COVID-19 PROPOSAL

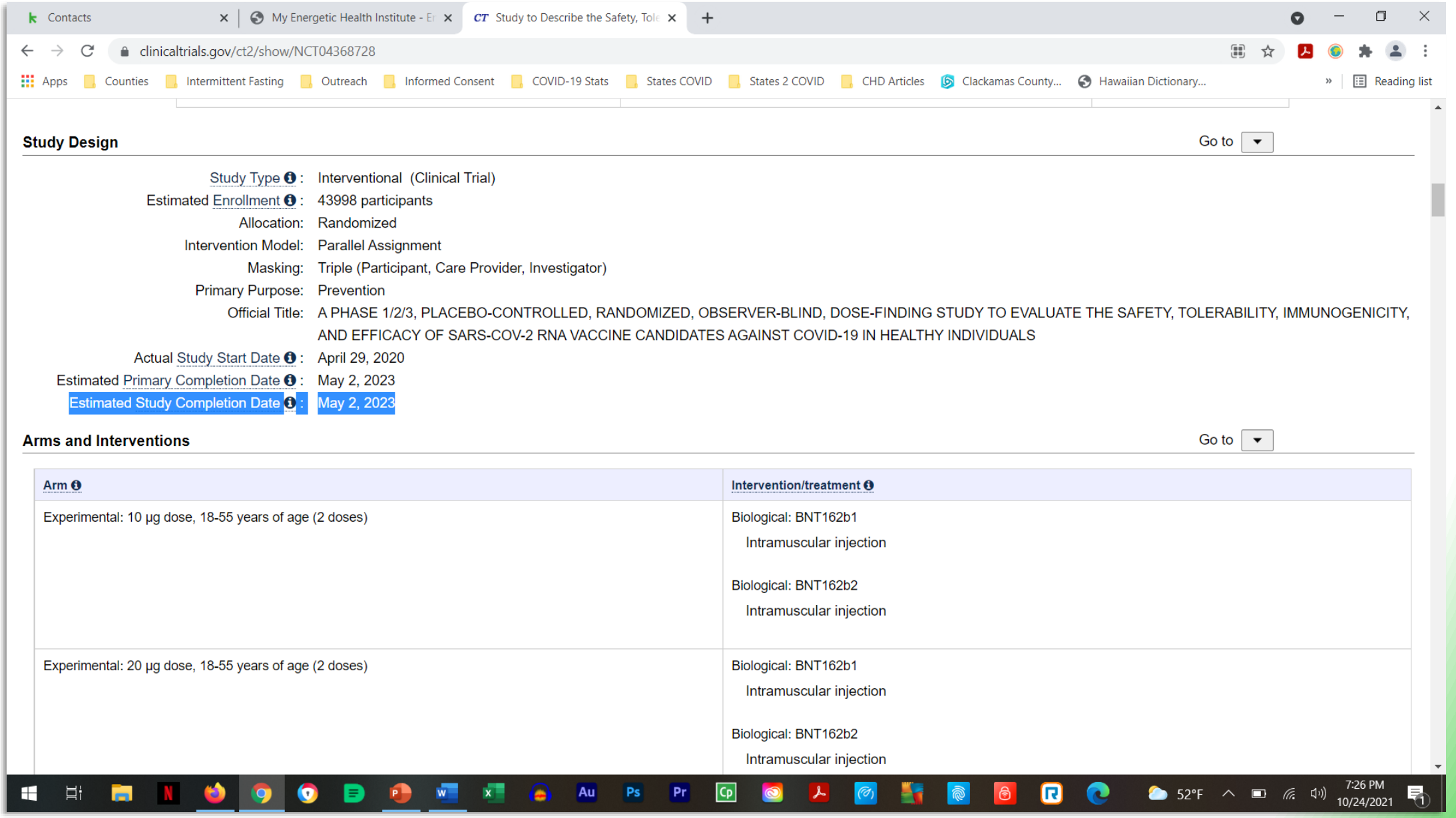
NUTRITIONAL RECOMMENDATIONS FOR IMMUNOLOGICAL PREVENTION DEVELOPED FROM EVIDENCE-BASED CLINICAL STUDIES

Presentation Disclaimer

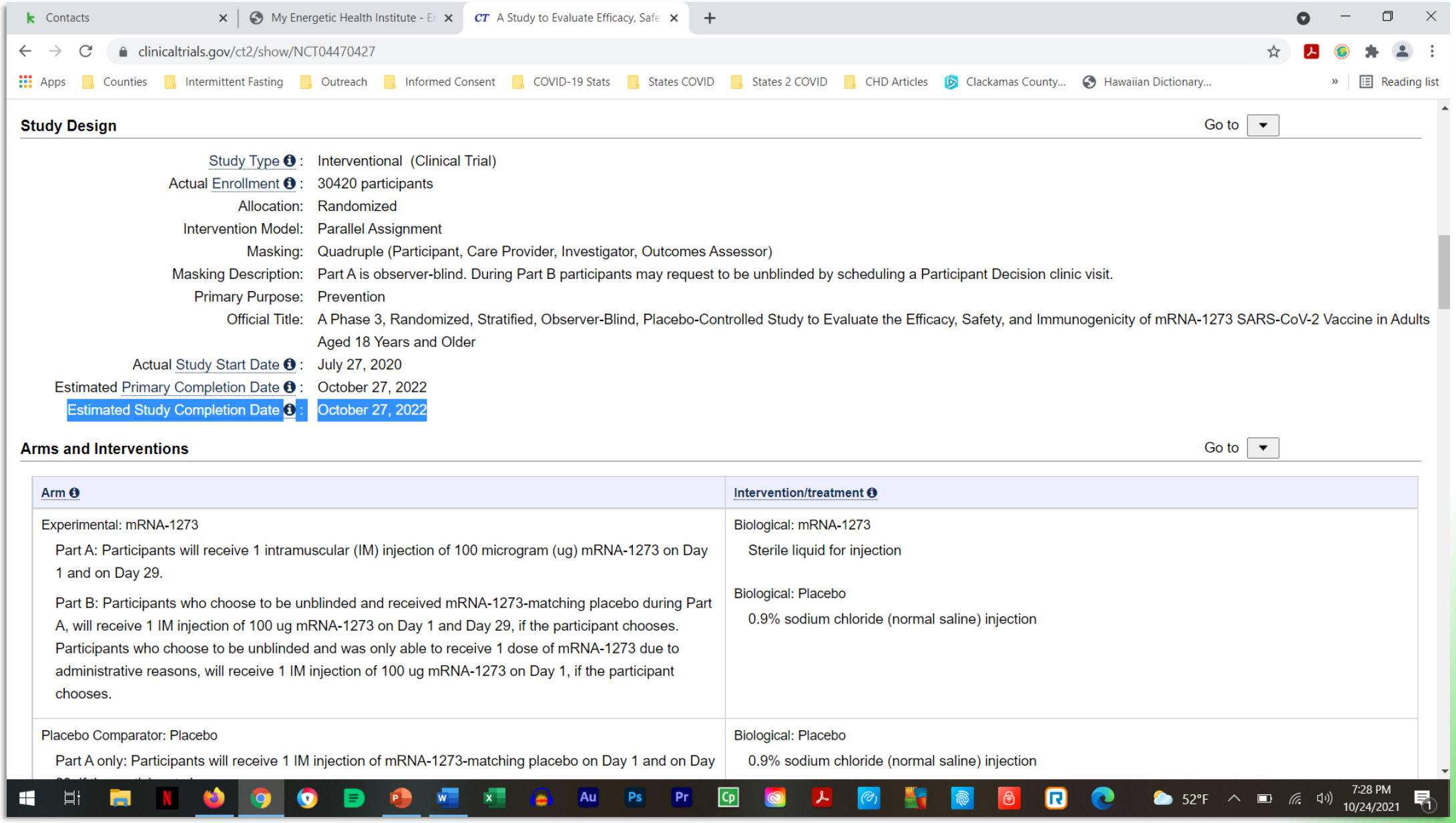
- The Information Presented In This Presentation Is A Matter Of Public Record Presented During Invited Expert Forums & Public Workshops.
- The Information Presented Is An Effort To Collaborate With Public Health Officials At City, County, State & Federal Levels To Issue Evidence-Based Nutritional Guidance For The Safe Reopening Of Schools, Small Businesses & Places Of Worship.
- The Information Presented Is For Educational Purposes Only And Should Be Discussed With A Licensed Primary Care Doctor With An Educational Background In Clinical Nutrition & Biochemistry Before Implementing.
- The Information Presented Is Not Intended To Conflict With Guidance Provided By The US FDA, CDC or State Health Departments.
- The Information Presented Is Intended To Create Collaboration & Discussion That Can Help Develop Additional Options To Protect Americans.

ARE THE INOCULATIONS EXPERIMENTAL?

PFIZER/BIONTECH – MAY 2, 2023



MODERNA/NIAID – OCT 27, 2022



Study Design

Go to

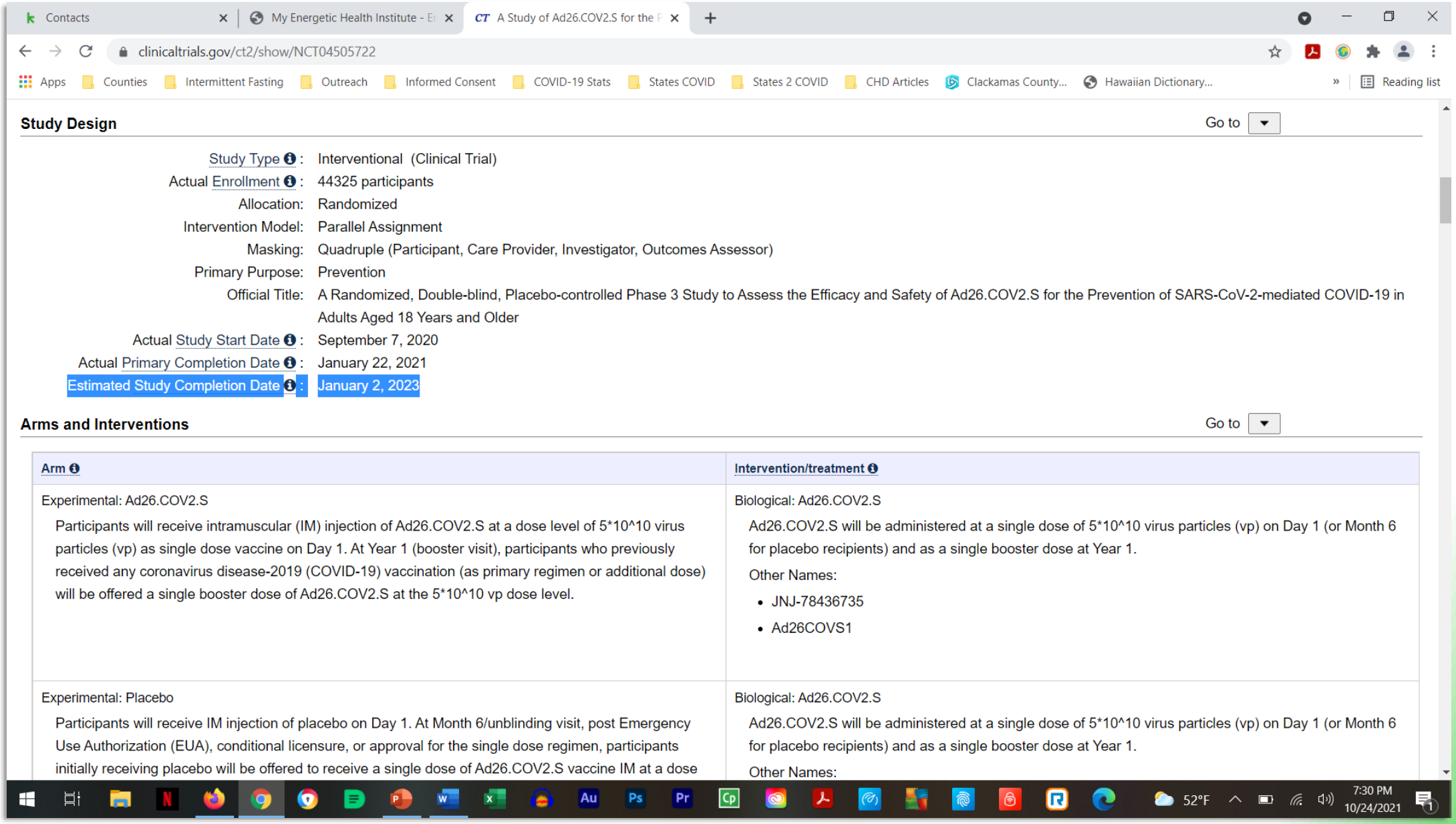
Study Type :	Interventional (Clinical Trial)
Actual Enrollment :	30420 participants
Allocation:	Randomized
Intervention Model:	Parallel Assignment
Masking:	Quadruple (Participant, Care Provider, Investigator, Outcomes Assessor)
Masking Description:	Part A is observer-blind. During Part B participants may request to be unblinded by scheduling a Participant Decision clinic visit.
Primary Purpose:	Prevention
Official Title:	A Phase 3, Randomized, Stratified, Observer-Blind, Placebo-Controlled Study to Evaluate the Efficacy, Safety, and Immunogenicity of mRNA-1273 SARS-CoV-2 Vaccine in Adults Aged 18 Years and Older
Actual Study Start Date :	July 27, 2020
Estimated Primary Completion Date :	October 27, 2022
Estimated Study Completion Date :	October 27, 2022

Arms and Interventions

Go to

Arm	Intervention/treatment
Experimental: mRNA-1273 Part A: Participants will receive 1 intramuscular (IM) injection of 100 microgram (ug) mRNA-1273 on Day 1 and on Day 29. Part B: Participants who choose to be unblinded and received mRNA-1273-matching placebo during Part A, will receive 1 IM injection of 100 ug mRNA-1273 on Day 1 and Day 29, if the participant chooses. Participants who choose to be unblinded and was only able to receive 1 dose of mRNA-1273 due to administrative reasons, will receive 1 IM injection of 100 ug mRNA-1273 on Day 1, if the participant chooses.	Biological: mRNA-1273 Sterile liquid for injection Biological: Placebo 0.9% sodium chloride (normal saline) injection
Placebo Comparator: Placebo Part A only: Participants will receive 1 IM injection of mRNA-1273-matching placebo on Day 1 and on Day	Biological: Placebo 0.9% sodium chloride (normal saline) injection

J&J – JAN 2, 2023


Contacts
My Energetic Health Institute - E
A Study of Ad26.COV2.S for the P
clinicaltrials.gov/ct2/show/NCT04505722
Apps
Counties
Intermittent Fasting
Outreach
Informed Consent
COVID-19 Stats
States COVID
States 2 COVID
CHD Articles
Clackamas County...
Hawaiian Dictionary...
Reading list
Study Design
Go to
Study Type : Interventional (Clinical Trial)
Actual Enrollment : 44325 participants
Allocation: Randomized
Intervention Model: Parallel Assignment
Masking: Quadruple (Participant, Care Provider, Investigator, Outcomes Assessor)
Primary Purpose: Prevention
Official Title: A Randomized, Double-blind, Placebo-controlled Phase 3 Study to Assess the Efficacy and Safety of Ad26.COV2.S for the Prevention of SARS-CoV-2-mediated COVID-19 in Adults Aged 18 Years and Older
Actual Study Start Date : September 7, 2020
Actual Primary Completion Date : January 22, 2021
Estimated Study Completion Date : January 2, 2023
Arms and Interventions
Go to
Arm
Intervention/treatment
Experimental: Ad26.COV2.S
Participants will receive intramuscular (IM) injection of Ad26.COV2.S at a dose level of 5*10^10 virus particles (vp) as single dose vaccine on Day 1. At Year 1 (booster visit), participants who previously received any coronavirus disease-2019 (COVID-19) vaccination (as primary regimen or additional dose) will be offered a single booster dose of Ad26.COV2.S at the 5*10^10 vp dose level.
Biological: Ad26.COV2.S
Ad26.COV2.S will be administered at a single dose of 5*10^10 virus particles (vp) on Day 1 (or Month 6 for placebo recipients) and as a single booster dose at Year 1.
Other Names:
JNJ-78436735
Ad26COVS1
Experimental: Placebo
Participants will receive IM injection of placebo on Day 1. At Month 6/unblinding visit, post Emergency Use Authorization (EUA), conditional licensure, or approval for the single dose regimen, participants initially receiving placebo will be offered to receive a single dose of Ad26.COV2.S vaccine IM at a dose
Biological: Ad26.COV2.S
Ad26.COV2.S will be administered at a single dose of 5*10^10 virus particles (vp) on Day 1 (or Month 6 for placebo recipients) and as a single booster dose at Year 1.
Other Names:
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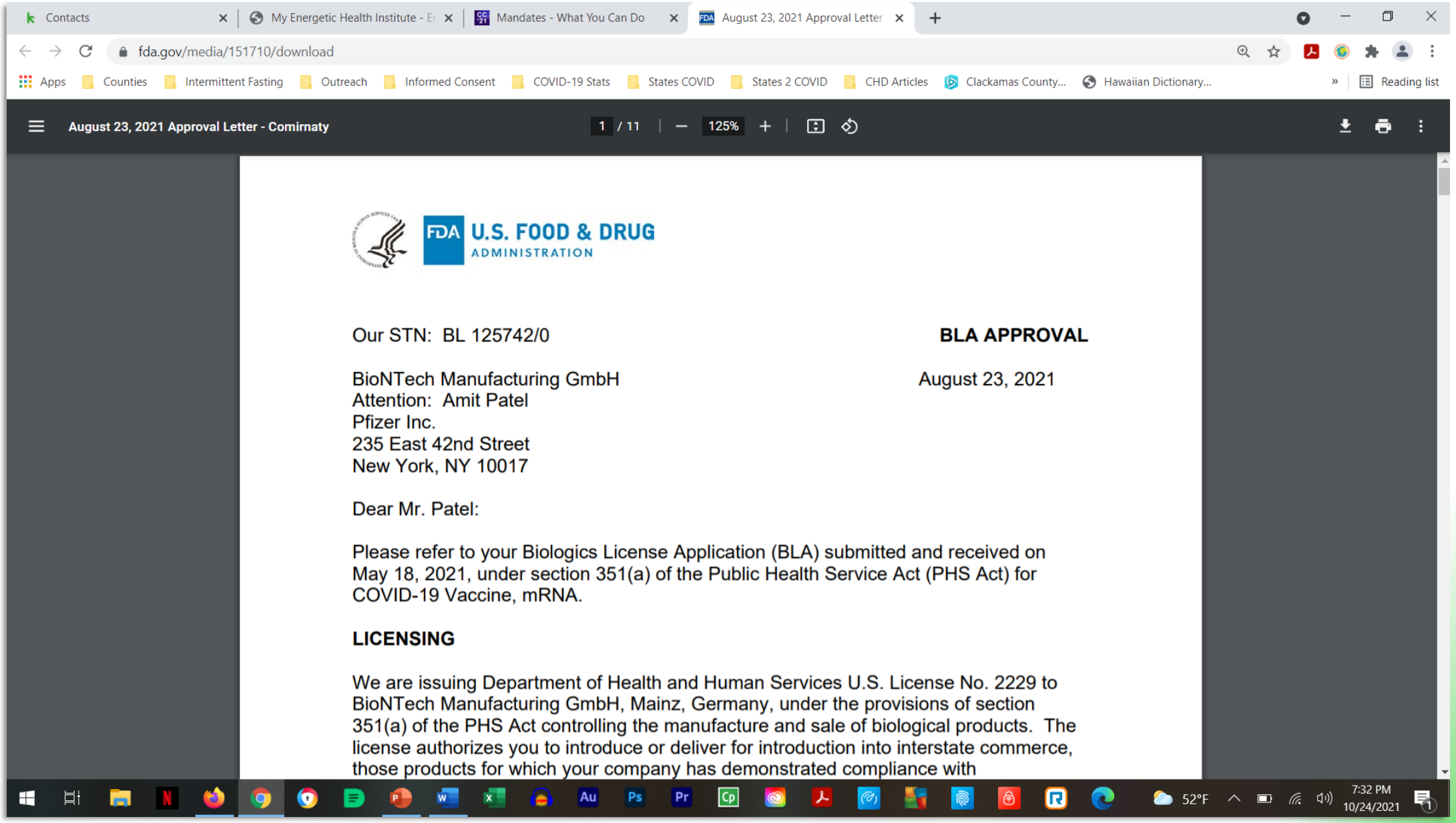
10/24/2021

IS COMIRNATY FULLY APPROVED BY THE FDA?

APPROVED CONDITIONALLY…BUT



Contacts | My Energetic Health Institute - E | Mandates - What You Can Do | August 23, 2021 Approval Letter

fda.gov/media/151710/download

Apps | Counties | Intermittent Fasting | Outreach | Informed Consent | COVID-19 Stats | States COVID | States 2 COVID | CHD Articles | Clackamas County... | Hawaiian Dictionary... | Reading list

August 23, 2021 Approval Letter - Comirnaty 1 / 11 125%

FDA U.S. FOOD & DRUG ADMINISTRATION

Our STN: BL 125742/0

BLA APPROVAL

August 23, 2021

BioNTech Manufacturing GmbH
Attention: Amit Patel
Pfizer Inc.
235 East 42nd Street
New York, NY 10017

Dear Mr. Patel:

Please refer to your Biologics License Application (BLA) submitted and received on May 18, 2021, under section 351(a) of the Public Health Service Act (PHS Act) for COVID-19 Vaccine, mRNA.

LICENSING

We are issuing Department of Health and Human Services U.S. License No. 2229 to BioNTech Manufacturing GmbH, Mainz, Germany, under the provisions of section 351(a) of the PHS Act controlling the manufacture and sale of biological products. The license authorizes you to introduce or deliver for introduction into interstate commerce, those products for which your company has demonstrated compliance with

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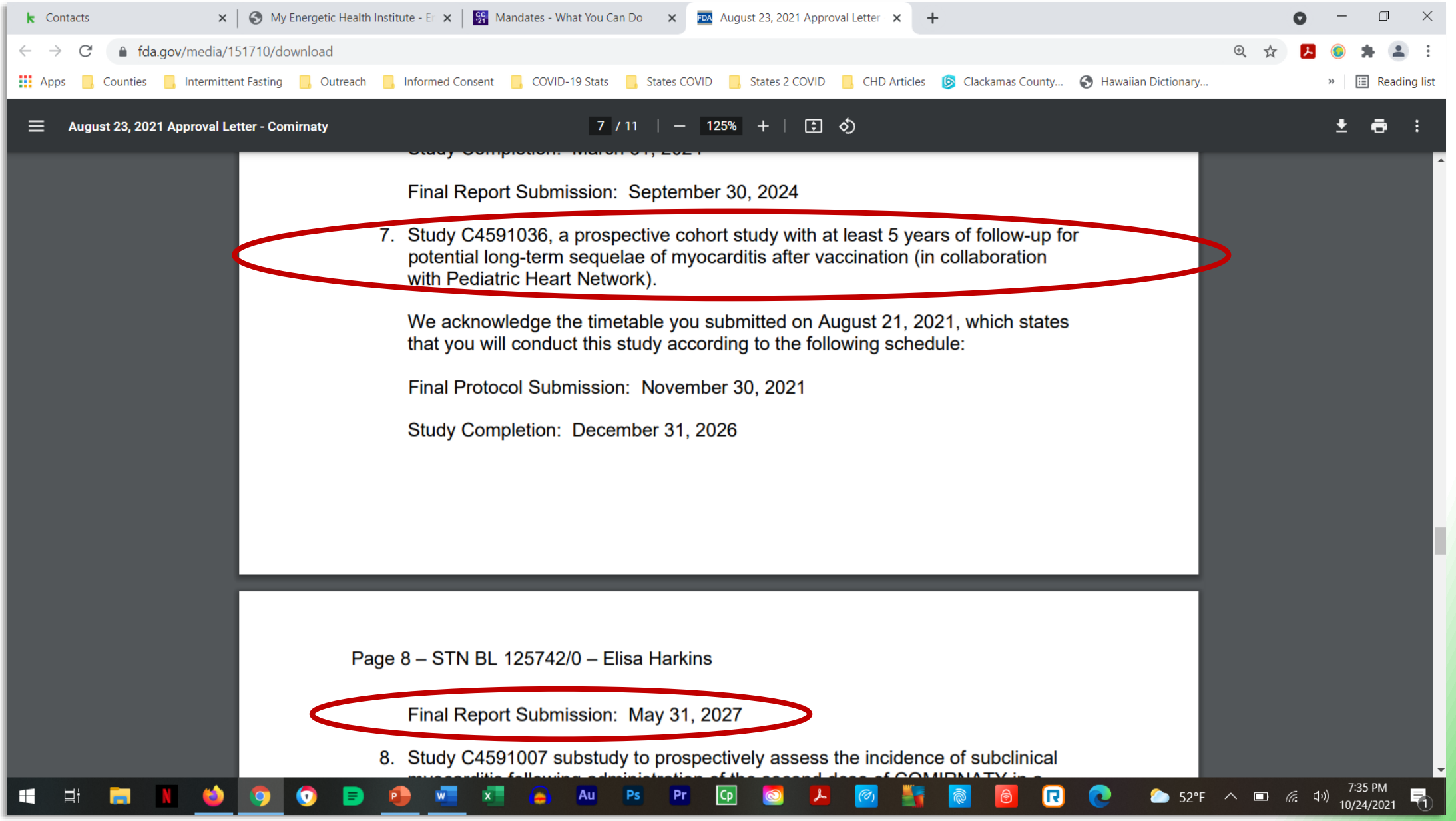
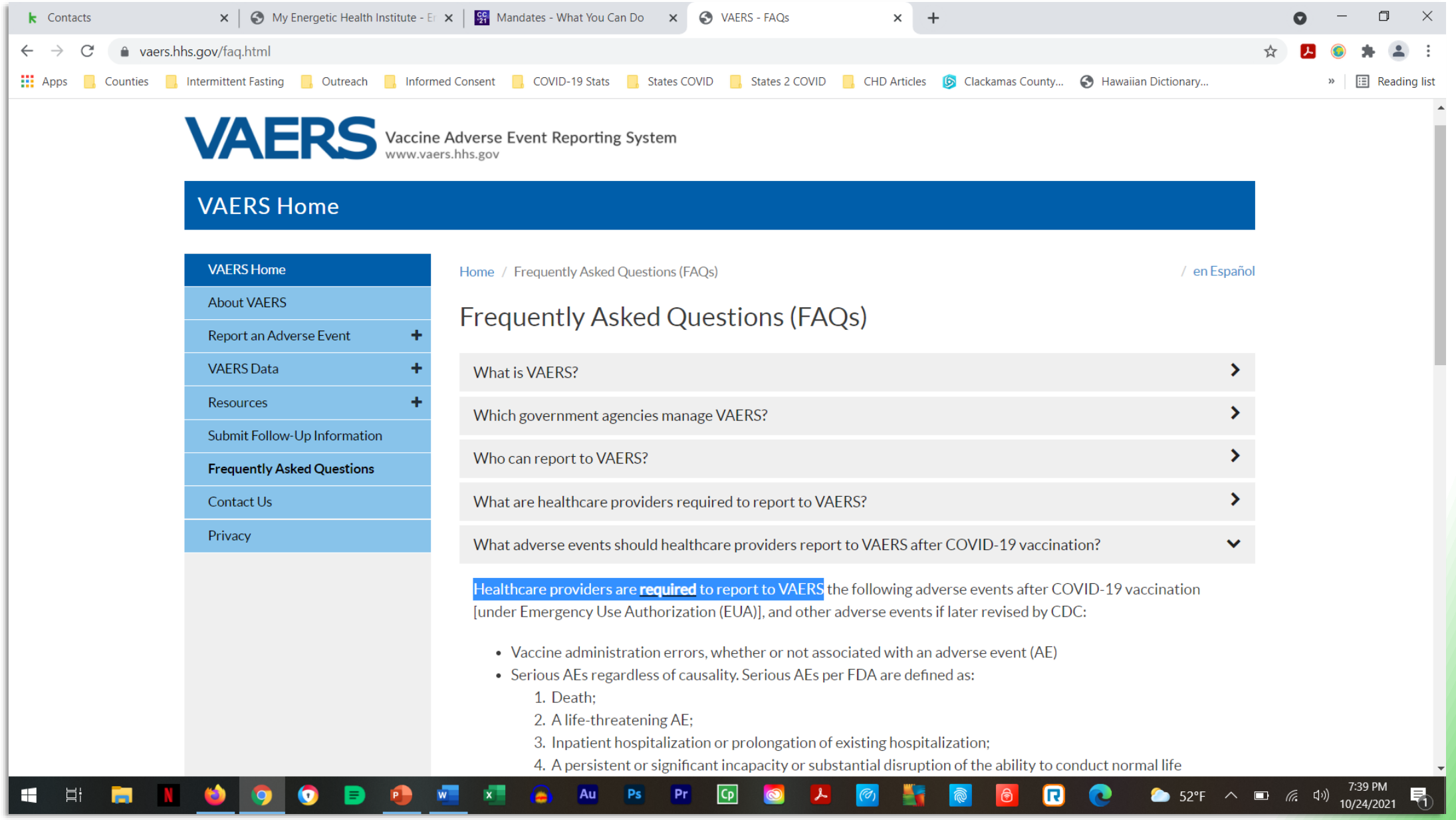
TRIALS DON'T END UNTIL MAY 31, 2027



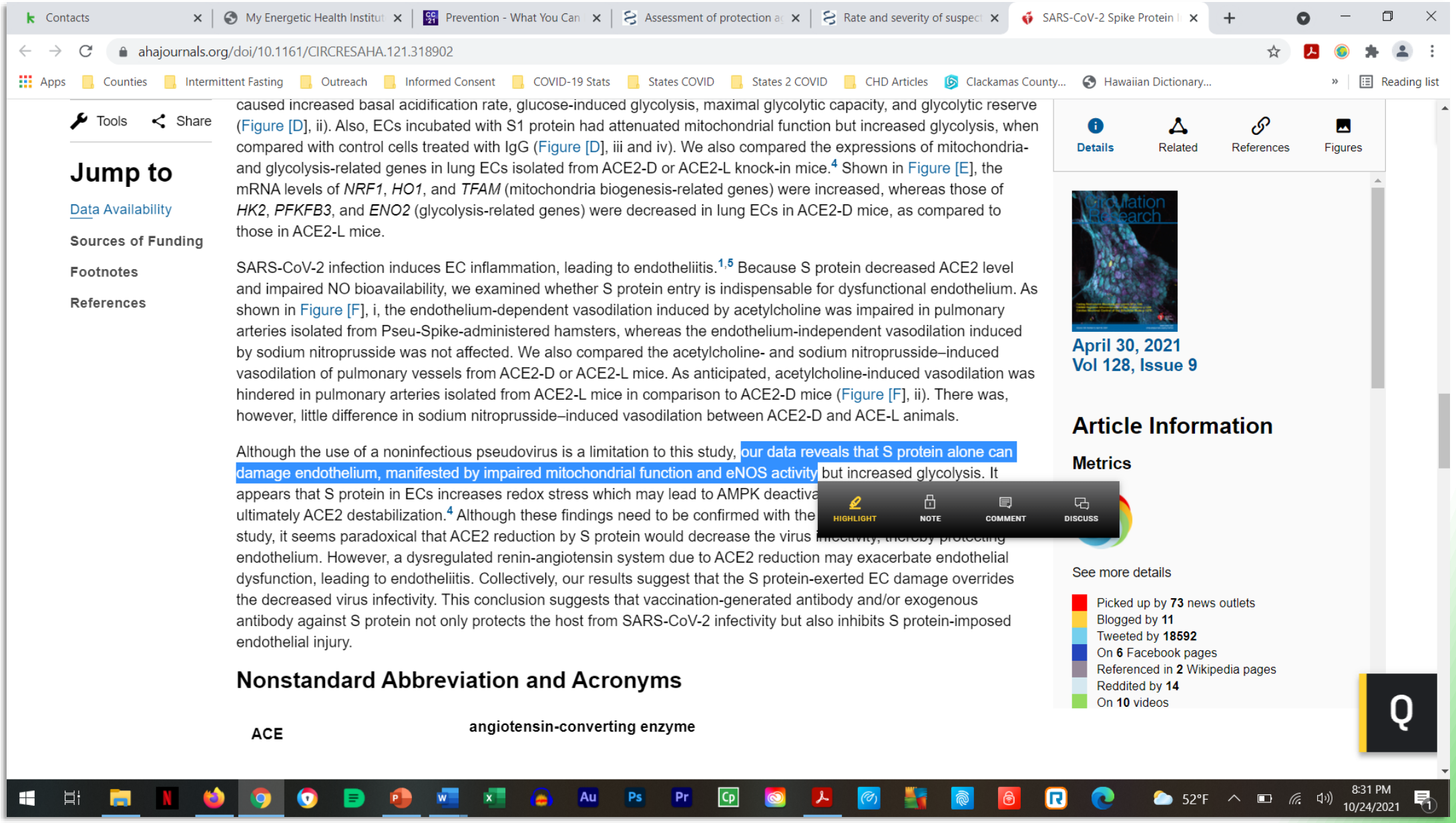
ARE MEDICAL PROFESSIONALS LEGALLY OBLIGATED TO REPORT ALL ADVERSE EVENTS TO VAERS?

APPROVED CONDITIONALLY…BUT



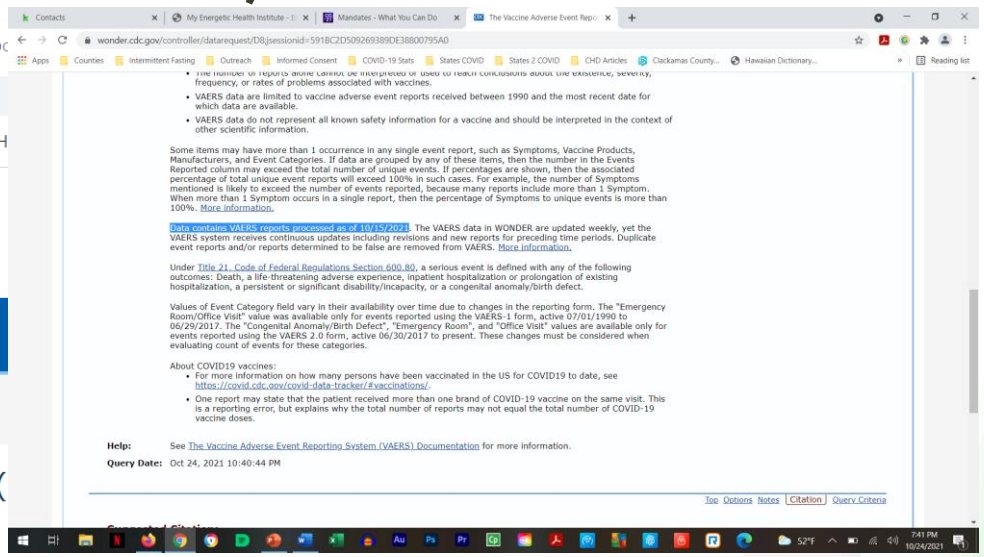
IS THE SPIKE PROTEIN (S PROTEIN) INJURIOUS TO THE HUMAN BODY IN AND OF ITSELF?

YES THE SPIKE PROTEIN IS INJURIOUS



WHAT IS THE CURRENT POST-INOCULATION SAFETY DATA?

OVERVIEW – THRU OCT 15, 2021



Contacts | My Energetic Health Institute - E | Mandates - What You Can Do | The Vaccine Adverse Event Repc

wonder.cdc.gov/controller/datarequest/D8;jsessionid=591BC2D509269389DE38800795A0

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Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

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Request Form | Results | Map | Chart | Report | About

Dataset Documentation | Other Data Access | Help for Results | Printing Tips | Help with Exports

Save | Export | Reset

Quick Options | More Options

Top | Notes | Citation | Query Criteria

Messages:

- **VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.**
- **These results are for 818,044 total events.**

Event Category	Events Reported	Percent (of 818,044)
Death	17,128	2.09%
Life Threatening	18,924	2.31%
Permanent Disability	26,199	3.20%
Congenital Anomaly / Birth Defect *	575	0.07%
Hospitalized	83,412	10.20%
Existing Hospitalization Prolonged	1,064	0.13%
Emergency Room / Office Visit **	57	0.01%
Emergency Room *	91,961	11.24%
Office Visit *	127,640	15.60%
None of the above	538,327	65.81%
Total	**905,287**	**110.66%**

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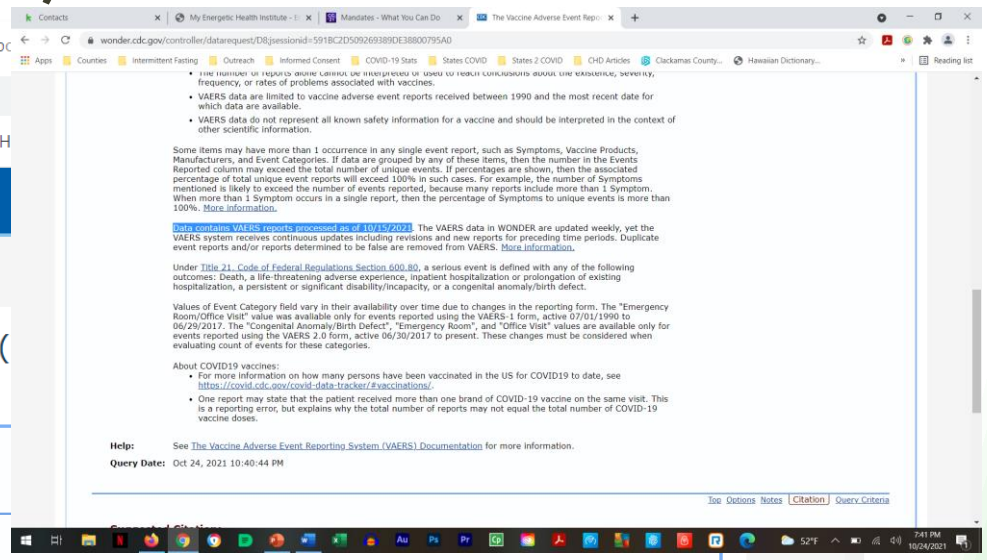
BY AGE – THRU OCT 15, 2021



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Request Form | Results | Map | Chart | Report | About

Dataset Documentation | Other Data Access | Help for Results | Printing Tips | Help with Exports

Quick Options | More Options

Messages:

- **VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.**
- **These results are for 818,044 total events.**

Age	Events Reported	Percent (of 818,044)
< 6 months	102	0.01%
6-11 months	50	0.01%
1-2 years	79	0.01%
3-5 years	53	0.01%
6-17 years	24,124	2.95%
18-29 years	83,708	10.23%
30-39 years	111,319	13.61%
40-49 years	109,116	13.34%
50-59 years	109,922	13.44%
60-64 years	51,166	6.25%
65-79 years	118,307	14.46%
80+ years	34,301	4.19%
Unknown	175,797	21.49%
Total	**818,044**	**100.00%**

Note: Submitting a report to VAERS does not mean that healthcare personnel or the vaccine caused or contributed to the adverse event (possible side effect).

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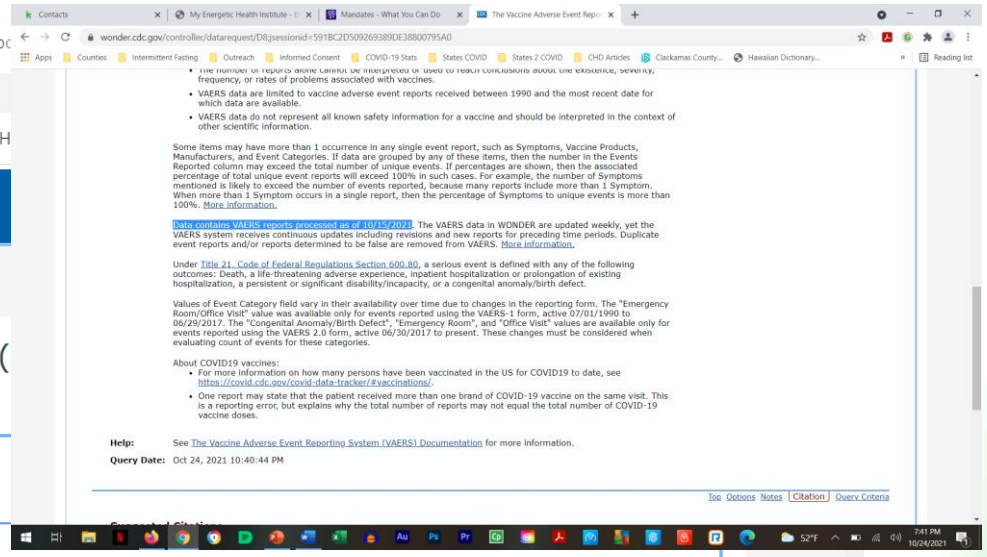
DEATH – THRU OCT 15, 2021



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Apps | Counties | Intermittent Fasting | Outreach | Informed Consent | COVID-19 Stats | States COVID | States 2 COVID | CH

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Request Form | Results | Map | Chart | Report | About

Dataset Documentation | Other Data Access | Help for Results | Printing Tips | Help with Exports

Quick Options | More Options

Messages:

- **VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.**
- **These results are for 17,128 total events.**
- **Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.**

Age	Events Reported	Percent (of 17,128)
< 6 months	2	0.01%
1-2 years	2	0.01%
6-17 years	37	0.22%
18-29 years	173	1.01%
30-39 years	292	1.70%
40-49 years	434	2.53%
50-59 years	915	5.34%
60-64 years	771	4.50%
65-79 years	3,713	21.68%
80+ years	4,406	25.72%
Unknown	6,383	37.27%
Total	**17,128**	**100.00%**

Note: Submitting a report to VAERS does not mean that healthcare personnel or the vaccine caused or contributed to the adverse event (possible side effect).

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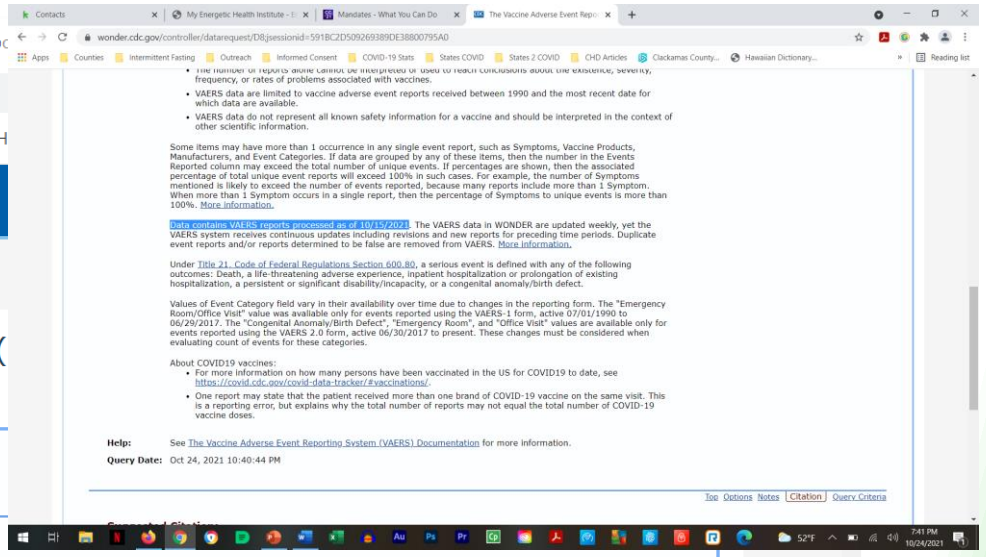
DEATH W/IN 48 HOURS – THRU OCT 15, 2021



Contacts | My Energetic Health Institute - E | Mandates - What You Can Do | The Vaccine Adverse Event Repc

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Request Form | Results | Map | Chart | Report | About

Dataset Documentation | Other Data Access | Help for Results | Printing Tips | Help with Exports

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Messages:

- **VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.**
- **These results are for 5,489 total events.**
- **Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.**

Age	Events Reported	Percent (of 5,489)
< 6 months	1	0.02%
1-2 years	2	0.04%
6-17 years	6	0.11%
18-29 years	76	1.38%
30-39 years	96	1.75%
40-49 years	174	3.17%
50-59 years	343	6.25%
60-64 years	277	5.05%
65-79 years	1,254	22.85%
80+ years	1,626	29.62%
Unknown	1,634	29.77%
Total	5,489	100.00%

Note: Submitting a report to VAERS does not mean that healthcare personnel or the vaccine caused or contributed to the adverse event (possible side effect).

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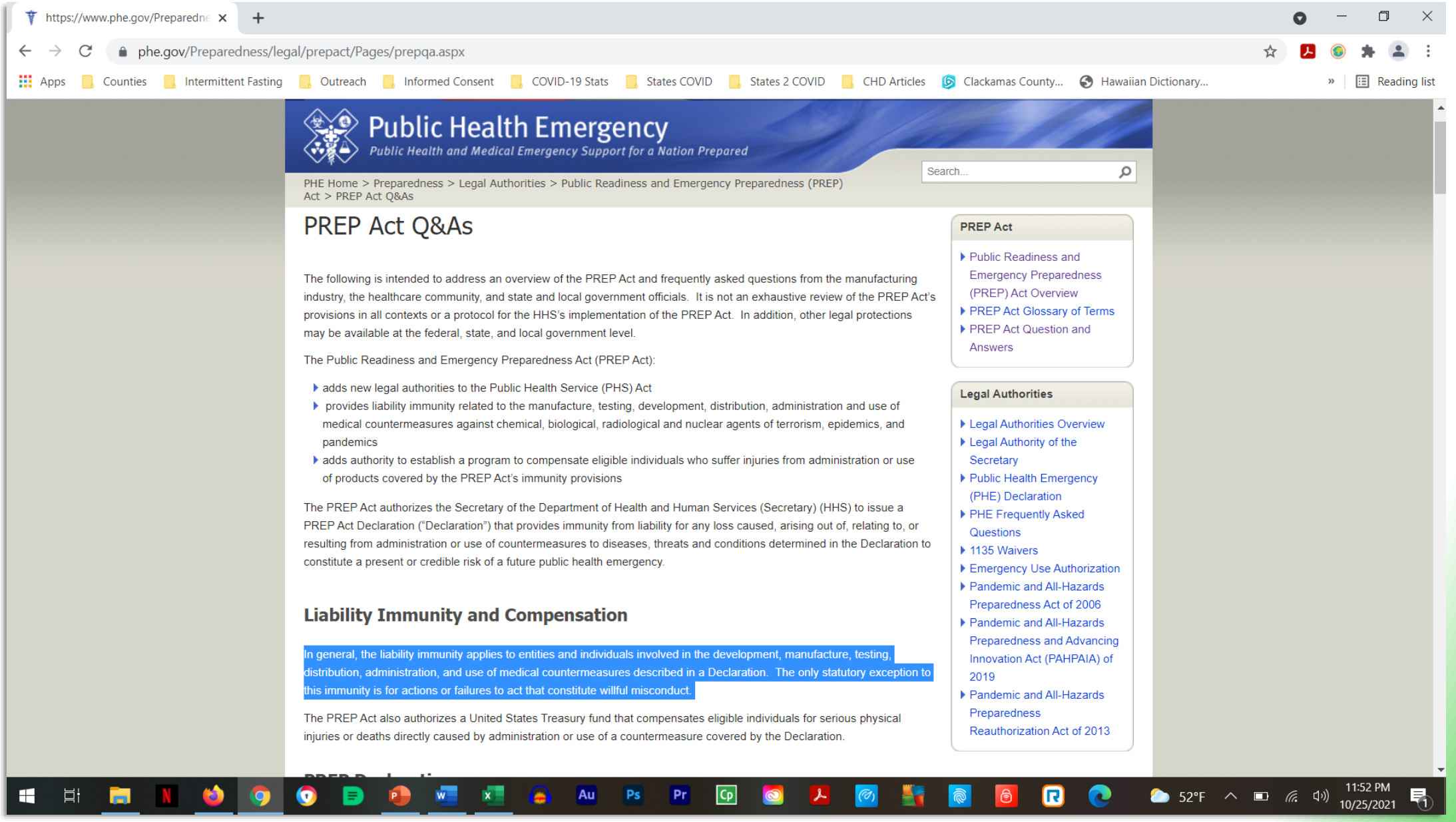
CAN VACCINE MANUFACTURERS BE SUED IF THEIR PRODUCTS INJURE OR KILL INNOCENT PEOPLE ?

PREP ACT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Apps
Counties
Intermittent Fasting
Outreach
Informed Consent
COVID-19 Stats
States COVID
States 2 COVID
CHD Articles
Clackamas County...
Hawaiian Dictionary...
Reading list
Public Health Emergency
Public Health and Medical Emergency Support for a Nation Prepared
Search...
PHE Home > Preparedness > Legal Authorities > Public Readiness and Emergency Preparedness (PREP) Act > PREP Act Q&As
PREP Act Q&As
The following is intended to address an overview of the PREP Act and frequently asked questions from the manufacturing industry, the healthcare community, and state and local government officials. It is not an exhaustive review of the PREP Act's provisions in all contexts or a protocol for the HHS's implementation of the PREP Act. In addition, other legal protections may be available at the federal, state, and local government level.
The Public Readiness and Emergency Preparedness Act (PREP Act):
adds new legal authorities to the Public Health Service (PHS) Act
provides liability immunity related to the manufacture, testing, development, distribution, administration and use of medical countermeasures against chemical, biological, radiological and nuclear agents of terrorism, epidemics, and pandemics
adds authority to establish a program to compensate eligible individuals who suffer injuries from administration or use of products covered by the PREP Act's immunity provisions
The PREP Act authorizes the Secretary of the Department of Health and Human Services (Secretary) (HHS) to issue a PREP Act Declaration ("Declaration") that provides immunity from liability for any loss caused, arising out of, relating to, or resulting from administration or use of countermeasures to diseases, threats and conditions determined in the Declaration to constitute a present or credible risk of a future public health emergency.
Liability Immunity and Compensation
In general, the liability immunity applies to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of medical countermeasures described in a Declaration. The only statutory exception to this immunity is for actions or failures to act that constitute willful misconduct.
The PREP Act also authorizes a United States Treasury fund that compensates eligible individuals for serious physical injuries or deaths directly caused by administration or use of a countermeasure covered by the Declaration.
PREP Act
Public Readiness and Emergency Preparedness (PREP) Act Overview
PREP Act Glossary of Terms
PREP Act Question and Answers
Legal Authorities
Legal Authorities Overview
Legal Authority of the Secretary
Public Health Emergency (PHE) Declaration
PHE Frequently Asked Questions
1135 Waivers
Emergency Use Authorization
Pandemic and All-Hazards Preparedness Act of 2006
Pandemic and All-Hazards Preparedness and Advancing Innovation Act (PAHPAIA) of 2019
Pandemic and All-Hazards Preparedness Reauthorization Act of 2013
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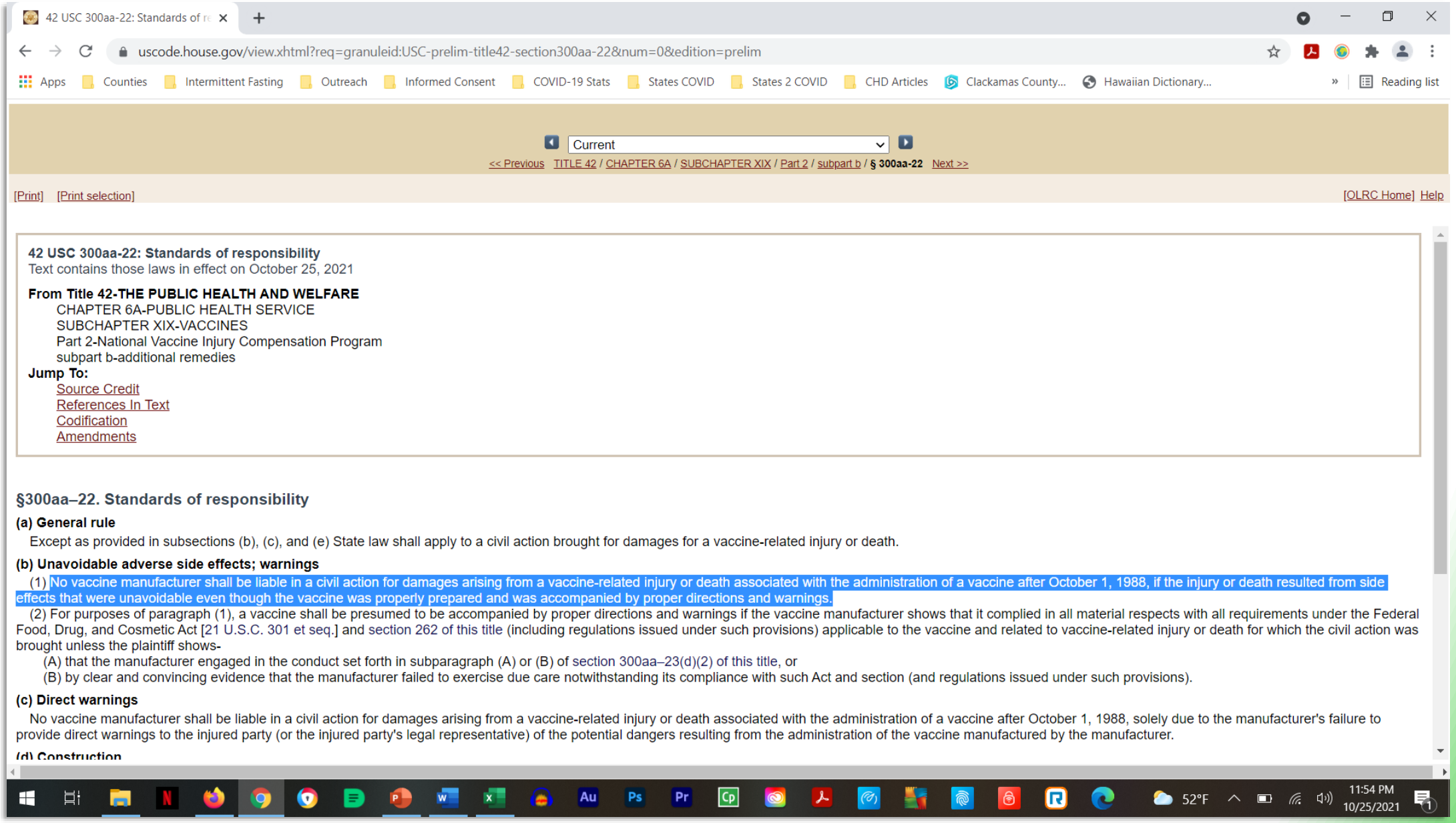
1986 NATIONAL CHILDHOOD VACCINE INJURY ACT



42 USC 300aa-22: Standards of re

uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section300aa-22&num=0&edition=prelim

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Current

<< Previous TITLE 42 / CHAPTER 6A / SUBCHAPTER XIX / Part 2 / subpart b / § 300aa-22 Next >>

[Print] [Print selection] [OLRC Home] Help

42 USC 300aa-22: Standards of responsibility
Text contains those laws in effect on October 25, 2021

From Title 42-THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A-PUBLIC HEALTH SERVICE
SUBCHAPTER XIX-VACCINES
Part 2-National Vaccine Injury Compensation Program
subpart b-additional remedies

Jump To:
Source Credit
References In Text
Codification
Amendments

§300aa–22. Standards of responsibility

(a) General rule

Except as provided in subsections (b), (c), and (e) State law shall apply to a civil action brought for damages for a vaccine-related injury or death.

(b) Unavoidable adverse side effects; warnings

(1) No vaccine manufacturer shall be liable in a civil action for damages arising from a vaccine-related injury or death associated with the administration of a vaccine after October 1, 1988, if the injury or death resulted from side effects that were unavoidable even though the vaccine was properly prepared and was accompanied by proper directions and warnings.

(2) For purposes of paragraph (1), a vaccine shall be presumed to be accompanied by proper directions and warnings if the vaccine manufacturer shows that it complied in all material respects with all requirements under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.] and section 262 of this title (including regulations issued under such provisions) applicable to the vaccine and related to vaccine-related injury or death for which the civil action was brought unless the plaintiff shows-

(A) that the manufacturer engaged in the conduct set forth in subparagraph (A) or (B) of section 300aa–23(d)(2) of this title, or

(B) by clear and convincing evidence that the manufacturer failed to exercise due care notwithstanding its compliance with such Act and section (and regulations issued under such provisions).

(c) Direct warnings

No vaccine manufacturer shall be liable in a civil action for damages arising from a vaccine-related injury or death associated with the administration of a vaccine after October 1, 1988, solely due to the manufacturer's failure to provide direct warnings to the injured party (or the injured party's legal representative) of the potential dangers resulting from the administration of the vaccine manufactured by the manufacturer.

(d) Construction

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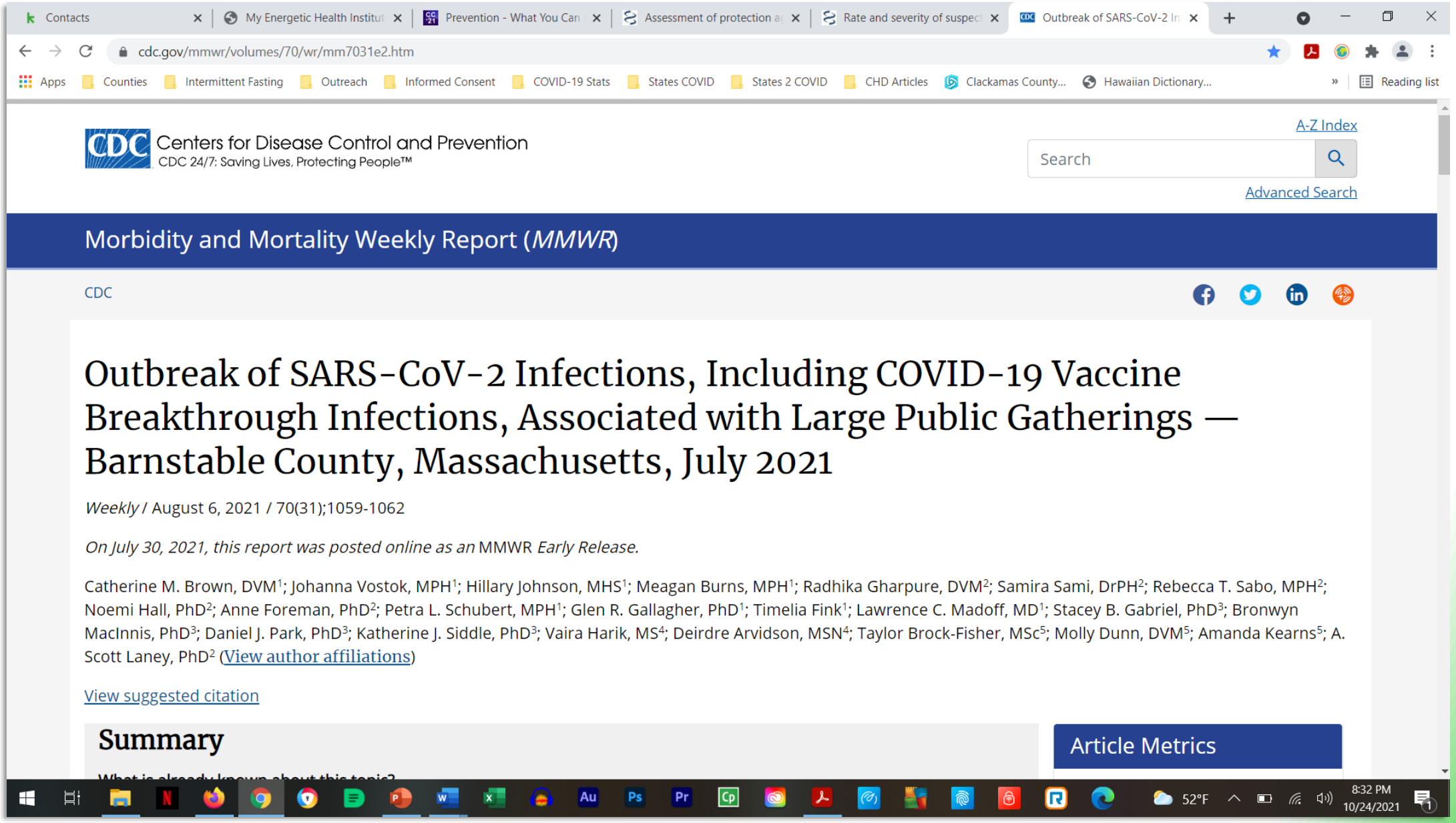
HOW PROTECTIVE ARE THE EXPERIMENTAL INOCULATIONS?

BARNSTABLE STUDY



BARNSTABLE STUDY

Jurisdictions might consider expanded prevention strategies, including universal masking in indoor public settings, particularly for large public gatherings that include travelers from many areas with differing levels of SARS-CoV-2 transmission.

During July 2021, 469 cases of COVID-19 associated with multiple summer events and large public gatherings in a town in Barnstable County, Massachusetts, were identified among Massachusetts residents; vaccination coverage among eligible Massachusetts residents was 69%. Approximately three quarters (346; 74%) of cases occurred in fully vaccinated persons (those who had completed a 2-dose course of mRNA vaccine [Pfizer-BioNTech or Moderna] or had received a single dose of Janssen [Johnson & Johnson] vaccine ≥14 days before exposure). Genomic sequencing of specimens from 133 patients identified the B.1.617.2 (Delta) variant of SARS-CoV-2, the virus that causes COVID-19, in 119 (89%) and the Delta AY.3 sublineage in one (1%). Overall, 274 (79%) vaccinated patients with breakthrough infection were symptomatic. Among five COVID-19 patients who were hospitalized, four were fully vaccinated; no deaths were reported. Real-time reverse transcription–polymerase chain reaction (RT-PCR) cycle threshold (Ct) values in specimens from 127 vaccinated persons with breakthrough cases were similar to those from 84 persons who were unvaccinated, not fully vaccinated, or whose vaccination status was unknown (median = 22.77 and 21.54, respectively). The Delta variant of SARS-CoV-2 is highly transmissible (*1*); vaccination is the most important strategy to prevent severe illness and death. On July 27, CDC recommended that all persons, including those who are fully vaccinated, should wear masks in indoor public settings in areas where COVID-19 transmission is high or substantial.* Findings from this investigation suggest that even jurisdictions without substantial or high COVID-19 transmission might consider expanding prevention strategies, including masking in indoor public settings regardless of vaccination status, given the potential risk of infection during attendance at large public gatherings that include travelers from many areas with differing levels of transmission.

During July 3–17, 2021, multiple summer events and large public gatherings were held in a town in Barnstable County, Massachusetts, that attracted thousands of tourists from across the United States. Beginning July 10, the Massachusetts Department of Public Health (MA DPH) received reports of an increase in COVID-19 cases among persons who reside in or recently visited Barnstable County, including in fully vaccinated persons. Persons with COVID-19 reported attending densely packed indoor and outdoor events at venues that included bars, restaurants, guest houses, and rental homes. On July 3, MA DPH had reported a 14-day average COVID-19 incidence of zero cases per 100,000 persons per day in residents of the town in Barnstable County; by July 17, the 14-day average incidence increased to 177 cases per 100,000 persons per day in residents of the town (*2*).

During July 10–26, using travel history data from the state COVID-19 surveillance system, MA DPH identified a cluster of cases among Massachusetts residents. Additional

DOD - PROJECT SALUS

Effectiveness of mRNA COVID-19 Vaccines Against the Delta Variant Among 5.6M Medicare Beneficiaries 65 Years and Older

Weekly update of September 28, 2021

humetrix®

Project Salus

JAIC

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Executive Summary

Basic questions which require data-driven answers

- Is vaccine effectiveness (VE) **waning** over time?
- Is VE **reduced** for the **Delta variant**?
- Does the need vary by **sub-population**?

Project Salus provides answers to these questions

- VE of both mRNA vaccines appears to wane over time in this large 5.6M US-based 65 & over vaccinated cohort
- Risk of breakthrough hospitalization increases with time elapsed since mRNA vaccination with odds ratio increasing to 2.5 at 6 months post vaccination
- VE against Delta breakthrough hospitalization (62%) exceeds VE against Delta infection (41%)
- Prior COVID-19 infection has a major protective effect against breakthrough hospitalization
- Older age groups (75-84 & 85 and older) experienced further reduction in vaccine protection against hospitalization
- Hospitalization rate (21% vs 32%) and death rate (4% vs 12%) of breakthrough infections lower than rates observed in Covid-19 cases in pre-vaccination pandemic phase in 2020

Graphic adapted from CDC Presentation ACIP Meeting August 30, 2021
Oliver, S. Framework for Booster Doses of COVID-19 Vaccines

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JAIC
Project Salus

Salus Platform for COVID-19 Analyses

VE Study Attributes

Cohort

20M Medicare beneficiaries nationwide with 16M individuals 65 years and older

Exposure

5.6M fully vaccinated with 2.7M Pfizer and 2.9M Moderna

Period of study

January - August 21 2021

Breakthrough Key Metrics

161K Breakthrough cases

33K Breakthrough hospitalizations

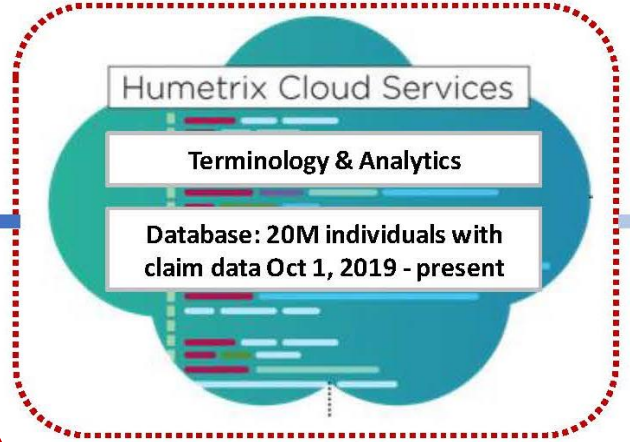
10.4K requiring ICU admissions

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

CDC

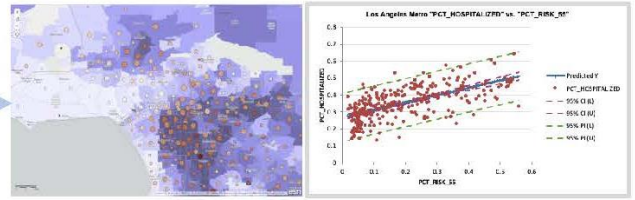
100+M weekly Medicare claim records

SVI data



Other Platform Applications

Nationwide Mapping of COVID-19 Outcomes
Hospitalizations, ICU, Ventilator Rx, Deaths



Disease Risk Models with Population Risk Profiling: Severe COVID-19 risk with Validation with Hospitalization Rates

Vaccination Mapping overlaid on severe COVID-19 risk

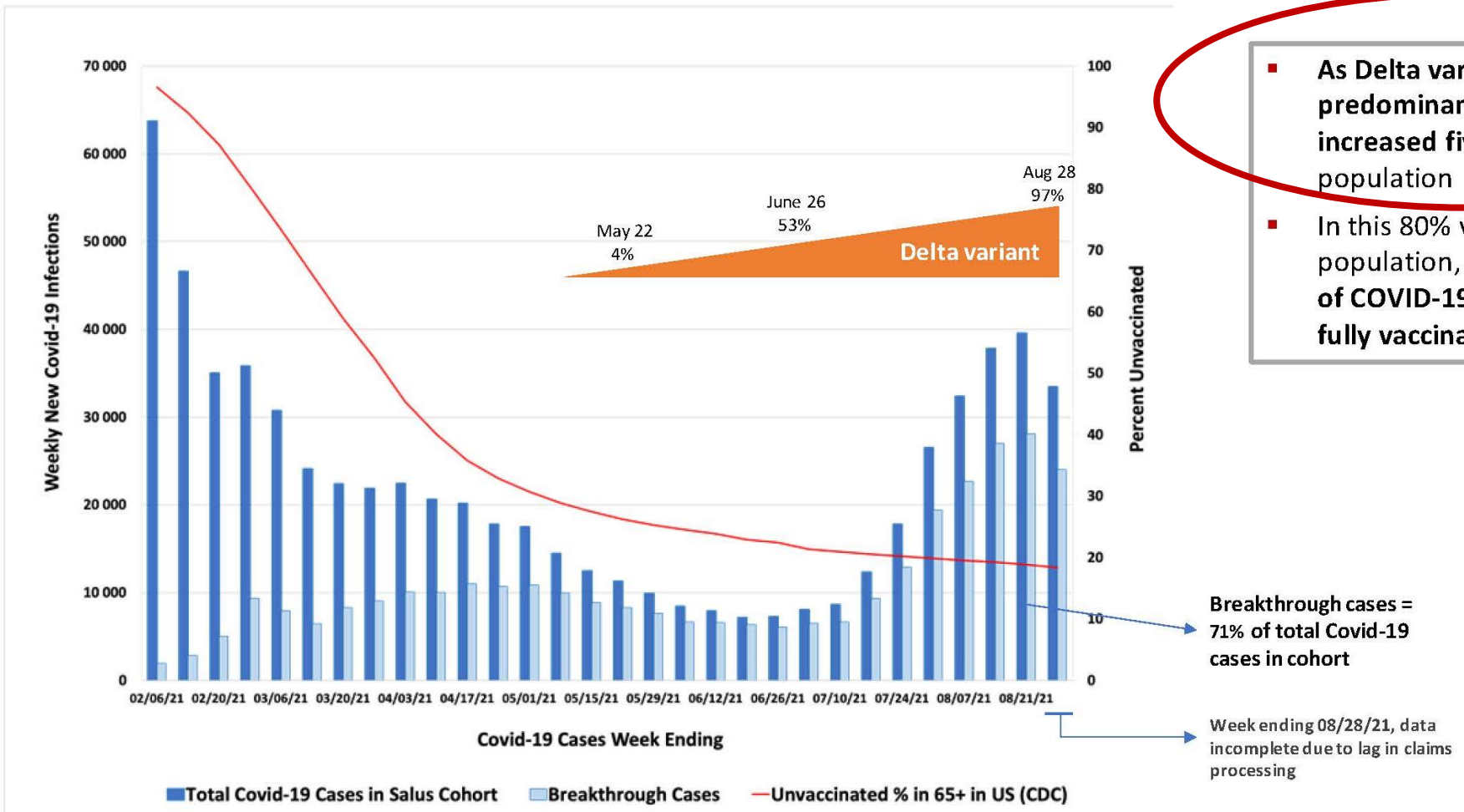
humetrix

* Medicare data and Humetrix software are hosted in a secure government enclave of the Department of Defense

DOD - PROJECT SALUS

JAIC
Project Salus

Total & Breakthrough Cases in the 65 Years and Older Salus Cohort



- **As Delta variant became predominant, COVID-19 cases increased five-fold** in the >=65 population
- In this 80% vaccinated >=65 population, an estimated **71% of COVID-19 cases occurred in fully vaccinated individuals**

Breakthrough cases = 71% of total Covid-19 cases in cohort

Week ending 08/28/21, data incomplete due to lag in claims processing

*CDC data: % of SARS-CoV-2 genomes sequenced

humetrix

DOD - PROJECT SALUS

JAIC
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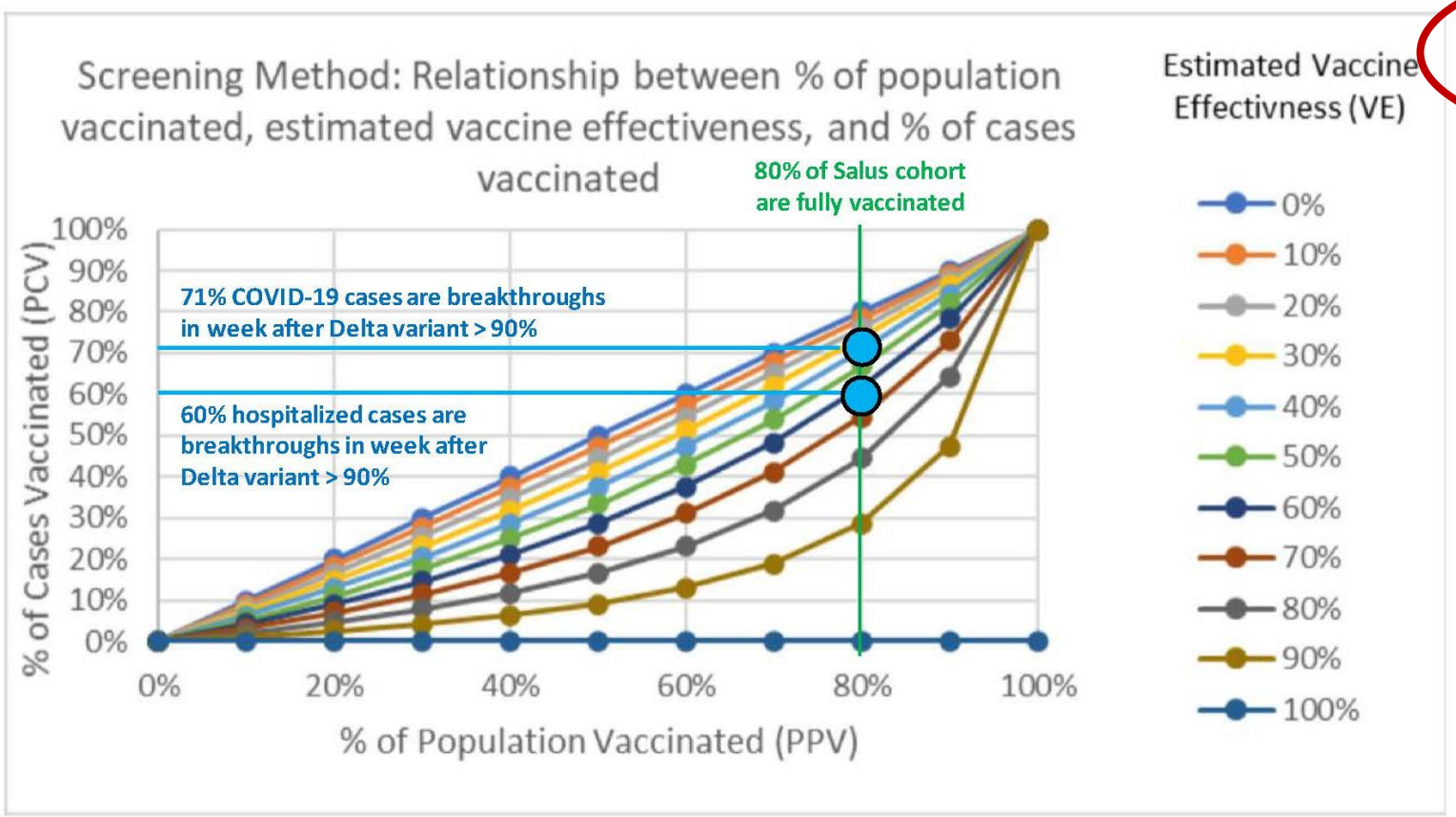
What is the Vaccine Effectiveness Against the Delta Variant in the Salus Cohort? – Using the CDC Screening Approach



- **41% calculated VE against infection**
- **62% calculated VE against hospitalization**

VE Screening method

VE = 1- [(PCV/(1-PCV))((1-PPV)/PPV)]

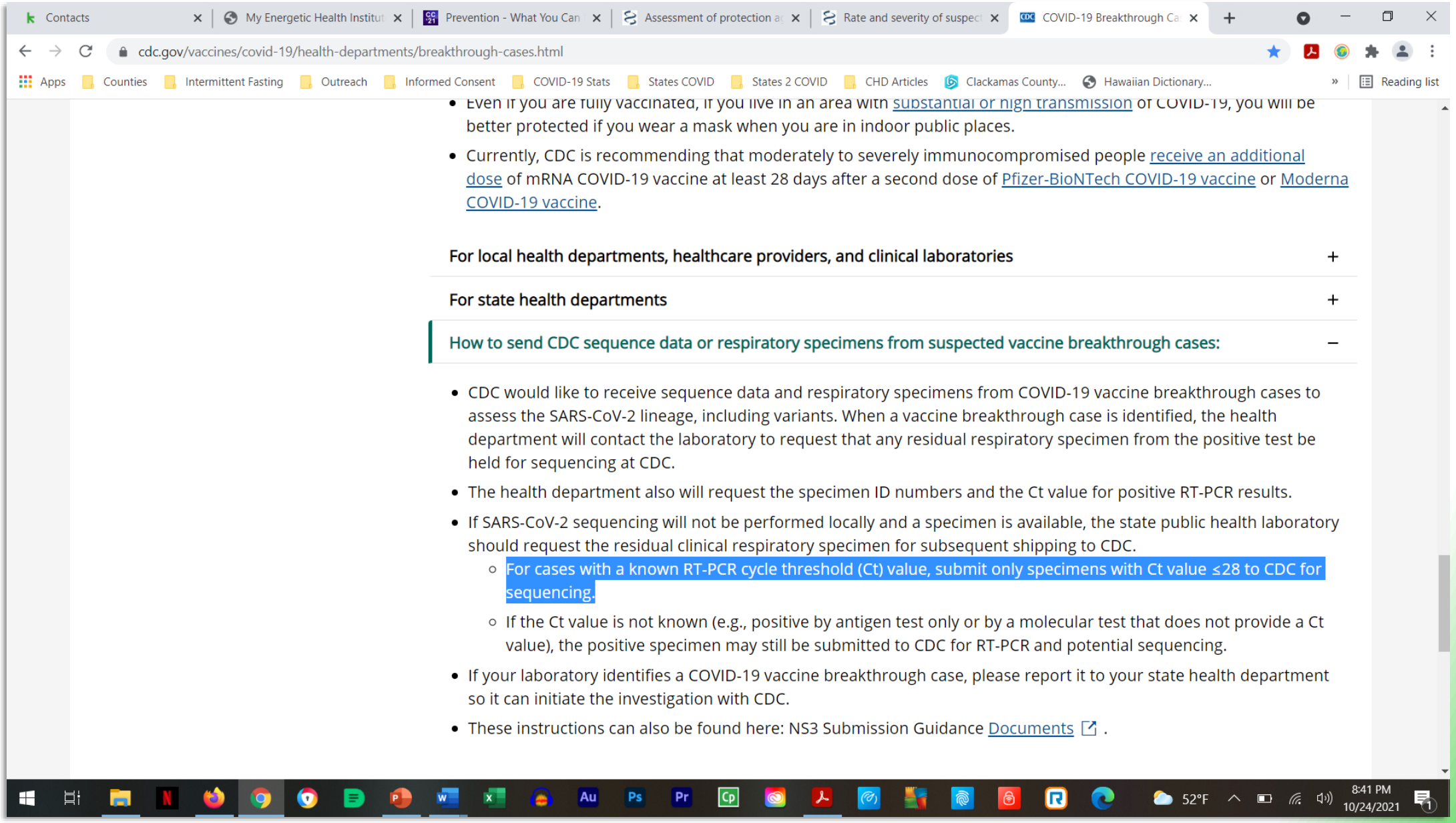
PCV = proportion cases vaccinated

PPV = proportion population vaccinated

Graphic adapted from CDC Presentation July 30, 2021
Improving communication around vaccine breakthrough and vaccine effectiveness

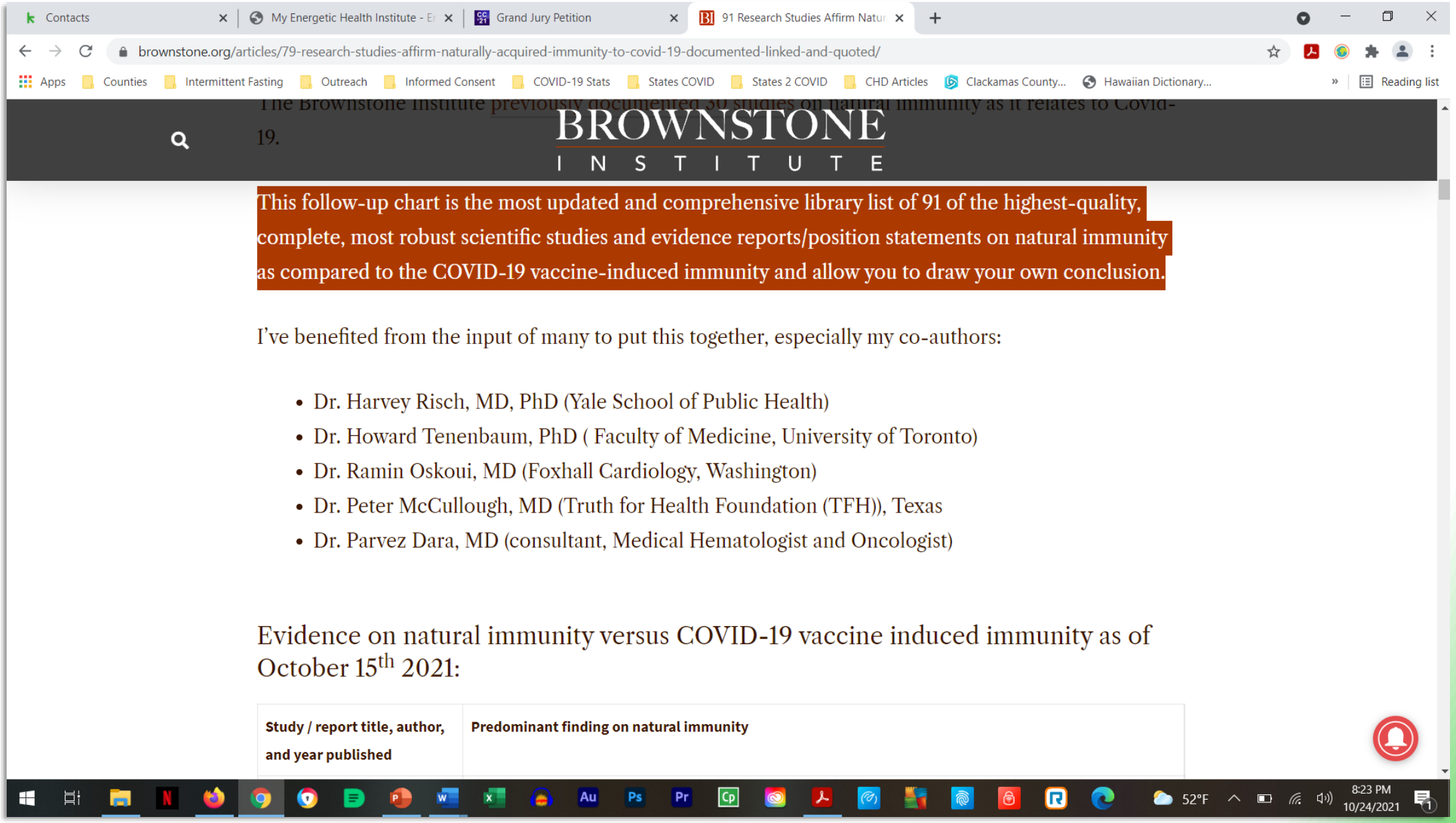
ARE THERE SPECIAL RULES FOR WHAT CONSTITUTES A BREAKTHROUGH CASE?

YES, THERE ARE SPECIAL RULES



IS NATURAL IMMUNITY DEVELOPED POST-INFECTION SUPERIOR TO IMMUNITY POST-EXPERIMENTAL INOCULATION?

91 STUDIES – THRU OCT 15, 2021



HTTPS://BROWNSTONE.ORG/ARTICLES/79-RESEARCH-STUDIES-AFFIRM-NATURALLY-ACQUIRED-IMMUNITY-TO-COVID-19-DOCUMENTED-LINKED-AND-QUOTED/

HAVE WE ATTEMPTED TO COLLABORATE WITH PUBLIC HEALTH OFFICIALS?

INITIAL ATTEMPTS

- On June 30, 2020 Dr. Dean Sidelinger was kind enough to give a colleague and I, 20 minutes of his time via zoom.
- The focus of the meeting was to discuss data errors we were finding and to offer our services on a volunteer basis to develop nutritional guidelines to augment the existing guidelines for masking and social distancing.
- The meeting went very well. Dr. Sidelinger and Ms. Heiberg we're very open to hearing our presentation. Dr. Sidelinger admitted that there hadn't been nearly enough done to educate the public on nutrition during this crisis.
- Dr. Sidelinger also stated that he was open to reviewing any studies on nutrition we could provide him.
- Our follow-up requests to work in collaboration with the OHA to develop nutritional guidelines on a volunteer basis were never responded to.
- **It is our goal to work with the OHA on behalf of all Oregonians**

JUN 30TH COMMUNICATION

Gmail

Henry Ealy <heneleeale@gmail.com>

meeting at 1:30 today

2 messages

Tue, Jun 30, 2020 at 5:00 AM

To: DAWN.L.QUITUGUA@dhsoha.state.or.us, DEAN.E.SIDELINGER@dhsoha.state.or.us, HOLLY.HEIBERG@dhsoha.state.or.us
Cc: Dr Henele <heneleeale@gmail.com>, Kautz Kristine M <KRISTINE.M.KAUTZ@dhsoha.state.or.us>, "Sugarman, Maxine" <Maxine.Sugarman@mail.house.gov>

Thank you for agreeing to meet us at 1:00 by zoom.

We are very interested in best supporting the OHA to help usher in a positive conclusion to this pandemic crisis. Below is a list of our agenda items. J

1. We have a very comprehensive data set filled with nationwide as well as individual state data from all 56 US State & Territory Health Departments we would like to share with the OHA. There's a lot of very revealing information within it with respect to demographics for Cases, Hospitalizations, & Fatalities for Age as well as Comorbidity. We believe this can be of some great assistance to OHA and would like Dr. Sidelinger's insights on it.

2. We have found some interesting peer-reviewed data from the Linus Pauling Institute at Oregon State University that we think can be instrumental in helping to protect our most vulnerable citizens as well as aiding in recovery efforts for all Oregonians and would like Dr. Sidelinger's insights.

3. We also are curious to know if Dr. Sidelinger is aware of the Probability of Recovery in the Age 0 to 19, Age 20 to 49, Age 50+ Demographics?

4. If time allows, we're curious as to Dr. Sidelinger's opinion on the increases in testing and what role that may be having in recent case increases, hot spots, etc.

Thank you in advance, we are very excited to do our part for the citizens of Oregon.

JUL 13TH FOLLOW-UP

Gmail

Henry Ealy <heneleeale@gmail.com>

Request For A Follow Up Meeting To Discuss Nutrition

7 messages

Dr Henele <heneleeale@gmail.com>
To: DEAN.E.SIDELINGER@dhsoha.state.or.us, HOLLY.HEIBERG@dhsoha.state.or.us

Mon, Jul 13, 2020 at 1:00 PM

Aloha Fellow Oregonians,

Can you please instruct me as to what do I need to do to schedule another meeting with you both, so we can objectively discuss the importance of offering some additional guidance to the people of Oregon on the safe use of nutrition to aid their immune system?

I am deeply concerned with the following statistics, how the Oregonian is portraying them, and the immense adverse ramifications for the people of our great state.

July 5th to July 12th
Positive Confirmed Cases - 2,004 New Cases
Confirmed Negatives - 30,031 Negatives
Confirmed Hospitalizations - +23 Hospitalizations
Fatalities - 19 New Fatalities
Recoveries - 250 New Recoveries

Part of our work as medical professionals is in bringing hope and reassurance to people who have been beleaguered by all of the fear and negativity this crisis has created. If we're not bringing hope to people in great need of it, then the potential for unintended collateral damage skyrockets in my personal and professional opinion.

The Oregonian is reporting is that there were 2 new fatalities in the 20 to 49 Age Demographic, but isn't talking about the Recoveries. The Oregonian is warning that this is going to get worse over the next 6 weeks? But does it really have to?

I know in my heart that we can do so much better than this...doesn't nutrition deserve even a chance to be considered?

All I'm seeing online and in society are people afraid of each other in spite of the very high Recovery numbers nationwide and in our state.

I am BEGGING you both to at least hear me out, let's talk about what nutrition can do to make an incredibly positive impact on our society and bring us back together again. We were told to stay home to flatten the curve and we did. Oregonians were told to wear masks and we have. Oregonians can answer this call too but they need the resources for their immune system to be able to do so.

HAS ASYMPTOMATIC TRANSMISSION EVER BEEN PROVEN?

ASYMPTOMATIC TRANSMISSION

Never Proven - https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html
Wuhan 10 Million Study Using PCR - https://www.nature.com/articles/s41467-020-19802-w

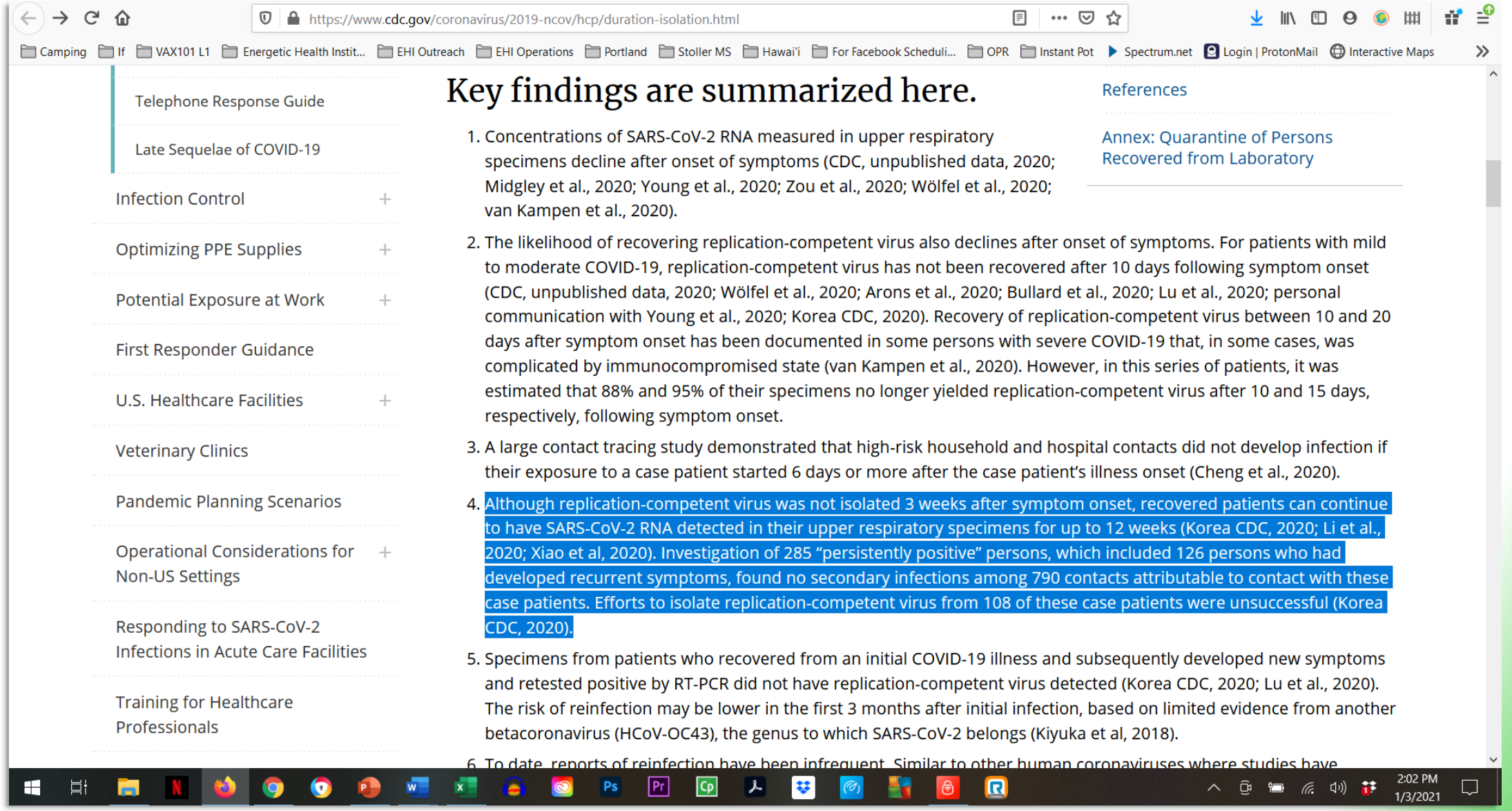
What Would Be Required To Prove It?

1. No Clinical Symptoms (Cough, HA, Muscle Aches, Loss of Smell, Fever/Chills, Etc.)
2. Positive For Serologic Viral Antigen Load
3. Negative For Serologic IgM & IgG Antibodies

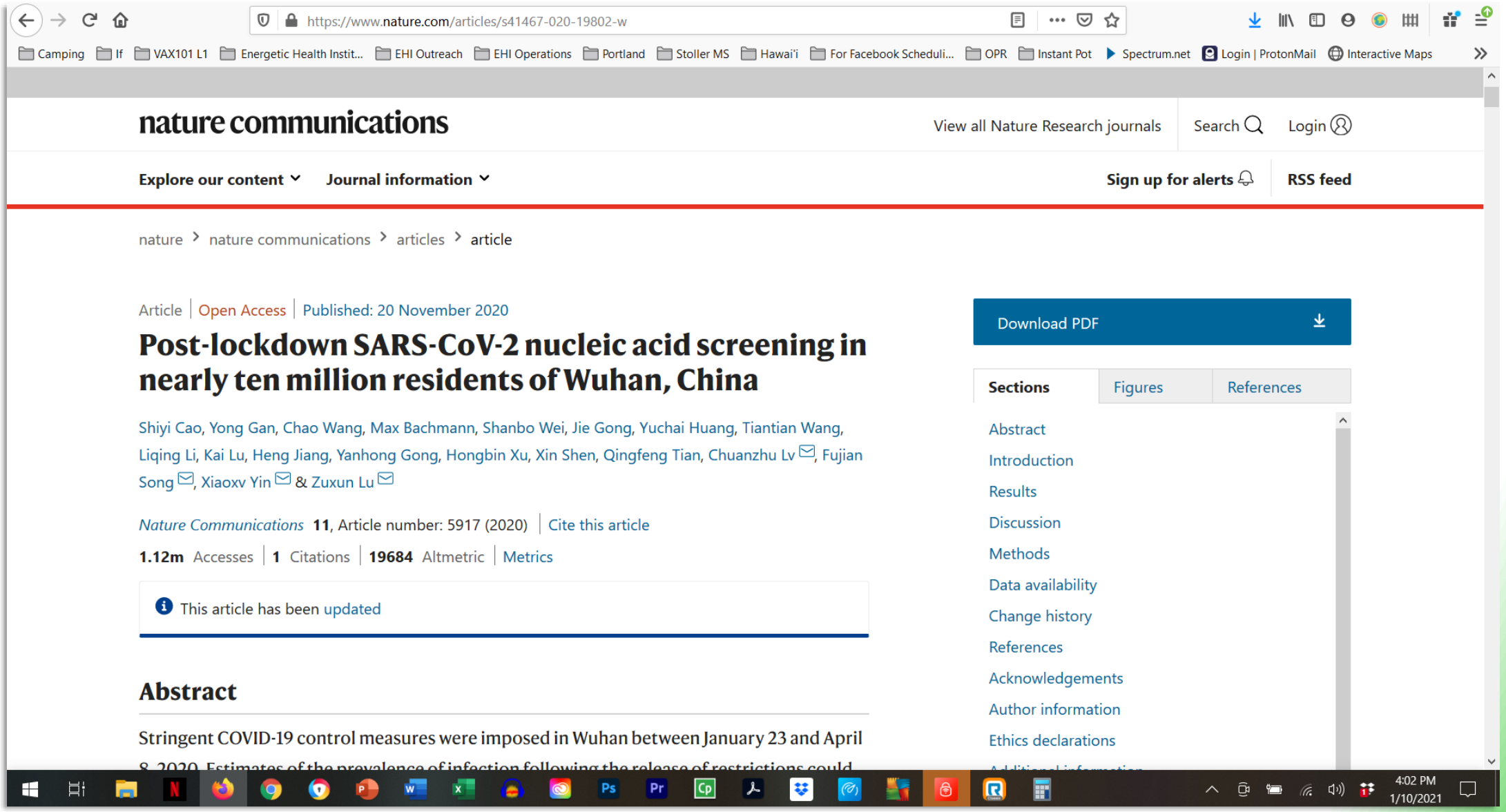
To Date This Study Has Never Been Conducted To Prove Asymptomatic Carriers Exist.

"The one thing historically that people need to realize is that even if there is some asymptomatic transmission, in all the history of respiratory-borne viruses of any type, asymptomatic transmission has never been the driver of outbreaks. The driver of outbreaks is always a symptomatic person. Even if there's a rare asymptomatic person that might transmit, an epidemic is not driven by asymptomatic carriers." – **Dr. Anthony Fauci**

INTERESTING STUDIES



10 MILLION PEOPLE TESTED



https://www.nature.com/articles/s41467-020-19802-w

Camping | If | VAX101 L1 | Energetic Health Instit... | EHI Outreach | EHI Operations | Portland | Stoller MS | Hawai'i | For Facebook Scheduli... | OPR | Instant Pot | Spectrum.net | Login | ProtonMail | Interactive Maps

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Article | Open Access | Published: 20 November 2020

Post-lockdown SARS-CoV-2 nucleic acid screening in nearly ten million residents of Wuhan, China

Shiyi Cao, Yong Gan, Chao Wang, Max Bachmann, Shanbo Wei, Jie Gong, Yuchai Huang, Tiantian Wang, Liqing Li, Kai Lu, Heng Jiang, Yanhong Gong, Hongbin Xu, Xin Shen, Qingfeng Tian, Chuanzhu Lv, Fujian Song, Xiaoxv Yin & Zuxun Lu

Nature Communications **11**, Article number: 5917 (2020) | Cite this article

1.12m Accesses | **1** Citations | **19684** Altmetric | Metrics

This article has been updated

Download PDF

Sections | Figures | References

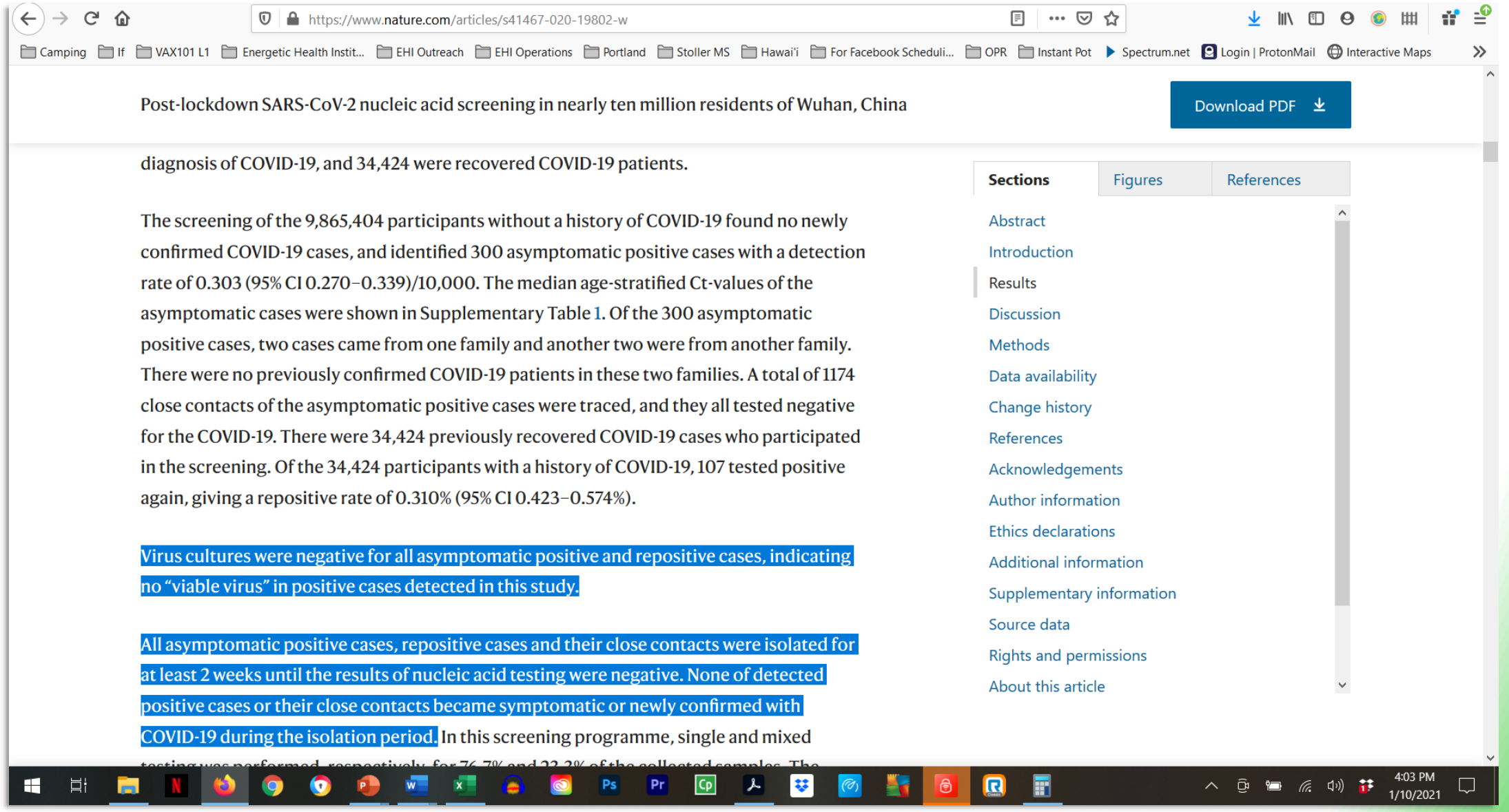
Abstract
Introduction
Results
Discussion
Methods
Data availability
Change history
References
Acknowledgements
Author information
Ethics declarations

Abstract

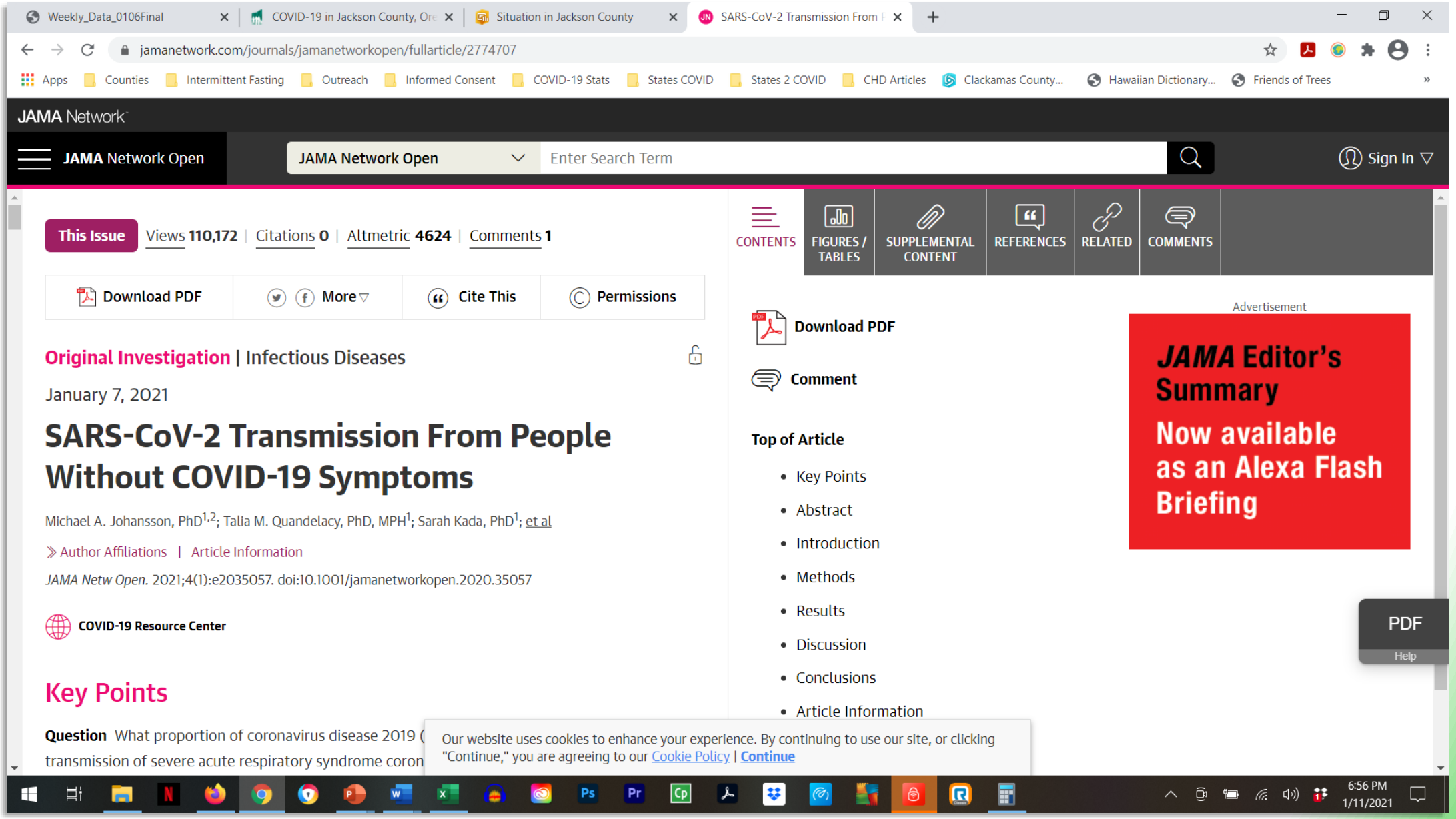
Stringent COVID-19 control measures were imposed in Wuhan between January 23 and April 8, 2020. Estimates of the prevalence of infection following the release of restrictions could

4:02 PM
1/10/2021

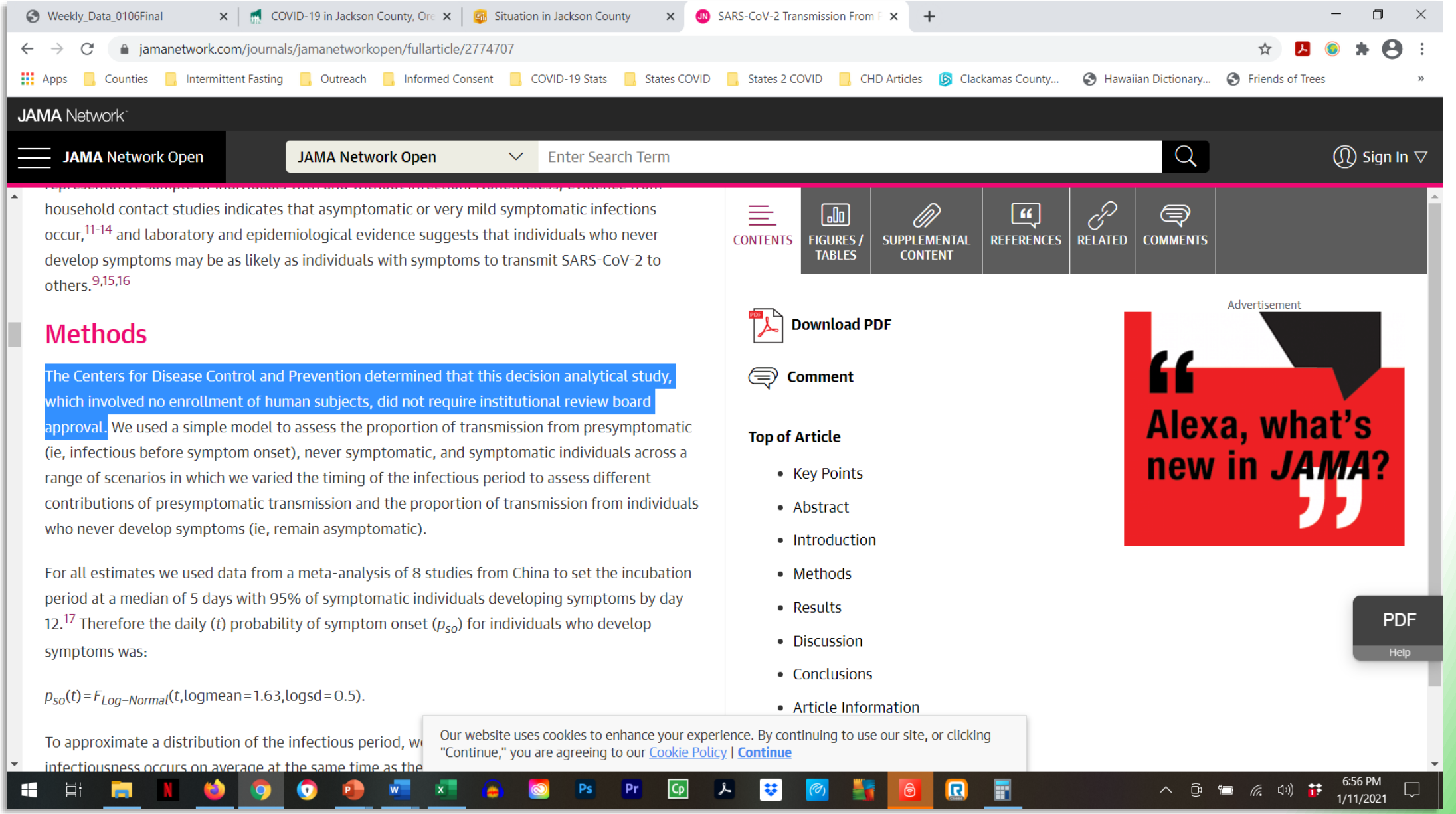
300 ‘ASYMPTOMATIC’ PCR CASES – 0 CONTAGIOUS, ALL LIKELY FALSE POSITIVE



59% OF TRANSMISSIONS ASYMPTOMATIC????



ZERO PARTICIPANTS…FUN WITH MATH



COMPARISON OF STUDIES REGARDING ASYMPTOMATIC TRANSMISSION

Category	Wuhan Study	US Study
Location	Wuhan, China	None
Publishing Journal	Nature	JAMA
Publishing Date	11/20/2020	1/7/2021
Peer-Reviewed	Yes	No
Enrolled Participants	9,898,828	0
Methods	PCR, Antibody, Viral Culture	Math Assumptions Only
Suspected Asymptomatic Carriers	300 Total	NA
Actual Asymptomatic Carriers	29 Possible	NA
Asymptomatic Contacts	1,174	None
Asymptomatic Contacts Infected	0	NA
Asymptomatics w/ Replication Competent Virus	0	NA
% Asymptomatic Carriers	0.00029%	Not Stated
% Asymptomatic Transmitters	0.00000%	59%

Wuhan Study - https://www.nature.com/articles/s41467-020-19802-w

US Study - https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774707

ASYMPTOMATIC TRANSMISSION

Science is the pursuit of verifiable, reproducible data.

Projections are not data.

Projections should never supplant data.

The Wuhan Study is the largest study ever performed in human history.

It is peer-reviewed.

Its methods are solid and while missing the Viral Antigen Load Testing did attempt to culture replication-competent virus.

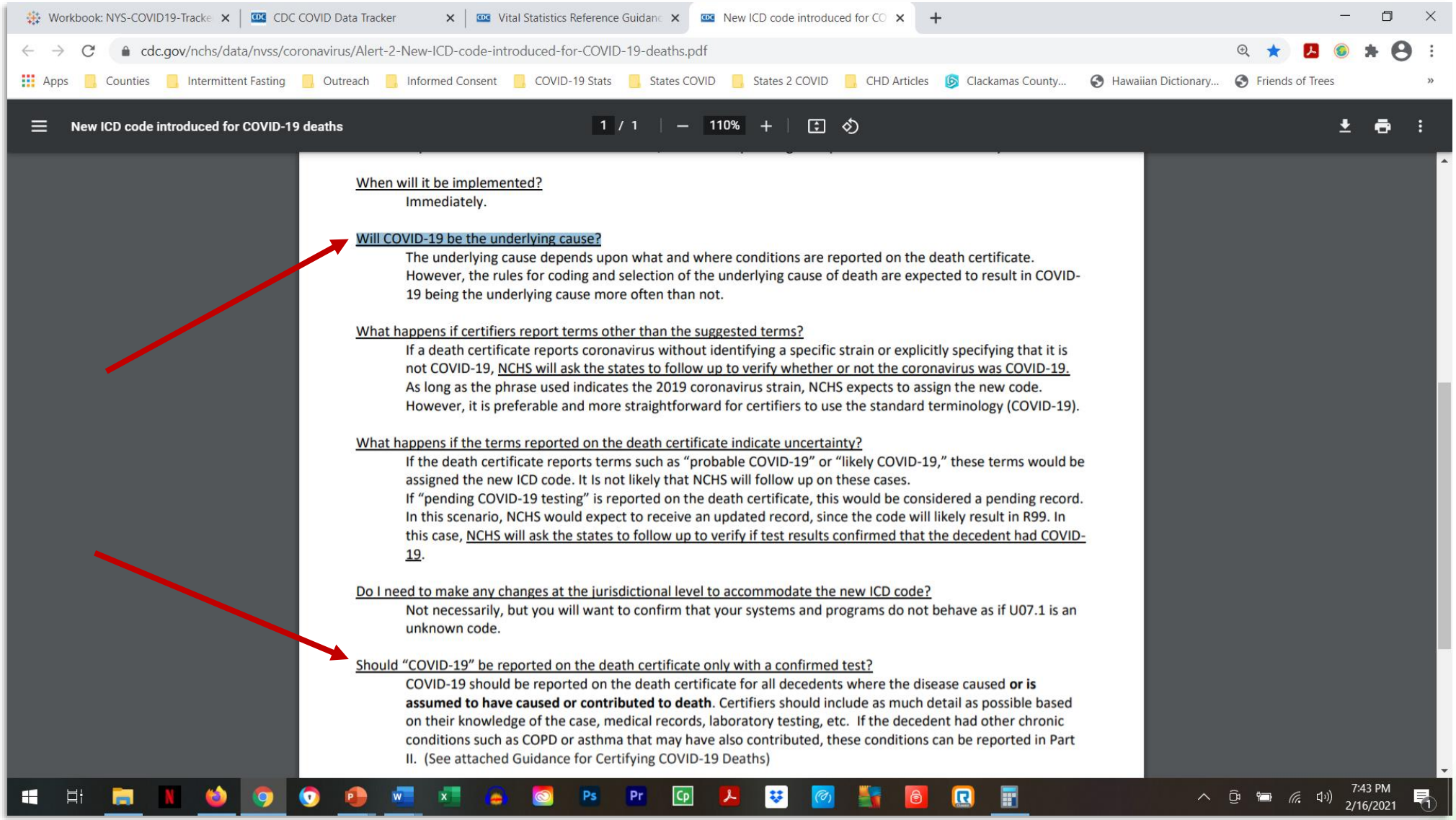
29 people out of 9,898,828 satisfied their criteria for Asymptomatic Carriers.

None of the Asymptomatic Carriers were contagious.

DID THE CDC VIOLATE MULTIPLE FEDERAL LAWS AND IN DOING SO HYPERINFLATE CASE, HOSPITALIZATION, & FATALITY DATA?

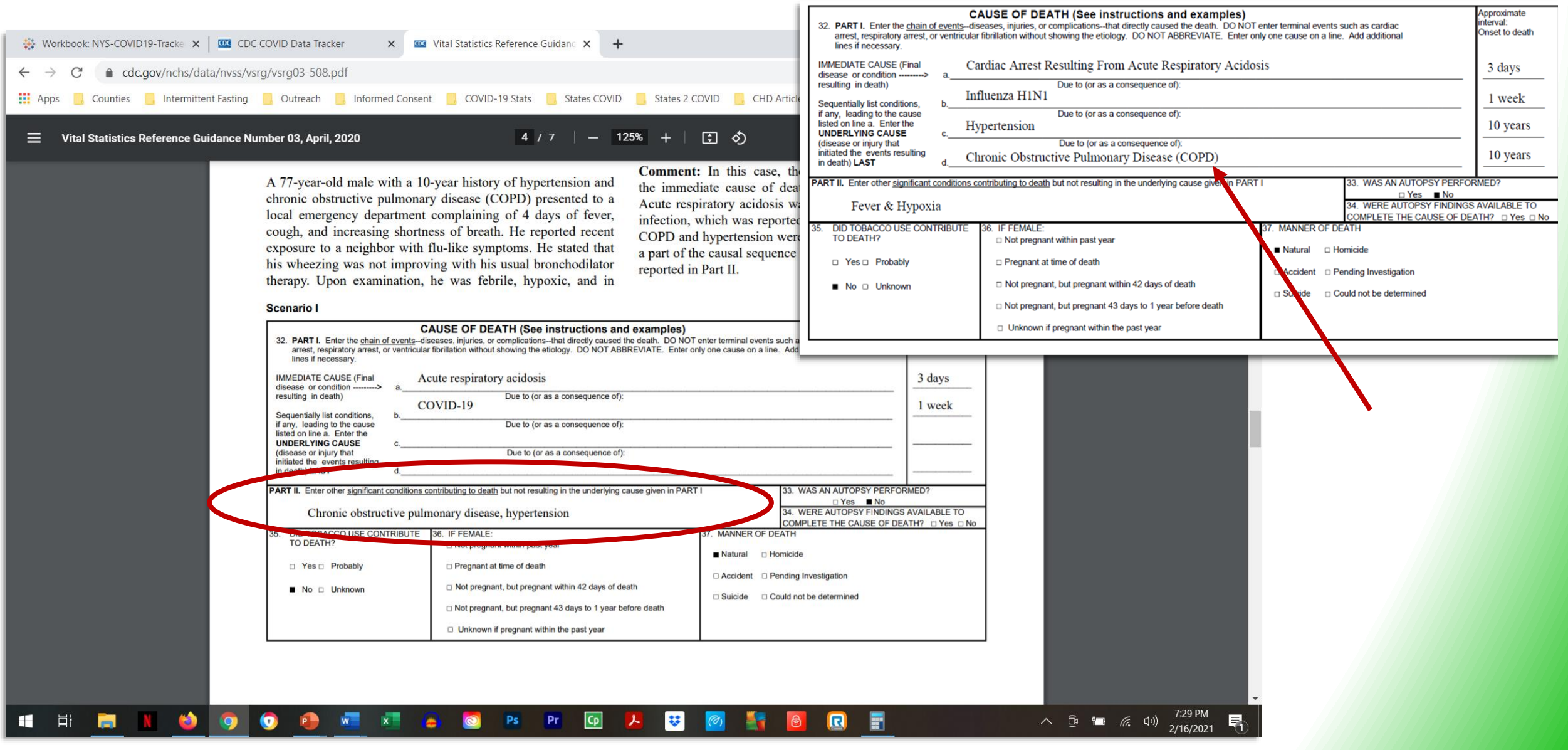
NVSS COVID-19 ALERT NO.2

HTTPS://WWW.CDC.GOV/NCHS/DATA/NVSS/CORONAVIRUS/ALERT-2-NEW-ICD-CODE-INTRODUCED-FOR-COVID-19-DEATHS.PDF



GUIDANCE FOR CERTIFYING DEATHS DUE TO COVID-19

HTTPS://WWW.CDC.GOV/NCHS/DATA/NVSS/VSRG/VSRG03-508.PDF



Workbook: NYS-COVID19-Tracke | CDC COVID Data Tracker | Vital Statistics Reference Guidanc

cdc.gov/nchs/data/nvss/vsrg/vsrg03-508.pdf

Apps | Counties | Intermittent Fasting | Outreach | Informed Consent | COVID-19 Stats | States COVID | States 2 COVID | CHD Article

Vital Statistics Reference Guidance Number 03, April, 2020 — 4 / 7 — 125%

A 77-year-old male with a 10-year history of hypertension and chronic obstructive pulmonary disease (COPD) presented to a local emergency department complaining of 4 days of fever, cough, and increasing shortness of breath. He reported recent exposure to a neighbor with flu-like symptoms. He stated that his wheezing was not improving with his usual bronchodilator therapy. Upon examination, he was febrile, hypoxic, and in

Comment: In this case, th
the immediate cause of dea
Acute respiratory acidosis w
infection, which was reporte
COPD and hypertension wer
a part of the causal sequence
reported in Part II.

Scenario I

CAUSE OF DEATH (See instructions and examples)

32. **PART I.** Enter the chain of events--diseases, injuries, or complications--that directly caused the death. DO NOT enter terminal events such a
arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add
lines if necessary.

		Approximate interval: Onset to death
IMMEDIATE CAUSE (Final disease or condition ---------> resulting in death)	a. Acute respiratory acidosis	3 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the **UNDERLYING CAUSE** (disease or injury that initiated the events resulting in death) **LAST**	b. COVID-19	1 week
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I

Chronic obstructive pulmonary disease, hypertension

33. WAS AN AUTOPSY PERFORMED? ☐ Yes ■ No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

35. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ■ No ☐ Unknown

36. IF FEMALE: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year

37. MANNER OF DEATH ■ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined

CAUSE OF DEATH (See instructions and examples)

32. **PART I.** Enter the chain of events--diseases, injuries, or complications--that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

		Approximate interval: Onset to death
IMMEDIATE CAUSE (Final disease or condition ---------> resulting in death)	a. Cardiac Arrest Resulting From Acute Respiratory Acidosis	3 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the **UNDERLYING CAUSE** (disease or injury that initiated the events resulting in death) **LAST**	b. Influenza H1N1	1 week
	Due to (or as a consequence of):	
	c. Hypertension	10 years
	Due to (or as a consequence of):	
	d. Chronic Obstructive Pulmonary Disease (COPD)	10 years

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I

Fever & Hypoxia

33. WAS AN AUTOPSY PERFORMED? ☐ Yes ■ No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

35. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ■ No ☐ Unknown

36. IF FEMALE: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year

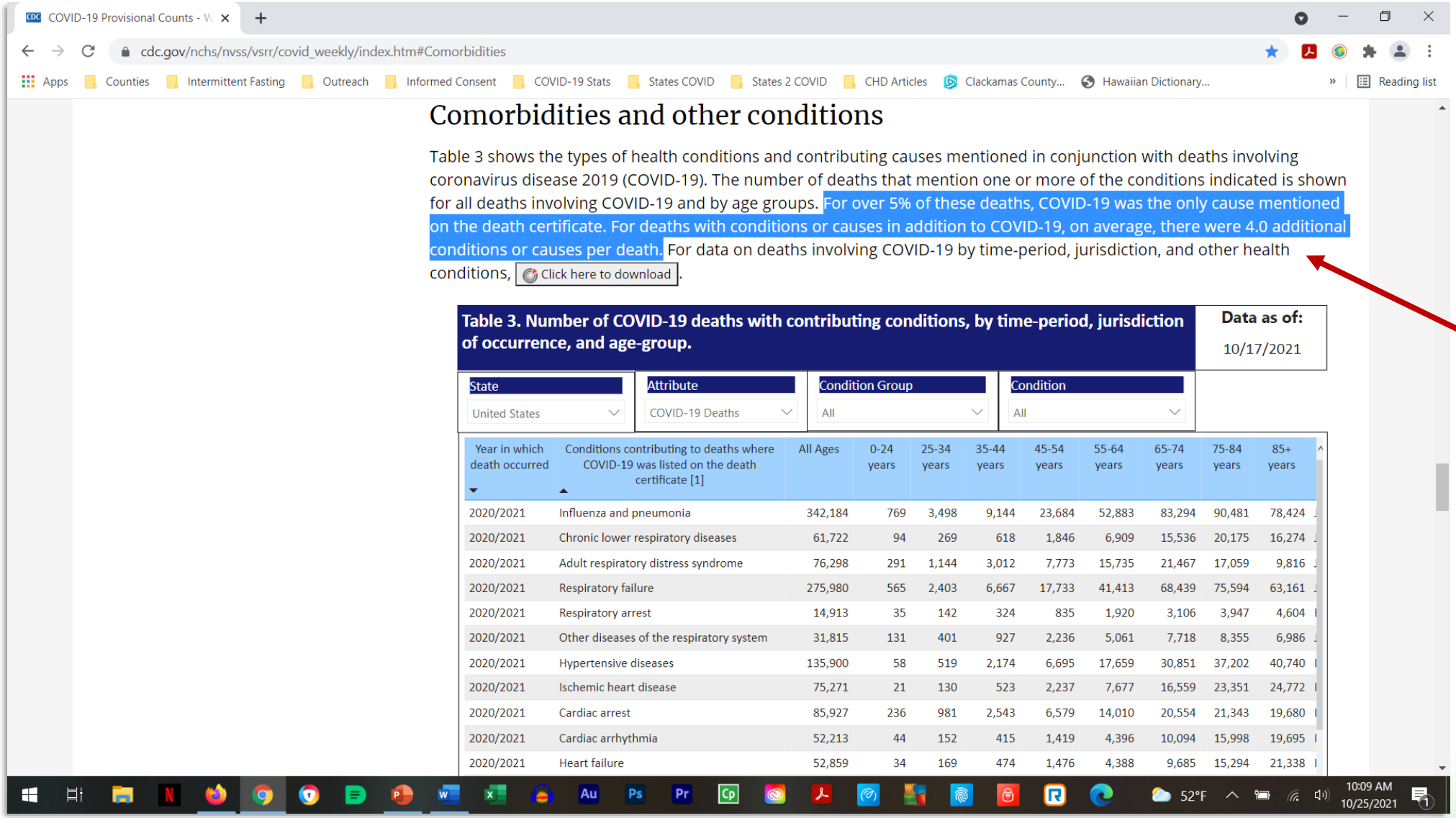
37. MANNER OF DEATH ■ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined

7:29 PM 2/16/2021

WHAT PERCENTAGE OF DEATH CERTIFICATES HAD SIGNIFICANT COMORBIDITIES?

94% OF ALL DEATH CERTIFICATES HAD 4.0 COMORBIDITIES ON AVERAGE

HTTPS://WWW.CDC.GOV/NCHS/NVSS/VSRR/COVID_WEEKLY/INDEX.HTM#COMORBIDITIES



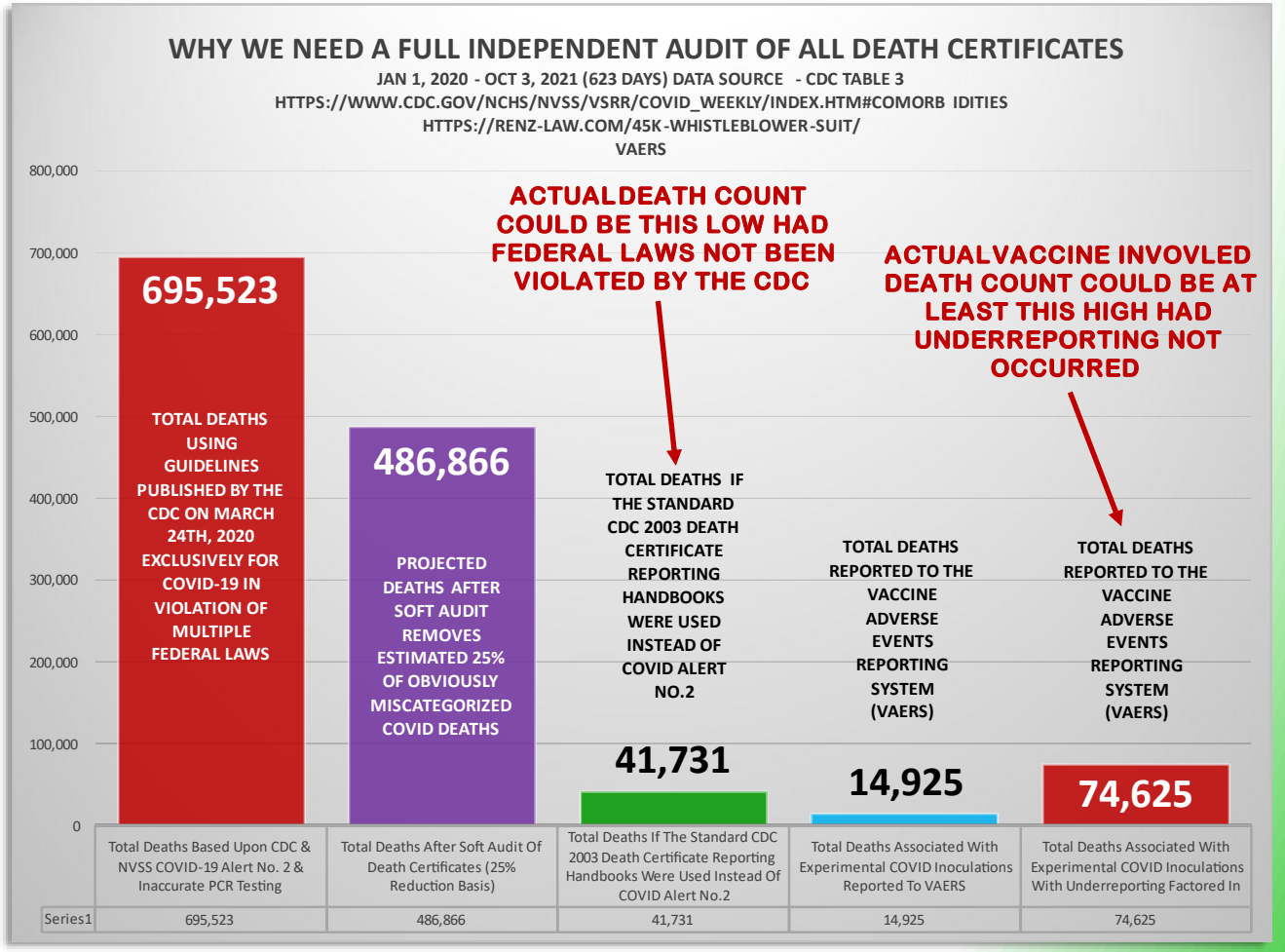
IS THE DEATH COUNT ACCURATE?

WHICH NUMBER IS ACCURATE?

- How Many Deaths Were **Caused** By COVID?
- How Many Deaths Did COVID **Contribute** To?
- How Many Deaths Were Due To Comorbidities **Initiated By** COVID?
- Currently We Don't Know, They're All Grouped Together And As Of Dec 13th Can Include **COVID Vaccine Induced Fatalities** As Well.
- We Need A Full **Independent Audit** With Health Histories & PCR Results & Vaccine History.

- In June of 2021, the Santa Clara County California public health department performed a 'soft' audit of death certificate records where COVID was listed as the cause of death and found that the data was hyperinflated by 22%.

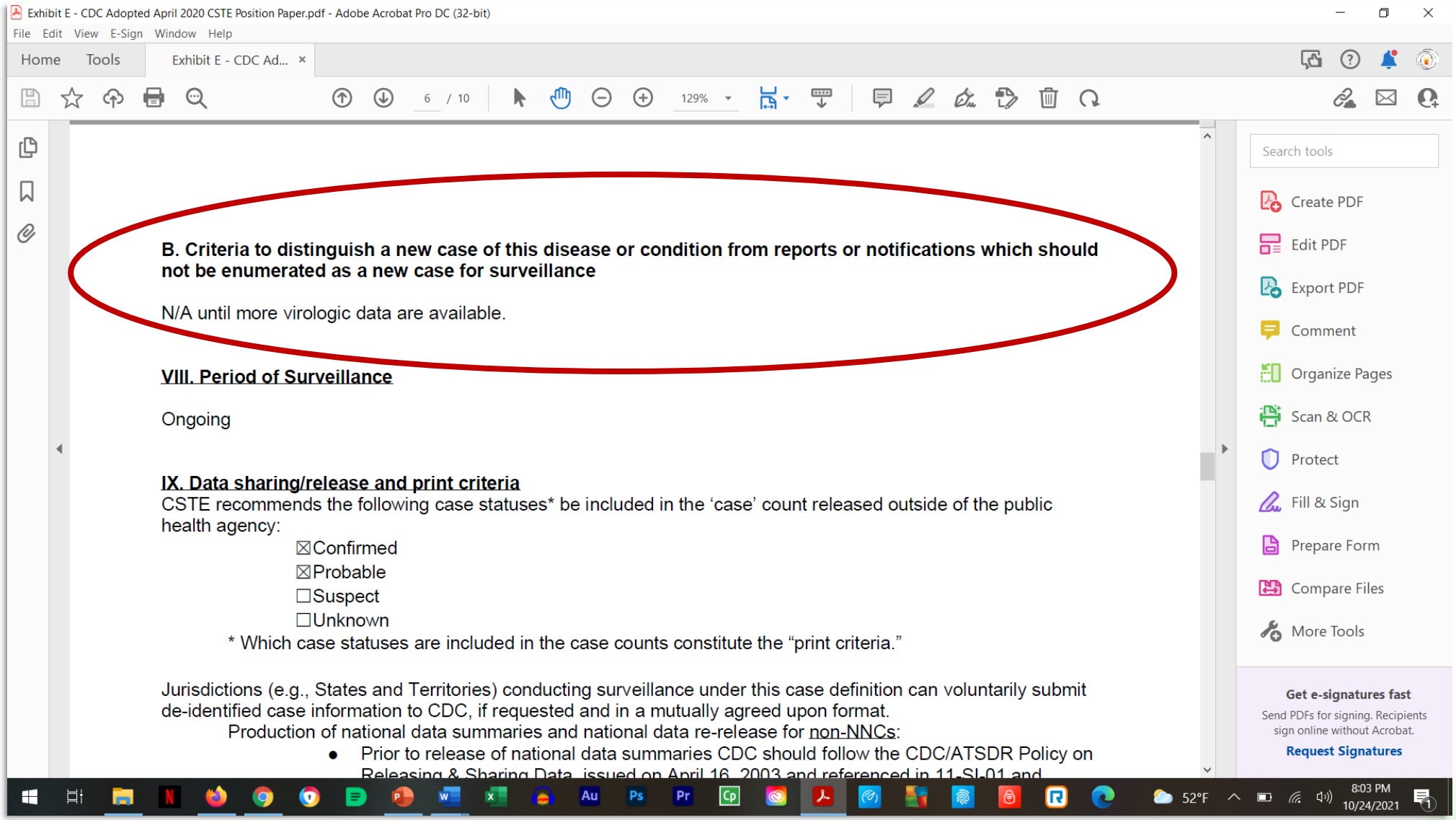
- In July of 2021, the Alameda County California public health department performed a 'soft' audit of death certificate records where COVID was listed as the cause of death and found that the data was hyperinflated by 25%.



WHAT STEPS WERE TAKEN TO ENSURE THE SAME PERSON COULDN'T BE COUNTED MULTIPLE TIMES?

CSTE POSITION PAPER – ADOPTED BY CDC APRIL 14, 2020

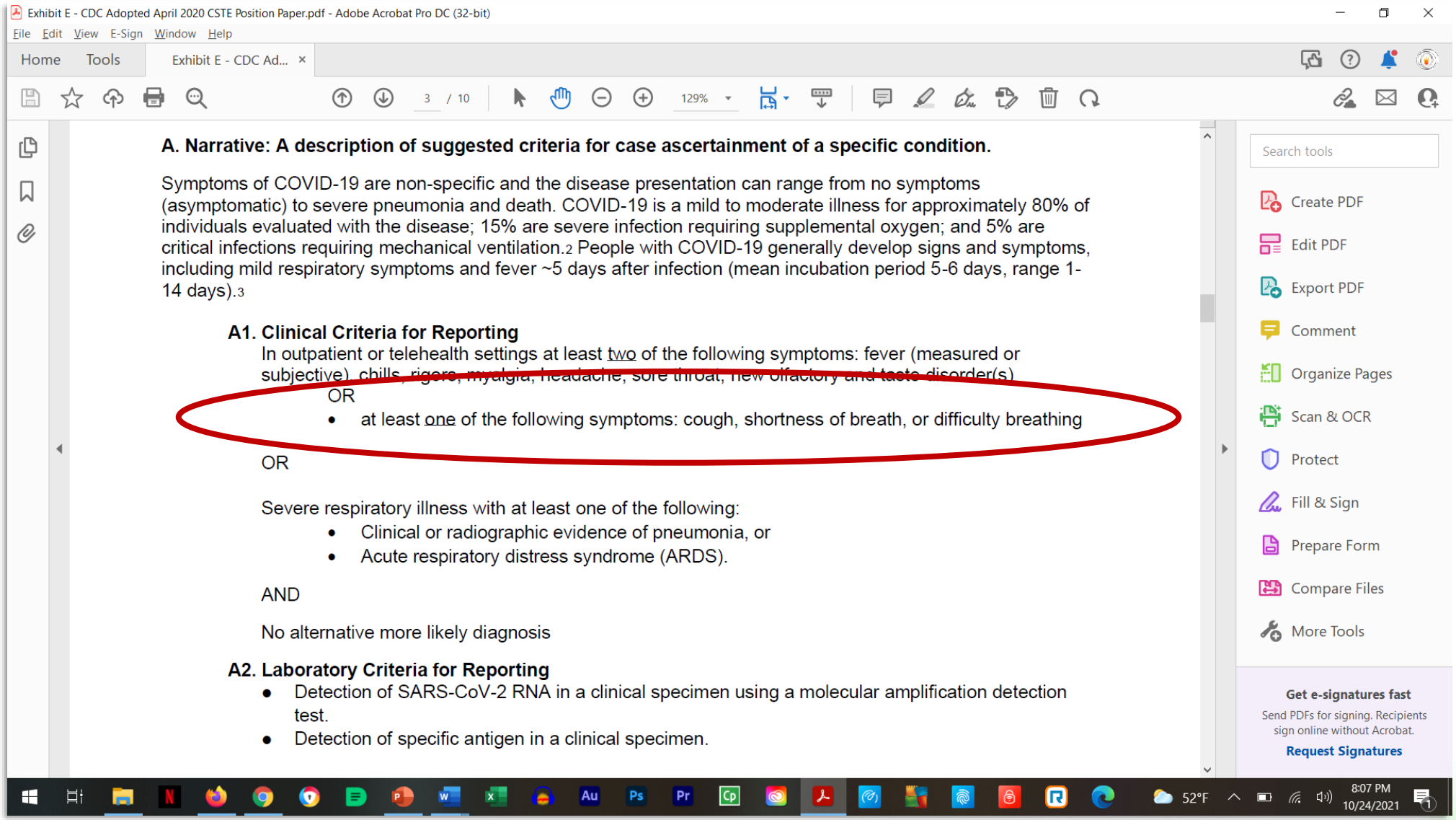
HTTPS://CDN.YMAWS.COM/WWW.CSTE.ORG/RESOURCE/RESMGR/2020PS/INTERIM-20-ID-01_COVID-19.PDF



WHAT WAS THE MINIMAL SYMPTOM PRESENTATION NECESSARY IN ORDER TO BE CLASSIFIED AS COVID POSITIVE?

CSTE POSITION PAPER – ADOPTED BY CDC APRIL 14, 2020

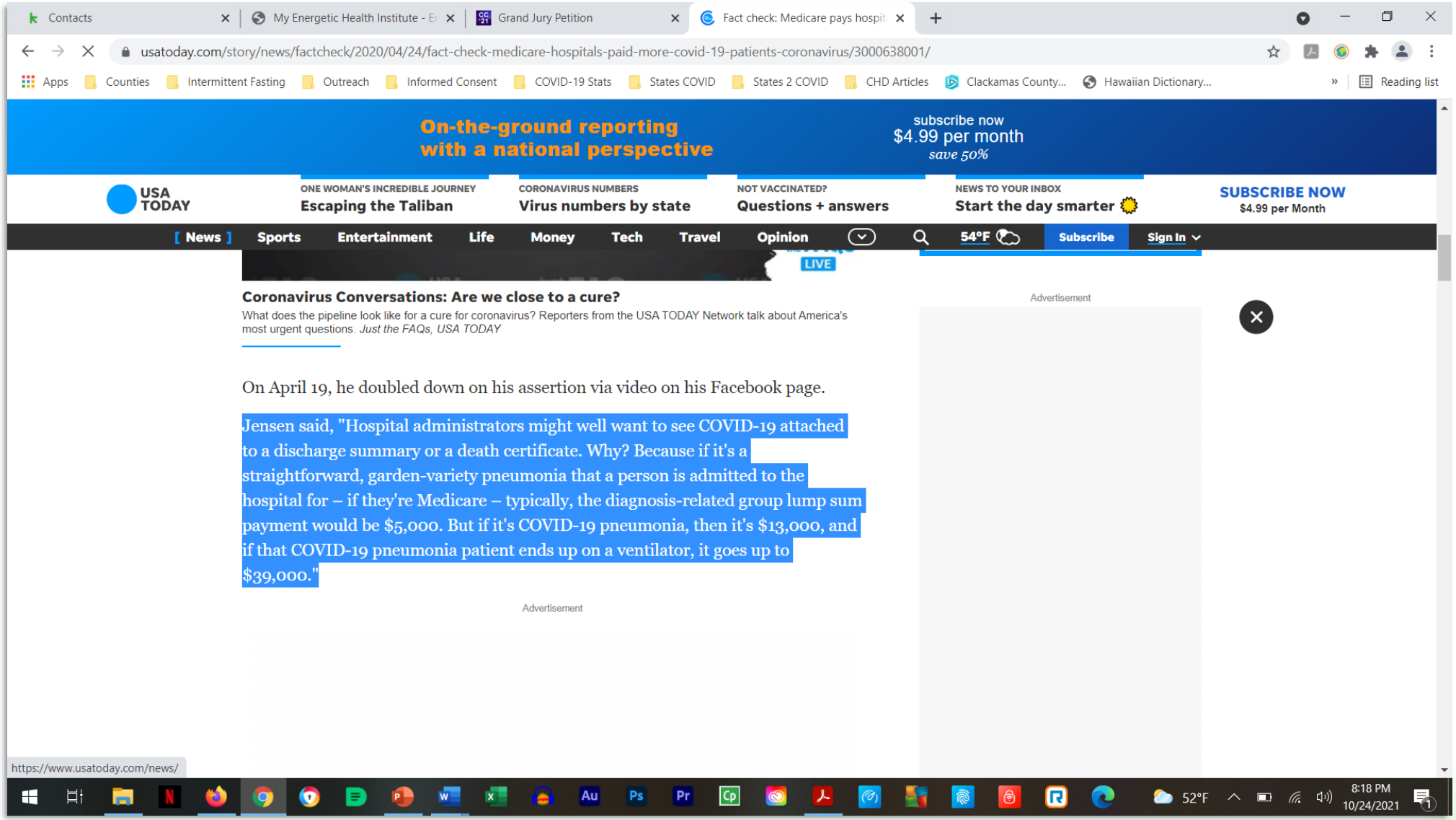
HTTPS://CDN.YMAWS.COM/WWW.CSTE.ORG/RESOURCE/RESMGR/2020PS/INTERIM-20-ID-01_COVID-19.PDF



WAS THE HYPERINFLATION OF DATA FINANCIALLY INCENTIVIZED?

YES, COVID DIAGNOSIS WAS FINANCIALLY INCENTIVIZED

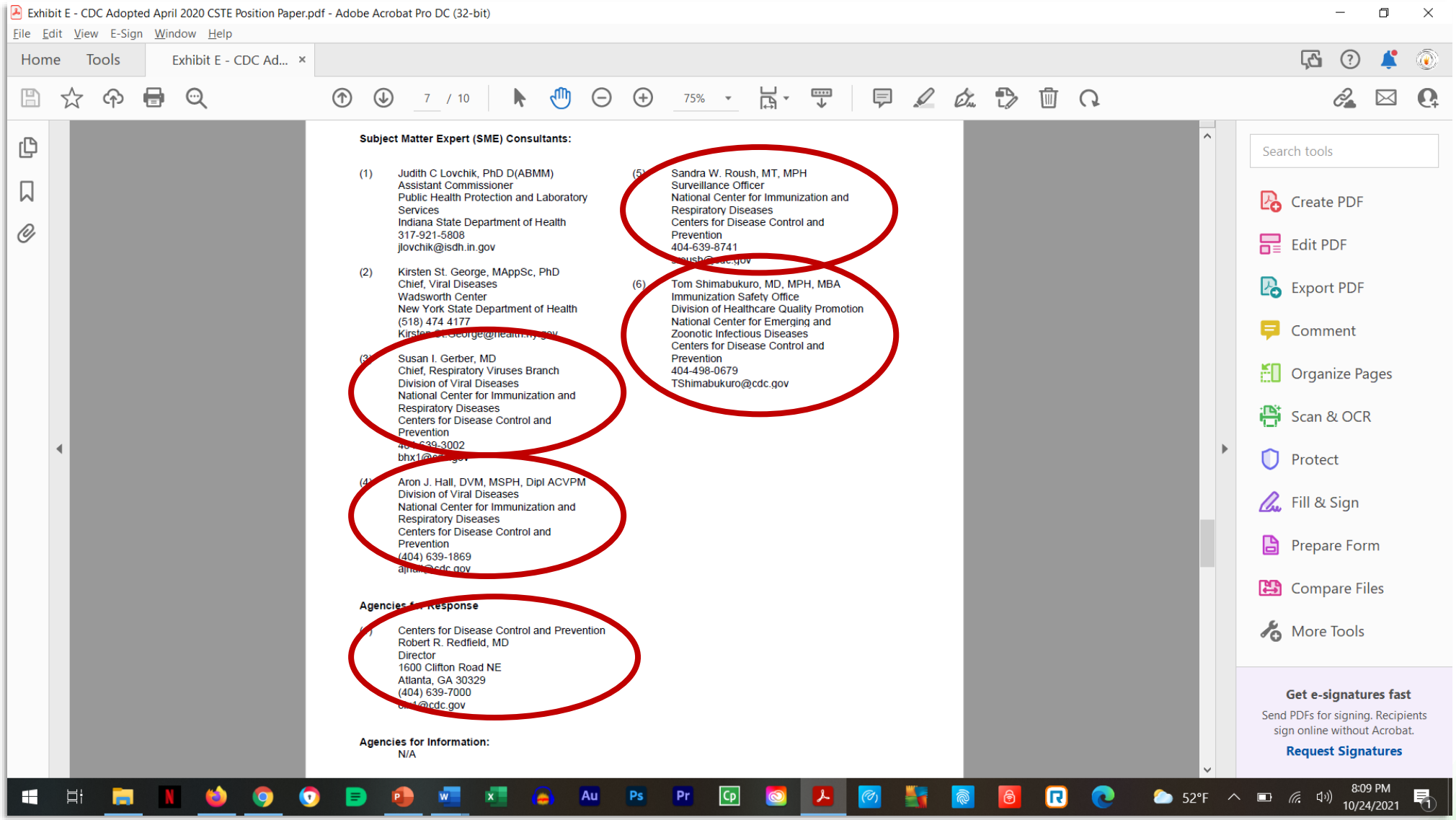
HTTPS://WWW.USATODAY.COM/STORY/NEWS/FACTCHECK/2020/04/24/FACT-CHECK-MEDICARE-HOSPITALS-PAID-MORE-COVID-19-PATIENTS-CORONAVIRUS/3000638001/



WHO WERE THE SUBJECT MATTER EXPERTS ADVISING THE CSTE?

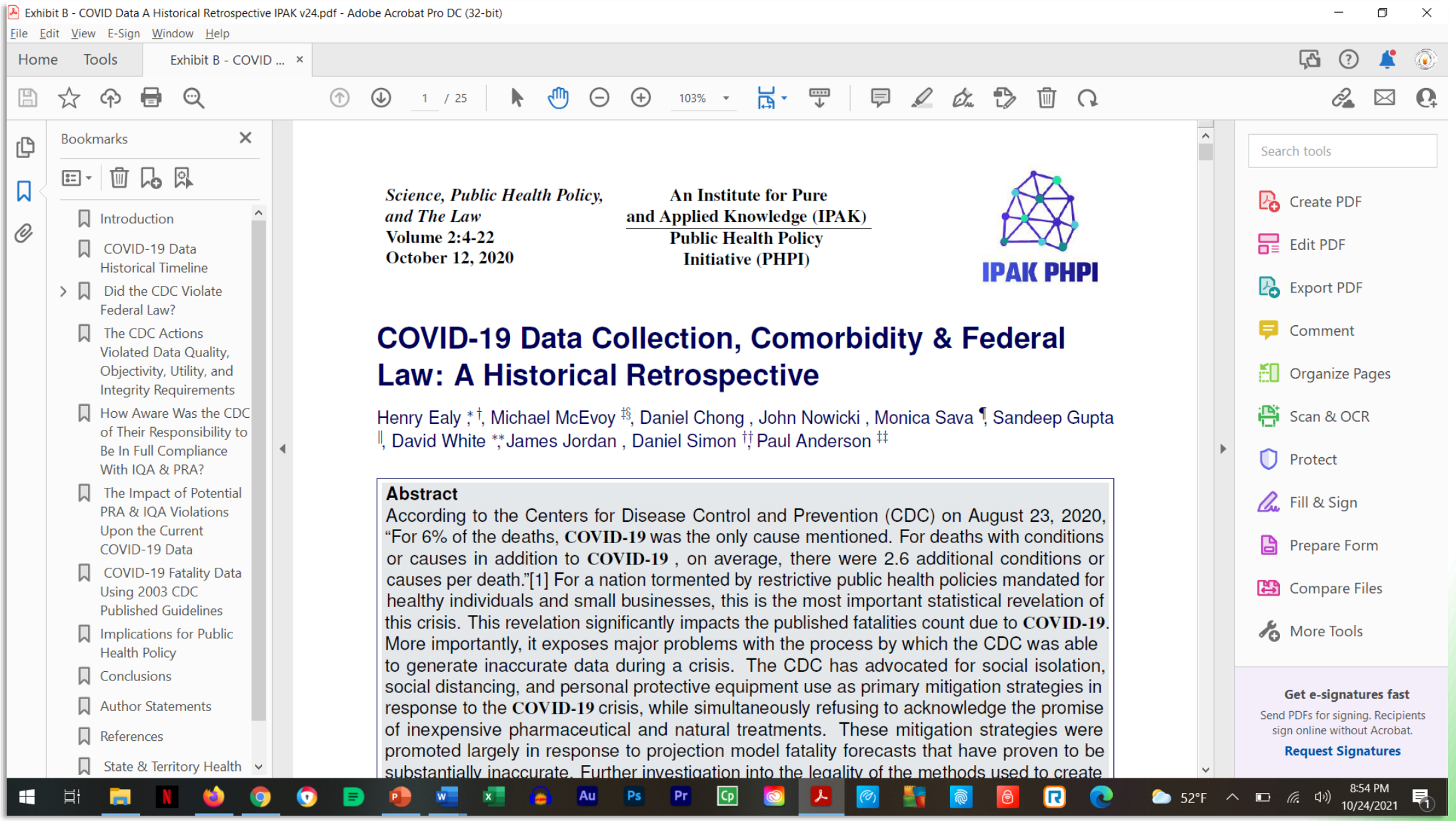
CSTE POSITION PAPER – ADOPTED BY CDC APRIL 14, 2020

HTTPS://CDN.YMAWS.COM/WWW.CSTE.ORG/RESOURCE/RESMGR/2020PS/INTERIM-20-ID-01_COVID-19.PDF



HAVE OUR FINDINGS SURVIVED PEER-REVIEW?

YES, THESE FINDINGS HAVE



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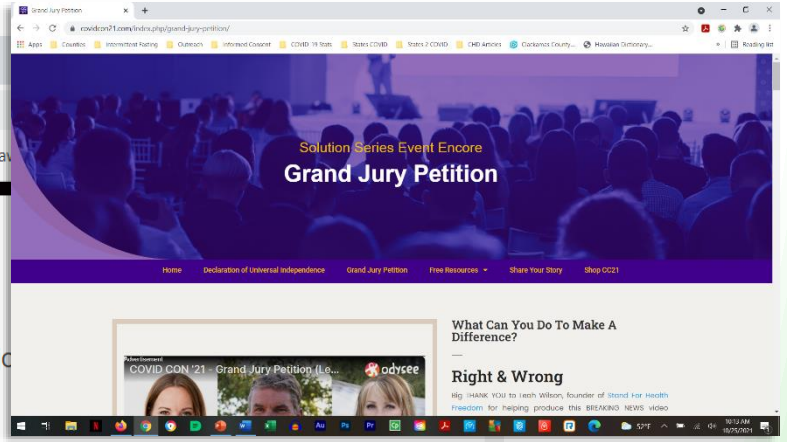
WHAT'S BEING DONE?

GRAND JURY PETITION FILED



Grand Jury Petition

covidcon21.com/index.php/grand-jury-petition/

Apps | Counties | Intermittent Fasting | Outreach | Informed Consent | COVID-19 Stats | States COVID | States 2 COVID | CHD Articles | Clackamas County...

AUDIT EVERY DEATH CERTIFICATE

In October 2020, COVID-19 Data Collection, Comorbidity & Federal Law: A Historical Retrospective was published in the jc
Health Policy Initiative by the Institute for Pure and Applied Knowledge.

In March of 2021, the COVID research team took the liberty of collecting, organizing, and publishing hundreds of references in this wide-ranging, peer-reviewed magnum opus, COVID-19: Restoring Public Trust During A Health Crisis. The peer-reviewed scientific literature and clinical evidence overwhelmingly demonstrates that asymptomatic transmission is a failed theory, PCR testing is fatally flawed, evidence-based treatments exist, projection models have been massively inaccurate, clinical trials for the experimental biologics have not demonstrated safety or effectiveness, and that the greatest freedoms under assault are compassion, love, and moral courage in medicine.

In June of 2021, the Santa Clara County California public health department performed a 'soft' audit of death certificate records where COVID was listed as the cause of death and found that the data was hyperinflated by 22%.

In July of 2021, the Alameda County California public health department performed a 'soft' audit of death certificate records where COVID was listed as the cause of death and found that the data was hyperinflated by 25%.

Soft audits of death certificates entail removing obvious reporting inaccuracies such as car accidents, physical accidents, etc. being counted as COVID caused deaths.

Full audits of death certificates, **which my research team has been calling for for more than a year**, entail a review of full medical records, including any autopsy results, so the cause of death can be definitively confirmed.

52°F 10:14 AM 10/25/2021

HTTPS://WWW.COVIDCON21.COM/INDEX.PHP/GRAND-JURY-PETITION/

WHAT ARE THE GAIN OF BENEFIT VS RISK OF INJURY STATISTICS FOR THE EXPERIMENTAL INOCULATIONS?

RISK VS BENEFIT ANALYSIS

COVID-19 US Risk vs Benefit Analysis By Age - GREEN = Low Risk, RED = High Risk, BLUE = Only Demographics That Should Be Experimental Inoculation Eligible

Data Source CDC COVID Data Tracker - Thru Aug 22, 2021 SARS-CoV-2 Infection Data						Data Source CDC COVID Data Tracker & VAERS - Thru Aug 13, 2021 Experimental Inoculation Data					
Demographic	Cases[1]	Deaths[2]	Recoveries[3]	Recovery Rate	Gain of Benefit	Demographic	People Inoculated	Reported Injuries[4]	Reported Deaths[5]	Risk Of Injury	Risk vs Benefit[6]
Age 0 to 4	664,936	147	641,542	99.978%	0.022%	Age <12	200,375	208	3	0.104%	4.7 Times Greater Risk Than Benefit Age <12
Age 5 to 17	3,201,308	324	3,089,064	99.990%	0.010%	Age 12 to 17	11,354,161	17,887	18	0.158%	15.8 Times Greater Risk Than Benefit Age 12 to 17
Age 18 to 39	11,677,068	9,709	11,259,122	99.917%	0.083%	Age 18 to 39	54,110,388	150,702	299	0.279%	3.4 Times Greater Risk Than Benefit Age 18 to 39
Age 40 to 49	4,387,635	16,211	4,218,030	99.631%	0.369%	Age 40 to 49	26,233,660	86,083	282	0.328%	Almost Equivical Risk To Benefit
Age 50 to 64	5,908,030	80,606	5,620,876	98.636%	1.364%	Age 50 to 64	46,591,119	124,430	1,176	0.267%	5.1 Times Greater Benefit Than Risk Age 50 to 64
Total 0 to 64	25,838,977	106,997	24,828,635	99.586%	0.414%	Total 0 to 64	138,489,703	379,310	1,778	0.274%	-----
Age 65 to 74	2,163,251	112,284	1,975,339	94.81%	5.191%	Age 65 to 74	27,749,040	84,628	2,730	0.181%	28.7 Times Greater Benefit Than Risk Age 65 to 74
Age 75+	1,735,001	300,605	1,373,739	82.67%	17.326%	Age 75+	18,994,427	24,212	3,604	0.069%	251.1 Times Greater Benefit Than Risk Age 75+
Total 65 & Over	3,898,252	412,889	3,349,078	89.41%	10.592%	Unknown Age	16,192,615	107,472	4,946	0.049%	-----
Total	29,737,229	519,886	28,177,713	98.25%	1.748%	Total	201,425,785	595,622	13,058	0.296%	-----

Data Source Cases, Fatalities, People Inoculated - NVSS Published By CDC - https://covid.cdc.gov/covid-data-tracker

Data Source Reported Injuries - VAERS By CDC - https://wonder.cdc.gov/ - Data Processed Through Aug 13th, 2021

1 - Data Published from Jan 1st, 2020 to Aug 22, 2021 (595 Days). Typically Data Collection Is Reset Every Jan 1st. That Has Not Happened For COVID Data

2 - Deaths May Include Some People Who Died Due To Experimental COVID Inoculation As Well As Some People Who Were Incorrectly Categorized As A COVID Death

3 - Recoveries Are Estimates Based Upon CDC Guidelines For 10 Days & Current Death & Current Hospitalization Data. Recoveries = Cases 10 Days Prior - Current Hospitalizations - Current Deaths

4 - Reported Injuries From VAERS Do Not Match Each COVID Data Tracker By Age Demographics. Age 65 to 74 Includes VAERS Data Age 65 to 79, Age 75+ Includes VAERS Data Age 80+.

5 - Reported Deaths To VAERS Does Not Include The More Than 1,505 Spontaneous Miscarriages Related To The Experimental COVID Inoculations As Of Aug 13, 2021.

6 - Children Under 12 Years of Age Are Not Authorized To Receive The Experimental Inoculations, but 195,577 Already Have According To the CDC. Inoculation Data Is Insufficient Currently To Gain A Complete Picture Of Risk.

STATISTICALLY SPEAKING, IS THIS AN EMERGENCY FOR EVERYONE OR AN EMERGENCY FOR THE HIGH-RISK?

NATIONAL - RECOVERY RATES

Is This An Emergency? Data Source CDC COVID Data Tracker - Thru Oct 6, 2021					
Demographic	Cases[1]	Deaths[2]	% Of Deaths	Recoveries[3]	Recovery Rate
Age 0 to 4	847,589	214	0.04%	822,166	99.97%
Age 5 to 17	4,160,595	444	0.08%	4,036,408	99.99%
Age 18 to 39	13,324,287	12,244	2.14%	12,915,758	99.91%
Age 40 to 49	5,015,543	20,188	3.52%	4,846,185	99.60%
Age 50 to 64	6,656,629	93,783	16.37%	6,364,868	98.59%
Total 0 to 64	30,004,643	126,873	22.14%	28,985,385	99.58%
Age 65 to 74	2,458,058	124,808	21.78%	2,260,144	94.92%
Age 75+	1,931,204	321,335	56.08%	1,552,432	83.36%
Total 65 & Over	4,389,262	446,143	77.86%	3,812,576	89.84%
Total	34,393,905	573,016		32,797,961	98.33%

Data Source Cases, Fatalities, People Inoculated - NVSS Published By CDC - https://covid.cdc.gov/covid-data-tracker

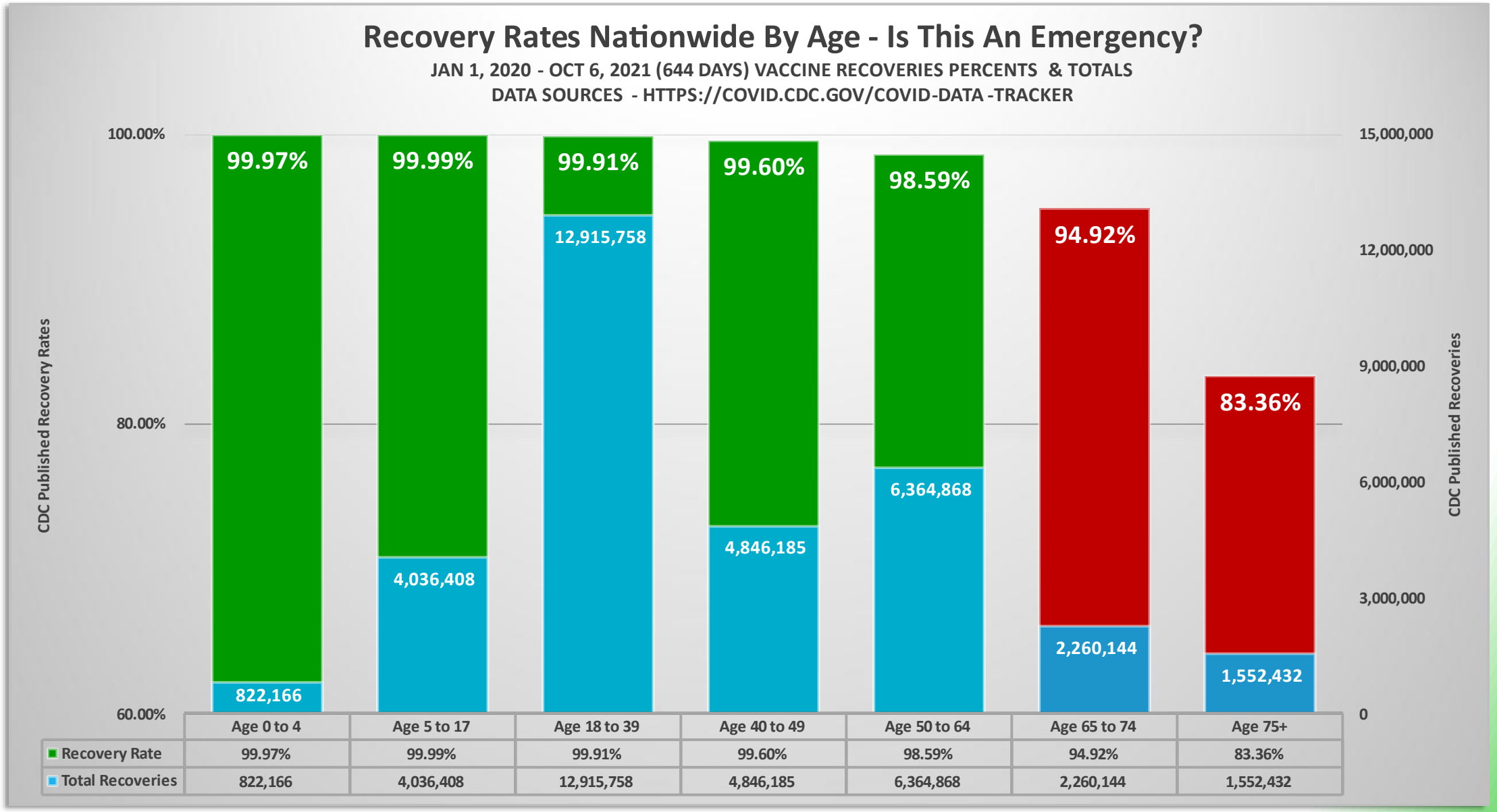
1 - Data Published from Jan 1st, 2020 to Oct 6, 2021 (644 Days). Typically Data Collection Is Reset Every Jan 1st. That Has Not Happened For COVID Data

2 - Deaths May Include Some People Who Died Due To Experimental COVID Inoculation As Well As Some People Who Were Incorrectly Categorized As A COVID Death

3 - Recoveries Are Calculated By Subtracting An Age Demographic Estimate Of New Cases OverThe Previous 10 Days, The Number Of Hospitalizations & the Number Of Deaths From Total Published Cases

According to the Centers for Disease Control and Prevention (CDC) on August 23, 2020, ***"For 6% of the deaths, COVID-19 was the only cause mentioned. For deaths with conditions or causes in addition to COVID-19, on average, there were 2.6 additional conditions or causes per death."***
According to the Centers for Disease Control and Prevention (CDC) on October 3, 2021, ***"For Over 5% of the deaths, COVID-19 was the only cause mentioned. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death."***

NATIONAL - RECOVERY RATES



WHILE PCR SHOULD NEVER BE USED DIAGNOSTICALLY, WHAT SHOULD THE CYCLE THRESHOLD HAVE BEEN SET TO?

PROPOSED PCR DIAGNOSTIC

PROPOSAL FOR CALIBRATING COVID RT-qPCR TESTING BASED UPON VIRAL REPLICATION-COMPETENCE

DIAGNOSTIC INTERPRETATION	CYCLE THRESHOLD	PROPOSED ACTION
Infectious	< 25.00	Quarantine/Isolation Until No Longer Symptomatic + 2 Days. Administration Of Evidence-Based Nutritional Guidance. Retest Serologic Antibodies To Confirm (+ IgG, - IgM).
Possibly Infectious	25.00 - 33.99	Confirmatory Lab Testing. Serologic Antigen Or Live Human Cell Culture. Quanantine/Isolation Until Confirmed. Administration Of Evidenced-Based Nutritional Guidance As Precaution.
Not Infectious	≥ 34.00	Recommendation Of Evidence-Based Nutritional Guidance As Precaustion.

Oxford Academic (Jefferson) - https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1764/6018217

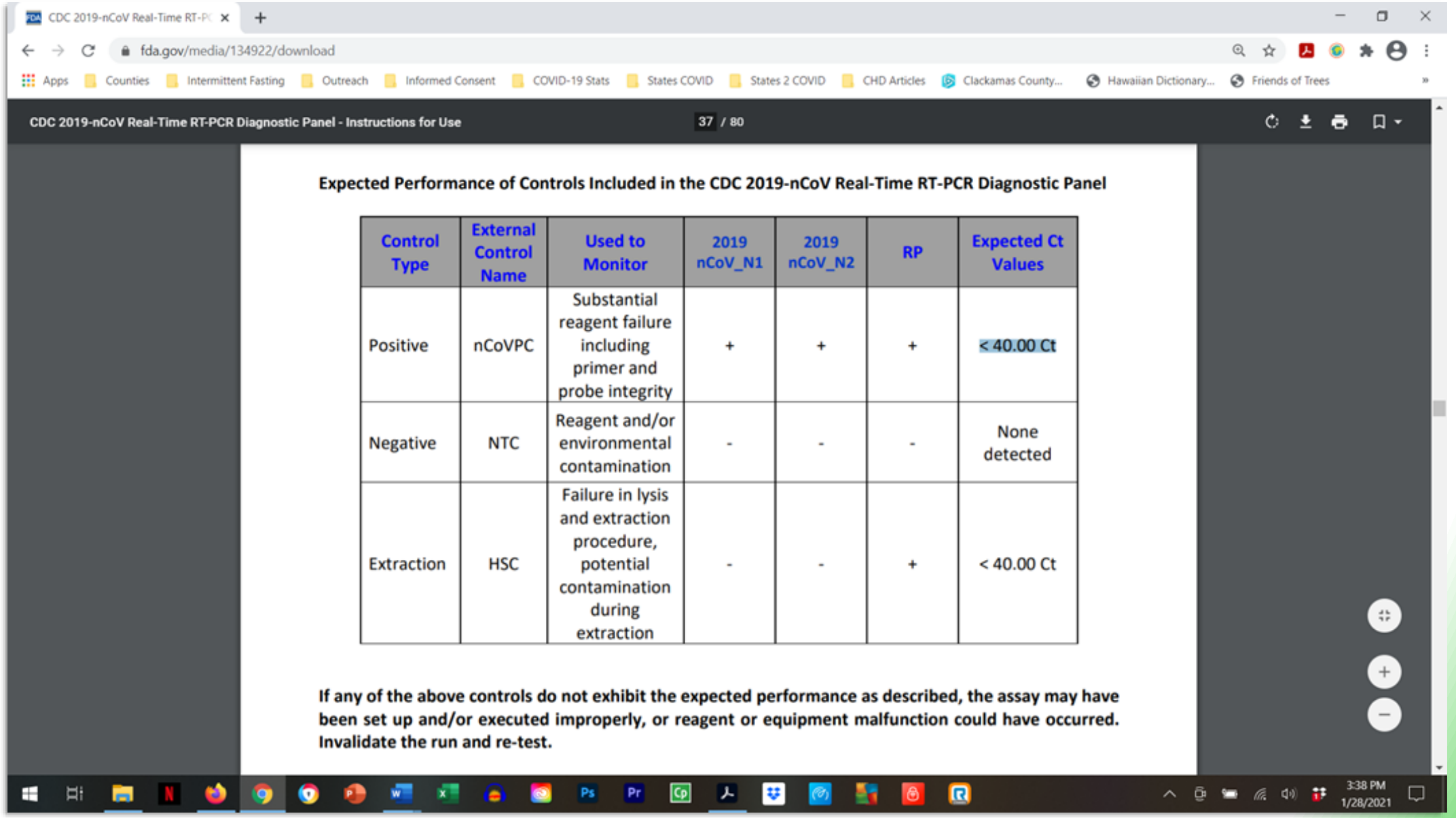
NEMJ Hospital Study - https://www.nejm.org/doi/full/10.1056/NEJMc2027040

Caco-2 Cell Human Cell Line Infectiveness - https://pubmed.ncbi.nlm.nih.gov/32966582/

VERO Monkey, HUH7.0 Human, 293T Human Cell Line Infectiveness - https://wwwnc.cdc.gov/eid/article/26/6/20-0516_article

WHAT IS THE CYCLE THRESHOLD SET TO AND HOW LONG HAS IT BEEN SET TO THIS LEVEL?

CT < 40.00 = POSITIVE



IS THERE EMPIRICAL EVIDENCE SUPPORTING NUTRITION FOR PREVENTION & EARLY TREATMENT?

LINUS PAULING INSTITUTE - OSU

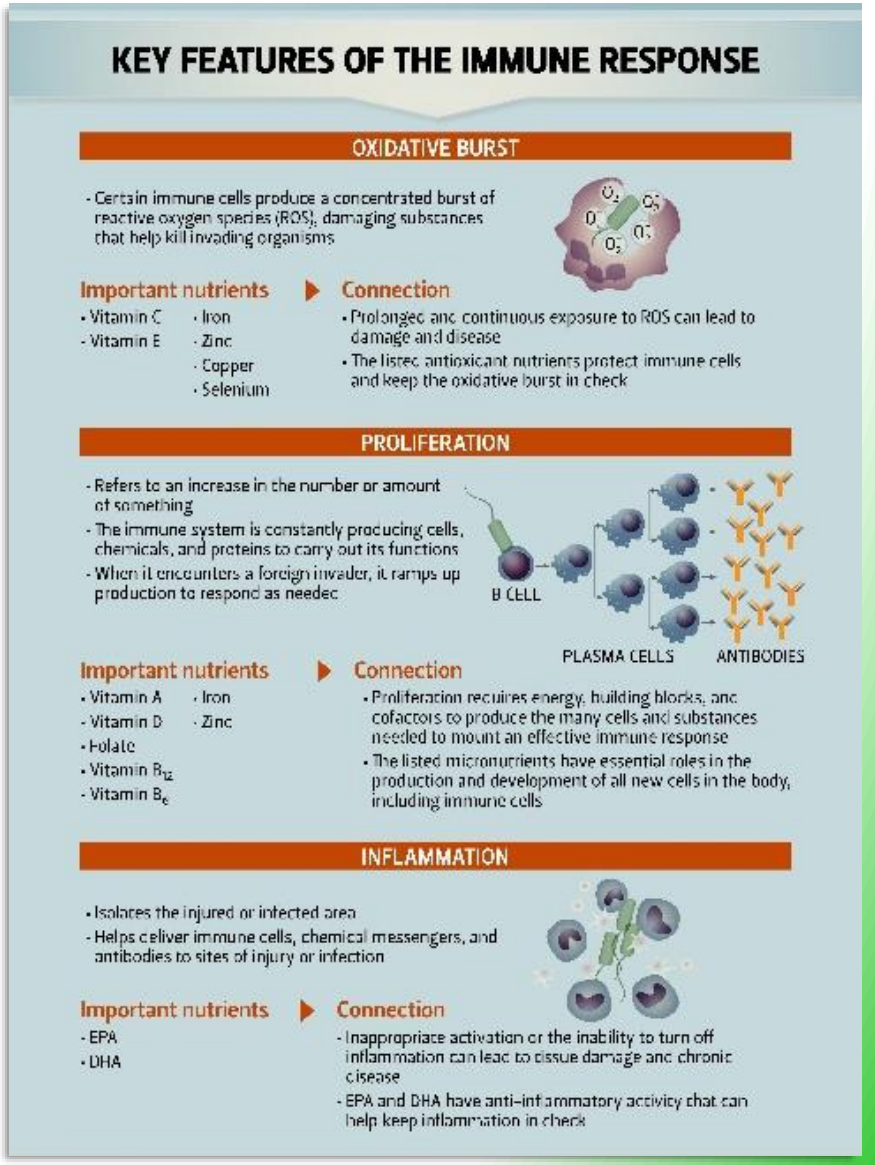
- Premier Nutrient Research Center in the US
- 267 Peer-Reviewed References for Nutrition and Natural Adaptive Immunity Alone

Key Nutrients

- Vitamin A
- Vitamin C
- Vitamin D
- Vitamin E
- Zinc
- Iron, Selenium
- Omega 3 Fatty Acids
- Mitochondrial Nutrients (B-Complex)

- https://lpi.oregonstate.edu/mic/health-disease/immunity
- https://lpi.oregonstate.edu/sites/lpi.oregonstate.edu/files/lpi-immunity-infographic.pdf

- Section 9 - Vitamins modulating the immune system during COVID-19
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7547582/#s0045title



NHANES STUDIES SUMMARY – **THRU 2004**

- **All NHANES Data Is Published By The CDC**
- National Health And Nutrition Examination Survey (NHANES)
- Serologic Nutrient Studies Confirming Extensive Nutrient Deficiencies In Americans For Decades

NHANES Key Results

- **Vitamin A** – 44% of Americans had inadequate dietary intakes of RDA 700-900micrograms/day (2,333- 3,000 IU/day).
- **Vitamin C –** 31% of Americans had inadequate dietary intakes of RDA 75-90mg/day.
    - 2002, 21 Million Americans have serious Vitamin C deficiency, and 66 million more will develop serious deficiency including smokers/vapers and citizens in low-income groups.
- **Vitamin D** – 66% of Americans had inadequate dietary intakes of RDA 600-800 IU/day and Vitamin D requirements increase in all people over 70 years of age. Most Americans over 50 years of age regardless of gender did not meet minimal daily intakes.
- **Vitamin E** – 93% of Americans had inadequate dietary intakes of RDA 15mg/day (22 IU/day).
- **Zinc:** NHANES III data: 35%–45% of adults aged 60 years or older had zinc intakes below the estimated average requirement of 6.8 mg/day for elderly females and 9.4 mg/day for elderly males. When the investigators considered intakes from both food and dietary supplements, they found that 20%–25% of older adults still had inadequate zinc intakes.
- **Lower Household Income** – Americans in lower income brackets consistently had a higher prevalence of inadequate intake of Vitamin A, Vitamin C, Vitamin B6, Folate. All nutrients essential for healthy natural adaptive immune response.

- https://www.nutri-facts.org/en_US/news/u-s---nhanes.html
- https://www.cdc.gov/nchs/nhanes/index.htm
- Schleicher R. L. et al. Serum vitamin C and the prevalence of vitamin C deficiency in the United States: 2003–2004 National Health and Nutrition Examination Survey (NHANES). Am J Clin Nutr, August 2009.
- https://ods.od.nih.gov/factsheets/Zinc-HealthProfessional/#en24

NHANES STUDIES SUMMARY – **2005 TO 2016**

Dietary Intake Only

Sample Size & Age of Participants

- **26,282 adults** (Age >19 years)

Study Findings: Dietary Inadequacies:

- **Vitamin A:** 45% of U.S. population does not meet dietary EAR (estimated average requirement)
  - Average Vitamin A Intake from Diet: 639ug (2,130 IU). EAR=700-900ug (2,333- 3,000 IU/day).
- **Vitamin C:** 46% of U.S. population does not meet dietary EAR (estimated average requirement)
  - Average Vitamin C Intake from Diet: 83mg. **Optimal Daily Intake = 200mg**
- **Vitamin D:** 95% of U.S. population does not meet dietary EAR (estimated average requirement)
  - Average Vitamin D Intake from Diet: 188 IU RDA = 600-800 IU
  - **(NOTE: Endocrine Society recommends 1,500-2,000 IU)**
- **Vitamin E:** 84% of U.S. population does not meet dietary EAR (estimated average requirement)
  - Average Vitamin E Intake from Diet: 9mg (13 IU). RDA = 15mg/daily (22 IU/day)
  - Recommendation for Older Adults For Immune Health: 134mg/daily (200 IU/day)
- **Zinc:** 15% of U.S. population does not meet dietary EAR (estimated average requirement)
  - Average Zinc Intake from Diet: 12mg. RDA = 8-11mg for healthy populations;
  - **Optimal Intake for Higher Risk Populations: 30mg**

1. Reider, C. A., Chung, R.-Y., Devarshi, P. P., Grant, R. W., & Hazels Mitmesser, S. (2020). Inadequacy of Immune Health Nutrients: Intakes in US Adults, the 2005–2016 NHANES. Nutrients, 12(6), 1735. doi:10.3390/nu12061735
2. Balz Frei, Ines Birlouez-Aragon, Jens Lykkesfeldt: Authors' perspective: What is the optimum intake of vitamin C in humans? Crit Rev Food Sci Nutr.2012;52(9):815-29. doi: 10.1080/10408398.2011.649149.
3. Simin Nikbin Meydani, Erin Diane Lewis, Dayong Wu; Perspective: Should Vitamin E Recommendations for Older Adults Be Increased? Advances in Nutrition, Volume 9, Issue 5, September 2018, Pages 533–543, https://doi.org/10.1093/advances/nmy035
4. Barnett, J.B.; Dao, M.C.; Hamer, et al. Effect of zinc supplementation on serum zinc concentration and T cell proliferation in nursing home elderly: A randomized, double-blind, placebo-controlled trial. Am. J. Clin. Nutr. 2016, 103, 942–951, doi:10.3945/ajcn.115.115188

NHANES NUTRIENT DATA: 2005-2016

NHANES NUTRITIONAL ANALYSIS STUDIES - SUMMARY

Nutrient	RDA/EAR/ODI	Adults 2005-2016	Nutritional Deficit For Minimum Requirements	% US Population Deficient*
Vitamin A	2,333-3,000 IU	2,130 IU	870 IU	35-45%
Vitamin C	75-200 mg	83 mg	117 mg	37-46%
Vitamin D	600-800 IU	188 IU	612 IU	65-95%
Vitamin E	22-200 IU	13 IU	187 IU	60-84%
Zinc	8-30 mg	12 mg	18 mg	11-15%

Data Source - NVSS Published By CDC - https://www.cdc.gov/nchs/nhanes/index.htm

*Low End Of Range Adjusted For Supplemental Nutrient Intake Plus Dietary Intake - Reider, C. A., Chung, R.-Y., Devarshi, P. P., Grant, R. W., & Hazels Mitmesser, S. (2020). Inadequacy of Immune Health Nutrients: Intakes in US Adults, the 2005–2016 NHANES. Nutrients, 12(6), 1735. doi:10.3390/nu12061735

Statistical Interpretation

- An Alarming & Statistically Significant Percentage of Adult **Americans Over 19 Years of Age are Nutritionally Deficient in Minimum Requirements for Key Nutrients** that Engage the Natural Adaptive Immune Response at the Cellular Level.
- Americans Deficient in these Key Nutrients, particularly Americans with Underlying Medical Conditions and at Advanced Age, are at **VERY HIGH-RISK for Prolonged Recovery Times, Adverse Events & Fatality** from ALL Respiratory Infections including, but not limited to the SARS-CoV-2 Virus.
- Addressing These Nutrient Deficiencies Are Key Factors In Developing Effective Treatments & Limiting the Spread of the SARS-CoV-2 Virus.
- **NUTRITIONAL GUIDANCE MUST BE ISSUED FOR ALL AMERICANS IMMEDIATELY (see later slides)**

VITAMIN D

- http://orthomolecular.activehosted.com/index.php?action=social&chash=b73ce398c39f506af761d2277d853a92.164&s=a3b8ba524fa5d84e9ad7899052087eb7

Key Results

- **Philippine Study** - With a deficient vitamin D status (<50nmol/L) the probability of becoming Severe or Critical with COVID-19 was 72.8% against 7.2% with adequate vitamin D (>75nmol/L).
- **Indonesian Study** - With a deficient vitamin D status (<50nmol/L) the mortality rate from COVID-19 was 98.8% against 4.1% with adequate vitamin D (>75nmol/L).
- 3 studies referenced show that a vitamin D3 blood level of at least 75 nmol/L (30 ng/ml) is needed for protection against COVID-19. Government recommendations for vitamin D intake - 600 IU/day for the USA (800 IU for >70 years) are based primarily on bone health. This is woefully inadequate in the pandemic context. An adult will need to take 4000 IU/day of vitamin D3 for 3 months to reliably achieve a 75 nmol/L level. Persons of color may need twice as much. These doses can reduce the risk of infection but are not for treatment of an acute viral infection. And since vitamin D is fat-soluble and its level in the body rises slowly, for those with a deficiency, **taking a initial [loading] dose of 5-fold the normal dose (20,000 IU/day) for 2 weeks can help to raise the level up to an adequate level to lower infection risk**.

Other essential nutrients can help

- As mentioned above, many studies have shown that for those deficient in essential nutrients, a protocol that includes vitamin D, vitamin C, magnesium, and zinc can decrease the risk of infection for viruses, including those similar to COVID-19.[1] **Recommended preventive adult doses are vitamin C, 3000 mg/day (in divided doses, to bowel tolerance), magnesium, 400 mg (in malate, citrate, or chloride form), zinc, 20 mg.** [1]

VITAMIN D, MAGNESIUM, B12

- https://www.medrxiv.org/content/10.1101/2020.06.01.20112334v2

Methods

- Cohort observational study of all consecutive hospitalized COVID-19 patients aged 50 and above in a tertiary academic hospital who received DMB compared to a recent cohort who did not. Patients were administered **oral vitamin D3 1000 IU OD, magnesium 150mg OD and vitamin B12 500mcg OD (DMB)** upon admission if they did not require oxygen therapy.

Conclusions

- DMB combination in older COVID-19 patients was associated with a **significant reduction in proportion of patients with clinical deterioration requiring oxygen support and/or intensive care support**.

VITAMIN D

- https://www.grassrootshealth.net/wp-content/uploads/2020/04/Grant-GRH-Covid-paper-2020.pdf?fbclid=IwAR1On0EDZ_Nb6xTBWGjztDhx7PhmENIjlIAGlp9ZRWEalmoAE2geBBca5ww
- Evidence that Vitamin D Supplementation Could Reduce Risk of Influenza and COVID-19 Infections and Deaths
- 157 References

Key Findings

- To reduce the risk of infection, it is recommended that people at risk of influenza and/or COVID-19 consider taking **10,000 IU/d of vitamin D3 for a few weeks to rapidly raise 25(OH)D concentrations, followed by 5000 IU/d**. The goal should be to raise 25(OH)D concentrations above 40–60 ng/mL (100–150 nmol/L). For treatment of people who become infected with COVID-19, higher vitamin D3 doses might be useful.
- A study involving 33 participants, including seven taking 4000 IU/d of vitamin D3 and six who took 10,000 IU/d of vitamin D3 for 8 weeks, reported that 25(OH)D concentrations increased from 20 ± 6 to 39 ± 9 for 4000 IU/d and from 19 ± 4 to 67 ± 3 for 10,000 IU/d and improved gut microbiota with no adverse effects [138]
- **A recent review suggested using vitamin D loading doses of 200,000–300,000 IU in 50,000-IU capsules to reduce the risk and severity of COVID-19** [43]

VITAMIN D

- Castillo, M. E., Entrenas Costa, L. M., Vaquero Barrios, J. M., Alcalá Díaz, J. F., Miranda, J. L., Bouillon, R., & Quesada Gomez, J. M. (2020). "**Effect of Calcifediol Treatment and best Available Therapy versus best Available Therapy on Intensive Care Unit Admission and Mortality Among Patients Hospitalized for COVID-19: A Pilot Randomized Clinical study."** The Journal of Steroid Biochemistry and Molecular Biology, 105751. doi:10.1016/j.jsbmb.2020.105751

Key Findings

- Vitamin D3 significantly reduced ICU admission rates, as well as reduced the severity COVID-19 disease. Of the 50 total patients who received vitamin D3, 1 was admitted to the ICU (2%). Of the 26 patients who were not administered vitamin D3, 13 were admitted to the ICU (50%). **Of the 50 patients treated with vitamin D3, 0 deaths occurred, and all 50 patients were eventually discharged without complications.**

VITAMIN D

- Marcos Pereira, Alialdo Dantas Damascena, Laylla Mirella Galvão Azevedo, Tarcio de Almeida Oliveira & Jerusa da Mota Santana (2020) **Vitamin D deficiency aggravates COVID-19: systematic review and meta-analysis**, Critical Reviews in Food Science and Nutrition, DOI: 10.1080/10408398.2020.1841090

Key Findings

- Vitamin D deficiency was associated with increased hospitalizations (OR = 1.81, 95% CI = 1.41–2.21), and increased mortality (OR = 1.82, 95% CI = 1.06–2.58). Severe cases of COVID-19 were 64% more likely to be vitamin D deficient than mild cases of COVID-19 (OR = 1.64; 95% CI = 1.30–2.09). **Vitamin D deficiency is associated with higher infection rates, increased incidence of sepsis, and increased mortality risk, among critically ill populations.**

VITAMIN D

- Kaufman HW, Niles JK, Kroll MH, Bi C, Holick MF (2020) SARS-CoV-2 positivity rates associated with circulating 25-hydroxyvitamin D levels. PLoS ONE 15(9): e0239252. https://doi.org/10.1371/journal.pone.0239252

Key Findings

- A total of 191,779 patients were included (median age, 54 years [interquartile range 40.4–64.7]; 68% female. The SARS-CoV-2 positivity rate was 9.3% (95% C.I. 9.2–9.5%) and the mean seasonally adjusted 25(OH)D was 31.7 (SD 11.7). **The SARS-CoV-2 positivity rate was higher in the 39,190 patients with "deficient" 25(OH)D values (<20 ng/mL) (12.5%, 95% C.I. 12.2–12.8%) than in the 27,870 patients with "adequate" values (30–34 ng/mL) (8.1%, 95% C.I. 7.8–8.4%) and the 12,321 patients with values ≥ 55 ng/mL (5.9%, 95% C.I. 5.5–6.4%).** The association between 25(OH)D levels and SARS-CoV-2 positivity was best fitted by the weighted second-order polynomial regression, which indicated strong correlation in the total population (R2 = 0.96) and in analyses stratified by all studied demographic factors. The association between lower SARS-CoV-2 positivity rates and higher circulating 25(OH)D levels remained significant in a multivariable logistic model adjusting for all included demographic factors (adjusted odds ratio 0.984 per ng/mL increment, 95% C.I. 0.983–0.986; p<0.001). **SARS-CoV-2 positivity is strongly and inversely associated with circulating 25(OH)D levels, a relationship that persists across latitudes, races/ethnicities, both sexes, and age ranges.** Our findings provide impetus to explore the role of vitamin D supplementation in reducing the risk for SARS-CoV-2 infection and COVID-19 disease.

VITAMIN D

- Lorenz Borsche, Bernd Glauner, Julian von Mendel doi: https://doi.org/10.1101/2021.09.22.21263977

Key Findings

- **Results** One population study and seven clinical studies were identified, which reported D3 blood levels pre-infection or on the day of hospital admission. They independently showed a negative Pearson correlation of D3 levels and mortality risk (r(17)=-.4154, p=.0770/r(13)=-.4886, p=.0646). For the combined data, median (IQR) D3 levels were 23.2 ng/ml (17.4 – 26.8), and a significant Pearson correlation was observed (r(32)=-.3989, p=.0194). **Regression suggested a theoretical point of zero mortality at approximately 50 ng/ml D3.**

- **Conclusions** The two datasets provide strong evidence that low D3 is a predictor rather than a side effect of the infection. **Despite ongoing vaccinations, we recommend raising serum 25(OH)D levels to above 50 ng/ml to prevent or mitigate new outbreaks** due to escape mutations or decreasing antibody activity.

VITAMIN C

- https://isom.ca/article/intravenous-ascorbic-acid-for-supportive-treatment-in-hospitalized-covid-19-patients/
- Intravenous Ascorbic Acid (IVAA) is an FDA Approved Nutraceutical Therapy

Key Results

- Chinese facility patient load: 358 total COVID-19 patients as of March 17th, 2020.
- Facility treated approximately **50 cases** (of the 358) of **moderate to severe COVID-19** infection with IVAA.
- The IVAA dosing was moderate and affordable and dose determined by clinical status.
- Dose Strategy successful in managing Cytokine Storms.
- **All patients who received IVAA improved.**
- **There was no mortality in the IVAA group.**
- There were no side effects reported from any patients in the IVAA group.
- Average COVID-19 patients had a 30-day hospital stay, but **COVID-19 patients that received IVAA had a hospital stay that was 3 to 5 days shorter than the non IVAA treated patients**.
- Treatment cost per patient is approximately $12.00 – 24.00 per day of treatment.

Technical Notes & Updates

- Literature to date indicates that 2-8g Vitamin C daily may reduce the incidence and duration of respiratory infections and intravenous vitamin C (6–24 g/day) has been shown to reduce mortality, intensive care unit (ICU) and hospital stays, and time on mechanical ventilation for severe respiratory infections [3]. https://www.mdpi.com/2072-6643/12/12/3760
- A study of 21 critically ill COVID-19 patients admitted to ICU in the US found a mean level of 22 µmol/L, thus a majority had hypovitaminosis. The mean level for 11 survivors was 29 µmol/L compared to 15 µmol/L for the 10 non-survivors; of these five (50%) had ≤11 µmol/L [1].
- Cohort ICU study found that 94.4% of COVID-19 ARDS (acute respiratory distress syndrome) patients had undetectable levels of Vitamin C [2]

1. Arvinte, C.; Singh, M.; Marik, P.E. Serum levels of vitamin C and vitamin D in a cohort of critically ill COVID-19 patients of a north American community hospital intensive care unit in May 2020: A pilot study. Med. Drug Discov. 2020, doi:10.1016/j.medidd.2020.100064
2. Luis Chiscano-Camón, Juan Carlos Ruiz-Rodriguez, et al: Vitamin C levels in patients with SARS-CoV-2-associated acute respiratory distress syndrome; Critical Care volume 24, Article number: 522 (2020) https://ccforum.biomedcentral.com/articles/10.1186/s13054-020-03249-y
3. Holford, P., Carr, A. C., Jovic, et al. Vitamin C—An Adjunctive Therapy for Respiratory Infection, Sepsis and COVID-19. Nutrients, 12(12), 2020 3760. doi:10.3390/nu12123760

ZINC

- https://pubmed.ncbi.nlm.nih.gov/32920234/
- COVID-19: Poor outcomes in patients with zinc deficiency

Key Findings

- **Results:** COVID-19 patients (n = 47) showed significantly lower zinc levels when compared to healthy controls (n = 45): median 74.5 (interquartile range 53.4-94.6) µg/dl vs 105.8 (interquartile range 95.65-120.90) µg/dl ($p < 0.001$). Amongst the COVID-19 patients, 27 (57.4%) were found to be zinc deficient. **These patients were found to have higher rates of complications ($p = 0.009$), acute respiratory distress syndrome (18.5% vs 0%, $p = 0.06$), corticosteroid therapy ($p = 0.02$), prolonged hospital stay ($p = 0.05$), and increased mortality (18.5% vs 0%, $p = 0.06$).** The odds ratio (OR) of developing complications was 5.54 for zinc deficient COVID-19 patients.

- **Conclusions:** The study data clearly show that **a significant number of COVID-19 patients were zinc deficient. These zinc deficient patients developed more complications, and the deficiency was associated with a prolonged hospital stay and increased mortality.**

NUTRITIONAL COMBINATION THERAPY: VITAMINS A,C,D, IODINE & HYDROGEN PEROXIDE

- Brownstein, Ng, Rowen, et al: A Novel Approach to Treating COVID-19 Using Nutritional and Oxidative Therapies; Science, Public Health Policy, and The Law Volume 2:4-22, July, 2020
- https://cf5e727d-d02d-4d71-89ff-9fe2d3ad957f.filesusr.com/ugd/adf864_cc5004cfa84a46d3b1a0338d4308c42c.pdf

Key Findings

- **Study Design:** 107 consecutive COVID-19 patients treated with nutritional & oxidative therapies in a family practice clinic in a Detroit, MI suburb. Patient age range: 2-85. Median Age: 56.5. Gender distribution: Female: 75%, Male: 25%
- **Most Common Symptoms:** Fever (81%), upper respiratory symptoms (69%) (rhinorrhea, drippy eyes, cough, congestion), shortness of breath (68%), G.I. symptoms (27%)
- **Oral Nutritional Dosing** given to 99% of patients for first 4 days of symptom onset: Vitamins A (100,000 I.U.), Vitamin C (1,000mg/hour during waking times), Vitamin D (50,000 I.U.daily) and Lugol's Iodine (25mg/daily)
- **Nebulize (vaporous inhalation):** Most patients instructed to nebulize solution 0.04% H2O2 in saline with 1CC Mg Sulfate
- **If symptoms worsened**, patients were treated with I.V. nutrition or I.M: I.V. Vitamin C (35%), I.V. H2O2 (30%) & I.M. Ozone (35%)
- **Symptomatic Improvement After Intervention:** 1st Improvement: 2.5 days, Mostly Better: 4.5 days, Completely Better: 7 Days
- **Outcome: 100% improvement in all 107 patients treated**

MASKS, DISTANCE & NUTRITION

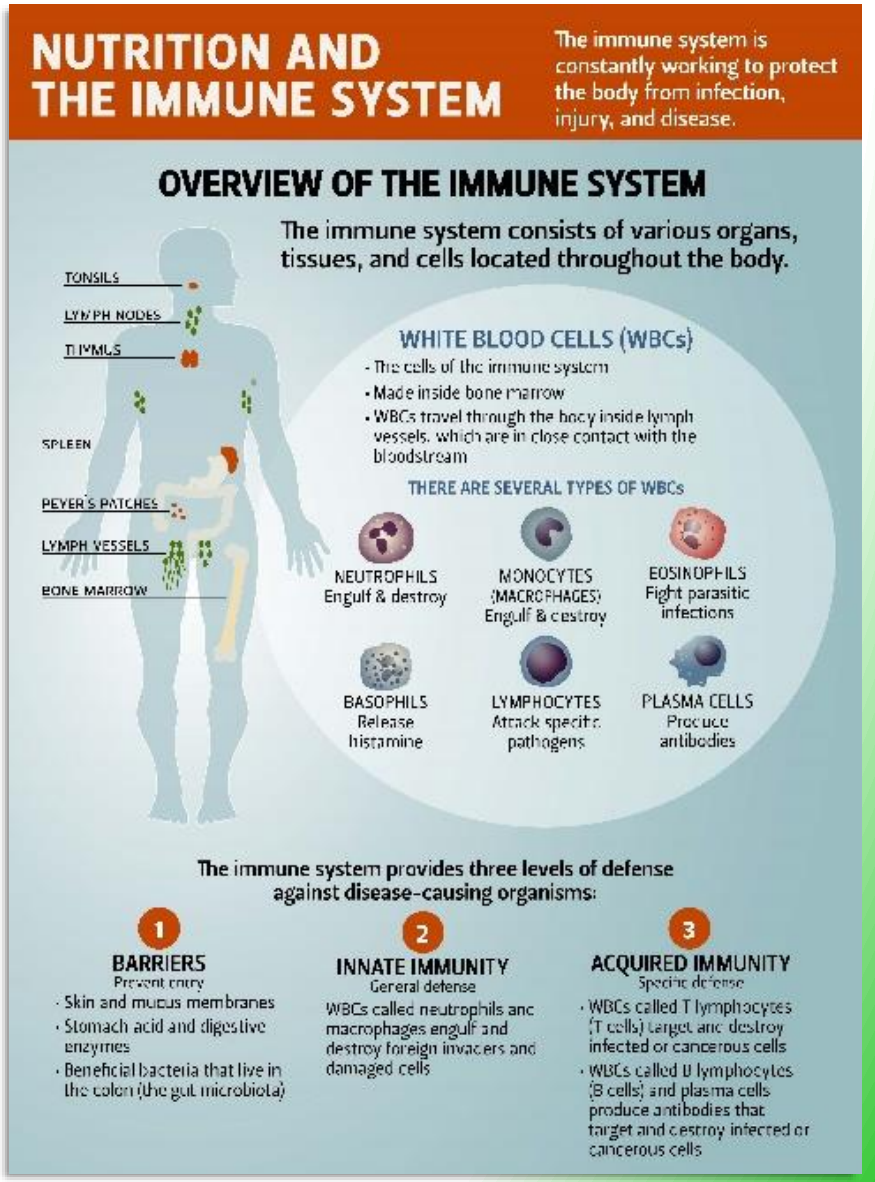
- Perhaps the best defense is a well-nourished immune system

Preliminary Recommendations for Teens & Adults

- **Vitamin A** – 5,000 IU per day 6 days per week
- **Vitamin C** – 3,000 to 5,000 mg per day
- **Vitamin D** – 14-Day Loading Dose 10,000 IU per day, followed by 5,000 IU per day 6 days per week.
- **Vitamin E** – 200 to 600 IU per day
- **Zinc** – 25mg per day
- **Multivitamin** – 6 days per week
- **Omega 3 Fatty Acids** – 6 days per week

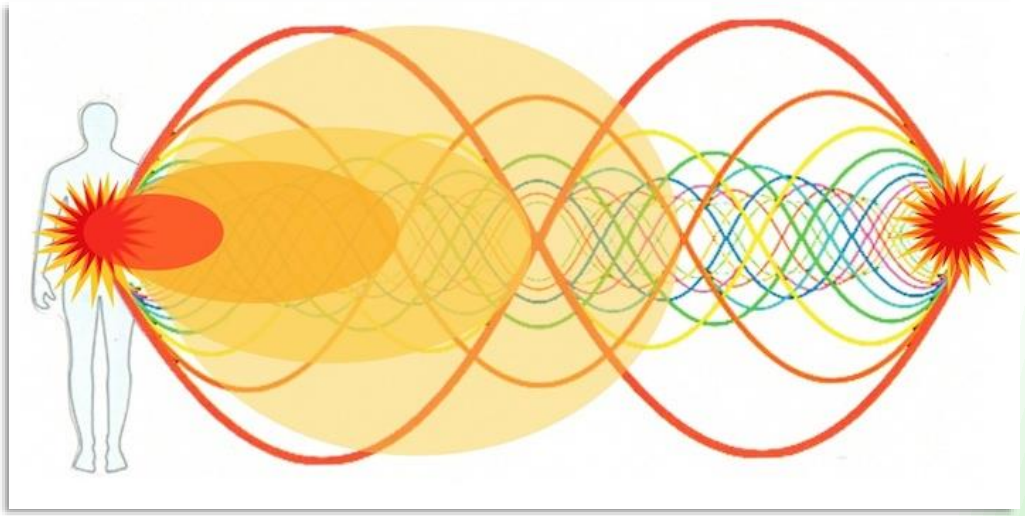
- https://lpi.oregonstate.edu/mic/health-disease/immunity
- https://lpi.oregonstate.edu/sites/lpi.oregonstate.edu/files/lpi-immunity-infographic.pdf

- Section 9 - Vitamins modulating the immune system during COVID-19
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7547582/#s0045title



THERAPEUTIC RANGE

- ***Therapeutic Range is a Clinical Guideline for the amount of Daily Nutrient Density required to Fire Up the Mitochondria, amplify Cellular Enzymatic Production, & achieve Cellular Healing Resonance.***



Therapeutic Range is a compilation of the following resources:

- Suggested Optimal Nutrient Allowance (SONAs)
- Linus Pauling Institute Micronutrient Center Research
- Summary of Well Known Naturopathic Clinical Texts (Murray, Pizzorno, Marz, Mateljan, Etc.)
- Pubmed & Google Scholar Research Updates, Thorne Research, Pure Encapsulations Research, Research of Trusted Nutraceutical Companies
- Observations in My Private Clinical Practice Shared and Confirmed by Colleagues & Student Practitioners since 2007. (n>3500)

Cool Mitochondrial Factoid

- Did you know the average person has literally hundreds *to* thousands of Mitochondria per cell that make up approximately 10% of their total body weight?

SENIORS, ADULTS & TEENS

KEY NUTRIENTS	THERAPEUTIC RANGE	RDA
VITAMIN A (Beta-Carotene)	5,000 IU	1,500-2,167 IU
VITAMIN C	3000-5000 mg	65-125 mg
VITAMIN D3	10,000 IU (14-Days) 5,000 IU (After)	600-800 IU
VITAMIN E	200-600 IU	22-28 IU
ZINC	25-40 mg (min 30mg for High-Risk)	8-11 mg

- **Age 13 & Up**
- **For All Genders**
- **Includes Expecting Mothers & Breastfeeding Mothers As Well**
- **Nutrients Should Be Taken With Small Amount Of Food To Minimize Any Nausea**
- **Multivitamin & Omega 3 Fatty-Acids Recommended As Well**

CHILDREN AGE 5 TO 12

KEY NUTRIENTS	THERAPEUTIC RANGE	RDA
VITAMIN A (Beta-Carotene)	5,000 IU	1,000-2,000 IU
VITAMIN C	2,000-4,000 mg	25-45 mg
VITAMIN D3	5,000 IU (14-Days) 2,000 IU (After)	200 IU
VITAMIN E	100 IU	10-17 IU
ZINC	25 mg	8 mg

- **Age 5 To 12**
- **For All Genders**
- **Nutrients Should Be Taken With Small Amount Of Food To Minimize Any Nausea**
- **Multivitamin & Omega 3 Fatty-Acids Recommended As Well**

CHILDREN AGE 1 TO 4

KEY NUTRIENTS	THERAPEUTIC RANGE	RDA
VITAMIN A (Beta-Carotene)	2,000 IU	1,000-1,500 IU
VITAMIN C	500-1,000 mg	15-50 mg
VITAMIN D3	1,000-2,000 IU	200 IU
VITAMIN E	50 IU	6-9 IU
ZINC	10 mg	3 mg

- **Age 1 To 4**
- **For All Genders**
- **For Infants No Longer Breast Feeding**
- **Liquid Multivitamin & Omega 3 Fatty-Acids Recommended As Well**

SAFE CLASSROOMS – UV LIGHTS

- https://www.jpost.com/health-science/tel-aviv-research-999-percent-of-covid-19-germs-dead-in-30-seconds-with-uv-leds-653315
- https://www.sciencedirect.com/science/article/abs/pii/S1011134420304942?via%3Dihub

- Ultraviolet radiation is a common method of killing bacteria and viruses. Now, **researchers from Tel Aviv University have proven that the novel coronavirus, SARS-CoV-2, can be killed efficiently, quickly and cheaply using ultraviolet (UV) light-emitting diodes (UV-LEDs) at specific frequencies.**
- "We discovered that it is quite simple to kill the coronavirus using LED bulbs that radiate ultraviolet light," said Prof. Hadas Mamane, head of the Environmental Engineering Program at Tel Aviv University's School of Mechanical Engineering, who led the study with Prof. Yoram Gerchman and Dr. Michal Mandelboim.
- She said that the **UV-LED bulbs require less than half a minute to destroy more than 99.9% of the coronaviruses.**

- The study is the first of its kind in the world. An article about it was published earlier this month in the *Journal of Photochemistry and Photobiology B: Biology*.

SAFE CLASSROOMS – DEIONIZERS?

- https://www.newscientist.com/article/dn3228-air-ionisers-wipe-out-hospital-infections/
- From the UK, 2003
- Repeated airborne infections of the bacteria acinetobacter in an intensive care ward have been eliminated by the installation of a negative air ioniser.
- In the first such epidemiological study, researchers found that the infection rate fell to zero during the year long trial. **“We were absolutely astounded to find such clear cut results,”** engineer Clive Begg at the University of Leeds, UK, told New Scientist.
- Stephen Dean, a consultant at the St James’s Hospital in Leeds where the trial took place says: **“The results have been fantastic – so much so that we have asked the university to leave the ionisers with us.”**

SAFE CLASSROOMS – GREEN CLEANERS

- https://www.housebeautiful.com/lifestyle/cleaning-tips/a32291832/epa-approves-thymol-cleaners/
- https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19
- https://cleanwelltoday.com/

- The EPA's extensive list includes a few all-natural products containing the ingredient thymol.

- Thymol is a component found in thyme oil, which is a naturally occurring mixture of compounds from, yup, the thyme plant, according to the EPA.

- Four cleaning products that contain thymol make the EPA's list. Two of these products come from eco-friendly brand CleanWell. While CleanWell's entire line uses thymol, only the Benefect Botanical Daily Cleaner Disinfectant Spray and the Benefect Botanical Daily Cleaner Disinfectant Towelette made the EPA's cut. According to the brand's website, **"each of CleanWell's thymol cleaning products contains a 0.05% concentration of thymol and is designed to kill 99.9% of germs, bacteria, and viruses.."** Not only that, but these products are alcohol-free, non-toxic, and safe for food surfaces.

ORAL HYGIENE – MOUTH RINSES

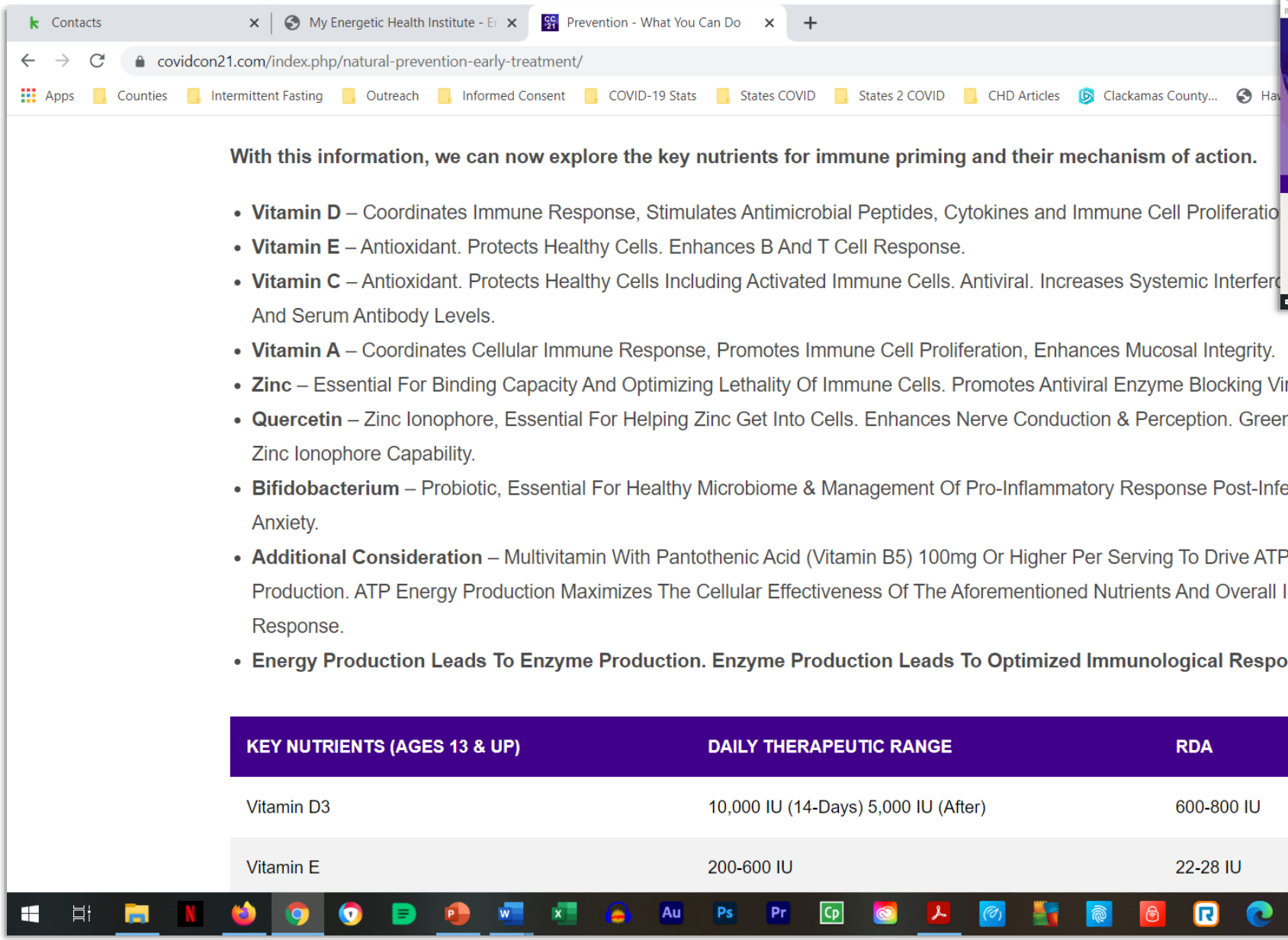
- https://www.rutgers.edu/news/certain-mouthwashes-might-stop-covid-19-virus-transmission

- The study found two other mouthwashes showed promise in potentially providing some protection in preventing viral transmission: Betadine, which contains Povidone-iodine, and Peroxal, which contains hydrogen peroxide. However, only Listerine and Chlorhexidine disrupted the virus with little impact on skin cells inside the mouth that provide a protective barrier against the virus.

- “Both Povidone-iodine and Peroxal caused significant skin cell death in our studies, while both Listerine and Chlorhexidine had minimal skin-cell killing at concentrations that simulated what would be found in daily use,” said Fine.

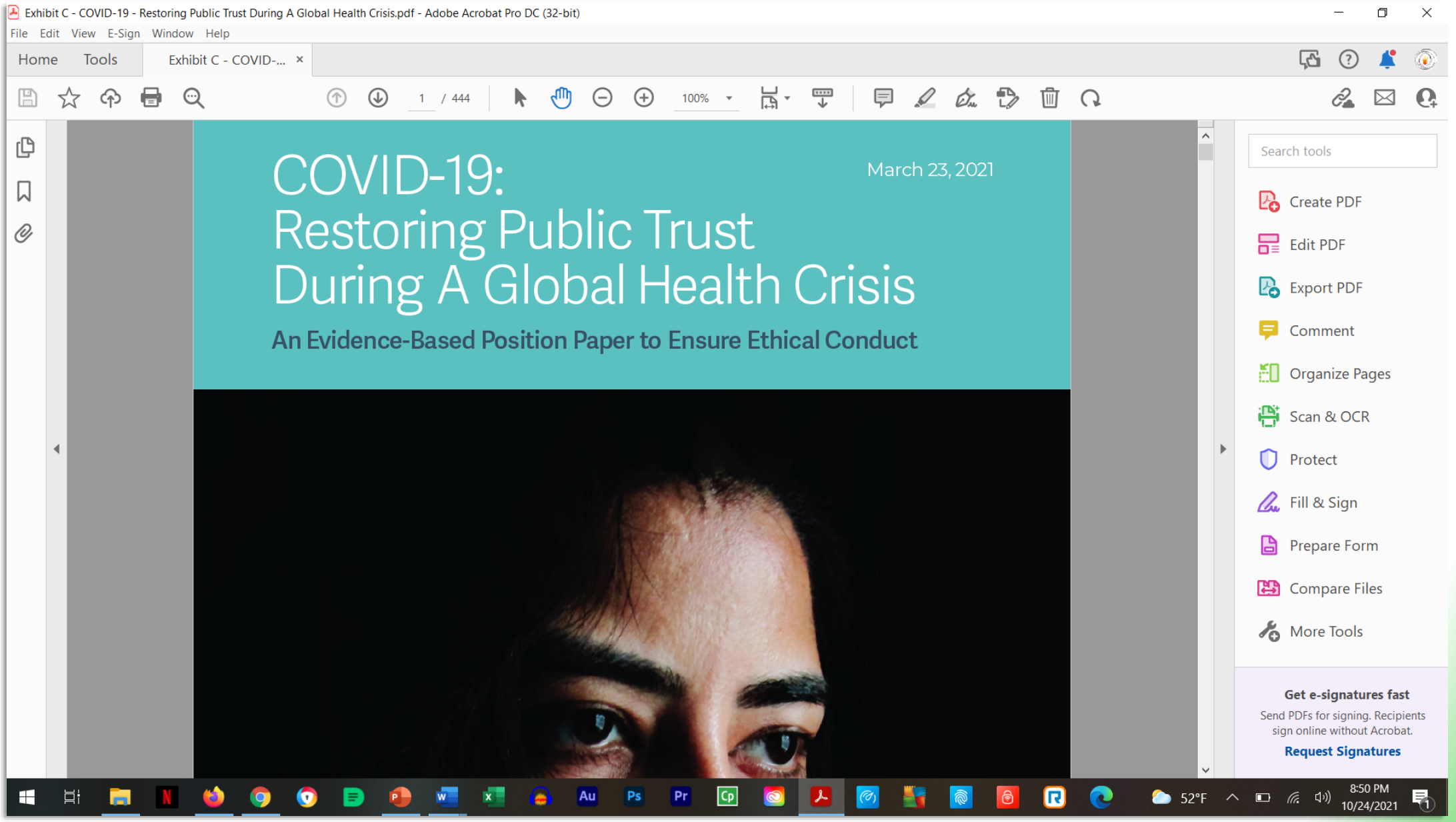
HAS EVEN MORE EMPIRICAL EVIDENCE EMERGED SUPPORTING NUTRITION & OFF-LABEL THERAPEUTIC INTERVENTIONS?

YES, THERE IS OVERWHELMING EVIDENCE



HTTPS://WWW.COVIDCON21.COM/INDEX.PHP/NATURAL-PREVENTION-EARLY-TREATMENT/

YES, THERE IS OVERWHELMING EVIDENCE



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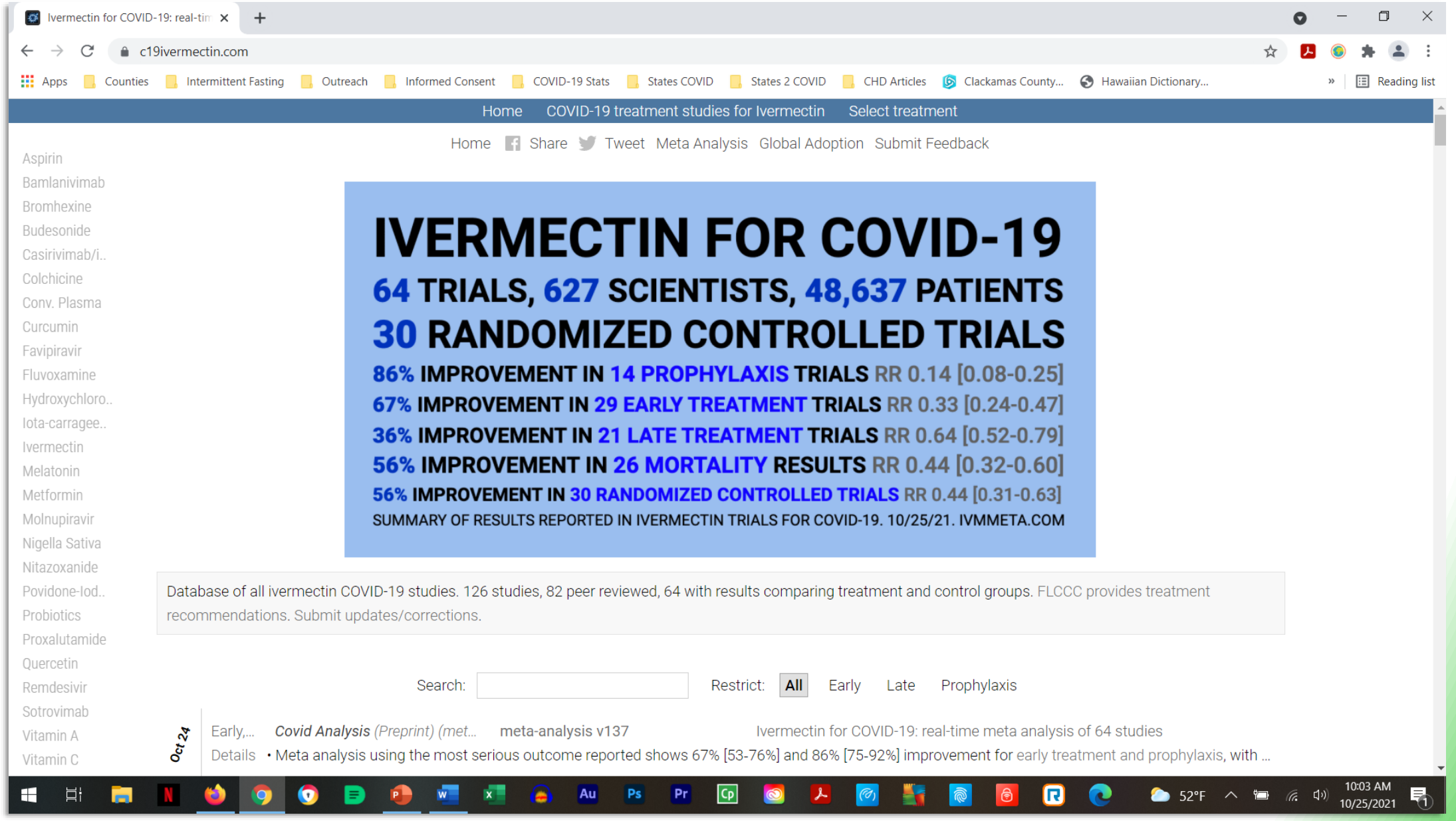
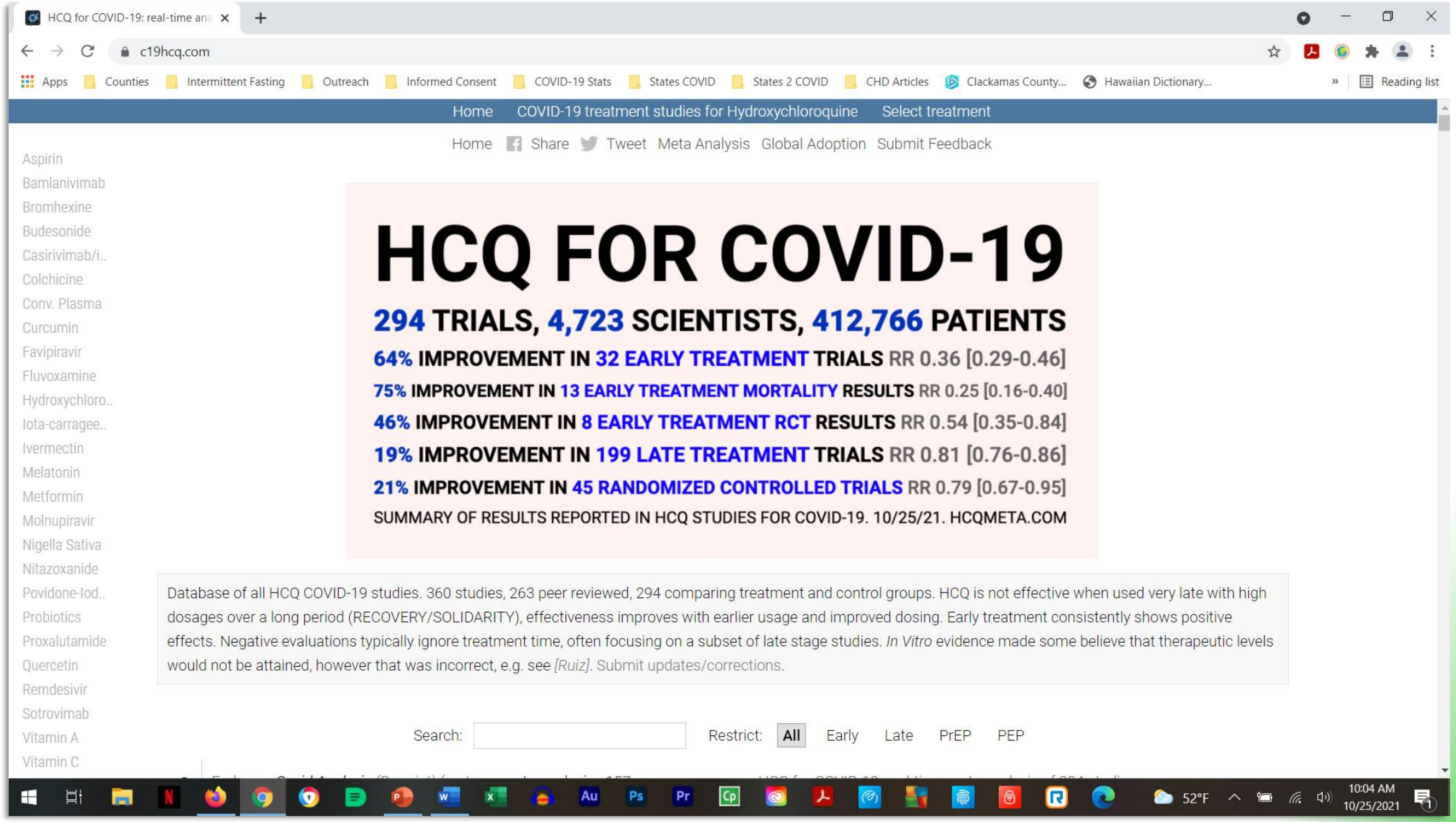
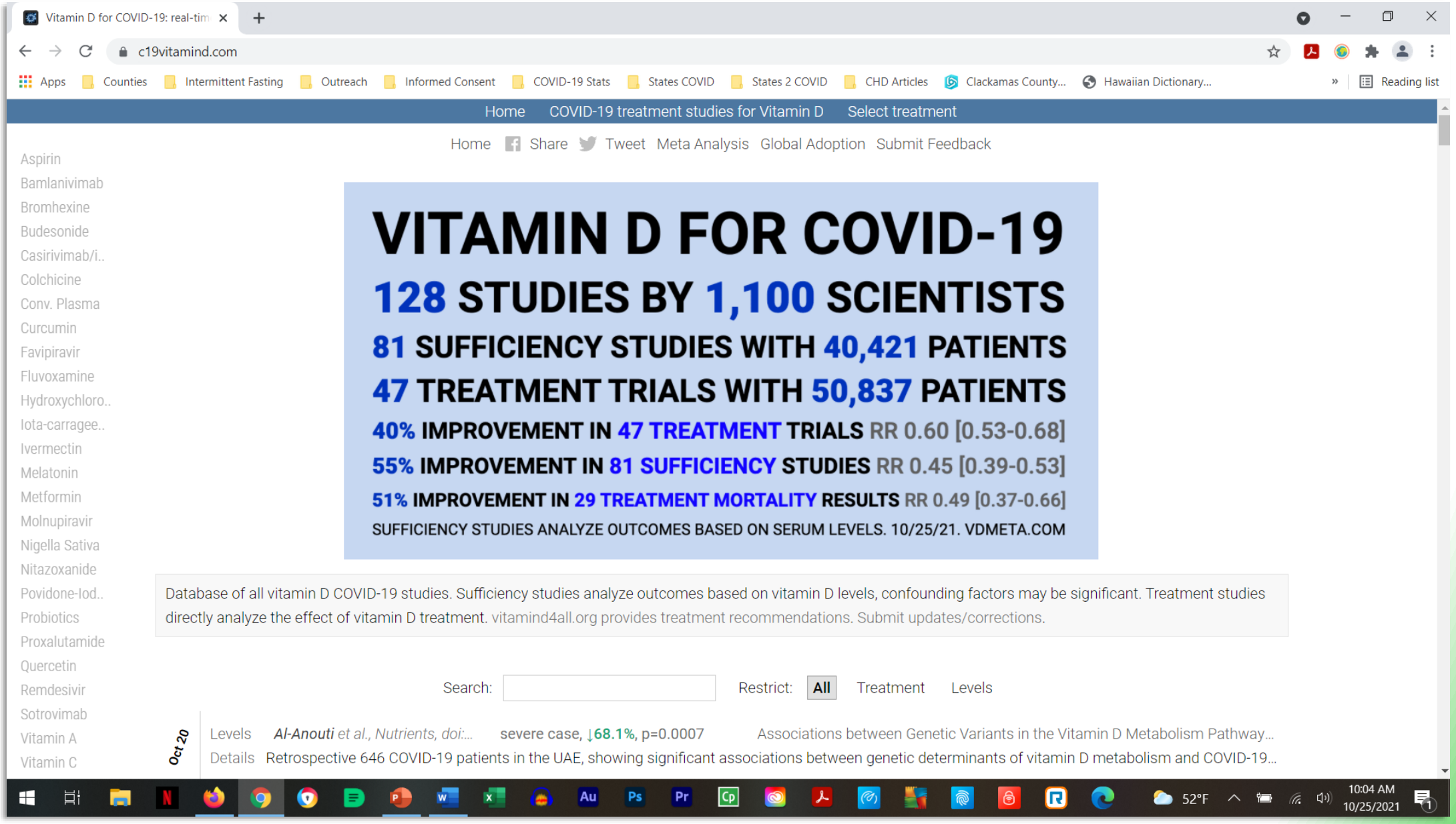
MUCH MORE EVIDENCE



MUCH MORE EVIDENCE



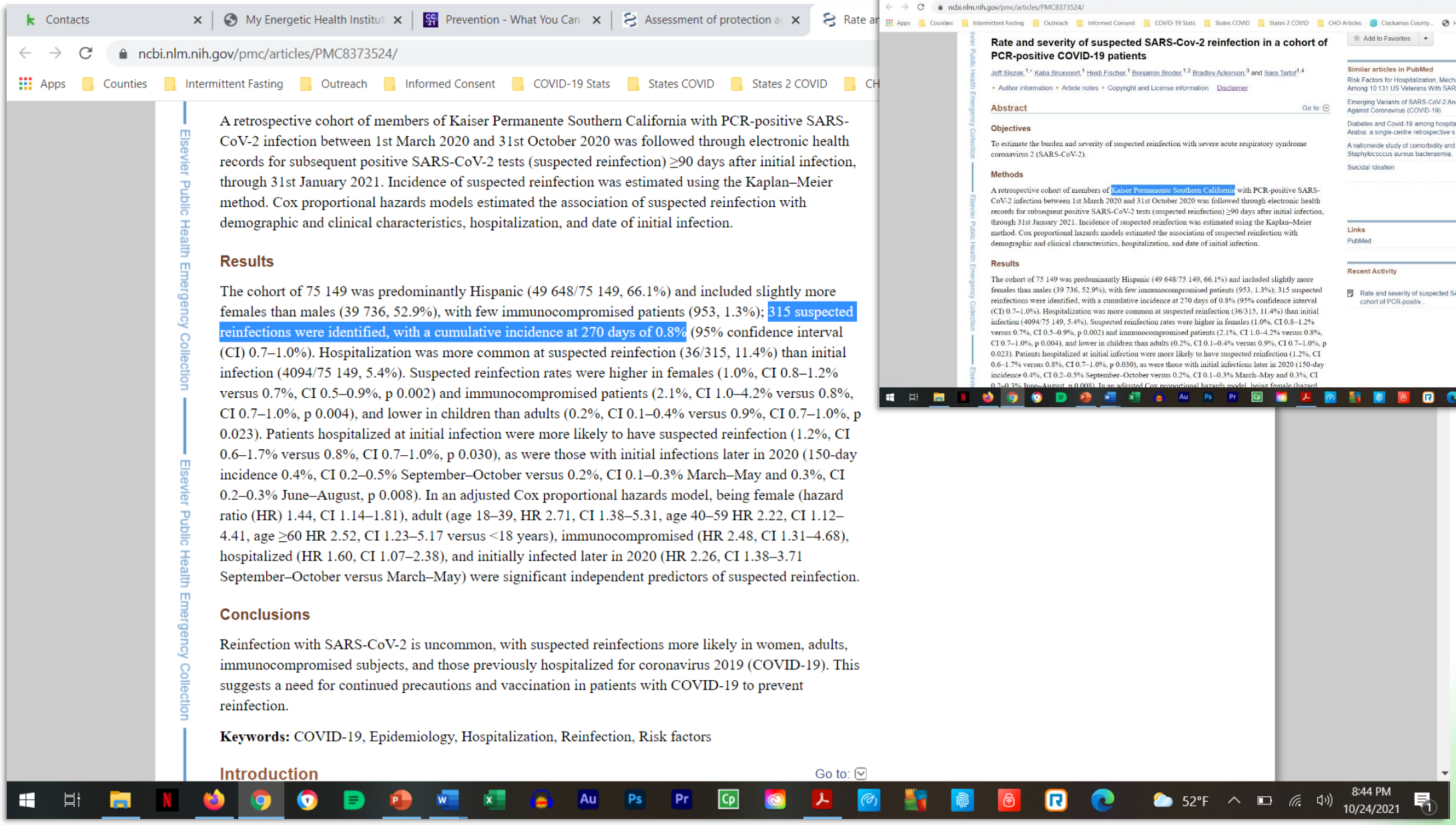
MUCH MORE EVIDENCE



HTTPS://C19EARLY.COM/

WHAT IS THE LIKELIHOOD OF REINFECTION POST-RECOVERY FROM INFECTION?

MAX 0.8%, KAISER STUDY



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Elsevier Public Health Emergency Collection

A retrospective cohort of members of Kaiser Permanente Southern California with PCR-positive SARS-CoV-2 infection between 1st March 2020 and 31st October 2020 was followed through electronic health records for subsequent positive SARS-CoV-2 tests (suspected reinfection) ≥90 days after initial infection, through 31st January 2021. Incidence of suspected reinfection was estimated using the Kaplan–Meier method. Cox proportional hazards models estimated the association of suspected reinfection with demographic and clinical characteristics, hospitalization, and date of initial infection.

Results

The cohort of 75 149 was predominantly Hispanic (49 648/75 149, 66.1%) and included slightly more females than males (39 736, 52.9%), with few immunocompromised patients (953, 1.3%); 315 suspected reinfections were identified, with a cumulative incidence at 270 days of 0.8% (95% confidence interval (CI) 0.7–1.0%). Hospitalization was more common at suspected reinfection (36/315, 11.4%) than initial infection (4094/75 149, 5.4%). Suspected reinfection rates were higher in females (1.0%, CI 0.8–1.2% versus 0.7%, CI 0.5–0.9%, p 0.002) and immunocompromised patients (2.1%, CI 1.0–4.2% versus 0.8%, CI 0.7–1.0%, p 0.004), and lower in children than adults (0.2%, CI 0.1–0.4% versus 0.9%, CI 0.7–1.0%, p 0.023). Patients hospitalized at initial infection were more likely to have suspected reinfection (1.2%, CI 0.6–1.7% versus 0.8%, CI 0.7–1.0%, p 0.030), as were those with initial infections later in 2020 (150-day incidence 0.4%, CI 0.2–0.5% September–October versus 0.2%, CI 0.1–0.3% March–May and 0.3%, CI 0.2–0.3% June–August, p 0.008). In an adjusted Cox proportional hazards model, being female (hazard ratio (HR) 1.44, CI 1.14–1.81), adult (age 18–39, HR 2.71, CI 1.38–5.31, age 40–59 HR 2.22, CI 1.12–4.41, age ≥60 HR 2.52, CI 1.23–5.17 versus <18 years), immunocompromised (HR 2.48, CI 1.31–4.68), hospitalized (HR 1.60, CI 1.07–2.38), and initially infected later in 2020 (HR 2.26, CI 1.38–3.71 September–October versus March–May) were significant independent predictors of suspected reinfection.

Conclusions

Reinfection with SARS-CoV-2 is uncommon, with suspected reinfections more likely in women, adults, immunocompromised subjects, and those previously hospitalized for coronavirus 2019 (COVID-19). This suggests a need for continued precautions and vaccination in patients with COVID-19 to prevent reinfection.

Keywords: COVID-19, Epidemiology, Hospitalization, Reinfection, Risk factors

Introduction

Go to:

Rate and severity of suspected SARS-Cov-2 reinfection in a cohort of PCR-positive COVID-19 patients

Jeff Slezak,[1,*] Katia Bruxvoort,[1] Heidi Fischer,[1] Benjamin Broder,[1,2] Bradley Ackerson,[3] and Sara Tartof[1,4]

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Abstract

Objectives

To estimate the burden and severity of suspected reinfection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

Methods

A retrospective cohort of members of Kaiser Permanente Southern California with PCR-positive SARS-CoV-2 infection between 1st March 2020 and 31st October 2020 was followed through electronic health records for subsequent positive SARS-CoV-2 tests (suspected reinfection) ≥90 days after initial infection, through 31st January 2021. Incidence of suspected reinfection was estimated using the Kaplan–Meier method. Cox proportional hazards models estimated the association of suspected reinfection with demographic and clinical characteristics, hospitalization, and date of initial infection.

Results

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Diabetes and Covid-19 among hospitalized patients in Saudi Arabia: a single-centre retrospective s [Cardiovasc Diabetol. 2020]

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SO WHY AM I DOING THIS?

IN LOVING MEMORY OF ALL CHILDREN WHO DIED BY SUICIDE BECAUSE OF COVID HEALTH POLICIES

- **Hayden Hunstable, 12**
- https://www.10tv.com/article/news/local/ohio-state-alum-shares-story-childs-suicide-tells-parents-covid-19-isolation-real-2020-may/530-c62f7060-3775-448a-bfd9-d21ad5aeeca5

- **Jo'Vianni Smith, 15**
- https://www.bet.com/news/national/2020/04/13/karl-anthony-mother-dies-coronavirus.html

- **Dylan Buckner, 18**
- https://www.nbcchicago.com/news/local/suburban-football-star-dies-in-apparent-suicide-family-says-covid-worsened-depression/2411545/

IN LOVING MEMORY OF ALL CHILDREN WHO DIED DUE TO INJURIES FROM THE EXPERIMENTAL VACCINES

Simone Scott, 19

- https://circleofmamas.com/health-news/19-year-old-simone-scott-dies-from-heart-failure-after-moderna-vaccine/

- **On June 11, Simone's parents were called in to say their last goodbyes. Simone passed away that Friday morning.**

- **"I lost my only daughter. I never thought I'd have to give up my daughter for the greater good of society. I do suspect it was the vaccine. If not directly, it played a role. I never knew that there was a risk for something as serious as this. I would have wanted to." — V. Scott, mother**

IN LOVING MEMORY OF ALL DIED ALONE BECAUSE OF COVID HEALTH POLICIES

- **Ana Martinez**
- https://www.voicesforseniors.com/

- **Irene Wright**
- https://abc11.com/coronavirus-covid-19-death-vance-county-dies-alone/6173081/

- **Rosanna Un**
- https://ca.news.yahoo.com/mom-did-not-die-alone-165144824.html

ABOUT DR. EALY

Dr. Henry Ealy (Dr. H) is the Founder of, & Executive Community Director for, the Energetic Health Institute. He holds a Doctorate in Naturopathic Medicine from SCNM, a Bachelor of Science in Mechanical Engineering from UCLA, is Board Certified in Holistic Nutrition by the NANP and a proud Jackie Robinson Scholarship Alumnus. He has over 20 years of teaching & clinical experience helping people care for their amazing body by unlocking the healing potential of Natural Medicines.

Dr. H hosts a weekly nationwide program, Energetic Health Radio, and is a regular writer on the America Out Loud network detailing the latest empirical evidence and research regarding the COVID crisis. You can listen to and read his volunteer effort on his America Out Loud team page.

He is the executive producer for COVID CON '21 and lead author for the COVID Research Team that has published 5 manuscripts including the peer-reviewed and highly acclaimed COVID-19 Data Collection, Comorbidity & Federal Law: A Historical Retrospective and the 444 page peer-reviewed position statement on willful misconduct COVID-19: Restoring Public Trust During A Public Health Crisis. His team's work has been covered by Dr. Mercola, Green Med Info, USA Today, Stand for Health Freedom, the Organic Consumer's Association and many highly respected news outlets. His team is the first to submit Formal Grand Jury Petitions exposing the rampant acts of alleged willful misconduct and call for a Congressional Investigation into the CDC's violations of multiple federal laws.

As an Ordained Minister for all denominations, Dr. H has been additionally certified as a Yoga Teacher, Clinical Massage Therapist, Human Anatomy & Physiology Teacher, as well as American Kenpo Teacher.

Having taught at the university graduate and undergraduate levels, he has a strong background in and deep passion for Data Verification & Analysis, Teaching & Personal Development, Curricula Design, American History, Herbalism, Traditional Chinese Medicine, Yoga & Ayurvedic Medicine, Meditation, Clinical Massage Therapy, Lab Testing & Assessment, The Basic Human Sciences, Environmental Medicine, Climate Science, Holistic Nutrition & Naturopathic Medicine.

Dr. Ealy is the author of Energetic Health – Interesting Insights Into Advanced Natural Medicine and also holds educational copyrights on over 200 published works regarding Natural Medicine, Vaccine Education, Medical Cannabis, Cellular Cleansing & Detoxification, Release Point Therapy Clinical Massage & Holistic Nutrition.