Brianna Swett
Maine State School Nurse
Milbridge, Maine
LD 174
LD 727

Thank you to the committee of Education and Cultural Affairs for allowing my written testimony to be shared. I am writing to you all in strong support of both LD 174 (An Act to Restore Religious Exemptions to Immunization Requirements) and LD 727 (An Act to Repeal Certain Immunization Requirements for Schools). I have been a registered nurse for 10 years. During my time as a nurse I have spent the majority of my career in the acute dialysis setting specializing in nephrology nursing and taking care of our hospitals sickest patients. I have been recognized at a national level for my nursing skills. During the COVID19 pandemic I worked within close proximity and for the longest amount of one on one time with our COVID positive patients. I did so after returning from maternity leave with my first daughter in 2019 and through my entire pregnancy with my second daughter. I ultimately left my position at the hospital when I could no longer work the demanding hours and shifts with two young children at home in 2021. I then changed career paths and have been working as a school nurse.

I have always had a great respect for science and my colleagues. As a medical professional I naturally have the curiosity to ask questions and do my own research. I have had the experience of being a "healthcare hero" working during COVID19 while the majority of the world was on lock down. I carried a letter proving my essential worker status in my vehicle in case I was pulled over by police and questioned for being outside of my home. That empowering experience was then followed by that of being told I could either take an experimental vaccine while pregnant or be fired for refusing to do so. Presently, as a school nurse, I am expected to gather data to help the state enforce vaccine mandates on kids who otherwise are forced to be homeschooled. This unique pairing of life experiences on top of becoming a mother has completely changed my beliefs on our current mandated vaccine schedule for school aged children and vaccines in general. My first daughter, despite having a neural tube defect, has been completely vaccinated. When I questioned the safety of vaccines with her condition and being an infant I quickly trusted the physicians who ensured their safety. My second has been partially vaccinated as I started to question vaccines during the pandemic. Currently my infant twin boys are not vaccinated and I hope this law will be reversed before they are old enough to attend public school. I would like to share with you all the research I have gathered on the current mandated vaccines and the risks of these vaccines vs. the risks of the diseases and conditions they help to protect against. For the sake of your time I will only cover the four vaccines (13 doses) currently mandated for entry into kindergarten. All of this information has been gathered from The Centers for Disease Control and Prevention (CDC), The Food and Drug Administration (FDA), Institute of Medicine (IOM), National Library of Medicine (NIH), Physicians for Informed Consent Organization (PIC), United States Department for Health and Human Services (HHS), and The World Health Organization (WHO).

The DTaP Vaccine offers some protection to diphtheria, tetanus, and pertussis. The intent of getting the vaccine is to decrease the severity of the symptoms that develop if a person contracts one of these conditions. It does not prevent asymptomatic infection or the spread of diphtheria or pertussis according to PIC. This vaccine therefore does not offer protection to the unvaccinated against diphtheria or pertussis regardless of the community vaccination rates. It has

been shown to decrease the mortality rates of the vaccinated. This vaccine also has no effect on the transmission of tetanus. Tetanus is not contagious, it can not spread person to person.

One possible side effect of the DTaP vaccine is seizures, which can occur in about 1 in 683 children, according to the VAERS system, CDC, and PIC. The DTaP vaccine contains between 330mcg and 625mcg of aluminum per dose. This is 60 to 120 times higher than the maximum safe level of aluminum that should be in an 11-pound infant's bloodstream per day, according to the Agency for Toxic Substances and Disease Registry. In Maine, children are currently mandated to receive five doses of this vaccine, or four doses if the fourth is given after their fourth birthday. On average, a 2-month-old baby weighs between 11 to 12 pounds, a 4-month-old weighs between 14 to 15 pounds, and a 6-month-old weighs between 16 to 17 pounds. The CDC schedule recommends that children receive their doses at 2, 4, and 6 months, again at 15-18 months, and then at 4-6 years old. Additionally, the manufacturer inserts for the DTaP vaccine also state that the vaccine has not been tested for carcinogenic or mutagenic potential or impairment of fertility. Furthermore, the VAERS system averages 130 cases of permanent injury or death on an annual basis. Per the CDC the VAERS system is known to be under utilized and therefore is assumed to only receive a small portion of the overall vaccine injuries and deaths.

According to HHS aluminum is a neurotoxin. In June of 2003 the FDA warned about aluminum toxicity in infants and children stating: "Term infants with normal renal function may also be at risk because of their rapidly growing and immature brain and skeleton, and an immature blood-brain barrier. Until they are 1 to 2 years old, infants have lower glomerular filtration rates than adults, which affects their kidney function. The agency is concerned that young children and children with immature renal function are at a higher risk resulting from any exposure to aluminum."

According to the CDC's 2024 annual report there were 6 pertussis related deaths in the United States for children under the age of 1. This number includes partially vaccinated and unvaccinated based on the CDC schedule. There were an additional 4 cases over the age of one, for a total death rate in 2024 of 10. The total number of pertussis cases reported in 2024 were 35,435. This means the death rate for last year was 0.028%. Outside of 2024, the general risk of an infant contracting a fatal pertussis infection is about 0.002% or 1 in 46,000. It was a FDA study that showed this vaccine does not prevent asymptomatic infection or transmission.

According to the CDC "The last U.S. case of confirmed respiratory diphtheria was in 1997. A small number of cutaneous cases associated with international travel have been reported since then." The annual risk of a child in the U.S. under 10 years old contracting a fatal diphtheria infection in the 21st century—without mass vaccination—is about 1 in 1.7 million, or 0.00006%. This extremely low risk is largely due to the association of diphtheria with overcrowding and poor sanitation, factors that are less common today.

Per the CDC, Tetanus transmission occurs primarily through contaminated wounds and is not contagious. The bacteria that causes tetanus is primarily found in animal feces and soil and the bacteria needs to enter an open wound in order for infection to occur. Per PIC the annual risk of a child under 10 years of age contracting fatal tetanus is about 1 in 784,000 or 0.0001%.

If we know for a fact that this particular vaccine does not decrease transmission rates, has not been rigorously tested, and has known toxic levels of ingredients in it then how can we as a population demand that every vulnerable child in our state receive it OR go without the right to public education? This does not take into account the many other known possible side effects and or harmful ingredients listed in the manufacturers insert. Please also take into consideration that

when these vaccines were created the overall sanitation and hygiene in the United States was much less and that alone led to a much larger presence of these infections. Our medical system and technology is also much more advanced and more capable of diagnosing and treating these conditions.

The Polio Vaccine (IPV) does not prevent asymptomatic infection or transmission. The CDC states that polio is spread mainly through fecal to oral pathways and possibly, at a smaller rate, oral to oral. According to PIC and CDC About 95 percent of polio infections have no symptoms. About 0.5% to 0.05% of polio infections result in paralysis. Of that small percentage 84 percent of cases recover without disability. The polio vaccine, similarly to the DTaP vaccine, has not been tested for carcinogenic potential or impairment of fertility. In comparison to the DTaP vaccine a more serious side effect of the IPV polio vaccine is also seizures. 1 in 829 children vaccinated with the polio vaccine may experience seizures. According to the VAERS system 99 cases of permanent injury and death are reported annually. Although the VAERS system is flawed, this is definitely worth taking into consideration when discussing giving these vaccines and mandating them to our children.

The National Library of Medicine states that the last wild polio death was in 1979 and there have been no cases of wild polio since then. The last paralytic poliomyelitis case was in 2022 and was found to be from a Hungarian traveler due to that traveler receiving the oral polio vaccine. Per the CDC the OPV (oral poliovirus) vaccine is no longer used in the U.S due to the now known risk of vaccine-associated paralytic polio.

We know for a fact that there are risks with receiving the polio vaccine. We know that the vaccine is not thoroughly tested. We know that the vaccine has serious reported side effects on an annual basis. We know the vaccine does not decrease the spread of polio. However, we are asking that despite no known cases of wild polio in 46 years in the U.S that we inject our young children 4 times with this vaccine before they are school aged or they are not allowed to attend public school. We give parents no choice in the matter if they can not afford to homeschool their children. This is not medical freedom.

The MMR Vaccine, unlike the DTaP and Polio vaccines, does help to reduce the transmission of measles, mumps and rubella between humans. Based on the data reported by PIC by the age of fifteen 60 percent of vaccinated children are susceptible to a measles infection and 25 percent of children are susceptible to mumps. By the age of 20 one third of vaccinated people are susceptible to Rubella. 1 in 10,000 measles cases are fatal (0.01% nationally). 1 in 93,000 or 0.001% of measles cases with normal levels of vitamin A result in permanent disability and death. The lifetime risk for contracting a mumps infection that is fatal or results in permanent disability is 0.002%. National tracking of rubella cases before the vaccine program was rolled out found that 0.0005% or 1 in 210,000 rubella cases contracted after birth were fatal. Unborn babies that contracted a fatal or permanent disability as a result of a Rubella infection were 0.0035% or 1 in 29,000. The majority of measles, mumps, and rubella cases are benign and not reported. According to the vaccine insert the MMR II vaccine has not been evaluated for carcinogenic or mutagenic potential or impairment of fertility. As stated by the PIC a more serious side effect of the MMR vaccine is seizures. This can occur in 1 in 640 children. This is five times more often than seizures from the actual measles infection.

The MMR vaccine is not thoroughly tested. The immunity of the vaccine decreases significantly over time. The likelihood of getting any of the three conditions it protects against and having a poor outcome are all less than 1 percent individually. The possibility of some of the side effects from the vaccine itself are much higher. The current law requires students to receive

this vaccine twice before entering kindergarten. Why are we mandating this vaccine for school aged children when we know the above information is true. With all of the focus in the media currently around the measles outbreaks, why are we not educating families on the importance of proper nutrition and foods high in vitamin A as a preventative measure to help keep our children safe and healthy. If we are genuinely concerned about our children in America who are in these outbreak areas then why is our government not providing free nutritious meals high in vitamin A to these citizens instead of, or at least in addition to, pushing the MMR vaccine? Research as I listed above showed a huge decrease in the mortality rates of children who were not malnourished.

The varicella vaccine came out in 1995. According to the CDC it is not known how long a vaccinated person is protected against the virus. More than 96 percent of infections are benign. Fatal cases of varicella in the U.S before the vaccine was introduced were 1 in 40,000 or 0.003%. Hospitalized cases of varicella before the vaccine were 3 in 1,000 or 0.3%. For some people who contract varicella in childhood later develop the shingles virus. This is due to the dormant virus resurfacing for unknown reasons. According to the CDC today 1 in 3 adults will contract shingles and out of those adults less than 100 a year die from the shingles. Only 1 percent to 4 percent of people with shingles go to the hospital. Thirty percent of that small percentage of people hospitalized for the shingles have a weakened immune system. Interestingly enough, according to the Institute For Medicine the "evidence convincingly supports a casual relationship between varicella vaccine and vaccine-strain viral reactivation." This means that it is possible that people vaccinated against varicella may have a rebound varicella infection from the vaccine. Additionally, according to the CDC and the VAERS system a potential side effect of the varicella vaccine is a seizure. This may occur in 1 in 940 children vaccinated with varicella, the percentage equivalent to this would be 0.11%. The VAERS system reports approximately 33 cases annually of permanent injury or death from varicella vaccines. Please note again that the CDC states "VAERS receives reports for only a small fraction of actual adverse events".

The varicella vaccine is not thoroughly tested. The risk to children contracting a fatal infection of varicella before the vaccine was low. There is a chance of getting varicella from the varicella vaccine. The chances of contracting a fatal shingles diagnosis later in life is also very low. The percentage of having a possible seizure to the vaccine is higher than the likelihood of a fatal or permanent complication from a varicella or shingles infection individually. 96 percent of infections are benign. This vaccine should not be mandated for a public school education.

To summarize the overall findings listed above, currently students entering kindergarten are required to receive 5 DTaP vaccines, 4 polio vaccines, 2 MMR vaccines, and 2 varicella vaccines. Out of those 13 vaccine doses only 4 are proven to decrease the transmission of the virus they offer some protection against. The other 9 vaccines do not help with decreasing the transmission of their respective diseases. The overall probability of contracting these diseases and viruses are low. The likelihood of them having a permanent or fatal response if you do contract one of them, is even lower. However, we are refusing our children a public education based on this overall low risk profile. Parents should have the freedom to choose to make an educated decision to give or withhold these poorly tested vaccines on their small, vulnerable, and developing babies and toddlers. We have a lot of facts about these vaccines, viruses, and diseases but we also have a lot of questions left unanswered. Our children can not advocate for themselves but as parents we can, and should be allowed to do as we see fit. The majority of parents do not make these decisions lightly. These decisions should not negate their internationally recognized human right to a public education. America needs to do better. Maine

needs to do better. There is a reason why we have seen an increase in vaccine hesitancy and it is not due to a lack of intelligence of the deciding individuals or a lack of research to support that hesitancy. Instead of isolating our children we should be focusing on other ways we can increase the health of our population from a young age. Prevention is key to a healthy population.

I believe that our focus should shift towards promoting outdoor play, exercise, and a balanced approach to learning, rather than pushing aggressive academic agendas and relying heavily on screen time, especially for our 5-year-olds. Additionally, we need to rethink the nutritional options available to our students. A breakfast consisting of a Pop-Tart (71 grams of carbs) and chocolate milk (22 grams of carbs) amounts to 93 grams of processed carbohydrates. This is hardly the kind of fuel needed to support young minds and bodies.

Furthermore, it is critical that we address the mental health challenges facing our children. There is a severe shortage of therapists and mental health services available for students, from kindergarten through college, and we must make a concerted effort to increase these resources.

Substance abuse education also needs an earlier introduction, particularly around the risks of vaping. We are witnessing an alarming epidemic of 11-year-olds and older engaging in this activity, yet there seems to be little effective support to address it.

As a school nurse, I believe that if we truly cared about our children's overall well-being, these are the areas where we should be directing our attention, rather than focusing on excluding a small number of children who, based on the hard facts, do not pose a risk to others. I hope that this testimony encourages a thoughtful and bipartisan discussion about the reality of vaccines, the associated viruses, and diseases, and their relevance to the world we live in today. I encourage the committee to cross-reference my research and consider these important issues as we move forward and that ultimately