No. 21A____

In the Supreme Court of the United States

JOHN DOE, an individual; JANE DOE, individually and as parent and next friend of JILL DOE, a minor child; and JILL DOE, a minor child, by and through her next friend, JANE DOE,

Applicants,

v.

SAN DIEGO UNIFIED SCHOOL DISTRICT; RICHARD BARRERA, in his official capacity as Board President; SHARON WHITEHURST-PAYNE, in her official capacity as Board Vice President; MICHAEL MCQUARY, in his official capacity as Board Member; KEVIN BEISER, in his official capacity as Board Member; SABRINA BAZZO, in her official capacity as Board Member; and LAMONT JACKSON, in his official capacity as Interim Superintendent,

Respondents.

APPENDIX OF EXHIBITS

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EXHIBIT 1-1

FOR PUBLICATION

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MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JOHN DOE, an individual; et al., Plaintiffs-Appellants, v. SAN DIEGO UNIFIED SCHOOL DISTRICT; et al., Defendants-Appellees.	No. 21-56259 D.C. No. 3:21-cv-01809-CAB-LL Southern District of California, San Diego ORDER

Before: BERZON, IKUTA, and BENNETT, Circuit Judges.

Order by Judges BERZON and BENNETT; Dissent by Judge IKUTA.

Appellants, a 16-year-old high school student and her parents, filed an emergency motion for an injunction pending appeal, seeking to enjoin San Diego Unified School District ("SDUSD") from requiring compliance with a student vaccination mandate. On November 28, 2021, we granted Appellants' motion in part. We ordered that an injunction shall be in effect only while a "per se" deferral of vaccination is available to pregnant students under SDUSD's student vaccination mandate, and that the injunction shall terminate upon removal of the "per se" deferral option for pregnant students.

On November 29, 2021, appellees filed a letter and supporting declaration

from Interim Superintendent Lamont Jackson explaining that the deferral option for pregnant students has been removed from the mandate. Appellants' responsive letter does not dispute that the pregnancy deferral option has been validly removed.

Given the removal of the "per se" deferral option for pregnant students, the injunction issued in the November 28, 2021 order has terminated under its own terms. This order provides our reasoning for why an injunction pending appeal is not warranted as to the now-modified student vaccination mandate.

***

SDUSD's student vaccination mandate provides that students who are 16 years or older as of November 1, 2021, and who are not fully vaccinated against COVID-19, will not be permitted to participate after January 24, 2021 in on-site education or extracurricular activities without a qualified exemption or conditional enrollment.[1]

SDUSD allows for medical exemptions to the mandate as well as conditional enrollment in on-site education for 30 days for certain categories of newly enrolling students (students who are homeless, in "migrant" status, in foster care,

[1] Some record materials refer to January 21 as the start date for the spring semester, but it appears that date has now been amended to January 24. *See Covid-19 Status: Safety Comes First*, San Diego Unified Sch. Dist., https://sandiegounified.org/covid-19_status (last visited Dec. 3, 2021).

or in military families).[2] The mandate also provides certain procedural protections and accommodations to students with Individualized Education Programs (IEPs), to comply with statutory "stay put" requirements. *See, e.g.*, 20 U.S.C. § 1415(j). Previously, the mandate provided for a "per se" pregnancy deferral, under which a pregnant student could defer vaccination until after pregnancy; as noted, the "per se" pregnancy deferral no longer exists. SDUSD does not allow for an exemption to the mandate on the basis of religious belief.

Appellants allege that the student vaccination mandate violates the Free Exercise Clause, both facially and as applied, by failing to exempt Jill Doe, the high school student plaintiff, in light of a religious belief that prohibits her from taking any of the available vaccines,[3] and by treating "comparable secular activity

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[2] These categories were drawn from California state law provisions applicable to other immunizations required for students. *See, e.g.*, Cal. Educ. Code §§ 48204.7, 48850, 48852.7, 49069.5, 49701; Cal. Health & Safety Code § 120341.

[3] The complaint and emergency motion explain that Jill Doe's reason for abstaining from vaccination is that "[a]ll three of the[] vaccines have been manufactured or tested using material derived from stem cell lines from aborted fetuses." The one vaccine approved for use in 16-year-olds is the Pfizer-BioNTech vaccine. *See COVID-19 Vaccines for Children and Teens*, Ctrs. for Disease Control & Prevention (Nov. 23, 2021), https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/children-teens.html. That vaccine is not manufactured using stem cells. Third parties tested the vaccine using fetal cell lines, which are laboratory-grown cells originally derived from two fetuses aborted in 1973 and 1985. *See, e.g.*, *COVID-19 Vaccine and Fetal Cell Lines*, L.A. Cnty. Dep't of Pub. Health (Apr. 20, 2021), http://publichealth.lacounty.gov/media/Coronavirus/docs/vaccine/VaccineDevelopment_FetalCellLines.pdf. Jill Doe explains that her Christian faith prevents her from using any vaccines that depend

more favorably than religious exercise" through the granting of medical exemptions, conditional enrollments for certain categories of students, and procedural protections for students with IEPs. *See Tandon v. Newsom*, 141 S. Ct. 1294, 1296 (2021) (per curiam).

To determine whether to grant an injunction pending appeal, this court applies the test for preliminary injunctions. *Se. Alaska Conservation Council v. U.S. Army Corps of Eng'rs*, 472 F.3d 1097, 1100 (9th Cir. 2006). "A plaintiff seeking a preliminary injunction must establish that [she] is likely to succeed on the merits, that [she] is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in [her] favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). The Ninth Circuit applies a "sliding scale" approach to preliminary injunctions such that a preliminary injunction can issue "where the likelihood of success is such that 'serious questions going to the merits were raised and the balance of hardships tips sharping in [plaintiff's] favor.'" *All. for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th Cir. 2011) (alteration in original); *see*

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on use of fetal cell lines at any stage of their development. We may not and do not question the legitimacy of Jill Doe's religious beliefs regarding COVID-19 vaccinations. *Cf. Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n*, 138 S. Ct. 1719, 1731 (2018).

also id. at 1131–35 (explaining that the sliding scale test "remains viable after the Supreme Court's decision in *Winter*").

The Supreme Court has held that "the right of free exercise does not relieve an individual of the obligation to comply with a 'valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes).'" *Emp. Div., Dep't of Human Res. of Or. v. Smith*, 494 U.S. 872, 879 (citations omitted). "[A] law that is neutral and of general applicability need not be justified by a compelling governmental interest even if the law has the incidental effect of burdening a particular religious practice . . . . A law failing to satisfy these requirements must be justified by a compelling governmental interest and must be narrowly tailored to advance that interest." *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 531–32 (1993).

Appellants have not demonstrated a sufficient likelihood of success in showing that the district court erred in applying rational basis review, as opposed to strict scrutiny, to the student vaccination mandate.[4]

[4] We note that although a "published motions panel order may be binding as precedent for other panels deciding the same issue," its analysis is not binding on panels deciding distinct issues. *See E. Bay Sanctuary Covenant v. Biden*, 993 F.3d 640, 660 (9th Cir. 2021). "In deciding whether the court should stay the grant or denial of a preliminary injunction pending appeal," for example, "the motions panel is predicting the likelihood of success of the appeal." *Id.* Put differently, the

First, in our view, the plaintiffs have not raised a serious question as to whether the mandate is neutral. The terms of the mandate do not make any reference to religion or "a religious practice without a secular meaning discernable from the language or context." *Lukumi*, 508 U.S. at 533 (describing minimum requirement of facial neutrality). Looking beyond facial neutrality, Appellants have not shown a likelihood of establishing that the mandate was implemented with the aim of suppressing religious belief, rather than protecting the health and safety of students, staff, and the community. *See id.* at 533–42 (examining direct and circumstantial evidence in the record to determine the object of a law).

Second, the plaintiffs have not raised a serious question as to whether the mandate is generally applicable. The only currently enrolled students who are fully exempt from the requirement to be vaccinated for on-site learning and extracurricular activities are students who qualify for a medical exemption. The medical exemption is limited to students with contraindications or precautions recognized by the Centers for Disease Control and Prevention or the vaccine

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motions panel is forecasting how the merits panel might rule, and its reasoning is "an additional step removed from the underlying merits." *Id.* at 660–61. "Such a predictive analysis should not, and does not, forever decide the merits of the parties' claims." *Id.* at 661. "This sort of pre-adjudication adjudication would defeat the purpose of a stay, which is to give the reviewing court the time to act reasonably, rather than doling out justice on the fly." *Id.* (citation omitted) (internal quotation marks omitted). Because this order is similarly "predicting the likelihood of success of the appeal," our legal analysis is "persuasive but not binding" on future merits panels. *Id.* at 660–62.

manufacturer, and the request must be certified by a physician. Limitation of the medical exemption in this way serves the primary interest for imposing the mandate—protecting student "health and safety"—and so does not undermine the District's interests as a religious exemption would.[5] *See Fulton v. City of Philadelphia*, 141 S. Ct. 1868, 1877 (2021) ("A law . . . lacks general applicability if it prohibits religious conduct while permitting secular conduct that undermines the government's asserted interests in a similar way."); *Tandon*, 141 S. Ct. at 1296 ("[W]hether two activities are comparable for purposes of the Free Exercise Clause must be judged against the asserted government interest that justifies the regulation at issue."); *Smith*, 494 U.S. at 874, 878–82 (state law prohibiting possession of a controlled substance, but containing exception for substances prescribed by a medical practitioner, was generally applicable); *We The Patriots USA, Inc. v. Hochul*, No. 21-2179, 2021 WL 5121983, at *12 (2d Cir. Nov. 4, 2021) (medical exemption from healthcare worker COVID-19 vaccination mandate differed from religious exemption in that mandating the vaccination of people with medical

[5] The dissent insists on a narrower formulation of SDUSD's asserted interest, characterizing that interest as "ensur[ing] 'the safest environment possible for all students and employees' by preventing the transmission and spread of COVID-19." *See, e.g.*, Dissent at 8. Although promoting a safe school environment is undoubtedly one of SDUSD's interests in promulgating both a student and employee vaccination mandate, the interest the District emphasizes most frequently in the record with respect to the student vaccination mandate is protecting the "health and safety" of students.

contraindications or precautions "would not effectively advance" the government's interest in "protecting the health" of such individuals).

Additionally, although the record does not disclose the number of students who have sought or are likely to seek a medical exemption, if that number is very small and the number of students likely to seek a religious exemption is large, then the medical exemption would not qualify as "comparable" to the religious exemption in terms of the "risk" each exemption poses to the government's asserted interests. *See We The Patriots USA, Inc.*, 2021 WL 5121983, at *12–13. Moreover, some of the medical exemptions are likely to be "limited in duration," unlike a religious exemption. *Id.* at *12. SDUSD's medical exemption form expressly states that "[n]o medical exception is permanent" and that any such exemption is valid only until the earliest date out of a list of dates, such as "[t]he end date specified by the physician" who fills out the exemption form. Students with health issues justifying a longer-term medical exemption will need to reapply for an exemption each year. Accordingly, although "it may be feasible for [SDUSD] to manage the COVID-19 risks posed by a small set of objectively defined and largely time-limited medical exemptions," "it could pose a significant barrier to effective disease prevention to permit a much greater number of permanent religious exemptions." *Id.*; *see also Lukumi*, 508 U.S. at 542–43 (the requirement of general applicability prohibits imposition of a burden only on

conduct motivated by religious belief, while failing to prohibit nonreligious conduct "that endangers [legitimate governmental] interests in a similar or greater degree").

The 30-day "conditional enrollment" period for the specified categories of newly enrolling students also does not raise a serious question concerning the mandate's general applicability. As was the case with currently enrolled students like Jill Doe,[6] conditionally enrolled students are simply given a grace period to provide documentation proving that they have been vaccinated before they may continue with on-site education; they are not exempted from the vaccination requirement itself. Thus, Appellants have not demonstrated that the mandate treats conditional enrollees more favorably than students who invoke religious beliefs as their ground for remaining unvaccinated. *See Tandon*, 141 S. Ct. at 1296 (strict scrutiny triggered whenever government regulations "treat *any* comparable secular activity more favorably than religious exercise"). And, in line with the above

[6] Currently enrolled students and their families were notified about the student vaccination mandate by letter on September 29, 2021. The letter advised students to receive their first dose of the vaccine by November 29, 2021 and their second dose by December 20, 2021. The letter also notified students that if they are not fully vaccinated prior to the start of the semester—which will occur on January 24, 2021—then they will be transitioned into a remote-learning "alternative education program" and will not be permitted to participate in extra-curricular activities. Currently enrolled students therefore received a grace period of well over 30 days in which to receive their vaccinations and provide documentation of those vaccinations.

analysis, the conditional enrollment period is both of temporary duration and of limited scope, and so does not undermine SDUSD's asserted interests in student health and safety the way a religious exemption would. *See Lukumi*, 508 U.S. at 542–43; *We The Patriots USA, Inc.*, 2021 WL 5121983, at *12–13.

The dissent recognizes that in-person attendance by unvaccinated students with an IEP is not comparable to in-person attendance by students with religious objections to vaccination because federal law—the IDEA—requires that a school "follow certain procedures before it can bar students [with IEPs] from in-person attendance." Dissent at 6 n.3. Although California does not yet require proof of COVID-19 vaccination for school attendance as a matter of state law, the Governor has announced plans to direct the California Department of Public Health to adopt such a requirement in the near future. *See California Becomes First State in Nation to Announce COVID-19 Vaccine Requirement for Schools*, Off. of Governor Gavin Newsom (Oct. 1, 2021), https://www.gov.ca.gov/2021/10/01/california-becomes-first-state-in-nation-to-announce-covid-19-vaccine-requirements-for-schools/; *see also* Cal. Health & Safety Code § 120335 (requiring student immunization for a list of diseases as well as "[a]ny other disease deemed appropriate by the department, taking into consideration the recommendations of" several health advisory bodies). At that point, SDUSD's policy of conditional enrollment for students who are homeless, in

"migrant" status, in foster care, or in military families will also be required by law. See Cal. Educ. Code §§ 48204.7, 48850, 48852.7, 49069.5, 49701; Cal. Health & Safety Code § 120341. For now, it parallels the requirements set by state law for other vaccines. *Id.*

Plaintiffs also take issue with the student vaccination mandate's procedural provision regarding students with IEPs. SDUSD maintains that once an IEP is in place, the Individuals with Disabilities Education Act requires SDUSD to implement the IEP. *See* 20 U.S.C. § 1415(j). The IEP cannot be changed unilaterally; it may be adjusted only through a process that provides the student with certain procedural protections. Until that process is complete, the IEP "shall remain" in effect. *Id.* The student vaccination mandate accounts for that legal requirement by declining to set a universal vaccination deadline for students with IEPs and by instead permitting conditional enrollment. This provision of the mandate is not comparable to a religious exemption. It provides temporary procedural protections to students with IEPs but does not grant them a permanent exemption from the mandate. Additionally, any delay in vaccination caused by this provision is likely to be brief and limited to a small number of students. Thus, for the reasons explained above, it is unlikely that the "risk" to the government's asserted interest posed by this provision would qualify as "comparable" to the risk

posed by a religious exemption provision. *We The Patriots USA, Inc.*, 2021 WL 5121983, at *12–13.

Moreover, in light of the rigidity of the medical exemption and the limited time period for conditional enrollees to obtain records or vaccine doses—which does not appear to be subject to discretionary extension—there is no "mechanism for 'individualized exemptions'" in this case. *See Does 1–3 v. Mills*, --- S. Ct. ----, 2021 WL 5027177, at *2 (Oct. 29, 2021) (Gorsuch, J., dissenting from the denial of an application for injunctive relief) (quoting *Lukumi*, 508 U.S. at 537); *Fulton*, 141 S. Ct. at 1878 (concluding that "the inclusion of a formal system of entirely discretionary exceptions" rendered the regulation at issue not generally applicable); *We The Patriots USA, Inc.*, 2021 WL 5121983, at *14–15.

Finally, plaintiffs gesture toward the inclusion of a religious accommodation procedure in SDUSD's *employee* vaccination mandate as evidence that the *student* vaccination mandate is not generally applicable. But that procedure does not apply to students and, in any event, is not a religious *exemption*. To the contrary, it is a legally required interactive process that may ultimately result in a denial of the requested accommodation. The EEOC has released guidance explaining that, although Title VII prohibits employment discrimination based on religion, an employee's request for an exemption from a COVID-19 vaccination mandate can be denied on the ground that the employee's belief is not truly religious in nature

or is not sincerely held, or on the ground that such an exemption would pose an "undue hardship" by burdening "the conduct of the employer's business" through increasing "the risk of the spread of COVID-19 to other employees or to the public." *What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws* at L.2 to L.3, U.S. Equal Emp. Opportunity Comm'n (Oct. 25, 2021), https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#L. The EEOC's guidance also suggests that SDUSD was right to circulate a religious accommodation form and information sheet. *Id.* at L.1 ("As a best practice, an employer should provide employees . . . with information about whom to contact, and the procedures (if any) to use, to request a religious accommodation.").

Appellants' emergency motion therefore fails to raise a serious question as to whether the vaccination mandate is not neutral and generally applicable. Accordingly, Appellants have not demonstrated a likelihood of success in showing that the district court erred by applying rational basis review. And Appellants do not argue that they are likely to succeed on the merits of their free exercise claim if rational basis review applies. *See Parents for Privacy v. Barr*, 949 F.3d 1210, 1238 (9th Cir. 2020) (stating standard for rational basis review).

Because Appellants have not established serious questions going to the merits of their free exercise claim, we need not consider the remaining factors for

an injunction. *See Disney Enters., Inc. v. VidAngel, Inc.*, 869 F.3d 848, 856 (9th Cir. 2017). Nonetheless, we briefly note that Appellants may not have demonstrated a likelihood of irreparable injury and have not established that the public interest tilts in favor of granting the emergency motion pending appeal, for several reasons.

First, this case is meaningfully distinct from the recent cases involving COVID-19 restrictions on worship in churches and private homes. *See, e.g.*, *Tandon*, 141 S. Ct. at 1296–97. In those cases, the plaintiffs were literally prevented from exercising their religion in group settings. *Id.* Here, in contrast, Jill Doe may exercise her religion by declining to receive the vaccination. Appellants argue that the student vaccination mandate nevertheless causes irreparable injury because it "burdens" their religion by making an "important benefit" contingent upon conduct that violates their faith. *See Thomas v. Rev. Bd. of the Ind. Emp. Sec. Div.*, 450 U.S. 707, 717–18 (1981). But the record is devoid of evidence indicating that SDUSD's remote-learning "alternative education program" is inferior to in-person education. And although Jill Doe states that, as she is a "preeminent athlete," the mandate would cause her irreparable injury by "dooming" her otherwise promising chances of receiving a sports scholarship, she

did not submit any details to support that claim.[7] She also elected to proceed anonymously in this case—including remaining anonymous to the District and its lawyers—thereby preventing SDUSD from contesting the truth of that statement.[8] Critical facts going to the "irreparable injury" inquiry are therefore unknowable in this case. Appellants thus have probably not carried their burden of showing that they are likely to suffer irreparable harm in the absence of preliminary relief.

Last, for completeness, we note that the public interest weighs strongly in favor of denying Appellants' motion. The COVID-19 pandemic has claimed the lives of over three quarters of a million Americans. *Covid Data Tracker*, Ctrs. for Disease Control & Prevention, https://covid.cdc.gov/covid-data-tracker/

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[7] The dissent states that Doe is "an athlete who believes she could earn a college scholarship if she completed a successful season." Dissent at 2. In her complaint, Doe claimed that "she *hopes* to draw the attention of college recruiters" and "*believes* that, *with a good season*, she *can* earn a sports scholarship." Even setting aside her anonymity and her alleged status as a "preeminent" athlete, her belief that she can win a scholarship is speculative. "Speculative injury does not constitute irreparable injury sufficient to warrant granting a preliminary injunction." *Caribbean Marine Servs. Co. v. Baldrige*, 844 F.2d 668, 674 (9th Cir. 1988); *see also Winter*, 555 U.S. at 21–22 ("Our frequently reiterated standard requires plaintiffs seeking preliminary relief to demonstrate that irreparable injury is *likely*" and not merely speculative (emphasis in original)).

[8] The district court temporarily allowed Appellants to proceed anonymously but indicated that it was "not persuaded" that, in the final analysis, Appellants could overcome the presumption that parties must use their real names in litigation. *See, e.g.*, *Doe v. Kamehameha Schs./Bernice Pauahi Bishop Est.*, 596 F.3d 1036, 1042 (9th Cir. 2010).

#datatracker-home (last visited Dec. 1, 2021). The record indicates that vaccines are safe and effective at preventing the spread of COVID-19, and that SDUSD's vaccination mandate is therefore likely to promote the health and safety of SDUSD's students and staff, as well as the broader community. And as the Supreme Court has long recognized, "the right to practice religion freely" is not "beyond regulation in the public interest," including regulation aimed at reducing the risk of "expos[ing] the community or the child to communicable disease or the latter to ill health or death." *Prince v. Massachusetts*, 321 U.S. 158, 166–67 (1944); *see also Vernonia Sch. Dist. 47J v. Acton*, 515 U.S. 646, 656 (1995) (noting that First Amendment rights "are different in public schools than elsewhere," including because, "[f]or their own good and that of their classmates, public school children are routinely required . . . to be vaccinated against various diseases"). The public interest therefore favors SDUSD's mandate.

In sum, Appellants have not carried their burden to establish a likelihood of success on the merits, or that they will suffer irreparable harm if this Court does not issue an injunction, or that the public interest weighs in their favor. Appellants' motion for an injunction pending appeal is therefore **DENIED**.

Jill Doe et al. v. San Diego Unified School District et al., No. 21-56259

Ikuta, Circuit Judge, dissenting

Jill Doe is a junior at Scripps Ranch High School, which is part of San Diego Unified School District (hereinafter the "School District"). The School District recently implemented a COVID-19 vaccine mandate in order to prevent the transmission and spread of COVID-19 in its schools, and thus "ensure the highest-quality instruction in the safest environment possible for all students and employees." As explained in the School District's "Back to School FAQ," San Diego Unified is requiring student vaccinations because:

> Scientific evidence shows that vaccinations are an essential part of protecting our communities. Vaccines are the *most preventive* of all strategies. Unlike masking, ventilation, and testing, vaccination protects students before the *virus is introduced into the setting*, reducing disease and new mutations.

Because, as the School District asserts, vaccinations interrupt "the chain of transmission" of COVID-19, its vaccine mandate protects the health and safety of students and staff by preventing transmission from infected individuals to other students and employees.

According to the appellants' emergency motion, all students sixteen and older were required to receive their first dose of the vaccine by November 29, 2021, and their second dose by December 20, 2021. Unvaccinated students are

generally not allowed to attend in-person classes or participate in extracurricular activities.

But the School District provides exemptions to this mandate for the benefit of students who have medical reasons for not getting vaccinated. It also provides exemptions for thirty days for students who are "conditional enrollees" (meaning homeless and migratory children, foster youth, and students from military families) who enroll in the School District in the future and may have logistical difficulties in obtaining vaccines or proof of vaccination status.[1] These exempted students, despite being unvaccinated, are permitted to attend in-person classes and participate in extracurricular activities if they comply with "non-pharmaceutical interventions (*e.g.*, face coverings, regular asymptomatic testing)." No similar accommodation is offered to students who are unvaccinated for religious reasons.

Doe is a Christian and is opposed to abortion on religious grounds. Doe's faith prevents her from taking any of the COVID-19 vaccines because they were developed using aborted fetal cell lines. Doe is also an athlete who believes she could earn a college scholarship if she completed a successful season. But under

[1] The School District also allowed pregnant students to defer vaccination until after their child was delivered. However, the School District removed the pregnancy deferral from its policy after the majority granted Doe an emergency injunction that would be in effect "only while a 'per se' deferral of vaccination is available to pregnant students."

the School District's vaccine mandate, Doe will not be permitted to attend in-person classes and will not be able to participate in extracurricular sports.

Doe argues that the School District's vaccine mandate violates the Free Exercise Clause of the First Amendment to the United States Constitution,[2] because it includes exemptions for secular activity without a similar accommodation for religious beliefs. Because we should grant Doe's motion for an injunction pending appeal, I dissent.

I

A party moving for preliminary injunctive relief must establish (1) a likelihood of success on the merits; (2) a likelihood of irreparable harm; (3) that the balance of harm tips in the movant's favor; and (4) that the injunction is in the public interest. *See All. for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th Cir. 2011). When a party seeks a preliminary injunction against the government, the balance of the equities and public interest factors merge. *Drakes Bay Oyster Co. v. Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014) (citing *Nken v. Holder*, 556 U.S. 418, 435 (2009)).

[2] "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof . . . ." U.S. Const. Amend. 1.

Additionally, this circuit employs a "sliding scale" approach to the four factors relevant to preliminary injunctive relief. *Wild Rockies*, 632 F.3d at 1131, 1134. Under the sliding scale approach, "'serious questions going to the merits' and a balance of hardships that tips sharply towards the plaintiff can support issuance of a preliminary injunction, so long as the plaintiff also shows that there is a likelihood of irreparable injury and that the injunction is in the public interest." *Id.* at 1135.

II

We should grant Doe's motion for an injunction pending appeal because Doe established that there are "serious questions going to the merits" of her Free Exercise claim and a likelihood of irreparable injury, and that the balance of hardships and public interest tip sharply in her favor. *Id.*

A

In evaluating whether there are serious questions going to the merits, we must first determine the appropriate level of scrutiny for Doe's Free Exercise claim. "[L]aws incidentally burdening religion are ordinarily not subject to strict scrutiny under the Free Exercise Clause so long as they are neutral and generally applicable" to secular and religious activity alike. *Fulton v. City of Philadelphia, Pennsylvania*, 141 S. Ct. 1868, 1876 (2021) (citing *Emp. Div., Dep't of Hum. Res.*

of Or. v. Smith, 494 U.S. 872, 878–82 (1990)). "[G]overnment regulations are not neutral and generally applicable, and therefore trigger strict scrutiny under the Free Exercise Clause, whenever they treat *any* comparable secular activity more favorably than religious exercise." *Tandon v. Newsom*, 141 S. Ct. 1294, 1296 (2021) (citing *Roman Catholic Diocese of Brooklyn v. Cuomo*, 141 S.Ct. 63, 67–68 (2020)).

"[W]hether two activities are comparable for purposes of the Free Exercise Clause must be judged against the asserted government interest that justifies the regulation at issue." *Id.* (citation omitted). Courts must compare "the risks various activities" pose to the government's asserted interest. *Id.* A law is not generally applicable if secular activity and religious activity present "similar risks," but only the secular activity is allowed. *Id.* (citation omitted).

In light of the Supreme Court's guidance, the framework for determining whether a law is generally applicable for purposes of the Free Exercise Clause proceeds as follows. First, a court must identify the government's asserted interest that justifies the law at issue. Next, the court must identify the religious activity and secular activity that the plaintiff claims are comparable for purposes of the Free Exercise Clause, but that the law treats differently. Finally, the court must identify the risk posed by both the religious activity and the secular activity to the

government's asserted interest. If the religious activity and secular activity pose "similar risks" to the government interest but are treated differently by the law, then the law is not generally applicable. *Id.*

Here, the School District's asserted interest justifying the vaccine mandate is to "ensure the highest-quality instruction in the *safest environment* possible for all students and employees" by preventing the transmission and spread of COVID-19. The two activities that Doe claims are comparable are in-person attendance by students who are unvaccinated for religious reasons and in-person attendance by students who are unvaccinated for medical or logistical reasons.[3] These religious and secular activities pose identical risks to the government's asserted interest in ensuring the "safest environment possible for all students and employees," because both result in the presence of unvaccinated students in the classroom, who could spread COVID-19 to other students and employees.

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[3] Doe also argues that in-person attendance by unvaccinated students who are subject to an Individualized Education Program (IEP) is comparable to in-person attendance by students who are unvaccinated for religious reasons. This is incorrect. Students with an IEP are protected by a federal law that requires the School District to follow certain procedures before it can bar students from in-person attendance. *See* 20 U.S.C. § 1415(j) (a student's IEP "shall remain" in effect pending completion of proceedings required to modify the IEP). Because the vaccine mandate is not applicable to IEP students by force of federal law, we do not take the in-person attendance of unvaccinated IEP students into account in determining whether the School District has imposed a mandate that is generally applicable.

But the School District's mandate treats secular and religious activity differently. Specifically, the policy allows in-person attendance by students unvaccinated for medical reasons, and in-person attendance by unvaccinated new enrollees who meet certain criteria. By contrast, the policy does not allow *any* form of in-person attendance by students unvaccinated for religious reasons. Because in-person attendance by students who are unvaccinated for religious reasons poses "similar risks" to the school environment as in-person attendance by students who are unvaccinated for medical or logistical reasons, the mandate is not generally applicable.[4] *Tandon*, 141 S. Ct. at 1296. We must therefore apply strict scrutiny to the mandate. *Id.*

In concluding otherwise, the majority fails to follow the legal framework for determining whether a law is generally applicable. First, the majority argues that the medical exemption does not undercut the mandate's general applicability

[4] This does not mean that a vaccine mandate cannot be generally applicable if it allows in-person attendance for any unvaccinated student. For instance, suppose the evidence established that natural immunity (*i.e.*, immunity from prior infection) is just as effective as immunity through vaccination. (There is significant dispute regarding this issue, including in this case, and so this example is offered merely as a hypothetical.) If there were such evidence, a vaccine mandate that allowed students with natural immunity to attend in-person classes would be generally applicable because students with natural immunity would pose less of a risk to the school environment than students who are unvaccinated (and therefore have *no* immunity) on religious grounds.

because it furthers the School District's interest in "protecting student health and safety" by protecting the health of the particular student claiming the medical exemption. Maj. at 7. This argument incorrectly focuses on the reasons for the exemption rather than the asserted interest that justifies the mandate. No doubt the School District has a good reason for providing an exemption for medically vulnerable students in order to protect their health, although the School District could further this interest by allowing such students to participate in the remote-learning option. But "the reasons why" the School District allows in-person attendance for some unvaccinated students are irrelevant. *Tandon*, 141 S. Ct. at 1296 (citation omitted). Instead, "[c]omparability is concerned with the risks" in-person attendance by an unvaccinated student poses to the "asserted government interest." *Id.* (citation omitted). Here, the School District's asserted interest for imposing the vaccine mandate in the first place is to ensure "the safest environment possible for all students and employees" by preventing the transmission and spread of COVID-19.[5] Allowing students who are unvaccinated for medical reasons to

[5] The majority argues that the School District's interest is not an interest in "ensuring the safest environment possible for all students and employees" but rather the interest in "protecting the 'health and safety' of students." Maj. at 7 n.5. The majority's quibble over wording is irrelevant in this context. The School District has made clear that its justification for the vaccine mandate is to prevent the transmission and spread of COVID-19 from infected students to other

(continued...)

attend school in person undermines this interest. Thus, the majority errs at the first step in the framework by focusing on the School District's reasons for offering an exemption, rather than the interest that the School District actually asserts to justify the mandate.

Second, the majority claims that the risks posed by in-person attendance of students unvaccinated for medical reasons are not comparable to the risks posed by students unvaccinated for religious reasons because far fewer students will seek medical exemptions than religious exemptions.[6] Maj. at 8. This rationale is entirely speculative. As the majority acknowledges, "the record does not disclose the number of students who have sought or are likely to seek a medical exemption." *Id.* Nor is there any evidence in the record about how many students

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[5](...continued)
individuals at the school. Any medical exemption undercuts this goal, even if there are good reasons for the exemption.

[6] This claim is undercut by testimony from the School District's expert, who describes the medical exemption as having a potentially broad scope: "If a student's own physician confirms, through the same process used for other vaccinations, that an underlying medical problem *makes the vaccine unsafe for their patient*, and that physician is made available to discuss this issue with the District's physician, the student is eligible for a medical exemption." This characterization of the mandate not only casts doubt on the majority's view that the exemption covers only a small number of students, but also suggests that the medical exemption may be an example of the "individualized exemptions" that render government regulations not generally applicable. *Fulton*, 141 S. Ct. at 1877 (cleaned up).

would seek religious exemptions. A court may not base its rulings on such free-floating guesswork. Thus, there is no basis for the majority's claim that the School District will be flooded with requests for religious exemptions if they were offered.

The majority further errs in arguing that because the mandate gives students claiming a medical or logistical exemption only temporary relief, the risk posed by their in-person attendance is not comparable to the risk posed by the in-person attendance of students claiming a religious exemption.[7] Maj. at 8–10. But the majority identifies no authority suggesting that the School District can treat secular activity more favorably than religious activity simply because the disparate treatment is only temporary. *Cf. Elrod v. Burns*, 427 U.S. 347, 373 (1976) (citation omitted) ("The loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury."); *see also Armster v. U.S. Dist.*

[7] There is no basis for characterizing the medical exemption as temporary. According to the School District's medical exemption form (as opposed to the testimony of its expert, *see supra* at 9 n.6), students qualify for a medical exemption only if they have a "contraindication" or "precaution" recognized by the CDC or the vaccine manufacturer. The only such contraindication is a severe allergic reaction or known diagnosed allergy to the vaccine or its ingredients, and the only precaution is a history of immediate allergic reaction to other vaccines or injectable therapies. *See* CDC, Vaccines & Immunizations – Contraindications and Precautions, https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Contraindications (last updated November 29, 2021); *see also id.* Appendix B. Nothing in the record suggests that such allergies are temporary.

Ct. for the Cent. Dist. of California, 792 F.2d 1423, 1430 (9th Cir. 1986) ("A denial of a right need not be absolute before the Constitution is implicated. A temporary deprivation of a right, or a limitation on it, may violate the Constitution as well."). Even a temporary deferral would provide a religious student with some relief.

Finally, the majority argues that conditional enrollment deferrals are not comparable to a religious exemption because Doe had the same amount of time to comply with the mandate that new enrollees will have. Maj. at 9. This again confuses the *reasons* for the exemption with the *asserted interest* that justifies the mandate. While the School District may have a good reason to give new enrollees who meet certain criteria thirty days to comply with the mandate, the in-person attendance of such unvaccinated conditional enrollees poses an identical risk to the School District's asserted interest in preventing the spread of COVID-19 as the in-person attendance of unvaccinated students seeking a religious exemption. *See Tandon*, 141 S. Ct. at 1296. Therefore, the mandate is not generally applicable. Moreover, the vaccine mandate does not give even a new enrollee (*e.g.*, a student who moves to the School District next year) who seeks accommodation on religious grounds the same amount of time to comply with the mandate as a "conditional enrollee" whose logistical difficulties entitle them to a thirty-day

deferral. This further establishes that the vaccine mandate is not generally applicable.[8]

Because the School District's mandate is not generally applicable, strict scrutiny applies. *See id.* Strict scrutiny requires that the mandate be narrowly tailored to serve a compelling interest. *Diocese of Brooklyn*, 141 S. Ct. at 67. The School District's mandate does not satisfy this standard. "Stemming the spread of COVID–19 is unquestionably a compelling interest." *Id.* But if "the government permits other activities to proceed with precautions, it must show that the religious exercise at issue is more dangerous than those activities even when the same precautions are applied." *Tandon*, 141 S. Ct. at 1297. "Otherwise, precautions that

[8] The majority argues that the School District's mandate and exemptions may soon be consistent with state law, because California may implement a COVID-19 vaccine mandate for schools in the "near future," and state law already requires immediate enrollment of conditional enrollees even if they have not received vaccines currently required by state law. Maj. at 10–11. Of course, speculation about a potential state mandate provides no support for the majority's position that the School District's existing mandate is constitutional. Among other things, the current proposal for a California COVID-19 vaccine mandate includes a personal beliefs exemption. Moreover, any future California COVID-19 vaccine mandate could be applied equally to conditional enrollees and students claiming religious exemptions because the California Education Code does not require the *in-person attendance* of unvaccinated conditional enrollees, who could immediately enroll and participate in online learning until they comply with the mandate.

suffice for other activities suffice for religious exercise too." *Id.* (citations omitted).

Here, the School District has not met its burden of showing that the "non-pharmaceutical interventions (*e.g.*, face coverings, regular asymptomatic testing)" that exempted students must follow do not "suffice for religious exercise too." *Id.* Additionally, the School District already accommodates teachers and staff who remain unvaccinated due to personal beliefs by allowing them access to the campus, which shows that the School District has determined that it can satisfy its safety interests while still allowing persons unvaccinated on religious grounds to access campus. Accordingly, the vaccine mandate is stricter than necessary to meet the School District's asserted goals, and therefore is not narrowly tailored. Finally, California's proposed mandate will allow a personal beliefs exemption, *see* Cal. Health & Safety Code §§ 120335(b)(11), 120338, which further suggests that the School District's mandate is stricter than necessary, *see Diocese of Brooklyn*, 141 S. Ct. at 67 (finding COVID restrictions not narrowly tailored where they were more restrictive than "other jurisdictions hard-hit by the pandemic").

Accordingly, I would conclude that, at a minimum, Doe has established that there are "serious questions going to the merits." *See Wild Rockies*, 632 F.3d at 1135.

B

Doe has also established irreparable injury because "the loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury." *Diocese of Brooklyn*, 141 S. Ct. at 67 (cleaned up). The majority argues that Doe fails to establish irreparable injury because Doe may exercise her religion by declining to receive the vaccination and forego attending in-person learning.[9] Maj. at 14–15. But "it is too late in the day to doubt that the liberties of religion and expression may be infringed by the denial of or placing of conditions upon a benefit or privilege." *Trinity Lutheran Church of Columbia, Inc. v. Comer*, 137 S. Ct. 2012, 2022 (2017) (cleaned up). Moreover, in arguing that Doe's case is unlike recent cases involving COVID-19 restrictions on church gatherings because the plaintiffs in those cases were "literally prevented from exercising their religion in group settings," Maj. at 14, the majority improperly prioritizes some acts of religious exercise over others. *Cf. Thomas v. Rev. Bd. of Indiana Emp. Sec. Div.*, 450 U.S. 707, 714 (1981) (explaining that the

[9] The majority suggests that the School District's remote-learning option is not inferior to in-person education. Maj. at 14. But if that were true, then *all* unvaccinated students should participate in remote learning. Otherwise, the School District's mandate would be severely underinclusive. *See Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 544 (1993) (finding government ordinance unconstitutionally underinclusive because it failed to prohibit secular activity that also undermined government's asserted interest).

"determination of what is a 'religious' belief or practice . . . is not to turn upon a judicial perception of the particular belief or practice in question; religious beliefs need not be acceptable, logical, consistent, or comprehensible to others in order to merit First Amendment protection.").[10]

Finally, the balance of hardships and public interest (which merge in this case, *see Drakes Bay*, 747 F.3d at 1092) tip sharply in Doe's favor. Courts "have consistently recognized the significant public interest in upholding First Amendment principles," *Associated Press v. Otter*, 682 F.3d 821, 826 (9th Cir. 2012) (cleaned up), and the School District cites no evidence that granting a student's motion for temporary relief on religious grounds "will harm the public,"

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[10] In arguing that Doe fails to establish a likelihood of irreparable harm, the majority faults Doe for proceeding anonymously. Maj. at 15. But the majority fails to note the compelling reasons for doing so. As Doe explained in her declaration:

> Standing up for my beliefs has already been an act of courage. I learned that one of the teachers at my school read a news article to the class about this case. In response, certain students at my school got angry and upset about what I am doing. They're so upset that they claim that they want to find out who I am and hurt me.

The majority also concludes that Doe's inability to obtain an athletic scholarship due to the School District's mandate is too speculative to constitute irreparable injury for the purposes of a preliminary injunction. Maj. at 15 n.7. This argument misses the point: Doe's irreparable injury is not her inability to obtain an athletic scholarship, but the loss of her First Amendment rights, which "unquestionably constitutes irreparable injury." *Diocese of Brooklyn*, 141 S. Ct. at 67 (cleaned up).

or that "public health would be imperiled if less restrictive measures were imposed," *Diocese of Brooklyn*, 141 S. Ct. at 68. To the contrary, the School District already offers campus access to some unvaccinated teachers and staff, and also to unvaccinated students if they comply with "non-pharmaceutical interventions (*e.g.*, face coverings, regular asymptomatic testing)."

Because Doe established that there are "serious questions going to the merits" and a likelihood of irreparable injury, and the balance of hardships and public interest tip sharply in her favor, we should grant Doe's motion for an injunction pending appeal. *See Wild Rockies*, 632 F.3d at 1135. I therefore dissent.

EXHIBIT 1-2

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

FILED

NOV 28 2021

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

JOHN DOE, an individual; et al., Plaintiffs-Appellants, v. SAN DIEGO UNIFIED SCHOOL DISTRICT; et al., Defendants-Appellees.	No. 21-56259 D.C. No. 3:21-cv-01809-CAB-LL Southern District of California, San Diego ORDER

Before: BERZON, IKUTA, and BENNETT, Circuit Judges.

Order by Judges BERZON and BENNETT, Partial Dissent by Judge IKUTA.

Appellants' opposed emergency motion for an injunction pending appeal (Docket Entry No. 5) is granted in part. *See Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). The injunction shall be in effect only while a "per se" deferral of vaccination is available to pregnant students under San Diego Unified School District's COVID-19 vaccination mandate. The injunction shall terminate upon removal of the "per se" deferral option for pregnant students.

The panel is issuing this order today in an abundance of caution because the plaintiffs have represented, without contradiction from the defendants, that tomorrow, November 29, 2021, is the last date on which students sixteen and over must obtain their first vaccination dose to avoid restriction to independent study

beginning in January 2022.

Written dispositions explaining the panel members' conclusions will follow shortly.

IKUTA, Circuit Judge, concurring in part and dissenting in part:

I concur in granting Doe's emergency motion for an injunction pending appeal. But I would keep the injunction in effect until the San Diego Unified School District ceases to treat any students (not just pregnant students) seeking relief from the vaccination mandate for secular reasons more favorably than students seeking relief for religious reasons, because any unvaccinated student attending in-person classes poses the same risk to the school district's interest in ensuring a safe school environment. *See Tandon v. Newsom*, 141 S. Ct. 1294, 1296 (2021) (holding that strict scrutiny applies when government regulations "treat any comparable secular activity more favorably than religious exercise," and that "[c]omparability is concerned with the risks various activities pose" to the government's interest) (citing *Roman Catholic Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63, 67–68 (2020)).

EXHIBIT 2

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

JOHN DOE et al., Plaintiffs, v. SAN DIEGO UNIFIED SCHOOL DISTRICT et al., Defendants.	Case No.: 21-CV-1809-CAB-LL **ORDER VACATING HEARING AND DENYING APPLICATION FOR TEMPORARY RESTRAINING ORDER** [Doc. No. 7]

This matter is before the Court on Plaintiffs' application for a temporary restraining order. The application has been fully briefed, and a hearing is currently on calendar for November 19, 2021. Upon review of the briefs, however, the Court deems the application suitable for submission without oral argument. Accordingly, the hearing is **VACATED**, and for the reasons set forth below, the application is **DENIED**.

I. Background

A. SDUSD's Vaccination Roadmap

On September 28, 2021, Defendant San Diego Unified School District ("SDUSD") adopted, via a document called a Vaccination Roadmap, a requirement that all students eligible for a fully FDA approved COVID-19 vaccine receive all required doses of that vaccine by December 20, 2021, to attend school in-person and participate in extra-

curricular activities. [Doc. No. 1 at 31-34.] At the time the Vaccination Roadmap was published, and currently, the only COVID-19 vaccine fully FDA approved for minors is the BioNTech-Pfizer vaccine, now marketed as "Comirnaty," which is full approved only for individuals age 16 and older. [Doc. No. 15-2 at 5.] Thus, the Vaccination Roadmap currently requires only students age 16 and over to be vaccinated by December 20, 2021. [*Id.* at 33-34.] The BioNTech-Pfizer vaccine consists of two injections 21 days apart, meaning that students age 16 and older must receive their first dose by November 29, 2021, to complete the two dose regimen by December 20, 2021, in compliance with the Vaccination Roadmap. [*Id.*]

The Vaccination Roadmap allows for medical exemptions to the vaccination requirement, and also allows foster youth, homeless, migrant, military family, and students with an Individualized Education Program ("IEP") to conditionally enroll, consistent with state law applicable to other immunizations required for students. *See, e.g.*, Cal. Educ. Code §§ 48204.7, 48850, 48852.7, 49069.5, 49701; Cal. Health & Safety Code § 120341. Contrary to Plaintiffs' arguments, the Vaccination Roadmap does not exempt these students from receiving a fully FDA approved COVID-19 vaccine. [Doc. No. 15-4 at 5, ¶ 6.] The Vaccination Roadmap does not provide for religious or personal belief exemptions to the COVID-19 vaccine requirement, just as the state does not provide for such exemptions to state-wide immunization requirements for ten other diseases as a precondition for admission to school. Cal. Health & Safety Code § 120325 *et seq.*

B. Plaintiffs' Free Exercise Claim

Plaintiff Jill Doe is a 16-year-old student in her junior year at Scripps Ranch High School in SDUSD. [Doc. No. 1 at ¶ 10.] She asserts that her religious beliefs preclude her from taking any of the available COVID-19 vaccines. [Doc. No. 7-4.] On October 22, 2021, she and her parents filed this lawsuit against SDUSD and the individual members of SDUSD's board claiming that the Vaccination Roadmap violates her rights under the Free Exercise Clause of the First Amendment to the Constitution. They also request leave to proceed pseudonymously for fear of harassment by SDUSD officials, teachers, or students.

[Doc. No. 1 at ¶ 45.] In the prayer for relief, Plaintiffs ask that the Vaccination Roadmap, facially and as applied to Jill Doe, be declared as violating the First Amendment, and seek preliminary and permanent injunctions preventing SDUSD from granting any exemptions to the Vaccination Roadmap "unless they give the exact same exemption to individuals who cannot get vaccinated for religious reasons." [*Id.* at 18.]

On November 1, 2021, Plaintiffs filed the ex parte application for a temporary restraining order ("TRO") and for leave to proceed pseudonymously that is currently before the Court. Pursuant to a briefing scheduled agreed upon by the parties, Defendants filed their opposition on November 8, 2021 [Doc. No. 15], and Plaintiffs filed a reply on November 12, 2021 [Doc. No. 18].

The briefing includes various declarations with exhibits from the parties and their experts. Each side also submitted objections to the other side's evidence [Doc. Nos. 15-5, 15-6, 18-1, 19], most of which are based on relevance. Because the Court is competent to determine whether evidence is relevant and to disregard any evidence that is not, all of the evidentiary objections are overruled.

II. Standing for Scope of Injunction Sought

Although Defendants do not address the issue, "standing is a threshold issue" and the Court must "consider whether [the plaintiff] has demonstrated standing for the form of relief that is sought." *Yazzie v. Hobbs*, 977 F.3d 964, 966 (9th Cir. 2020) (internal quotation marks, brackets and ellipses omitted) (citing *Davis v. Fed. Election Comm'n*, 554 U.S. 724, 734 (2008)). At the preliminary injunction stage, the plaintiff "'must make a clear showing of each element of standing,' proving (1) an injury in fact that is 'concrete and particularized' and 'actual or imminent'; (2) 'a causal connection between the injury and the conduct complained of'; and that (3) 'the injury will likely be redressed by a favorable decision.'" *Id.* (quoting *Townley v. Miller*, 722 F.3d 1128, 1133 (9th Cir. 2013)). "'[S]tanding is not dispensed in gross': A plaintiff's remedy must be tailored to redress the plaintiff's particular injury." *Gill v. Whitford*, 138 S.Ct. 1916, 1934 (2018) (quoting *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 354 (2006)).

Although Plaintiff Jill Doe satisfies the first two requirements, the injunction Plaintiffs[1] seek here is not tailored to redress the injury Plaintiffs claim they will suffer as a result of the Vaccination Roadmap. The Vaccination Roadmap requires Jill Doe to either get vaccinated for COVID-19, which she is unwilling to do based on her religious beliefs, or stop attending in-person classes and participating in extra-curricular activities. Thus, the injury to Jill Doe is her inability to attend in person classes and participate in extra-curricular activities. The injunction Plaintiffs seek, however, does not require Defendants to allow Jill Doe to continue attending in-person classes and participating in extra-curricular activities without being vaccinated for COVID-19. Instead, Plaintiffs ask for the following injunction:

> Defendants, their agents, employees, and successors in office, are restrained and enjoined from granting any exemptions to the Vaccination Roadmap for medical reasons, foster youth, homeless youth, migrant youth, students with an IEP, and members of military families, unless they give the exact same or a better exemption to Plaintiff Jill Doe, who cannot get vaccinated for religious reasons.

[Doc. No. 7 at 2.] Although Defendants could comply with this injunction by granting an exemption to Jill Doe, they could also comply while preventing Jill Doe from attending in-person classes and participating in extra-curricular activities unless she gets vaccinated for COVID-19. Specifically, if the Court enters this injunction, Defendants could comply by eliminating all exemptions or exceptions to the vaccination requirements in the Vaccination Roadmap, in which case Jill Doe will be in the same position she is now—unable to attend in-person classes and unable to participate in extra-curricular activities. Thus, any claim that this injunction will redress Jill Doe's injury is merely speculative. *Lujan v. Defs. of*

[1] It also bears noting that although the complaint purports to assert claims on behalf of Jill Doe as well as individual claims by each of her parents, the complaint only asserts one claim for violation of the Free Exercise clause of the First Amendment to the Constitution. It is unclear how the Vaccination Roadmap, which does not require the parents to receive a COVID-19 vaccine, implicates the parents' free exercise rights or how they have individual standing to contest its constitutionality.

Wildlife, 504 U.S. 555, 561 (1992) ("[I]t must be 'likely,' as opposed to merely 'speculative,' that the injury will be 'redressed by a favorable decision.'"). In sum, Plaintiffs do not make a clear showing that a favorable decision on the broad injunction they seek is likely to redress Jill Doe's injury.[2] Accordingly, the instant motion can be denied on this ground alone.

III. Discussion

Even if Plaintiffs have standing for the injunction they seek, or actually sought an injunction tailored to their alleged injury, their motion fails on its merits. The standards for a TRO and preliminary injunction are "substantially identical." *Stuhlbarg Int'l Sales Co. v. John D. Brush & Co.*, 240 F.3d 832, 839 n.7 (9th Cir. 2001). "A preliminary injunction is an extraordinary and drastic remedy, one that should not be granted unless the movant, *by a clear showing*, carries the burden of persuasion." *Fraihat v. U.S. Immigr. & Customs Enf't*, 16 F.4th 613, 635 (9th Cir. 2021) (internal quotation marks and citation omitted) (*emphasis* in original). "[The] purpose of a preliminary injunction ... is to preserve the status quo and the rights of the parties until a final judgment issues in the cause." *Ramos v. Wolf*, 975 F.3d 872, 887 (9th Cir. 2020) (quoting *U.S. Philips Corp. v. KBC Bank N.V.*, 590 F.3d 1091, 1094 (9th Cir. 2010)).

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[2] Relatedly, the TRO Plaintiffs seek is overbroad. Overbreadth, though not typically addressed in the caselaw as such, appears to be another way of saying that the plaintiffs lack standing for the breadth of injunctive relief sought. *See generally Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1140 (9th Cir. 2009) (noting that an overbroad injunction is an abuse of discretion and that the "district court abused its discretion in enjoining the rules themselves as opposed to enjoining their enforcement as to the plaintiffs before him who asserted religious objections . . ."); *Bresgal v. Brock*, 843 F.2d 1163, 1170 (9th Cir. 1987) ("Where relief can be structured on an individual basis, it must be narrowly tailored to remedy the specific harm shown."); *cf. Columbia Pictures Indus., Inc. v. Fung*, 710 F.3d 1020, 1049 (9th Cir. 2013) ("Injunctive relief should be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs' before the court.") (internal quotation marks and citation omitted). The fact that Plaintiffs seek a declaration that the Vaccination Roadmap is unconstitutional does not warrant a *preliminary* injunction that would preclude enforcement as to anyone other than Jill Doe. *See McCormack v. Hiedeman*, 694 F.3d 1004, 1020 (9th Cir. 2012) (holding that the fact that the plaintiff may ultimately be entitled to declaration that the statute in question is unconstitutional and thus unenforceable against anyone "does not mean that the *preliminary* injunction should apply so broadly, at least in the absence of class certification.") (*emphasis* in original).

"A plaintiff seeking a preliminary injunction must establish [1] that he is likely to succeed on the merits, [2] that he is likely to suffer irreparable harm in the absence of preliminary relief, [3] that the balance of equities tips in his favor, and [4] that an injunction is in the public interest." *City & Cty. of San Francisco v. U.S. Citizenship & Immigr. Servs.*, 944 F.3d 773, 788–89 (9th Cir. 2019) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008)). Defendants here focus their opposition on the first requirement (likelihood of success on the merits), which "is the most important" factor. *Disney Enter., Inc. v. VidAngel, Inc.*, 869 F.3d 848, 856 (9th Cir. 2017).

A. Likelihood of Success on the Merits

The complaint asserts one claim under 42 U.S.C. § 1983—that the Vaccination Roadmap violates the Free Exercise clause of the First Amendment to the United States Constitution. Although the COVID-19 vaccines are new, the argument that vaccine requirements generally, and requirements that children obtain vaccinations to attend school, violate free exercise rights is not, and courts have consistently rejected it. *Prince v. Massachusetts*, 321 U.S. 158, 166–67 (1944) ("The right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death."); *Phillips v. City of New York*, 775 F.3d 538, 543 (2d Cir. 2015) ("New York could constitutionally require that all children be vaccinated in order to attend public school."); *Workman v. Mingo Cty. Bd. of Educ.*, 419 F. App'x 348, 353–54 (4th Cir. 2011) ("In sum, following the reasoning of *Jacobson* [*v. Massachusetts*, 197 U.S. 11 (1905)] and *Prince*, we conclude that the West Virginia statute requiring vaccinations as a condition of admission to school does not unconstitutionally infringe [the plaintiff's] right to free exercise. This conclusion is buttressed by the opinions of numerous federal and state courts that have reached similar conclusions in comparable cases."); *Klaassen v. Trustees of Indiana Univ.*, No. 1:21-CV-238 DRL, 2021 WL 3073926, at *39 (N.D. Ind. July 18, 2021) ("[C]ourts have consistently held that schools that provided a religious exemption from mandatory vaccination requirements did so *above and beyond* that mandated by the Constitution.") (*emphasis* in original) (citing cases); *Whitlow v.*

California, 203 F. Supp. 3d 1079, 1084 (S.D. Cal. 2016) ("[I]t is clear that the Constitution does not require the provision of a religious exemption to vaccination requirements."); *McCarthy v. Boozman*, 212 F. Supp. 2d 945, 948 (W.D. Ark. 2002) ("It is also well settled that a state is not required to provide a religious exemption from its immunization program. The constitutional right to freely practice one's religion does not provide an exemption for parents seeking to avoid compulsory immunization for their school-aged children."). In light of the overwhelming weight of authority upholding vaccination requirements in response to free exercise challenges, the Court finds that Plaintiffs are not likely to succeed on the merits of their claim.

Indeed, in the conclusion to their reply [Doc. No. 18 at 14], Plaintiffs acknowledge that the weight of authority (both Supreme Court and otherwise) is against them, arguing that this Court should ignore these cases and instead base its decision on a guess that the Supreme Court may overrule this precedent. Although they do not say so outright, Plaintiffs ask the Court to disregard *Employment Division, Department of Human Resources of Oregon v. Smith*, 494 U.S. 872, 879 (1990), and any other cases that relied on *Smith* when upholding laws in the face of free exercise challenges. The Supreme Court, however, expressly declined to revisit *Smith* in *Fulton v. City of Philadelphia, Pennsylvania*, 141 S.Ct. 1868, 1876-77 (2021), and this court declines Plaintiffs' invitation to disregard *Smith* here.

In *Smith*, the Court stated that "the right of free exercise does not relieve an individual of the obligation to comply with a valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes)." *Smith*, 494 U.S. at 879 (internal quotation marks and citation omitted). "*Smith* held that laws incidentally burdening religion are ordinarily not subject to strict scrutiny under the Free Exercise Clause so long as they are neutral and generally applicable." *Fulton*, 141 S.Ct. at 1876. Thus, "a law that is neutral and of general applicability need not be justified by a compelling governmental interest even if the law has the incidental effect of burdening a particular religious practice." *Church of the Lukumi*

Babalu Aye, Inc. v. City of Hialeah, 508 U.S. 520, 531 (1993). Further, "nowhere in [*Smith*] does the Supreme Court state that if the government provides a secular exemption to a law or regulation that it must also provide a religious exemption. Indeed, a majority of the Circuit Courts of Appeal have 'refused to interpret *Smith* as standing for the proposition that a secular exemption automatically creates a claim for a religious exemption.'" *Whitlow*, 203 F.Supp. 3d at 1086 (quoting *Grace United Methodist Church v. City of Cheyenne*, 451 F.3d 643, 651 (10th Cir. 2006)).

Plaintiffs point to recent Supreme Court cases finding a likelihood of success on free exercise challenges to restrictions on gatherings intended to curtail the spread of COVID-19,[3] and to *Fulton*, as supporting their position that the Vaccination Roadmap is not neutral and generally applicable and therefore is subject to strict scrutiny. Yet, circuit courts have distinguished these cases, holding that COVID-19 vaccination requirements that include medical exemptions[4] but do not allow for religious exemptions are subject to rational basis review and that plaintiffs seeking preliminary injunctions do not have a likelihood of success on their free exercise challenges to those mandates. *See We The Patriots USA, Inc. v. Hochul*, No. 21-2179, 2021 WL 5121983, at *14 (2d Cir. Nov. 4, 2021) (noting that "an exemption is not individualized simply because it contains express exceptions for objectively defined categories of persons" and that a medical exemption to a COVID-19 vaccination requirement did not "'invite' the government to decide which reasons for not

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[3] In particular, Plaintiffs rely on *Tandon v. Newsom*, 141 S.Ct. 1294 (2021); *South Bay United Pentecostal Church v. Newsom*, 141 S.Ct. 716 (2021); and, *Roman Cath. Diocese of Brooklyn v. Cuomo*, 141 S.Ct. 63 (2020).

[4] Plaintiffs also point to the provisions for conditional enrollment of certain categories of students without proof of vaccination as further evidence that the Vaccination Roadmap is not neutral and generally applicable. However, that the Vaccination Roadmap accommodates the unique circumstances of some students by giving them additional time to comply with the vaccine requirement does not mean that Defendants must allow others to avoid the vaccination requirement entirely to preserve the general applicability of the plan. *See generally Stormans, Inc.*, 586 F.3d at 1135 ("That the pharmacy regulations recognize some exceptions cannot mean that the Board has to grant all other requests for exemption to preserve the 'general applicability" of the regulations.'").

complying with the policy are worthy of solicitude.") (quoting *Fulton*, 141 S. Ct. at 1879); *Does 1-6 v. Mills,* 16 F.4th 20, 31 (1st Cir. 2021) ("The medical exemption is meaningfully different from exemptions to other COVID-19-related restrictions that the Supreme Court has considered. In those cases, the Supreme Court addressed whether a state could prohibit religious gatherings while allowing secular activities involving everyday commerce and entertainment and it concluded that those activities posed a similar risk to physical health (by risking spread of the virus) as the prohibited religious activities.") (citing *Tandon*, 141 S.Ct. at 1297, *Roman Cath. Diocese of Brooklyn*, 141 S.Ct. at 66-68, and *S. Bay Pentecostal Church*, 141 S.Ct. at 717); *cf. Klaassen*, 2021 WL 3073926, at *24 (noting "the consistent use of rational basis review to assess mandatory vaccination measures."). Like these other cases, the Court finds that the Vaccination Roadmap is subject only to rational basis review. Further, the Roadmap easily passes that test as "a reasonable exercise of the State's power to enact rules to protect the public health." *We the Patriots*, 2021 WL 5121983, at *15.

In sum, "State Legislatures have a long history of requiring children to be vaccinated as a condition to school enrollment, and for as many years, both state and federal courts have upheld those requirements against constitutional challenge. History, in itself, does not compel the result in this case, but the case law makes clear that States may impose mandatory vaccination requirements without providing for religious or conscientious objections." *Whitlow*, 203 F. Supp. 3d at 1092. The mere possibility that the Supreme Court could hold that these cases were decided incorrectly is insufficient for this Court to find that Plaintiffs have a likelihood of success on their free exercise claim here.

B. Irreparable Harm

Because Plaintiffs fail to demonstrate a likelihood of success on the merits, "the court need not consider the other factors" required for a preliminary injunction. *Disney Enter.,* 869 F.3d at 856. For completeness, however, the Court also finds that Plaintiffs do not establish irreparable harm as required for the issuance of a TRO.

Plaintiffs point out that "[t]he loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury." *Roman Cath. Diocese of*

Brooklyn, 141 S.Ct. at 67 (quoting *Elrod v. Burns*, 427 U.S. 347, 373, (1976) (plurality opinion)). Plaintiffs also quote another case involving COVID-19 capacity restrictions on religious services for the proposition that "[r]eligious adherents are not required to establish irreparable harm independent of showing a Free Exercise Clause violation." *Agudath Israel of Am. v. Cuomo*, 983 F.3d 620, 636 (2d Cir. 2020). Plaintiffs make no other argument as to how a failure to issue a TRO here will constitute irreparable harm to Jill Doe (or her parents).

The flaw in Plaintiffs' argument is that unlike either of these New York cases, where the restrictions in question, if not enjoined, would preclude people from attending religious services, failure to issue a TRO here will not cause Jill Doe to lose her right to free exercise of her religion. She asserts that taking any of the available COVID-19 vaccines would violate her religious beliefs. The Vaccination Roadmap, however, does not require her to take a COVID-19 vaccine; it just precludes her from attending in-person classes or participating in extra-curricular activities if she is not vaccinated. Thus, the harm Jill Doe will suffer if a TRO does not issue is not, like the plaintiffs in *Roman Catholic Diocese of Brooklyn* and *Agudath Israel of America*, the loss of a First Amendment freedom, but rather the ability to attend in-person classes or participate in extra-curricular activities at her current public high school. Because Plaintiffs make no effort to demonstrate how this harm would be irreparable in the absence of the injunction they seek here, they have not satisfied this requirement for the issuance of a TRO.

IV. Request to Appear Pseudonymously

Within the same application for a TRO, Plaintiffs ask for permission to proceed using pseudonyms. The Court finds this issue more suitable for a separate motion than for inclusion in a TRO application. Further, the Court is not persuaded that Plaintiffs have overcome the presumption that parties must use their real names in litigation.[5]

[5] *See Doe v. Kamehameha Sch./Bernice Pauahi Bishop Est.*, 596 F.3d 1036, 1042 (9th Cir. 2010) ("To determine whether to allow a party to proceed anonymously when the opposing party has objected, a

Nevertheless, in light of the instant ruling and Plaintiffs' professed intention to file an immediate appeal, the Court will temporarily permit Plaintiffs to proceed anonymously. The Court will revisit this permission if and when this case returns after Plaintiffs' appeal, and it is without prejudice to Defendants filing a motion seeking to require Plaintiffs to reveal their real names.

V. Conclusion

For the foregoing reasons, the Court finds that Plaintiffs lack standing for the injunction they seek in the instant application, and that they have not established a likelihood of success on the merits or that they will suffer irreparable harm if the Court does not issue a TRO. Accordingly, Plaintiffs' application for a TRO is **DENIED**. For the same reasons, an injunction pending any appeal of this ruling is not warranted.

It is **SO ORDERED**.

Dated: November 18, 2021

Hon. Cathy Ann Bencivengo
United States District Judge

district court must balance five factors: '(1) the severity of the threatened harm, (2) the reasonableness of the anonymous party's fears, ... (3) the anonymous party's vulnerability to such retaliation,' (4) the prejudice to the opposing party, and (5) the public interest.") (quoting *Does I Thru XXIII v. Advanced Textile Corp.*, 214 F.3d 1058, 1069 (9th Cir.2000)).

EXHIBIT 3-1

San Diego Unified School District
Board of Education Meeting
September 28, 2021

(Part 1)

PRESIDENT RICHARD BARRERA: Okay. And with that, we will move on to Item H3, and this is the plan for vaccine mandates. And we'll turn it over to Superintendent

INTERIM SUPERINTENDENT LAMONT JACKSON: Thank you, President Barrera. And just for, you know, the sake of reminder, you know, throughout this pandemic, we as a school district, we have focused on the health and safety of our students and our staff in our community.

We had a commitment to doing this following the health guidelines and the science. And when this first happened, you know, we -- as we continued to maintain a focus on equity and access, and focusing on teaching and learning, we made a huge move to ensure our community was healthy and safe. And what we did is we closed our schools, and that was a big decision by us. And we led the way for others to do the same.

And we also led the way by reopening our schools in a phased approach during the 2021 school year. And again, we partnered with our professionals at UCSD. We worked with Dr. Taras and Barndollar, and we committed to following the

health and safety guidelines.

We invested millions of dollars in mitigation and monitoring to ensure the health and safety of our staff and our students, and we returned our students. In partnership with our labor groups, we launched one of the largest testing approaches, vaccine initiatives. Our contact tracing was launched as well as ensuring masking for all.

And so we have maintained this focus, and we have not wavered from that. And you know, I want to -- I want to remind us that the beacon along the way has been working in partnership with our health professionals and (indiscernible).

So when I was asked to bring a plan by our board officers, of course the answer was yes because we -- I knew that we as a collective board and a collective district, we are going to do the right thing by our children, following the science. And there is a great debate, and as Trustee Beiser said, we're going to engage in a discussion.

And so the purpose of us bringing a plan was to create the foundation for a

discussion, not to set something in stone but to let the Board trustees know that we have a way forward, should they decide to move forward with mandating a vaccine for staff and students, both as a condition of employment and also being onsite learning.

We will remain committed to teaching and learning whether students are onsite or virtually. We committed to that, and we opened our virtual academy, so that is not going to change.

My hope is that we as a community can come together, and I continue to say we because this is a collective community effort to focus on our children, to focus on our staff, and to focus on the health and safety of our great community.

And so we may not always agree, but we can have healthy discourse and hear folks. And so I want the greater community to know that I have received e-mails. I've read those e-mails. I've shared those sentiments with the -- with staff. And we will come together looking at science, looking at data to make the best decision for our students, and our staff, and our community.

And as the super -- interim superintendent, that is my commitment, and that is our Board's commitment, and so I open this discussion with welcoming staff who will present the plan that we were able to put together so that it can launch the Board's discussion this evening with the community.

So I'm going to turn it over to Dr. Taras who will begin the presentation with staff. Thank you, Dr. Taras.

DR. HOWARD TARAS: Yes. My pleasure. Thank you.

And before leaders of the school district administration explain the program they are proposing to the Board of Education, as a consultant to the school district, I'm going to speak a little bit about the medical public health benefits of having a very large portion of students and staff vaccinated for COVID.

And essentially, this is really all about education. Vaccinated students are far more likely to remain in school all day and every day for several reasons. They are exponentially less likely to become infected and positive for COVID, so they won't be going home for isolation

for 10 days.

Vaccinated students also will not be going home for quarantine whenever a close-by classmate, bus mate, or teammate is found to be COVID positive.

And having vaccinated school population would almost eliminate the chances of school outbreaks and classroom closures.

A high proportion of vaccinated school populations also allow our principals, our school nurses, and mostly our teachers to stop focusing on COVID testing programs and focusing on contact tracing.

You know, currently, at any one of our schools, dozens and dozens of hours of these staff members' time are spent every week on administering or implementing testing and contact tracing plans. And with vaccinated school populations, all these hours will be refocused back to children's education and to other aspects of their wellbeing.

So if you turn to the slide that says "The Science," which I think is Number 3, I write that, you know, vaccines are really only fully approved by the FDA once an extremely high level

of confidence exists that the effectiveness and the benefits of that vaccine clearly outweigh the known or potential risks.

Two, vaccines are really the most preventative of all the strategies. Unlike masking, ventilation, and testing -- which are extremely important -- vaccination protects the students before the virus is ever even introduced into the setting, thereby reducing disease and new mutations. It protects unvaccinated family members and other adults who have and haven't been vaccinated who -- people that are in that child's life.

You know, school-age children get sick and do contribute to new infections even though their rate of sickness is very low compared to adults, but they are the greatest proportion of unvaccinated people in the U.S. right now, and more children have been hospitalized recently than in any previous time during the epidemic.

And when you think about variants, a virus is really most likely to mutate when replicating, which happens with each new infection in a population, so unvaccinated children do contribute to new variants, although

I think a lot of that contribution comes from even other countries. We also in this country contribute to that.

I have a few other slides that is -- are going to be difficult to read, but they are quotes from various epidemiologists and infectious disease specialists. I rely on a lot of the expertise of these specialists when you think about, you know, maximizing the number of people that are vaccinated, and I ask them this question. Would you or would you not support a vaccine mandate for students who are doing in-school education? And their responses -- and you can read them later. They're on public record -- were, you know, uniformly pro such a mandate.

Now, there were two additional infectious disease experts that didn't get their comments into me in time to make it into these slides, but both of them approved of the vaccine mandate, but they had some additional comments as well, so -- they're not on the public record yet, so I'll just mention what those things are.

Dr. Pong of UCSD Pediatric Infectious Diseases, she felt that immunization mandates would ultimately lead to better school

attendance, reducing a lot of the mental health issues that occur when students are being stuck at home. And interestingly, she also felt that the mandate should not be enforced until there was full FDA approval and consulting body approval.

The other doctor that didn't make it into the slides was Dr. Bradley, also from Infectious Diseases at UCSD, Pediatric Infectious Disease Department, who felt that emergency use approval should be considered by the Board as a criteria because elementary school children may actually not receive full approval for this vaccine until October 2022, if things look good.

Now, as I understand it, the proposal you're going to hear today from the school administration to be presented to the Board of Education is to recommend but not to mandate vaccines when they become available for any age group when they are under emergency use authorization, but they will, I believe, wait until there is full FDA approval before actually requiring the vaccine.

I'm going to stop talking now because I would like to introduce another expert. His name

is Dr. Richard Pan, who like me is a pediatrician, but very unlike me, you may recognize him as a California state senator. And Dr. Pan has extensive knowledge about the importance of vaccines in public health.

So Dr. Pan, if you connected, please (indiscernible).

DR. RICHARD PAN: Thank you, Dr. Taras. I really appreciate your presentation. And also, I want to thank the members of the Board of Trustees for your consideration of this very important policy.

I'm Dr. Richard Pan. I'm a pediatrician and also a California state senator. I chair the Senate committee on health, and I've been working to stop this COVID pandemic for more than a year now here in California.

I really appreciate all the efforts of people of San Diego, and also particularly this school board to try to mitigate the disease. I really appreciate that you have stepped up in terms of masking requirements, being sure that we have a safe environment in the school.

And fundamentally, you know this better than I, that your main duty is to be sure we get

kids educated. That's a -- they have a constitutional right to be educated. And also to keep children safe in school.

I think as Dr. Taras said, what we need to do is be sure we have a safe school environment so that the kids can stay in school and get educated. And a vaccine mandate or requirement for being in school is very important to being able to achieve that goal.

Every time there is an outbreak or an exposure, there are students who basically won't be able to attend school, may have to be sent home for quarantine if they're not vaccinated because they become a risk to other students, and there are students who -- they have preexisting conditions or other issues that make them particularly more vulnerable to getting very sick or even dying from this disease.

There is a myth out there that children are not affected by COVID, and we know that's not true. Right. Over 500 children have died of COVID in the United States. We see, as Dr. Taras said, hospitalizations rising. We're not even talking about things like long COVID, inflammation, inflammatory disease that's

happened afterwards, other types of injury that can happen as a result of COVID.

So what's really important is that we have a safe environment so that parents feel safe sending their kids to school, right? Otherwise, if parents are afraid to send their kids to school, they're not going to -- you're going to have challenge with education.

When the kids are at school, that we're not disrupting their education, that we're going to be sure that the kids are going to be safe, that they can stay in school. And that's something I know that the vast majority of parents want, right? They want -- they want that for their children. They want their children to be safe. They want their children to be at school. They want their children to be able to stay at school.

That's what this policy really is about. That's really what vaccine requirements have been about. We passed the first vaccine requirements in California I think back in the '60s, right, because people recognized that.

We have a new virus here. It's called COVID. It's called coronavirus. It causes

COVID-19. Let's keep our children safe. Let's be sure we have policies in place that prevent them from getting this disease, prevent the disease from spreading in the school, and let's try to --

We have a safe and effective vaccine that's already been, you know, administered to hundreds of millions of people in the United States around the world. Yes, we need to be sure that it's fully evaluated in children. That's -- I think you have a very prudent policy here, but let's go ahead and when that has been approved, be sure that the kids who are going to school have been vaccinated so that they can participate safely and that they can fully engage in the education that you're providing them.

So again, thank you so very much for this opportunity to talk to all of you. And again, really appreciate your leadership in ensuring that the children at San Diego Unified School District have a safe environment and get educated as the right -- as is their right under the California constitution.

Thank you.

PRESIDENT RICHARD BARRERA: Thank you

so much, Dr. Pan, for joining us tonight and for your comments. Thank you so much.

Superintendent Jackson, sorry. I'll turn it back over.

INTERIM SUPERINTENDENT LAMONT JACKSON: We'll continue with the slide presentation if we can get that back up. Next slide, please. And one more slide. Two more. Sorry. Thank you. Okay.

ACACIA THEDE: Let's go back one slide.

INTERIM SUPERINTENDENT LAMONT JACKSON: One slide. There we go.

ACACIA THEDE: There we go. Thank you so much.

INTERIM SUPERINTENDENT LAMONT JACKSON: Thank you, Ms. Thede.

ACACIA THEDE: All right. Thank you, Dr. Jackson. Thank you, Dr. Taras and Dr. Pan.

In the same manner that the vaccine ensures students don't miss school, the vaccine ensures that our employees are able to teach, transport, counsel, guide, mentor, support, and feed our students.

For this reason, we're recommended the district hire employees, partners, contractors,

and other adults who work directly with students and district employees on district property with students to be fully vaccinated on or before December 20th of this year. We recommend this mandate be a condition of employment and a requirement for contracted services. Next slide, please.

We've been working with our employees (indiscernible) to ensure that they have access to the vaccine. Due to these efforts, you'll see that we have more than 40 percent -- or I'm sorry. Excuse me -- 80 percent of our employees have at least the first dose, and 76 percent of our employees are full vaccinated.

The health and safety of our students and staff remain paramount. You can see from this snapshot last week that COVID continues to impact our employees. Mandating the vaccine ensures our students and staff remain in our schools. Next slide, please.

This recommendation to mandate vaccines for employees provides approximately 98 days from today with a peak immunity deadline of January 4th, 2022. This is a reasonable timeline for the remaining 24 percent of our employees to obtain

the vaccine and to reach peak immunity.

We used a similar timeline as we launch the vaccine rollout in March of this year. Therefore, we believe this timeline, which is longer, is much -- is very reasonable. And what you see in this timeline, if the Board approves, tomorrow we would notify employees of the mandate.

The first -- the latest date that employees could start with the first dose would be by November 22nd for the Moderna, and Pfizer would be on November 29th. By December 30th, the second dose should be administered, which would allow our employees to reach peak immunity by then. Next slide, please.

In order to ensure the remaining approximate 24 percent of our employees are able to obtain the vaccine, we will provide the following supports to -- in support of our employees. These include allowing employees to use up to two hours of personal business to be vaccinated during their workday, be allowed time if there is a vaccination reaction, be allowed to take up to two hours of their workday to take a dependent minor to be vaccinated. Reason being

we know that many of our employees have children in our schools, and we want our children to be safe, so we're going to allow that time.

We'll also ensure that we are following federal law in regards to accommodation processes. As we have shared, the health and safety of our students is paramount. Therefore, we are recommending -- can you all hear me? I just got an unstable -- let me say that again. So I'll start it again.

As we've shared, the health and safety of our student is paramount. Therefore, we're recommending vaccines be mandated as a condition of employment. As a condition of employment, the district may take disciplinary action up to and including termination for employees who do not comply with (indiscernible).

With that, as you've heard the staff's recommendation for our employees, I'll turn next to our executive director of nursing and wellness, Susan Barndollar, who will share our recommendations (indiscernible) to students.

SUSAN BARNDOLLAR: Thank you, Acacia. Good evening, everyone. Next slide, please.

The district's recommendation for

vaccines for students is a staggered approach to have all eligible students vaccinated against COVID-19 as a condition of attending in-person learning. The timeline for requiring the mandated vaccination will be aligned to full FDA approval of that age group.

To clarify, only full FDA approval has been granted to Pfizer vaccine for children and adults age 16 and older. For students age 12 to 16, Pfizer COVID vaccine is authorized for use and recommended, but it's only been granted emergency use authorization. So we wanted you to be aware of the differences.

Qualified exemptions and conditional admissions will be considered, and more information around the staggered approach and the exemptions will be on the next few slides.

Mandatory testing will be required for all unvaccinated students in specific timelines as well. Next slide, please.

This slide mirrors for students what Acacia had presented around our staff. From the San Diego County Immunization Registry measured on September 14th, of our students age 12 and over, 64.6 percent of students have received at

least one dose of Pfizer COVID vaccine with 57.2 percent of that same age group receiving both doses and are therefore fully vaccinated.

Since the information was published, we received data on our students age 16 and over. In the district, we have approximately 14,360 students who are age 16 and older. Of those students, 61.9 percent are partially vaccinated, and 56.2 percent are fully vaccinated. These numbers are very close to our data on the screen but for 16 and over are slightly lower overall.

A sample of our current student impact regarding COVID infection is reflected in our PowerSchool data in the box on the right. this is a snapshot of just one day. This data was taken from PowerSchool on Wednesday, September 22nd. As of that day, 1,352 students were currently impacted across 73 schools. 67 students isolating at home because they had a positive COVID test. 272 students in quarantine at home because they -- these students are unvaccinated and were a close contact to a positive person. 122 six -- 126 students on a modified quarantine. A modified quarantine is when unvaccinated students are close contacts

from an exposure at school and are allowed to come to school as long as they test twice a week, and only go to school and not experience -- do not interact in extracurricular activities.

Please note that vaccinated students do not have to quarantine when exposed.

Also on this screen, 887 students were absent due to COVID-19 symptoms. Next screen, please.

This table reflects our vaccination and testing roadmap for students. We will only mandate vaccines as they are issued with full FDA approval. For Stage 1, because the vaccine already has full FDA approval for this age group, we will implement a vaccine mandate for all students age 16 and older. At the same time, we will also implement a mandatory testing schedule for unvaccinated students in the same school.

The cadence of the testing will be based on the guidance in tandem with the current COVID conditions. The stages of the testing mandate will follow the grade levels of the vaccine mandate. For example, if Stage 1 is implemented, all unvaccinated students attending in-person high schools will also have a mandatory

testing schedule. Next slide, please.

This slide presents the timeline for the first stage for students. For Stage 1, for students 16 and older, they will be mandated to have full vaccine immunity by January 4th. To achieve this immunity by January 4th, the first dose of vaccine would have to be administered by November 29th or sooner so that the second dose can be admitted by December 20th. Remember, it's two weeks after the second dose that full immunity is achieved.

If you look at the end of the timeline, after the deadline of January 4th, all eligible unvaccinated students would then need to move from onsite learning at the start of the second semester, January 21st. Next slide, please.

For Stages 2 and 3, the timeline would fall in the same consistent frame with dates to allow our students time to get vaccinated and for peak immunity to be achieved. The district will plan this timeline around regular intervals with an appropriate time for transition.

Once FDA approval -- full FDA approval is achieved for a different age group, we will then notify families, and then create a timeline

with an acceptable window with which to get vaccinated. Again, at the end of the window, any non-vaccinated students would need to change to an independent study program. Next slide, please.

We recommend approving the district's staggered approach to have all eligible students vaccinated against COVID-19 pending full FDA approval, and students who are eligible for the vaccine and not vaccinated by established deadlines be required to participate in an independent study program.

Specifically regarding students, as vaccine clinics are available at school sites, all vaccine clinics will require parental consent for all students under the age of 18. Students will be afforded the opportunity for medical exemptions similar to any other mandated vaccine. State law does not recognize religious or personal belief exemptions for student immunizations.

When enrolling, students may be conditionally admitted without evidence of COVID vaccine for in-person learning if they are in one of the following groups: foster youth, homeless,

migrant, military family, or have an IEP.

Regarding extracurricular actives, students who are in a mandatory vaccine age group who are not vaccinated will not be permitted to participate unless the student is below the age range of the FDA's full approval or has an exemption.

To give a little more explanation around this medical exemption, I'd like to pass the floor over to Dr. Taras. After his explanation, he'll then pass it back to Acacia for a few final words.

DR. HOWARD TARAS: Oh, sure. Yeah. I just wanted to explain that the definition of medical exemption is that it should come from a California-licensed MD or California-licensed DO, doctor of osteopathy, nurse practitioner, or physician assistant.

Any medical exemption to be considered must also include a medical rationale, and also be accompanied by a parent-signed consent for the school health team to call and clarify about medical exemption rationale with the medical practitioner, even though in only some of those cases will such clarification be necessary.

So go ahead, Acacia.

ACACIA THEDE: All right. Thank you, Howard. Thank you, Susan. Upon Board approval -- oh, I'm sorry. Excuse me. Go ahead, Mr. Jackson, with the next slide.

Upon Board approval, staff will implement the following next steps. We will develop the full implementation plan. We'll also develop a frequently asked questions resource for employees as well as students.

We'll conduct communication and outreach for our employees and their families and (indiscernible). We'll also conduct any required impacts and effects targeting within our union, and we will continue our legislative advocacy on the importance (indiscernible). Next slide, please.

At this time, we're asking the Board to take action on the plan proposed. To require district employees, partners, contractors, and other adults who will work directly with students (indiscernible) employees on district property to be fully vaccine on or before December 20th, 2021. This mandate would be a condition of employment, and a requirement for contracted

services.

We also ask that the Board approve a staggered approach to have all eligible students vaccinated against COVID-19 as a condition of attending in-person learning. The timeline for requiring the mandated vaccine will be aligned to the full FDA approval. Mandatory testing will be required for all unvaccinated students until full FDA approval of the vaccine, or (indiscernible).

We thank you for your time, and we will end the formal presentation, and I'll return it back to you, Board President Barrera.

PRESIDENT RICHARD BARRERA: Thank you so much, Acacia. And thank you, everybody who helped put this personation together.

Okay. So we have -- obviously many speakers who have signed up for public comment.

(Part 2)

PRESIDENT RICHARD BARRERA: Okay. So again, thank you so much for everybody who spoke tonight. We're sorry if your comments got cut off. We certainly welcome you submitting your comments in writing. We also thank everybody who was unable to speak tonight. Your names will be entered into the official record, and of course

we also welcome your comments in writing. And thank you to the Board for extending our time tonight.

Okay. We have a staff recommendation. In order to kick off Board discussion, can we have a motion and a second on staff recommendation?

VICE PRESIDENT SHARON WHITEHURST-PAYNE: (Indiscernible) motion.

PRESIDENT RICHARD BARRERA: Okay. I see moved by Vice President Whitehurst-Payne, seconded by Trustee Bazzo. Okay. We'll open it up to Board discussion and questions now. Who wants to go first? Trustee McQuary. Yes. Thank you.

TRUSTEE MICHAEL MCQUARY: Yeah. I'd like to have some more information about the comments that were made about special ed and in terms of the IEPs, and what corrections if -- or mitigations would be necessary to meet those particular mandates.

PRESIDENT RICHARD BARRERA: Who's best to answer that question, Superintendent?

INTERIM SUPERINTENDENT LAMONT JACKSON: Let's go -- I'm going to go with Susan.

PRESIDENT RICHARD BARRERA: Okay.

SUSAN BARNDOLLAR: So for all other state-mandated vaccines, there is a process by which students with IEPs go through that's more extensive than students who don't have IEPs. And so we would continue to go through that process with any other mandated vaccine, even though -- if it was mandated from the district.

Dr. Taras, do you want to add anything to that?

DR. HOWARD TARAS: Right. I mean, the way that it was explained to me is that for all other previous mandated vaccines by the state, we still have to meet students' IEP requirements.

Now, not all of them require that that student be in school, so if a student is just getting speech therapy, for example, the legislative intent of a vaccine mandate for all these other vaccines has been that they can't come to school for their speech therapy, and they still have to be home because they're not vaccinated for everything else.

It's only when the rest of the school day is integrated into their entire IEP that the vaccine mandate that applies to being in school

full time. That's how I understand it.

TRUSTEE MICHAEL MCQUARY: Okay. Thank you. That helps. The other group that came up had to do with foster children and homeless. What mitigations are there being made for them?

SUSAN BARNDOLLAR: So those populations of students, the intention around that is a longer period of time for them to get their vaccine and get their vaccine records.

So we recognize that with those groups, there's frequent moving. There may be records that are lost or maybe records that haven't arrived in town yet. And so we give them a conditional entrance, and we give them an extra 30 days to get those records, to get what they need so that they can start to get caught up on their immunizations if they need to, or be able to get their records.

PRESIDENT RICHARD BARRERA: Thank you, Dr. McQuary. Thank you, Susan and Howard.

Other Board questions or comments? Vice President Whitehurst-Payne?

VICE PRESIDENT SHARON WHITEHURST-PAYNE: Earlier, I mentioned that I was at Clark on -- yesterday. And I believe Dr. Jackson has some

photos of that and some information on that. I decided to talk to them. I was -- they wanted to know who I was and what we do, and I gave them an example of this upcoming issue. And these were seventh-grade students. They weighed in on what they thought about vaccines and how we should go about dealing with this.

I think overall this is something that the student just before -- I think it was the next-to-the-last person who commented on how he feels about vaccinations, and how he'd like to move forward with us supporting them so that they can get back to their normal lives. And overall, I think all of us have heard a lot of things.

Thank you, Dr. Jackson, you can -- you may take it down.

That class was very interested in this and, as I said, this was a middle school class. The children are not unaware of what's going on. They want to be in school. They recognize that this is -- this is something that we need to embrace. The majority of them believe that we need to embrace it. Granted, this was not a scientific study or anything, but it was an indication of how children are feeling, and it

would be interesting to know how most of them are feeling.

Personally and the way I plan to build on this is I support it because, number one, people are saying that we haven't had enough cases. When you've had this number of people vaccinated with the outcome versus those who are unvaccinated, and those are the numbers that folks really need to look it. I think we have an obligation to try to keep kids safe and society safe.

I said at the last meeting that I personally donate monies to the Rotary's polio effort, which is an international effort to vaccinate people all over the world against polio because that's the only way you're going to have a common good for international health, and I believe at one point we had gotten it down to just three countries: Pakistan, Afghanistan, and India. I'm not sure where we are with that now, but that was our goal, to eradicate polio in all the countries and everywhere. And I feel the same way about this.

The last comment I would make concerning this is someone pointed out that the

children were unaware that they had been vaccinated all the time for things they didn't know about measles, rubella, and all the other things, but it's a common part of health that we've been practicing for years, so I don't think we can just say, "Well, we haven't had 100 years to study this." The fact of the matter is that back then, we had Model T cars when some of these things happened. Now we have computers, so we can move faster to do things than we could then because of modern technology.

So I support it, and I am going to vote for this. This business about money, I don't really know whose money, the money that the pharmaceutical companies are getting, that's something you should take up with the federal government that offers us this -- the funding of it.

But for us personally, I don't know anybody who's putting any money in our pockets to vote a certain way. It's about healthcare, safety, looking out for people, ensuring that we can get back to some normality here. So that's the way I vote.

PRESIDENT RICHARD BARRERA: Thank you,

Vice President Whitehurst-Payne.

Trustee Patterson?

TRUSTEE ZACHARY PATTERSON: Thank you, Board President Barrera.

Well, I don't know if I've shared this with all of you before, but I am immunocompromised. I have a disease called dermatomyositis. Three in every 1 million teenagers have it, and it's a disease that I have to take weekly shots for. I take a medication called methotrexate, and I take this in order to make sure that my red blood cells don't attack my blood vessels because if that happens and if I were to stop taking my medication, well, then I would get calcium buildups that would likely debilitate me, stop me from being able to walk, and -- at worst case -- affect my larynx and my ability to talk.

So I do this because I want to stay healthy and because I can, despite being -- as you all know, I can live a full life. I can be happy. I can grow old, and I'm super fortunate to have the technology to do that.

And when I think about where we are today and I think about why we produce vaccines,

we produce vaccines to stop a virus. We're producing the coronavirus vaccine in the end so we can get to a point to where this virus does not affect us as human beings, and that has always been the purpose, and that always will be the purpose of what we do.

And I hear the concern of so many, but what I would say is when we see the public overwhelmingly moving in the direction of getting vaccinated, and we see -- especially when we look at our own elected leaders -- republican, democrat, and everything in between -- actually getting vaccinated themselves, getting their kids vaccinated, and we point at that. They care about their children. Everyone does. I know my mom cares deeply about me, and my health, and my success. Both of my parents do, and they're not going to do anything to put me in danger.

But when I look at an organization like the Centers for Disease Control, and when I look at the FDA, and when I think about the work that has gone in to getting this vaccine to approval and emergency authorization, I know that I can trust that because it's been tested thousands of times. We have millions of people that have used

it, and we are doing this because we know it works, and because we know that it is making an impact.

And when I look at our schools, I do want to remind us of something. We currently -- in our current state with students being vaccinated, we see that the reason we have our virus spreading is because of unvaccinated people that are spreading it and causing these breakthrough infections, and it is so important to understand that if we had a 95, 96, 97 percent vaccination rate, we would not see these issues nearly as much.

And that leads me to a question I wanted to ask Dr. Taras to get a better understanding. So FDA emergency authorization is already a very high level of testing and understanding. Do we have any clear evidence to support the danger for vaccination for students age 12 to 15 under the current emergency authorization?

DR. HOWARD TARAS: No, not really. But I think the reason that they don't approve of it and that they do use emergency use authorization as another level of approval is because you are

not going to find the very rare problems if you only have 4,000 or 5,000 people who have received it, and 4,000 or 5,000 controls. If something occurs one in 10,000 or, you know, you're not going to find that. And sometimes even if it's one in 4,000 or 5,000, you won't find it because it just didn't happen to happen in that group.

So -- and that is the reason why, at least in this country, there are those two levels of --

TRUSTEE ZACHARY PATTERSON: I guess I just checked, so I believe it's around 7,400,000 people ages -- in the United States -- ages 12 to 15 that have gotten the coronavirus vaccination, and with all those people -- so I can -- am I able to say with confidence that the FDA has looked at this vaccine enough to where we can say it is safe to take? Is that a fair -- is that a fair thing to say?

DR. HOWARD TARAS: Yeah. I think it is, excepting that they have to analyze that data now, right? It has to be compiled and studied, make sure it's corrected, and take out the errors, and look for the natural number of times that a certain abnormal finding occurs without a

vaccine, and compare that to how often they're seeing it with the vaccine, et cetera.

And that's why I think it's going to take a little while before we jump to the 12- to 15-year-olds getting the full approval, not because there haven't been enough children of that age group who have been vaccinated but because the analysis (indiscernible).

TRUSTEE ZACHARY PATTERSON: Okay. So I guess we do have the analysis taking time, but we see how effective it is.

And I do just want to provide something for all of you all to think about. So the average student in 11th grade is 16, and the average age of a student in 12th grade is 17. The average age of a seventh grader is 12, so per our current proposal, we propose that students 16 and up are vaccinated. This means that at maximum, half of students in high school would have a vaccination requirement.

Vaccinations at 12 and up per the policies of Los Angeles Unified, Oakland, Hayward, Culver City, and what we've seen in over 7 million people taking that would mean that seventh grade, eighth grade, ninth grade, 10th

grade, 11th grade, and 12th grade would see that, a little bit less than half of our student population.

And we're making a big decision tonight, but I think it's important that we make sure that this decision is really effective. We have an opportunity to make sure students 12 and up are vaccinated, and we want to ensure the security of our high schools, and we can do that for the entirety of high school and for part of middle school. But knowing that we see the safety in this vaccine, and we see the millions of students that have taken it in the United States and abroad, significantly larger as well, we do see the safety in this.

And with that, I want to -- I want to propose that we consider looking to align ourselves with what we've seen our other school districts doing across the state. And I would -- I would move to consider having the vaccination be for age -- ages 12 and above per the emergency authorization, as we've seen in other school districts, and I would move to amend to do that, and I'd like to hear discussion on that.

PRESIDENT RICHARD BARRERA: Okay.

Thank you, Trustee Patterson. So Trustee Patterson is proposing an amendment to the motion which would make students 12 and up come under the vaccine requirement prior to full FDA approval of the vaccine for that age group. Is -- I guess what I need to ask the maker of the motion, which I believe is Vice President Whitehurst-Payne, will you accept this as a friendly amendment?

TRUSTEE MICHAEL MCQUARY: President Barrera?

PRESIDENT RICHARD BARRERA: Yes.

TRUSTEE MICHAEL MCQUARY: What I'll do for the sake of discussion, I'll second the amendment so that we can -- so that we can discuss the amendment separate from the main motion.

PRESIDENT RICHARD BARRERA: Okay. So we've got a proposal and a second on the amendment to the original motion. Any Board questions or comments on Trustee Patterson's proposed amendment?

I would ask Andra to give us some perspective from a legal side on this question of waiting for full FDA approval for people over 12.

Do we have a screen available? I don't think so.

GENERAL COUNSEL ANDRA GREENE: You have me. Here I am.

PRESIDENT RICHARD BARRERA: Okay.

GENERAL COUNSEL ANDRA GREENE: It took a minute to unmute me. Sorry about that.

PRESIDENT RICHARD BARRERA: That's okay.

GENERAL COUNSEL ANDRA GREENE: That's something I think we should think about and revisit before we make that decision. It's not something I would advise we do at the moment.

PRESIDENT RICHARD BARRERA: Okay. Okay. Any other thoughts or comments on the proposed amendment?

TRUSTEE MICHAEL MCQUARY: I would -- brief comment, and maybe we could have Zachary expand on his rationale a little bit more is that we have clear direction on FDA on moving forward with the motion as is, and I think the amendment may increase the risk higher than maybe we can -- we can accept.

PRESIDENT RICHARD BARRERA: Let me -- let me -- I'll make a comment. So I think that the rationale that Trustee Patterson has laid out

is compelling, and I think that the -- I think what we're hearing from Dr. Taras is we're not sure when we would see full FDA approval for people 12 and above. And in fact, we heard sort of -- Dr. Taras gave us kind of the two different perspectives from the folks from the UCSD panel who weighed in after the presentation went live, one encouraging us to move along with FDA approval, the other for us to consider moving under emergency use authorization. And I think that second comment also referred to when we get to the point that the emergency use authorization is available to students under 12.

So I think the -- I think what we're weighing here is the clear benefits if we were to say the reasonable or prudent approach of moving forward with FDA approval, giving us more security is maybe the right way to put it -- more security about the safety of the vaccines, and that's what Dr. Taras just went through.

But we're weighing that against the likelihood that the vaccine requirement may not then go into effect for a large percentage of our students, even at the point that those students are allowed access to the vaccine, as obviously

students over 12 already are. So I think it's a -- I think it's an important question for us to consider.

I guess my feeling about the proposal tonight, the proposed amendment tonight, is that we should come back to it. So I will not support the proposed amendment tonight. However, I do want us to check in at our -- one of our meetings in October and then certainly at our first meeting in November. Get a sense of what we're seeing in terms of the percentage of students 12 and above who are getting the vaccine.

And also maybe if we have a little bit more sense by that point about how close we may be to FDA approval. So I don't think we should shut off our ability to come back and include students in the vaccine requirement even before we get FDA approval. I don't think we should shut that option off. I just wouldn't move towards that option tonight is my opinion.

Vice President Whitehurst-Payne?

VICE PRESIDENT SHARON WHITEHURST-PAYNE: Thank you for that clarity because I think most of us took the vaccinations ourselves before it was fully approved, and we were in the

experimental phase of it. And some of us were back as far as January taking the shot. So I don't think we should force people to rush before the FDA has finally -- and CDC have finally approved moving forward tonight.

And I think that we are taking a big step by just going forward with letting folks know that we are serious about it, enough to make this decision, which is very controversial as we've listened to all these -- all the testimony and also all the write-ups that have come, e-mails by the thousands.

So I don't want to change the motion myself.

PRESIDENT RICHARD BARRERA: Okay. Yes, Trustee Bazzo.

TRUSTEE SABRINA BAZZO: Yeah. I would agree with both Trustee Barrera and Trustee Whitehurst-Payne in that right now -- I mean, the science is strong and I see where Trustee Patterson is coming from, but I think we're continuing to collect that data, specifically for the younger audience, and I wouldn't want to put at risk what we have on the table right now.

And I think the tiered approach is --

would be, I guess, more effective in terms of -- with our community right now than being too extreme and, as you mentioned, rushing in to anything. So I think I'd prefer to stay with the motion as it is.

PRESIDENT RICHARD BARRERA: Yes, Trustee Patterson?

TRUSTEE ZACHARY PATTERSON: Yeah. I completely am respectful of your opinions and I completely understand where you are coming from in saying that.

I will say from a health perspective and from a safety perspective, I feel like I have seen compelling evidence to support this vaccination, and I think a lot of us would agree with that. And I also think that seeing other school districts moving in this direction with 12, being those of the other school districts are largest L.A., looking at Oakland, looking at Culver City, and seeing that. I do understand, however, why you all don't feel comfortable quite yet.

And what I would say with that in mind, seeing that I don't see general support for this, I would be willing to consider tabling this

motion for a period of time to be defined, let's say one month.

Could we consider moving -- I'm not sure what the formal procedure, if you could help me with this. But I'd be willing to table this motion for one month to bring it up at our -- I guess our last meeting of October in order to discuss this more -- or in order to discuss this again if we see that we haven't received FDA authorization, and we want to look at that again.

PRESIDENT RICHARD BARRERA: Yeah. I think we can absolutely do that, Trustee Patterson.

Trustee McQuary, as the second, are you comfortable with tabling the motion?

TRUSTEE MICHAEL MCQUARY: I agree.

PRESIDENT RICHARD BARRERA: Okay. So I -- but I think what Trustee Patterson and Trustee McQuary are saying is they do want to bring this motion back for discussion at the second meeting in October, and so we should be -- we should be prepared for that.

Vice President Whitehurst-Payne?

VICE PRESIDENT SHARON WHITEHURST-PAYNE: There's another factor, which we don't know how

the state's going to weigh in on this, or other entities, or even whether or not CDC is -- I mean, there are some other factors.

I think tonight we're making a statement that we believe in the science, we believe in the process, and that we are serious about this, that we want to protect children. And this is a first step. As we gain more information, we modify. We change things. We update. That's what science does.

So down the road, I think it's appropriate to take a look at what he's requesting, but for tonight, I want to stick with what we have.

PRESIDENT RICHARD BARRERA: Okay. Great. So I think we're going to table Trustee Patterson's motion to the second meeting in October, so which brings us back to the original motion, which is to accept the staff recommendation.

Do we have -- yes. Trustee Bazzo.

TRUSTEE SABRINA BAZZO: So I'd like to just speak on the original motion. I will be also voting in favor of this mandate this evening, and I think it'll probably one of -- be

one of the most important votes I have on school board, frankly, you know, impact -- some of the greatest impact.

And I'm a public health educator. I've been one for 25 years in San Diego. I got my master's degree at San Diego State, and I work closely with public health, you know, leaders, family physicians from not only across San Diego, but these are also leaders at our county level, at our state level, at our national level, some of whom you've heard from tonight.

I just want to also thank the San Diego County Medical Society as well as the other physicians that have weighed in, and just share that these are people, as we know, that have dedicated their lives to the treatment of their patients in healthcare, and in no way are they making any kind of profit off of this.

In fact, it's very frustrating to me because a lot of these are the physicians that are on the frontlines. They're the ones that are putting their health in danger to help those, including those who are not vaccinated. So if anything, it's actually the opposite. They're putting their lives in danger to, you know, care

for their patients.

Also, I just had Dr. Taras about a month ago speak at a family physician conference with over 240 doctors on this very issue. And without fail, everyone I've spoken to, every single physician I've spoken to, is very much in favor of this manage.

But more than that, I also want to share that as a parent, the thing I always try to go back to is that what would I do if I was a parent right now? I mean, I am a parent, but both my daughters have graduated. But I can't imagine the anxiety and what it must feel like sending your, say, third grader to school every day, and you don't know that that teacher is vaccinated, or you don't know that that person at the front desk is vaccinated, or, you know, the school bus driver. And how that must feel.

And so for me, it comes down to that -- to a personal, you know, perspective that, you know, these parents that are putting their kids' lives in danger for what? For no reason. There's a vaccination. It's called public health because this is a public health epidemic and, you know, we need to do the right thing now, tonight.

And I think we're all pretty much on that same page.

And also, I wanted to share my daughter, who's 21 years old, a college -- she goes to school in Colorado. She had COVID. She had long-term symptoms. You know, it took her a long time. She's 21, and she's completely healthy, and she suffered from COVID. And my 85-year-old mother had COVID. My daughter who's 21 had worse symptoms than my 85-year-old mother. So just because kids are young doesn't mean they don't suffer. You know, they may not go to the hospital, but they're suffering all the same.

So again, I feel that it's the right thing to do. I thank all of you for this discussion. I think it's the responsibility to stand up for our community and choose this option.

And again, I'm going to be voting in favor of the mandate for all those reasons. Thank you.

PRESIDENT RICHARD BARRERA: Thank you, Trustee Bazzo.

Okay. I will also support the motion and the staff recommendation tonight. I very

much want to thank Superintendent Jackson for pulling together a thoughtful plan to roll this out. I know there's so many things that the staff has to -- has to think about as we move this plan forward.

But I know that first and foremost, you're guided by Howard, and Susan, and our team from UCSD whose focus is on health and safety. And when we ask Howard and Susan, and when Howard has asked our UCSD panel, is this the right thing to do from a health and safety perceptive for our students and for our staff, the answer is unanimously yes.

And as Superintendent Jackson mentioned at the beginning, every decision that we've made since the beginning of the pandemic has first been about, from a health and safety preceptive, what's the right thing to do? So I think it -- I think it could not be clearer that this is the right move for us to take tonight.

I will say that the issue that concerns me the most about moving forward is the communication that we have primarily with our parents -- our staff as well, but primarily with our parents. We just do not want to get to a

point that parents have not yet given us consent or given us proof of vaccination, not because they're opposed to vaccinations but because they may not be aware yet of the requirement, or they may not know where to go to get their students vaccinated, or they may have questions, you know, that have come up tonight about is this really safe? What's the -- you know, on balance what's the right course for us to take?

So that level of communication with our families, it will be absolutely critical as we move forward. We do not want to have at the end of -- you know, moving this policy forward, we do not want to have students who are not coming to school, not because their parents made a clear choice to choose not to have them vaccinated but because the parents didn't get the right information at the right time. So that effort I know is first and foremost in the superintendent's mind as well, and that's all about communication, and it's all about education.

But with that and with the confidence that we have in our staff to move forward and to implement this policy successfully, I'll call for

the vote, and we'll begin with Trustee Patterson.

TRUSTEE ZACHARY PATTERSON: Aye.

PRESIDENT RICHARD BARRERA: Thank you. Trustee Bazzo?

TRUSTEE SABRINA BAZZO: Aye.

PRESIDENT RICHARD BARRERA: Trustee Beiser?

TRUSTEE KEVIN BEISER: Aye.

PRESIDENT RICHARD BARRERA: Trustee McQuary?

TRUSTEE MICHAEL MCQUARY: Aye.

PRESIDENT RICHARD BARRERA: Vice President Whitehurst-Payne?

VICE PRESIDENT SHARON WHITEHURST-PAYNE: Aye.

PRESIDENT RICHARD BARRERA: And Barrera, aye. Okay. Thank you.

Okay. Last on the agenda tonight, non-agenda public comment.

C E R T I F I C A T I O N

I, Sonya Ledanski Hyde, certify that the foregoing transcript is a true and accurate record of the proceedings.

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Date: November 5, 2021

EXHIBIT 3-2

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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

JOHN DOE, an individual, et al.,,

Plaintiffs,

v.

SAN DIEGO UNIFIED SCHOOL DISTRICT, et al.,,

Defendants.

Case No.: 3:21-cv-01809-CAB (LL)

DECLARATION OF SUSAN BARNDOLLAR IN OPPOSITION TO PLAINTIFFS' EX PARTE APPLICATION FOR TEMPORARY RESTRAINING ORDER AND ORDER TO SHOW CAUSE RE: PRELIMINARY INJUNCTION; AND FOR LEAVE TO PROCEED PSEUDONYMOUSLY

Judge: Hon. Cathy Ann Bencivengo
Courtroom: 15A

Date: November 19, 2021
Time: 2:00 p.m.

Complaint Filed: October 22, 2021
Trial Date: None

I, Susan Barndollar, declare as follows:

1. I am employed by the San Diego Unified School District ("District") as its Executive Director, Nursing & Wellness. I have held this position since October, 2020, and have been employed by the District in positions related to student health and wellness since 2001. I am a Registered Nurse licensed by the California Board of Registered Nursing. I also possess a Masters in Nursing, and am certified as a Family Nurse Practitioner. I also possess a School Nurse Services Credential and an Administrative Services Credential from the California Commission on Teacher Credentialing. My duties including planning, organizing, managing, and directing the District's Nursing and Wellness programs, reviewing, developing, implementing, and communicating District-wide policies and procedures to ensure compliance including with student vaccine mandates, implementing best practices for student health and wellness, advising the Superintendent and Board of Education of unusual trends or problems and recommending appropriate corrective action, and acting as a liaison with community agencies and social service organizations and institutions to ensure supports that provide students access to school.

2. Since the onset of the COVID-19 pandemic, I have been working with Dr. Howard Taras, a pediatrician who serves as the District's Consulting Physician, and with a panel of public health experts at the University of California, San Diego ("UCSD Expert Panel"), regarding measures to protect the health and safety of District students and staff, of their families, and of the San Diego community.

3. On September 28, 2021 I recommended, along with Dr. Taras, the UCSD Expert Panel, and State Senator Dr. Richard Pan, a licensed pediatrician, that the Board of Education adopt a Vaccination Roadmap that includes a student vaccination mandate. Dr. Taras and I reviewed the feedback sought from the UCSD expert panel as well as information from the CDC and FDA to evaluate at what age group the COVID-19 had been fully authorized. Based on my professional training and experience in San Diego in general and in the District in particular, and my

interaction and consultation with Dr. Taras and the UCSD Expert Panel, it was and is my opinion that adopting a student vaccine mandate is necessary to enhance the health and safety of District students and staff, of their families, and of the San Diego community.

4. Since the Board of Education adopted the Vaccination Roadmap on September 28, 2021, I have led the process of implementing the student vaccine mandate, including but not limited to the process for students to seek and, where documented as necessary for the health and safety of an individual student, obtain a medical exemption from the mandate. California law prohibits a school district from "unconditionally admitting" a child who has not been vaccinated against ten (10) enumerated diseases, unless the child obtains a medical exemption, and California law contains specific objective requirements for students to obtain a medical exemption to promote the health and safety of those students, an important consideration consistent with the goal of promoting the health and safety of students. For the District student vaccine mandate, we have implemented those specific requirements, which are reflected in the Request for Medical Exemption/Pregnancy Deferral for COVID-19 Vaccine form attached to this declaration as **Exhibit A**. Specifically, consistent with and similar to the requirements of the California Health and Safety Code, the Medical Exemption/Pregnancy Deferral for COVID-19 Vaccine forms requires the following information:

a. The name, California medical license number, business address, and telephone number of the physician and surgeon who issued the medical exemption, and of the primary care physician of the child, if different from the physician and surgeon who issued the medical exemption. The form must be completed by a Doctor of Medicine (M.D.) or a Doctor of Osteopathic Medicine (M.O.).

b. If the issuing physician and surgeon is not the child's primary care physician, an explanation as to why the issuing physician and not the primary care physician is filling out the medical exemption form.

c. The name of the child for whom the exemption is sought, the name and address of the child's parent or guardian, and the name and address of the child's school or other institution.

d. A certification that the student has one or more of specifically-identified the contraindications or precautions recognized by the Centers for Disease Control (CDC) or vaccine manufacturer.

e. A description of the medical basis for the contraindication identified.

f. Whether the medical exemption is permanent or temporary, including the date upon which a temporary medical exemption will expire, which shall not exceed 12 months.

g. Authorization from the parent/guardian of the child for the health care provider issuing the medical certification and District Nursing and Wellness Staff to confer with each other and to disclose medical records of the child, including evaluation, diagnosis, and treatment of the child to the Enforcement Programs of the Medical Board of California/Osteopathic Medical Board of California, for their official use.

5. After a Medical Exemption/Pregnancy Deferral for COVID-19 Vaccine request is submitted to my Department, and as is reflected in Part 3 of the Request form, a registered nurse in the District's Immunization Program, and Dr. Taras, will review the Request to determine whether it provides the information required for approval. If a Request does not contain the necessary information to qualify for a medical exemption, i.e. "the exemption request form was not complete and/or the reason provided did not meet applicable Centers for Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices (ACIP), and American

Academy of Pediatrics (AAP) criteria or the standard of medical care," the Request will be denied and the student will be enrolled in independent study unless they are vaccinated. If the Request is complete, and the reason provided meets applicable CDC, ACIP, and AAP criteria or the standard of medical care, it will be approved.

6. California and federal law also recognize that certain categories of students are in circumstances where it might be difficult to access medical records or obtain access to mandated vaccinations, and for those student groups (e.g. homeless students, foster youth, students in military families) the law calls for "conditional enrollment" of those students. The District's student vaccine mandate recognizes and applies these legal provisions for these students. Importantly, "conditional enrollment" is not an exemption from vaccine mandates. Rather, it provides a period of thirty (30) days for the student to get vaccine shots or obtain their records evidencing that mandatory vaccines have been administered. Also, in the District's student vaccine mandate, "conditional enrollment" is available only to students enrolling in the District for the first time after the mandate takes effect — it does not give additional time or waive the vaccine timeline for any currently-enrolled students.

7. District compliance with the federal Individuals With Disabilities Education Act (IDEA) and Americans With Disabilities Act (ADA) also requires the District to provide a free and appropriate public education (FAPE), which requires review on a case-by-case basis the circumstances of each student with one or more identified disabilities and implement an Individual Education Program (IEP) agreed-upon with the student's parent/guardian (or dictated through administrative litigation). Once an IEP is in place, the District is mandated by federal law to implement that IEP, and cannot unilaterally change it without following due process protections afforded to students. During that process a "stay put" mandate dictates that the student's current IEP remain in place. It is for this reason that the Vaccination Roadmap referenced students with IEP, noting that

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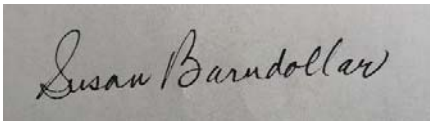
compliance with IDEA and ADA does not authorize an immediate vaccination deadline as a condition of a student with disabilities accessing the services required by their IEP.

8. As specified in the District's Board of Education-adopted Local Control Accountability Plan ("LCAP"), the District is the second largest school district in California, educating approximately 97,675 students in 176 educational facilities — 120 elementary schools, including K-8, 23 middle schools, 24 high schools, 2 atypical schools, and 7 additional educational program sites.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 8th day of November, 2021, at San Diego, California.



Susan Barndollar, RN, MN, FNP

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EXHIBIT A

San Diego Unified SCHOOL DISTRICT

Request for Medical Exemption/Pregnancy Deferral for COVID-19 Vaccine

Part 1: To be completed by Parent/Guardian

Student Information

Last Name:	First Name:	DOB:
School Name:	Student ID:	Current Grade:

Parent/Guardian Information

Last Name:	First Name:	Relationship:		
Mailing Address:	City:	State:	Zip:	
Phone: ( )	Email:			

Terms of Agreement: By signing below, you agree to all terms listed.

Attestation: The information submitted in this form is true, accurate, and complete

Authorization: I hereby authorize the health care provider issuing the medical exemption and San Diego Unified School District's Nursing and Wellness Staff to confer with each other and to disclose medical records, including evaluation, diagnosis, and treatment of my child to the Enforcement Programs of the Medical Board of California/Osteopathic Medical Board of California, for their official use.

- This authorization shall remain valid for four years from the date of issuance and cannot be revoked before then
- A copy of this authorization shall be valid as the original
- I understand that I have a right to receive a copy of this authorization by printing this form or if otherwise requested by me.
- I understand that I have the right to decline this authorization, and that by doing so, a medical exemption will not be issued.

Parent/Guardian Signature: _____ Date:_____

If any part of this form is incomplete or crossed off, the exemption will not be approved

Page 1: Parent/Guardian **Page 2:** California Licensed MD/DO **Page 3:** San Diego Unified School District

Request for Medical Exemption/Pregnancy Deferral for COVID-19 Vaccine

Part 2: To be completed by California licensed MD/ DO

Patient's Last Name:	First Name:	DOB:

Issuing Physician Information:

Last Name: First Name: License Type ☐MD ☐DO

Phone Number: Fax Number: License Number:

Address: City: Zip:

Primary Care Provider: ☐ Same as issuing provider
☐ Last Name: First Name:
Reason not issued by primary care provider:

MEDICAL EXEMPTION:

I certify that the above named student has one or more of the contraindications or precautions recognized by the CDC or vaccine manufacturer insert (check appropriate box and complete description below)

☐ **Severe allergic reaction** (one that needs to be treated with epinephrine or EpiPen or with medical care) after receiving first dose of COVID-19 vaccine

☐ **Immediate allergic reaction** (reaction within 4 hours of exposure, including symptoms such as hives, swelling, or wheezing/respiratory distress) even if it was not severe, after receiving the first dose of COVID-19 vaccine or to any ingredient in the COVID-19 vaccine *(nucleoside-modified messenger RNA (mRNA) encoding the viral spike (S) glycoprotein of SARS-CoV-2: lipids (4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2-(polyethylene glycol 2000)-N,N-ditetradecylacetamide, 1,2-distearoyl-sn-glycero-3-phosphocholine, cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, sucrose)*

Description of contraindication meeting criteria checked above: _____
_____

This exemption is:

☐ Permanent [valid only until COVID-19 vaccine is added to CAIR-ME, or end of grade span, whichever comes first]
☐ Temporary until _____ (not to exceed 12 calendar months)

PREGNANCY DEFERRAL – student/parent/guardian may request deferral of COVID-19 vaccine due to pregnancy.

COVID-19 vaccination is recommended during pregnancy due to the increased risk of severe COVID-19 during pregnancy, and increase risk of preterm birth and other adverse pregnancy outcomes.
Proof of vaccination or medical exemption is required to return to school after delivery.
☐ I certify that the patient listed above is currently pregnant. Estimated Due Date: _____

Physician Signature: _____ Date Issued: _____

San Diego Unified SCHOOL DISTRICT

Approval/Denial: Request for Medical Exemption/Pregnancy Deferral for COVID-19 Vaccine

Part 3: To be completed by San Diego Unified Nursing & Wellness Staff

Student Name: DOB: ID:

On _____, we received your request for a medical exemption/pregnancy deferral for the COVID-19 vaccination requirement specified in San Diego Unified's COVID-19 Immunization Process.

Based on the information provided, your request for exemption has been:

☐ APPROVED, subject to the requirement that your student complies with the **Non-Pharmaceutical Interventions** specified below.
No medical exemption is permanent and all are subject to review with changes in Public Health and legal requirements. This approval is valid until the earliest of:

- When COVID-19 vaccine is added to the California Immunization Registry – Medical Exemptions,
- The end date specified by the physician,
- The end of the grade span as defined by the State of California,
- The end of the pregnancy, or
- Changes in Public Health Department or legal requirements at which time, you will need to provide a new Medical Exemption or proof of vaccination.

☐ DENIED, because the exemption request form was not complete and/or the reason provided did not meet applicable Centers for Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices (ACIP), and American Academy of Pediatrics (AAP) criteria or the standard of medical care.

You have until _____ (10 school days from the denial date below) to submit proof that your student has received the first dose of COVID-19 vaccine; you then have 30 school days to submit proof of the second dose of COVID-19 vaccine. If these deadlines are not met, your student will be required to participate in an online instruction program and will not be permitted to participate in extracurricular activities.

Your student must comply with the **Non-Pharmaceutical Interventions** (e.g., face coverings, regular asymptomatic testing) for unvaccinated or not fully vaccinated individuals as a condition of your student's physical presence at any San Diego Unified School District location, facility, or program. These required Non-Pharmaceutical Interventions are defined by San Diego Unified School District, the Public Health Department, environmental health and safety, or infection prevention authorities.

_____ Date: _____
SDUSD Nursing & Wellness staff

EXHIBIT 3-3

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Attorneys for Defendants

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

JOHN DOE, an individual, et al.,,

Plaintiffs,

v.

SAN DIEGO UNIFIED SCHOOL DISTRICT, et al.,,

Defendants.

Case No.: 3:21-cv-01809-CAB (LL)

DECLARATION OF DR. HOWARD TARAS IN OPPOSITION TO PLAINTIFFS' EX PARTE APPLICATION FOR TEMPORARY RESTRAINING ORDER AND ORDER TO SHOW CAUSE RE: PRELIMINARY INJUNCTION; AND FOR LEAVE TO PROCEED PSEUDONYMOUSLY

Judge: Hon. Cathy Ann Bencivengo
Courtroom: 15A

Date: November 19, 2021
Time: 2:00 p.m.

Complaint Filed: October 22, 2021
Trial Date: None

I, Howard Taras, MD, FAAP, declare as follows:

Background and Experience

1. I am a pediatrician, actively licensed by the Medical Board of the State of California and am certified as a pediatrician by the American Board of Pediatrics. I am employed by the University of California-San Diego ("UCSD") and am on the faculty of the UCSD School of Medicine, Department of Pediatrics, and the Division of Child and Community Health.

2. My professional training includes: Medical Degree from McMaster University (graduated 1982); Pediatric Residency Training at University of Toronto, Hospital for Sick Children (1985); and Fellowship Training in General Academic/Community Pediatrics; University of California-San Diego (1987).

3. My roles at UCSD have been: general pediatric practice, manuscript reviewer for 18 scientific journals, co-chief editor of a national school health publication, director of several public health outreach programs (sub-contracted by San Diego County Health and Human Services Agency), and over 35 years of experience providing consultation to school districts. I have over 100 professional publications, primarily in peer-reviewed journals. I once chaired and am still an active member of the American Academy of Pediatrics Council on School Health, as well as other national and international professional school health bodies. (A true and correct copy of my curriculum vitae is attached as **Exhibit A**.)

4. My current professional role includes advising school districts, county offices of education, private schools and charter schools that seek physician services from UCSD School of Medicine, and teaching school health to medical trainees and pediatric residents. I currently provide medical consultation services to school districts in several counties in Northern California, and to multiple districts in Riverside, San Bernardino, Los Angeles, Orange, and Imperial counties. In San Diego County, I consult currently to over 25 schools/districts and am the UCSD contracted physician for San Diego Unified School District ("SDUSD" or

"District"). This is an advisory role on medical policy, children with special health care needs, and school health programs. I have extensive experience of how to bridge up-to-date medical practices with K-12 educational settings. It is in my capacity as SDUSD's physician that I am authoring this Declaration.

SDUSD's Mandated Vaccine Policy

5. In September 2021, I was asked by the SDUSD Superintendent and School Board President to advise the School Board on the health risk/benefit of mandating vaccinations for students.

6. A panel of UCSD experts in COVID-19 ("Expert Panel") had already been formed in July 2020, in conjunction with and cooperation of Chancellor Pradeep Khosla, of UCSD. This Expert Panel has been assisting me with infectious disease, epidemiological, pediatric, atmospheric chemistry and public health expertise throughout the COVID-19 pandemic. Various members of the Expert Panel assisted me in preparing reports for the District's Board in August 2020 (**Exhibit B**), February 2021 (**Exhibit C**), May 2021 (**Exhibit D**), and August 2021 (**Exhibit E**). The entire Expert Panel is listed below, and all members with the exception of Dr. Prather, the atmospheric chemist, consulted with me on the issue of a student vaccine mandate in SDUSD:

a. John Bradley, MD; Pediatric Infectious Disease, UCSD and Rady Children's Hospital. (A true and correct copy of Dr. Bradley's curriculum vitae, from the UCSD website, is attached as **Exhibit F**.)

b. Kimberley Brouwer PhD; Wertheim School of Public Health & Human Longevity Science. (A true and correct copy of Dr. Brouwer's curriculum vitae, from the UCSD website, is attached as **Exhibit G**.)

c. Richard Garfein, PhD; MPH, Div of Infectious Disease & Global Public Health. (A true and correct copy of Dr. Garfein's curriculum vitae, from the UCSD website, is attached as **Exhibit H**.)

d. Natasha Martin, DPhil/PhD; Division of Infectious Diseases and Global Health, UCSD. (A true and correct copy of Dr. Martin's curriculum vitae, from the UCSD website, is attached as **Exhibit I**.)

e. Alice Pong, MD; Pediatric Infectious Diseases, UCSD and Rady Children's Hospital. (A true and correct copy of Dr. Pong's curriculum vitae, from the UCSD website, is attached as **Exhibit J**.)

f. Kimberly Prather, PhD; Scripps Institute of Oceanography, Atmospheric Chemistry, UCSD. (A true and correct copy of Dr. Prather's curriculum vitae, from the UCSD website, is attached as **Exhibit K**.)

g. Mark Sawyer, MD; Division of Infectious Diseases; UCSD Pediatrics, and Member of FDA Advisory Committee. (A true and correct copy of Dr. Sawyer's curriculum vitae, from the UCSD website, is attached as **Exhibit L**.)

h. Robert Schooley, MD; Department of Medicine; Global Public Health. (A true and correct copy of Dr. Schooley's curriculum vitae, from the UCSD website, is attached as **Exhibit M**.)

i. Davey Smith, MD, MAS; Chief, Division of Infectious Diseases & Global Public Health. (A true and correct copy of Dr. Smith's curriculum vitae, from the UCSD website, is attached as **Exhibit N**.)

j. Stephen Spector, MD; Division of Infectious Diseases; UCSD Pediatrics. (A true and correct copy of Dr. Spector's curriculum vitae, from the UCSD website, is attached as **Exhibit O**.)

7. This Expert Panel collected uniformly positive statements in favor of the vaccine mandate overall, with some enthusiasm for even giving the vaccine before full approval by the Food and Drug Administration ("FDA"), and some trepidation for a vaccine that had not received full FDA approval. (A true and correct copy of these statements are attached as **Exhibit P**.)

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8. The BioNTech-Pfizer COVID-19 vaccine, now marketed as "Comirnaty," is the only vaccine considered both effective and safe for children ages 16 years and over. It is a 2 shot series to be given 21 days apart. This vaccine received FDA approval on August 23, 2021 for individuals 16 years of age and older. Vaccines that have only received Emergency Use Authorization (currently that is BioNTech-Pfizer COVID-19 vaccine for those younger than 16 years of age) are not covered by the District's mandate for students. The vaccine is mandated only for those students who reach the age of 16 years by November 1, 2021. Newly eligible students who turn 16 years of age after this date will not be required to be vaccinated until the start of the new school year.

9. There were questions from the public to District on the efficacy and safety of the Pfizer vaccine. To answer these, a "Frequently Asked Questions" document was prepared for the District's website. Members of the Expert Panel assisted me to address and answer these questions. A true and correct copy of these questions and answers are attached as **Exhibit Q**, and many of these same points are addressed explicitly elsewhere in this Declaration as they were brought up in the Declarations of Drs. Richard Scott French and Jayanta Bhattacharya.

10. Clinical trials show that COVID-19 vaccines are safe and effective in people with underlying medical conditions, including those that place them at increased risk for severe COVID-19 symptoms, compared to people without underlying medical conditions. A COVID-19 vaccine cannot make you sick with COVID-19. Both these assertions have been published online by the Centers for Disease Control and Prevention ("CDC"). These assertions can be found at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/underlying-conditions.html. (A true and correct copy of this CDC publication is attached as **Exhibit R**.)

11. The safety and effectiveness of the Pfizer vaccine for individuals over the age of 16 has been established by the FDA, the CDC and their advisory

committees. (A true and correct copy of the Summary Basis for Regulatory Action for this vaccine is attached as **Exhibit S**.)

Declarations of Drs. Richard Scott French and Jayanta Bhattacharya

12. There are many misconceptions and there is much misinformation about the District's vaccine mandate, the safety of the vaccine and the value of vaccinating large cohorts of youth. Most of these are echoed by Dr. Richard Scott French and Dr. Jayanta Bhattacharya in each of their Declarations, which I have thoroughly reviewed prior to preparing this declaration.

13. The most significant problem with these two Declarations is that the authors "cherry-pick" only those research articles that meet the purpose of doubting the effectiveness and safety of the vaccine. They do not provide a fair, comprehensive literature review, weighing the favorable and unfavorable elements of a vaccine and then come to their conclusion. Had they done so, the health benefits of increasing vaccine penetration into our youth's population would have been the only obvious conclusion. One could potentially reason that I, arguing in favor of the health benefits of a vaccine mandate, am doing the same – ignoring all the research that negates the health benefits of the vaccine. However, this is not the case. There is arguably only one group of scientists in the United States who gather all the credible research, whether it comes out for or against the vaccine's safety and purpose, and weigh that evidence fairly without predetermining the outcome: scientists in the FDA and those university-, laboratory-, and community-based scientists and clinicians on advisory boards who make recommendations to the FDA. It is for this purpose that my citations are heavily weighted on summaries and unbiased documents from the FDA, its advisory boards and the CDC that reviews and then endorses (or not) the outcomes of this process.

14. Dr. Richard Scott French submitted the following flawed arguments with the intention of putting the safety and the effectiveness of the District's vaccine mandate in doubt: (a) Vaccines are not yet proven to be safe and effective in young

children, and in particular the mRNA vaccines are experimental; (b) Transmission of the disease is not prevalent in school age children; (c) Mortality in school age children is not an adequately significant factor to warrant such actions that promote vaccination; (d) the COVID-19 vaccine lacks 100% effectiveness; (e) Natural immunity is superior than vaccination to reduce transmission; (f) The long term serious adverse reactions of vaccinations in youth are probable; (g) Government mandates produce adverse behavioral health, cognitive harm and obesity, and (h) There is an unfavorable risk/benefit ratio of vaccinating healthy children. These are addressed herein.

15. Dr. Jayanta Bhattacharya submitted the following flawed arguments that put the safety and the effectiveness of the District's vaccine mandate in doubt: (a) Vaccination for those who have recovered from the disease puts them at a small but significant risk, and without benefit; (b) the heightened risk of myocarditis, especially for young men, is greater than all risks of getting the disease; (c) the vaccine has not been studied in patients with certain chronic conditions, such as multiple sclerosis, so therefore it should not be mandated for the general population; (d) other mitigations in school (testing, symptoms screening, etc.) are as effective as ending this pandemic as maximizing the number of students who are vaccinated. These are addressed herein.

16. Each of the above points is flawed and most do not take into account the available full body of medical literature that has been weighted for its quality.

17. Dr. French wrote about the unknown incidence of myocarditis in children ages 12-15, other adverse effects of the vaccine in children ages 12-15, MISC-C in children under 16 admitted to an ICU, increases in body mass index (obesity) in children 5-15 years of age, anxiety and depression in children ages 7-15 years, ICU admissions in the 5-11 year olds, potential for auto-immune diseases developing in children 5-11 years old, and only having emergency use authorization, not full approval, yet for children. Dr. French is apparently under the impression that

the SDUSD mandate applies to children under age 16 and/or for vaccines/age groups having only emergency use authorization. It does not. Therefore, there is little relevance for much of this document, specifically to the entirety of points in paragraph nos. 16, 19, 21, 32, 33, 49, 51, 64, 9, 92-96, 100, 101.

18. In addition to the aforementioned specific Items in Dr. French's argument, most of the other "age-specific" Items in his Declaration refer to the entirety of K-12 populations or to research that was performed in the entire K-12 population. This makes his argument much less relevant to the matter under judicial review. For example, Dr. French professes there is low transmission of COVID-19 in schools, citing data collected for the entirety of Kindergarten to 12th grade. Data on this large population (ages 5 through 18) dilutes the far older and smaller population of interest (ages 16-18). And they are different. There is evidence that SARS-CoV-2 could spread more easily within high school than elementary school settings.[1] Researchers in Italy identified and tested nearly all (99.8%) contacts of 1,198 cases in school settings and reported an attack rate that was 17 times higher in high schools than in elementary schools (elementary schools had 0.38% attack rate; middle and high schools a 6.46% attack rate).[2] This pattern was consistent with findings from a study in New South Wales, Australia, that reported higher attack rates in high schools than in elementary/primary schools.[3] Dr. French's arguments and citations that address K-12 in their entirety simply cannot be assumed to apply to the population affected by this mandate.

[1] See Goldstein E, Lipsitch M, Cevik M. On the Effect of Age on the Transmission of SARS-CoV-2 in Households, Schools, and the Community. J Infect Dis 2021;223(3):362-369. doi:10.1093/infdis/jiaa691, attached hereto as **Exhibit T**.

[2] See Larosa E, Djuric O, Cassinadri M, et al. Secondary transmission of COVID-19 in preschool and school settings in northern Italy after their reopening in September 2020: a population-based study. Euro Surveill 2020;25(49). doi:10.2807/1560-7917.Es.2020.25.49.2001911, attached hereto as **Exhibit U**.

[3] See National Centre for Immunisation Research and Surveillance. COVID-19 in schools and early childhood education and care services – the Term 3 experience in NSW, Report from National Centre for Immunisation Research and Surveillance, October 9, 2020, attached hereto as **Exhibit V**.

19. The increased risk of SARS-CoV-2 transmission among adolescents does not only occur in schools, but high school youth have social interactions with non-household members outside schools that contribute to disease, when they are not vaccinated.[4] The CDC advises that uptake of COVID-19 vaccines in adolescents is likely to alter these transmission dynamics.[5]

20. Is it possible that Dr. French may have made a deliberate attempt to misguide the reader in his Item 49? He cites an article in the Wall Street Journal titled, "Some European Countries Are Limiting the Use of Moderna's Covid-19 Vaccine in Younger Ages." This article describes how European countries are promoting Pfizer's vaccine (the only one that SDUSD students are eligible to get) over Moderna's vaccine after they found that Moderna was associated with a high level of myocarditis as an adverse reaction. Yet, Dr. French's commentary lumps Moderna and Pfizer together as mRNA vaccines and uses this article as a reason to dissuade people from getting Pfizer, quite the opposite of these nations' intention, and the message of the article.

21. Dr. French describes the experience with Dengue Fever as a reason to avoid vaccination for COVID-19 (Item 54). There is no basis for such a comparison. Dengue Fever has typically mild symptoms upon the first infection, with subsequent infections producing life-threatening symptoms. It was found that giving the Dengue Fever vaccine to those who never had a previous infection simulated the first infection, thus making the next exposure to Dengue Fever virus more dangerous than had a vaccine not been received at all. As such, as to this disease, a vaccine is often only prescribed after the first natural infection. There is absolutely no parallel

[4] See Murillo-Llorente MT, Perez-Bermejo M. COVID-19: Social Irresponsibility of Teenagers Towards the Second Wave in Spain. J Epidemiol 2020;30(10):483. doi:10.2188/jea.JE20200360, attached hereto as **Exhibit W**.

[5] See https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/transmission_k_12_schools.html, attached hereto as **Exhibit X**.

with COVID-19 or any other coronavirus. Second infections with COVID-19 do not produce more severe disease, and in fact they are typically milder.

22. Dr. French states that the Pfizer vaccine is without sufficient animal testing and human trials. This is not true. All the approved vaccines in the U.S. have been put through standard safety testing before being rolled out to the public. mRNA vaccines have been held to the same rigorous safety and effectiveness standards as all other types of vaccines in the United States.[6] The only COVID-19 vaccines the FDA makes available for use in the United States (by approval or emergency use authorization) are those that meet these standards. (See Exhibit S.)

23. Dr. French cites the mRNA technology as untested and potentially less safe than traditional vaccine technology. While it is true that these are the first mRNA vaccines to be rolled out to the general public, they are considered safer and more specific to the dreaded virus by many experts. Other vaccines put a weakened or inactivated germ into our bodies. The mRNA vaccines do not. The Pfizer vaccine uses mRNA created in a laboratory to teach cells how to make a piece of a protein, that triggers an immune response inside our bodies. This mRNA is in the vaccine and injected into a muscle in one's arm. After the mRNA produces the spike protein that is found on the surface of the COVID-19 virus, it is known that (because of decades of experience with this technology), our cells break down the mRNA in a matter of days and our bodies break down the protein that mRNA created in a matter of weeks. Both are removed in their entirely from our body. But because that protein was present for a short while, the body produces antibodies and other immune cells to fight off what it thinks was an infection. mRNA vaccines do not

[6] U.S. Department of Health and Human Services, Food and Drug Administration; Centers for Biologics Evaluation and Research (June 2020) Development and Licensure of Vaccines to Prevent COVID-19: Guidance for Industry. https://www.fda.gov/media/139638/download, attached hereto as **Exhibit Y**.

use live virus and so cannot cause infection. mRNA never enters the nucleus of the cell where DNA is located, so it cannot influence genes.

24. Dr. French indicates that a vaccine mandate will increase obesity and mental anguish among youth, although the mechanism of how a vaccine mandate can lead to more obesity and mental distress is not explained. The research quoted in his Declaration demonstrates, correctly, that during the COVID epidemic both obesity and mental health disorders (suicide, depression, anxiety) among youth become more prevalent. However, this feeds into the argument that school districts, among other institutions, need to take actions that end the epidemic sooner rather than later; actions such as mandating vaccines when they have been fully studied and determined to be safe. A vaccine mandate is in addition to, not instead of, a more robust mental health screening and intervention program that SDUSD has started putting into place with COVID-19-related funds.

25. Dr. French points out, correctly, that obesity among youth is a major risk factor for severe disease from the virus that causes COVID-19. His solution to this grave association between obesity and severe disease outcome with COVID infection is curious: don't mandate vaccines. It takes years for an individual to combat obesity[7] and even then, diets and exercise have relatively low rates of permanent success. Even major gastric surgery is fraught with remissions. So, if obesity and COVID-19 disease are a dangerous combination for life-threatening outcomes, then a vaccine mandate, which increases the chances for immunization against COVID-19, is the far more certain and proximate solution to protect obese students from the potentially dire consequences of contracting the disease.

[7] Aruchuna Ruban, Kostadin Stoenchev, Hutan Ashrafian, Julian Teare. Et al Clin Med (Lond); 2019 May;19(3):205-212. doi: 10.7861/clinmedicine.19-3-205. doi: DOI: 10.7861/clinmedicine.19-3-205; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6542229/, attached as **Exhibit Z**.

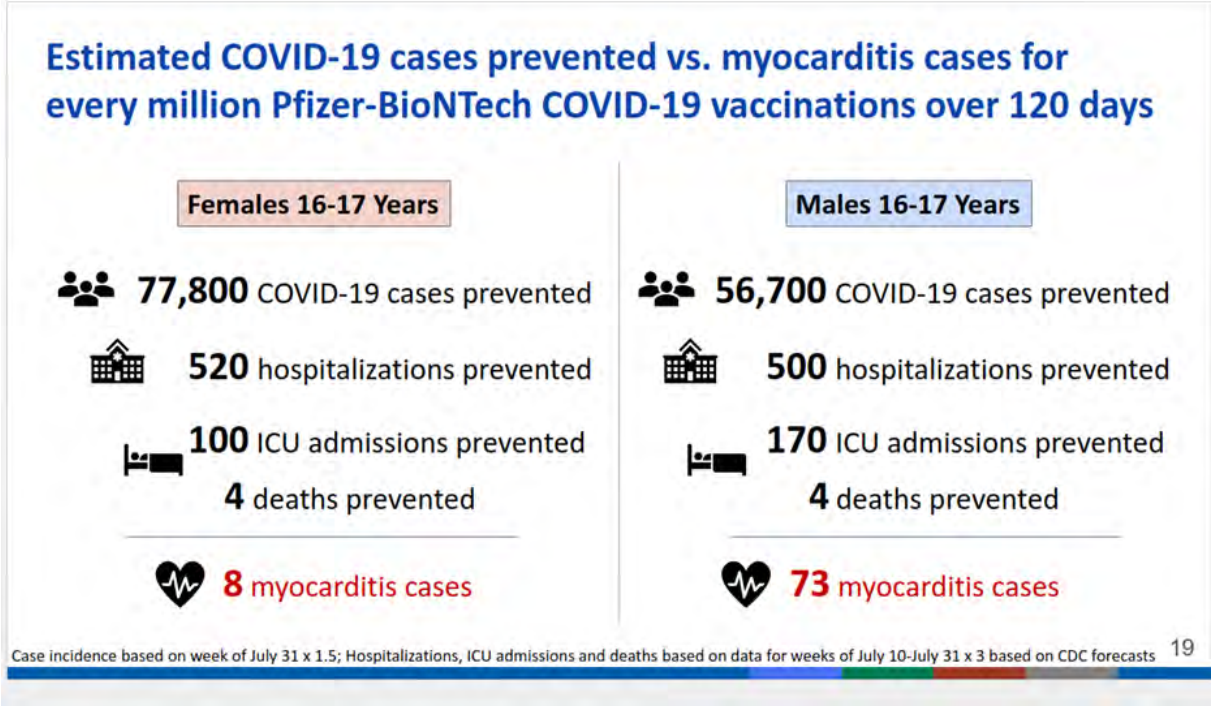
26. Drs. French and Bhattacharya both argue that morbidity and mortality among school age children are not adequately significant to warrant promoting vaccination. They reason that illness and death are so rare among school age children, that known and potential risks of the vaccine make it unworthy of promoting. What these gentlemen do not do, however, is compare the morbidity and mortality of the vaccine against the morbidity and mortality of not getting the vaccine. However, the CDC and FDA and advisors to the FDA have done just that, with the Advisory Committee on Immunizations Practices ("ACIP") demonstrating this very clearly.

27. The ACIP of the CDC has 15 voting members responsible for making vaccine recommendations. They have expertise in vaccinology, immunology, pediatrics, internal medicine, nursing, family medicine, virology, public health, infectious diseases and/or preventive medicine. There is also a representative for social and community aspects of vaccination.[8] The ACIP has a methodological way to assess the benefit to risk ratio, with methods adjusted to account for rising COVID-19 cases.

28. The ACIP demonstrated that for every 1,000,000 males aged 16-17 years who are vaccinated, there will be 73 cases of myocarditis. However, 56,700 cases of COVID will have been prevented, 500 hospitalizations will have been prevented, 170 ICU admissions prevented, and 4 deaths prevented. As for the 73 cases of myocarditis, there would be no deaths. This is a self-resolving disease that has been monitored closely and shown to be mild and without complications in almost all cases. As can be seen on the image below, the situation among females who are vaccinated is even better than that. Moreover, adverse vaccine effects occur within 4-6 weeks, and with tens of millions of youth already vaccinated (with

[8] Advisory Committee on Immunization Practices (ACIP) https://www.cdc.gov/vaccines/acip/members/index.html, attached as **Exhibit AA**.

the Pfizer vaccine) across the globe and closely observed for much longer than this period of time, data show this is a safe and effective vaccine.



29. It was argued by Dr. French that because the vaccine lacks 100% effectiveness, that it is not worthy of such promotion policies. There is virtually no vaccine that is 100% effective. Herd immunity occurs when a significant portion of a population becomes immune to an infectious disease, limiting further disease spread. With herd immunity, those who are not immune are indirectly protected because the ongoing disease spread is small. When a vaccine is not 100% effective, herd immunity can still be achieved, but only if a high proportion of the population has immunity. Experts estimate that herd immunity would require around 80-90% of the population to have COVID-19 immunity. This rate of immunity cannot be achieved without high rates of vaccination.

30. Dr. Bhattacharya argues that because the vaccine has not been studied in patients with certain chronic conditions, such as multiple sclerosis, it should not be mandated for the general population. It is true that about a dozen trials studying the vaccine safety for multiple sclerosis have not yet been completed. However, it

should be noted that the National Multiple Sclerosis Society strongly recommends that people with this disease be vaccinated against COVID-19, that the risks of COVID-19 outweigh any potential risks from the vaccine. They also recommend that those with COVID-19 who have recovered, should also get the vaccine, and even a booster. [9] However, the most significant counterargument to Dr. Bhattacharya's assertion that the vaccine should not be mandated for all because rare diseases in combination with the vaccine are not fully studied is that SDUSD has a process for medical exemptions. If a student's own physician confirms, through the same process used for other vaccinations, that an underlying medical problem makes the vaccine unsafe for their patient, and that physician is made available to discuss this issue with the District's physician, the student is eligible for a medical exemption and remain in school as long as that student is screen tested regularly for COVID-19.

31. Both Dr. Bhattacharya and Dr. French argue that natural immunity is adequate or even superior than vaccination to reduce virus transmission, making the vaccine mandate unnecessary for large swaths of children with history of the disease. In fact, a recent Morbitiy and Mortality Weekly Report ("MMWR") study examined more than 7,000 people across 9 states who were hospitalized with COVID-like illness. Among COVID-19–like illness hospitalizations among those whose previous infection or vaccination occurred 90–179 days earlier, the adjusted odds of laboratory-confirmed COVID-19 among those unvaccinated with previous SARS-CoV-2 infection were 5.49-fold higher than the odds among fully vaccinated recipients of an mRNA COVID-19 vaccine who had no previous documented

[9] COVID-19 Vaccine Guidance for People Living with MZ, National Multiple Sclerosis Society (accessed November 4, 2021): https://www.nationalmssociety.org/coronavirus-covid-19-information/multiple-sclerosis-and-coronavirus/covid-19-vaccine-guidance, attached as **Exhibit BB**.

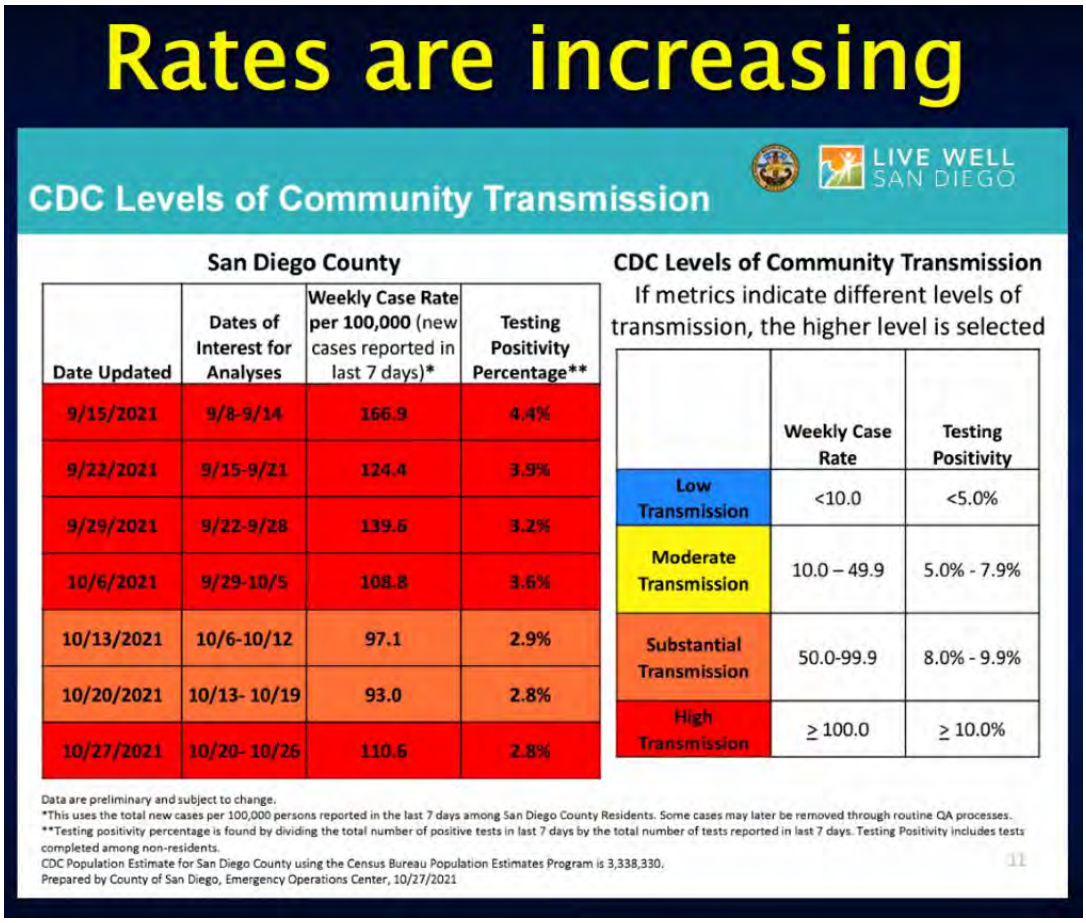
infection. The vaccine gives far better immunity than the natural disease. The vaccine is also more predictable for immunity within any specific age group.

32. Data demonstrate that vaccination can provide a higher, more robust, and more consistent level of immunity to protect people from hospitalization for COVID-19 than infection alone for at least 6 months.[10]

33. Dr. Bhattacharya argues that other mitigations in school (testing, symptoms screening, etc.) are as effective as ending this pandemic as vaccination, so there is no sense in maximizing the number of students who are vaccinated through a mandate. However, even with all these other mitigation strategies in place (testing, symptom screening, masks), new Covid Hospital admissions are increasing among young individuals since the Delta Variant became the dominant variant in the summer of 2021.[11] This is not only true nationwide, but also here in San Diego, as shown in the image below. In the past week, weekly case rates went from 12 to 14. With Thanksgiving and Christmas holidays ahead, the rates in January are anticipated to be much higher, unless vaccinations rates climb significantly.

[10] Bozio CH, Grannis SJ, Naleway AL, Ong TC, et al; Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19-Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity - Nine States, January-September 2021. MMWR Morb Mortal Wkly Rep. 2021 Nov 5;70(44):1539-1544. doi:10.15585/mmwr.mm7044e1. https://www.cdc.gov/mmwr/volumes/70/wr/mm7044e1.htm?s_cid=mm7044e1_w, attached as **Exhibit CC**.

[11] Rosenblum H; "Pfizer-BioNTech COVID-19 vaccine and myocarditis in individuals aged 16-29 years: Benefits-Risk Discussion" ACIP Meeting August 30, 2021; Centers for Disease Control and Prevention; https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-08-30/06-COVID-Rosenblum-508.pdf. (Attached as **Exhibit DD**.)



34. Dr. Bhattacharya argues that pregnancy and recent documented evidence of disease should allow students to be excluded from the vaccine mandate. Although the vaccine is recommended in both these circumstances, the District has a process to delay required vaccination during pregnancy. Similarly, the District has a process for medical exemptions, as described above.

35. In conclusion, achieving a high vaccination rate among youth is a critical factor to successfully combatting the COVID pandemic for people of all ages, including school-age children. Strategies to increase vaccination rates must be employed. Youth have the lowest rates of vaccination. The vaccine, even with its well-studied adverse reactions, is exponentially safer than the chances of getting the

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disease and being hospitalized or dying. The vaccine is only being mandated by the school district if there is full approval, not emergency use authorization, limiting the mandate to those 16 years and older. Medical exemptions are granted when the health and safety of an individual necessitate the use of other protective measures. Natural immunity has been shown to be unpredictable and inadequate in the long term.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 8th day of November, 2021, at San Diego, California.

Howard Taras, MD, FAAP

EXHIBIT 3-4

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Attorneys for Defendants

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

JOHN DOE, an individual, et al.,,

Plaintiffs,

v.

SAN DIEGO UNIFIED SCHOOL DISTRICT, et al.,,

Defendants.

Case No.: 3:21-cv-01809-CAB (LL)

DECLARATION OF ACACIA THEDE IN OPPOSITION TO PLAINTIFFS' EX PARTE APPLICATION FOR TEMPORARY RESTRAINING ORDER AND ORDER TO SHOW CAUSE RE: PRELIMINARY INJUNCTION; AND FOR LEAVE TO PROCEED PSEUDONYMOUSLY

Judge: Hon. Cathy Ann Bencivengo
Courtroom: 15A

Date: November 19, 2021
Time: 2:00 p.m.

Complaint Filed: October 22, 2021
Trial Date: None

I, Acacia Thede, declare as follows:

1. I am employed by the San Diego Unified School District ("District") as its Chief Human Resources Officer. I have held this position since 2014, and have been employed by the District since 2014 in administrative capacities. I possess an Administrative Services Credential, a Single Subject Teaching Credential (Social Science), and a Crosscultural, Language and Academic Development Certificate (CLAD) all issued by the California Commission on Teacher Credentialing.

2. The District employs approximately 14,000 people in various capacities. Employees fall into two categories under state law: 1) certificated employees, who are required as a condition of their employment to possess certification from the California Commission on Teacher Credentialing ("CTC"); and 2) classified employees, who occupy positions that do not require CTC certification and provide services in maintenance, operations, transportation, clerical assistance, campus supervision, and the like. The approximately 14,000 District employees fall into various other categories — part-time, full-time, management, non-management, substitute, temporary, probationary, and permanent.

3. Among the many duties of my position, I am responsible for coordinating and overseeing District compliance with state and federal law regarding the rights of our employees, including but not limited to the right, where applicable, to reasonable accommodation of disabilities and religion.

4. After the Board of Education adopted a Vaccination Roadmap on September 28, 2021, I spearheaded the process of notifying employees of the Board's action and information on their rights under state and federal law. Specifically:

a. On September 29, 2021, the day after the Board's action, I sent a letter to all District employees notifying them of the Board action, as well as an acknowledgment of the legally-mandated "interactive process to determine if a reasonable accommodation exists to permit an employee to continue

working who cannot take the vaccine due to disability or sincerely held religious belief." (A true and correct copy of this letter is attached as **Exhibit A**.)

b. On October 15, 2021 I sent to all employees Administrative Circular No. 75, regarding Religious Accommodation Requests, which provided a summary of federal law regarding religious accommodations of employees and information on how to apply for an accommodation. (A true and correct copy of this Circular is attached as **Exhibit B**.) This Circular included links to the previous letter (**Exhibit A**), instructions for the intake form to request reasonable accommodation (a true and correct copy is attached as **Exhibit C**), and to the intake form itself (a true and correct copy is attached as **Exhibit D**).

c. On October 15, 2021 I also re-distributed Administrative Circular No. 26, regarding Disability Accommodation Requests, which provided information consistent with federal law regarding disability accommodations of employees and information on how to apply for an accommodation. (A true and correct copy of this Circular is attached as **Exhibit E**.) This Circular included links instructions for the intake form to request reasonable accommodation. (A true and correct copy of the form is attached as **Exhibit F**) The Circular also includes links to an ADA Intake Packet which includes a section for medical information to assess the existence of a disability as defined by law (a true and correct copy is attached as **Exhibit G**), and an ADA Flowchart (a true and correct copy is attached as **Exhibit H**).

5. During the COVID-19 pandemic we have received, separate from the vaccine mandate, accommodation requests arising from other events and requirements such as returning to work after the closure of schools and offices, the state's mask wearing mandate, etc. For each of these requests we have followed the

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legal mandates regarding the good faith, interactive process to determine whether employees are entitled to accommodations, and if so what range of accommodation options are available (e.g. continuing to work remotely, approved leave of absence, etc.) This process will continue with accommodation requests related to the vaccine mandate.

6. As of the date of signing this declaration, November 8, 2021, the District has received 238 employee requests for religious accommodations related to the District's employee vaccine mandate, and 26 employee requests for disability accommodations related to the District's employee vaccine mandate.

7. In my capacity as Chief Human Resources Officer I am required to attend meetings of the District's Board of Education, and have done so during the COVID-19 pandemic. Contrary to the suggestion by the Plaintiffs in this lawsuit, since the beginning of the COVID-19 pandemic all public participation at all Board of Education meetings has been remote, not in-person.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 8th day of November, 2021, at San Diego, California.

_Acacia Thede_____

Acacia Thede

EXHIBIT 3-5

Docket No. 21-56259

In the

United States Court of Appeals

for the

Ninth Circuit

JOHN DOE, *et al.*,
Plaintiffs-Appellants,

v.

SAN DIEGO UNIFIED SCHOOL DISTRICT, *et al.*
Defendants-Appellees.

On Appeal from the United States District Court
for the Southern District of California
Case No. 21-cv-01809-CAB-LL,
Hon. Cathy Ann Bencivengo, District Judge

DECLARATION OF LAMONT A. JACKSON REGARDING INJUNCTION PENDING APPEAL

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Attorneys for Appellees

DECLARATION OF LAMONT A. JACKSON

I, Lamont Jackson, declare as follows:

1. I am the Interim Superintendent of the San Diego Unified School District ("District"). This Declaration is regarding and related to the Order issued by the United States Court of Appeals for the Ninth Circuit, on November 28, 2021, in *John Doe, et al. v. San Diego Unified School District, et al.*, Case No. 21-56259. The Order imposes an injunction and states that "[t]he injunction shall terminate upon removal of the 'per se' deferral option for pregnant students."

2. To address the Court's concern stated in the Order, earlier today I authorized and directed that the option for pregnant students to request a deferral of the vaccine mandate be removed from the vaccine mandate program and requirements. Therefore, there is no longer any "'per se' deferral option for pregnant students." I will send a communique to District parents notifying them that pregnant students no longer have the option to request a deferral of the vaccine mandate as soon as the Court terminates the injunction, and the form to apply for a medical exemption has already been edited to remove the deferral option. (A true and correct copy of the revised form is attached as

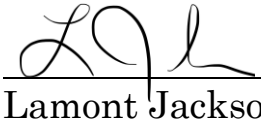
Exhibit A.) References to the option for pregnant students to request a deferral during their pregnancy will also be removed from the information provided to the public on the District's website.

3. My duties as Interim Superintendent include ensuring that District policies and practices approved by action of the Board of Education be modified or terminated only by subsequent action of the Board. In this case, the pregnancy deferral option was not the result of action or direction by the Board. Therefore, no Board action was or is necessary for the option for pregnant students to request a deferral of the vaccine mandate to be removed from the vaccine mandate program.

4. As of this date, the District has not received any pregnancy deferral requests, so the action to remove the deferral request option for pregnant students will not result in the reversal of any previously-granted deferral requests.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 29th day of November, 2021, at San Diego, California.



Lamont Jackson

EXHIBIT A

San Diego Unified
SCHOOL DISTRICT

Request for Medical Exemption for COVID-19 Vaccine

Part 1: To be completed by Parent/Guardian

Student Information

Last Name:	First Name:	DOB:
School Name:	Student ID:	Current Grade:

Parent/Guardian Information

Last Name:	First Name:		Relationship:	
Mailing Address:		City:	State:	Zip:
Phone: ( )	Email:			

Terms of Agreement: By signing below, you agree to all terms listed.

Attestation: The information submitted in this form is true, accurate, and complete

Authorization: I hereby authorize the health care provider issuing the medical exemption and San Diego Unified School District's Nursing and Wellness Staff to confer with each other and to disclose medical records, including evaluation, diagnosis, and treatment of my child to the Enforcement Programs of the Medical Board of California/Osteopathic Medical Board of California, for their official use.

- This authorization shall remain valid for four years from the date of issuance and cannot be revoked before then
- A copy of this authorization shall be valid as the original
- I understand that I have a right to receive a copy of this authorization by printing this form or if otherwise requested by me.
- I understand that I have the right to decline this authorization, and that by doing so, a medical exemption will not be issued.

Parent/Guardian Signature: _____ Date:_____

If any part of this form is incomplete or crossed off, the exemption will not be approved

Page 1: Parent/Guardian **Page 2:** California Licensed MD/DO **Page 3:** San Diego Unified School District

San Diego Unified
SCHOOL DISTRICT

Request for Medical Exemption for COVID-19 Vaccine

Part 2: To be completed by California licensed MD/ DO who is currently managing this person's care

Patient's Last Name:	First Name:	DOB:

Issuing Physician Information:

Last Name:	First Name:	License Type ☐MD ☐DO
Phone Number:	Fax Number:	License Number:
Address:	City:	Zip:

Primary Care Provider: ☐ Same as issuing provider
☐ Last Name: First Name:
Reason not issued by primary care provider:

MEDICAL EXEMPTION:

I certify that the above named student has one or more of the contraindications or precautions recognized by the CDC or vaccine manufacturer insert (check appropriate box and complete description below)

☐ **Severe allergic reaction** (one that needs to be treated with epinephrine or EpiPen or with medical care) after receiving first dose of COVID-19 vaccine

☐ **Immediate allergic reaction** (reaction within 4 hours of exposure, including symptoms such as hives, swelling, or wheezing/respiratory distress) even if it was not severe, after receiving the first dose of COVID-19 vaccine or to any ingredient in the COVID-19 vaccine *(nucleoside-modified messenger RNA (mRNA) encoding the viral spike (S) glycoprotein of SARS-CoV-2: lipids (4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2-(polyethylene glycol 2000)-N,N-ditetradecylacetamide, 1,2-distearoyl-sn-glycero-3-phosphocholine, cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, sucrose)*

Description of contraindication meeting criteria checked above: _____
_____

This exemption is:

☐ Permanent [valid only until COVID-19 vaccine is added to CAIR-ME, or end of grade span, whichever comes first]
☐ Temporary until _____ (not to exceed 12 calendar months)

Physician Signature: _____ Date Issued: _____

San Diego Unified
SCHOOL DISTRICT

Approval/Denial: Request for Medical Exemption for COVID-19 Vaccine

Part 3: To be completed by San Diego Unified Nursing & Wellness Staff

Student Name: DOB: ID:

On _____, we received your request for a medical exemption for the COVID-19 vaccination requirement specified in San Diego Unified's COVID-19 Immunization Process.

Based on the information provided, your request for exemption has been:

☐ APPROVED, subject to the requirement that your student complies with the **Non-Pharmaceutical Interventions** specified below.
No medical exemption is permanent and all are subject to review with changes in Public Health and legal requirements. This approval is valid until the earliest of:

- When COVID-19 vaccine is added to the California Immunization Registry – Medical Exemptions,
- The end date specified by the physician,
- The end of the grade span as defined by the State of California,
- Changes in Public Health Department or legal requirements

at which time, you will need to provide a new Medical Exemption or proof of vaccination.

☐ DENIED, because the exemption request form was not complete and/or the reason provided did not meet applicable Centers for Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices (ACIP), and American Academy of Pediatrics (AAP) criteria or the standard of medical care.

You have until _____ (10 school days from the denial date below) to submit proof that your student has received the first dose of COVID-19 vaccine; you then have 30 school days to submit proof of the second dose of COVID-19 vaccine. If these deadlines are not met, your student will be required to participate in an online instruction program and will not be permitted to participate in extracurricular activities.

Your student must comply with the **Non-Pharmaceutical Interventions** (e.g., face coverings, regular asymptomatic testing) for unvaccinated or not fully vaccinated individuals as a condition of your student's physical presence at any San Diego Unified School District location, facility, or program. These required Non-Pharmaceutical Interventions are defined by San Diego Unified School District, the Public Health Department, environmental health and safety, or infection prevention authorities.

_____ Date: _____
SDUSD Nursing & Wellness staff

CERTIFICATE OF SERVICE

I hereby certify that on November 29, 2021, I electronically filed the foregoing document with the Clerk of the Court by using the CM/ECF system.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

Date: November 29, 2021

/s/ Mark Bresee
Mark Bresee

EXHIBIT 4-1

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*Application forthcoming

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

JOHN DOE, an individual, et al.,

Plaintiffs,

v.

SAN DIEGO UNIFIED SCHOOL DISTRICT, et al.,

Defendants.

Case No.: 3:21-cv-01809-CAB (LL)

Declaration of Plaintiff Jill Doe in Support of Plaintiffs' Ex Parte Application for a Temporary Restraining Order, and Order to Show Cause re: Preliminary Injunction; and for Leave to Proceed Pseudonymously

Judge: Hon. Cathy Ann Bencivengo
Courtroom: 15A

I, Jill Doe, declare as follows:

1. I am a plaintiff in this action. I am a 16 year old minor. I am a junior attending Scripps Ranch High School within the San Diego Unified School District. I am identifying myself as "Jill Doe" to protect my privacy and safety, as explained further below. The matters discussed below are based on my own personal knowledge.

2. I've grown up in the church my entire life, and it's become my second home. My entire life and everything I do is centered around my church. My whole family serves, we use the gym and participate in sports ministry. I have life-long friends and family, I'm in a small group with amazing girls who I get to share life with, and most importantly it's the place where I learn about my Jesus.

3. Jesus has always been my rock and my solid ground. I try my best to live my life with Him in the center. I've never known life without Him. It's such a beautiful thing to be able to have a true relationship with the Creator of the Universe. I get to talk to Him and listen to Him through prayer, I get to learn and grow through reading scripture and my Bible, and I get to spread His love and joy to those around me which has been extra important during these times.

4. One thing that scripture teaches me is that everyone crafted in a womb has a unique purpose and a plan designed by God for their lives. God doesn't make mistakes. Period. For this reason, I am strongly against abortion. It's simply unacceptable to be killing innocent babies who were carefully crafted by my God and given a plan on this earth. There's absolutely no explanation and justification. I refuse to be involved with anything that has to do with abortion or the use of aborted parts. That is against my beliefs. I have learned from my pastors and my parents about how all of the Covid vaccines were developed using material from abortions from long ago. Some are worse than others, but because I am strongly against abortion, and believe there's never a justification for participating or cooperating with it, I cannot take any of the vaccines.

5. As a Christian, I also believe that my body is a holy temple for God. For this reason, I am careful with what I chose to put inside of it. I don't drink, I don't smoke,

I don't do drugs, and I work hard to keep my body clean. It's important to take care of the body that I was blessed with and it's important to stay healthy. But I've had Covid already and it barely affected me. In that situation, I don't believe I should introduce something into God's temple that is new and unknown and unnecessary.

6. Standing up for my beliefs has already been an act of courage. I learned that one of the teachers at my school read a news article to the class about this case. In response, certain students at my school got angry and upset about what I am doing. They're so upset that they claim that they want to find out who I am and hurt me. This makes no sense to me because it's about my beliefs and only my beliefs. However, it shows that this situation is truly spiritual warfare, and I will continue to have faith in my God. I truly hope that I am able to continue to go to Scripps Ranch, participate in memorable high school activities, and play the sports I love.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed this 29th day of October, 2021, at San Diego County, California.

Jill Doe, a pseudonym

EXHIBIT 4-2

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*Application forthcoming

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

JOHN DOE, an individual, et al.,

Plaintiffs,

v.

SAN DIEGO UNIFIED SCHOOL DISTRICT, et al.,

Defendants.

Case No.: 3:21-cv-01809-CAB (LL)

Declaration of Plaintiff Jane Doe in Support of Plaintiffs' Ex Parte Application for a Temporary Restraining Order, and Order to Show Cause re: Preliminary Injunction; and for Leave to Proceed Pseudonymously

Judge: Hon. Cathy Ann Bencivengo
Courtroom: 15A
Date: November 19, 2021
Time: 2:00 p.m.

I, Jane Doe, declare as follows:

1. I am a plaintiff in this action. I am the mother and legal guardian of a 16 year old daughter attending Scripps Ranch High School within the San Diego Unified School District. I am identifying myself as "Jane Doe" to protect my and my daughter's privacy and safety. The matters discussed below are based on my own personal knowledge.

2. On Tuesday, November 9, 2021, I received an email from the San Diego Unified School District, signed by Interim Superintendent Jackson, about the school district's COVID-19 vaccination mandate. A true and correct copy of that email, with my name redacted, is attached hereto as **Exhibit 1**.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed this 12th day of November, 2021, at San Diego County, California.

Jane Doe

Jane Doe, a pseudonym

EXHIBIT 1

From: **San Diego Unified School District** <noreply@sandi.net>
Date: Tue, Nov 9, 2021, 5:05 PM
Subject: CDC Vaccination Recommendation
To:

Dear San Diego Unified Families,

San Diego Unified wants every school to be a place of great teaching and learning, safety and wellness. Vaccinations are a crucial part of the multi-layered protection against COVID-19, and getting your student vaccinated is one of the best ways to protect against the spread of the virus.

The latest vaccine recommendation from the CDC this week means the vast majority of students in kindergarten through high school are now eligible to be vaccinated against COVID-19, signaling a major step toward preventing the spread of the virus in our community and nationwide.

Under a vaccine mandate approved by the Board of Education, San Diego Unified will require students who are 16 and older as of November 1, 2021 and who wish to continue learning in-person to be fully vaccinated, effective January 24, 2022 at the start of the new semester/quarter. **Full FDA approval is in place for this student group.**

Students ages 5 to 15 are recommended to receive a COVID-19 vaccine by the FDA and the CDC. San Diego Unified supports this recommendation, but will **not** require the COVID-19 vaccination for this student group at this time.

We understand you may have questions about the new CDC decision approving vaccinations for students 5 to 11. Please **click here** for more information on the safety of the vaccinations.

Families are encouraged to check with their healthcare providers about getting the vaccine as soon as possible. **MyTurn.ca.gov** offers information about getting a vaccine at Rady Children's Hospital through walk-in and scheduled appointments. **Click here** for information on where to get a free vaccine elsewhere in the community.

Our community health partners plan to supplement vaccine availability by offering vaccine clinics on school sites. Check **here** frequently for current schedules and updates.

Under San Diego Unified's vaccine mandate for students who are 16 and older as of November 1, 2021, students who are not fully vaccinated by December 20, 2021 will transition from in-person learning to an independent study program at the start of the new semester and quarter on January 24, 2022. To view a district presentation on the mandate, visit this **LINK**.

All students 16 and older who are eligible for the COVID-19 vaccine under the district mandate are required to be vaccinated, excluding those with qualified exemptions or conditional admissions. San Diego Unified does not allow religious exemptions for this

particular vaccine.

We will share information in the coming days about how the district will verify student vaccination status, how to apply for qualified exemptions or conditional admissions, and how to learn about independent study options. These details are also available on the student COVID-19 vaccine FAQ page, **here**.

Sincerely,

Dr. Lamont Jackson

Interim Superintendent

EXHIBIT 4-3

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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

JOHN DOE, an individual, et al.,

Plaintiffs,

v.

SAN DIEGO UNIFIED SCHOOL DISTRICT, et al.,

Defendants.

Case No.: 3:21-cv-01809-CAB (LL)

Declaration of Jayanta Bhattacharya, M.D., Ph.D., in Support of Plaintiffs' Ex Parte Application for a Temporary Restraining Order, and Order to Show Cause re: Preliminary Injunction; and for Leave to Proceed Pseudonymously

Judge: Hon. Cathy Ann Bencivengo
Courtroom: 15A

NO ORAL ARGUMENT UNLESS REQUESTED BY THE COURT

I, Dr. Jayanta Bhattacharya, declare as follows:

1. I am an adult of sound mind and make this statement voluntarily, based upon my own personal knowledge, education, and experience.

2. Based on my training and experience, I have formed an opinion on the reasonableness of the requested accommodations and on the possibility of other accommodations not listed to a reasonable degree of scientific certainty.

EXPERIENCE & CREDENTIALS

3. I am a former Professor of Medicine and current Professor of Health Policy at Stanford University School of Medicine and a research associate at the National Bureau of Economic Research. I am also Director of Stanford's Center for Demography and Economics of Health and Aging. I hold an M.D. and Ph.D. from Stanford University. I have published 154 scholarly articles in peer-reviewed journals in the fields of medicine, economics, health policy, epidemiology, statistics, law, and public health, among others. My research has been cited in the peer-reviewed scientific literature more than 11,600 times. My curriculum vitae is attached to this declaration as **Exhibit A**.

4. I have dedicated my professional career to the analysis of health policy, including infectious disease epidemiology and policy, and the safety and efficacy of medical interventions. I have both studied extensively and commented publicly on the necessity and safety of vaccine requirements for those who have contracted and recovered from COVID-19 (individuals who have "natural immunity"). I am intimately familiar with the emergent scientific and medical literature on this topic and pertinent government policy responses to the issue both in the United States and abroad.

5. My assessment of vaccine immunity is based on studies related to the efficacy and safety of the one vaccine to receive full approval from the Food and Drug Administration (FDA) and the two vaccines that the FDA has granted Emergency Use Authorization (EUA) for use in the United States. These include two mRNA-

technology vaccines (manufactured by Pfizer-BioNTech and Moderna) and an adenovirus-vector vaccine technology (manufactured by Johnson & Johnson). Of those, the Pfizer vaccine, also known as Comirnaty, has full FDA approval.

6. I have not and will not receive any financial or other compensation to prepare this Declaration or to testify in this case. Nor have I received compensation for preparing declarations or reports or for testifying in *any* other case related to the COVID-19 pandemic, or any personal or research funding from any pharmaceutical company. My participation here has been motivated solely by my commitment to public health, just as my participation in other cases has been.

7. I have no prior relationship with any of the plaintiffs.

8. I have reviewed the Verified Complaint filed in this action and thus understand that San Diego Unified School District ("SDUSD") has imposed a COVID-19 vaccination mandate for both its employees and students. For employees, exemptions are permitted for medical or religious reasons. However, for students, only medical exemptions are available. I have been asked to provide my opinion on several matters related to that vaccine mandate as related to this case, brought on behalf of a student with a religious objection to vaccination, including the following:

- Whether, based on the current medical and scientific knowledge, immunity after COVID recovery (sometimes referred to as natural immunity) is categorically inferior to vaccine immunity to prevent reinfection and transmission of the SARS-CoV-2 virus;
- Whether, based on the existing medical and scientific understanding of SARS-CoV-2 transmission and recovery, there is any categorical distinction between natural immunity and vaccine immunity;
- An assessment of the comparative safety to recipients of administering vaccines to those who have natural immunity relative to immunologically naïve recipients with no prior history of COVID infection;
- Whether vaccines pose any risks to individuals;

- The safety of providing accommodations to (1) those who have recovered from COVID and (2) those who have religious reasons for declining to be vaccinated; and
- What those accommodations could look like in practice.

9. My opinions are partly summarized in a recent article I published and which I reaffirm here: "[R]ecovered COVID patients have strong long-lasting protection against severe disease if reinfected, and evidence about protective immunity after natural infection is at least as good as from the vaccines. Hence, it makes no sense to require vaccines for recovered patients. For them, it simply adds a risk, however small, without any benefit."[1]

10. I also offer my opinion that certain individuals may face heightened risk of vaccine side effects. Though the vaccines are safe for most patients, the FDA has identified a heightened risk of myocarditis and pericarditis after vaccination with the mRNA vaccines—especially for young men. It has also identified a heightened risk of clotting abnormalities in young women taking the adenovirus vector vaccine. Even more importantly, the vaccine has not been thoroughly tested for safety and efficacy in patients with certain chronic conditions such as Multiple Sclerosis, so there is still considerable scientific uncertainty about these heightened risks for some patients.

11. I also conclude that SDUSD can safely accommodate COVID-recovered students by exempting them from vaccine requirements since they possess better immunity via prior infection than a vaccinated student who never had COVID possesses from vaccination. SDUSD could also safely accommodate those students who have not previously been infected with from COVID-19 but have religious reasons for not wanting the vaccine by requiring daily symptom checking paired with rapid antigen tests to confirm if a student is infectious. To reduce the risk from

[1] Kulldorff, M., & Bhattacharya, J. (2021, June 17). The ill-advised push to vaccinate the young. *The Hill.*

asymptomatically infected students, SDUSD can require students to conduct weekly PCR or antigen tests, though if it adopts this accommodation, it would be best practice to require it of both vaccinated and unvaccinated students since both groups can spread the virus asymptomatically. If implemented, these accommodations would keep SDUSD's employees and students as safe as possible from the risk of COVID infection, while preserving the educational opportunities of thousands of SDUSD students.

EXPERT OPINIONS

I. NATURAL IMMUNITY PROVIDES DURABLE PROTECTION AGAINST REINFECTION AND AGAINST SEVERE OUTCOMES IF REINFECTED; COVID-19 VACCINES PROVIDE LIMITED PROTECTION AGAINST INFECTION BUT DURABLE PROTECTION AGAINST SEVERE OUTCOMES IF INFECTED.

12. Both vaccine-mediated immunity and natural immunity after recovery from COVID infection provide extensive protection against severe disease from subsequent SARS-CoV-2 infection. There is no reason to presume that vaccine immunity provides a higher level of protection than natural immunity. Since vaccines arrived one year after the disease, there is stronger evidence for long lasting immunity from natural infection than from the vaccines.

13. Both types are based on the same basic immunological mechanism—stimulating the immune system to generate an antibody response. In clinical trials, the efficacy of those vaccines was initially tested by comparing the antibody levels in the blood of vaccinated individuals to those who had natural immunity. Later Phase III studies of the vaccines established 94%+ clinical efficacy of the mRNA vaccines against

severe COVID illness.[2, 3] A Phase III trial showed 85% efficacy for the Johnson & Johnson adenovirus-based vaccine against severe disease.[4]

14. Immunologists have identified many immunological mechanisms of immune protection after recovery from infections. Studies have demonstrated prolonged immunity with respect to memory T and B cells[5], bone marrow plasma cells[6], spike-

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[2] Baden, L. R., El Sahly, H. M., Essink, B., Kotloff, K., Frey, S., Novak, R., Diemert, D., Spector, S. A., Rouphael, N., Creech, C. B., McGettigan, J., Khetan, S., Segall, N., Solis, J., Brosz, A., Fierro, C., Schwartz, H., Neuzil, K., Corey, L., Zaks, T. for the COVE Study Group (2021). Efficacy and Safety of the mRNA-1273 SARS-CoV-2 Vaccine. *The New England Journal of Medicine*, *384*(5), 403-416. doi: 10.1056/NEJMoa2035389

[3] Polack, F. P., Thomas, S. J., Kitchin, N., Absalon, J., Gurtman, A., Lockhart, S., Perez, J. L., Pérez Marc, G., Moreira, E. D., Zerbini, C., Bailey, R., Swanson, K. A., Roychoudhury, S., Koury, K., Li, P., Kalina, W. V., Cooper, D., Frenck, R. W. Jr., Hammitt, L. L., Gruber, W. C. (2020). Safety and Efficacy of the BNT162b2 mRNA Covid-19 Vaccine. *The New England Journal of Medicine*, *387*(27), 2603-2615. doi: 10.1056/NEJMoa2034577

[4] Sadoff, J., Gray, G., Vandebosch, A., Cárdenas, V., Shukarev, G., Grinsztejn, B., Goepfert, P. A., Truyers, C., Fennema, H., Spiessens, B., Offergeld, K., Scheper, G., Taylor, K. L., Robb, M. L., Treanor, J., Barouch, D. H., Stoddard, J., Ryser, M. F., Marovich, M. A., Douoguih, M. for the ENSEMBLE Study Group. (2021). Safety and Efficacy of Single-Dose Ad26.COV2.S Vaccine against Covid-19. *The New England Journal of Medicine*, *384*(23), 2187-2201. doi: 10.1056/NEJMoa2101544

[5] Dan, J. M., Mateus, J., Kato, Y., Hastie, K. M., Yu, E. D., Faliti, C. E., Grifoni, A., Ramirez, S. I., Haupt, S., Frazier, A., Nakao, C., Rayaprolu, V., Rawlings, S. A., Peters, B., Krammer, F., Simon, V., Saphire, E. O., Smith, D. M., Weiskopf, D., Crotty, S. (2021). Immunological memory to SARS-CoV-2 assessed for up to 8 months after infection. *Science*, *371*, 1-13. doi: 10.1126/science.abf4063 (finding that memory T and B cells were present up to eight months after infection, noting that "durable immunity against secondary COVID-19 disease is a possibility in most individuals").

[6] Turner, J. S., Kim, W., Kalaidina, E., Goss, C. W., Rauseo, A. M., Schmitz, A. J., Hansen, L., Haile, A., Klebert, M. K., Pusic, I., O'Halloran, J. A., Presti, R. M. & Ellebedy, A. H. (2021). SARS-CoV-2 infection induces long-lived bone marrow

specific neutralizing antibodies[7], and IgG+ memory B cells[8] following naturally acquired immunity.

15. Multiple extensive, peer-reviewed studies comparing natural and vaccine immunity have now been published. These studies overwhelmingly conclude that natural immunity provides equivalent or greater protection against severe infection than immunity generated by mRNA vaccines (Pfizer and Moderna).

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plasma cells in humans. *Nature*, *595*(7867), 421-425. doi: 10.1038/s41586-021-03647-4 (study analyzing bone marrow plasma cells of recovered COVID-19 patients reported durable evidence of antibodies for at least 11 months after infection, describing "robust antigen-specific, long-lived humoral immune response in humans"); Callaway, E. (2021, May 26). Had COVID? You'll probably make antibodies for a lifetime. *Nature*. https://www.nature.com/articles/d41586-021-01442-9#:~:text=Many%20people%20who%20have%20been,recovered%20from%20COVID%2D191 ("The study provides evidence that immunity triggered by SARS-CoV-2 infection will be extraordinarily long-lasting" and "people who recover from mild COVID-19 have bone-marrow cells that can churn out antibodies for decades").

[7] Ripperger, T. J., Uhrlaub, J. E., Watanabe, M., Wong, R., Castaneda, Y., Pizzato, H. A., Thompson, M. R., Bradshaw, C., Weinkauf, C. C., Bime, C., Erickson, H. L., Knox, K., Bixby, B., Parthasarathy, S., Chaudhary, S., Natt, B., Cristan, E., El Aini, T., Rischard, F., Bhattacharya, D. (2020). Orthogonal SARS-CoV-2 serological assays enable surveillance of low-prevalence communities and reveal durable humor immunity. *Immunity*, *53*(5), 925-933. doi: 10.1016/j.immuni.2020.10.004 (study finding that spike and neutralizing antibodies remained detectable 5-7 months after recovering from infection).

[8] Cohen, K. W., Linderman, S. L., Moodie, Z., Czartoski, J., Lai, L., Mantus, G., Norwood, C., Nyhoff, L. E., Edara, V. V., Floyd, K., De Rosa, S. C., Ahmed, H., Whaley, R., Patel, S. N., Prigmore, B., Lemos, M. P., Davis, C. W., Furth, S., O'Keefe, J., McElrath, M. J. (2021). Longitudinal analysis shows durable and broad immune memory after SARS-CoV-2 infection with persisting antibody responses and memory B and T cells. *medRxiv*, Preprint. (study of 254 recovered COVID patients over 8 months "found a predominant broad-based immune memory response" and "sustained IgG+ memory B cell response, which bodes well for rapid antibody response upon virus re-exposure." "Taken together, these results suggest that broad and effective immunity may persist long-term in recovered COVID-19 patients").

16. Specifically, studies confirm the efficacy of natural immunity against reinfection of COVID-19[9] and show that the vast majority of reinfections are less

[9] Shrestha, N. K., Burke, P. C., Nowacki, A. S., Terpeluk, P. & Gordon, S. M. (2021). Necessity of COVID-19 vaccination in previously infected individuals. *medRxiv*, Preprint. doi: 10.1101/2021.06.01.21258176 ("not one of the 1359 previously infected subjects who remained unvaccinated had a SARS-CoV-2 infection over the duration of the study" and concluded that those with natural immunity are "unlikely to benefit from COVID-19 vaccination"); Perez, G., Banon, T., Gazit, S., Moshe, S. B., Wortsman, J., Grupel, D., Peretz, A., Tov, A. B., Chodick, G., Mizrahi-Reuveni, M., & Patalon, T. (2021). A 1 to 1000 SARS-CoV-2 reinfection proportion in members of a large healthcare provider in Israel: A preliminary report. *medRxiv*, Preprint. doi: 10.1101/2021.03.06.21253051 (Israeli study finding that approximately 1/1000 of participants were reinfected); Bertollini, R., Chemaitelly, H., Yassine, H. M., Al-Thani, M. H., Al-Khal, A., & Abu-Raddad, L. J. (2021). Associations of vaccination and of prior infection with positive PCR test results for SARS-CoV-2 in airline passengers arriving in Qatar. *JAMA*, *326*(2), 185-188. doi: 10.1001/jama.2021.9970 (study of international airline passengers arriving in Qatar found no statistically significant difference in risk of reinfection between those who had been vaccinated and those who had previously been infected); Pilz, S., Chakeri, A., Ioannidis, J. P. A., Richter, L., Theiler-Schwetz, V., Trummer, C., Krause, R., Allerberger, F. (2021). SARS-CoV-2 re-infection risk in Austria. *European Journal of Clinical Investigation*, *51*(4), 1-7. doi: 10.1111/eci.13520 (previous SARS-CoV-2 infection reduced the odds of re-infection by 91% compared to first infection in the remaining general population); Breathnach, A. S., Duncan, C. J. A., El Bouzidi, K., Hanrath, A. T., Payne, B. A. I., Randell, P. A., Habibi, M. S., Riley, P. A., Planche, T. D., Busby, J. S., Sudhanva, M., Pallett, S. J. C. & Kelleher, W. P. (2021). Prior COVID-19 protects against reinfection, even in the absence of detectable antibodies. *The Journal of Infection*, *83*(2), 237-279. doi: 10.1016/j.jinf.2021.05.024 (0.86% of previously infected population in London became reinfected); Tarke, A., Sidney, J., Methot, N., Yu, E. D., Zhang, Y., Dan, J. M., Goodwin, B., Rubiro, P., Sutherland, A., Wang, E., Frazier, A., Ramirez, S. I., Rawlings, S. A., Smith, D. M., da Silva Antunes, R., Peters, B., Scheuermann, R. H., Weiskopf, D., Crotty, S., Grifoni, A. & Sette, A. (2021). Impact of SARS-CoV-2 variants on the total $CD4^+$ and $CD8^+$ T cell reactivity in infected or vaccinated individuals, *Cell Reports Medicine 2*(7), 100355 (an examination of the comparative efficacy of T cell responses to existing variants from patients with natural immunity compared to those who received an mRNA vaccine found that the T cell responses of both recovered COVID patients and vaccines were effective at neutralizing mutations

severe than first-time infections.[10] For example, an Israeli study of approximately 6.4 million individuals demonstrated that natural immunity provided equivalent if not better protection than vaccine immunity in preventing COVID-19 infection, morbidity, and mortality.[11] Of the 187,549 unvaccinated persons with natural immunity in the study, only 894 (0.48%) were reinfected; 38 (0.02%) were hospitalized, 16 (0.008%) were hospitalized with severe disease, and only one died, an individual over

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found in SARS-CoV-2 variants).

[10] Abu-Raddad, L. J., Chemaitelly, H., Coyle, P., Malek, J. A., Ahmed, A. A., Mohamoud, Y. A., Younuskunju, S., Ayoub, H. H., Kanaani, Z. A., Kuwari, E. A., Butt, A. A., Jeremijenko, A., Kaleeckal, A. H., Latif, A. N., Shaik, R. M., Rahim, H. F. A., Nasrallah, G. K., Yassine, H. M., Al Kuwari, M. G., Al Romaihi, H. E., Al-Thani, M. H., Al Khal, A., Bertollini, R. (2021). SARS-CoV-2 antibody-positivity protects against reinfection for at least seven months with 95% efficacy. *EClinicalMedicine*, *35*, 1-12. doi: 10.1016/j.eclinm.2021.100861 (finding that of 129 reinfections from a cohort of 43,044, only one reinfection was severe, two were moderate, and none were critical or fatal); Hall, V. J., Foulkes, S., Charlett, A., Atti, A., Monk, E. J. M., Simmons, R., Wellington, E., Cole, M. J., Saei, A., Oguti, B., Munro, K., Wallace, S., Kirwan, P. D., Shroti, M., Vusirikala, A., Rokadiya, S., Kall, M., Zambon, M., Ramsay, M., Hopkins, S. (2021). SARS-CoV-2 infection rates of antibody-positive compared with antibody-negative health-care workers in England: a large, multicentre, prospective cohort study. *The Lancet*, *397*(10283), 1459-1469. doi: 10.1016/S0140-6736(21)00675-9 (finding "a 93% lower risk of COVID-19 symptomatic infection… [which] show[s] equal or higher protection from natural infection, both for symptomatic and asymptomatic infection"); Hanrath, A. T., Payne, B., A., I., & Duncan, C. J. A. (2021). Prior SARS-CoV-2 infection is associated with protection against symptomatic reinfection. *The Journal of Infection*, *82*(4), e29-e30. doi: 10.1016/j.jinf.2020.12.023 (examined reinfection rates in a cohort of healthcare workers and found "no symptomatic reinfections" among those examined and that protection lasted for at least 6 months).

[11] Goldberg, Y., Mandel, M., Woodbridge, Y., Fluss, R., Novikov, I., Yaari, R., Ziv, A., Freedman, L., & Huppert, A. (2021). Protection of previous SARS-CoV-2 infection is similar to that of BNT162b2. vaccine protection: A three-month nationwide experience from Israel. *medRxiv*, Preprint. doi: 10.1101/2021.04.20.21255670

80 years of age. Another study, analyzing data from Italy found that only 0.31% of COVID-recovered patients experienced a reinfection within a year after the initial infection, despite the circulation of the Delta variant.[12] In summary, the overwhelming conclusion of the pertinent scientific literature is that natural immunity is at least as effective against subsequent reinfection as even the most effective vaccines.

17. Based on such evidence, many scientists have concluded that natural protection against severe disease after COVID recovery is likely to be long-lasting. A survey article published on June 30, 2021, in the *British Medical Journal* concluded, "[t]here is reason to think that immunity could last for several months *or a couple of years*, at least, given what we know about other viruses and what we have seen so far in terms of antibodies in patients with COVID-19 and in people who have been vaccinated."[13]

18. 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

[12] Vitale, J., Mumoli, N., Clerici, P., de Paschale, M., Evangelista, I., Cei, M. & Mazzone, A. (2021). Assessment of SARS-CoV-2 reinfection 1 year after primary infection in a population in Lombardy, Italy. *JAMA Internal Medicine*, *181*(10), 1407-1409. doi: 10.1001/jamainternmed.2021.2959

[13] Baraniuk, C. (2021). How long does covid-19 immunity last? *The British Medical Journal*, *373*, 1-3. doi: 10.1136/bmj.n1605 (emphasis added).

epidemic.[14] 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.[15]

19. 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, the researchers argue that they can best surmise the predicted durability of vaccine immunity by looking at the expected durability of natural immunity.[16]

20. A recent study from Qatar by Chemaitelly and colleagues, which tracked 927,321 individuals for six months after vaccination concluded that the Pfizer vaccine's "induced protection against infection appears to wane rapidly after its peak right after the second dose, but it persists at a robust level against hospitalization and death for at least six months following the second dose."[17]

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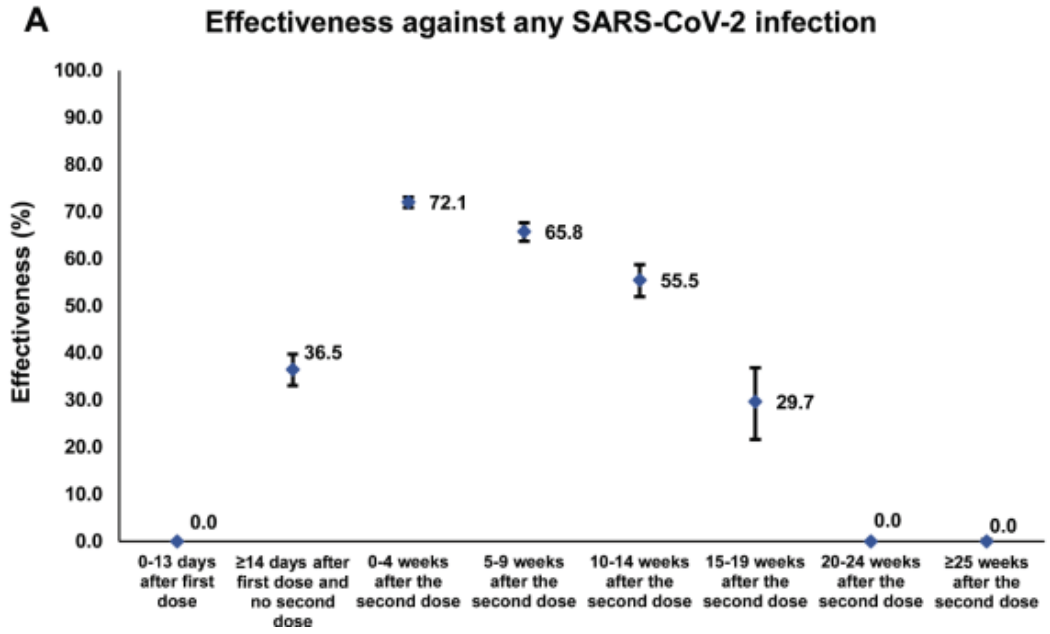
[14] Le Bert, N., Tan, A. T., Kunasegaran, K., Tham, C. Y. L., Hafezi, M., Chia, A., Chng, M. H. Y., Lin, M., Tan, N., Linster, M., Chia, W. N., Chen, M. I. C., Wang, L. F., Ooi, E. E., Kalimuddin, S., Tambyah, P. A., Low, J. G. H., Tan, Y. J. & Bertoletti, A. (2020). SARS-CoV-2-specific T cell immunity in cases of COVID-19 and SARS, and uninfected control. *Nature*, *584*, 457-462. doi: 10.1038/s41586-020-2550-z

[15] Yu, X., Tsibane, T., McGraw, P. A., House, F. S., Keefer, C. J., Hicar, M. D., Tumpey, T. M., Pappas, C., Perrone, L. A., Martinez, O., Stevens, J., Wilson, I. A., Aguilar, P. V., Altschuler, E. L., Basler, C. F., & Crowe Jr., J. E. (2008). Neutralizing antibodies derived from the B cells of 1918 influenza pandemic survivors. *Nature*, *455*, 532-536. doi: 10.1038/nature07231

[16] Ledford, H. (2021). Six months of COVID vaccines: What 1.7 billion doses have taught scientists. *Nature*, *594*(7862), 164-167. doi: 10.1038/d41586-021-01505-x (study notes that "Six months is not much time to collect data on how durable vaccine responses will be. . . . In the meantime some researchers are looking to natural immunity as a guide.").

[17] Chemaitelly, H., Tang, P., Hasan, M. R., Al Mukdad, S., Yassine, H. M., Benslimane, F. M., Khatib, H. A. A., Coyle, P., Ayoub, H. H., Kanaani, Z. A., Kuwari, E. A., Jeremijenko, A., Kaleeckal, A. H., Latif, A. N., Shaik, R. M., Rahim, H. F. A., Nasrallah, G. K., Kuwari, M. G. A., Romaihi, H. E. A., Abu-Raddad, L. J. (2021).

21. The key figures from the Qatari study are reproduced immediately below. Panel A shows that vaccine mediated protection against infection peaks at 72.1% zero to four weeks after the second dose, and then declines to 0%, 20 weeks after the second dose. According to this result, vaccines only protect against infection (and therefore disease spread) for a short period of time after the second dose of the mRNA vaccines.



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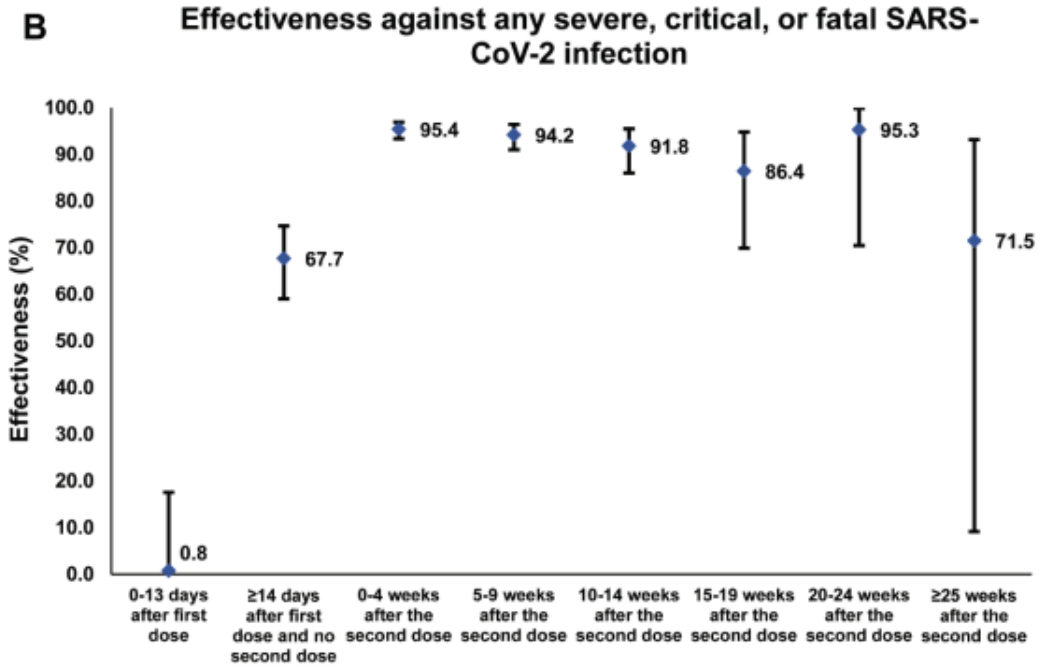
Waning of BNT162b2 vaccine protection against SARS-CoV-2 infection in Qatar. *medRxiv*, Preprint. doi: 10.1101/2021.08.25.21262584

22. On the other hand, Panel B shows that protection versus severe disease is long lasting after vaccination—even though the person will no longer be fully protected against infection and, presumably, disease spread. At 20-24 weeks after the second dose, the vaccine remains 95.3% efficacious versus severe disease. While it appears to dip after 25 weeks to 71.5% efficacy, the confidence interval is so wide that it is consistent with no decrease whatsoever even after 25 weeks.



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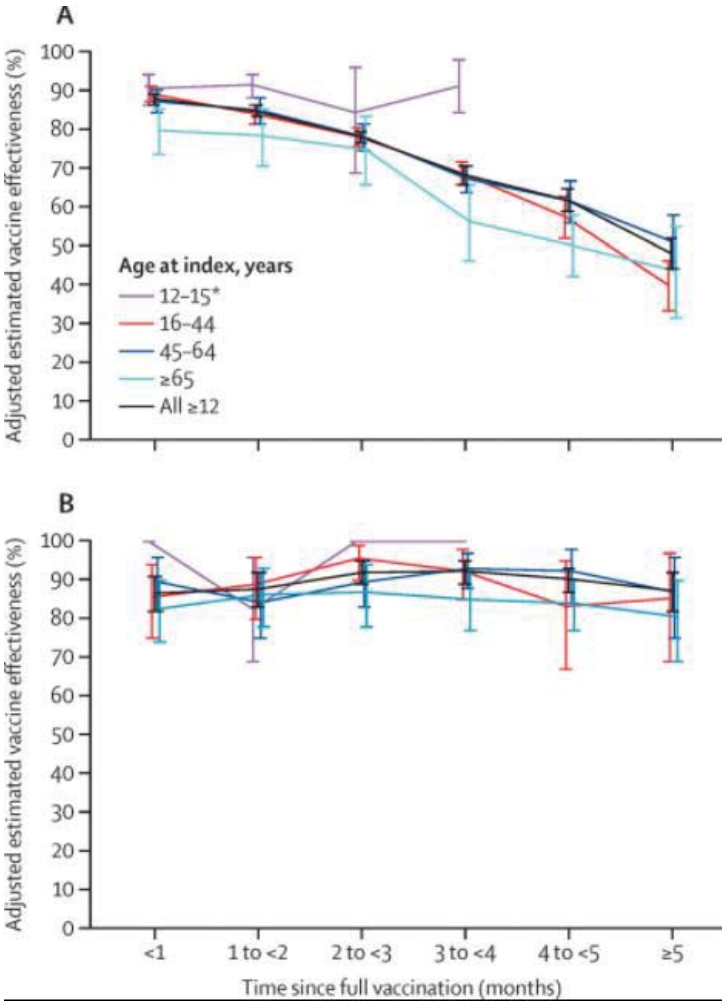
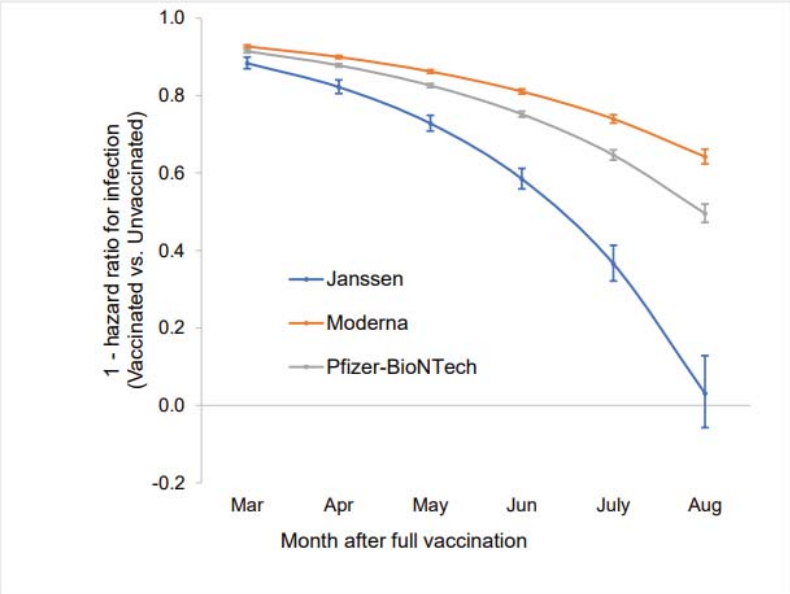
23. The Qatari study is no outlier. A large study in California tracked the infection rates for nearly 5 million patients vaccinated with two doses of the Pfizer mRNA vaccine. The study tracked both SARS-CoV-2 infections as well as COVID-19 related hospitalizations. The figure immediately below plots the trend in vaccine efficacy over time for different age groups in the population cohort. **Panel A** on the right plots effectiveness versus SARS-CoV-2 *infections*.[18] Though the drop in effectiveness is not as steep as in the Qatari study, there is nevertheless a sharp drop. While in the first month, vaccine effectiveness is near 90% for all age-groups, by month 5, it drops to nearly 50% for all the groups. By contrast, **Panel B** plots vaccine efficacy versus *hospitalizations*. It remains high with no decline over time –near 90% throughout the period. The vaccine provides durable private protection versus severe disease, but declining protection versus infection (and hence transmission).



[18] Tartof SY, Slezak JM, Fischer H, Hong V, Ackerson BK, Ranasinghe ON, Frankland TB, Ogun OA, Zamparo JM, Gray S, Valluri SR, Pan K, Angulo FJ, Jodar L, McLaughlin JM. Effectiveness of mRNA BNT162b2 COVID-19 vaccine up to 6 months in a large integrated health system in the USA: a retrospective cohort study. *Lancet*. 2021 Oct 16;398(10309):1407-1416. doi: 10.1016/S0140-6736(21)02183-8. Epub 2021 Oct 4. PMID: 34619098; PMCID: PMC8489881.

24. Another recent study tracked 620,000 vaccinated US veterans to measure breakthrough infections for the three vaccines in common use in the US.[19] Like the other studies, the authors of the study found a sharp decline in vaccine effectiveness versus infection. Five months after vaccination, the effectiveness of the J&J vaccine dropped from ~90% to less than 10%; the Pfizer vaccine dropped from ~90% to ~50%; and the Moderna dropped from ~90% to ~65%. The figure on this page tracks the decline in effectiveness of the vaccines against infection over time documented in this study. This study corroborates yet another study that documented declining vaccine efficacy in the first three months after vaccination against disease transmission in the era of the Delta variant.[20]



[19] Cohn BA, Cirillo PM, Murphy CC, et al. Breakthrough SARS-CoV-2 Infections in 620,000 U.S. Veterans, February 1, 2021 to August 13, 2021. medRxiv. October 14, 2021. https://doi.org/10.1101/2021.10.13.21264966;

[20] Eyre, D. W., Taylor, D., Purver, M., Chapman, D., Fowler, T., Pouwels, K. B., Walker, A. S. & Peto, T. E. A. (2021). The impact of SARS-CoV-2 vaccination on Alpha & Delta variant transmission. *medRxiv*, Preprint. doi: 10.1101/2021.09.28.21264260

25. Yet another study, conducted in Wisconsin, confirmed that vaccinated individuals can shed infectious SARS-CoV-2 viral particles.[21] The authors analyzed nasopharyngeal samples to check whether patients showed evidence of infectious viral particles. They found that vaccinated individuals were at least as likely as unvaccinated individuals to be shedding live virus. They concluded:

> Combined with other studies these data indicate that vaccinated and unvaccinated individuals infected with the Delta variant might transmit infection. Importantly, we show that infectious SARS-CoV-2 is frequently found even in vaccinated persons.

26. In summary, the evidence to date strongly suggests that while vaccines—like natural immunity—provide protection against severe disease, they, unlike natural immunity, provide only short-lasting protection against subsequent infection and disease spread. In short, there is no medical or scientific reason to believe that vaccine immunity will prove longer lasting than natural immunity, much less that all currently approved vaccines will be expected to prove more durable than natural immunity despite their different technological foundations and dosing protocols.

II. VACCINE SIDE EFFECTS, THOUGH RARE, DO OCCUR AND CAN BE DEADLY.

27. Though the COVID vaccines are safe by the standards of many other vaccines approved for use in the population, like all medical interventions, they have side effects. In summarizing the evidence on vaccine side effects, the CDC lists both common side effects, at least one of which occurs in over half of all people who receive

[21] Riemersma, K. K., Grogan, B. E., Kita-Yarbro, A., Halfmann, P. J., Segaloff, H. E., Kocharian, A., Florek, K. R., Westergaard, R., Bateman, A., Jeppson, G. E., Kawaoka, Y., O'Connor, D. H., Friedrich, T. C., & Grande, K. M. (2021). Shedding of infectious SARS-CoV-2 despite vaccination. *medRxiv*, Preprint. doi: 10.1101/2021.07.31.21261387

the vaccines, as well as deadly side effects that occur rarely in demographic subsets of the vaccinated population.

28. The common side effects include pain and swelling at the vaccination site and fatigue, headache, muscle pain, fever, and nausea for a limited time after vaccination.[22] Less common but severe side effects also include severe and non-severe allergic (anaphylactic) reactions that can occur immediately after vaccination, which can typically be treated with an epinephrine injection.[23] Finally, the CDC's vaccine safety committee has identified rare but deadly side effects, including a heightened risk of clotting abnormalities[24] in young women after the Johnson & Johnson (J&J) vaccination, elevated risks of myocarditis and pericarditis[25] in young people—but especially young men—after mRNA vaccination, and higher risk of Guillane-Barre Syndrome[26] after the J&J vaccine. There is still the possibility of severe side effects

[22] Centers for Disease Control and Prevention. (2021, September 30). *Possible side effects after getting a COVID-19 vaccine*. Retrieved October 1, 2021 from https://www.cdc.gov/coronavirus/2019-ncov/vaccines/expect/after.html

[23] Centers for Disease Control and Prevention. (2021, August 30). *What to do if you have an allergic reaction after getting a COVID-19 vaccine*. Retrieved October 1, 2021 from https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/allergic-reaction.html

[24] Kulldorff, M. (2021, April 17). The dangers of pausing the J&J vaccine. *The Hill*. https://thehill.com/opinion/healthcare/548817-the-dangers-of-pausing-the-jj-vaccine

[25] National Center for Immunization & Respiratory Diseases, Centers for Disease Control and Prevention. (2021, August 23). *Clinical considerations: Myocarditis and pericarditis after receipt of mRNA COVID-19 vaccines among adolescents and young adults*. Retrieved October 1, 2021 from https://www.cdc.gov/vaccines/covid-19/clinical-considerations/myocarditis.html

[26] LaFraniere, S. & Weiland, N. (2021, July 12). FDA attaches warning of rare nerve syndrome to Johnson & Johnson vaccine. *The New York Times*. https://www.nytimes.com/2021/07/12/us/politics/fda-warning-johnson-johnson-

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.

29. Though the CDC[27] still recommends the vaccines for children 12 years old and up despite the evidence of elevated risk of myocarditis, other analysts[28] have objected to overly rosy assumptions made in the CDC analysis about vaccine side effects. Those analysts suggest that the CDC's recommendation is fragile to minor perturbation in their assumptions. The critical point for my analysis—undisputed in the scientific literature—is that the vaccines do have side effects, some of which are severe and not all of which are necessarily known now.

III. The Risk of Those Side Effects Is Heightened In Certain Groups & Clinical Data on Vaccine Safety and Efficacy are Not Available for Patients with Certain Chronic Diseases.

30. The CDC lists two primary contraindications to COVID vaccination: (1) "severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine"; and (2) "immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the COVID-19 vaccine."[29] Among the inactive ingredients of the COVID vaccines, polyethylene

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vaccine-nerve-syndrome.html

[27] Walensky, R. (2021, May 12). CDC director statement on Pfizer's use of COVID-19 vaccine in adolescents age 12 and older. *Center for Disease Control and Prevention*. Retrieved October 1, 2021 from https://www.cdc.gov/media/releases/2021/s0512-advisory-committee-signing.html

[28] Pegden, W. (2021, June 24). Weighing myocarditis cases, ACIP failed to balance the harms vs benefits of 2nd doses. *Medium.* https://medium.com/@wpegden?p=d7d6b3df7cfb

[29] National Center for Immunization & Respiratory Diseases, Centers for Disease Control and Prevention. (2021, September 27). *Interim clinical considerations for use of COVID-19 vaccines currently approved or authorized in the United States*. Retrieved October 1, 2021 from https://www.cdc.gov/vaccines/covid-19/clinical-

glycol (PEG)—which is used in other drugs and vaccines—is most likely to induce an allergic reaction. In addition to contraindications, the CDC lists several precautions to vaccination, including known allergic reactions to polysorbate or PEG or to other non-COVID vaccines and injectable therapies. Patients with precautions are encouraged to consult with an allergist or immunologist and to conduct an individualized risk assessment by the vaccination provider before getting the vaccine.[30]

31. Some clinical evidence indicates that those who have recovered from COVID-19 could have a *heightened* risk of adverse effects compared with those who have never had the virus.[31, 32] This may be because vaccine reactogenicity after the first

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considerations/covid-19-vaccines-us.html

[30] Centers for Disease Control and Prevention. (2021, September 27). *Interim clinical considerations for use of COVID-19 vaccines currently approved or authorized in the United States: Contraindications and precautions*. Retrieved Oct. 1, 2021 from https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fcovid-19%2Finfo-by-product%2Fclinical-considerations.html#Contraindications

[31] Mathioudakis, A. G., Ghrew, M., Ustianowski, A., Ahmad, S., Borrow, R., Papavasileiou, L. P., Petrakis, D., & Bakerly, N. D. (2021). Self-reported real-world safety and reactogenicity of COVID-19 vaccines: A vaccine recipient survey. *Life*, *11*(3), 249. doi: 10.3390/life11030249

[32] Menni, C., Klaser, K., May, A., Polidori, L., Capdevila, J., Louca, P., Sudre, C. H., Nguyen, L. H., Drew, D. A., Merino, J., Hu, C., Selvachandran, S., Antonelli, M., Murray, B., Canas, L. S., Molteni, E., Graham, M. S., Modat, M., Joshi, A. D., Spector, T. D. (2021). Vaccine side-effects and SARS-CoV-2 infection after vaccination in users of the COVID Symptom Study app in the UK: A prospective observational study. *The Lancet Infectious Diseases*, *21*(7), 939-949. doi: 10.1016/S1473-3099(21)00224-3 (finding that "Systemic side-effects were more common (1.6 times after the first dose of ChAdOx1 nCoV-19 [i.e., AstraZeneca vaccine] and 2.9 times after the first dose of BNT162b2 [i.e., Pfizer/BioNTech vaccine]) among individuals with previous SARS-CoV-2 infection than among those without known past infection. Local effects were similarly higher in individuals previously infected than in those without known past infection (1.4 times after the first dose of ChAdOx1 nCoV-19 and

dose is higher among those with prior immunity.[33] Despite this evidence, the CDC does not list prior immunity as a contraindication to vaccination, though it does recommend waiting 90 days after recovering before vaccination.

32. Though the CDC recommends the COVID vaccines for all adults, because they are novel—available for use in the population for only 9-10 months—there remain open questions about their use in special populations because they have not been tested in subgroups of patients with particular clinical conditions. For instance, in a comprehensive discussion of the biology of immune responses to vaccination (including COVID-19 vaccination) for patients with Multiple Sclerosis published in June 2021, Coyle et al. emphasize the lack of high-quality evidence available to guide recommendations for MS patients. They point out that three of six medical societies that focus on MS patients have failed to make a recommendation on whether MS patients should receive the COVID-19 vaccines. They and other authorities[34] emphasize the need for personalized decision making based on the clinical condition of the MS patient:[35]

1.2 times after the first dose of BNT162b2).").

[33] Krammer, F., Srivastava, K., the PARIS team & Simon, V. (2021). Robust spike antibody responses and increased reactogenitiy in seropositive individuals after a single dose of SARS-CoV-2 mRNA vaccine. *medRxiv*, Preprint. https://www.medrxiv.org/content/10.1101/2021.01.29.21250653v1 (concluding that "vaccine reactogenicity after the first dose is substantially more pronounced in individuals with pre-existing immunity." The authors note that "quantitative serological assays that measure antibodies to the spike protein could be used to screen individuals prior to vaccination," which would "limit the reactogenicity experienced by COVID-19 survivors.").

[34] Ciotti, J. R., Valtcheva, M. V. & Cross, A. H. (2020). Effects of MS disease-modifying therapies on responses to vaccinations: A review. *Multiple Sclerosis Related Disorders*, *45*, 1-11. doi: 10.1016/j.msard.2020.102439

[35] Coyle, P. K., Gocke, A., Vignos, M. & Newsome, S. D. (2021). Vaccine considerations for multiple sclerosis in the COVID-19 era. *Advances in Therapy*, *38*(7),

> Currently, three COVID-19 vaccines have been granted emergency use authorization in the USA on the basis of promising interim findings of ongoing trials. Because analyses of these vaccines in people with MS are not available, decisions regarding COVID-19 vaccination and DMT choice should be informed by data and expert consensus, and personalized with considerations for disease burden, risk of infection, and other factors.

33. The paucity of data on the COVID-19 vaccine on patients with particular conditions is not limited to Multiple Sclerosis. Pregnant women were excluded from participating in the COVID-19 vaccination trials, consequently only limited randomized trial data are available about COVID-19 vaccine safety for that group.[36] Though the CDC and obstetrics focused specialty organizations nevertheless recommend COVID vaccination for pregnant women, many authors in peer reviewed journal articles have pointed to the lack of scientific data regarding vaccine safety in this group as a problem for clinicians providing accurate advice to pregnant women.[37] Given this uncertainty, Nicola Volpe and her colleagues[38] writing in the *Journal of Perinatal Medicine* explicitly recommend that "Women should discuss with healthcare

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3550-3588. doi:10.1007/s12325-021-01761-3

[36] Rasmussen, S. A., Kelley, C. F., Horton, J. P., & Jamieson, D. J. (2021). Coronavirus disease 2019 (COVID-19) vaccines and pregnancy: What obstetricians need to know. *Obstetrics & Gynecology*, *137*(3), 408-414. doi: 10.1097/AOG.0000000000004290 Erratum in: *Obstetrics & Gynecology,* *137*(5), 962. doi: 10.1097/AOG.0000000000004379

[37] Holness, N. A., Powell-Young, Y. M., Torres, E., DuBois, S., & Giger, J. N. (2021) Covid-19, pregnancy, and vaccinations. *Journal of National Black Nurses Association*, *32*(1), 1-9..

[38] Volpe, N., Luca Schera, G. B., Dall'Asta, A., Di Pasquo, E., & Ghi, T. (2021) COVID-19 in pregnancy: Where are we now? *Journal of Perinatal Medicine*, *49*(6), 637-642. doi: 10.1515/jpm-2021-0309.

professionals about the benefits and risks of having the vaccine, allowing an informed decision." In recent months some observational studies have shown reassuring results, including that pregnant woman face no greater risk of complications during pregnancy or delivery,[39] or of spontaneous abortion or miscarriage after vaccination.[40] Nevertheless, there is still an area of active research where safety signals may still emerge. A large French study of vaccine safety in pregnancy expects to report complete results in late 2022.[41] After a thorough review of mostly reassuring data on the safety of the vaccine for pregnant women, Lydia Shook and some of her colleagues at Massachusetts General Hospital write that—given the recent introduction of the vaccine into use by pregnant women—it may be some time before full safety data become available:[42]

> Complete pregnancy outcomes data from people vaccinated in the first and early second trimesters are not yet available as most of these pregnancies are ongoing. Durability of IgG in the blood of neonates born to vaccinated mothers has not yet been defined, nor has whether the anti-SARS-CoV-2

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[39] Theiler, R. N., Wick, M., Mehta, R., Weaver, A. L., Virk, A., & Swift, M. (2021). Pregnancy and birth outcomes after SARS-CoV-2 vaccination in pregnancy. *American Journal of Obstetrics & Gynecology MFM*, *3*(6), 100467. doi: 10.1016/j.ajogmf.2021.100467 Online ahead of print.

[40] Kharbanda, E. O., Haapala, J., DeSilva, M., Vazquez-Benitez, Vesco, K. K., Naleway, A. L., & Lipkind, H. S. (2021). Spontaneous abortion following COVID-19 vaccination during pregnancy. *JAMA*, e2115494. Online ahead of print. doi:10.1001/jama.2021.15494

[41] Cottin, J., Benevent, J., Khettar, S., & Lacroix, I. (2021). COVID-19 vaccines and pregnancy: What do we know? *Therapie*, *76*(4), 373-374. doi: 10.1016/j.therap.2021.05.011

[42] Shook, L. L., Fallah, P. N., Silberman, J. N., & Edlow, A. G. (2021) COVID-19 vaccination in pregnancy and lactation: Current research and gaps in understanding. *Frontiers in Cellular and Infection Microbiology*, *11*, 735394. doi: 10.3389/fcimb.2021.735394

> IgG generated influences the response to other childhood vaccines. Information on postnatal outcomes and offspring development will require long term follow-up of children born to individuals who received the vaccine during pregnancy.

34. There are also patients with particular genetic conditions where vaccine safety data are not adequate. For instance, for patients with alpha-1 antitrypsin deficiency (AATD), an inherited disorder that predisposes a patient to enzymatic tissue injuries and inflammation—especially in the lungs—there are no clinical data whatsoever regarding the safety and efficacy of the COVID-19 vaccines. Writing in *Lancet Respiratory Medicine*, Yang and Zhao hypothesize "individuals with AATD might derive limited benefit from the current COVID-19 vaccines." They note that "even though vaccination has been prioritised to more vulnerable populations (such as people with AATD), individuals with AATD are usually not included in clinical trials (as reported in ClinicalTrials.gov), and thus the effectiveness and adverse event profile of vaccination in this population are unknown."[43] The same can be said for other patients with many other chronic diseases, for whom the decision whether to vaccinate should be an individual decision made in consultation with their physicians, rather than coerced by a firm or the government.

IV. Asymptomatic Disease Spread is Rare.

35. In this section, I discuss the evidence regarding the asymptomatic transmission of disease. This is important because if asymptomatic disease spread is rare, SDUSD can keep its employees and students safe from COVID disease spread by the simple expedient of requiring those who have not been vaccinated (and even those who have been) to report daily through an online app whether they are

[43] Yang, C. & Zhao, H. (2021) COVID-19 vaccination in patients with α1-antitrypsin deficiency. *The Lancet, Respiratory Medicine*, *9*(8), 818-820. doi:10.1016/S2213-2600(21)00271-X

experiencing symptoms consistent with COVID-19. Those who are experiencing symptoms would be asked to stay at home from school and get tested; returning to school only if the test is negative.

36. The best evidence on how frequently asymptomatic disease spread occurs comes from a large meta-analysis of 54 studies from around the world of within-household spread of the virus—that is, from an infected person to someone else living in the same home (Madewell et al. 2020). This study represents the most comprehensive survey of the vast empirical literature on asymptomatic spread. At home, *of course*, none of the safeguards often recommended in public spaces outside of home (such as masking and social distancing) are typically applied. Because the study focuses on a single setting (household transmission), it is not subject to the same problems that other studies on this topic might have. In particular, by focusing on a homogenous setting where few safeguards exist, the estimate represents an upper bound on the frequency that someone positive for the virus but with no symptoms (and hence either pre-symptomatic or asymptomatic) may spread the virus to close contacts. The primary result is that symptomatic patients passed on the disease to household members in 18% of instances. In comparison, those infected but without symptoms (asymptomatic and pre-symptomatic patients) passed on the infection to household members in only 0.7% of instances.[44]

37. There is some additional evidence on how frequently asymptomatic disease spread occurs. A large study of 10 million residents of Wuhan, China, all tested for the presence of the virus, found a total of 300 cases, all asymptomatic. A comprehensive contact tracing effort identified 1,174 close contacts of these patients, none of whom

[44] Madewell, Z. J., Yang, Y., Longini, I. M., Halloran, M. E. & Dean, N. E. (2020). Household transmission of SARS-CoV-2: A systematic review and meta-analysis. *JAMA Network Open*, *3*(12), 1-17. doi:10.1001/jamanetworkopen.2020.31756

tested positive for the virus.[45] This is consistent with a vanishingly low level of asymptomatic spread of the disease. Given the late date of the study relative to the date of the large first wave of infections in Wuhan, it is likely that none of the 300 asymptomatic cases were likely ever to develop symptoms. A separate, smaller meta-analysis similarly found that asymptomatic patients are much less likely to infect others than symptomatic patients.[46]

38. By contrast with asymptomatic patients, symptomatic patients are very likely to infect others with the virus during extended interactions, especially in the initial period after they develop symptoms. A careful review of 79 studies on the infectivity of COVID-19 patients found that even symptomatic patients are infectious for only the first eight days after symptom onset, with no evidence of live virus detected beyond day nine of illness.[47]

39. Much of the support for the idea that asymptomatic disease spread is common comes from theoretical modeling work from earlier in the epidemic (including some of my own published research[48]), predicting some level of asymptomatic disease

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[45] Cao, S., Gan, Y., Wang, C., Bachmann, M., Wei, S., Gong, J., Huang, Y., Wang, T., Li, L., Lu, K., Jiang, H., Gong, Y., Xu, H., Shen, X., Tian, Q., Lv, C., Song, F., Yin, X. & Lu, Z. (2020). Post-lockdown SARS-CoV-2 nucleic acid screening in nearly ten million residents of Wuhan, China. *Nature Communications*, *11*(1), 5917. doi: 10.1038/s41467-020-19802-w

[46] Buitrago-Garcia, D., Egli-Gany, D., Counotte, M. J., Hossmann, S., Imeri, H., Ipekci, A. M., Salanti, G. & Low, N. (2020). Occurrence and transmission potential of asymptomatic and presymptomatic SARS-CoV-2 infections: A living systematic review and meta-analysis. *PLOS Medicine*, *17*(9), e1003346. doi: 10.1371/journal.pmed.1003346

[47] Cevik, M., Tate, M., Lloyd, O., Maraolo, A. E., Schafers, J. & Ho, A. (2021). SARS-CoV-2, SARS-CoV, and MERS-CoV viral load dynamics, duration of viral shedding, and infectiousness: A systematic review and meta-analysis. *The Lancet, Microbe*, *2*(1), e13-e22. doi: 10.1016/S2666-5247(20)30172-5

[48] Peirlinck, M., Linka, K., Costabal, F. S., Bhattacharya, J., Bendavid, E., Ioannidis,

spread. However, this sort of modeling work does not represent actual evidence that asymptomatic spread is common in the real world, since they rely on many modeling assumptions that are impossible to check.

40. There is at least one prominent real-world study that some have used to argue that asymptomatic disease spread is common. A meta-analytic study by Qiu et al. (2021) distinguishes the likelihood of disease spread by a pre-symptomatic individual from the likelihood of spread by an asymptomatic individual who never develops symptoms.[49] A primary finding of this study is that, while an asymptomatic individual who never develops symptoms is exceedingly unlikely to spread the disease, individuals who are not symptomatic now but will eventually develop symptoms are efficient at infecting others during their pre-symptomatic state.

41. Distinguishing between an infected individual who will eventually develop symptoms and an infected individual who will never develop symptoms is difficult without the passage of time. Infected individuals who will develop symptoms tend to do so within a very short interval (two to three days) after first becoming infected. Meanwhile, infected individuals who never develop symptoms may test positive with the PCR test for the virus for an extended period. These two groups of observationally identical individuals are mixed in the population in some unknown frequency that may change over time. Given this information constraint, from a policy point of view, the relevant question is how likely it is that an infected individual without symptoms (whether pre-symptomatic or purely asymptomatic) will spread the disease to close

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J. P. A. & Kuhl, E. (2020). Visualizing the invisible: The effect of asymptotic transmission on the outbreak dynamics of COVID-19. *Computer Methods in Applied Mechanics and Engineering*, *372*(1), 113140. doi: 10.1016/j.cma.2020.113410

[49] Qiu, X., Nergiz, A. I., Maraolo, A. E., Bogoch, I. I., Low, N. & Cevik, M. (2021). The role of asymptomatic and pre-symptomatic infection in SARS-CoV-2 transmission-A living systematic review. *Clinical Microbiology and Infection*, *27*(4), 511-519. doi: 10.1016/j.cmi.2021.01.011

contacts. The Madewell et al. (2020) study provides an answer (less than 0.7% secondary attack rate in household settings), while the Qiu et al. (2021) study does not. Additionally, unlike the Madewell et al. (2020) study, the Qiu et al. (2021) study does not concentrate its focus on a homogenous environment (households), which makes the results it reports harder to interpret.

42. In summary, asymptomatic individuals are an order of magnitude less likely to infect others than symptomatic individuals, even in intimate settings such as people living in the same household where people are much less likely to follow social distancing and masking practices that they follow outside the household. Spread of the disease in less intimate settings by asymptomatic individuals—including in the context of the school environment—is likely to be even less likely than in the household.

V. THERE ARE MULTIPLE SAFE ALTERNATIVES TO INDEPENDENT ONLINE STUDY THAT CAN BE OFFERED TO SDUSD STUDENTS.

43. Can SDUSD keep its employees and students safe if it does not mandate that all students be vaccinated? The answer is a definitive yes.

44. First and most obviously, SDUSD could adopt a robust sick policy, requiring that students who have not been vaccinated and who show symptoms consistent with COVID-19 infection stay at home from school, returning to school only once they have had a negative COVID-19 PCR or antigen test result. This could be implemented, for instance, by requiring students to complete a symptom self-check each day before coming to school. SDUSD would provide students with a supply of inexpensive rapid antigen tests, which are easy to self-administer at home, provide results within 30

minutes, and are highly accurate for detecting whether a patient is infectious.[50, 51] A large number of lateral flow antigen tests have received Emergency Use Authorization (EUA) by the US Food and Drug Administration.[52] Alternatively, SDUSD could require that any unvaccinated students obtain those tests themselves to keep its own costs down. Students who report COVID-19 like symptoms would be asked to send a picture of their positive test result to their teacher or a SDUSD school nurse by phone or email to verify their result.[53] A system that required the few students who seek the vaccine exemption to provide this information to their teacher each day before coming to school would be inexpensive—no online reporting system would be necessary.

45. For this symptom checking policy to be effective in reducing the risk of disease spread, it must be the case that symptomatic students are substantially more likely to infect others than students who are infected (that is, have evidence of the virus in the nasopharynx), but who have no symptoms. Fortunately, as we have seen in the

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[50] Surasi, K., Cummings, K. J., Hanson, C., Morris, M. K., Salas, M., Seftel, D., Ortiz, L., Thilakaratne, R., Stainken, C. & Wadford, D. A. (2021). Effectiveness of Abbott BinaxNOW rapid antigen test for detection of SARS-CoV-2 infections in outbreak among horse racetrack workers, California, USA. *Emerging Infectious Diseases*, *27*(11).

[51] Homza, M., Zelena, H., Janosek, J., Tomaskova, H., Jezo, E., Kloudova, A., Mrazek, J., Svagera, Z. & Pymula, R. (2021). Covid-19 antigen testing: Better than we know? A test accuracy study. *Infectious Diseases*, *53*(9), 661-668. doi: 10.1080/23744235.2021.1914857

[52] US FDA. (2021) In-Vitro Diagnostics EUA – Antigen Diagnostic Tests for SARS-CoV-2. Oct. 4, 2021. https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/in-vitro-diagnostics-euas-antigen-diagnostic-tests-sars-cov-2 Accessed Oct. 10, 2021

[53] Indeed, if SDUSD's goal is really to prevent the spread of COVID-19 as much as reasonably possible, symptom checking should be required of all employees and students, whether vaccinated or not, since the evidence shows that vaccination does not eliminate the possibility of infection and may provide less protection versus infection than immunity induced by prior COVID infection.

previous section, the best empirical evidence shows that the probability that an asymptomatic individual will spread the disease is very low. And because the overwhelming majority of SDUSD employees and students will themselves be vaccinated, they face even less risk from any of the asymptomatic, unvaccinated students who receive an accommodation from SDUSD for religious (or medical) reasons of developing severe COVID symptoms.

46. Second, SDUSD could implement a program of weekly PCR or antigen testing as a condition of a student's receiving an exemption. Many other organizations have implemented a testing regimen like this for all employees, including my home institution, Stanford University. Students receiving an exemption could take the test at school—there are versions of the test available that can be self-administered. Or students could be required to purchase and take the test at home.[54]

47. No detailed reporting mechanism or centralized system would be necessary for any of the accommodations that I proposed, Simply requiring its students to report to their teachers the results of their testing and/or the presence of any COVID symptoms would allow SDUSD to keep its employees and students safe—at least as safe as they would be under a universal vaccine mandate with no meaningful exemptions.

48. Third, SDUSD could simply exempt from its vaccine requirement all students who legitimately claim an exemption and have recovered from COVID infection. The evidence provided in this declaration shows that such students pose at least as little—and likely less—risk of spreading the SARS-CoV-2 virus than fully vaccinated students who are not among the set of COVID-recovered patients.

[54] Indeed, the safest option would be for both vaccinated and unvaccinated students to be required to provide a weekly test, since both can have asymptomatic SARS-CoV-2 infections.

49. While it is true that those who have recovered from COVID could incrementally reduce the infection risk they pose to others by *also* receiving the vaccine, it would make no sense for SDUSD to require that of those seeking a religious exemption. For one thing, the incremental safety benefit of such a requirement would be vanishingly small. A study analyzing 738 patients in Kentucky and published in the CDC's journal (MMWR), estimated that the odds that COVID-recovered patients who are vaccinated are 2.34 [95% CI: 1.58-3.47] times lower for reinfection than COVID-recovered patients who are not vaccinated.[55] However, this reduction in the relative risk of reinfection represents a vanishingly small absolute risk reduction. Recall the study of Italian COVID-recovered patients that I cite above reported a reinfection rate of 0.3%, or 3 out of 1,000 after one year.[56] If the Kentucky study is right, vaccinating COVID recovered patients prevents on the order 2 infections out of a 1,000 people. This reduction can easily be replicated and improved upon without forced vaccination but with the symptom checking and regular testing solutions I suggest.

50. Moreover, the proper baseline for assessing the reasonableness of an exemption policy is not what kind of policy would produce the *maximum* reduction in risk, but rather what exemption options would reduce the risk posed by those receiving an exemption to a level below that posed by those complying with SDUSD's vaccination requirement. After all, SDUSD is willing to tolerate the risk of infection posed by those who have received the vaccine—a risk that increases substantially a few

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[55] Cavanaugh AM, Spicer KB, Thoroughman D, Glick C, Winter K. Reduced Risk of Reinfection with SARS-CoV-2 After COVID-19 Vaccination — Kentucky, May–June 2021. MMWR Morb Mortal Wkly Rep 2021;70:1081-1083. DOI: http://dx.doi.org/10.15585/mmwr.mm7032e1

[56] Vitale, J., Mumoli, N., Clerici, P., de Paschale, M., Evangelista, I., Cei, M. & Mazzone, A. (2021). Assessment of SARS-CoV-2 reinfection 1 year after primary infection in a population in Lombardy, Italy. *JAMA Internal Medicine*, *181*(10), 1407-1409. doi: 10.1001/jamainternmed.2021.2959

months after vaccination. If the objective were to reduce infection risk as much as humanly possible, SDUSD would have to require its *vaccinated* students to find a way to contract COVID (and stay home until they recover)—since the combination of a vaccination and a prior COVID reduces infection risk compared to either alone. But SDUSD could not reasonably impose such a requirement, since an actual COVID infection would pose additional health risks to those who have been vaccinated. By the same risk/benefit logic—in light of the health risks posed by the vaccine itself—SDUSD cannot reasonably require those seeking an exemption who have recovered from COVID to also be vaccinated.

51. Finally, I would like to note that SDUSD has agreed to provide religious accommodations to its employees—just not its students—and medical accommodations for both This shows that that the risk posed by unvaccinated individuals can be mitigated with an expense that is bearable (since the expense is not likely to be large). There is no good reason to refuse to extend this accommodation to SDUSD students who decline the vaccine for religious reasons.

VI. Variants Do Not Alter the Conclusion that Accommodations Can Be Allowed Without Risk to Public Safety.

52. Since its spread through the human population, the SARS-CoV-2 virus—an RNA virus—has been mutating, including some forms that are likely more transmissible than the original wild-type virus that emerged from Wuhan, China, in 2019. As of the date of this declaration, the Delta variant is the dominant form of the SARS-CoV-2 virus worldwide. The virus will continue to mutate as it continues to spread. However, the possibility of such a mutation does not alter the conclusion that accommodations can be allowed without risk to public safety.

53. For one thing, the first two accommodations discussed above would be equally effective against variants as they are against the original Wuhan version. That is because all variants to arise thus far produce symptoms that can be checked for, and

can be identified through standard COVID testing. So regular symptom-checking and/or testing for those receiving religious accommodations is sufficient.

54. Variants likewise do not affect the reasonableness of the COVID-recovery alternative discussed above. The key point is that the mutant variants do not escape the immunity provided by prior infection with the wild-type virus or vaccination.[57, 58, 59] This is true of the delta variant as well. In a study of a large population of patients in Israel, *vaccinated* people who had not been previously infected were 13 times more likely to experience a breakthrough infection with the Delta variant than patients who had recovered from COVID.[60] Although reinfection can occur, people who have been previously infected by the virus are unlikely to have a severe outcome (hospitalization or death) after exposure to a variant virus (see section I above for citations). A variant

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[57] Tarke, A., Sidney, J., Methot, N., Yu, E. D., Zhang, Y., Dan, J. M., Goodwin, B., Rubiro, P., Sutherland, A., Wang, E., Frazier, A., Ramirez, S. I., Rawlings, S. A., Smith, D. M., da Silva Antunes, R., Peters, B., Scheuermann, R. H., Weiskopf, D., Crotty, S., Grifoni, A. & Sette, A. (2021). Impact of SARS-CoV-2 variants on the total $CD4^+$ and $CD8^+$ T cell reactivity in infected or vaccinated individuals, *Cell Reports Medicine 2,* 100355.

[58] Wu, K., Werner, A. P., Moliva, J. I., Koch, M., Choi, A., Stewart-Jones, G. B. E., Bennett, H., Boyoglu-Barnum, S., Shi, W., Graham, B. S., Carfi, A., Corbett, K. S., Seder, R. A. & Edwards, D. K. (2021). mRNA-1273 vaccine induces neutralizing antibodies against spike mutants from global SARS-CoV-2 variants. *bioRxiv*, Preprint. doi: 10.1101/2021.01.25.427948

[59] Redd, A. D., Nardin, A., Kared, H., Bloch, E. M., Pekosz, A., Laeyendecker, O., Abel, B., Fehlings, M., Quinn, T. C. & Tobian, A. A. (2021). $CD8^+$ T-cell responses in COVID-19 convalescent individuals target conserved epitopes from multiple prominent SARS-CoV-2 circulating variants. *Open Forum Infectious Diseases 8*(7), ofab143.

[60] Gazit, S., Shlezinger, R., Perez, G., Lotan, R., Peretz, A., Ben-Tov, A., Cohen, D., Muhsen, K., Chodick, G. & Patalon, T. (2021). Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: Reinfections versus breakthrough infections. *medRxiv*, Preprint. doi: 10.1101/2021.08.24.21262415

circulating in the population thus poses little additional risk of excess mortality due to viral infection.

55. The dissemination of vaccines that protect against hospitalizations and deaths upon COVID-19 infection throughout the older population in the United States has partially decoupled the growth in COVID-19 cases from COVID-19 mortality. Vaccinated people can still be infected but much less commonly have severe symptoms in response to infection. 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, in Sweden and the U.K., where vaccines have been provided to a large portion of the vulnerable elderly population and more, there have been "relatively few hospitalisations and deaths" in those countries.[61] Because of the success of the American vaccination effort among the vulnerable elderly, COVID-19 cases and COVID-19 deaths are at least partially decoupled, so the public danger from the continuing spread of COVID-19 disease is less than it was last year when the vaccine was not available.

VII. The Presence of Lingering Post-Viral Infection Symptoms in a Subset of Recovered COVID Patients ("Long COVID") Does Not Alter the Conclusion that Accommodations Pose No Threat to Public Safety.

56. Some analysts and politicians have used the possibility that a fraction of patients who recover from COVID infection will experience lingering symptoms to justify unyielding vaccine mandates. Long COVID, as this phenomenon is called, includes a complex set of clinical outcomes with a poorly understood link to acute

[61] Bhattacharya, J., Kulldorff, M. & Gupta, S. (2021, July 12). Sweden's lessons for the UK's third wave. *The Spectator*. https://www.spectator.co.uk/article/sweden-shows-that-the-uk-s-third-wave-won-t-sting

COVID infection.[62] One cross-sectional study found that about 30% of recovered COVID patients reported at least one symptom months after recovery, with fatigue and anosmia (loss of sense of smell) by far the most common.[63] A separate study with a more convincing longitudinal methodology, by contrast, concluded that only 2.3% of patients experienced such symptoms three months after recovery.[64] Patients who suffered a more severe acute course of COVID, including hospitalization, were more likely to report lingering symptoms after recovery.[65] A study of children who recovered from COVID found the same rate of long COVID symptoms as a control group of children who had no serological evidence of prior COVID infection.[66] Some analysts

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[62] Nalbandian, A., Sehgal, K., Gupta, A., Madhavan, M. V., McGroder, C., Stevens, J. S., Cook, J. R., Nordvig, A. S., Shalev, D., Sehrawat, T. S., Ahluwalia, N., Bikdeli, B., Dietz, D., Der-Nigoghossian, C., Liyanage-Don, N., Rosner, G. F., Bernstein, E. J., Mohan, S., Beckley, A. A. & Wan, E. Y. (2021). Post-acute COVID-19 syndrome. *Nature Medicine*, *27*(4), 601-615. doi: 10.1038/s41591-021-01283-z

[63] Logue, J. K., Franko, N. M., McCulloch, D. J., McDonald, D., Magedson, A., Wolf, C. R., & Chu, H. Y. (2021). Sequelae in adults at 6 months after COVID-19 infection. *JAMA Network Open, 4*(2), e210830. doi: 10.1001/jamanetworkopen.2021.0830

[64] Sudre, C. H., Murray, B., Varsavsky, T., Graham, M. S., Penfold, R. S., Bowyer, R. C., Pujol, J. C., Klaser, K., Antonelli, M., Canas, L. S., Molteni, E., Modat, M., Cardoso, M. J., May, A., Ganesh, S., Davies, R., Nguyen, L. H., Drew, D. A., Astley, C. M., Steves, C. J. (2021). Attributes and predictors of long COVID. *Nature Medicine*, *27*(4), 626-631. doi: 10.1038/s41591-021-01292-y

[65] Arnold, D. T., Hamilton, F. W., Milne, A., Morley, A. J., Viner, J., Attwood, M., Noel, A., Gunning, S., Hatrick, J., Hamilton, S., Elvers, K. T., Hyams, C., Bibby, A., Moran, E., Adamali, H. I., Dodd, J. W., Maskell, N. A., Barratt, S. L. (2021). Patient outcomes after hospitalisation with COVID-19 and implications for follow-up: Results from a prospective UK cohort. *Thorax*, *76*, 399-401. doi: 10.1136/thoraxjnl-2020-216086

[66] Radtke, T., Ulyte, A., Puhan, M. A. & Kriemler, S. (2021). Long-term symptoms after SARS-CoV-2 infection in school children: Population-based cohort with 6-months follow-up. *JAMA*, *326*(9), 869-871. doi: 10.1001/jama.2021.11880

have noted the similarity between "long COVID" symptoms and other functional somatic syndromes that sometimes occur after other viral infections and other triggers (and sometimes with no identifiable etiology).[67]

57. To summarize, as with other viruses, long COVID symptoms occur in a minority of patients who recover from COVID and pose a real burden on patients who suffer from it. However, this fact does not alter the logic of my point about accommodations. On the contrary. After suffering through a COVID infection, with or without long COVID, such individuals should not be forced to also endure common, but mild, vaccine adverse reactions or risk rare—but serious—adverse reactions. Moreover, the successful vaccine rollout in the United States—where every teenager and adult now have free access to the vaccines—addresses the problem of long COVID, just as it addresses COVID-associated mortality.

VIII. The CDC's Recommendation for Vaccination of Recovered COVID Patients Applies with Equal Force to Those Who Have Been Previously Vaccinated, Whose Protection Against Infection Wanes Within a Few Months After Vaccination.

58. The CDC, in the Frequently Asked Questions (FAQ) section of its website encouraging vaccination, provides the following advice to previously recovered patients:[68]

> Yes, you should be vaccinated regardless of whether you already had COVID-19. That's because experts do not yet know how long you are protected from getting sick again after recovering from COVID-19. Even if you have already

[67] Ballering, A., Olde Hartman, T. & Rosmalen, J. (2021). Long COVID-19, persistent somatic symptoms and social stigmatization. *Journal of Epidemiology and Community Health*, *75*, 603-604. doi: 10.1136/jech-2021-216643

[68] Centers for Disease Control and Prevention. (2021, September 28). Frequently asked questions about COVID-19 vaccination. Retrieved October 1, 2019 from https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html

> recovered from COVID-19, it is possible—although rare—that you could be infected with the virus that causes COVID-19 again. Studies have shown that vaccination provides a strong boost in protection in people who have recovered from COVID-19. Learn more about why getting vaccinated is a safer way to build protection than getting infected.

59. The text of this advice by the CDC does not address any of the scientific evidence included here about the lack of necessity for recovered COVID patients to be vaccinated. While it is true that I do not know how long natural immunity after recovery lasts, the immunological evidence to date suggests that protection against disease will last for years.[69] Uncertainty over the longevity of immunity after recovery is a specious reason for not exempting COVID-recovered patients from vaccination mandates, since the same can be said about vaccine mediated immunity. I do not know how long it will last either, and there is no reason to believe it provides longer lasting or more complete immunity than recovery from COVID.

60. Similarly, just as reinfections are possible though rare after COVID recovery, breakthrough infections are possible after vaccination, as the CDC's team investigating vaccine breakthrough infections itself recognizes.[70] On the same CDC FAQ webpage I cite above,[71] the CDC writes about vaccine mediated immunity, "We don't know how long protection lasts for those who are vaccinated."

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[69] Patel, N. V. (2021, January 6). *Covid-19 immunity likely lasts for years*. MIT Technology Review. https://www.technologyreview.com/2021/01/06/1015822/covid-19-immunity-likely-lasts-for-years/

[70] CDC COVID-19 Vaccine Breakthrough Case Investigations Team. (2021). COVID-19 Vaccine Breakthrough Infections Reported to CDC — United States, January 1–April 30, 2021. *Morbidity and Mortality Weekly Report (MMWR)*, *70*(21), 792-793. doi: http://dx.doi.org/10.15585/mmwr.mm7021e3

[71] Centers for Disease Control and Prevention. (2021, September 28). Frequently asked questions about COVID-19 vaccination. Retrieved October 1, 2021 from

61. The CDC's main concern in this FAQ seems to be to help people understand that it is safer to attain immunity against SARS-CoV-2 infection via vaccination rather than via infection. This is a point not in dispute. Rather, the question is whether someone who *already* has been infected and recovered will benefit on net from the additional protection provided by vaccination. On this point, the CDC's statement in the FAQ is irrelevant. Here again, the possibility of reinfection does not alter the conclusion that, especially for those who have already recovered from COVID, accommodations can be allowed without threatening public safety.

IX. Fetal Cell Lines Were Used to Develop the Johnson & Johnson Vaccine and Were Used to Test the Two mRNA Vaccines.

62. Many people of religious faith have a deeply held objection to benefitting from abortion of a human fetus. At the same time, much modern biological research, development, and production employs fetal cell lines that are derived from an abortion that occurred decades ago. The fetal tissue used in biological work is not the actual tissue from the aborted baby—it is a clone of cells sampled from that tissue. Nevertheless, many religious people object to the personal use of any product that involved the use of these fetal tissue cell lines. In the context of the COVID-19 vaccines, fetal tissue lines were used in the research and testing of both the mRNA vaccines (Pfizer and Moderna) and the adenovector vaccine (Johnson & Johnson).

63. While aborted fetal tissue is not used in the production of the mRNA vaccines, they are used in the production of the Johnson & Johnson vaccine.[72] While some religious authorities have stated that the cell lines used in the development,

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https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html

[72] Zimmerman, R. K. (2021). Helping patients with ethical concerns about COVID-19 vaccines in light of fetal cell lines used in some COVID-19 vaccines. *Vaccine*, *39*(31), 4242-4244. doi: 10.1016/j.vaccine.2021.06.027

production, and testing of these vaccines are remote enough from the act of abortion that it is permissible for faithful people to be vaccinated with these vaccines,[73] other religious authorities disagree[74] reflecting longstanding objections to vaccines derived using aborted tissue lines.[75] Ultimately, it is a matter of individual conscience for each person to decide whether the benefits derived from the vaccines in terms of protection against severe COVID disease should be eschewed in light of sincere moral/religious qualms about deriving that benefit as the ultimate fruit of an action that the faithful person deems sinful.

X. Conclusion

64. A fundamental ethical principle guiding the practice of medicine is that any medical intervention, whether surgical, pharmacological, or a vaccine, should be recommended and undertaken only if it is deemed medically necessary. Any medical procedure, including vaccination, involves risk. No medical procedure is 100% safe, especially those involving a new vaccine, which by definition has not been studied for long-term adverse side effects. For this reason, it is a fundamental principle of medical ethics that the risks of the procedure be balanced against the potential benefits.

65. As I established earlier, based on the scientific evidence to date, those who have recovered from a SARS-CoV-2 infection possess immunity as robust and durable

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[73] Giangrave, C. & Jenkins J. (2021, August 18). *As US bishops reject exemptions, Pope Francis dubs COVID-19 vaccine 'act of love'*. Religious News Service. https://religionnews.com/2021/08/18/pope-francis-declares-getting-a-covid-19-vaccine-an-act-of-love/

[74] Piper, J. (2021, January 4). *Can I take a vaccine made from aborted babies?* Desiring God. https://www.desiringgod.org/interviews/can-i-take-a-vaccine-made-from-aborted-babies

[75] Pelčić, G., Karačić, S., Mikirtichan, G. L., Kubar, O. I., Leavitt, F. J., Tai, M. C., Morishita, N., Vuletić, S. & Tomašević, L. (2016). Religious exception for vaccination or religious excuses for avoiding vaccination. *Croatian Medical Journal, 57*(5), 516-521. doi: 10.3325/cmj.2016.57.516

(or more) as that acquired through vaccination. The existing clinical literature overwhelmingly indicates that the protection afforded to the individual and community from natural immunity is as effective and durable as the efficacy levels of the most effective vaccines to date. There is no good reason for those who have such protection and who have sincere religious objections to be vaccinated. At the very least, the decision should be left to them, and without coercion from the government.

66. In sum, based on my analysis of the existing medical and scientific literature, any exemption policy that does not recognize natural immunity is irrational, arbitrary, and counterproductive to community health.[76]

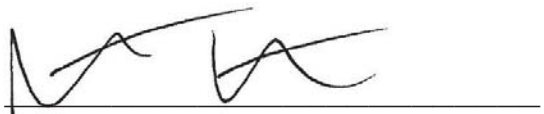
67. Indeed, now that every American adult and teenager has free access to the vaccines, the case for a vaccine mandate is weaker than it once was. There is no good public health case for SDUSD to require proof of vaccination for students who have recovered from COVID-19 and have a sincere religious objection to vaccination. Since the successful vaccination campaign already protects the vulnerable population, the unvaccinated—especially recovered COVID patients—pose a vanishingly small threat to the vaccinated. They are protected by an effective vaccine that dramatically reduces the likelihood of hospitalization or death after infections to near zero. At the same time, natural immunity provides benefits that are at least as strong and may well be stronger than those from vaccines.

68. In conclusion, the emerging evidence from the medical literature finds that COVID-recovered patients have robust and long lasting immunity against SARS-CoV-2 reinfection; that this immunity against infection is better than vaccinated patients who have never had COVID; that the vaccines—though safe for most people—do sometimes cause known severe side effects; that for patients with particular chronic

[76] Bhattacharya, J., Gupta, S. & Kulldorff, M. (2021, June 4). *The beauty of vaccines and natural immunity.* Smerconish Newsletter. https://www.smerconish.com/exclusive-content/the-beauty-of-vaccines-and-natural-immunity

conditions, including Multiple Sclerosis, the data on the safety and efficacy of the vaccine is still uncertain; that the development of the mRNA vaccines and the production of the adenovirus vector vaccines both involved the use of fetal tissue cell lines, to which some people have sincere religious objections; and finally, that there exist inexpensive safe accommodations that SDUSD can adopt which would protect both employees and students against SARS-CoV-2 infection without requiring students to enroll in independent online study.

I declare under penalty of perjury under the laws of the United States of America that, to the best of my knowledge, the foregoing is true and correct this 27th day of October, 2021, at Stanford, California.



Jay Bhattacharya, MD, Ph.D.

EXHIBIT 4-4

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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

JOHN DOE, an individual, et al.,

Plaintiffs,

v.

SAN DIEGO UNIFIED SCHOOL DISTRICT, et al.,

Defendants.

Case No.: 3:21-cv-01809-CAB (LL)

Declaration of Richard Scott French, M.D., in Support of Plaintiffs' Ex Parte Application for a Temporary Restraining Order, and Order to Show Cause re: Preliminary Injunction; and for Leave to Proceed Pseudonymously

Judge: Hon. Cathy Ann Bencivengo
Courtroom: 15A

NO ORAL ARGUMENT UNLESS REQUESTED BY THE COURT

I, Richard Scott French, M.D., declare and state as follows:

1. I am a board-certified emergency medicine physician, licensed by the Medical Board of the State of California, with an active practice and thus significant experience in treating and managing COVID-19 patients in California and several other states.

2. I have been asked to provide an expert medical opinion in this matter regarding the recent COVID-19 vaccine mandate issued by the San Diego Unified School District ("SDUSD"), which requires most students to be vaccinated against COVID-19 in order to attend classes in-person. In this declaration, I will explain the low risk of COVID-19 to children, the potential harm to children from the currently available COVID-19 vaccines, how the COVID-19 disease is currently spreading, and the serious adverse mental health consequences associated with many of the public health mandates imposed upon children.

3. I have personal knowledge of the matters set forth below and could and would testify competently to them if called upon to do so.

Professional Background

4. I graduated from Harbor-UCLA Emergency Medicine Residency in June 1986. After completing my residency in Emergency Medicine, I joined the faculty of Stanford University Medical School as a full time Assistant Professor in the Department of Surgery, in the Division of Emergency Medicine, in July 1986.

5. Since that time, I have held full-time teaching faculty positions at Stanford University Medical School and University of North Carolina Medical School. I have also had several part time clinical faculty teaching appointments, including at the University of Washington, Oregon Health Systems University, Emory University, and the University of Washington. In my teaching capacities, I have given presentations on immunology, as well viral pathogen prevention, diagnosis, treatment, and management.

6. I have continuously held a California medical license since 1984, and practiced medicine off and on in the State of California since that time. I became Regional Medical Director of a large California physician group in 2018, and I oversaw eight California Emergency Departments.

7. I was personally involved as well as provided oversight in setting up COVID-19 transmission mitigation (to prevent the spread of COVID-19) for our patients and staff in four California Emergency Departments. I also managed a mixed-age private community population (which included school aged children) in Hawaii with respect to COVID-19 prevention and transmission mitigation. Once transmission mitigation was fully implemented, there were no hospital-wide or community-wide outbreaks of COVID-19 caused by ER patients or staff.

8. I have had extensive prior experience in population management and disease management as Chief Medical Officer of a large health plan in California, with over 1 million senior members.

Expert Opinions

9. All medical and public health interventions are ever-evolving and based on the best available science at the time, and the response to COVID-19 should be no exception. Healthy debate of "what is working, what is not working" is a normal part of ensuring that the health care system is utilizing the most effective and safe medical interventions.

10. Every vaccine has risks and benefits and should be considered prior to establishing a vaccine mandate. There are populations where COVID-19 vaccinations have a favorable risk/benefit, such as those over age 65, and/or those with significant chronic diseases such as diabetes and hypertension. However, the K-12 pediatric population is not at high risk for death from COVID-19 infection, and thus a favorable risk/benefit must be demonstrated for a novel type of vaccine, untested in the pediatric population.

11. The mRNA vaccines are indeed a new class of vaccine, with an innovative mechanism of action, and thus the short and long term benefits and harms of them need to be analyzed. Unfortunately, no California health agency, school district, or clinician is in the position of having studied the long term risk of serious and/or fatal complications of the novel COVID-19 vaccination in healthy children under the age of 17, because long term studies have not yet been conducted.

12. Whether the San Diego Unified School District has legitimate standing to act akin to a public health agency with respect to "mandatory" vaccinations, and whether it has the requisite medical experts to render guidance essentially akin to a California public health agency, is not part of this declaration. However, because SDUSD is mandating COVID-19 vaccines, SDUSD must take a reasoned approach based on the best available science with respect to the risk/benefit of the COVID-19 vaccine. Physicians follow the Hippocratic Oath of "do no harm," and all medical ethics and medical liability laws in California affirm this obligation.

13. As a medical professional, I must come to a reasoned conclusion with respect to the safety, efficacy, benefit, and harms engendered by the COVID-19 vaccine mandate for children under 17 based on the best available evidence. Coming from the standpoint of a practicing physician, daily involved in preventing, diagnosing, and treating COVID-19, I have a unique 360 degree view of COVID-19. In order to come to a reasoned conclusion, I based my analysis on currently available relevant medical studies, cases, and literature and published official data, as well as my own personal experience.

14. As I will demonstrate with peer reviewed studies, the various serious and fatal complications of the COVID-19 vaccine are becoming apparent, as we begin to gather more data and experience about the complications of the novel COVID-19 vaccine in children.

15. The incidence of unique complications and the number and type of these most likely unique complications in children cannot be known until long term studies are performed in children.

16. We will see below that there are already reports of vaccine induced myocarditis and pericarditis in young males with the vaccine trials in those children aged 12–15. This has long been known to be a complication of certain viruses, but now this condition is due to a vaccine that interacts with the pediatric immune system. Is this an early warning of an impending catastrophe? How can we know that this therapy is safe without long term trials?

17. We will explore the medical literature indicating that there may very well be significant future harm to healthy children under 17 from the COVID-19 vaccine. The often neglected mental health harms caused by various mandates, including a vaccine mandate must be considered as well.

18. In addition, I will demonstrate that the harm of vaccinating healthy children with a COVID-19 vaccine will outweigh the benefit of a COVID-19 vaccine. Thus, the decision to vaccinate must be made by the parent/child and their individual Pediatrician.

19. The relevant literature reviewed will cover the following areas:

A. Schools are not a significant source of COVID-19 transmission and/or death in a community;

B. CDC and worldwide data of mortality of COVID-19 in children under 17 years of age is exceedingly low;

C. The primary risk factor for significant morbidity and mortality for children under age 17 is obesity;

D. The COVID-19 novel mRNA vaccine lacks 100% effectiveness in preventing COVID-19 infection, including the delta and future variants;

E. Natural immunity is superior in reducing transmission of COVID-19 and its variants, reducing mortality, and increasing the duration of immunity;

F. There are known adverse effects as well as known adverse immunological effects of novel COVID-19 vaccine in children aged 12-15;

G. There are unknown yet probable long term risk of serious adverse effects of vaccinating healthy K-12 children without known risk factors;

H. Children have been subject to significant adverse behavioral health and cognitive harm, due to the various public health and government mandates imposed; and

I. Conclusion: There is an unfavorable risk/benefit ratio of vaccinating healthy children under the age of 17, which violates medical rule of "do no harm."

OPINION A: SCHOOLS ARE NOT A SIGNIFICANT SOURCE OF COVID-19 TRANSMISSION AND/OR DEATH IN A COMMUNITY

20. A CDC study published on eight Georgia elementary schools, found that it was when teachers did not follow the basic precautionary measures that there was spread of COVID-19 in the school setting. The researchers concluded: "Educators were central to in-school transmission networks."[1]

21. A study of schools in Sweden indicates that schools were not a significant cause of spread/transmission of COVID-19, or ICU admission of children with COVID-19. The authors note: "Among the 1.95 million children who were 1 to 16 years of age, 15 children had COVID-19, MIS-C, or both conditions and were admitted to an ICU, which is equal to 1 child in 130,000."

[1] Alexander Nazaryan, *Teachers, not students, drove coronavirus spread in Georgia schools, study finds*, YAHOO! NEWS (Feb. 22, 2021).

22. In a letter published in the New England Journal of Medicine, the Swedish authors noted that despite Sweden not mandating masks and their school systems not being closed, there was a low incidence of severe COVID-19 in children and adults. The incidence of ICU admission for adults was lower in teachers than other occupations not exposed to children.[2]

23. In February 2021, the CDC published a study of Wisconsin schools that monitored 5,530 students and staff over a 3 month period, where a total of 191 COVID-19 cases were reported. Seven of the cases, 3.7%, resulted from in-school transmission and occurred among students. There were no reported instances of student to adult transmission, while the surrounding Wisconsin community positive rate ranged from 7% to 40%. The conclusion of this CDC study of unvaccinated children is that: "Attending school where recommended mitigation strategies are implemented might not place children in a higher risk environment than exists in the community."[3]

24. Another review of COVID-19 transmission in K-12 schools that was conducted by the CDC came to the same conclusion: children are not a significant source of COVID-19 transmission. Their analysis demonstrated that transmission of COVID-19 in schools was far more likely to come from adults (staffs and teachers) than children.[4]

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[2] Jonas F. Ludvigsson, et al., *Open Schools, Covid-19, and Child and Teacher Morbidity in Sweden*, N. ENGL. J. MED. (Feb. 18, 2021).

[3] Allison Pohle, *Do Schools Spread Covid-19? Face Masks, Variants and Everything Else You Need to Know*, WALL STREET J. (Feb. 17, 2021).

[4] CDC, *Science Brief: Transmission of SARS-Cov-2 in K-12 schools* (Mar. 19, 2021 update).

OPINION B: CDC AND WORLDWIDE DATA OF MORTALITY OF COVID-19 IN CHILDREN UNDER 17 YEARS OF AGE IS EXCEEDINGLY LOW

25. The American Academy of Pediatrics published data indicating that over 5 million children have tested positive for COVID-19. In the week prior to the report, approximately 252,000 cases were added. Their results demonstrate that in those States reporting, child mortality for those with COVID-19 was between 0.005%-0.03%. This is why clinicians are more concerned with increases in hospitalizations and of course deaths, rather than the number of new cases in the low risk pediatric populations.[5]

26. Another CDC data set looked at death by age and sex, from 1/04/2020 through 9/1/2021, and the findings were as follows:

0–4 years	Female	64 deaths
0–4 years	Male	80 deaths
5–18 years	Female	148 deaths
5–18 years	Male	178 deaths

A total of 470 deaths in a 20 month window.[6]

27. In comparison, in the 2009 pandemic of H1N1, a total of 358 children died of the new H1N1 strain from April 2009 to September 2010, a 17 month period. At the time, there was no public health push for mandatory vaccination for children in the 2009 H1N1 pandemic, yet in 2021, the death rate was similar for COVID-19 and mandatory vaccinations are being imposed on our children.[7]

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[5] Am. Acad. of Pediatrics, *Children and COVID-19: State-Level Data Report* (Sep. 2, 2021 update).

[6] CDC, *Deaths by Sex, Ages 0–18 years* (Jan. 4, 2020–Aug. 28, 2021).

[7] CDC, *2019–20 Season's Pediatric Flue Deaths Tie High Mark Set During 2017–18 Season* (Aug. 21, 2020).

OPINION C: THE PRIMARY RISK FACTOR FOR SIGNIFICANT MORBIDITY AND MORTALITY FOR CHILDREN UNDER AGE 17 IS OBESITY

28. A landmark study with respect to increased risk of severe COVD-19 was published in August 2021. For children under 17, the greatest risk factor for morbidity and mortality is obesity, as reflected by a BMI greater than 30. In fact, the data suggests a 5–10% higher risk for COVID-19 hospitalization for every kg/m2 higher BMI.

29. While a novel interaction, the good news is that this risk factor is highly modifiable yet has not garnered any prompt action with respect to prevention and treatment from a public health standpoint. Vaccinations are only a holding pattern; the underlying risk factor of obesity must be addressed. The physiologic mechanism of the increased risk due to obesity is still being investigated; however, obesity often leads to diabetes, and diabetics have depressed immune responses.[8]

30. We have long known in immunology that as we age our immune system's potency degrades: our bodies and our immune system follow natural laws. The second law of thermodynamics (entropy) is operative in our world: complex degrades to simple over time. In a JAMA article, Ig G immunoglobulin antibody response to COVID-19 infection was studied in pediatric and adult patients. Not surprisingly, the adult patients had produced significantly less Ig G immunoglobulin than the children.

[8] Naveed Sattar & Jonathan Valabhij, *Obesity as a Risk Factor for Severe COVID-19: Summary of the Best Evidence and Implications for Health Care*, CUR. OBES. REP. (Aug. 10, 2021).

31. Since there were approximately 56 million school-aged children and adolescents in the United States in the 2020–2021 school year, the study highlights that both age and obesity are significant risk factors.[9]

32. In a study conducted at Kaiser Permanente in Southern California, the findings were as follows: BMI increased by 1.57 for 5–11 year old's and BMI increased by 0.91 for the 12–15 year old's. "Youths gained more weight during the COVID-19 pandemic than before the pandemic."[10]

33. This is a very disturbing finding, since obesity is the biggest risk factor for death and ICU admissions among healthy youth. This means that the very public health mitigation methods used for COVID-19, are in fact only exacerbating the risk of death to the pediatric population, due to increasing obesity.

34. We must immediately and fundamentally rethink our public health measures if they unintentionally cause more death and disability in our children by the very nature of the public health measures.

35. Our children have the lowest risk of death of the entire population, yet our public health measures applied inappropriately to children will increase the number of deaths. This adverse behavioral consequence of increasing obesity will result in even more short term COVID-19 deaths, but this will raise the risk factor for these children as they grow up and become adults. Thus, we will be dealing with the consequences of this public health disaster for decades to come.

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[9] He S. Yang, et al., *Association of Age With SARS-CoV-2 Antibody Response*, JAMA NETWORK OPEN (Mar. 22, 2021).

[10] Corinna Koebnick, *Research Letter: Changes in Body Mass Index Among Children and Adolescents During the COVID-19 Pandemic*, JAMA (Oct. 12, 2021).

OPINION D: THE COVID-19 NOVEL MRNA VACCINE LACKS 100% EFFECTIVENESS IN PREVENTION OF COVID-19 INFECTION AND TRANSMISSION, INCLUDING THE DELTA VARIANT

36. In an article published in JAMA, the author noted:

> The SARS-CoV-2 serology tests that eventually received FDA Emergency Use Authorization (EUA) have demonstrated high sensitivity and specificity, but that accuracy is for detecting antibodies. *Their ability to predict protection against the virus based on those antibodies hasn't been proven*. Plus, the FDA cautioned that some tests detect antibodies the immune system likely produces only after natural infection with the virus.

37. The article notes that in a May 19, 2021 communication, the FDA stated that "results from currently authorized SARS-CoV-2 antibody tests should not be used to evaluate a person's level of immunity or protection from COVID-19 at any time, and especially after the person received a COVID-19 vaccination." Nicole Doria-Rose, PhD, chief of the Humoral Immunology Core at the National Institutes of Health's Vaccine Research Center, further noted in the communication that neutralizing antibodies "do correlate with protection." The problem is the test for neutralizing antibodies is not widely available, and the threshold level that indicate immunity of these antibodies has not been established.[11]

38. An analysis of breakthrough infections of vaccinated healthcare workers in Israel published in the New England Journal of Medicine demonstrated that, surprisingly, even some asymptomatic health care workers with breakthrough infections had been infectious and "that would not have been detected without the rigorous screening that followed any minor known exposure."[12]

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[11] Jennifer Abbasi, *The Flawed Science of Antibody Testing for SARS-CoV-2 Immunity*, JAMA (Oct. 21, 2021).

[12] Moriah Bergwerk, et al., *Covid-19 Breakthrough Infections in Vaccinated Health Care*

39. The current mRNA vaccine does not appear to be near 100% effective in preventing transmission/spread in adults, and thus it is unclear if vaccinating children will be more effective in preventing spread /transmission. Thus, there is no evidence that vaccinating 100% of children will prevent the spread/transmission of COVID-19.

OPINION E: NATURAL IMMUNITY IS SUPERIOR IN REDUCTION OF TRANSMISSION OF COVID-19 AND VARIANTS AND DEATH, AND IN INCREASING THE DURATION OF IMMUNITY

40. A Swedish study published in JAMA on October 11, 2021 concluded the following: "This nationwide cohort study showed that individuals without COVID-19 immunity had a 45% to 97% lower risk of infection that was in line with the increase in the number of immune family members. Similar results were found regardless of whether immunity was acquired from a previous infection, a single dose of vaccine, or full vaccination."

41. The authors then went on to state that "caution is warranted given the emerging variants of concern (delta), which appear more transmissible and may be less sensitive to a single dose of vaccine." This concern is not repeated for those that recover from COVID-19 (natural immunity).

42. This study thus validates what is taught in medical schools across the country and the world: natural immunity is more effective than vaccine mediated immunity, and naturally acquired immunity lasts longer. Hence, there is a rush to get "booster" vaccines approved by the FDA.[13]

Workers, N. ENGL. J. MED. (Oct. 14, 2021).

[13] Peter Nordtröm, et al., *Association Between Risk of COVID-19 Infection in Nonimmune Individuals and COVID-19 Immunity in Their Family Members*, JAMA INTERN. MED. (Oct. 11, 2021).

43. A study by the Cleveland clinic posted on June 19, 2021 found that over a 5 month study period, COVID-19 infection did not reoccur, despite exposure in 1,359 employees who had recovered from a previous COVID-19 infection.

44. In their conclusions, they stated "This study shows that subjects previously infected with SARS-CoV-2 are unlikely to get COVID-19 reinfection whether or not they get the vaccine. This finding calls into question the necessity to vaccinate those who have already had SARS-CoV-2 infection."[14]

45. An article posted on May 3, 2021 looked beyond the antibody production in natural immunity and vaccine induced immunity. Their analysis found that the natural immune process after infection utilized a highly augmented interferon response, which was largely absent in the vaccine recipients.[15]

46. Medical science has made massive advancements in modern times as the understanding of our amazingly complex and complementary immune system has made great leaps in the 21st century. Medical scientists have long understood that viral immunity is far more robust than just relying on antibodies, and even these antibodies are differentiated to have different roles. Thus, it is naïve to expect that antibody titers alone will indicate infection.

47. The role of T cells—both CD4 and CD8—demonstrate the complexity of the natural immune system as the cells have different understandings of immunity. Memory B cells (which produce antibodies) are still present in the bone marrow long after the antibody levels drop but reactivate once exposed to the COVID-19 virus or its mutated forms. T cells are also long lasting, and some are direct "natural killers" and do not produce antibodies. Attached is a resource guide from UpToDate.com, which is a recognized online treatise used at all hospitals and medical schools. It just

[14] Nabin K. Shrestha, et al., *Necessity of COVID-19 vaccination in previously infected individuals*, MEDRXIV PREPRINT (Jun. 19, 2021).

[15] Ellie Ivanova, et al., *Discrete Immune Response Signature to SARs-CoV-2 mRNA Vacicnation Versus Infection*, IMMUNITY (May 3, 2021).

gives a small glimpse at some marvelous adaptive complexity of the finely tuned immune system.[16]

48. The above studies clearly demonstrate the superiority of naturally acquired immunity. This makes sense because our immune system is finely tuned and has evolved and perfected over thousands of years. The immune system uses an entire host of circulating cells and factors that work together in a beautifully orchestrated dance in order to kill or neutralize viruses. While the mRNA vaccines are a brilliant innovation, they bypass part of the natural immune system. This will result in good effects and bad effects in both the short and long term, and only time will tell whether the benefits will outweigh the risks for a lifetime for our children.

OPINION F: THERE ARE KNOWN ADVERSE EFFECTS AS WELL AS KNOWN ADVERSE IMMUNOLOGICAL EFFECTS OF NOVEL COVID-19 VACCINE IN CHILDREN AGED 12–15

49. An article from October 7, 2021 notes that Finland, Sweden, Denmark, and Norway are putting a pause on using mRNA vaccines in younger age groups due to the risk of pericarditis and myocarditis. Myocarditis and pericarditis appear to be rare and occur mostly in young males. The concern is that for the younger populations, since there is no long term data, it is unclear if the myocarditis recurs and/or worsens over time.[17]

50. An article on the course of symptomatic myocarditis in seven male adolescents after Pfizer vaccination was published in Pediatrics. Heart damage was documented in at least one previously healthy male, and all recovered. The authors

[16] Jennifer Heimall, *The adaptive cellular immune response: T cells and cytokines*, UPTODATE.COM (Luigi D. Notarangelo & Elizabeth TePas, eds., Jul. 2021).

[17] Jenny Strasburg & Dominic Chopping, *Some European Countries Are Limiting the Use of Moderna's Covid-19 Vaccine in Younger Ages*, WALL STREET J. (Oct. 7, 2021).

note that the incidence of myocarditis/pericarditis due to the mRNA vaccine is unknown, and caution pediatricians to monitor children with chest pain after an mRNA COVID-19 vaccine.[18]

51. Since COVID-19 vaccination has not been FDA approved for younger children, there is no data on the adverse effects in this age group. Children are not little adults. This is in part why long term studies have been the rule for treatment of children. As we know in pediatric medicine that a child's physiology is different than an adult's and therefore, the benefits of as well as the adverse reactions to treatments, vaccinations, and medications are not the same as that of adults.

OPINION G: THERE ARE UNKNOWN YET PROBABLE LONG TERM RISK OF SERIOUS ADVERSE EFFECTS OF VACCINATING HEALTHY K-12 CHILDREN WITHOUT KNOWN SIGNIFICANT RISK FACTORS

52. Long term Safety of the novel Pfizer and Moderna mRNA vaccines in children under 17 has not been established, since there are no requisite long term studies in animals or humans for the novel COVID-19 vaccine.

53. There is a significant risk of children developing delayed autoimmune disorders, including the potentially lethal Antibody Dependent Enhancement (ADE) disorder. On August 23, 2021, CDC Director Dr. Rochelle Walensky warned about the possibility of the potentially lethal Antibody Dependent Enhancement. Dr. Walensky made this announcement after looking at the preliminary Israeli data of vaccinated individuals. ADE is an immune system overreaction and can lead to death. ADE occurs when the vaccinated individual, after exposed to the natural virus, then has a cascade of antibody activation that can lead to death. ADE has been documented in other viral vaccinations, such as for RSV, and Dengue virus.

[18] Mayme Marshall, et al., *Symptomatic Acute Myocarditis in Seven Adolescents Following Pfizer-BioNTech COVID-19 Vaccination*, PEDIATRICS (Sep. 2021).

54. The Dengue virus vaccine developed in the Philippines, had so many reports of adverse side effects that its use was suspended in 2017.[19]

55. Since children are not " little adults," and have different physiology, we have no way of knowing a priori the type and incidence of vaccine complications. In addition, as opposed to adults, children will have a long term horizon on which to suffer complications of a vaccine that has a novel mechanism of action with the robust pediatric immune system.

56. What if there are long term autoimmune disorders? We already know that there are several devastating autoimmune disorders, such as multiple sclerosis and rheumatoid arthritis. Researchers are still exploring the triggers for the many autoimmune disorders, but viruses and the changes they cause in human cells appear in some cases to be the trigger for autoimmune disorders.

57. This is exactly the scenario of the mRNA vaccine, where the human cell now produces the COVID-19 spike protein. What if this production of the spike protein by the novel mRNA vaccine causes the child's robust immune system to cause a devastating autoimmune disorder?

OPINION H: CHILDREN HAVE BEEN SUBJECT TO SIGNIFICANT ADVERSE BEHAVIORAL HEALTH AND COGNITIVE HARM, DUE TO THE VARIOUS PUBLIC HEALTH AND GOVERNMENT MANDATES IMPOSED

58. Children are not little adults, and their cognitive, social skills, and coping skills are fragile and developing. Many parents are also currently under incredible stress, including economic stresses. The resultant effect on families during the COVID-19 pandemic has been particularly tragic. There has been a growing chorus of warning signs of the impending behavioral health crisis in K-12 children.

[19] Jeffrey Dach, *Director of CDC, Rochelle Walensky warns of ADE, Antibody Dependent Enhancement From Israel Data*, JEFFREYDACHMD (Aug. 23, 2021).

This now has culminated in several emergency declarations of a "mental health" crisis in our children.

59. On May 25, 2021 Jena Hausmann, CEO of Children's Hospital in Aurora, Colorado declared a state of emergency in youth mental health due to an "astronomical increase in pediatric mental health issues, including suicide, which has overwhelmed the institution." Suicide is now the number one cause of death among youth and occurs in children as young as 10 years of age.[20,21]

60. Unfortunately, our public health policies that contain severe and long lasting lockdowns and mandates have inflicted a grave wound on our children. Yet another mandate—this time mandatory vaccination—will only cause more fear of death, anxiety, stress, depression, and suicidal behavior.

61. If the trend continues, the deaths due to suicide and other behavioral health disorders may well exceed the excess deaths from COVID-19 in our youth

62. The CDC's MMWR report for June 11, 2021 confirmed our worst fears about the adverse effects of the lockdown and other public health policies imposed on our youth. Suicide attempts among girls aged 12–17 were up an unprecedented 50.6% in 2020 compared to 2019. Since adolescent girls are more susceptible to peer pressure, the concern is that the mandatory vaccine mandate may cause yet another tragic spike in suicide attempts in this vulnerable population.

63. CS Mott Children's Hospital in Michigan conducted a national poll on children's health as a result of the pandemic which was published on March 15, 2021. Highlights of the report included:

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[20] Batya Swift Yasgur, *Child Suicides Drive Colorado Hospital to Declare State of Emergency*, MEDSCAPE (Jun. 4, 2021).

[21] Ellen Yard, et al., *Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic—United States, January 2019–May 2021*, MMWR (Jun. 11, 2021).

A. 3 out of 4 parents say COVID-19 has had a negative impact on their teens being able to interact with friends;

B. 1 in 3 teen girls and 1 in 5 teen boys have experienced new or worsening anxiety since March 2020;

C. 31% of parents are noting either an increase or new onset of depression in teen girls, and 18% of parents with teen boys; and

D. 14% of parents are noting an increase or new onset of withdrawing from family in teen girls, and 13% in teen boys.[22]

64. The Wall Street Journal on April 9, 2021 cited a Harvard University study of 224 children ages 7 to 15 which found a clinically significant increase in anxiety and depression. The authors also quoted Dr. David Axelson, chief of psychiatry, who noted a 14% increase in visits to his hospital's psychiatric crisis center for emergencies related to suicidal thoughts, aggression and psychosis from the year prior.[23]

65. The UN published a report on the world-wide adverse mental effects that COVID-19 has had on children. The Executive Director of UNICEF is quoted as saying: "With nationwide lockdowns and pandemic-related movement restrictions, children have spent indelible year of their lives away from family, friends, classrooms. Play-key elements of childhood itself. . . The impact is significant, and it is just the tip of the iceberg. Even before the pandemic, far too many children were burdened under the weight of unaddressed mental health issues." Note that measures that isolate or impact children in the school setting are particularly harmful.[24]

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[22] C.S. Mott Children's Hospital, *How the Pandemic Has Impacted Teen Mental Health*, MOTT POLL REPORT (Mar. 15, 2021).

[23] Andrea Petersen, *Loneliness, Anxiety and Loss: the Covid Pandemic's Terrible Toll on Kids*, WALL STREET J. (Apr. 9, 2021).

[24] United Nations, *Pandemic impact 'tip of the iceberg' after years of neglecting child mental health*, U.N. NEWS (Oct. 4, 2021).

66. An article from India looked at the impact worldwide of the effect of lockdowns on the different age sub-groups of children. A synopsis of some of their findings are as follows:

A. "In young children and adolescents, the pandemic and lockdown have a greater impact on emotional and social development compared to that in grown-ups."

B. "The home confinement of children and adolescents is associated with uncertainty and anxiety[.]"

C. "Consequently, the constraint of movement imposed on them [children and adolescents] can have a long term negative effect on their overall psychological wellbeing."[25]

67. A study from Brazil that also examined the worldwide devastating effect of the lockdowns found that "children from all development phases had high rates of depression, anxiety, and post-traumatic symptoms[.]"[26]

68. The mental health-public health emergencies should serve as wake-up call to our public health leadership to change direction and focus. How many more deaths of despair, fear, anxiety, and depression do we need to see before we pivot to promoting the health and mental well-being of our children? What if the self-induced, increased deaths from our current health policies ends up exceeding the deaths from COVID-19 infection in our children?

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[25] Shweta Singh, et al., *Impact of COVID-19 and lockdown on mental health of children and adolescents: A narrative review with recommendations*, PSYCHIATRY RES. (23 Aug. 2020).

[26] Debora Marques de Miranda, et al., *How is COVID-19 pandemic impacting mental health of children and adolescents?*, INT. J. DISASTER RISK REDUCT. (Sep. 3, 2020).

CONCLUSION: THERE IS AN UNFAVORABLE RISK/BENEFIT RATIO FOR VACCINATING HEALTHY CHILDREN, WHICH VIOLATES THE MEDICAL RULE OF "DO NO HARM"

69. Children are not little adults and are in the most important stage of development of cognitive and behavioral health skills. There are multiple studies documenting the devastating effect to our K-12 children due to the "one size fits all" public health approach, as well as vaccination mandates that we have taken in the United States.

70. The studies reviewed indicate that schools and their children are not a significant source of COVID-19 transmission and/or death in a community. Thus, a vaccine mandate for K-12 will not be one of the most valuable actions to take in reducing its transmission. There is growing evidence that with highly infectious agents such as COVID-19, 100% elimination of transmission is not possible.

71. Mortality of COVID-19 in children under 17 years of age is exceedingly low. K-12 children with obesity do have an increased risk, and so efforts to reduce obesity in children are much more important.

72. The current COVID-19 vaccines do not eliminate the spread and transmission of COVID-19 and its variants. The COVID-19 vaccines do appear to significantly reduce ICU admissions and death. However, immunity after recovering from an infection appears to be more effective in reducing spread/transmission of COVID-19, more effective in preventing ICU admissions and death, and has the additional benefit of a significantly longer lasting natural immunity than the duration of protection from the mRNA vaccines.

73. There is no available medical literature which demonstrates that the spread and transmission of COVID-19 to vulnerable individuals will cease if only we vaccinate every child. That of course ignores the consequent short and long term risk of death and serious adverse effects for the individual child. This utilitarian view has

an underlying assumption that some lives are more valuable than others, and physicians are bound to "do no harm" for all individuals.

74. As documented above, myocarditis is an adverse immunological outcome that has been observed, and there is concern that this autoimmune disorder recurs if the child is exposed to COVID-19 or a future variant.

75. There is also grave concern that other future unknown autoimmune effects will be seen in the longer term with the K-12 population, since they have 70 plus years to develop an autoimmune disorder.

76. There is a significant risk of children developing the dreaded Antibody Dependent Enhancement (ADE) as described above. ADE has been associated with coronavirus in animal trials, and there have been no long term trials in the K-12 population.

77. Parents need to be made aware of these real risks that can adversely affect their unique child. It is the parents that need to make the informed decision based on the best evidence, for their own child with unique risk factors and potential harms. This is what we have always done in the past with vaccines/medications that are novel and untested in children.

78. Thalidomide was a medication that was designed to help adults, but no studies were performed on pregnant women, and the results were devastating for the unborn child. Let's not repeat the same mistake in assuming that children are little adults.

79. As we have clearly demonstrated, K-12 children have borne the brunt of the significant adverse behavioral health and cognitive harm. This is due to the fact that various state public health and federal government mandates and policies have imposed upon children without taking into consideration the unique needs and challenges of the K-12 pediatric population.

80. With respect to mandating vaccinations in K-12 children, this will likely cause further stress and isolation, particularly of adolescents of the "in-group"

vaccinated children versus the "out-group," or as has been already adversely labeled in social media the "antivacc/anti-science" group. Adolescents are particularly prone to social pressure to be accepted as "normal."

81. Thus, there is a clearly no favorable risk/benefit for vaccinating healthy children under the age of 17 with no known risk factors. There are at risk children that should be considered for vaccination in consultation with the parents and their pediatrician. The population of K-12 children that would benefit from COVID-19 vaccination is very small and does not justify a "one size fits all" vaccination mandate, and most likely will produce more harm than benefit in the overwhelming majority of the K-12 population.

82. It seems obvious that our continued draconian public health response of mask mandates, lockdowns, and now mandatory vaccinations are fueling this tragic crisis of mental health. Despite data indicating that our youth are not at significant risk of death, a message of fear continues to be promulgated by health care officials and media outlets.

83. This message of fear results in our youth developing an inordinate fear of significant harm and/or not being able to return to "normal" for themselves and their peers. We all see catastrophe for our youth unfolding before our eyes. The fear, depression and anxiety in our children has been fueled by the very public health officials that are there to protect the public.

84. In the October 2021 issue of AAP News, the American Association of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP), and the Children's Hospital Association (CHA) have declared a national emergency in children's mental health due to COVID-19.[27] In fact, the mental health

[27] Am. Acad. of Pediatrics, *AAP, AACAP, CHA declare national emergency in children's mental health*, AAP NEWS (Oct. 19, 2021).

crisis is directly causing more obesity in our children, and thus will lead to more deaths, since obesity is the most significant risk factor for children.[10]

85. Mandatory vaccination of children with a very low risk of death also violates standard public health principles of focusing maximal efforts on the vulnerable. These maximal efforts include prevention, treatment, vaccination, and isolating the vulnerable.

86. Squandering precious medical resources on those at low risk, puts those at high risk in more jeopardy. We must instead focus our public health efforts on reducing the major risk factor for children, which is obesity.

87. Data from the CDC in 2017–2018 for children and adolescents indicates the following:[28]

A. The prevalence of obesity was 19.3% and affected about 14.4 million children and adolescents
B. Obesity prevalence was 13.4% for 2–5 year olds
C. 20.3% among 6–11 year olds
D. 21.2 % among 12–19 year olds
E. Obesity prevalence was 25.6% among Hispanic Children
F. 24.2% among non-Hispanic Black children
G. 16.1 % among non-Hispanic White children,
H. 8.7% among non-Hispanic Asian children

88. We know that this obesity epidemic has only grown, and grown even more due to the lockdown measures.

89. Why can't we slow down and wait for more data and analysis with respect to long term benefit and harms for K-12 children with respect to the new mRNA class of vaccines?

[28] CDC, *Childhood Obesity Facts: Prevalence of Childhood Obesity in the United States* (Apr. 5, 2021 update)

90. Now that we know that K-12 children are at low risk of dying from COVID-19, we can ensure we do not fall into the literal death trap of "the cure is worse than the disease." If the mortality were near what it is for children with Ebola (near 100%) then it would be prudent to do whatever we could, and the risk/benefit ratio would be favorable no matter what the adverse effects of the vaccination. But this is clearly not the case with COVID-19 mortality in K-12 children.

91. Dr. Fiona Havers did a presentation at the October 26, 2021 VRBPAC meeting.[29] One slide summarized the clinical interventions (slide 11) on the mortality of COVID-19 ICU admission with respect to children 5–11 in the 14 state COVID-NET study group from March 1, 2020–August 31, 2021, compared to the same 14 state FluSurv-Net study group for the 2017/2018, 2018/2019, and 2019/2020 flu seasons. As we can see in the slide below, the COVID-NET ICU mortality of 4 deaths out of 222 ICU admissions, translates to a 1.8% mortality rate. This COVID-NET mortality percentage is less than that for the same 14 state FluSurv-Net ICU mortality, which was 11 deaths out of 398 ICU admissions, or 2.7%. mortality rate.

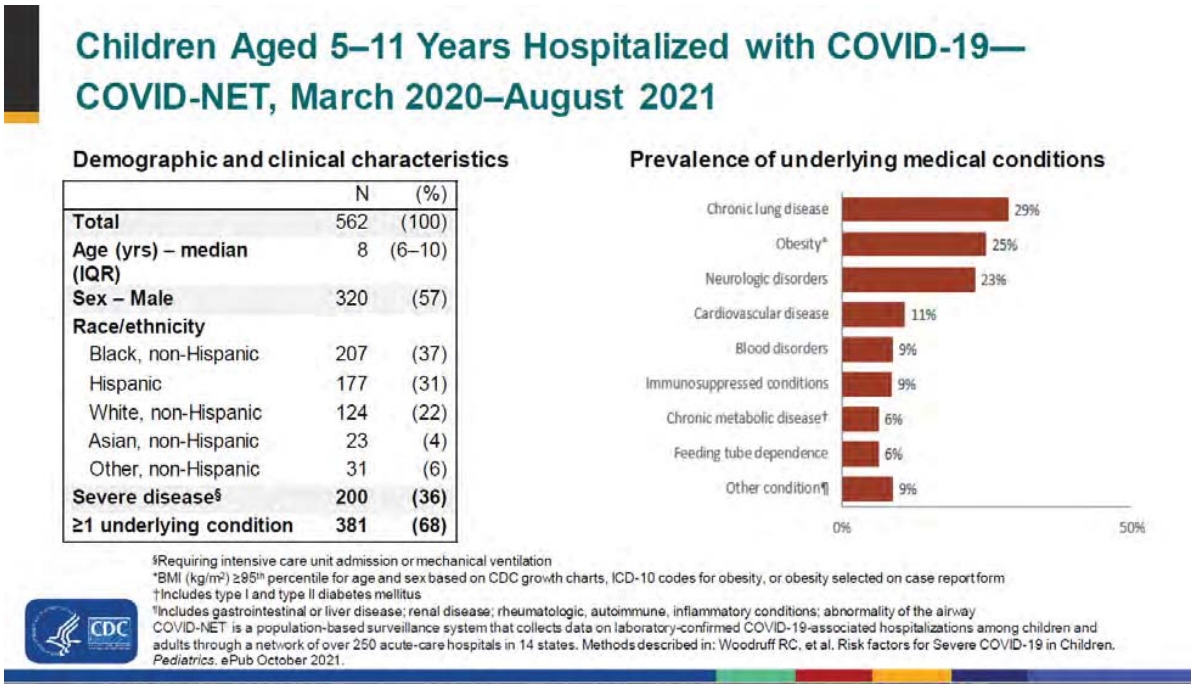
Clinical Interventions and Outcomes of Children Aged 5-11 years with COVID-19 or Influenza-Associated Hospitalizations, COVID-NET[1] and FluSurv-NET[2]

	FluSurv-NET 2017-2018, 2018-2019, and 2019-2020 (N = 1,874),[3] n (%)	COVID-NET March 1, 2020–August 31, 2021 (N = 696),[4] n (%)
Hospital length of stay (median, IQR)	2 (1-4)	3 (2-6)
ICU admission	398 (**21.2**)	222 (**31.9**)
Invasive mechanical ventilation	87 (**4.6**)	50 (**7.2**)
Died during hospitalization	11 (**0.6**)	4 (**0.6**)

1 COVID-NET-California, Colorado, Connecticut, Georgia, Iowa, Maryland (entire state), Michigan, Minnesota, New Mexico, New York, Ohio, Oregon, Tennessee, and Utah.
2 FluSurv-NET: California, Colorado, Connecticut, Georgia, Maryland (Baltimore Metropolitan Area), Michigan, Minnesota, New Mexico, New York, Ohio, Oregon, Tennessee, and Utah. Surveillance conducted from October 1-April 30 each season
3 Includes those with complete clinical data (~97% of pediatric cases) on hospital length of stay, ICU admission, invasive mechanical ventilation, and disposition discharge (i.e., discharged alive or died in-hospital).
4 Includes those with complete clinical data (~90% of pediatric cases) on hospital length of stay, ICU admission, invasive mechanical ventilation, and disposition discharge (i.e., discharged alive or died in-hospital).

[29] CDC, *Epidemiology of COVID-19 in Children Aged 5–11 years*, VRBPAC MEETING (Oct. 26, 2021).

92. Another slide (slide 12) demonstrated that out of 562 intensive care admission or mechanical ventilation admissions for the COVID-Net group, 68% had more than 1 underlying medical condition. Children with obesity, which is defined as a BMI(kg/m2) greater than the 95 percentile for age and sex, made up 25% of the underlying medical conditions, second only to Chronic Lung. Children with chronic metabolic disease, defined as those aged 5–11 with type 1 and type 2 diabetes, made up 6% of the underlying medical conditions. Obesity is the cause of type 2 diabetes, and used to be rare in children 5–11, but the data provided does not give a percentage of type 1 verses type 2 diabetes. Thus, we can see for children 5–11, obesity is the most serious public health problem, and can be addressed by public health interventions.



Children Aged 5–11 Years Hospitalized with COVID-19—COVID-NET, March 2020–August 2021

Demographic and clinical characteristics

	N	(%)
Total	562	(100)
Age (yrs) – median (IQR)	8	(6–10)
Sex – Male	320	(57)
Race/ethnicity		
Black, non-Hispanic	207	(37)
Hispanic	177	(31)
White, non-Hispanic	124	(22)
Asian, non-Hispanic	23	(4)
Other, non-Hispanic	31	(6)
Severe disease§	**200**	**(36)**
≥1 underlying condition	**381**	**(68)**

Prevalence of underlying medical conditions

§Requiring intensive care unit admission or mechanical ventilation
*BMI (kg/m²) ≥95th percentile for age and sex based on CDC growth charts, ICD-10 codes for obesity, or obesity selected on case report form
†Includes type I and type II diabetes mellitus
¶Includes gastrointestinal or liver disease; renal disease; rheumatologic, autoimmune, inflammatory conditions; abnormality of the airway
COVID-NET is a population-based surveillance system that collects data on laboratory-confirmed COVID-19-associated hospitalizations among children and adults through a network of over 250 acute-care hospitals in 14 states. Methods described in: Woodruff RC, et al. Risk factors for Severe COVID-19 in Children. *Pediatrics*. ePub October 2021.

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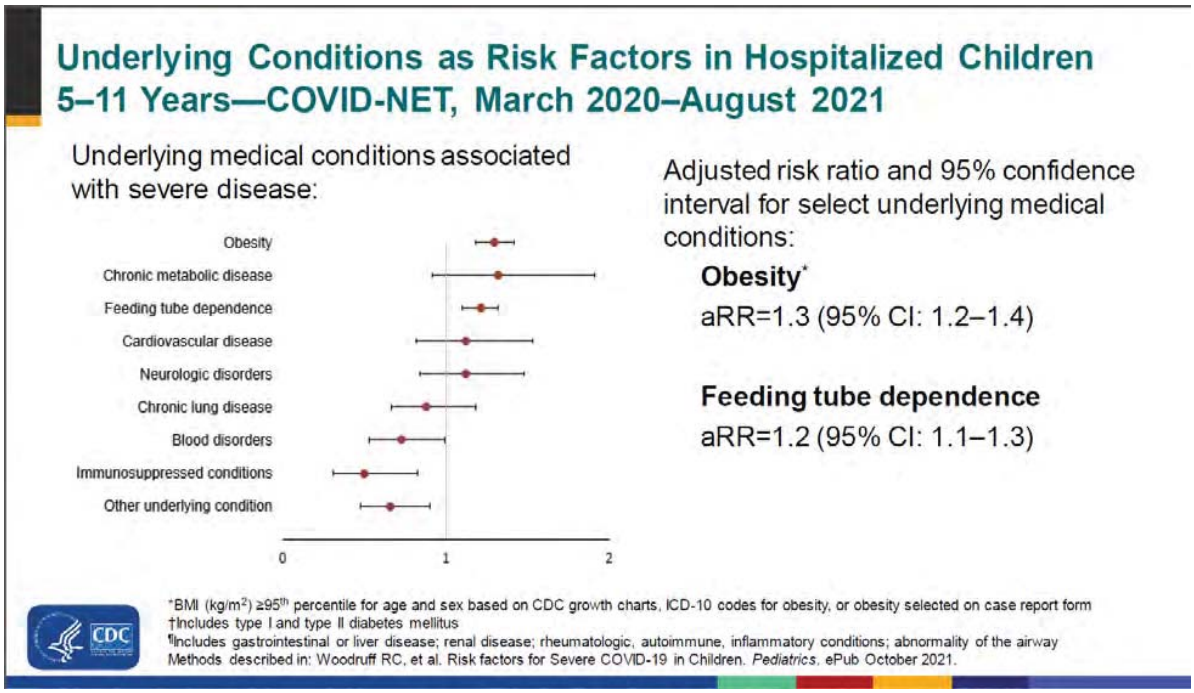
93. The graphic below (slide 14) illustrates the high risk that obesity confers to our children with respect to COVID- 19.



94. Lauren Neergaard and Matthew Perrone of the Associated Press reported on the Food and Drug Administration advisory panel meeting of October 27, 2021, where the panel endorsed the use of COVID-19 in children 5–11.[30]

95. The details of the meeting reveal that: "Panelists stressed they weren't supporting vaccine mandates for young children—and the FDA doesn't make mandate decisions. FDA vaccine chief Dr. Peter Marks also said it would be highly unusual for other groups to mandate something that's cleared only for emergency use. Several advisers said they wished they could tailor the shots for the highest—risk youngsters, a decision that would fall to the CDC."

[30] Lauren Neergaard & Matthew Perrone, *FDA panel backs Pfizer's low-dose COVID-19 vaccine for kids*, ASSOCIATED PRESS (Oct. 26, 2021).

96. Thus, the FDA panel tasked with overseeing the COVID-19 vaccine safety and efficacy **does not** advocate vaccine mandates for children 5–11. Yet the SDUSD does advocate for mandatory vaccines, so is SDUSD utilizing other experts?

97. However, it is always in the best interest of public health to speak to the parents about risk/benefit and obtain informed consent. I do that all the time with many diseases, for example, like appendicitis, where lack of treatment (surgery) will most likely cause death. It is important that the parent understand the risks.

98. Unfortunately, there is not a clear low risk / high benefit outcome with COVID-19 vaccinations in K-12 children.

99. In the United States, we have informed consent because every treatment has good and bad effects. With children, there have been long term tragic consequences for therapies that, in the short term, appeared to have great benefit with little harm.

100. Additional details from the above Associated Press article reveal that this same panel also struggled with the potential of auto immune diseases developing in children 5–11. The associated press reporters write: "But that study [2,300 children] isn't large enough to detect any extremely rare side effects, such as the heart inflammation that occasionally occurs after the second full-strength dose, mostly in young men and teen boys. The panel spent hours discussing if younger children, given a smaller dose, might face that side effect too."

101. I have the same concerns, and the word "occasionally" translates into a potentially large number of children that could develop adverse immunological effects from the COVID-19 vaccine, far exceeding the number of children dying due to COVID-19.

102. The Associated Press article also recounts a shocking statement was made by adviser Dr. Eric Rubin of Harvard University: "It's really going to be a question of what the prevailing conditions are but we're never going to learn about how safe this vaccine is unless we start giving it." This appalling statement goes

against every principle of "do no harm" and assuring the safety of a novel form of vaccine, both short and long term, for our children.

103. The mental health-public health emergencies should serve as wake up call to our public health leadership to change direction. Our public health officials should "do no harm."

104. Our state and federal public health leadership need to stop pushing fear and uncertainty, and instead give reassurance to our K-12 children that we have effective treatments if they become ill and are not at high risk of serious illness. Fear, anxiety, chronic stress, and depression also increase cortisol levels in the blood, and chronic high levels of cortisol weaken the immune system.

105. This would then be a "golden" teaching moment about prevention, and the association with obesity as a risk factor for COVID-19 as well as other diseases as they age. We have far too long ignored this crisis in our youth.

106. State and federal public health promotion of staying indoors may induce a dangerous decrease in vitamin D levels, which also weakens the immune system. Mortality statistics demonstrate that those individuals with lower vitamin D levels had higher mortality form COVID-19, as vitamin D is important for our immune system.

107. We need to redirect our focus from mandatory vaccinations of children, and instead attack the most significant risk factors for our youth which is obesity. The reduction in childhood mortality in COVID-19 and diabetes due to combating obesity, will far exceed the reduction in mortality of vaccinating all children.

108. It is tragic, yet obvious that our unfocused public health response of mask mandates, lockdowns, and now mandatory vaccinations are fueling this self-induced crisis of mental health.

109. Our children are our future and we can already see the mental health devastation that has been brought down upon the most vulnerable members of our society, our children.

110. History will judge us as irrational and "not following the science" if we rush headlong into yet another mandate that will have devastating consequences for our children.

111. I see no harm, in the short term, in granting an immediate injunction against the vaccine mandate, however the evidence overwhelmingly indicates there is a very high likelihood of exacerbating the significant mental health harm of our children if the vaccine mandate stands.

112. Since we are dealing the future of our society (our children), we should be very prudent about universally mandating a unique vaccine for children utilizing a unique immune mechanism, that has not been subject to long term trials in K-12 children.

113. It would seem prudent that the burden of proof would be for those advocating a universal vaccine mandate for children to demonstrate that there is a significant benefit and no harm. As I have shown there is a lack of compelling data for both long and short term safety of the COVID-19 vaccine. In light of the fact that we are already seeing evidence of adverse effects in the small trials of 12–15 year old's, it does appear to be reckless to mandate vaccinations. Let's let the parents in consultation with their pediatrician do their own risk/benefit analysis on their own unique child. These same preliminary trials cause many thoughtful clinicians to be concerned about the potential for even greater autoimmune issues and/or other abnormalities of the immune system coming to light in the future decades of life of these children. Let's let the parents and their physician make that calculation that could adversely impact their children for a lifetime.

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114. **CONCLUSION:** My review of the currently available "best" literature, particularly with respect to mental health, conclusively demonstrates that there is a lack of substantial benefit of mandating vaccination of K-12 children, and yet the potential for significant harm in the long term.

I declare until penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct.

Executed on November 1, 2021, in San Diego, California

Richard Scott French, M.D.

EXHIBIT 4-5

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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

JOHN DOE, an individual, et al.,

Plaintiffs,

v.

SAN DIEGO UNIFIED SCHOOL DISTRICT, et al.,

Defendants.

Case No.: 3:21-cv-01809-CAB (LL)

Supplemental Declaration of Richard Scott French, M.D., in Support of Plaintiffs' Ex Parte Application for a Temporary Restraining Order, and Order to Show Cause re: Preliminary Injunction; and for Leave to Proceed Pseudonymously

Judge: Hon. Cathy Ann Bencivengo
Courtroom: 15A
Date: November 19, 2021
Time: 2:00 p.m.

I, Richard Scott French, M.D., declare as follows:

1. I am a board-certified emergency medicine physician, licensed by the Medical Board of the State of California, with an active practice and thus significant experience in COVID-19 infection prevention, diagnosis, treating and managing COVID-19 patients in California and several other states.

2. I have been asked to provide an expert medical opinion in this matter regarding the recent COVID-19 vaccine mandate issued by the San Diego Unified School District ("SDUSD"), which requires most students to be vaccinated against COVID-19 in order to attend classes in-person.

3. I have personal knowledge of the matters set forth below and could and would testify competently to them if called upon to do so.

4. In this declaration, I will respond to the criticisms leveled against my opinions by Defendants' expert, Dr. Howard Taras, in his declaration dated November 8, 2021 ("Taras Decl."). I will demonstrate in my response to Dr. Taras that the SDUSD vaccine mandate is unprecedented and potentially dangerous for K-12 children—with no real need. There are no long term studies in children with respect to the unique and novel mRNA vaccines. This is not a mere academic debate or exercise, as there are real-life, long-term consequences to the health and well-being of our children, who are our future.

5. As an Emergency Physician, I am on the front lines witnessing the medical and behavioral effects of both COVID-19 infection, as well as the medical effects of the novel COVID vaccine and the behavioral effects of the various mandates imposed upon our children. A society is judged by how it treats the most vulnerable, and that includes our children.

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A COVID-19 Vaccine Mandate is not Needed and Potentially Dangerous

6. In paragraph 13, lines 17–25, Dr. Taras claims in his declaration that: "There is arguably only one group of scientists in the United States who gather all credible research, whether it come out for or against the vaccine's safety and purpose, and weigh the evidence fairly without predetermining the outcome: scientists in the FDA and those university, laboratory, and community based scientists and clinicians on advisory boards who make recommendations to the FDA. It is for this purpose that my citations are heavily weighted on the summaries and unbiased documents from the FDA, its advisory boards and the CDC that reviews and then endorses (or not) the outcomes of this process."

7. Oh, how we all wish it were true that as Dr. Taras' claims, the FDA and CDC are always infallible, unbiased, and consider all the "credible" evidence with complete impartiality. This is an unfortunate medical myth that history has proven time and time again. How else can we explain the statement from Dr. Eric Rubin of the FDA panel that approved the COVID-19 EAU for children aged 5–11: "But we are never going to learn about how safe this vaccine is unless we start giving it. That is just the way it goes," as recorded by Lauran Neergaard and Matthew Perrone of the Associated Press?[30]

8. Really? We are going to forgo long term trials because "we are never going to learn how safe this vaccine is unless we start giving it"? When have we ever been so reckless with our children? Are all our children dying so we are justified in doing whatever we can to save them? What about the "do no harm" and risk/benefit analysis?

[30] Lauren Neergaard & Matthew Perrone, *FDA panel backs Pfizer's low-dose COVID-19 vaccine for kids*, Associated Press (Oct. 26, 2021).

9. To their credit, the FDA "[p]anelists stressed they weren't supporting vaccine mandates for young[er] children." Further, "[s]everal advisers said they wished they could tailor the shots for the highest-risk youngsters, a decision that would fall to the CDC."

10. I agree, offer the COVID vaccine to the small portion of the high-risk K-12 population, but leave the decision to the parents in consultation with their pediatricians. Dr. Taras disagrees and says vaccination must be mandated in the older K-12 children. Unfortunately, we have seen the result of this sort of thinking in the past.

11. In a 1996 British Medical Journal article, the authors recount the 10 standards that were adopted worldwide as a result of war crimes tribunal at Nuremberg to combat the medical abuses by NAZI physicians.[31] Those universal standards are now part of modern medical ethics:

> Amongst other requirements, this document enunciates the requirement of *voluntary informed consent* of the human subject. The principle of voluntary informed consent protects the right of the individual to control his own body. [¶] This code also recognizes that the risk must be weighed against the expected benefit and that unnecessary pain and suffering must be avoided. [¶] This code also recognizes that doctors should avoid actions that injure human patients. [¶] The principle established by this code for medical practice now have been extended into general codes of medical ethics.

12. So, what has been universally accepted now no longer applies? The "experts" are 100% certain that no harm will come from vaccinating healthy K-12 children despite evidence to the contrary with respect to myocarditis, and no long term studies?

[31] *Nuremburg Doctor's Trial*, 313(7070) BRITISH MED. J. 1445, 1448 (1996).

13. An article in Cal Matters highlights the potential harm of this type of thinking in the form of a new California law that has great potential to increase the harm inflicted on our children with respect to mandatory COVID-19 vaccination. According to that article, with respect to state-wide vaccine mandates: "Starting next year, the state [the California Department of Public Health, "CDPH"] will review all medical exemptions at schools where fewer than 95% of the students are vaccinated, from doctors who submit five or more exemptions in one year and from schools that haven't shared vaccination rates."[32]

14. This law is unprecedented in the history of the United States, and a frightening turn for our children and the practice of medicine in California. For the first time, a physician will be pressured to choose between avoiding unnecessary government scrutiny and the health and safety of the patient.

15. Those physicians will have their practice reviewed if they serve children that need a medical exemption. If the number of exemptions exceeds an arbitrary number of five, there is the danger that physicians will be reluctant to advocate for a medical exemption for their patients. What if at least some physicians become concerned they can lose their license if they go against the state mandate for vaccinations? Physicians are trained to advocate for the individual patient and to follow the Hippocratic oath of "to do no harm."

16. Although the COVID-19 vaccine mandate here is not being imposed by the State, Executive Director Barndollar's declaration states that SDUSD is following this model, but with Dr. Taras reviewing physicians' medical exemptions, not the CDPH. It is not clear whether this will remain the case even though the CDPH is now issuing its own, separate COVID-19 vaccination mandate (that allows for personal belief exemptions). But it is clear that Dr. Taras has a conflict of interest

[32] Elizabeth Aguilera, *Five things to know about California's new vaccine law*, CAL MATTERS (Sep. 15, 2019).

in both advising SDUSD to implement a COVID-19 vaccination mandate, being its litigation expert, and then also getting to have the final say on medical exemptions.

17. In any event, is the SDUSD and Dr. Taras in a better position to know what is best for every physician's patient? Do we really need an oversight committee to oversee any decision related to a novel vaccination that has not undergone the standard long term testing on K-12 children? Is there evidence that there will be a public health disaster if not all adolescents are vaccinated? Why is there no debate on what is the right course? The house of medicine has always advocated for robust debate, as we don't have perfect knowledge in a unique and novel situation. Are we certain that Dr. Taras is infallible and anyone that disagrees with anything he says is in error, or worse, lying?

18. Let's consider again the principal of informed voluntary consent, and the fact that the individual, not the government has the right to control their own body. Nor should the government coerce a physician to comply with government mandates that may harm the patient.

19. In paragraph 19 of his declaration, Dr. Taras states: "The increased risk of SARS-CoV-2 transmission among adolescents does not only occur in schools, but high school youth have social interactions with non-household members outside schools that contribute to disease, when they are not vaccinated.[4] The CDC advises that uptake of COVID-19 vaccines in adolescents is likely to alter these transmission dynamics.[5]"

20. This is plausibly true, but Dr. Taras cites no study. Footnote 5 of his declaration (Ex. XX), is from the CDC Guidance for Industry. In addition, SDUSD's advisory panel from UCSD, attached as Exhibit C to his declaration, contradicts his claim:

> All panelists felt vaccination of school staff should be a priority. Although none felt it was a condition of reopening, one panelist felt it should be received by staff working with children at high risk for severe disease or who themselves

> (or a household member) had high risk of severe disease. One felt that if 50% of all teachers were immunized and it was available to all others, schools could open completely. . . . One expert noted that vaccination of staff, and not students, could still help to reduce transmission among students, especially in secondary schools.

(Taras Decl., Ex. C, p.4.)

21. And another citation from the same advisory panel also in Dr. Taras' attachments, from the "Raw Responses from UCSD Experts," states the obvious with COVID-19:

> From John Bradley, Pediatric Infectious Diseases:
> General Responses:
> 1. There is no completely safe way to get kids back to school, but some approaches are more safe than others.
> 2. The risk of serious illness in school children is quite low, and many may actually have the infection without symptoms, but *we have not clearly defined the risk for infection from an asymptomatic child to others*.

(Taras Decl., Ex. B, p.27 (italics added).)

22. Dr. Bradley's conclusions are correct. Studies have demonstrated that the COVID-19 vaccine is not fully effective in stopping the transmission and spread of COVID-19: "Our findings help explain how and why the delta variant is being transmitted so effectively in populations with high vaccine coverage. Although current vaccines remain effective at preventing severe disease and deaths from COVID-19, or findings suggest that *vaccination alone is not sufficient to prevent all transmission of the delta variant in the household setting, where exposure is close and prolonged*." (italics added).[33]

[33] *Community transmission and viral load kinetics of the SARS-CoV-2 delta variant in vaccinated and unvaccinated individuals*, DG ALERTS (Nov. 1, 2021).

23. In paragraph 20, Dr. Taras makes an unsubstantiated and outrageous accusation posed as a question: "Is it possible that Dr. French may have made a deliberate attempt to misguide the reader in his Item 49?" Dr. Taras is employing an ad hominem attack to divert the reader's attention from the real issue, namely that in several European countries there is real concern about myocarditis being induced by mRNA vaccines. It is irrelevant that the Pfizer vaccine for the time being has a lower incidence of myocarditis than Moderna's mRNA vaccine. The attack rate differences of myocarditis between Pfizer and Moderna could very easily oscillate many times as we gain more "experience" with the novel vaccinations. This is precisely the problem engendered by a lack of long term studies for our youth.

24. These particular European public health departments are appropriately being cautious with respect to this totally unexpected adverse medical condition of myocarditis primarily in young males—and are now also investigating a new complication of capillary leak syndrome.[34] I don't share the cavalier attitude expressed by Dr. Taras with respect to this potentially serious adverse effect of myocarditis. No one can predict what the future will bring to our youth with respect to attack rates and recurrence of potentially fatal myocarditis. It is irresponsible for a physician to assert that the future can be known with certainty, and that there is no appreciable long term risk.

25. Again, since no country has long term experience or long term studies of the novel mRNA vaccines, public health officials in some of the northern European countries are being very prudent.

26. In a way I am grateful for Dr. Taras to inadvertently shine a light on this potentially very serious complication of myocarditis due to mRNA vaccines. No culture can survive if is advocates "rolling the dice" on its children based on very incomplete knowledge about the risk and benefits with respect to mandatory

[34] *Covid-19 vaccine safety update*, EUROPEAN MEDICINES AGENCY (Nov. 11, 2021).

vaccinations of these same children. If the "experts" are wrong, it could prove to be catastrophic for our society. Why can't we take a measured approach? It is not as if all our children are dying of COVID-19 and we must grasp at anything to prevent a catastrophe.

27. In paragraph 22, Dr. Taras asserts that "mRNA vaccines have been held to the same rigorous safety and effectiveness standards as all other types of vaccines in the United States." Yet, he contradicts himself in paragraph 23, where he states: "Dr. French cites the mRNA technology as untested and potentially less safe that traditional vaccine technology. While it is true that these are the first mRNA vaccines to be rolled out to the general public, they are considered safer and more specific to the dreaded virus by many experts."

28. The operative phrase is "considered safer." What Dr. Taras leaves out is the fact that there are no long term trials conducted yet in K-12 children. Further, Dr. Taras knows or should know that K-12 children are not little adults, and you can't extrapolate adult vaccine trial results with K-12 children. Yet, this is precisely what he does. Normally, expert opinions are tested, not just reasserted.

29. Further, Dr. Taras' assertion that the mRNA vaccines are "more specific" for the COVID-19 virus is not substantiated in the literature. In an article in Cell Reports Medicine, they looked at the T cell activity in individuals who recovered from COVID-19 infection and found that the CDD4 and CD8 activity was maintained for the COVID-19 variants tested.[35]

30. A brief synopsis of the antibody and T cell response due to natural infection is summarized as:

> For most healthy people, immunologists say, antibodies seem to last in the body at some level following both infection and vaccination for as long as data is available.

[35] Alison Tarke, et al., *Impact of SARS-Cov-2 variants on the total CD4* and CD8* T cell reactivity in infected or vaccinated individuals*, CELL REPORTS MED. (Jul. 20, 2021).

> Reports of antibodies waning a few months after infection earlier in the pandemic sparked some concern that the immune response might be short-lived. But immunologists say such declines can also be an indication of a properly functioning immune response. Antibody levels often peak shortly after an infection, during the initial response to an unfamiliar invader. They often then stabilize at lower levels until a person is re-exposed to the same threat.
>
> "We shouldn't get scared when we see the antibody response go down," said Miriam Merad, director of the Precision Immunology Institute at the Icahn School of Medicine at Mount Sinai.
>
> Some immunologists have also reported other parts of the immune system adapting to recognize the virus that causes Covid-19, such as Memory B cells that churn out antibodies and T-cells that can direct an immune response or kill infected cells.
>
> In a May study in the scientific journal Nature, researchers found Covid-19-specific immune cells in the bone marrow from 15 of 19 patients who had experienced a mild infection as much as eight months earlier.[36]

In the 21st century we have come to more fully understand the beautifully orchestrated and complex immune response, as is taught at all medical schools.

31. In paragraph 25, Dr. Taras offers a misunderstanding of my views: "Dr. French points out, correctly, that obesity among youth is a major risk factor for severe disease from the virus that causes COVID-19. His solution to this grave solution is curious: don't mandate vaccines."

32. I do not believe, and never stated, that children at risk (including at risk children due to obesity) should not get vaccinated against COVID-19. Instead, the parents of those at risk K-12 children should consult with a Pediatrician with respect

[36] Brianna Abbott, *Covid-19 Immune Response Could Be Long Lasting, but Variants Present Risks*, WALL STREET J. (Jul. 16, 2021).

to whether the COVID-19 vaccination is appropriate for the individual child. Otherwise, yes, we should not "mandate" the COVID-19 vaccine.

33. In my declaration, I made a four-fold evidence based argument:

a. *First*: Those children who are at an extremely low risk of dying from COVID-19 infection (which is virtually almost all K-12 except those with known risk factors, including obesity) will not benefit from vaccination. In a worldwide survey of mortality, the authors note "Mortality in children seems to be near zero (unlike flu) which is also reassuring and will act to drive down the IFR significantly."[37] A CDC presentation of October 26, 2021 illustrates the relative risk of COVID-19 death in children as well as the contribution of risk factors and in comparison, to influenza (Slides 12, 13, and 16).[29]

b. *Second*: There is an unknown risk of short term and long term risks of the novel COVID-19 mRNA vaccination since there are no long term studies in children, or for that matter adults either. Every medication and treatment have risks, and we are not practicing evidence based medicine if we push ahead with vaccine mandates.

c. *Third*: We must conclude that since there is such a low risk of death for healthy young children, and an unknown risk of short term and long term adverse reactions to the vaccine, including death, there is no compelling risk/benefit for mandatory vaccinations of K-12 children.[29]

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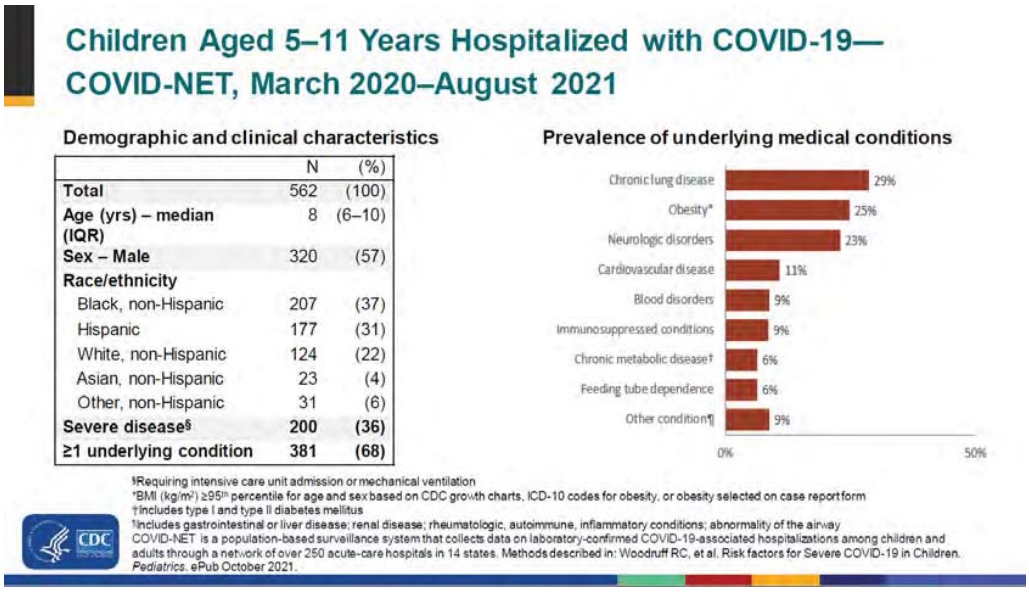
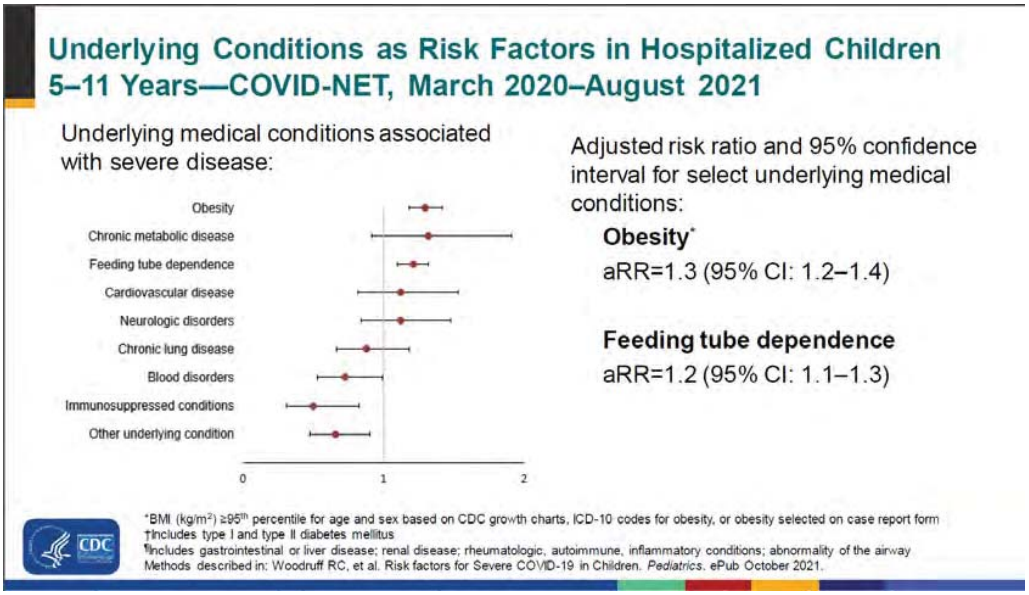
[37] Jason Oke & Carl Heneghan, *Global Covid-19 Case Fatality Rates*, CTR. FOR EVID.-BASED MED. (Oct. 7, 2020 update).

[29] CDC, *Epidemiology of COVID-19 in Children Aged 5–11 years*, VRBPAC MEETING (Oct. 26, 2021).





d. *Fourth*: We should focus on intensive public health efforts to combat obesity in our children, precisely because it does take time to take effect. This increased morbidity and mortality due to obesity for COVID-19 extends throughout the child's life, which is both shortened and includes devastating disabilities. A partial listing of the increased risk of death and disabilities includes increased risk of stroke, heart disease, kidney failure, and many other chronic debilitating diseases. Again, I see first-hand the results of the horrendous toll obesity takes on our

vulnerable youth. We also now have effective treatments for COVID-19 and do not need to rely solely on vaccinations.

34. In paragraph 26, Dr. Taras again misinterprets my opinion: "Drs. French and Bhattacharya both argue that morbidity and mortality are not adequately significant to warrant promoting vaccination."

35. There is no problem with *promoting* vaccines, the problem is in *mandating* vaccines. Mandating a novel vaccine with a unique mechanism of action on healthy children without risk factors *and* without long term studies is reckless at best. There is the potential to cause long term significant harm and to increase the number of deaths in children.

36. Even nonphysicians and the media are beginning to question the logic of mandating vaccination of our healthy youth, as discussed in a November 10, 2021 WSJ article penned by Jenin Younes appropriately titled: "Forced Vaccination for Kids is Unlawful."[38] As stated in that article:

> While parents may choose to vaccinate their own children, these mandates are unethical and unlawful. Advocates of mandating Covid vaccines equate them with standard childhood shots against polio, chickenpox, TDaP (tetanus, diphtheria and pertussis) and MMR (measles, mumps and rubella). But those decades-old vaccines have gone through the full FDA testing regime. The Covid vaccine has received only emergency-use authorization for this age group, meaning its safety and efficacy have not yet been established to the FDA's satisfaction.
>
> The emergency-use authorization of the Covid vaccine also creates a legal distinction. Federal law requires, among other things, that potential recipients of EUA products be informed "of the option to accept or refuse administration of the product, of the consequences, if any, of refusing

[38] Jenin Younes, *Forced Covid Vaccination for Kids Is Unlawful*, WALL STREET J. (Nov. 9, 2021).

> administration of the product, and of the alternatives to the product that are available and of their benefits and risks."
>
> Put plainly, this means that patients—in this case children—may not be forced, coerced or pressured into taking EUA products and are entitled by law to refuse them.

37. In light of this, it is admirable that the SDUSD Board of Education pushed back against, and rejected, one board member's proposal to mandate COVID-19 vaccination even in advance of full FDA approval (i.e., for children aged 5–15), and instead tied the mandate to go into effect as soon as there is full FDA approval. But the rationale of this law—the medical ethical rational—applies equally to "fully approved" novel vaccines of such recent origin.

38. In paragraph 28, Dr. Taras dismisses the 73 cases of myocarditis in males aged 16-17 and 8 cases in females by saying they all recovered, and no one died. Instead, it is very concerning that myocarditis occurred at all; myocarditis has traditionally been seen as a rare occurrence with certain viruses, but this is the first time we have seen myocarditis develop secondary to vaccine administration. In the past, this would have appropriately raised alarm bells in the FDA and CDC. Inexplicably and unfortunately, this is not the case with respect to the CDC and FDA today.

39. In fact, a review of myocarditis in children was published in Circulation in August 2021, which highlighted the seriousness of myocarditis. This is in sharp contrast to Dr. Taras opinion about the alarming novel myocarditis due to a vaccine rather than a virus. The authors note that:

> Myocarditis in children challenges the practitioner on every front, from the appropriate diagnostic workup to the aggressiveness of intervention and the type and extent of follow up after recovery. Many patients have spontaneous recovery, and just as many will sustain irreversible myocardial injury, sometimes pressing the practitioner to

> make medical decisions without a confirmed diagnosis or decisions on therapy that are not evidence based. Myocarditis in children shares features with that in adults, such that a supplemental section on the adult perspective highlights some of these major similarities and differences. However, given its distinct characteristics in children and the potential impact on their lifelong health, the American Heart Association commissioned this statement to provide guidance on management specific to the pediatric population.[39]

40. In addition, the authors supplied a supplemental table that lists the etiology (proximate cause) of myocarditis. While viruses are a known cause of myocarditis, "vaccines" have not been a cause of myocarditis. There are autoimmune causes of myocarditis listed, and most thoughtful physicians are concerned autoimmunity is the cause of mRNA vaccine myocarditis.[39]

41. Since we have zero experience with vaccine-induced myocarditis, French health officials have put a pause on using the Moderna mRNA vaccine for those under 30. Moderna has a much higher rate of myocarditis than Pfizer, but Pfizer is not at zero with the small sample studied.[40]

42. I will summarize the emerging picture from these two articles, which normally would cause us to take a pause before we mandate a vaccine that may not have a favorable risk/benefit for K-12 children, or even just the adolescents:

a. Myocarditis is a serious disease in children, and can cause severe disability and death.

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[39] Yuk M. Law, et al., *Diagnosis and Management of Myocarditis in Children*, 144 CIRCULATION e123 (Aug. 10, 2021).

[40] *French Health Authority Advises Against Moderna COVID-19 Vaccine for Under 30s*, REUTERS (Nov. 10, 2021).

b. Yes, we have been fortunate that in the small and short trials there have been no deaths, however in medicine we do not rely on luck, particularly with our children.

c. The risk of an adverse reaction, disability or death will continue for many decades, unlike older adults.

d. Adolescents and children are not little adults, and so we do not know what the best therapies will be, as we can't rely solely on adult data.

e. The future is very uncertain and not predictable when you mix a novel vaccine with a novel adverse outcome caused by the vaccine.

f. Prudence and abundance of caution normally causes physicians to wait for longer term studies, before rushing ahead with therapies that have not had adequate testing. Of course, if the fatality rate due to COVID-19 were severe, then that would change the risk/benefit calculation for vaccinating healthy children.

g. The risk/benefit for at-risk children would favor vaccination, but only with the consent parent and their physician.

h. We do not have experience with vaccine-induced myocarditis, so nobody can assert with confidence that it will not reoccur, and the reoccurrence could be much worse, and eventually lead to severe life-long disability and/or death.

i. The state, or SDUSD school district does not have bodily rights above and beyond the parents for their own child.

43. We do have experience with fatalities due to viral-induced myocarditis. It is foolish to assert that fatalities will not occur with vaccine-induced myocarditis. Where is the evidence that the risk is zero? In addition, Dr. Taras must know that equating the immunology of older adolescents with adults is not accepted pediatric medical thinking.

44. In paragraph 30, Dr. Taras notes that the lack of studies of COVID-19 vaccines with respect to "rare" medical conditions should be no concern, because "SDUSD has a process for medical exemptions. If a student's own physician confirms, through the same process used for other vaccinations, that an underlying medical problem makes the vaccine unsafe for their patient, and that physician is made available to discuss this issue with the District's physician, the student is eligible for a medical exemption and remain in school as long as that student is screen tested regularly for COVID-19."

45. Yet, given Dr. Taras prior statements and his ad hominem attack, Dr. Taras displays a dangerous confirmation bias. In medicine, we normally have robust debates when the risk/benefit of a new vaccine is introduced. This confirmation bias is further revealed, as Dr. Taras has made clear that he views any evidence that contradicts his narrative of universal vaccination as "false."

46. I want to thank Dr. Taras for doing such an outstanding job in guiding SDUSD through the pandemic, it demonstrates a dedication and persistence that was very much needed. Dr. Taras deserves high praise. Unfortunately, all this excellent and hard work may sometimes lead to a lack of objectivity with respect to studies that don't confirm closely held views and hard fought experience.

47. Since Dr. Taras is part of the panel of experts for SDUSD and crafting policy, he also is reviewing the medical exemptions submitted to SDUSD. This is in addition to the new California law, where if a physician issues more than five medical exemptions, they will be subject to scrutiny by the CDPH.

48. Unfortunately, the net result of this two staged "review" will most likely result in very few exemptions being submitted. Physicians become unemployable if they have an "adverse" decision, and thus this may induce a physician to not advocate for his patient because of the risk of an adverse decision from either the state or SDUSD.

49. These policies will not promote the health and safety of our children and are unprecedented in the history of the United States. Unfortunately, they are very common in totalitarian regimes, and the health of those populations suffer greatly. Parents should be in charge of the health of their children in consultation with their physician, unless of course they are a danger to their own children.

50. Due to the novel COVID-19 vaccines, and future novel complications, physicians will need to exercise wide discretion in deciding whether to advise against vaccination. Every child has a unique DNA profile and has a unique set of risk factors due to that DNA profile. Particularly in the realm of autoimmune disease the standard of care is not to combine a novel therapeutic with a condition like myocarditis for which we have little experience, and no experience with a vaccine-induced myocarditis. What if the treatment of vaccine induced myocarditis is different not only because it in a child or adolescent, but what if the mechanism for this unique myocarditis is mediated differently?

51. In paragraph 31, lines 1–2, Dr. Taras asserts that "[t]he vaccine gives far better immunity than the natural disease. The vaccine is also more predictable for immunity within any specific age group."

52. There is a paucity of support for these assertions; however, there is a significant amount of peer reviewed literature supporting that immunity acquired after recovering from a COVID-19 infection is in fact superior to vaccine induced immunity. One study in Austria notes "We observed a relatively low re-infection rate of SARS Co-V-2 in Austria. Protection against SARS-CoV-2 after natural infection is comparable with the highest available estimate on vaccine efficacies."[41]

53. Yet another peer reviewed study reported in Clinical Infectious Diseases came to the following conclusion: "Prior infection in patients with COVID-19 was

[41] Stefan Pilz, et al., *SARS-CoV-2 re-infection risk in Austria*, 51(4) EURO. J. OF CLINICAL INVEST. 13520 (Feb. 13, 2021).

highly protective against reinfection and symptomatic disease. This protection increased over time[.]"[42]

54. In a study of UK health care workers who recovered from infection with COVID-19, it was found that "[t]he presence of anti-spike or anti-nucleocapsid IgG antibodies was associated with a substantially reduced risk of SARS-CoV-2 reinfection in the ensuing 6 months."[43]

55. The fact that anti-nucleocapsid IgG antibodies were just as effective in reducing reinfection as anti-spike antibodies is significant. This is a key in understanding the superiority of natural immunity, precisely because natural immunity does not rely solely on the spike protein, which also turns out to be highly mutagenic. This is why "booster" vaccinations are required for delta and other COVID-19 variants, but those with naturally required immunity do not require "boosters."

56. The mRNA vaccines induce the production of spike proteins by the human cells of the vaccinated individual. However, the mRNA vaccines only code for spike proteins, not capsid proteins. Our immune system is then trained to mount a response solely to the spike protein. Stated differently, the mRNA vaccines do not induce immunity to capsid proteins, and also are only "training" the immune system to respond to the original COVID-19 spike protein, not the mutated delta variant spike protein.

57. This explains the superiority of those who have acquired natural immunity to COVID-19 versus those with vaccine induced immunity: the natural immune system is looking at other antigens of the COVID-19 virus in addition to the

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[42] Megan M. Sheehan, et al., *Reinfection Rates Among Patients Who Previously Tested Positive for Coronavirus Disease 2019: A Retrospective Cohort Study*, CLINICAL INFECTIOUS DISEASES (Mar. 15, 2021).

[43] Sheila F. Lumley, et al., *Antibody Status and Incidence of SARS-CoV-2 Infection in Health Care Workers*, 384(6) N. ENGL. J. MED. 533–40 (Feb. 11, 2021).

spike protein. It also explains why natural immunity would be superior in the COVID-19 variant cases such as the delta variant. The variation in the delta variant appears to be specific to spike protein mutations (the capsid proteins are not mutated). Thus, a vaccinated individual's immune system may not attack either a mutated virus spike protein, or a capsid protein of the virus. This is in contrast to the individual with natural immunity whose immune system has been trained to attack both the spike protein (mutated or not) and the capsid protein.

58. On the European Medicines Agency's page for Spikevax—the tradename for the Moderna mRNA vaccine—there is an expandable header for "How long does protection from Spikevax last?" That item then opens up to state: " It is not currently known how long protection given by Spikevax lasts. The people vaccinated in the clinical trial will continue to be followed for 2 years to gather more information on the duration of protection."[44] This again confirms that there is no compelling evidence that the mRNA vaccines are more effective than the duration of immunity associated with naturally acquired immunity after COVID-19 infections.

59. In paragraph 33, Dr. Taras contends that a vaccine mandate is necessary to fight the pandemic. Other than a remark in paragraph 25 (about how a mandate will help the obesity pandemic), paragraph 33 appears to be the only place where Dr. Taras supports the actual necessity of a vaccine mandate at all. In all other places, he simply argues that the vaccines are safe.

60. There, Dr. Taras states that "even with . . . other mitigation strategies in place (testing, symptom screening, masks), new Covid Hospital admissions are increasing among young individuals since the Delta Variant became the dominant variant in the summer of 2021.[fn] This is not only true nationwide, but also here in San Diego, as shown in the image below."

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[44] *Spikevax (previously COVID-19 Vaccine Moderna)*, EUROPEAN MEDICINES AGENCY (as of Nov. 12, 2021), https://www.ema.europa.eu/en/medicines/human/EPAR/spikevax.

61. Although Dr. Taras does not explain where the image he pasted in his declaration comes from, it comes from the October 27, 2021 edition of County of San Diego "COVID-19 Weekly Update." As is clear from its title, that document is updated weekly, with the most recent version dated November 10, 2021.[45]

62. In addition to that document, the County puts out a "COVID-19 Watch: Weekly Coronavirus Disease 2019 (COVID-19) Surveillance Report," the latest version of which is also dated November 10, 2021.[46]

63. Also posted online are the November 10, 2021 editions of the County of San Diego 'Coronavirus Disease 2019 (COVID-19) Hospitalizations Summary,"[47] and a chart titled "COVID-19 Hospitalizations in San Diego County by Date Admitted."[48]

64. The last two documents make very clear that hospitalizations for COVID-19 in San Diego County are falling overall,[46] and hospitalizations are negligible for people under the age of 19.[45] The age group of 10-19 had 406 total hospitalizations for COVID-19, amounting to just 2.2% of the total hospitalizations.[45]

65. Page 14 of the Surveillance Report also shows that COVID-19 cases in children have also always been extremely small and are falling.[44] Finally, as to the Weekly Update, its page 14 confirms that hospitalizations are falling, and its page 25 shows that the vast majority of COVID-19 outbreaks are not in schools, but businesses.[43]

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[45] https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/Epidemiology/COVID-19_Daily_Status_Update.pdf

[46] https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/Epidemiology/COVID-19%20Watch.pdf

[47] https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/Epidemiology/COVID-19%20Hospitalizations%20Summary_ALL.pdf

[48] https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/Epidemiology/COVID-19%20Hospitalizations%20by%20Date%20Admitted.pdf

66. Presumably, these statistics explain why—even though Governor Newsom announced his state-wide COVID-19 vaccine mandate over a month ago on October 1, 2021—to date no other state besides California has imposed a COVID-19 vaccine mandate for K-12 children.

CONCLUSION

67. In conclusion, the available peer reviewed literature indicates that high vaccination rates do not necessarily equate to reduction in transmission of COVID-19, particularly the COVID-19 variants including the delta variant. K-12 children are at very low risk of death except for those children with the known risk factors. The available literature supports the empirical observation that natural immunity is significantly more effective in preventing spread of COVID-19 variants than COVID-19 vaccines, and it provide immunity with greater longevity. Estimates vary with respect to the number of K-12 children, including adolescents that have recovered from a COVID-19 infection, and even the low estimations are sizeable, in the millions. These individuals have better immunity than those who have received the COVID-19 vaccination. Thus, there is no compelling public health need to mandate vaccinations of healthy K-12 children.

68. Those at high risk should be vaccinated, but it must be voluntary with the consent of the parents in consultation with their pediatrician. The risk of autoimmune disease, both short- and long-term, is real, and with no long term studies, it is unknown if the number and severity of the myocarditis and other potential devastating autoimmune disorders will emerge. Thus, especially when there is a comprehensive fact based analysis, there does not appear to be a favorable risk/benefit analysis given the available evidence at this time in order to justify mandate vaccinations of K-12 children.

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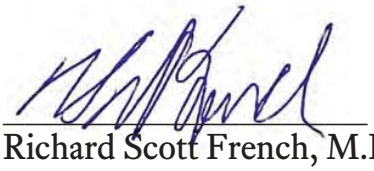
I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct.

Executed on November 12, 2021, in San Diego, California.



Richard Scott French, M.D.

EXHIBIT 4-6

What you need to know about San Diego Unified's vaccine mandate

RN Connie Garcia extracts a dose of the Moderna Covid-19 vaccine which will be administered to a Texas Tech University Health Science Center student at Texas Tech University Health Science Center's Academic Building Monday, Jan. 4, 2021, in Odessa, Texas. (Jacob Ford/Odessa American via AP) (ASSOCIATED PRESS)

Mandate will immediately affect 6,300 students, 16 and older, who are not fully vaccinated

BY KRISTEN TAKETA

SEPT. 29, 2021 8:14 PM PT

Several thousand San Diego Unified students, age 16 and older, will soon have to get a COVID vaccine or else be barred from in-person learning.

The San Diego Unified School Board approved a vaccine mandate for all staff and eligible students at its Tuesday board meeting. District leaders said it's needed for several reasons: it will help reduce the spread of COVID in and out of schools, it will help keep students in school by minimizing how often students have to quarantine at home, and it will help increase herd immunity in San Diego.

"We understand the complexity of the decision we made, but we as a board went forward unanimously with six votes in support because we follow the science and we know what the right thing to do is," said Zachary Patterson, a student who is a

school board trustee, at a press conference Wednesday.

Here are answers to common parent questions about the new vaccine mandate.

Is the COVID vaccine safe?

The Food and Drug Administration approved the COVID vaccine because its benefits in reducing the chances of getting sick from COVID clearly outweigh the potential risks, experts said.

Of about 392 million vaccine doses administered to 214 million Americans so far, 0.01 percent may have resulted in serious side effects, according to reports in the federal Vaccine Adverse Event Reporting System website. Experts caution that not all those adverse events reported on VAERS were caused by the vaccine, and VAERS relies on self-reported data and so may be incomplete.

Dr. Howard Taras, San Diego Unified's consulting physician, said people shouldn't just look at a handful of medical studies about a vaccine's safety. He added that it's the FDA's job to review all the research data and literature about a vaccine.

"Very few people have the time and energy to go through all the pro and con arguments, and that is why we have the FDA and the advisory committees to the FDA," Taras said.

"When I say I'm pro getting as many students vaccinated as possible if there's FDA approval, it's because I believe in that process, an unbiased, objective process that can either ... approve or not approve a vaccine."

Kristen Taketa on our San Diego News Fix podcast:

Who at San Diego Unified has to be fully vaccinated, and by when?

All students age 16 and older must be fully vaccinated — meaning they must have received both shots — by Dec. 20. Also all adults who work directly with students, including district staff, contractors, and nonprofit partners, as well as district employees who work on district property, will have to be fully vaccinated by Dec. 20.

Why do only 16-year-olds and older students have to comply?

San Diego Unified's vaccine mandate is tied to full approval of the vaccine by the FDA.

The Pfizer/BioNTech COVID vaccine has received full approval for people age 16 and older, so far. The vaccine is authorized by the FDA for emergency use for people 12 and older.

Once the FDA fully approves the vaccine for younger age groups, those students will have to get vaccinated. In the meantime, all those students will be required to test regularly for COVID.

What happens if students or staff don't get fully vaccinated by Dec. 20?

Age-eligible students who don't comply will be barred from in-person learning and will be required to learn from home via the district's online academy. They also will be barred from extracurricular activities.

The district said it will discipline employees — including but not limited to termination — who don't comply with the vaccination rule.

San Diego Unified's teachers union had not taken a position on the vaccine mandate as of Tuesday. But union President Kisha Borden said courts and the district's attorneys have made it clear that the law allows San Diego Unified, like other employers, to require staff to be vaccinated against COVID.

How many people in San Diego Unified will need to be vaccinated?

The district enrolls about 14,360 students who are 16 and older. Of those, 62 percent have received at least one dose and 56 percent are fully vaccinated, so about 6,300 students will need to be fully vaccinated by Dec. 20. That's out of about 99,000 total students attending school in person.

As for employees, about 81 percent of the district's roughly 14,000 staff have received at least one dose, and 76 percent are fully vaccinated. About 3,400 staff will need to get fully vaccinated.

Prior to Tuesday's meeting, San Diego Unified already required staff to either be fully vaccinated or test weekly for COVID.

Will there be exceptions to the mandate?

Students and staff may be given medical exemptions from the mandate on a case-by-case basis.

The mandate allows for "conditional enrollment" of students in certain disadvantaged groups, including homeless students, foster youth, migrant students, military students and students with disabilities.

However, that doesn't mean those students are exempted from the mandate. Those students may have an extra 30-day window to comply with the mandate, because their student records may be more difficult to access, said San Diego Unified School Board President Richard Barrera.

Students with disabilities may also qualify for conditional enrollment based on their medical needs.

Can I get a "personal belief" exemption from the vaccine mandate?

San Diego Unified students will not be allowed to opt out of the mandate for personal beliefs.

A 2015 state law banned personal belief exemptions from school vaccines that were required by the state at the time, but it allowed for personal belief exemptions from future school vaccines mandated by the state. The COVID vaccine is not yet mandated by the state.

San Diego Unified is not allowing personal belief exemptions, to follow the logic of that law, Barrera said.

"This is a health and safety issue, and we know from states that allow these sort of personal belief (exemptions), that creates kind of a loophole that means large numbers people don't, in the end, get vaccinated," he said.

San Diego Unified staff, however, will have the chance to apply for religious exemptions, Barrera said. That's because federal law requires employers to offer religious exemptions, he said.

Which other school districts mandate COVID vaccines?

San Diego Unified joined a small but growing number of California districts that are mandating COVID vaccines, including Los Angeles Unified, Oakland Unified and Culver City Unified.

County school officials said San Diego Unified is the first San Diego County district they have seen approve a student vaccine mandate.

California health officials are considering a statewide school COVID vaccine mandate, officials said last week. Barrera said he hopes San Diego Unified and the other districts that approved mandates will create enough momentum to convince the state to implement it statewide.

Kristen Taketa

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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

JOHN DOE, an individual; JANE DOE, individually and as parent and next friend of JILL DOE, a minor child; and JILL DOE, a minor child, by and through her next friend, JANE DOE,

Plaintiffs,

v.

SAN DIEGO UNIFIED SCHOOL DISTRICT; RICHARD BARRERA, in his official capacity as Board President; SHARON WHITEHURST-PAYNE, in her official capacity as Board Vice President; MICHAEL MCQUARY, in his official capacity as Board member; KEVIN BEISER, in his official capacity as Board member; SABRINA BAZZO, in her official capacity as Board member; and LAMONT JACKSON, in his official capacity as Interim Superintendent,

Defendants.

Case No.: '21CV1809 L LL

VERIFIED COMPLAINT FOR DECLARATORY, INJUNCTIVE, AND OTHER RELIEF

Today's order should have been needless; the lower courts in these cases should have followed the extensive guidance this Court already gave.

~S. Bay United Pentecostal Church v. Newsom,
141 S. Ct. 716, 719 (2021) (Statement of Gorsuch, J.)

INTRODUCTION

1. For 115 years, courts have relied on *Jacobson v. Commonwealth of Massachusetts,* 197 U.S. 11 (1905), to dismiss objections of all stripes to compulsory vaccination laws. Whether based on substantive due process, equal protection, or free exercise of religion, all objections fail in the face of *Jacobson*. Then, with the emergence of the COVID-19 pandemic, in April 2020, the Southern District of California became the first venue in the nation to apply *Jacobson* to Free Exercise challenges in a pandemic generally—outside the context of compulsory vaccination.

2. This was a jurisprudential error that spread as its own pandemic through the federal courts, and which took six emergency trips to the Supreme Court before it was effectively stamped out—including five from California and the Ninth Circuit. But now, the ghost of *Jacobson* has raised its ugly head again.

3. Ignoring the pleas of thousands of parents, the Board of Education of the San Diego Unified School District voted to make vaccination from COVID-19 a requirement to attend school. In advance of the Board meeting, the Board made clear that no religious exemptions would be allowed for students. Teachers could get a religious exemption, in light of Title VII, but not students. Students can get a medical exemption, and certain preferred categories of students are not currently bound by this mandate, but students cannot get a religious exemption.

4. The Supreme Court made crystal clear in its six emergency orders that governments cannot justify burdens on the free exercise of religion through appeals to an "emergency," and courts can no longer rely on *Jacobson* as good law in the Free Exercise context. But California officials have apparently not learned the lesson. Disfavored religious minorities are not second-class citizens. Thus, Plaintiffs bring

this action, presenting both facial and as-applied challenges to San Diego Unified School District's vaccination mandate under the Free Exercise clause of the First Amendment.

JURISDICTION AND VENUE

5. This action arises under 42 U.S.C. § 1983 in relation to Defendants' deprivation of Plaintiffs' constitutional rights to freedom of religion under the First Amendment to the U.S. Constitution. Accordingly, this Court has federal question jurisdiction under 28 U.S.C. §§ 1331 and 1343.

6. This Court has authority to award the requested declaratory relief under 28 U.S.C. § 2201; the requested injunctive relief and damages under 28 U.S.C. § 1343(a); and attorneys' fees and costs under 42 U.S.C. § 1988 and Cal. Code Civ. Proc. § 1021.5.

7. The Southern District of California is the appropriate venue for this action pursuant to 28 U.S.C. §§ 1391(b)(1) and (2) because it is the District in which Defendants maintain offices, exercise their authority in their official capacities, and will enforce their Vaccination Roadmap; and it is the District in which substantially all of the events giving rise to the claims occurred.

THE PARTIES

8. Plaintiff John Doe is the parent and legal guardian of Jill Doe, a minor, who is a 16-year-old Junior enrolled at Scripps Ranch High School within the San Diego Unified School District. Plaintiff John Doe is suing on his own behalf. At all relevant times, Plaintiff John Doe resided within the County of San Diego.

9. Plaintiff Jane Doe is the parent and legal guardian of Jill Doe, a minor, who is a 16-year-old Junior enrolled at Scripps Ranch High School within the San Diego Unified School District. Plaintiff Jane Doe is suing on her own behalf and on behalf of Jill Doe as her next friend. At all relevant times, Plaintiff Jane Doe resided within the County of San Diego.

/ / /

10. Plaintiff Jill Doe is a 16-year old minor child and a Junior enrolled at Scripps Ranch High School within the San Diego Unified School District. Plaintiff Jill Doe is suing through her next friend, Jane Doe. At all relevant times, Plaintiff Jill Doe resided within the County of San Diego.

11. Defendant San Diego Unified School District ("SDUSD") is a public entity established and organized under California law and subject to the restrictions of the United States Constitution. SDUSD may sue and be sued in its own name.

12. Defendant Richard Barrera, at all relevant times, was President of the Board of Education for SDUSD acting under color of state law. The Board of Education ("Board") is SDUSD's governing body and is responsible for creating, adopting, and implementing its policies, practices, customs, acts, and omissions, including the challenged policies, practices, and procedures set forth in this Complaint. Defendant Barrera is sued in his official capacity.

13. Defendant Sharon Whitehurst-Payne, at all relevant times, was Board Vice President for SDUSD acting under color of state law. Defendant Whitehurst-Payne is sued in her official capacity.

14. Defendant Michael McQuary, at all relevant times, was a Board member for SDUSD acting under color of state law. Defendant McQuary is sued in his official capacity.

15. Defendant Kevin Beiser, at all relevant times, was a Board member for SDUSD acting under color of state law. Defendant Beiser is sued in his official capacity.

16. Defendant Sabrina Bazzo, at all relevant times, was a Board member for SDUSD acting under color of state law. Defendant Bazzo is sued in her official capacity.

17. Defendant Lamont Jackson, at all relevant times, was the Interim Superintendent of SDUSD. Defendant Jackson is responsible for creating, adopting, and implementing SDUSD policies, practices, customs, and acts, including the

challenged policies, practices, and procedures set forth in this Complaint. Defendant Jackson is sued in his official capacity.

FACTUAL ALLEGATIONS

A. INTRODUCTION

18. In early 2020, a novel coronavirus called SARS-CoV-2, which causes the disease COVID-19, emerged on American shores. Fear of COVID-19 gripped California, the nation, and the world. On March 4 and 13, 2020, both former President Donald J. Trump and Governor Gavin Newsom proclaimed a State of Emergency as a result of the threat of the emergence of COVID-19.[1] The coronavirus outbreak turned the world upside-down, causing profound damage to the lives of all Americans and to the national economy.

19. In response to the virus, many states imposed "stay-at-home" orders to "flatten the curve" of the spread of the virus. In the vast majority of states, these stay-at-home orders protected the constitutional rights of churches and religious believers during the coronavirus pandemic. Those states recognized that, during this pandemic, Americans need the Spirit of Almighty God even more to help them weather these dark times—and that this need is no less "essential" than any other need.

20. In other states, the government treated religious beliefs and practices as mere entertainment—or a disposable pastime—that must bend to the "real" needs of the moment. After six emergency strips to the Supreme Court, that court unequivocally held that the former states had it right.[2]

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[1] President Donald J. Trump, *Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak* (Mar. 13, 2020), https://bit.ly/3aYrQHH; Governor Gavin Newsom, *Proclamation of a State of Emergency* (Mar. 4, 2020), https://www.gov.ca.gov/wp-content/uploads/2020/03/3.4.20-Coronavirus-SOE-Proclamation.pdf.

[2] *Roman Cath. Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63 (2020); *Harvest Rock Church, Inc. v. Newsom*, 141 S. Ct. 889 (2020); *S. Bay United Pentecostal Church v. Newsom*, 141 S. Ct. 716 (2021); *Gish v. Newsom*, 141 S. Ct. 1290 (2021); *Gateway City*

21. Fundamental and unalienable rights are, by their very nature, "essential"—they are the essential rights which led to the founding of this country and this state. For more than four hundred years, people have come to America in a quest for religious freedom. Like the Puritans, most of these pilgrims were fleeing religious persecution in Europe. They understood that "*[n]o* place, not even the unknown, is worse than *any* place whose state forbids the exercise of your sincerely held religious beliefs." *On Fire Christian Ctr., Inc. v. Fischer*, 453 F. Supp. 3d 901, 906 (W.D. Ky. 2020).

B. The Abortion Taint of the COVID-19 Vaccines

22. Within the past year, the U.S. Food and Drug Administration approved three COVID-19 vaccines for emergency use in the United States. These vaccines—in order of approval—were produced by Pfizer-BioNTech (Dec. 11, 2020),[3] Moderna (Dec. 18, 2020),[4] and Janssen Biotech, a subsidiary of Johnson & Johnson (Feb. 27, 2021).[5] The Pfizer vaccine was approved for emergency use with individuals age 16 and up, but the Moderna and Johnson & Johnson vaccines were only approved for individuals age 18 and up.

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Church v. Newsom, 141 S. Ct. 1460 (2021); *Tandon v. Newsom*, 141 S. Ct. 1294 (2021).

[3] U.S. Food & Drug Administration, *Comirnaty and Pfizer-BioNTech COVID-19 Vaccine* (Sep. 24, 2021 update), https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/comirnaty-and-pfizer-biontech-covid-19-vaccine.

[4] U.S. Food & Drug Administration, *Moderna COVID-19 Vaccine* (Aug. 31, 2021 update), https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/moderna-covid-19-vaccine.

[5] U.S. Food & Drug Administration, *Janssen COVID-19 Vaccine* (Sep. 29, 2021 update), https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/janssen-covid-19-vaccine.

23. In the following months, approval of use of the Pfizer vaccine has expanded. On May 10, 2021, emergency use of the Pfizer vaccine was expanded to include children age 12 and up, and on August 23, 2021, full approval was granted for the Pfizer vaccine for individuals age 16 and up.[6] The Moderna and Johnson & Johnson vaccines remain available solely for adults on an emergency basis.

24. All three of these vaccines have been manufactured or tested using material derived from stem cell lines from aborted fetuses.[7] Making the vaccines in this manner was a grave oversight by the U.S. government and the pharmaceutical industry in light of many Americans' belief that abortion is a grave evil in which they cannot participate, and from which they cannot benefit, even remotely.

C. The Vaccination Mandates

25. Despite the morally problematic nature of the currently available COVID-19 vaccines, on August 18 and September 9, 2021, respectively, Culver City Unified School District and Los Angeles Unified School District mandated that all students receive a COVID-19 vaccination in order to attend in-person classes. This sparked a closed-door session of the SDUSD Board of Education, on September 15, 2021, to consider a similar mandate.[8]

26. As a result of this closed-door session, the next day, September 16, 2021, SDUSD proposed holding a public board meeting to discuss imposing a COVID-19

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[6] Press Release, U.S. Food & Drug Administration, FDA Approves First COVID-19 Vaccine (Aug. 23, 2021), https://www.fda.gov/news-events/press-announcements/fda-approves-first-covid-19-vaccine.

[7] David Prentice, Ph.D., *Update: COVID-19 Vaccine Candidates and Abortion-Derived Cell Lines*, Charlotte Lozier Inst. (Jun. 2, 2021 update), https://lozierinstitute.org/update-covid-19-vaccine-candidates-and-abortion-derived-cell-lines/.

[8] Rory Devine, *San Diego Unified Mulls Vaccine Mandate for Students, Staff*, NBC 7 San Diego (Sep. 15, 2021), https://www.nbcsandiego.com/videos/san-diego-unified-mulls-vaccine-mandate-for-students-staff/2717893/.

vaccination mandate.[9] And the day after that, September 17, Urban Discovery Schools—a charter school in East Village, San Diego—imposed its own COVID-19 vaccination mandate.[10]

27. Following this, many other school districts began contemplating mandating vaccination from COVID-19 to attend school in person, including Oakland Unified School District, Piedmont Unified School District, and Hayward Unified School District—all in Alameda County. From all of these, only Oakland broke the trend and allowed students to opt out of vaccination due to personal or religious beliefs.[11]

28. The SDUSD Board of Education scheduled its open meeting to discuss imposing a COVID-19 vaccine mandate for Tuesday, September 28, 2021 at 5:00 pm. In advance of that meeting, SDUSD Board President Beiser shared Interim Superintendent Jackson's proposed Vaccination Roadmap (Ex. 1),[12] and in interviews made clear that no religious objection would be considered.[13]

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[9] *San Diego Unified to publicly discuss potential vaccine mandate for eligible students*, KUSI NEWS (Sep. 16, 2021), https://www.kusi.com/san-diego-unified-to-publicly-discuss-potential-vaccine-mandate-for-eligible-students/.

[10] *Urban Discovery Schools in San Diego Mandate COVID-19 Vaccines for Students Age 12+*, NBC 7 SAN DIEGO (Sep. 23, 2021), https://www.nbcsandiego.com/news/local/urban-discovery-schools-in-san-diego-mandate-covid-19-vaccines-for-students-age-12/2726286/.

[11] Sasha Hupka, *Can California School Districts Independently Mandate COVID-19 Vaccines For Students?*, CAPRADIO (Sep. 29, 2021), https://www.capradio.org/articles/2021/09/29/can-california-school-districts-independently-mandate-covid-19-vaccines-for-students/.

[12] San Diego Unified School District, *Vaccination Roadmap* (Sep. 28, 2021), https://go.boarddocs.com/ca/sandi/Board.nsf/files/C797R4004A4C/$file/Vaccine%20Mandate%20Plan.pdf.

[13] Allie Raffa, *San Diego Unified School District to Vote on Vaccine Mandate For Students, Staff*, NBC 7 SAN DIEGO (Sep. 26, 2021), https://www.nbcsandiego.com/

29. According to that Vaccination Roadmap, all eligible students—i.e., students in an age group for which there is a fully FDA approved COVID-19 vaccine, currently ages 16 and up—must be fully vaccinated by December 20, 2021. The only vaccine available to students is a double-dose vaccine, which requires the first dose be taken by November 29. (*See* Ex. 1 at pp. 8, 13.) As soon as the FDA approves vaccines for children ages 12 and up, and then children ages 5 and up, SDUSD will inform the parents of students that they must get their children vaccinated to continue attending school in-person. (*See* Ex. 1 at pp. 12, 14.)

30. Despite these requirements, according to that Vaccination Roadmap children "in one of these groups: foster youth, homeless, migrant, military family, or have an IEP," need not get a COVID-19 vaccination at this time, and "[m]ay be conditionally enrolled via in-person learning[.]" (Ex. 1 at p. 15.)

31. For those students, SDUSD officials have the discretion to craft a unique requirement for them. For example, for students with an IEP, if they are not on SDUSD property for too long, they may be exempt from vaccination. For foster youth and homeless youth, SDUSD officials can extend the time for them to get vaccinated based on their own personal circumstances.[14]

32. In the very next sentence, the Vaccination Roadmap states that religious faith will not be considered a valid basis for an exemption: "State law does not recognize religious or personal belief exemptions for student immunizations." (Ex. 1 at p. 15.)

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news/local/san-diego-unified-school-district-to-vote-on-vaccine-mandate-for-students-staff/2728805/.

[14] San Diego Unified School District, *San Diego Unified School District, Board of Education Meeting*, YOUTUBE at 3:32:30–35:15 (Sep. 28, 2021), https://youtu.be/ve3YmKiOoY8?t=12750.

33. On September 28, 2021, the SDUSD Board of Education held its open meeting to discuss imposing a COVID-19 vaccine mandate.[15] The vaccine requirement was Agenda Item H.3. (Ex. 2.)[16] Strangely, that meeting was held virtually even though there are currently no limitations on large gatherings, and no safety reason to limit them. However, this is probably explained best by the fact that approximately 1,651 parents signed up to speak in opposition to the COVID-19 vaccine mandate.[17]

34. At the meeting, non-voting Student Board Member Zachary Patterson offered an amendment to the Vaccination Roadmap to require COVID-19 vaccination for children ages 12 and up, regardless of full FDA approval, and in line with some other school districts.[18] However, upon receiving push-back from other members of the Board, this proposed amendment was tabled for a month to be discussed at the October 26, 2021 meeting.[19]

35. At the end of the meeting, the Board voted unanimously to approve the vaccination mandate.[20] The next day, September 29, 2021, SDUSD issued a press release (Ex. 3),[21] sent a letter to all parents (Ex. 4),[22] and updated their FAQ page (Ex. 5),[23] all to update the public about its new mandate.

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[15] YOUTUBE, *supra* n.14, https://www.youtube.com/watch?v=ve3YmKiOoY8.

[16] San Diego Unified School District, *Agenda Item Details # H.3*, BOARDDOCS (Sep. 28, 2021), https://go.boarddocs.com/ca/sandi/Board.nsf/goto?open&id=C797QH82AB01.

[17] YOUTUBE, *supra* n.14, at 2:17:59, https://youtu.be/ve3YmKiOoY8?t=8279.

[18] YOUTUBE, *supra* n.14, at 3:46:46, https://youtu.be/ve3YmKiOoY8?t=13606.

[19] YOUTUBE, *supra* n.14, at 3:55:44, https://youtu.be/ve3YmKiOoY8?t=14144.

[20] YOUTUBE, *supra* n.14, at 4:04:37, https://youtu.be/ve3YmKiOoY8?t=14677.

[21] Press Release, San Diego Unified School District, San Diego Unified to Require COVID-19 Vaccines (Sep. 29, 2021), https://sandiegounified.org/about/newscenter/

36. A few days later, on Friday, October 1, 2021, Governor Newsom decided to dictate via executive fiat that all public school students must be vaccinated against COVID-19 in order to attend any school—whether public or private. (Ex. 6.)[24] However, Governor Newsom acknowledged that because he was promulgating this rule via executive fiat and administrative rule—not legislative change—it was subject to exemptions "for both medical reasons and personal beliefs." (Ex. 7 (quoting Cal. Health & Saf. Code § 120338).)[25]

37. On October 12, 2021, a coalition of parents filed a lawsuit in San Diego County Superior Court, alleging that SDUSD's vaccination mandate violated many provisions of California law. These arguments include that SDUSD's local mandate is preempted by state-wide law, which occupies the field, and violates several provisions of the California Constitution.[26]

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all_news/san_diego_unified_to_require_covid-19_vaccines.

[22] Letter from San Diego Unified School District to San Diego Unified Families (Sep. 29, 2021), https://drive.google.com/file/d/1j3iWGAmour-NGqomJ7GSj-Xxsa9DfMj3/view.

[23] San Diego Unified School District, *Back to School FAQ*, https://sandiegounified.org/cms/One.aspx?portalId=27732478&pageId=35471525#Vaccines.

[24] Press Release, Office of Governor Gavin Newsom, California Becomes First State in Nation to Announce COVID-19 Vaccine Requirements for Schools (Oct. 1, 2021), https://www.gov.ca.gov/2021/10/01/california-becomes-first-state-in-nation-to-announce-covid-19-vaccine-requirements-for-schools/.

[25] *California Becomes First State in Nation to Announce COVID-19 Vaccine Will Be Added to List of Required School Vaccinations*, GET VACCINATED CALIFORNIA (Oct. 1, 2021), https://www.gov.ca.gov/wp-content/uploads/2021/10/California-Becomes-First-State-in-Nation-to-Announce-COVID-19-Vaccine-to-List-of-Required-School-Vaccinations.pdf.

[26] *Let Them Choose v. San Diego Unified School District*, S.D. Cnty. No. 37-2021-00043172-CU-WM-CTL (Cal. Super. Oct. 12, 2021).

38. Since that time, SDUSD has not updated any of its public documents to indicate that it will allow a religious exemption.

D. The Doe Family

39. Mr. and Mrs. Doe, and their daughter Jill Doe, are bringing this case to protect each of their Free Exercise rights. Jill Doe is a junior enrolled at Scripps Ranch High School within the San Diego Unified School District. Jill Doe is 16 years old and has played multiple sports for Scripps Ranch High School.

40. Jill Doe's faith prevents her from taking any of the currently available COVID-19 vaccinations due to their taint with aborted fetal cells. As a result, according to SDUSD's vaccination mandate, she must either abandon her faith or enroll in independent, online study at SDUSD. Mr. and Mrs. Doe share Jill Doe's religious beliefs.

41. Jill Doe is a preeminent athlete. She is looking forward to her sports season this winter because she hopes to draw the attention of college recruiters. Jill Doe believes that, with a good season, she can earn a sports scholarship. However, SDUSD's vaccination mandate also requires that she either abandon her faith or abandon extracurricular sports at Scripps Ranch—dooming any chances at a sports scholarship.

42. The Doe family attends a Christian church in San Diego County. The Does' faith tradition recognizes the morally problematic nature of the currently available COVID-19 vaccines. Therefore, the Does cannot take any of the currently available COVID-19 vaccines without violating their sincere religious beliefs. Many other Christian faith traditions have similar objections to the COVID-19 vaccines.[27]

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[27] *See, e.g.,* The National Catholic Bioethics Center, *Vaccine Exemption Resource for Individuals* (Jul. 21, 2021), https://static1.squarespace.com/static/5e3ada1a6a2e8d6a131d1dcd/t/60f85922ae6a2d324b74741e/1626888482625/NCBC+Vaccine+Exemption+Resource+updated.pdf; Colorado Catholic Conference, *A letter from the bishops of Colorado on COVID-19 vaccine mandates*, Denver Catholic (Aug. 6, 2021),

43. In the past five years especially, Jill Doe's faith has significantly deepened. She is firmly pro-life and accepts her faith's teaching that she cannot participate in the horror of abortion in any way. In the past year, the COVID-19 pandemic has only deepened her faith, teaching her that life is short and precious, and that she must stand up every day for her faith.

44. Last spring, Jill Doe and several others were exposed to an individual who tested positive for COVID-19. All of the other individuals in the group quickly contracted COVID-19, but Jill Doe never got sick and never tested positive. Confused by this, Jill Doe took an antibody test which showed that she had already contracted the virus much earlier. Thus, Jill Doe has natural immunity that is sufficiently potent to prevent her from catching and spreading COVID-19 even when those immediately around her contract it.

45. Plaintiffs request leave to proceed pseudonymously for fear of retaliation and harassment by SDUSD officials, teachers, or students. Similar requests have recently been granted in similar cases. *Dr. A. v. Hochul*, No. 1:21-CV-1009, 2021 WL 4734404, at *11 (N.D.N.Y. Oct. 12, 2021).

FIRST CLAIM FOR RELIEF

Free Exercise Clause of First Amendment to U.S. Constitution

(By all Plaintiffs against All Defendants)

46. Plaintiffs incorporate by reference all allegations contained in the preceding paragraphs as though fully set forth herein.

47. The First Amendment to the U.S. Constitution provides that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof[.]" U.S. Const., amend. I. This Free Exercise clause applies to the

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https://denvercatholic.org/a-letter-from-the-bishops-of-colorado-on-covid-19-vaccine-mandates/; Catherine Ruth Pakaluk, Ph.D., et al., *Statement of Conscience to Awaken Conscience* (Mar. 2021), https://mailchi.mp/7742dd12483f/statement-of-conscience-to-awaken-conscience.

states through the Due Process Clause of the Fourteenth Amendment. *Cantwell v. Connecticut*, 310 U.S. 296 (1940).

48. Under the Free Exercise clause, if "challenged restrictions are not 'neutral' and of 'general applicability,' they must satisfy 'strict scrutiny,' and this means that they must be 'narrowly tailored' to serve a 'compelling' state interest." *Roman Cath. Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63, 67 (2020).

49. A regulation is not "neutral" and "generally applicable" if the government "openly impose[s] more stringent regulations on religious institutions than on many businesses." *S. Bay United Pentecostal Church v. Newsom*, 141 S. Ct. 716, 717 (2021) (Statement of Gorsuch, J.).[28] In that context, there is no need to assess "whether a law reflects 'subtle departures from neutrality,' 'religious gerrymander[ing],' or 'impermissible targeting' of religion." *Id.* (cleaned up). However, if "statements made in connection with the challenged rules can be viewed as targeting" religion, that is also evidence that the regulation is not "neutral." *Roman Cath. Diocese*, 141 S. Ct. at 66.

50. Stated differently, "government regulations are not neutral and generally applicable, and therefore trigger strict scrutiny under the Free Exercise Clause, whenever they treat *any* comparable secular activity more favorably than religious exercise." *Tandon v. Newsom*, 141 S. Ct. 1294, 1296 (2021) (original emphasis). "It is no answer that a State treats some comparable secular businesses or other activities as poorly as or even less favorably than the religious exercise at issue." *Id.* "[W]hether two activities are comparable for purposes of the Free Exercise Clause must be judged against the asserted government interest that justifies

[28] The reasoning in Justice Gorsuch's statement was joined by four other Justices, making it a binding opinion. *See Brach v. Newsom*, 6 F.4th 904, 933 n.26 (9th Cir. 2021); *Roman Cath. Archbishop of Washington v. Bowser*, ___ F. Supp. 3d ___, 2021 WL 1146399, at *15 n.15 (D.D.C. 2021); *see also Tandon v. Newsom*, 141 S. Ct. 1294, 1296–97 (2021).

the regulation at issue. Comparability is concerned with the risks various activities pose, not the reasons why people gather." *Id.* (citations omitted).

51. Once strict scrutiny is triggered, the government must show that the regulations are " 'narrowly tailored' to serve a 'compelling' state interest." *Roman Cath. Diocese*, 141 S. Ct. at 66. "[N]arrow tailoring requires the government to show that measures less restrictive of the First Amendment activity could not address its interest in reducing the spread of COVID. Where the government permits other activities to proceed with precautions, it must show that the religious exercise at issue is more dangerous than those activities even when the same precautions are applied. Otherwise, precautions that suffice for other activities suffice for religious exercise too." *Tandon*, 141 S. Ct. at 1296–97.

52. Further, evidence that the regulation is "more severe than what many other jurisdictions have done" "negat[es] any suggestion that [the government] adopted the least restrictive means of accomplishing its compelling interest." *Brach v. Newsom*, 6 F.4th 904, 932 (9th Cir. 2021). "[B]road measures that fail to take proper account of relevant differences between the school-age population and others are, by definition, not narrowly tailored." *Id.* at 932.

53. Here, Plaintiffs' religious faith precludes them from receiving any of the FDA approved COVID-19 vaccines because those vaccines were either manufactured or tested using material derived from stem cell lines from aborted fetuses.

54. However, under the Vaccination Roadmap, if Plaintiff Jill Doe is not fully vaccinated from COVID-19 by December 20, 2021, with a first dose administered by November 29, 2021, at the latest, she will have to cease in-person learning at Scripps Ranch High School. She will also have to cease participating in extracurricular activities, including high school sports. This is a substantial burden on Plaintiff Jill Doe in light of the benefits of in-person learning and her efforts to achieve a sports scholarship to attend college. This is a substantial burden on

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Plaintiffs Mr. and Mrs. Doe because they will have to find an alternative educational opportunity for Plaintiff Jill Doe.

55. The Vaccination Roadmap is neither neutral nor of general application because it "openly impose[s] more stringent regulations on" individuals who cannot get vaccinated for religious reasons than individuals who cannot get vaccinated for other reasons. *S. Bay*, 141 S. Ct. at 717 (Statement of Gorsuch, J.); *accord Tandon*, 141 S. Ct. at 1296. The Vaccination Roadmap specifically allows individuals with medical issues to not get vaccinated, and provides conditional in-person learning without vaccination for foster youth, homeless youth, migrant youth, students with an IEP, and members of military families. (Ex. 1 at p. 15.)

56. The Vaccination Roadmap is also not of general application because it contains a system of individualized exemptions for various youth if their circumstances make getting a COVID-19 vaccine a hardship, subject to the discretion of SDUSD officials. *See Fulton v. City of Philadelphia, Pennsylvania*, 141 S. Ct. 1868, 1877 (2021) ("A law is not generally applicable if it invites the government to consider the particular reasons for a person's conduct by providing a mechanism for individualized exemptions.") (cleaned up). The Vaccination Roadmap specifically allows individuals with medical issues, foster youth, homeless youth, migrant youth, students with an IEP, and members of military families to not get vaccinated depending on an individualized exemption crafted by SDUSD officials. (Ex. 1 at p. 15.)

57. The Vaccination Roadmap is also not neutral because it directly references religion to identify it as an invalid basis for not being able to be vaccinated. *See Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 533 (1993) ("A law lacks facial neutrality if it refers to a religious practice without a secular meaning discernable from the language or context."). Throughout the Vaccination Roadmap, it goes out of its way to expressly disclaim any willingness to accommodate religious practices. (*See* Ex. 1, p. 15; Ex. 5, p. 12.)

58. Facially and as applied, the Vaccination Roadmap is not narrowly tailored to further any compelling governmental interest because Defendants permit numerous students to obtain in-person learning without vaccination. The Vaccination Roadmap specifically allows individuals with medical issues, foster youth, homeless youth, migrant youth, students with an IEP, and members of military families to not get vaccinated. (Ex. 1 at p. 15.)

59. Facially and as applied, the Vaccination Roadmap is also not narrowly tailored to further any compelling governmental interest because it permits teachers and other employees to not get vaccinated if, for religious reasons, they cannot. (Ex. 3, p. 3.)

60. Facially and as applied, the Vaccination Roadmap is also not narrowly tailored to further any compelling governmental interest because "Covid's effects exhibit a significant age gradient, . . . having little impact, statistically speaking, on children." *Brach*, 6 F.4th at 932. Thus, Defendants' allowance of religious exemptions for teachers, but not students, is at best poorly tailored, and at worst simply illogical.

61. Facially and as applied, the Vaccination Roadmap is also not narrowly tailored to further any compelling governmental interest because it is "more severe than what many other jurisdictions have done[.]" *Brach*, 6 F.4th at 932. Thus, the fact that the State itself allows religious exemptions in other school districts, "negat[es] any suggestion that [SDUSD] adopted the least restrictive means of accomplishing its compelling interest." *Id.*

62. As applied, the Vaccination Roadmap is not narrowly tailored to further any compelling governmental interest because Plaintiff Jill Doe already contracted and recovered from COVID-19 granting her natural immunity to COVID-19 greater than any vaccine.

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63. Plaintiffs have no adequate remedy at law and will suffer serious and irreparable harm to their constitutional rights unless Defendants are enjoined from implementing and enforcing the Vaccination Roadmap.

64. Pursuant to 42 U.S.C. §§ 1983 and 1988, Plaintiffs are entitled to nominal damages, declaratory relief, and temporary, preliminary, and permanent injunctive relief invalidating and restraining enforcement of the Vaccination Roadmap.

65. Plaintiffs found it necessary to engage the services of private counsel to vindicate their rights under the law. Plaintiffs are therefore entitled to an award of attorneys' fees and costs pursuant to 42 U.S.C. § 1988 and Cal. Code Civ. Proc. § 1021.5.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully pray for judgment against Defendants and request the following relief:

A. An order and judgment declaring that the Vaccination Roadmap, facially and as-applied to Plaintiff Jill Doe, violates the First Amendment to the U.S. Constitution;

B. An order temporarily, preliminarily, and permanently enjoining and prohibiting Defendants from granting any exemptions to the Vaccination Roadmap for medical reasons, foster youth, homeless youth, migrant youth, students with an IEP, and members of military families, unless they give the exact same exemption to individuals who cannot get vaccinated for religious reasons;

C. Nominal damages;

D. Attorneys' fees and costs; and

E. Such other and further relief as the Court deems appropriate and just.

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Respectfully submitted,

LiMANDRI & JONNA LLP

Dated: October 22, 2021 By: 

Charles S. LiMandri
Paul M. Jonna
Mark D. Myers
Jeffrey M. Trissell
Robert E. Weisenburger
Milan L. Brandon II
Attorneys for Plaintiffs

VERIFICATION

I, Jane Doe, am a plaintiff in this action. I have read the above Verified Complaint and know its contents. The information supplied in the foregoing is based on my own personal knowledge or has been supplied by my attorneys or other agents or compiled from available documents. The information in the foregoing document is true to the extent of my personal knowledge. As to the information provided by my attorneys or other agents or compiled from available documents, including all contentions and opinions, I do not have personal knowledge but made a reasonable and good faith effort to obtain the information by inquiry to other natural persons or organizations, and believe it is true.

Thus, I am informed and believe that the matters stated in the foregoing document are true and on that ground certify or declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct.

Executed this 22nd day of October 2021, at San Diego, California.

Jane Doe

EXHIBIT 1

Vaccination Roadmap

September 28, 2021

Why are we recommending mandating vaccines for staff and students?

San Diego Unified is working to ensure the highest-quality instruction in the safest environment possible for all students and employees. Strong scientific evidence shows that vaccinations are an essential part of protecting our communities.

The Science

- Vaccines are fully approved by FDA only once an extremely high level of confidence that effectiveness and benefits clearly outweigh known or potential risks.

- Vaccine the most *preventive* of all strategies. Unlike masking, ventilation, and testing, vaccination protects students before the virus is introduced into the setting, reducing disease and new mutations.
  - Protects unvaccinated family members and other adults who have and haven't been vaccinated

- School-age children get sick and contribute to new infections. They are the greatest proportion of unvaccinated in US. More children have been hospitalized recently than any previous time during the epidemic
  - *New Variants*: A virus is most likely to mutate when replicating, i.e., with each new infection in a population. Unvaccinated children contribute to new variants.

UCSD EXPERT PANEL

In addition to protecting children from illness and missing school due to SARS-CoV-2 infection, I fully support a COVID-19 vaccination requirement in schools to minimize disruption in learning that would occur if there are outbreaks in schools. Preventing COVID-19 in children through vaccination will also avoid parents having to take time off work to care for children in isolation or quarantine. Although children are less likely to have symptomatic infection compared to adults, infected school children may introduce the virus into households with family members who are unvaccinated and at risk for severe illness. As equally important members of our community, children need also be vaccinated to achieve herd immunity. As the partner of an elementary school teacher who taught in-person all last year and co-investigator on a research study involving COVID-19 testing San Diego County schools, I can attest to the benefits of masking in schools; however, infections did occur. Therefore, a vaccine requirement for school attendance will add one more layer of protection for the students, staff, teachers and the wider community. **Richard Garfein, PhD, MPH, Div of Infectious Disease & Global Public Health**

I also wholeheartedly support making vaccinations a requirement for in person learning. FDA approval comes with extensive safety checks and the risk/benefit ratio clearly favors vaccination over the risk of symptomatic COVID infections, multisystem inflammatory syndrome, and community spread. This decision would be in line with existing, non-COVID vaccine requirements school children already meet for school and public health safety. On a personal note, both of my kids are attending school in SDUSD. The oldest is already fully vaccinated and the younger one will be vaccinated as soon as it is approved. **Kimberly Brouwer, PhD; Wertheim School of Public Health & Human Longevity Science**

I strongly support the vaccine mandate- our modeling in university settings indicates this will substantially reduce infections and transmissions among the students, as well as, of course, onwards transmission to other household members and the broader community. **Natasha Martin, DPhil; Division of Infectious Disease & Global Public Health**

UCSD EXPERT PANEL

I'm also strongly in favor of a vaccine mandate for students to go with the one already in place for faculty and staff. It will reduce their risk for disease with its short and long-term clinical implications. It will reduce transmission in schools and protect those who are medically vulnerable despite vaccination. It will reduce absenteeism and the likelihood that schools will need to be closed for outbreaks. It will enable schools to operate more "normally" with sports, field trips and group activities. It will also "mainstream" the policy around COVID. Politically driven COVID "exceptionalism" has resulted in hundreds of thousands of unnecessary deaths, a prolongation of the epidemic with all of its attendant impacts on the economy and has endorsed a broader departure from science-based decision-making in government and society. **Robert (Chip) Schooley, Div of Infectious Disease & Global Public Health**

I strongly support the school district mandating COVID-19 immunizations for all students for in-person learning once a vaccine is approved for the age cohort. This will improve the safety of the learning environment. **Davey Smith, MD, MAS; Chief Division of Infectious Diseases & Global Public Health**

I strongly support the school district mandating COVID-19 immunization for all students for in-person learning once a vaccine is approved for the age cohort. This will help to protect children, teachers and families against COVID-19, will help to achieve herd immunity within the population, and decrease the risk for the development of new SARS-CoV-2 variants. **Stephen Spector, MD; Division of Infectious Diseases, Department of Pediatrics**

I support a mandate. Obviously we mandate many vaccines for school to prevent infectious diseases that are transmitted in schools and COVID clearly is one of these. The non-pharmacologic measures (e.g. masks, ventilation, cohorting) are not going to be sufficient to prevent some transmission. Rates of COVID are going up in children. Consistent with current California law, religious or personal belief exemptions should not be allowed. **Mark Sawyer, MD; Division of Infectious Diseases, Dept of Pediatrics, UCSD**

Recommendation - Employees

Require District employees, partners, contractors and other adults who work directly with students and district employees on district property to be fully-vaccinated on or before **December 20, 2021***. This mandate would be a condition of employment and a requirement for contracted services.

* Employees receive the 2nd dose of Pfizer or Moderna or single Johnson & Johnson shot by this date

Current Data - Employees

From the San Diego County Immunization Registry

80.7% of employees received at least 1 dose

76.0% are fully vaccinated

Employee Impact:
Snapshot -
Wednesday, September 22

- ❏ **27** Staff in **Isolation** due to positive COVID-19 test
- ❏ **16** Staff in **Quarantine**
- ❏ **34** Staff absent due to **COVID-19 symptoms**

Recommended Mandated Vaccine for Employees

August 23

Full FDA Approval

September 28

Board of Education Meeting

October 1

Notify SDUSD Employees

November 22- 29

Administration of 1st Dose: Moderna by Nov 22/ Pfizer by Nov 29

By December 20

Administration of 2nd Dose of Pfizer/Moderna or one dose of Johnson/Johnson

By January 4

Peak Immunity

Information for Employees

Require District employees, partners, contractors and other adults who work directly with students and district employees on district property to be fully-vaccinated on or before **December 20, 2021**. This mandate would be a condition of employment and a requirement for contracted services.*

The District may take disciplinary action, up to and including termination for employees who do not comply with this mandate.

Employees will:

- Be allowed to use up to 2 hour personal business to be vaccinated during their workday
- Be allowed time for vaccine reaction
- Be allowed to take up to 2 hours during their work day to take a dependent minor to be vaccinated.

*Subject to impacts and effects bargaining

Second Recommendation - Students

The district's recommendation is a staggered approach to have all eligible* students vaccinated against COVID-19, as a condition of attending in-person learning. The timeline for requiring the mandated vaccination will be aligned to the full FDA approval. Mandatory testing will be required for all unvaccinated students until full FDA approval of the vaccine for their age group.

*All students who are eligible for the COVID-19 vaccine are required to be vaccinated, excluding those with qualified exemptions or conditional admissions.

Current Data - Students

From the San Diego County Immunization Registry

Of our students age 12 and older:

64.6% of students received at least 1 dose

57.2% are fully vaccinated

Student Impact:
Snapshot - Wednesday, September 22

- **67** Students **isolating** - positive COVID-19 test
- **272** Students in **Quarantine**
- **126** Students in **Modified Quarantine**
- **887** Students absent due to **COVID-19 symptoms**

Vaccination* & Testing Roadmap

Stage 1

- **Mandatory Vaccines**
  - For students **16 & older** (FDA approved)
- **Mandatory Routine Testing**
  - Unvaccinated High School Students under Age 16

Stage 2

- **Mandatory Vaccines**
  - For students **12 & older** (Pending FDA approval)
- **Mandatory Routine Testing**
  - Unvaccinated Middle School Students under Age 12

Stage 3

- **Mandatory Vaccines**
  - For students **5 & older** (Pending FDA approval)
- **Mandatory Routine Testing**
  - Unvaccinated Students under Age 5

*SDUSD recommends all students be vaccinated during the emergency FDA approval period. Current ages in the emergency FDA approval period are 12-15 year olds.

Stage 1 - Students Ages 16 & Older

September 28

Board of Education Meeting

October 1

Notify SDUSD Families

By November 29

Administration of 1st Dose

By December 20

Administration of 2nd Dose

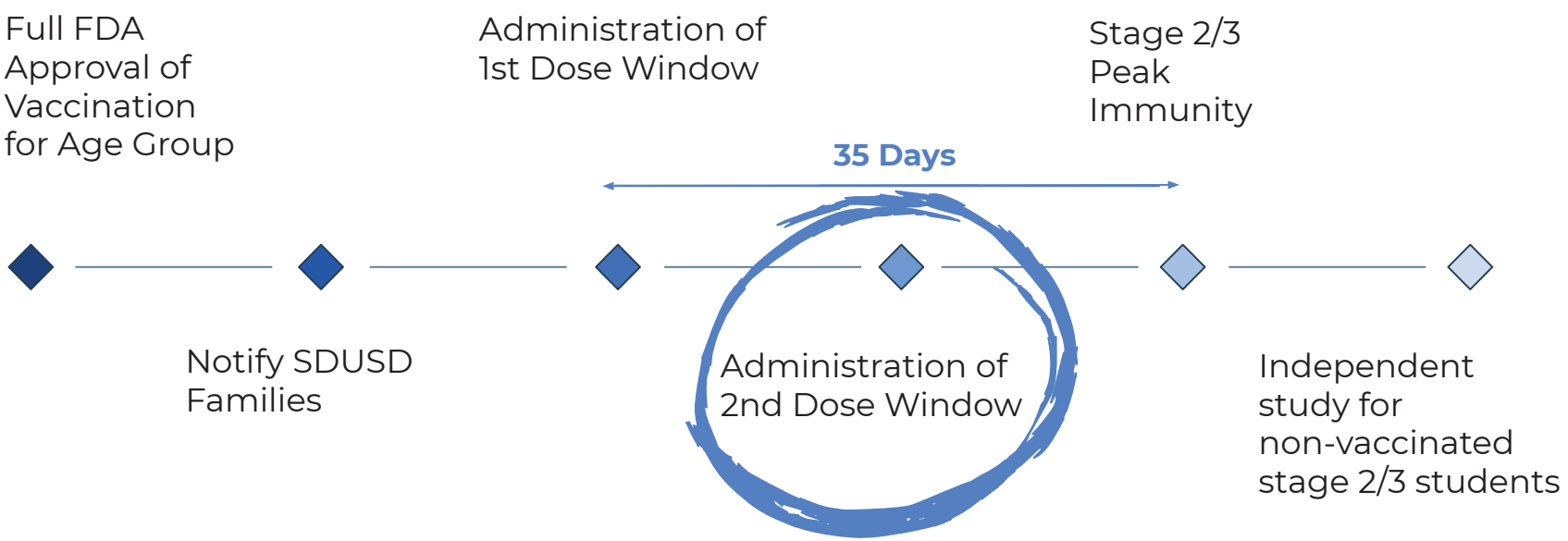
By January 4

Phase 1 Peak Immunity

January 21 (Start of Spring Semester)

Independent study for non-vaccinated Stage 1 students

Stages 2-3 Timeline



Information for Students

Recommend approving the district's staggered approach to have all eligible students vaccinated against COVID-19 pending Full FDA approval.

Students who are eligible for the vaccine and not vaccinated by established deadlines will be required to participate in independent study programs.

Students:

- Will require parental consent for all students under the age of 18.
- Will be afforded the opportunity for medical exemptions
- May be conditionally enrolled via in-person learning if they are in one of these groups: foster youth, homeless, migrant, military family, or have an IEP. State law does not recognize religious or personal belief exemptions for student immunizations.
- Who are not vaccinated will not be permitted to participate in extracurricular activities unless the student is below the age range of FDA's full approval or has an exemption.

Next Steps

- Develop full implementation plan
- Develop an FAQ for Employees and Students
- Communication and outreach to Employees and Families
- Conduct any required impacts and effects bargaining with unions
- Continue Legislative Advocacy

Board Action

- Require District employees, partners, contractors and other adults who work directly with students and district employees on district property to be fully-vaccinated on or before December 20, 2021. This mandate would be a condition of employment and a requirement for contracted services.

- Approve a staggered approach to have all eligible students vaccinated against COVID-19, as a condition of attending in-person learning. The timeline for requiring the mandated vaccination will be aligned to the full FDA approval. Mandatory testing will be required for all unvaccinated students until full FDA approval of the vaccine for their age group.

EXHIBIT 2

San Diego Unified SCHOOL DISTRICT

Agenda Item Details

Meeting	Sep 28, 2021 - Regular Meeting, 5:00 p.m.
Category	H. District Operations
Subject	3. Vaccine Mandate Plan
Type	Action

RECOMMENDATION: Approve staff recommendation to require district employees, partners, contractors and other adults who work directly with students and district employees on district property to be fully-vaccinated on or before December 20, 2021. This mandate would be a condition of employment and a requirement for contracted services.
Approve the recommendation to require all eligible students to be vaccinated against COVID-19, as a condition of participating in-person (on campus) learning. The timeline for requiring the mandated vaccination will be aligned with full FDA approval. Mandatory testing will be required for all unvaccinated students until full FDA approval of the vaccine for their age group.

FISCAL IMPACT: None.

PRIOR YEAR FISCAL IMPACT: None.

IMPACT TO DISTRICT STAFFING: This mandate would be a condition of employment for all district staff.

CONSULTATION WITH BOARD ADVISORY COMMITTEE: Not applicable.

BACKGROUND: San Diego Unified School District is working to ensure the highest-quality instruction in the safest environment possible for all students and employees. Strong scientific evidence shows that vaccinations are an essential part of protecting our communities.

[Originator/Contact: Lamont Jackson, Interim Superintendent, 619.725.5506, superintendent@sandi.net]

Vaccine Mandate Plan.pptx (1,721 KB) Vaccine Mandate Plan.pdf (164 KB)

Workflow

Workflow	Sep 24, 2021 10:51 PM :: Submitted by Callie Harrington. Routed to Lamont Jackson for approval. Sep 24, 2021 10:55 PM :: Final approval by Lamont Jackson

Last Modified by Lamont Jackson on September 24, 2021

EXHIBIT 3

SAN DIEGO UNIFIED TO REQUIRE COVID-19 VACCINES

NEWS RELEASE: San Diego Unified to Require Covid-19 Vaccines for Age-Eligible Students and Staff
Posted on 09/29/2021

New Covid-19 vaccine initiative to help protect schools, families and community from virus

SAN DIEGO – To protect schools and the community from Covid-19, San Diego Unified School District staff and students, ages 16 and up, will be required to be fully vaccinated against the virus, under an initiative unanimously approved by the Board of Education on Tuesday evening.

The vaccine requirement follows similar policies implemented in districts across the state, including the Los Angeles Unified and Oakland school districts, and comes as the spread of Covid-19 continues to raise concerns among health professionals, educators, and families.

“As a district, we are obligated to make our schools as safe as possible for the students we are trusted to care for and educate, as well as for our dedicated educators and staff members,” said Board President Richard Barrera. “The science is clear. Vaccines are absolutely essential when it comes to protecting students and staff, and the whole community, against Covid-19.”

Many students in San Diego Unified have been eligible to receive Covid-19 vaccines for several months, but many have not, due to lack of access, among other reasons.

“Anything we can do to increase the pool of vaccinated individuals will benefit our schools and our entire community as we continue to fight this virus,” said district pediatrician Dr. Howard Taras, who is a professor of pediatrics at UC San Diego. “Vaccines are our best defense against Covid-19.”

State Senator and pediatrician Dr. Richard Pan, D-Sacramento, who chairs the Senate Committee on Health,

said the notion that kids are not impacted by Covid-19 is false.

“There is a myth out there that children are not affected by Covid. We know that’s not true. Over 500 children have died of Covid in the United States,” Dr. Pan said.

Dr. Pan commended the school board for considering the mandate, and said its passage will ultimately allow more students to maintain attendance in the classroom.

“What we need to do is have a safe school environment so kids can stay in school and get educated, and a vaccine mandate or requirement for staying in school is very important to being able to achieve that goal,” Dr. Pan said.

The timeline to receive full Covid-19 vaccinations will be based on age groups, aligned with full FDA approval. Currently, the FDA has fully approved vaccinations for children ages 16 and older. Because of that, for those 16 and older who have not yet been vaccinated, San Diego Unified has set a schedule requiring a first Covid-19 vaccination by November 29 and a second dose by December 20.

Students 16 and older who are not fully vaccinated by December 20 would not be permitted to participate in on-site education and would instead be offered an alternative education program.

The FDA has given emergency approval for Covid vaccinations to be administered in the 12-15 age group. San Diego Unified recommends the vaccine for that group, although it won’t be required until full FDA approval is granted. Currently, more than 64 percent of San Diego Unified students 12 and older have received at least one dose of the Covid-19 vaccine, and more than 57 percent are fully vaccinated.

Strong scientific evidence has shown that vaccinations are an essential part of protecting our communities as we move forward:

- Vaccines are fully approved by the FDA only once an extremely high level of confidence is achieved that effectiveness and benefits clearly outweigh known or potential risks.
- Vaccines are the most preventive of all strategies. Unlike masking, ventilation, and testing, vaccination protects

students before the virus is introduced into the setting, reducing disease and new mutations.

- Vaccines protect unvaccinated family members and other adults who have and haven't been vaccinated.
- School-age children get sick and contribute to new infections. They are the greatest proportion of unvaccinated in the U.S. More children have been hospitalized recently than any previous time during the pandemic.

San Diego Unified's vaccine mandate would require all staff members to get vaccinated, unless they have a bonafide medical or religious exemption. The majority of district staff, an estimated 76 percent, has been fully vaccinated under a district initiative that went into effect earlier this year. The District will bargain any required impacts and effects related to this vaccine mandate with the labor unions.

San Diego Unified is making its largest investment, nearly $3 billion, in safety, student success and classrooms this year, a 14 percent increase per-student from a year ago. More information about this investment and the safety measures already in place are in the new **Back to School Guide** and**Frequently Asked Questions**.

To reduce the possibility of Covid-19 transmission at schools, the district has already adopted a wide range of measures that include:

- Upgraded HVAC filtration from MERV 8 to a MERV 13 (or portable HEPA filtered device), meeting or exceeding current requirement
- Portable air purifiers for areas not adequately served by a MERV /HVAC or other ventilation system.
- Face masks required indoors and outdoors at all times, except when students are eating (and in some circumstances when participating in some exertive physical activities and performing arts) with nearly 1 million masks distributed to schools since reopening in April
- Handwashing stations and cleaning wipes in multiple location

- A particulate sensor and CO2 monitor at each site for monitoring the school's indoor air quality
- Electrostatic disinfectant sprayers for cleaning school buses
- Protocols in place for contact tracing, should it be necessary
- An up-to-date **COVID dashboard** on our website

Families and staff will receive information on how and where to get free vaccines. A Covid-19 safety forum will be held via Zoom at 5:30 p.m. on Thursday, September 30, giving families a chance to hear from health experts and ask questions. Sponsored by San Diego Unified's Family Engagement Department, the event will be moderated by Californians for Safe Schools. Interpretation services will be available, beginning at 5:15 p.m. More information is available on the school district website.

EXHIBIT 4

San Diego Unified
SCHOOL DISTRICT

September 29, 2021

Dear San Diego Unified Families,

We hope this finds you healthy and happy as we approach the end of the first month of the 2021-22 school year.

At Tuesday night's Board of Education meeting, trustees voted unanimously to require Covid-19 vaccinations for eligible students as a condition of attending in-person learning, excluding those with qualified exemptions or conditional admissions.

Other school districts across the state have already taken similar action regarding Covid-19, including L.A. Unified and several districts in the Bay Area. As you are aware, other vaccinations have long been required to attend public schools to prevent the spread of infectious disease.

The timeline to receive full Covid-19 vaccinations will be based on age groups, aligned with full FDA approval. Currently, the FDA has fully approved vaccinations for children ages 16 and older. Because of that, for those 16 and older who have not yet been vaccinated, San Diego Unified has set a schedule requiring a first Covid-19 vaccination by November 29 and a second dose by December 20.

Students 16 and older who are not fully vaccinated by December 20 would not be permitted to participate in on-site education and would instead be offered an alternative education program. Those students would also be excluded from participating in extracurricular activities.

The FDA has given emergency approval for Covid-19 vaccinations to be administered in the 12-15 age group. San Diego Unified recommends the vaccine for that group, although it won't be required until full FDA approval is granted. Currently, over 64 percent of San Diego Unified students 12 and older have received at least one dose of the Covid-19 vaccine, and over 57 percent are fully vaccinated.

Strong scientific evidence has shown that vaccinations are an essential part of protecting our communities as we move forward:

- Vaccines are fully approved by the FDA only once an extremely high level of confidence is achieved that effectiveness and benefits clearly outweigh known or potential risks.
- Vaccines are the most preventive of all strategies. Unlike masking, ventilation, and testing, vaccination protects students before the virus is introduced into the setting, reducing disease and new mutations.

- Vaccines protect unvaccinated family members and other adults who have and haven't been vaccinated.
- School-age children get sick and contribute to new infections. They are the greatest proportion of unvaccinated in the U.S. More children have been hospitalized recently than any previous time during the pandemic.
- A virus is most likely to mutate into a new variant when replicating, i.e., with each new infection in a population. Unvaccinated children contribute to new variants.
- We understand you may have additional questions regarding the board's decision and how it affects you. We've assembled a series of answers to some of the more frequently asked questions in our **Back to School FAQ**.

We also invite you to attend our next webinar forum **Parents as Partners Covid-19 Safety Forum at 5:30 p.m. Thursday, September 30** (Webinar Link). The forum is the latest in a series of Covid-19 safety sessions sponsored by San Diego Unified's Family Engagement Department. The event will be moderated by Californians for Safe Schools. Interpretations services will be available, beginning at 5:15 p.m. If you need interpretation in another language, please click on the link and fill out the form: https://docs.google.com/forms/d/e/1FAIpQLSdApWgHsZutmQ3DcxhUS2R_BWEBU5UFANGDJ_vVCzPC0_sKEQ/viewform

Wishing you good health today and always.

Sincerely,

San Diego Unified School District

EXHIBIT 5

BACK TO SCHOOL FAQ

1. Enrollment
2. Heading Back to School
3. Science
4. Safety
5. Masks
6. Testing
7. Vaccines
8. Students on campus
9. Coming on to campus
10. Online option
11. Social and emotional well-being
12. Making sure students feel welcome
13. Student Success
14. Digital access
15. Special Educational
16. English Learners
17. Specific subjects
18. Athletics

Enrollment

Is there still time to enroll for school, including the Virtual Academy?

Yes. See Enrollment Options for more info.

How do I enroll my student in San Diego Unified?

All students are guaranteed enrollment in their neighborhood school. Families who are new to the district may pre-enroll online or in person. For details on the enrollment process, please visit our Office of Neighborhood Schools and Enrollment Options. There, you will find information on enrollment procedures for continuing and new-to-district families, along with other useful information.

How do I enroll for the online school (virtual academy)?

We understand that not everyone will be ready or comfortable with returning to in-person learning. With that in mind, all San Diego Unified K-12 students have the option to enroll in the new online Virtual Academy for the 2021-22 school year.

Students who still wish to enroll in the Virtual Academy should complete this interest form or simply email virtualacademy@sandi.net with your child's name, grade level for 2021-22, student ID number, and current school of attendance.

Students and families will be sent classroom information prior to the first day of school.

If I enroll for the online school, will I lose my place at my current school of attendance, Prime Time or other after school options?

No.

Can I apply to attend a school outside of my neighborhood?

Yes, families who are new to the district are welcome to enroll via the Choice program for 2021-2022. If space is still available, your student may be offered enrollment. For more, please visit our Office of Neighborhood Schools and Enrollment Options.

How can I apply to an Early Learning program for my 3 or 4 year old?

Many elementary schools in San Diego Unified are now offering Universal Transitional Kindergarten for students who will be 4 by September 1. The program provides students with a full day of learning through exploration, inquiry, and interaction every day. It's a great way to give your children the knowledge and skills needed for kindergarten success. If your student is too young for the full-day program, or you are interested in a part-day program for any other reason, many schools have morning and afternoon-only options available.

There are no school boundary requirements for either program, and if your first school choice isn't available, you're free to choose another. To enroll in either program, please call the Neighborhood School and Enrollment Options office at (619) 260-2410. You may

also visit us in person at 4100 Normal Street, Annex 12. Our office hours are from 8:30a to 4:30p, and Zoom appointments are also available. You may also enroll directly in transitional kindergarten by contacting any of the schools offering the program. Over the next few years, the district will expand early learning across the entire district. We're looking forward to seeing your little ones!

Heading back to school

How do I prepare my student to return to the classroom successfully?

Our Back to School Guide includes resources and up-to-date information for families on the new school year. Please see page 18 for information specifically intended to help prepare your student for a successful school year.

One of the most important things you can do right now is to enroll your student in the District's comprehensive on-site COVID testing program. Getting tested at school may allow students to stay in school - even if another classmate tests positive for Covid-19. The new modified quarantine option allows students to remain in school, so long as they take part in regular testing. Previously, students were required to quarantine alone at home. In short, students can frequently "test in school to stay in school" this year.

How can families help their students transition back to school?

- Establishing routines that work best for your child
- Continuing ongoing communication with your child's educators
- Assuring your child they will be cared for and supported at school
- Having a designated time and space to read, review school content or study
- Scheduling special times when students can discuss their school experiences

Tips and strategies families can cultivate at home:

- Stay healthy: Continue to follow all public health guidelines to protect you and others from the COVID-19 pandemic.
- Monitor district communication for up-to-date information.
- Communicate with school staff regarding technology needs. The district has set up a technology helpline to assist students and families. The Family Technology Support Line is available to assist families. Please call (619) 732-1400 from 8:00 am to 5:00 pm.

- Continue to enhance your wellness and the well-being of your family. Our Wellness website has family and student resources.
- For more information please visit, LiveWell@Home San Diego.
- Be gentle with yourself and your family. Remember: We are in this together and we are here to support you.

Will the district be partnering with parents to offer support?

Yes. The Family Engagement Department has resources available to help parents:

- Families can use High Impact Home Strategies to support their child's learning at home.
- *Online training modules* for students and families. These modules will be available for families to access at their convenience.
- The Family Engagement Department, will continue to offer weekly family workshops, designed for parents and students participation, to enhance student learning and family engagement. Family Engagement Events Calendar

The Family Engagement team has office hours available to support families. To learn more about the many resources offered by the Family Engagement Department, their website.

What other services will be provided to families?

Parents as Partners will continue to support families as the new year begins. The district is committed to helping families in an effort to accelerate student learning.

Parent coaching sessions will continue to be online to accommodate the schedules of our families. The platform provides our families the convenience of joining virtual sessions from any location using the device of their choice. Coaching sessions allow families and district staff to deepen connections, listen to a variety of voices, seek input, and answer questions.

We know family involvement impacts student growth and achievement, and therefore we are excited to continue these monthly coaching sessions. For more information, please view our Back to School Guide, pages 32 and 33.

Science

How was the decision made to return to school full time, five days a week?

We have been preparing to reopen schools as soon as it would be safe to do so for more than a year. Returning to in-person, full time instruction is based on reopening standards proposed by the State Legislature and current public health guidelines. It is also based on teacher access to COVID-19 vaccines and testing.

Has San Diego Unified consulted with scientific and medical experts regarding reopening?

Yes. The district has been consulting with a panel of researchers and medical experts from UCSD throughout the pandemic.

Safety

Will school sites follow COVID-19 safety guidelines?

Yes. San Diego Unified has put into place substantial measures to protect the safety of all students, faculty, and staff on our campuses this year, including upgraded HVAC filtration from MERV 8 to a MERV 13, use of highly effective portable HEPA air purifiers, exceeding current requirements, and a requirement to wear masks indoors at all times, and outdoors in certain high density settings. For more information, please take a look at the Back to School Guide.

What ventilation protocols is the district implementing to keep my student safe?

Ventilation is a key component to reduce the spread of COVID-19 in schools. As the district moves to having more people on campus and students in classrooms, ensuring adequate room ventilation is key to reducing the airborne transmission of COVID-19 indoors. The District's Back to School Guide, page 15 provides more information related to ventilation.

Adequate ventilation is achieved by bringing in more outdoor air through open windows and doors, and by providing recirculated air that is highly filtered. These are best practices for diluting or displacing airborne COVID-19 particles, if the particles happen to be present in a room.

San Diego Unified is finalizing a program to provide air conditioning in every classroom in every school. The vast majority of schools are air-conditioned.

The district has planned for maximum ventilation, with our goal to maintain five air exchanges per hour in the classroom. This is based

on guidance from Harvard and the University of Colorado Boulder and in collaboration with our UCSD expert panel. In order to achieve this, the district has implemented the following:

- All existing HVAC systems have been serviced and filters have been replaced. Higher levels of filtration (i.e. Merv-13) are being installed in all systems that can accommodate them. Systems have been adjusted to bring in more outside air.
- Using natural ventilation (opening doors and windows, even when the HVAC is running).
- Using air purifiers with HEPA filters (provides a higher level of filtration). Air purifiers have been allocated to each site, and the numbers of purifiers in a classroom will vary based on MERV rating, room size, number of windows, type of HVAC system, etc. Air purifiers will be placed in strategic locations for maximum effectiveness.

San Diego Unified is monitoring ventilation effectiveness in our school sites to ensure that the air exchanges are occurring and that the air is healthy for students and staff. This is done by monitoring remote sensors spread across the district. Indoor particulate sensors, which can measure microscopic size particles that could transport COVID-19 virus, are deployed and will be rotated to various rooms to gather information and inform decisions. Also, carbon dioxide (CO2) detectors are in place in various classrooms to test the air. This has a different function than the particulate sensor and will help to determine the amount of fresh air entering the room. Neither monitor detects COVID-19 but does help us to determine if we are providing quality room ventilation. If either sensor records concerning numbers, district staff will determine what measures can be taken to correct the issue.

What is the expectation for sanitation in classrooms?

Cleansing wipes (otherwise known as baby wipes) will be provided to schools to clean desks and chairs. Students may be asked to wipe down chairs and desks after use. Our Back to School Guide provides more information.

What safety protocols will be in place during on-campus meal times?

Schools are planning to serve all meals outdoors, weather and space permitting. Schools may use areas throughout the campus to assist in distancing children while they eat.

Hand sanitizing dispensers will be located in lunch areas. Students will need to either wash their hands with soap and water or use hand sanitizer prior to picking up their food.

What is the district doing to keep students safe while riding a school bus?

Students will be wearing masks, they will be seated strategically, windows will be open and a vent will be used for circulation. Page 16 of our Back to School Guide, has more information on boarding & disembarking, disinfecting & cleaning, and face mask requirements.

Masks

What is the district's policy on the use of masks?

The district follows the guidance of the Centers for Disease Control and the California Department of Public Health. The Back to School Guide, page 14 provides useful information related to use of masks. Please visit the link to the CDC's study of the effectiveness of masks: Scientific Brief: Community Use of Cloth Masks to Control the Spread of SARS-CoV-2 | CDC

Are masks required at all times?

Masks are always required indoors. Masks are now required outdoors at all times while students are on campus, unless they are eating. Currently, large-scale events are not recommended for any school sites due to the increased risk of exposure.

We highly encourage students to take mask breaks outdoors. During these breaks students should maintain 6 feet distance from each other. Wearing masks outdoors lessens the likelihood of student exposure and allows more students to qualify for a modified quarantine.

Masks may be removed outdoors in certain situations and with certain distancing recommendations during physical educator, athletics and performing arts programs.

Will the district provide masks of varying levels of comfort, fit, and filtering ability?

Yes. The district has a variety of masks for student and staff use. The district has a supply of cloth and disposable masks, N95 masks for staff use, masks with clear insert for TK - 2 students, for language development, and a supply of KF94 masks, a mask with higher level filtration, are on their way from one of our suppliers.

Can wearing a mask for long periods of time harm my student?

We consult with district pediatrician, Dr. Howard Taras, who specializes in the fields of School Health, community engagement

and clinical research and is also a professor of pediatrics at UCSD School of Medicine.

Dr. Taras has advised it is a misconception that rebreathing your own exhaled carbon dioxide by continually wearing a mask will cause health problems. Carbon dioxide will not build up behind a regular cloth or surgical mask. Cloth or surgical masks allow gases to pass through easily in both directions trapping particles (droplets) out. Dr. Taras further advised that months of experience with children and adults worldwide wearing masks prove the safety and benefits of wearing a mask.

Testing

***We update our FAQs on a regular basis to stay current with district, local and state guidelines**

Is COVID-19 testing conducted weekly or bi-weekly for the asymptomatic testing program?

Testing is conducted weekly.

Are schools providing rapid antigen or PCR tests?

UC San Diego is contracted to offer PCR tests at most district high schools. In some of our busier high schools, Responsive Lab Partners is also on site administering rapid antigen tests. Elementary and middle schools offer antigen tests for screenings (as well as for students who present at school with symptoms or who are close contacts with a COVID-positive individual). When a rapid antigen test is positive, our lab partners will soon have the capacity to do a confirmatory PCR test before the student leaves campus.

Will on-site tests be available to all students, or just those who enroll in the surveillance program?

San Diego Unified has an "opt-in" form that parents are encouraged to sign. Once they sign the "opt-in" form they then must also consent to testing from our partner laboratory. Only those students who signed consent can get testing at school sites. Parents can opt in or opt out at any time.

Will tests that are administered outside of the school system be accepted for re-entry into the classroom before traditional quarantine is completed, assuming the test results are negative?

Tests done outside of the school testing program are honored as equal to any test that is done at a school setting. These tests can shorten or eliminate an "at-home" quarantine, as long as they are

within the regulations defined by the California Department of Public Health. The County's public health order (and this district) do not have any quarantine or isolation practices that differ from those that the State requires. Please note that home tests are not honored.

The issue of performing an antigen vs PCR test in the weekly asymptomatic testing program at school can impact the value of testing from the individual's standpoint as well as the risk of false positives, forced quarantines, etc.

When an antigen test is negative from an asymptomatic individual, that test is not repeated with a PCR or other test. However, an antigen test that is negative from any symptomatic individual must always be followed by a lab-based PCR test, immediately afterwards, in most cases. This practice and policy has been endorsed and encouraged by the San Diego County Laboratory Testing Task Force as well as by Dr. Carol Glaser at California Department of Public Health.

Where can I find the latest COVID-19 testing data?

COVID-19 test results will be updated as they are received and promptly published to the district website: sandiegounified.org/covidtesting

Is testing available to all students and staff on campus?

Yes. Beginning Aug. 30, the first day of school, all schools and main district administrative offices will have COVID testing capabilities.

Online learners can go to the County website for test availability. San Diego County has convenient testing facilities located near your home or school. For a list of those sites and their hours of operation, see this County map, or call 211 for information.

Why is the district not mandating testing for all students like Los Angeles Unified?

San Diego Unified is making testing universal by visiting every school campus at least once per week to test all unvaccinated staff members. Any student may get tested at that time, and many students will be required to take part in testing in order to participate in after school athletics. Additionally, schools may do follow-up testing of close contacts of anyone who tests positive. This follow-up testing means after close contact with someone at school, who tests positive, students must either quarantine at home or take part in frequent testing at school, subject to the County decision tree.

I heard testing participation was very low last spring. Will it be higher for the fall?

Yes, not only is testing more widely available than it was in the spring, but every student now has a strong incentive to get tested. In the spring, many families chose not to test their students because the rates of infection were declining and a positive test would result in a student being sent home, missing out on the chance for in-person learning. Now, every student has a strong incentive to get tested, because getting tested at school may allow students to stay in school - even if another classmate tests positive for Covid-19. The new modified quarantine option frequently allows students to remain in school, so long as they take part in regular testing. Previously, students were required to quarantine alone at home. In short, students can "test in school to stay in school" this year.

All families will be required to state their testing choice within two weeks of the start of the new school year. Families may either choose to opt into testing, or they may decide not to participate. However, in the event of a close contact or becoming symptomatic, unvaccinated students who are not taking part in testing will be required to quarantine at home and out of the classroom environment due to County guidelines.

If a staff member or student tests COVID-19 positive, what are the protocols?

The District follows the San Diego County Office of Education and San Diego County Public Health's co-developed Decision Tree which is designed to assist school personnel in making decisions on how to handle students or staff members who become ill or present symptoms while at school. Students and staff who test positive or are a close contact of someone who tests positive may be required to stay home for a prescribed period of time as determined by a county public health decision tree. Please contact your site nurse for more specific information. Our Back to School Guide, page 11-12 outlines the notification protocol.

Vaccines

Vaccine Requirement for Students

Who is required to get the COVID-19 vaccine?

The district approved a staggered approach to have all eligible students vaccinated against COVID-19, as a condition of attending in-person learning. The timeline for requiring the required vaccination will be aligned to the full FDA approval. Mandatory testing will be required for all unvaccinated students until full FDA approval of the vaccine for their age group.

All students who are eligible for the COVID-19 vaccine are required to be vaccinated, excluding those with qualified medical exemptions

or conditional admissions. For more information, please see the Board of Education report (Item H.3).

What is the deadline for my student to receive the COVID-19 vaccine?

Vaccine deadlines are staggered beginning with stage 1 for students 16 years and older. Students in stage 1 are required to receive their first vaccine by November 29 and their second dose by December 20. Stage 2 and 3 applies to students ages 15 and younger who will be required to receive the vaccine, pending FDA approval for their age group.

What happens if my student does not get the COVID-19 vaccine?

Eligible students who do not have proof of vaccination against COVID-19 will be excluded from in-person instruction without a qualified exemption or conditional admission. Those students who are not eligible for in-person instruction would be offered an alternative education program.

Why is San Diego Unified requiring student vaccinations?

San Diego Unified is working to ensure the highest-quality instruction in the safest environment possible for all students. Scientific evidence shows that vaccinations are an essential part of protecting our communities. Vaccines are the most preventive of all strategies. Unlike masking, ventilation, and testing, vaccination protects students before the virus is introduced into the setting, reducing disease and new mutations. Vaccines protect unvaccinated family members and other adults who have and haven't been vaccinated. School-age children get sick and contribute to new infections. They are the greatest proportion of unvaccinated in the U.S. More children have been hospitalized recently than any previous time during the epidemic. For more information, please see the Board of Education report (Item H.3).

How much will the COVID-19 vaccine cost?

The COVID-19 vaccine is available to all students at no cost, regardless of insurance or immigration status.

Where can I take my student to get a COVID-19 vaccine?

For a list of vaccine centers near you, please go to http://myturn.ca.gov/. If you cannot find a vaccine center near you, please contact your primary care provider or health office. Information from the County of San Diego can be found here. The district will be hosting vaccine clinics at school sites. Information will be posted on the district COVID-19 vaccine website.

Can my student participate in in-person extracurricular activities (sports, after school programs, district sponsored events) if they are not fully vaccinated?

Your child will not be permitted to participate in in-person extracurricular activities without proof of vaccination if they qualify to receive the COVID-19 vaccine. Extracurricular activity takes place outside of the instructional day that is supervised or financed by the district where students represent the school/district.

What do I do if I have lost my vaccination card?

If a student has lost their vaccine record, they can get a digital record at https://myvaccinerecord.cdph.ca.gov.

Are there religious exemptions for students?

As with other immunizations for students, state law does not recognize religious or personal belief exemptions.

When vaccines are offered at school sites, do parents or guardians need to accompany students to be vaccinated?

Parents and guardians do not need to accompany students to be vaccinated so long as the student is enrolled at the school offering vaccines. Parents and guardians are welcome to accompany students or to designate a responsible adult to accompany their child. Eligible students will be vaccinated if they present a vaccination consent form signed by a parent or guardian. See the district's Nursing & Wellness website for more details for vaccine availability.

Do students need parental consent to be vaccinated?

Yes. With limited exceptions for emancipated minors and others legally permitted to self-consent, students age 12-17 will not be vaccinated without written consent from a parent or legal guardian. See the district's Nursing & Wellness website for more details for vaccine availability.

My child is already vaccinated. Do I need to do anything?

Not yet. You may have to submit a copy of your immunization record for our files but that is to be determined.

My child will be vaccinated soon. How do I submit proof and keep them enrolled in class?

The district is working on a system that will allow parents/guardians to upload their student(s) vaccine card. The district will notify families once this system is ready.

My child is not yet 16 but will turn 16 this year. How long after their birthday do I have to submit proof of vaccination?

If your student turns 16 by November 1, 2021, or sooner, you will be required to have proof of the COVID-19 vaccination to attend in-person learning. This requirement may change once the State of California COVID-19 vaccine requirements are implemented.

Where do I submit a medical exemption request or letter from my child's qualified medical professional?

You can submit your request to your site nurse or at immunizations@sandi.net. Medical exemption requests must be from a California licensed doctor of medicine, doctor of osteopathic medicine, nurse practitioner or a physician assistant and include a medical rationale and a release of information to allow school health staff to communicate with the medical professional.

What will happen when San Diego Unified athletic teams play against schools with no vaccine mandate?

San Diego Unified students will be allowed to play teams with unvaccinated players. Because our students are vaccinated, if there was a case of COVID-19 during play, our vaccinated students do not have to quarantine and would be able to continue their season without delay.

Students on campus

What will instruction look like for the new year?

Students on campus will take part in in-person instruction, maintain connection with teachers and peers, access to supports and enrichment opportunities and incorporate technology in new ways.

How will attendance be taken?

Student attendance will be taken daily in PowerSchool. Visit our Back to School Guide, page 24 for more information related to attendance taking procedures.

My student is in quarantine. Will they be marked absent during quarantine?

Page 24 of the District's Back to School Guide, page 24 for more information related to attendance.

Will my student have access to on-campus meals?

Yes. All meals are available at no charge for all students, regardless of family income. School sites will provide contact-free meal service to protect students and employees. Students participating in on-site learning will receive a nutritious lunch daily. School sites will offer

take-home meal bags with breakfast for the next day, evening and weekend meals to all students as they depart for the day. For more information, please take a look at our Back to School Guide, page 17.

Some middle and high schools may offer breakfast on-campus during their nutrition break passing period. Students participating in Primetime and 21st Century after school programs will be offered their evening meals on-campus during those programs.

Is there a certain protocol for students using the restroom?

Page 14 of the Back to School Guide includes useful information related to physical distancing.

What is the protocol for PE classes? Will students have access to locker rooms?

Physical distancing is no longer required during PE. Should a student contract COVID-19, the school site will follow the school/district policy. If parents have a concern with their student participating in PE due to COVID-19, they should speak with their school site to request a modified program.

Students will have access to locker rooms. As a reminder, students and staff must wear masks indoors. Due to possible changes to COVID-19 protocols and guidelines, please confirm this information with your school site.

What is the district doing to keep students safe while riding a school bus?

Students will be wearing masks, they will be seated strategically, windows will be open and a vent will be used for circulation. Page 16 of our Back to School Guide, has more information on boarding & disembarking, disinfecting & cleaning, and face mask requirements.

Coming onto campus

Are families able to come on campus?

To comply with the health and safety guidelines, only “essential” visitors or volunteers will be on campus. Please contact your school site to learn who qualifies as an essential visitor/volunteer. All visitors and volunteers must comply with the district’s school health and safety guidelines.

Can parents volunteer during the first week of school?

Yes - with approval by their school administration. All volunteers must adhere to our health and safety guidelines as well as the

California Department of Public Health guidance for K12 schools.

Online Option

Is there still time to enroll for school, including online school?

Yes. See Enrollment Options.

How do I enroll for the online school?

We understand that not everyone will be ready or comfortable with returning to in-person learning. With that in mind, all San Diego Unified K-12 students have the option to enroll in the new online Virtual Academy for the 2021-22 school year.

Students who still wish to enroll in the Virtual Academy should complete this interest form at https://tinyurl.com/yebjh4hg or simply email virtualacademy@sandi.net with your child's name, grade level for 2021-22, student ID number, and current school of attendance.

Students and families will be sent classroom information prior to the first day of school.

If I enroll for the online school, will I lose my place at my current school of attendance?

No.

What will online learning look like?

Students enrolled in the Virtual Academy will participate in both "live" & asynchronous instruction. Students will have cameras on during "live" whole group and small group. Be ready to learn with materials. Have a dedicated space at-home for learning. Instruction for elementary students includes 1/3 "live" whole group instruction, 1/3 "live" small group instruction, and 1/3 independent practice.

Instruction for secondary students will include three classes per quarter: 1/3 "live" whole group instruction,1/3 additional whole group or small group instruction, 1/3 office hours & independent practice and additional 90 minutes asynchronous learning. Our Back to School Guide, page 19-26 has more information related to instruction.

What will students be expected to do?

Virtual learners will have 360 instructional minutes, not inclusive of snack or lunch breaks; Online academic instruction, social-emotional learning, and opportunities for onsite learning, extracurriculars, and special in-person events.

How will attendance be taken?

Student attendance will be taken daily in PowerSchool. Visit our Back to School Guide, page 24 for more information related to attendance taking procedures.

My student is in quarantine. Will they be marked absent during quarantine?

Page 24 of the District's Back to School Guide, page 24 for more information related to attendance.

Will school sites offer Grab & Go Meals?

Yes. The district will distribute curbside Grab n' Go meals at designated school locations. Grab & Go Meals include breakfast, lunch, evening and weekend meals to all students participating in Virtual Academy. Grab & Go Meal sites will follow health and safety protocols, including hand hygiene, physical distancing, wearing face coverings and gloves.

Social and emotional well-being

Will the district support students' physical, social and emotional well-being?

Yes. The district continues to support students' social, emotional and physical well-being during these unprecedented times. Students are provided with a positive school environment, wellness lessons included in everyday instruction, connecting families with needed social services, and referral and intervention services. Page 22 of our Back to School Guide, has more information.

Is my school counselor available to offer support?

Yes, school counselors will be offering direct student and family services. Counselors will be checking in with students and providing support to students in their academic progress and social-emotional health. Students and families may be offered individual, group interventions or a combination of both.

I need help (mental health)

Mental health and wellness is critical for parents and students during this challenging time. The district has created a web site with available resources. There's also a self-care tool for youth Gritx.org and a mindfulness platform specifically designed for mental health, Inner Explorer, that includes short, 5-10 minute activities for our students and families. Below are additional resources available to our students and families.

Mental Health Resource Center

Our Mental Health Resource Center offers a variety of mental health services to our students, including services for students with IEPs.

Please see services provided to students here.

School Link Mental Health

Teen Recovery Centers

Other additional resources:

The California Department of Education - Student and Family Mental Health Resources
Child Abuse Hotline 1-858-560-2191
National Domestic Violence Hotline 1-800-799-7233
Mental Health and Substance Use Services 1-888-724-7240
National Suicide Prevention Lifeline 1-800-273-8255
We can all help prevent suicide. The Lifeline provides 24/7, free and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals.

How else can we stay healthy?

Stay active! Our physical education teachers have set up a site for continued learning. The district athletics department has also shared information.

Making sure all students feel welcome

What is the district doing to build anti-racist and restorative school communities?

The Board of Education recently approved the revision of our suspension/expulsion procedures as well as the implementation of our Restorative Discipline Policy.

How do the actions taken by the Board of Education help eliminate inequities?

The revision of our suspension/expulsion procedures and our Restorative Discipline Policy will eliminate the barriers that prevent our students of color from receiving equitable access, experiences, and outcomes.

What other actions have the district implemented to eliminate inequities?

The district formed the Transforming School Police Working Group to improve student experiences with school police and eliminate the barriers that prevent students of color from receiving equitable access, experiences, and outcomes.

What was the outcome of the Transforming School Police Working Group?

The Board of Trustees approved the working group's recommendations to help guide the district's path forward as it works to transform the way we provide support to students through school police. Among the recommendations:

- Assess the impact of school police interactions with youth and community
- Train School Police on how to engage with youth and community members
- Train our site leaders around school police involvement
- Shift to a cluster-wide school police support model to ensuring school police resources are strategically deployed
- Change School Police uniforms to allow for more approachability while still maintaining identification that preserves the safety of the officer and those they serve

Student success

How will students be tested and assessed?

The District is committed to providing students with meaningful assessments and feedback. Educators will engage students in fair, valid and reliable formative and summative assessments to inform instruction and to provide regular and timely feedback. Page 23 of our Back to School Guide has more detailed information related to assessments.

Will we still have state testing?

Yes. The California Department of Education has released the testing calendar for the 2021-22 school year.

Can you explain how the standards-based grading policy works?

Our standards remain rigorous, relevant, and aligned to state standards. Providing opportunities for revision and reassessment will allow students to relearn content or material that they may not have fully understood the first time it was taught. Students will be able to learn from their mistakes and demonstrate mastery of knowledge at more than just one point in time. Our Back to School Guide, page 23 has more detailed information related to standard-based grading.

When will the revised grading policy be fully implemented for grades 6-12?

Staff have begun implementation of the policy and will continue to collaborate and align grading practices to the revised policy. New academic definitions, citizenship marks, and grading comments will be available for use within PowerSchool for the 2021-22 school year.

Why is the district making this shift?

Our focus as a district continues to be on educating the whole child and providing quality, standards-based instruction for each child in every neighborhood. At the elementary level, educators have been using standards-based grading and reporting practices for nearly a decade. The shift in our grading policy is to provide clarity and transparency in communicating progress toward mastery of standards for our entire San Diego Unified community, TK-12. By removing non-academic factors from the academic grade and ensuring students have multiple means and opportunities to demonstrate mastery, our academic grades will more accurately reflect student knowledge and skill.

What are the "nonacademic factors" that will move to the citizenship grade?

Nonacademic factors include general behavior, punctuality, effort, and work habits. Students are still expected to turn assignments in on time and behave appropriately, however these factors will now directly affect the citizenship grade rather than the academic grade. Educators will still have due dates for assignments and will establish a timeframe for when late work will be accepted.

Will ALL assignments be revised or reassessed?

Educators will provide "opportunities" for revision and reassessment. Educators will determine the type and frequency of revisions and reassessments based on their content area. Due dates for class assignments, late submissions, revisions and reassessments will also be established in order to give educators enough time to enter scores into the final grade. Over the next few weeks, educators, grade-level teams, departments and school sites will determine which assignments can be revised or reassessed and will communicate directly with families the type, frequency, and timeframe.

Digital access

Will students be required to transport their devices each day?

Yes, students should be expected to transport their devices each day from home to school and back unless directed otherwise by their school and/or teacher. For more information, please view our Back to School Guide, page 28 and 29.

What if I don't have a computer?

We will continue to provide personal laptops to families that need them. Your school of enrollment will be able to distribute devices and will provide instructions so you may plan for a pick-up.

What do I have to bring to get a computer?

Your school of enrollment will provide you with this information. For more information, please view our Back to School Guide, page 28 and 29.

What if I am having issues with the computer I was given or need tech support?

The Family Technology Support Line is available to assist families. Please call (619) 732-1400 from 8:00 am to 5:00 pm.

What if I don't have access to the internet?

Families that need help with connectivity, call (619) 260-2460.

Will my student be safe online with a district-issued computer?

San Diego Unified has implemented a new cloud based-web filtering software for students called iboss. It allows the district to comply with the Children's Internet Protection Act (CIPA) and extends web filtering for student devices regardless of the location they are learning in. With the iboss cloud, security follows the student, and ensures that the same level of protection and compliance is applied to a student regardless of whether they are on campus or at home. All district distributed Chromebooks will have the web filtering extension installed on it, no action will be required from the students or school staff.

Special Education

How is the district supporting students with IEPs?

The Special Education department is committed to supporting students and families in an integrated way by providing increased Related Service providers (Speech and Language Pathologists and School Psychologists) assigned to school sites. Visit our Back to School Guide, page 21 for more information related to Special Education.

English Learners

How is the district supporting English Learners?

The Office of Language Acquisition (OLA) continues to support our multilingual learners with instructional supports to accelerate their language growth and development. The District's Back to School Guide, page 21 has more information related to multilingual learners. If you have additional questions, please email ola@sandi.net

Specific Subjects

What do you have for the Arts?

The health and safety of all students is the highest priority of the Visual and Performing Arts (VAPA) Department. As such, the VAPA staff continues to inform and support teachers and schools to follow all health and safety guidance. Our Back to School Guide, page 27 has more information related to VAPA.

Will students be taught sex education and health education this year, whether online or in-person?

Students currently in grade 6, grade 8, in high school biology, or in a 10th grade class will receive sex education, whether offered in-person or online. If offered online, the curriculum has been adapted to an online learning environment.

Are my college courses still available online?

Most community college courses will remain online for Fall 2021. Students need to access the SDCCD Canvas Login Page and will need to use their 10-digit College Student Identification (CSID) number, and password, to access their coursework.

Athletics

Which sports are now taking place in San Diego Unified?

Traditional seasons for all student athletes (fall, winter, spring) are back for 2021-22. For more information, please view our Back to School Guide, page 30.

Due to possible changes to COVID-19 protocols and guidelines, please confirm all sports-related information with your school site.

Do students playing sports have to be tested?

Weekly testing will continue to be required for students who are not vaccinated for all sports. Contact your school site for more information regarding testing.

Now that all sports are open, can I watch my student play and practice?

Health and Safety Protocols have been established for all athletic events. Please check with your school site for indoor and outdoor spectator policies and viewing options.

Are parents allowed to watch their student athletes participate in indoor CIF sporting events?

Please check with your school site for indoor and outdoor spectator policies and viewing options. Parents can stay up-to-date by visiting

the CIF San Diego Section Updated Information and Calendars: www.cifsds.org/.

Other

How about my pets?

The San Diego Humane Society is supporting families and their pets who need extra help during the COVID-19 pandemic. For more information, please visit the Human Society website at https://www.sdhumane.org/programs/support-services/pantry-service.html

EXHIBIT 6

California Becomes First State in Nation to Announce COVID-19 Vaccine Requirements for Schools

Published: Oct 01, 2021

After implementing first-in-the-nation school masking and staff vaccination measures, California becomes the first state to announce plans to require student vaccinations – adding the COVID-19 vaccine to list of vaccinations required for school, such as the vaccines for measles, mumps, and rubella

Students will be required to be vaccinated for in person learning starting the term following FDA full approval of the vaccine for their grade span (7-12 and K-6).

SAN FRANCISCO – At a school in San Francisco, Governor Newsom announced plans to add the COVID-19 vaccine to the list of vaccinations required to attend school in-person when the vaccine receives full approval from the Food and Drug Administration (FDA) for middle and high school grades, making California the first state in the nation to announce such a measure. Following the other first-in-the-nation school masking and staff vaccination measures, Governor Newsom announced the COVID-19 vaccine will be required for in-person school attendance—just like vaccines for measles, mumps, rubella and more.

"The state already requires that students are vaccinated against viruses that cause measles, mumps, and rubella – there's no reason why we wouldn't do the same for COVID-19. Today's measure, just like our first-in-the-nation school masking and staff vaccination requirements, is about protecting our children and school staff, and keeping them in the classroom," said Governor Newsom. "Vaccines work. It's why California leads the country in preventing school closures and has the lowest case rates. We encourage other states to follow our lead to keep our kids safe and prevent the spread of COVID-19."

Thanks to the state's bold public health measures, California continues to maintain the lowest case rate in the entire country and is one of only two states to have advanced out of the CDC's 'high' COVID transmission category. More information about the announcement can be found here.

The vast majority of school districts have reported that over 95% of students have returned to in-person instruction this school year, as can be seen on the state's Student Supports & In-Person Dashboard. Thanks to unprecedented resources and public health measures (measures shown to be highly effective), California is leading national trends in preventing school closures and keeping kids in classrooms, accounting for only 14 out of over 2,000 school closures nationwide, or roughly 0.7% – despite the fact that California educates an estimated 12% of the nation's public school students. If California's rates had aligned with national trends, the state would have seen upwards of 240 school closures.

In order to further protect students and staff and continue supporting a safe return to in-person instruction for all students, the Governor directed the California Department of Public Health (CDPH) to follow the procedures established by the Legislature to add the COVID-19 vaccine to other vaccinations required for in-person school attendance—such as measles, mumps, and rubella—pursuant to the Health and Safety Code. COVID-19 vaccine requirements will be phased-in by grade span, which will also promote smoother implementation.

Upon full FDA approval of age groups within a grade span, CDPH will consider the recommendations of the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services, the American Academy of Pediatrics, and the American Academy of Family Physicians prior to implementing a requirement. Following existing statute, full approval of ages 12+ corresponds to grades 7-12, and full approval of ages 5-11 corresponds to grades K-6. Students who are under the age of full approval, but within the grade span, will be required to be vaccinated once they reach the age of full approval (with a reasonable period of time to receive both doses), consistent with existing procedures for other vaccines. The requirement will take effect at the start of the term following full approval of that grade span, to be defined as January 1st or July 1st, whichever comes first. Based on current information, the requirement is expected to apply to grades 7-12 starting on July 1, 2022. However, local health jurisdictions and local education agencies are encouraged to implement requirements ahead of a statewide requirement based on their local circumstances.

Governor Newsom's historic $123.9 billion Pre-K and K-12 education package is providing an unprecedented level of school and student funding to transform the state's public schools into gateways of equity and opportunity, supporting the potential of every California student by: achieving universal transitional kindergarten for four-year-olds by 2025, expanding afterschool and summer programs, providing universal free school nutrition, increasing the number of well-prepared staff per pupil, creating full-service community schools to support the mental and social-emotional well-being of students, and more.

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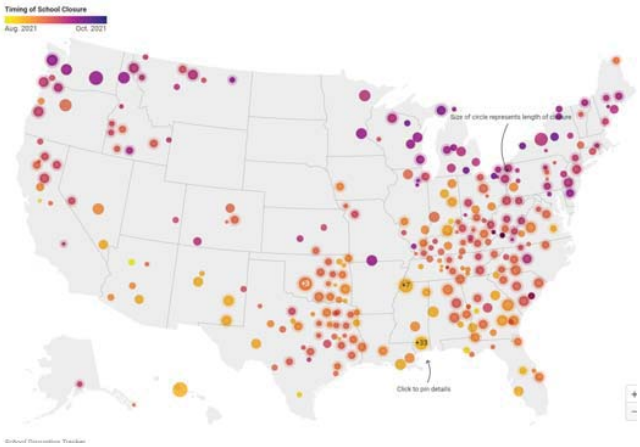
EXHIBIT 7

California Becomes First State in Nation to Announce COVID-19 Vaccine Will Be Added to List of Required School Vaccinations

Students will be required to be vaccinated for in person learning starting the term following FDA full approval of the vaccine for their grade span (7-12 and k-6).

Background

- California continues to lead the nation with the lowest COVID case rate, the lowest death rate, and the most vaccinations administered. The latest CDC data indicate that youth in California are being hospitalized at **less than one-fourth** the rate of states like Florida and **less than one-half** the rate of the nation as a whole.[1]
- This fall, millions of California students returned to their K-12 school classrooms. Thanks to California's nation-leading measures aimed at keeping campuses safe and open, including universal masking, our state has not faced the same number of outbreaks seen in other parts of the country.
- California's schools have been open for nearly a month longer than most other states, but have experienced school closures at a far lower rate. California educates approximately **12%** of students in the nation, but California schools account for approximately **0.5%** of school closures. And those closures have been localized to regions with lower vaccination rates.[2]



[1] https://covid.cdc.gov/covid-data-tracker/#new-hospital-admissions (as of 9/28/2021)
[2] https://cai.burbio.com/school-opening-tracker/ (as of 10/1/2021)

- Educators, public health experts and parents know there is no substitute for in-person instruction, but we also can't pretend the threat of COVID-19 and its variants are completely behind us.
- Schools are stepping up to keep students safe, and to meet their mental health, social-emotional, and academic needs like never before. The vast majority of schools report that **95-100%** of students have opted to return in-person; over **95%** of schools have expanded mental health services; nearly **83%** have expanded academic supports like high-dose tutoring; and over **74%** have expanded after-school programs.[3]
- We continue to urge everyone who is eligible to get vaccinated against COVID-19. Vaccines continue to be the best tool to end this pandemic once and for all. These vaccines are safe and effective, and the data has unequivocally shown that they prevent severe illness and death as a result of COVID-19 – nearly all of those who are ending up in ICU beds and dying are unvaccinated.

School Vaccine Requirement

- California is taking bold steps to minimize the transmission of COVID-19.
- Governor Gavin Newsom is directing the California Department of Public Health to add the COVID-19 vaccine to other vaccinations required for in-person school attendance—such as measles, mumps, and rubella—pursuant to the Health and Safety Code sections 120325 - 120380.
- This will be accomplished by regulations promulgated pursuant to section 120335(b)(11), which authorizes vaccine requirements for "any other disease deemed appropriate" by CDPH. This is also consistent with the overall intent of the law to achieve "eventual achievement of total immunization" against dangerous childhood diseases. (HSC section 120325(a)).
- COVID-19 vaccine requirements will apply to all "pupil[s] of any private or public elementary or secondary school[s]." (HSC section 120335(b)).
- COVID-19 vaccine requirements will be phased-in by grade span, grades K-6 and 7-12 This will also promote smoother implementation.
- This mandate will be a condition of in-person attendance. (HSC section 120335(f)). A student who is not vaccinated may remain enrolled in independent study, but may not attend in-person instruction.
- Requirements established by regulation, not legislation, must be subject to exemptions "for both medical reasons and personal beliefs." (HSC section 120338).

[3] https://experience.arcgis.com/experience/bf1878e63e294ff1b5c5d490085077ef (see also https://schools.covid19.ca.gov/)

- The Governor has also directed that adults be held to at least the same standards as students for the COVID-19 vaccine. While currently, California requires all K-12 staff to verify their vaccination status or be tested weekly, all staff will be required to be vaccinated no later than when the requirement takes effect for students.[4]
- The current verify-or-test requirement for staff will be converted to a vaccine mandate no later than when the first phase of the student requirement becomes effective.
- Five districts nationwide -- all in California -- have moved forward with a student mandate (in the following order): Culver City Unified; LA Unified; Oakland Unified; Piedmont Unified; and San Diego Unified. Local public health and school officials are encouraged to move forward with their own vaccine requirements.
- While individual counties and schools may accelerate vaccine requirements, the state requirement will create a statewide standard to ensure all staff and students will be vaccinated.

Timing

- Students will be required to be vaccinated for in person learning starting the term following FDA full approval of the vaccine for their grade span (7-12 and k-6).
- Upon full approval by the Food and Drug Administration (FDA) of a vaccine for age groups within a grade span, CDPH will consider relevant recommendations from the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services, the American Academy of Pediatrics, and the American Academy of Family Physicians prior to implementing a requirement, as required by the Health and Safety Code section 120335(b)(11).
- CDPH will then initiate the rulemaking process, which includes public comment. Regulations promulgated pursuant to that process will also address many of the details of the requirement, including the scope of exemptions, *etc.*
- The regulations will take effect at the start of the following term, meaning either January 1st or July 1st, whichever comes first. (Education Code 37200). This will also give both parents and schools sufficient time to prepare and implement.
- Based on current projections for full approval for ages 12+, we anticipate the requirement would apply to grades 7-12 starting on July 1, 2022.
- Students who are under the age of full approval, but within the grade span, will be required to be vaccinated once they reach the age of full approval (with a reasonable period of time to receive both doses), consistent with existing procedures for other vaccines.

[4] https://www.gov.ca.gov/2021/08/11/california-implements-first-in-the-nation-measure-to-encourage-teachers-and-school-staff-to-get-vaccinated/