Dear Sirs

**Ref: [NAME OF CHILD]**

**NOTICE OF THE REFUSAL OF CONSENT TO RECEIVE THE COVID-19 VACCINATION**

I am writing following the email/letter [delete as appropriate] dated [inset date] which I received from [insert name of school] (“the School”) informing me that the School intend to have medical practitioners on site on [inset date the school will be administering the vaccine] to administer the COVID-19 vaccination (“the vaccine”) to pupils. The purpose of this letter is to inform you that **I** **DO NOT CONSENT** to my child receiving the vaccine. Furthermore, for the reasons set out below, I do not accept that you or any medical professional administering the vaccine can override my refusal of consent by attempting to use “Gillick Competency” if my child says they agree to have the vaccine.

**REFUSAL OF CONSENT AND REASONS WHY**

1. As the parent of [insert name of child] I have parental responsibility until [name of child] turns 16. As such I am legally able to make important medical decisions such as this on behalf of [name of child].
2. Having reviewed all the available evidence in relation to the vaccine, **I AM NOT PREPARED TO CONSENT** to my child receiving the vaccine. Whilst I am under no obligation to justify my decision, my reasoning is relevant to the Gillick Competency section below. I therefore briefly set out below my rationale. I would also encourage you to read the two open letters from the UKMFA dated 25 February 2021 <https://uploads-ssl.webflow.com/5fa5866942937a4d73918723/60379523f61260115203f392_UKMFA%20_Covid-19_Vaccine_in_Children.pdf> and 7 June 2021 <https://uploads-ssl.webflow.com/5fa5866942937a4d73918723/60bf3f0affc4e3bf7d28d17f_UKMFA_Open_Letter_MHRA_Vaccines_Children.pdf> which set out in detail what I have summarised below.

The Clinical Trials

1. Only the Pfizer vaccine has received emergency approval for children aged 12-15 years. The vaccine uses completely new gene-based mRNA technology as opposed to traditional vaccines which use a live or attenuated virus. This technology has never previously been used in vaccines administered in either children or adults.
2. The clinical trials for children commenced in early 2021 in the US and only involved 1131 12–15-year-olds in the treatment (vaccine) arm of the trials. There have been no clinical trials for the Pfizer vaccine in the UK. According to the ONS, in 2019 there were around 12.7 million under 16s. The involvement of only 1131 children in the Trials represents only 0.000089% of the population of under 16s. That is not sufficient to determine the effect of any adverse reactions in the wider population as a whole.
3. According to the US VAERS reporting system, several children under the age of 18 have already, very sadly, died following the vaccine.
4. Furthermore, the MHRA gave the emergency approval based on only 2 months’ worth of interim data. As a result, there is extremely limited short-term and NO long-term safety data available. I repeat that the trial size was wholly underpowered to be able to identify any less common adverse reactions that may occur in the population as a whole.
5. The last time a vaccine for children was rushed through on an emergency basis was in the swine flu epidemic in 2009-2010. This resulted in significant injuries, with over 1000 cases of life-changing narcolepsy in children and teenagers across Europe, and the eventual withdrawal of the Pandemrix vaccine.

Safety and lack of benefits of the vaccine for children

1. The benefits of the vaccine for children are close to zero. The same cannot be said for the risks, which are both known and unknown. Many experts have said that vaccinating children is not necessary or justified. I have set out below 2 examples:
2. The minutes of the Joint Committee on Vaccination and Immunisation (JCVI) dated 16 February 2021 state:

*“..little impact of vaccinating children once all other adults were offered vaccine”* and *“that modelling results on the impact of vaccinating children were considered highly uncertain”*

1. Professor of Paediatrics and member of the JCVI, Adam Finn, said in an interview on the 20 May 2021 that it was *“an open question as to whether we need to immunise children at all”.*
2. The infection fatality rate in children under 16 is close to zero. The vast majority of those that catch COVID-19 remain asymptomatic or experience mild symptoms. Consequently, there is simply no emergency for children under 16 that would justify the approval. The potential benefit to an individual child from receiving the vaccine is statistically zero.
3. It has been shown that children play an insignificant role in transmission. Living with children may also reduce the risks of COVID-19. Transmission in schools has not been significant. Furthermore, the Trials have not shown whether the vaccines reduce asymptomatic infection or transmission, nor were the trials designed to obtain this information.
4. As I have said above the vaccines work completely differently to established childhood vaccines which used an attenuated virus strain to prompt an immune response. The COVID-19 vaccines introduce a synthetic gene which programmes the bodies’ own cells to produce spike proteins. There are published studies which suggest that the spike protein is a toxin which can cause harm in the body. As we have limited short-term and no long-term safety data, the possibility that children may produce higher quantities of the spike protein, potentially increasing the risk of side-effects, has not been ruled out.
5. Serious adverse events and vaccine-related deaths in adults have been reported in the UK, the US and Europe. MHRA records these events by its yellow card scheme, which is a passive reporting scheme that is believed to only capture a small percentage of adverse events. Many vaccine-related deaths and serious side-effects have been reported in the UK and international media. As of 13 May 2021, there were 822,078 reported adverse reactions in the UK, including seizures, paralysis, blindness, strokes, blood clots and acute cardiac events, and 1178 deaths were reported. Some life-threatening events, such as blood clots and myocarditis have been reported, which appear to occur more frequently in children and young adults. The CDC is currently investigating hundreds of reports of myocarditis following vaccination in teenagers in the US. As stated above, several children under 18 have sadly died.
6. Vaccine manufacturers have requested, and been granted, complete immunity from liability for any injuries or deaths caused by the vaccine. A spokesperson for AstraZeneca said they *“simply cannot take the risk if in ... four years the vaccine is showing side-effects”*. Children should not be expected to take this risk with their short and long-term health when they have their whole life ahead of them and COVID-19 presents very little, if any, risk to them.
7. Taking into account the above I have concluded that there is very little, if any benefit, to [insert name] receiving the vaccine. The risks far outweigh any benefits to my child. I am therefore not prepared to consent to my child receiving the vaccine.

**GILLICK COMPETENCY**

1. I am aware that some schools and/or medical practitioners may attempt to disregard my decision and argue that my child is “Gillick competent” and should be allowed to decide for themselves if they want the vaccine. I am stating here that I will not accept any attempt to override my decision by relying on Gillick Competency.
2. The test to assess whether a child under 16 is competent to make a medical decision was set down in the case of *Gillick v West Norfolk and Wisbech Health Authority [1985] 3 WLR 830.*  This requires the child to have "*a sufficient understanding and intelligence to enable them to comprehend fully what is proposed"* and:
3. understand the nature and implications of the decision and the process of implementing that decision;
4. understand the implications of not pursuing the decision;
5. retain the information long enough for the decision-making process to take place;
6. be of sufficient intelligence and maturity to weigh up the information and arrive at a decision; and
7. be able to communicate that decision.
8. The determination of competence must be decision-specific, child-specific, made with the specific factual context in mind, and based on the available evidence. This is an important requirement in light of consent for the vaccine.
9. A further, crucial requirement for “Gillick Competency” was set down by the High Court in the case of **An NHS Trust v A, B, C, A Local Authority** [2014] EWHC 1445. Mr Justice Mosytn, in relation to considering competency, also considered whether the decision of the child was given freely. He stated:

*“Dr Ganguly was also clear that the decision that was reached by A was hers alone and was not the product of influence by adults in her family. Dr Ganguly did not detect in her any sign of distress when she set out her position to her”*

1. Finding a child Gillick Competent only allows them to make a medical decision for themselves; however, vitally they must still provide valid consent. In order to be valid, i.e. lawful, consent must be given:
2. voluntarily and freely without pressure or undue influence being exerted on the person either to accept of refuse treatment;
3. informed which means age-appropriate information to understand the nature and purpose of the vaccine as well and any relevant information pertaining to risks and likelihood of success, side-effect and complications - in particular serious adverse outcomes;
4. treatment options including options not to treat; and
5. sufficient time for them to decide
6. As I am sure you are aware, children are often subject to peer pressure from their fellow pupils. They need to fit in. They need to conform, etc. Children also look up to their teachers and are also influenced by the media and celebrities. There has been a huge push on the vaccines in the media and by various well-known celebrities. I am also aware that highly misleading pro-vaccine literature has been circulating in some schools to encourage children to take the vaccine. See this link to an Open Letter from the UKMFA regarding a recent BBC Newsround Episode shown in schools which contained inaccurate and misleading information <https://www.ukmedfreedom.org/open-letters/open-letter-to-professor-devi-sridhar-re-bbc-newsround-episode-on-childrens-vaccines>
7. For these reasons it simply cannot be the case that a child will be able to make a fully informed decision, free from any peer pressure. This is of course a crucial requirement for competency following the decision at paragraph 18 above.
8. Finally, the completely novel technology of the vaccine, the lack of full safety data, the high number of serious adverse events being reported, and the fact that the vaccine is still in clinical trials (thus experimental), all make it difficult and complex for an adult to provide their fully informed consent. Applying the test at paragraph 16 above, it is not possible for a child to be Gillick Competent for this vaccine.

**SUMMARY**

1. I do not consent to the vaccine.
2. I do not accept that Gillick Competency can or should be used for my child (or indeed any other child) when it comes to this vaccine.
3. I therefore require your confirmation **within 48 hours of the date of this letter** that you and any medical practitioner attending at the School:
4. will not ask [insert name] if they want the vaccine;
5. will not seek to invoke Gillick Competency;
6. will advise me immediately should [insert name] attempt to consent to receiving the vaccine;
7. will not administer the vaccine under any circumstances without notifying me and specifically discussing this matter with me.
8. I place you on notice that administering or facilitating the administration of the vaccine without fully informed consent may be considered unlawful and potentially assault.

I look forward to receiving your urgent response.

Yours sincerely,