rights.

Thank you,
Alex Sullivan

1) Remove mask mandates and any associated metrics to put them back on - PARENTAL CHOICE

After two years of mask mandates, the science of masking children remains uncertain and no study or data has found a statistically significant positive effect in masking school children with regards to COVID transmission

Harvard and Stanford professors and experts Martin Kulldorf [Ph.D., an epidemiologist, biostatistician, and Professor of Medicine at Harvard Medical School] and Jay Bhattacharya [MD, Ph.D., Professor of Health Policy at Stanford University School of Medicine] vehemently disagree with masking for children based on the fact that no evidence has shown masking is effective. They state, “the gold standard of medical research is randomized trials, and there have now been two on COVID masks for adults. For children, there is no solid scientific evidence that masks work. A [Danish study](#) found no statistically significant difference between masking and not masking when it came to coronavirus infection. In a [study in Bangladesh](#), the 95 percent confidence interval showed that masks reduced transmission between 0 percent and 18 percent. Hence, masks are either of zero or limited benefit.”

Dr. Marty Makary [MD and MPH; Professor of Medicine at Johns Hopkins University] and Dr. H. Cody Meissner [MD; Chief Of Pediatric Infectious Disease At Tufts Children's Hospital And

A Professor Of Pediatrics At Tufts University School Of Medicine] agree: “We have been encouraging Americans to wear masks since the beginning of the pandemic. But special attention should be paid to the many children who struggle with masks. Public-health officials claim to base their decisions and guidance on science, but there’s no science behind mask mandates for children.”

Additionally, Dr. Vinay Prasad [MD and MPH; Professor at UCSF for Epidemiology & Biostatistics] states, “The CDC cannot ‘follow the science’ because there is no relevant science. The proposition is at best science-y; a best guess based on political pressure, pundit anxiety, and mechanistic understanding.”

A study published in [ScienceDirect](#) states, “While children have the lowest risk from COVID-19 directly, they risk suffering the indirect impacts of policy decisions, many of which appear to have been made with next to no explicit consideration of their interests. Public health interventions should not only be about infectious disease control, they should consider a broad set of outcomes. In addition, they ought to consider vulnerability, including that in early childhood - a time when young children's brains are developing rapidly and are most susceptible to adversity. We believe that mandating masking of pre-school children is not in line with public health principles, and needs to be urgently re-considered.”

The CDC’s own large-scale study compares classrooms within Georgia with different masking and ventilation situations and says: “The lower incidence in schools that required mask use among students was not statistically significant compared with schools where mask use was optional. This finding might be attributed to higher effectiveness of masks among adults, who are at higher risk for COVID infection.” Despite this lack of statistical significance, the CDC goes on to say that it recommends children over age two wear masks “because universal and correct use of masks can reduce COVID transmission and is a relatively low-cost and easily implemented strategy.” Given the now available evidence concerning the detrimental effects of masking, it is inappropriate to call this strategy low-cost and easily implemented.

Tracy Hoeg [MD, PhD Epidemiologist, PM&R Private Practice Physician, NCOA & UC-Davis] notes, “There are also [growing concerns](#) of detrimental impacts on language development and well-being from long-term masking in children. A large [observational pre-print study](#) analyzing data from the COVID-19 School Response Dashboard did not find any correlations between COVID-19 rates and mask mandates. Another study [out of Spain](#) failed to find any increase in COVID-19 cases in kids under six years old, who all remained unmasked, compared to older cohorts, which were required to wear masks.

Students with English as a second language, autism, hearing loss or speech and language delay are the most negatively impacted by continued masking in schools, as are children with behavioral challenges.

Of note, the European Centre for Disease Prevention and Control [does not recommend](#) masks for children in primary school and only recommends face masks for children over 12 years old in secondary schools situated in areas with community transmission of SARS-CoV-2.”

Dr Marty Makary and Dr. H. Cody Meissner state, “The possible psychological harm of widespread masking is an even greater worry. Facial expressions are integral to human connection, particularly for young children, who are only learning how to signal fear, confusion and happiness. Covering a child’s face mutes these nonverbal forms of communication and can result in robotic and emotionless interactions, anxiety and depression. Seeing people speak is a building block of phonetic development. It is especially important for children with disabilities such as hearing impairment.”

The following sources are mentioned above:

1. <https://www.acpjournals.org/doi/full/10.7326/M20-6817>
2. https://www.poverty-action.org/sites/default/files/publications/Mask_RCT_Symptomatic_Seropositivity_083121.pdf
3. <https://www.sciencedirect.com/science/article/pii/S2666535221001221#!>
4. <https://www.medrxiv.org/content/10.1101/2021.05.19.21257467v1>
5. https://journals.lww.com/pidj/Fulltext/2021/11000/Age_dependency_of_the_Propagation_Rate_of.2.aspx
6. <https://www.ecdc.europa.eu/en/covid-19/questions-answers/questions-answers-school-transmission>

We also draw attention to the numerous detrimental and harmful effects of long term masking of children. This includes: increased anxiety, difficulty breathing, increased acne and skin problems, increased dental issues, increased levels of carbon dioxide in the blood, mouth deformities and elongated faces, increased depression, severely falling behind in reading and writing, and more. See just a few research and articles below. Also, please refer to our own NCPS stats that were presented at the BOE meeting on Nov 22 which shows children did worse in ESL. Sources with discussions on these detrimental effects are listed here:

1. <https://governor.mt.gov/docs/Research-Report-on-Mask-Mandates-in-Schools.pdf>
2. <https://nymag.com/intelligencer/2021/07/the-kids-were-safe-from-covid-the-whole-time.html>
3. <https://www.medrxiv.org/content/10.1101/2021.08.10.21261846v1.full.pdf>
4. <https://www.theatlantic.com/ideas/archive/2021/09/school-mask-mandates-downside/619952/>
5. <https://www.wsj.com/articles/masks-children-parenting-schools-mandates-covid-19-coronavirus-pandemic-biden-administration-cdc-11628432716>

2) Remove or prevent vaccine mandates of teachers, volunteers, and students across all school, extra curricular, and town sanctioned events

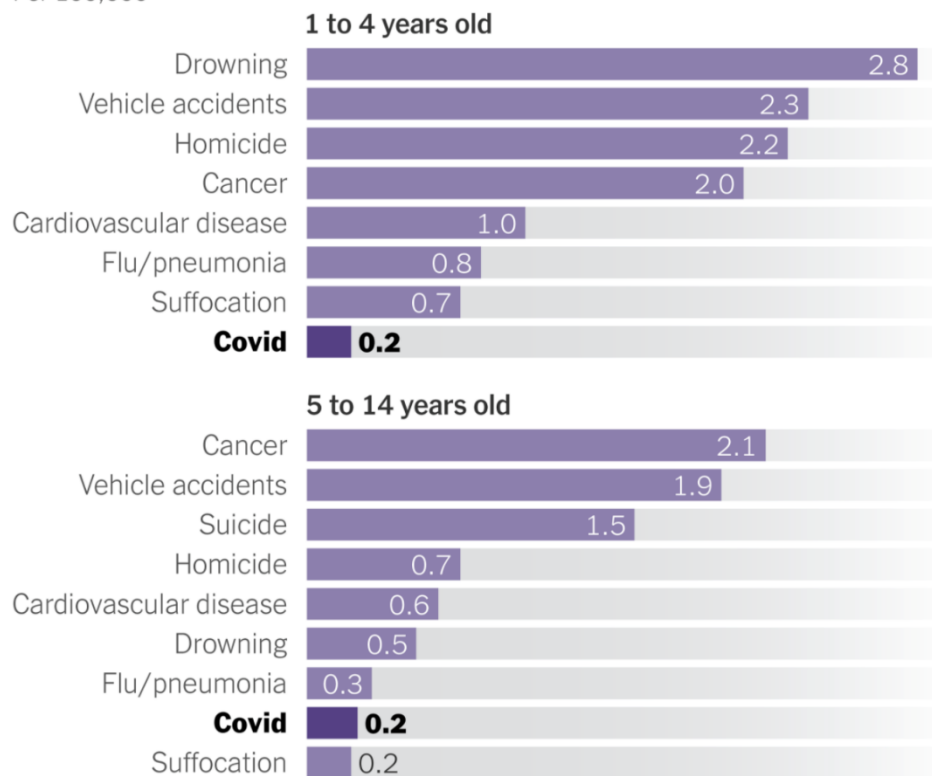
Reputable epidemiologists and COVID-cautious leaning media agree COVID is of very limited danger to children

“The biggest risk to your child’s health today almost certainly is not Covid. It’s more likely to be an activity that you have long decided is acceptable — like swimming, riding a bicycle or

traveling in a car,” a [NY Times](#) author correctly states after he has compiled a thorough comparison of the leading causes of child deaths using data directly from the CDC ([1](#)). His results (below) clearly indicate that the danger of COVID for children is much lower than other common illnesses such as flu or cardiovascular and common activities such as car transportation and swimming.

Annual Deaths Among Children in the United States

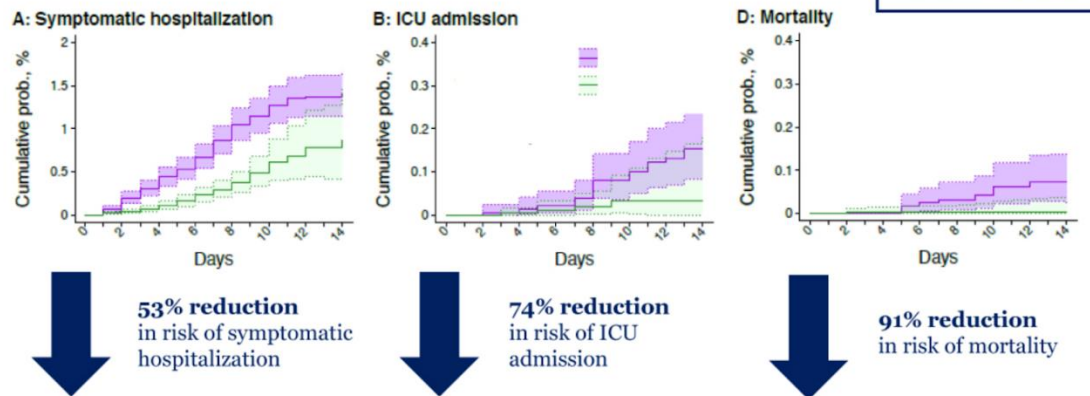
Per 100,000



Covid data is for the 52 weeks ending April 10, 2021. Other data is for 2018.

Much of the data we discuss here has been collected during either the alpha variant or the delta variant. However, recent studies show that the omicron variant has a significantly decreased severity over previous variants and does not pose additional danger. An example of a study, which has been [accepted and referenced](#) by CDC director Rochelle Walensky is one [Kaiser So Cal](#). The below data summarizes that this variant has yielded far lower risks for symptomatic hospitalization, ICU admission and mortality.

Kaiser Permanente Southern California Data



Dr. Tracy Hoeg, whose research on the spread of COVID has been relied upon by the CDC for reopening schools says in her article that “despite the accumulation of massive amounts of reassuring scientific data, the public continues to worry that COVID-19 poses a risk to children. Unfortunately, because of this, children are continuing to face strict restrictions in schools and sports, causing significant harms.”

She notes, “Data from [Public Health England](#) found that unvaccinated children are at a lower risk of hospitalization when compared with fully vaccinated 40–49-year-olds. And the delta variant, while more transmissible, does not appear to cause more severe disease in [children](#) or [adults](#).”

She continues to say, “We must put COVID-19’s pediatric mortality risk into context: according to U.S. Centres for Disease Control (CDC) data for 5-14 year-olds, motor vehicle accidents and suicide [are each responsible](#) for 10 times and 7 times the number of deaths than from COVID, respectively. The 700 American [children whose deaths](#) have been attributed to COVID-19 since January 2020 is less than the number of youth influenza deaths in the [2017-18](#) and [2018-19](#) seasons combined.”

On the subject of **long COVID**, Dr. Hoeg states, “Lasting COVID-19 symptoms is a potential concern for children. However, long COVID definitions include over 200 symptoms, many of which are nonspecific and common among kids who have not been infected with COVID-19. Despite sensational media claims that long COVID may develop in up to a quarter of infected children, recent studies with adequate sample sizes and control groups have shown that long COVID is much more rare in this population.

For example, the [Office of National Statistics](#) in the United Kingdom found the prevalence of persistent symptoms 12-16 weeks after a SARS-CoV-2 infection to be no different between infected and uninfected children. [Another study](#) found that four percent of children who tested positive reported at least one symptom lasting beyond 12 weeks, but this also happened in two per cent of the control subjects.”

Martin Kulldorf and Jay Bhattacharya state, “Schools are major transmission points for influenza, but not for COVID. While children do get infected, their risk for COVID death is minuscule, lower than their already low risk of dying from the flu. Throughout the 2020 spring wave, Sweden kept daycare and schools open for all its 1.8 million children ages 1 to 15, with no masks, testing or social distancing. The result? [Zero COVID deaths](#) among children and a [COVID risk to teachers](#) lower than the average of other professions. In fall 2020, most European countries followed suit, with similar results.”

The following sources are mentioned above:

1. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1016465/Vaccine_surveillance_report_-_week_36.pdf
2. <https://publications.aap.org/aapnews/news/15615?autologincheck=redirected>
3. <https://www.cdc.gov/mmwr/volumes/70/wr/mm7043e1.htm>
4. <https://www.nytimes.com/2021/06/18/briefing/kids-covid-and-delta.html>
5. <https://data.cdc.gov/NCHS/Provisional-COVID-19-Deaths-Focus-on-Ages-0-18-Yea/nr4s-juj3>
6. <https://www.cdc.gov/flu/about/burden/2017-2018/archive.htm>
7. <https://www.cdc.gov/flu/about/burden/2018-2019.html>
8. <https://www.folkhalsomyndigheten.se/contentassets/c1b78bffbde4a7899eb0d8fdb57b09/covid-19-school-aged-children.pdf>
9. <https://www.nejm.org/doi/full/10.1056/NEJMc2026670>
10. <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/technicalarticleupdatedestimatesoftheprevalenceofpostacuteinfectioussyndromesamongpeoplewithcoronaviruscovid19intheuk/26april2020to1august2021>
11. <https://jamanetwork.com/journals/jama/fullarticle/2782164>
12. <https://www.medrxiv.org/content/10.1101/2022.01.11.22269045v1>

The release of widely available vaccines that are highly effective in preventing severe outcomes allows any adults and families that are concerned with high risk children extra protection against COVID and renders the harmful policy of vaccine mandates or masks unnecessary

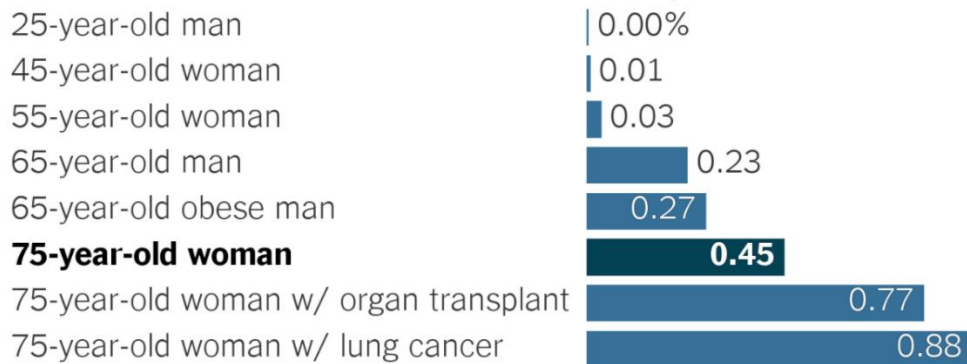
Experimental vaccines should not be required for children under 19. Firstly, because it is an unnecessary precaution for an age group that is statistically irrelevant to COVID. Secondly, because currently the most at-risk groups that have died from COVID (the elderly, ill and overweight adults) now have the ability to get a free and abundantly available vaccine if they would like one, as do any adult or child that attends school. To this end, we ask you to refer to the [CDC website](#), which states "Studies show that COVID-19 vaccines are effective at keeping you from getting COVID. Getting a COVID-19 vaccine will also help keep you from getting seriously ill even if you do get COVID-19."

At this point, the availability of vaccines and boosters has brought down the risk of death from COVID, even for older adults, in line with the flu.

A recent [NY Times article](#) states: “A team of British researchers, led by Dr. Julia Hippisley-Cox at the University of Oxford, has conducted some of the most detailed research on Covid risks for different groups of people. The BMJ, a peer-reviewed journal, published the work, and it is available [in an online calculator](#). The research was done before Omicron emerged and covers only residents of Britain, but it is still instructive.

Here are estimated post-infection death rates for several hypothetical people, all vaccinated.

Risk of death after Covid infection among the vaccinated



Unless noted, people are of average U.S. height and weight and lack major medical problems. | Source: QCovid

“One reassuring comparison is to a normal seasonal flu. The average death rate among Americans over age 65 who contract the flu has ranged between 1 in 75 and 1 in 160 in recent years, according to the C.D.C. Pre-Omicron versions of Covid, in other words, seem to present risks of a similar order of magnitude to vaccinated people as a typical flu. Some years, a flu infection may be more dangerous.

With Omicron, ‘I think the risk is not super high for relatively healthy and boosted people in their 70s,’ Janet Baseman, an epidemiologist at the University of Washington, told me. ‘I think it’s moderate at most.’”

Dr. Martin Kulldorff and Dr. Jay Bhattacharya [also point out](#), “the dissemination of vaccines that protect against hospitalizations and deaths upon COVID-19 infection throughout the older population in the United States has decoupled the growth in COVID-19 cases from COVID-19 mortality.” They go on to say, “Throughout last year, a rise in cases was inevitably accompanied by an increase in deaths with a two-to-three-week lag. However, during this most recent wave, there has been little rise in daily deaths to accompany the rise in cases because of the deployment of the vaccine in the vulnerable older population in the United States. The same is true in Sweden and the U.K., where vaccines have been provided to the entirety of the vulnerable elderly population and more. Because of the success of the American vaccination effort among the vulnerable elderly, COVID-19 cases and COVID-19 deaths are now effectively decoupled.”

Dr. Tracy Hoeg agrees that vaccine availability is a positive development for the most vulnerable adults and children. Given the rare children with comorbidities that may be at an increased risk

from COVID now have access to effective vaccines that will protect them against severe outcomes, it is time to finally focus on what is best for all the children and allow them to have a rapid return to normalcy.

She states, “A [study from England](#) of the 3,105 childhood deaths during the first 12 months of the pandemic found that only 25 of those deaths were due to COVID-19 — equivalent to a COVID-19 mortality rate of two per million children. Of these, over 75 per cent had co-morbidities and 60 per cent had a life-limiting condition, meaning it is important to identify the children at highest risk, prioritize them for vaccination and understand what works best to protect them.

In fact, [in its recommendation](#) of the pediatric vaccine, the National Advisory Committee [of Canada] for Immunization stated, “Given the short-term uncertainties surrounding pediatric vaccination at this time, children and their parents or guardians should be supported and respected in their decisions regarding COVID-19 vaccinations for the child, whatever decisions they make, and should not be stigmatized for accepting, or not accepting, the vaccination offer.”

Sources:

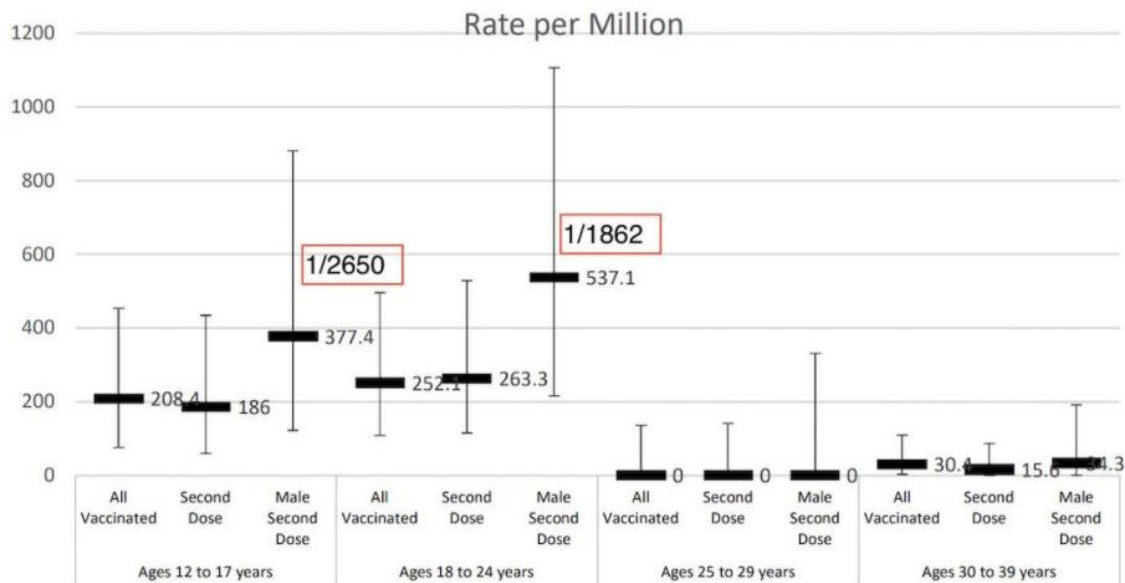
1. <https://www.nature.com/articles/s41591-021-01578-1>
2. <https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci/recommendations-use-covid-19-vaccines/pfizer-biontech-10-mcg-children-5-11-years-age.html>
3. <https://www.nytimes.com/2021/12/23/briefing/covids-risk-to-older-adults.html>
4. <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/effectiveness/index.html>

COVID vaccines carry risk for the young and the requirement to vaccinate or receive a booster need to also be optional and masks should be optional independent of the choice each family makes for the vaccine.

Due to little data on the new emergency authorized COVID vaccine and a number of adverse effects including myocarditis and pericarditis, a number of families that have traditionally vaccinated their children are not comfortable with the currently available vaccines for COVID. A number of countries are not recommending two doses of vaccines for non-high risk children under 18 for these reasons.

According to a study by [Kaiser Permanente Northwest](#), the rates of myocarditis among males age 12-17 is extremely high and can be summarized in the table below.

Figure 1: Rate per Million



Moreover, [a study](#) by Dr. Tracy Hoeg similarly determined that “For boys 12-15 without medical comorbidities receiving their second mRNA vaccination dose, the rate of CAE is 3.7 to 6.1 times higher than their 120-day COVID-19 hospitalization risk as of August 21, 2021 (7-day hospitalizations 1.5/100k population) and 2.6-4.3-fold higher at times of high weekly hospitalization risk (7-day hospitalizations 2.1/100k), such as during January 2021. For boys 16-17 without medical comorbidities, the rate of CAE is currently 2.1 to 3.5 times higher than their 120-day COVID-19 hospitalization risk, and 1.5 to 2.5 times higher at times of high weekly COVID-19 hospitalization.”

Dr. Martin Kulldorff and Dr. Jay Bhattacharya [write](#), “the mortality risk posed by COVID infection in the young is vanishingly small, while the threat posed to the elderly is orders of magnitude higher. One direct corollary of this point is that the corresponding personal benefit from vaccination, at least as far as mortality risk is concerned, is orders of magnitude lower for the young relative to the elderly. Another corollary is that the community benefit from vaccines mandates is orders of magnitude lower for a university compared to say a nursing home, where the average age is much higher.”

They also point out, “There is still the possibility of severe side effects that have yet to be identified as the vaccines have been in use in human populations for less than a year. Active investigation to check for safety problems is still ongoing.”

Given the new and experimental nature of these vaccines, the low risk of COVID to the young population and the high incidence of adverse effects, many families that have traditionally

followed the vaccine schedule are now uncomfortable with these vaccines for their children. This may include, but is not limited to, families with histories of heart issues.

Sources:

1. <https://www.medrxiv.org/content/10.1101/2021.12.21.21268209v1.full.pdf>
2. <https://www.medrxiv.org/content/10.1101/2021.08.30.21262866v1>
3. <https://nclalegal.org/wp-content/uploads/2021/11/Rodden-et-al-v.-Fauci-et-al-Complaint-Attachment-1-1.pdf>

Effect on underserved minorities, lower socioeconomic families and disadvantaged learners. Vaccine mandates are systemically racist.

There are currently vaccine-dependent mask policies in the state and in our schools (e.g. athletes that are vaccinated need not wear masks according to the state executive order and only vaccinated students may be camera anchors according to Janet Reed). This discriminatory practice prevents students that are not vaccinated from participating in the full school experience.

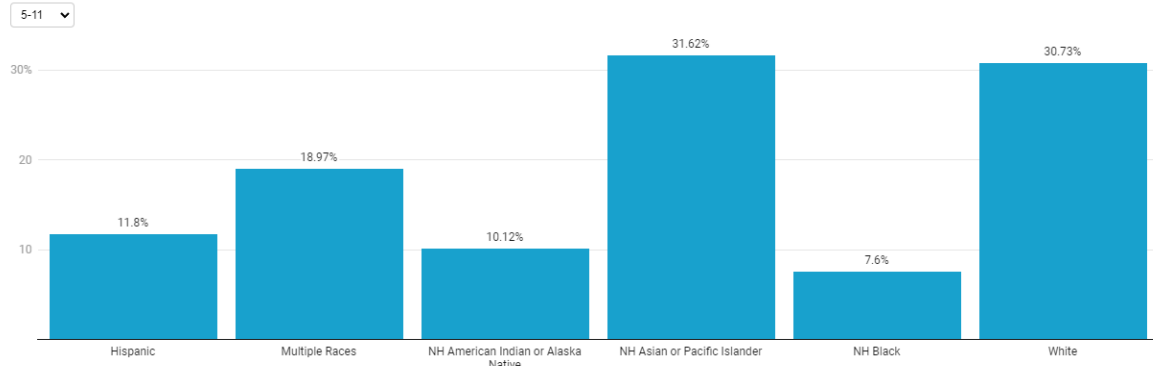
The state of Connecticut as well as NCPS independently has implemented masking policies that are vaccine-dependent.

DEI initiatives insist we make the educational environment better for students of color. Based on the [CT COVID statistics](#) as well as the entirety of the US, mandating a vaccine to remove a child's mask or be able to partake in certain extra curricular activities is systemic racism. Below are charts showing the racial divide. Additionally, see Brookings [article here](#) speaking to the point of people of color opposed to vaccine mandates.

[CDC Data](#)

Cumulative Percent of People who received At Least One Dose of COVID-19 Vaccination by Race/Ethnicity and Age Group

Vaccine administration records received by the CT Immunization Information System (CT WIZ)



Excludes Other Race and Unknown Race and patient records with missing age.

The percent of people classified as Other race (not specified) in CT WIZ (for COVID-19 vaccine records and all other vaccine records) is higher than would be expected based on census data. Other race and Unknown likely include people who should be classified as Asian, Black, Hispanic and White. Therefore, the coverage of these groups is likely underestimated and should be interpreted with caution.

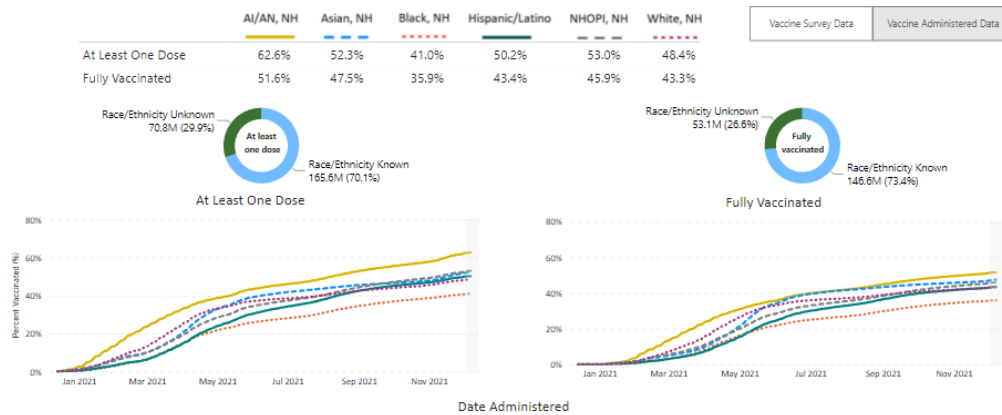
A person with reported Hispanic or Latino ethnicity is considered Hispanic regardless of reported race. A person with unspecified ethnicity is considered Non-Hispanic or Latino.

Population estimates: 2019 CT population estimates

Chart ver 5.27.21 • Source: [Connecticut Department of Public Health](#) • Embed • Download image • Created with [Datawrapper](#)

Percent of People Receiving COVID-19 Vaccine by Race/Ethnicity and Date Administered, United States

December 14, 2020 – December 07, 2021



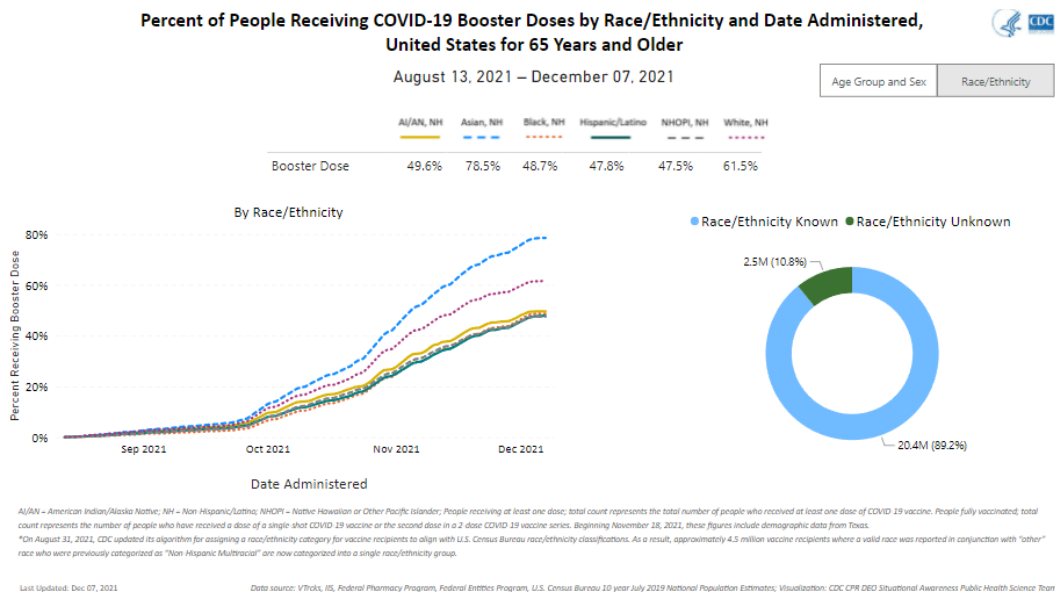
AI/AN = American Indian/Alaska Native; NH = Non-Hispanic/Latino; NHOPI = Native Hawaiian or Other Pacific Islander; People receiving at least one dose; total count represents the total number of people who received at least one dose of COVID-19 vaccine.

People fully vaccinated; total count represents the number of people who have received a dose of a single shot COVID-19 vaccine or the second dose in a 2 dose COVID-19 vaccine series. Due to the time between vaccine administration and when reported to CDC, vaccinations administered during the last 5 days may not yet be reported. This reporting lag is represented by the gray shaded box. Beginning November 18, 2021, these figures include demographic data from Texas.

*On August 31, 2021, CDC updated its algorithm for assigning a race/ethnicity category for vaccine recipients to align with U.S. Census Bureau race/ethnicity classifications. As a result, approximately 4.5 million vaccine recipients where a valid race was reported in conjunction with "other" race who were previously categorized as "Non-Hispanic Multiracial" are now categorized into a single race/ethnicity group.

Last Updated: Dec 07, 2021

Data source: Vitals, IS, Federal Pharmacy Program, Federal Entities Program, U.S. Census Bureau 10 year July 2019 National Population Estimates; Visualization: CDC OPR DEO Situational Awareness Public Health Science Team



In addition to racial divides, Dr. Tracy Hoeg notes the disproportionate effect on those with disadvantaged backgrounds from masks and disease mitigation measures. She states, “When it comes to children and COVID-19, the data are reassuring. Coming together to do the best thing for our children should involve an honest and apolitical look at the science, including both the risks to children from COVID-19 as well as the risks from disease mitigation measures. The latter also pose serious short- and long-term health risks, especially for children with special needs and those from socioeconomically disadvantaged backgrounds.”

Sources:

1. <https://data.ct.gov/stories/s/CoVP-COVID-Vaccine-Distribution-Data/bhcd-4mnv/>
2. <https://www.brookings.edu/blog/how-we-rise/2021/10/20/discrimination-in-the-healthcare-system-is-leading-to-vaccination-hesitancy/>

There is no reason adults should be mandated to make medical decisions that has now been proven to not prevent anyone other than themselves from getting severely sick.

Vaccines do not prevent transmission of COVID

First, as noted above, an unvaccinated child is already safer from COVID than a vaccinated 40-49 year old. For families that are concerned, a vaccine is available that is highly effective at preventing severe outcomes. There have also been thoughts of making mask requirements across school vaccine-dependent. This is a further discriminatory practice that is misguided and unnecessary.

The latest body of research points out that breakthrough cases among vaccinated individuals are highly prevalent and, moreover, that COVID vaccines do not prevent transmission of the virus. According to a [Lancet study](#) that collected data on vaccinated and unvaccinated spread of the virus, the results show: “Vaccination reduces the risk of delta variant infection and accelerates viral clearance. Nonetheless, fully vaccinated individuals with breakthrough infections have peak viral

load similar to unvaccinated cases and can efficiently transmit infection in household settings, including to fully vaccinated contacts. Host–virus interactions early in infection may shape the entire viral trajectory.”

Sources:

1. [https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(21\)00648-4/fulltext](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(21)00648-4/fulltext)

Vaccine mandates do not take into account natural immunity

At this point, multiple studies have looked at the incidence of breakthrough infections among the vaccinated vs. reinfection via natural immunity. Many indicate that natural immunity is actually at least as, or even more, effective than vaccine-induced immunity. Given the risk that vaccination carries, it does not make sense to impose mandates on those that have naturally acquired immunity.

Dr. Martin Kulldorff and Dr. Jay Bhattacharya [write](#), “Both vaccine-mediated immunity and natural immunity after recovery from COVID infection provide extensive protection against severe disease from subsequent SARSCoV-2 infection. There has never been a reason to presume that vaccine immunity provides a higher level of protection than natural immunity, and there is now evidence that natural immunity is stronger than vaccine immunity. Since vaccines arrived one year after the disease, there is also stronger evidence for long lasting immunity from natural infection than from the vaccines.”

They go on to point out, “an [Israeli study](#) of approximately 6.4 million individuals demonstrated that natural immunity provided excellent protection in preventing COVID-19 infection, morbidity, and mortality.¹⁷ Of the 187,549 unvaccinated persons with natural immunity in the study, only 894 (0.48%) were reinfectd; 38 (0.02%) were hospitalized, 16 (0.008%) were hospitalized with severe disease, and only one died, an individual over 80 years of age.”

In [another Israeli study](#), the authors conclude “This study demonstrated that natural immunity confers longer lasting and stronger protection against infection, symptomatic disease and hospitalization caused by the Delta variant of SARS-CoV-2, compared to the BNT162b2 two-dose vaccine induced immunity.” In this particular study, the primary findings are that vaccinated individuals had 13.1 times higher risk of testing positive [95% CI: 8.08-21.1], 27 times higher risk of symptomatic disease [95% CI: 12.7-57.5], ~8.1 times higher risk of COVID-related hospitalization [95% CI: 1.01- 64.55]. None of the patients in the study died due to COVID-related mortality. The vaccinated individuals were also at higher risk compared to those that had COVID disease before the vaccines became available.

Drs Kulldorff and Bhattacharya conclude, “These findings of highly durable natural immunity should not be surprising, as they hold for SARS-CoV-1 and other respiratory viruses. According to a paper published in Nature in August 2020, 23 patients who had recovered from SARS-CoV-1 still possess CD4 and CD8 T cells, 17 years after infection during the 2003 epidemic. A Nature paper from 2008 found that 32 people born in 1915 or earlier still retained some level of immunity against the 1918 flu strain— some 90 years later. In contrast to the concrete findings regarding the robust durability of natural immunity, it is yet unclear in the scientific literature how long-lasting vaccine-induced immunity will be. Notably, [researchers have argued](#) that they

can best surmise the predicted durability of vaccine immunity by looking at the expected durability of natural immunity.”

Sources:

1. <https://nclalegal.org/wp-content/uploads/2021/11/Rodden-et-al-v.-Fauci-et-al-Complaint-Attachment-1-1.pdf>
2. <https://www.medrxiv.org/content/10.1101/2021.04.20.21255670v1>
3. <https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1>
4. <https://www.nature.com/articles/d41586-021-01505-x>

3) Support the mental, emotional, and physical health of our children

The pandemic has created a mental crisis among children and adults world wide. The mental strain on children is far more deadly and concerning than COVID in the state of CT. In 2 years, 5 children under the age of 19 have died in CT *with* COVID. This means only 2.5 children annually have died *with* COVID in the entire state of CT. However, the total number of [suicides](#) deaths in 2019 and 2020 in children under the age of 19 is 35. This means 17.5 children die from suicide annually. This is referencing [Governor Lamont’s Office](#) providing updates on CT Coronavirus response efforts.

“Suicide [ATTEMPTS](#) among 12-17 year olds, especially adolescent girls, during the Covid-19 pandemic and got worse the longer social distancing orders and government lockdowns persisted, according to new data from the Centers for Disease Control and Prevention. From late July to late August 2020, the average weekly number of emergency department visits for suspected suicide attempts among 12- to 17-year-old girls increased by 26.2% from the same period a year prior.” The disruption of daily life with pandemic lockdowns and social distancing orders may have contributed to the rise in suicide attempts, the CDC said.

In addition, the drug [overdose](#) death rate in 2019 was 1,214. We do not currently have the 2020 or 2021 overdose rate, but we do know it will be higher as overdoses around the country are higher over the last two years.