UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 1:22-cv-00013

ANDREW GARLICK,
DR. THOMAS FOW, and
REBEKAH VOELKELT,

Plaintiffs,

v.

THE REGENTS OF THE UNIVERSITY OF COLORADO,
TODD SALIMAN, in his official capacity as President of University of Colorado,
DONALD M. ELLIMAN, JR., in his official capacity as Chancellor of University of Colorado Anschutz Medical Campus,
MICHELLE MARKS, in her official capacity as Chancellor of University of Colorado Denver,

*Defendant*s.

Verified Complaint for Declaratory and Injunctive Relief

Plaintiffs Andrew Garlick, Dr. Thomas Fow, and Rebekah Voelkelt ("**Students**") complain against Defendants as follows:

Introduction

1. This is a civil action for declaratory and injunctive relief arising under the First and Fourteenth Amendments to the United States Constitution and 42 U.S.C. § 1983.

2. It concerns the constitutionality of the University of Colorado ("**CU**") Vaccine Mandate

(the "**Mandate**")[1], requiring students to take COVID "vaccines,"[2] despite their objection.

3. The Mandate violates the liberty protected by the Fourteenth Amendment to the U.S. Constitution, which includes rights of bodily integrity and autonomy, and medical treatment choice.

4. The Mandates' exemption policies violate the Establishment Clause of the First Amendment to the United States Constitution.

5. The Mandate's exemption policies violate the Free Exercise Clause of the First Amendment to the United States Constitution.

6. The Mandate's exemption policies violate the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

7. Students' refusal of the vaccine and Mandate is based on legitimate concerns including underlying medical conditions, having natural antibodies, and the risks associated with the vaccine, as well as sincerely held religious objections.

8. The only way such rights can be infringed is for CU to justify its override of the student's choice within the boundaries of the U.S. Constitution, which it cannot do.

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[1] Students broadly challenge all portions of CU's requirement to take a COVID vaccine. Accordingly, the "Mandate" includes CU's general requirement, along with each campuses guidance and requirements for implementation and exemptions.

[2] While CU refers to COVID "vaccines," Plaintiffs show that all COVID "vaccinations" are, by traditional definition, not vaccines. *See infra* Part I.B.1. Instead, each of the COVID "vaccines" operate only as medical treatments or therapeutics—lessening symptoms and severity, but not preventing infection or transmission. *Id*. Accordingly, throughout this Complaint, Plaintiffs refer to all COVID "vaccines" as "COVID vaccine" or "COVID shot-treatment."

Jurisdiction and Venue

9. This action arises under the First and Fourteenth Amendments to the United States Constitution and is brought pursuant to 42 U.S.C. § 1983.

10. This Court has jurisdiction over all claims pursuant to 28 U.S.C. Sections 1331 and 1343(a). It also has jurisdiction pursuant to the Declaratory Judgment Act as codified at 28 U.S.C. Sections 2201 and 2202.

11. Venue is proper under 28 U.S.C. Section 1391(b) because Defendant resides in this District and because a substantial part of the events giving rise to the claim occurred in this District.

Parties

12. Plaintiff Andrew Garlick is a resident of Jefferson County, Colorado, and a junior at CU.

13. Plaintiff Doctor Thomas Fow is a resident of Jefferson County, Colorado, and a terminated student of CU.

14. Plaintiff Rebekah Voelkelt is a resident of Arapahoe County, Colorado, and a deferred student at the University of Colorado.

15. Defendant the Regents of the University of Colorado is the governing body of CU. Colo. Rev. Stat. ("**C.R.S.**") § 23-20-102. The Board of Regents is a "body corporate." Colo. Const. Art. IX, Sec. 12. It "has general supervision of the university" and is responsible for "enact[ing] laws for the government of the university[.]" C.R.S. §§ 23-20-111, 23-20-112;

University of Colorado, *Board of Regents*, https://regents.cu.edu/.[3]

16. Defendant Todd Saliman, in his official capacity as President, is the principal executive officer of CU. Colo. Const. Art. IX, Sec. 13; C.R.S. § 23-20-106; Board of Regents Policy ("**Regent Policy**") 3.A.1(B), https://www.cu.edu/regents/regent-policy-0. He is responsible for "carry[ing] out the policies and programs established by the board of regents." C.R.S. § 23-20-106; Regent Policy 3.A.1(A). He is also "responsible for the academic, administrative, and fiscal matters of the university[.]" Regent Policy 3.A.1(B).

17. Defendant Donald M. Elliman, Jr., in his official capacity as Chancellor of CU Anschutz, is "the campus's chief executive officer and . . . chief academic, fiscal and administrative officer responsible to the president for the conduct of the affairs of their respective campus in accordance with the policies of the Board of Regents." Regent Policy 3.B.1. He also has such other responsibilities as required by the board or "delegated by the president." *Id.*

18. Defendant Michelle Marks, in her official capacity as Chancellor of CU Denver, is "the campus's chief executive officer and . . . chief academic, fiscal and administrative officer responsible to the president for the conduct of the affairs of their respective campus in accordance with the policies of the Board of Regents." Regent Policy 3.B.1. She also has such other responsibilities as required by the board or "delegated by the president." *Id.*

[3] All websites herein were last visited on December 27, 2021.

I. Facts

A. The Mandate Overview and Implementation

19. CU is comprised of four campuses: Boulder ("**CU Boulder**"), Colorado Springs ("**CU Colorado Springs**"), Denver ("**CU Denver**"), and Anschutz Medical Campus ("**CU Anshutz**")—all governed by the Board of Regents. *About the CU System*, University of Colorado, https://www.cu.edu/about-cu-system.

20. On April 28, 2021, CU announced that these four campuses will require faculty, staff, and students to receive a COVID-19 ("**COVID**") vaccine for the fall 2021 semester. *University of Colorado COVID Vaccine Requirement*, University of Colorado, https://www.cu.edu/vaccine-requirement (last updated Aug. 23, 2021); *Statements from the President- CU Requires Vaccine for Fall Semester 2021*, University of Colorado (Apr. 28, 2021), https://president.cu.edu/statements/cu-requires-vaccine-fall-semester-2021.

21. Per their statement, CU's president and campus chancellors made the decision to mandate vaccination "after consulting state and local health departments, as well as CU experts." *University of Colorado COVID Vaccine Requirement*, University of Colorado, https://www.cu.edu/vaccine-requirement (last updated Aug. 23, 2021).

22. The Statement from CU's President does not provide a clear process as to how the decision to recommend the Mandate was made, nor does it state what evidence they relied upon. *See generally Statements from the President- CU Requires Vaccine for Fall Semester 2021*, University of Colorado (Apr. 28, 2021), https://president.cu.edu/statements/cu-requires-vaccine-

fall-semester-2021.

23. No explanation is given as to why the Mandate is needed if the vast majority of students will already be vaccinated, allowing CU's community to achieve herd immunity. *See* Part I.C.1. (showing that CU has reached herd immunity).

24. CU also did not explain why it was necessary to implement provisions which far exceed those imposed by the CDC or state and county authorities on the general public. *See infra* Parts I.B.5-I.B.7. (detailing the requirements for each).

25. On May 20, 2021, a Resolution providing that the "Board of Regents opposes the decisions by university administrators to mandate COVID vaccinations and instead seeks to promote a voluntary vaccination approach based on individual choice[]" was presented to the Board. *See CU Board of Regents Agenda Item*, Pls. Ex. 1 (providing full text of the Resolution). This Resolution was defeated by a decision of 6-3 on June 17, 2021. *See University of Colorado Board of Regents Minutes of the Regular Board Meeting*, *Thursday, June 17, 2021*, Pls. Ex. 2, at Sec. K.

26. The defeat of this Resolution constitutes acceptance and support of the President and Chancellors' decision to implement the Mandate.

27. While the Mandate applies generally to all campuses, each campus has campus-specific implementation. For example, each campus has determined its own processes for exemptions and has varying deadlines for complying with the Mandate. The relevant campuses will be discussed in turn.

28. Visitors on any CU campus are not required to show proof of vaccine. *University of*

Colorado COVID Vaccine Requirement, University of Colorado, https://www.cu.edu/vaccine-requirement.

1. CU Denver Implementation and Exemptions

29. For CU Denver, students, faculty, and staff were required to be fully vaccinated by August 23, 2021, and were required to self-disclose their vaccination status by August 27, 2021. *COVID-19 Vaccines and Testing*, University of Colorado Denver, https://www.ucdenver.edu/coronavirus/testing.

30. There are strong consequences for those who refuse the vaccine, even with an exemption. Those who don't receive the vaccine have to self-disclose their status and consent to weekly COVID-19 testing. *COVID-19 Vaccines and Testing*, University of Colorado Denver, https://www.ucdenver.edu/coronavirus/testing. Failure to complete weekly testing may result in disciplinary action. *Id*.

31. If a person chooses to receive the vaccination, CU Denver requires that such person enter into an online "COVID-19 vaccine verification system" using their university credentials. *COVID-19 Vaccines and Testing*, University of Colorado Denver, https://www.ucdenver.edu/coronavirus/testing. They then must identify which vaccine was received, and specifically when the dose(s) were received. *Id*. For Colorado students, CU Denver can also confirm vaccination status with the Colorado Department of Public Health & Environment. *Id*.

32. For CU Denver, individuals may request an exemption for religious, medical, or personal reasons. *Fall 2021 Vaccine Requirement*, University of Colorado Denver, https://www.ucdenver.edu/coronavirus.

33. But those who qualify for and are granted an exemption are still subject to additional requirements.[4]

34. These Extra Requirements include weekly mitigation testing, as well as mandatory face masks while indoors. *Id*.

35. While vaccinated individuals may remove their masks indoors when able to maintain ten feet of social distancing, unvaccinated individuals must wear a mask "at all times while indoors." *Id*.

36. Once an exemption form is completed online, CU Denver students are automatically routed into the mandatory weekly testing program. *Fall 2021 Vaccine Requirement*, University of Colorado Denver, https://www.ucdenver.edu/coronavirus. These students must schedule a COVID-19 test during *each* academic week of the semester. *Id*.

37. There are no exemptions from these Extra Requirements for those who qualify for an exemption. *Id*. There is no exemption from wearing a face mask in public spaces. *Id*. There is no exemption from participating in the mandatory weekly mitigation testing. *Id*.[5]

38. CU Denver does not include an exemption for those with natural immunity to COVID, including those who have previously been infected and fully recovered.

39. If a person with an exemption is discovered not wearing a face mask or does not

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[4] The additional requirements for exempted students at CU Denver and CU Anschutz (*see* ¶¶ 33-39, 47-53) will be jointly referred to as "**Extra Requirements**".

[5] The only exception to this is for online-only students who are "never required to visit any CU facility[.]" University of Colorado Denver, *COVID-19 Vaccines and Testing*, https://www.ucdenver.edu/coronavirus/testing; *see also* ¶ 219 (Garlick exemption paragraph).

participate in the mitigation testing, they face "disciplinary action." *Id*.

40. CU has alluded to the option of requiring boosters in the future, stating that it "will adhere to FDA guidance" when determining whether to require boosters. *University of Colorado COVID Vaccine Requirement,* University of Colorado, https://www.cu.edu/vaccine-requirement.

2. CU Anschutz Implementation and Exemptions

41. For CU Anschutz, students, faculty, and staff were required to be fully vaccinated by September 1. *COVID-19*, University of Colorado Anschutz Medical Campus, https://www.cuanschutz.edu/coronavirus.

42. There are strong consequences for those who refuse the vaccine, even with an exemption. Those who don't receive the vaccine will have to self-disclose their status and consent to weekly COVID-19 testing. *See COVID-19 Testing & Contract Tracing*, University of Colorado Anschutz Medical Campus, https://www.cuanschutz.edu/coronavirus/covid-19-testing-contact-tracing#ac-mandatory-covid-19-testing-program-0; *Vaccine Information*, University of Colorado Anschutz Medical Campus, https://www.cuanschutz.edu/coronavirus/vaccine-information. Failure to complete weekly testing may result in disciplinary action. *Id.*

43. If a person chooses to receive the vaccination, CU Anschutz requires that such person enter into an online "COVID-19 vaccine verification system" using their university credentials. *COVID-19, Vaccine Information, Verification*, University of Colorado Anschutz Medical Campus, https://www.cuanschutz.edu/coronavirus/vaccine-information/verification. They then must identify which vaccine was received, and specifically when the dose(s) were received. *Id.*

44. For CU Anschutz, individuals were able to request an exemption for religious or

medical reasons. *Medical & Religious Exemptions to COVID-19 Vaccination Requirement*, University of Colorado Anschutz Medical Campus, https://www.cuanschutz.edu/coronavirus/vaccine-information/exemptions; *Religious Exemption From COVID-19 Vaccination Requirement*, Pls. Ex. 3.

45. In denying certain religious exemption requests, CU Anschutz made it clear that it would only grant religious exemptions for "a person's religious belief whose teachings are opposed to all immunizations, i.e., your religion teaches you and all other adherents that immunizations are forbidden under all circumstances." *Infra* ¶ 238.

46. However, on September 24, 2021, CU updated its policy to indicate that "[r]eligious accommodations are not currently available to students or applicants." *COVID-19 Vaccination Requirement and Compliance*, University of Colorado Anschutz Medical Campus (Sept. 24, 2021), https://www.ucdenver.edu/docs/librariesprovider284/default-document-library/3000-facilities-management/3012---covid-19-vaccination-requirement-and-compliance.pdf?sfvrsn=3e48cbba_2. Religious exemptions are still available for employees. And medical exemptions are still available for both employees and students. *Id*.

47. Moreover, even those who qualify for and are granted an exemption are still subject to additional requirements.[6]

48. These Extra Requirements include weekly mitigation testing, mandatory face masks at all times, completing a daily health questionnaire, physical distancing at all times (both indoors

[6] *See supra* n. 3.

and outside), and self-report/stay home when sick. *Unvaccinated*, University of Colorado Anschutz Medical Campus, https://www.cuanschutz.edu/coronavirus/unvaccinated.

49. There are virtually no exemptions from these Extra Requirements for those who qualify for a religious or medical exemption. *Id.*; *COVID-19*, University of Colorado Anschutz Medical Campus, https://www.cuanschutz.edu/coronavirus.

50. There is no exemption from wearing a face mask indoors. *Id.* There is no exemption from weekly testing for those who do not receive the vaccine. *See generally*, *COVID-19 Testing & Contact Tracing*, University of Colorado Anschutz Medical Campus, https://www.cuanschutz.edu/coronavirus/covid-19-testing-contact-tracing#ac-mandatory-covid-19-testing-program-0.

51. CU Anschutz does not include an exemption for those with natural immunity to COVID, including those who have previously been infected and fully recovered. *Id*.

52. The *only exception* is that exempted students may remove their masks when more than 6 feet away from others while outdoors. *Id*. On the other hand, vaccinated individuals are permitted to remove their face masks while indoors and more then 6 feet away from others; and outdoor face masks are solely optional. *COVID-19 Updates*, University of Colorado Anschutz Medical Campus, https://www.cuanschutz.edu/coronavirus/updates.

53. If a person with an exemption is discovered not wearing a face mask or does not participate in the mitigation testing, they face "potential action and/or discipline." COVID-19 Vaccination Requirement and Compliance, University of Colorado Anschutz Medical Campus, https://www.ucdenver.edu/docs/librariesprovider284/default-document-library/3000-facilities-management/3012---covid-19-vaccination-requirement-and-compliance.pdf?sfvrsn=3e48cbba_2.

54. CU Anschutz is also now requiring booster shots. *Id*.

B. Context Surrounding the Mandate

1. COVID "Vaccines" Are Not Vaccines, in the Traditional Sense, but Operate Only as Medical Treatments or Therapeutics—Lessening Symptoms and Severity, but Not Preventing Infection or Transmission

55. COVID vaccines are not "vaccines" in the traditional sense. Instead, the FDA classifies them as "CBER-Regulated Biologics" otherwise known as "therapeutics" which falls under the "Coronavirus Treatment Acceleration Program." FDA, Coronavirus (COVID-19) | CBER-Regulated Biologics, https://www.fda.gov/vaccines-blood-biologics/industry-biologics/coronavirus-covid-19-cber-regulated-biologics; FDA, Coronavirus Treatment Acceleration Program (CTAP), https://www.fda.gov/drugs/coronavirus-covid-19-drugs/coronavirus-treatment-acceleration-program-ctap.

56. The vaccine is misnamed since it neither prevents infection, re-infection, nor transmission of the virus, the key elements of a vaccine. As shown below, the CDC has publicly stated that the vaccine is effective in reducing the severity of the disease but not transmission, infection, or re-infection. *See infra* ¶¶ 156-158.

57. Accordingly, the injection is a medical treatment or therapeutic, not a vaccine.

58. To account for the vaccines not qualifying as a "vaccine" in the tradition sense, the CDC changed its definition of "vaccination" in August 2021. The CDC previously described vaccination as: "the act of introducing a vaccine into the body to produce immunity to a specific disease." Now, the definition has since been changed and reads: "the act of introducing a vaccine into the body to produce protection from a specific disease." Katie Camero, *Why did CDC*

change its definition for 'vaccine'? Agency explains move as skeptics lurk (Updated Sept. 27, 2021), https://www.charlotteobserver.com/news/coronavirus/article254111268.html; Centers for Disease Control and Prevention, *Immunization: The Basics*, https://www.cdc.gov/vaccines/vac-gen/imz-basics.htm.

59. While CU refers to COVID "vaccines," Plaintiffs have shown that all COVID "vaccinations" are, by traditional definitions, not vaccines. Instead, each of the COVID "vaccines" operate only as medical treatments or therapeutics—lessening symptoms and severity, but not preventing infection or transmission. *Id*.

60. Moreover, COVID vaccines are unlike traditional vaccines because they cause cells to reproduce one portion of the virus, the spike protein. Center for Disease Control, COVID, *Understanding mRNA COVID-19 Vaccines*, https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/mrna.html. The vaccines thus induce the body to create spike proteins, causing a person to create antibodies only against this one limited portion (the spike protein) of the virus. Franz X. Heinz and Karin Stiasny, *Distinguishing features of current COVID-19 vaccines: knowns and unknowns of antigen presentation and modes of action,* npj vaccines 6, 104 (Aug. 16, 2021), https://www.nature.com/articles/s41541-021-00369-6. Doing so has multiple harmful effects.

61. First, these vaccines "mis-train" the immune system to recognize only a small part of the virus (the spike protein). Variants that differ, even slightly, in this protein, such as the Delta variant, are able to escape the narrow spectrum of antibodies created by the vaccines. *Id.*

62. Second, the vaccines make people become dependent upon regular booster shots,

because they have been "vaccinated" only against a tiny portion of a mutating virus. This will lead to a constant need for booster shots.

63. Third, the vaccines do not prevent infection in the nose and upper airways, and vaccinated individuals with breakthrough Delta have been shown to have much higher viral loads in these regions. Nguyen Van Vinh Chau, et al., *Transmission of SARS-CoV-2 Delta Variant Among Vaccinated Healthcare Workers, Vietnam*, The Lancet, (Oct. 11, 2021), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3897733. This can lead to the vaccinated becoming "super-spreaders" as they carry extremely high viral loads.

2. The Mandate is Contrary to the FDA Emergency Use Authorization

64. Currently, all but one of the publicly-available COVID vaccines have only "Emergency Use Authorization" status, and have not received full FDA approval.[7] These COVID vaccines are not vaccines licensed by the Food and Drug Administration ("FDA"), as they have not received[8] full FDA approval.

65. A drug classified under "Emergency Use Authorization" is a drug authorized by the Secretary of Health and Human Services for the duration of an emergency under 21 U.S.C.A.

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[7] The Pfizer vaccine is the only vaccine that has received full FDA approval. See *Comirnaty and Pfizer-BioNTech COVID-19 Vaccine*, U.S. Food and Drug Administration (updated Oct. 20, 2021), https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/comirnaty-and-pfizer-biontech-covid-19-vaccine. However, the Pfizer vaccine still only has Emergency Use Authorization for individuals under 16 and boosters.

[8] While one vaccine has been granted full approval, individuals choose which vaccine to receive (if any) based on a variety of reasons including the risks, side effects, development process, etc. So one having full approval does not negate the EUA issue. Moreover, Pfizer has not received full FDA approval for all contexts. *Supra* n. 6.

§ 360bbb-3.

66. As a matter of law, a drug given Emergency Use Authorization (EUA) status is one not already approved or licensed under the Public Health Service Act. 21 U.S.C.A. § 360bbb-3.

67. A drug receives EUA status once the Secretary, in consultation with the Assistant Secretary for Preparedness and Response, the Director of the National Institutes of Health, and the Director of the Centers for Disease Control and Prevention, concludes that (1) "that an agent . . . can cause a serious or life-threatening disease or condition;" (2) it is reasonable to believe the drug may be effective in diagnosing, preventing, or treating, the agent, and the known benefits of taking the drug outweigh the known risks; and (3) "that there is no adequate, approved, and available alternative to the product for diagnosing, preventing, or treating such disease or condition[.]" 21 U.S.C.A. § 360bbb-3(c).

68. A vaccine authorized under Emergency Use Authorization requires complete, informed, and voluntary consent. Indeed, as a condition of authorization under the Emergency Use Authorization provisions, the Secretary is required:

> "to ensure that individuals to whom the product is administered are informed—
> (I) that the Secretary has authorized the emergency use of the product;
> (II) *of the significant known and potential benefits and risks of such* use, and of the extent to which such benefits and risks are unknown; and
> (III) *of the option to accept or refuse administration of the product*, of the consequences, if any, of refusing administration of the product, and of the alternatives to the product that are available and of their benefits and risks.

21 U.S.C.A. § 360bbb-3(e)(1)(A)(ii)(I)-(III) (emphases added).

69. Consequently, all COVID vaccines currently available under EUA can only be administered to individuals in accordance with 21 U.S.C.A. § 360bbb-3(e)(1)(A)(ii)(III), which

requires the informed consent of the consumer before they receive the vaccination and the option to refuse or accept the drug.

70. The statute requires and, if followed, produces *medical* informed consent—consent based on medical information from medical providers. The "consequences" of refusing the product that are considered *and for which consent is secured* are medical consequences, not other types of consequences, like loss of employment or virtual expulsion from school.

71. The threat of virtual expulsion from school for students who refuse to take the vaccine, who do not qualify for an exemption, who do not participate in weekly testing is not an attempt to garner consent—it is coercion. In other contexts, even subtle, implied threats cannot constitutionally support "consent." *Schneckloth v. Bustamonte*, 412 U.S. 218, 228 (1973) (coerced police searches unconstitutional); *see also*, *Stolt-Nielsen S.A. v. AnimalFeeds Int'l Corp*., 559 U.S. 662, 681 (2010) (arbitration "is a matter of consent, not coercion").

72. While CU is not a provider and is not directly subject to the informed consent statute, the principles supporting EUA itself, as well as the informed consent law, supports voluntary informed consent from CU's students—not coercion from CU's administration.

73. Accordingly, the same processes should be used, and consents obtained, when suggesting that students get a vaccine that has only been approved for emergency use.

74. The Mandate is contrary to these principles, processes, and consents. It does not inform students that (1) two of the recommended vaccines are only authorized for emergency use, (2) that there are "significant known and potential benefits and risks of such use" (or "the extent to which such benefits and risks are unknown") or (3) that students have the "option to accept or

refuse administration of the product[.]"

75. Contrary to the requirements imposed on the general public, no CU student is given the option to accept or refuse the vaccine; it is mandated.

3. The Mandate is Contrary to Modern Medical Ethics

76. The Mandate is contrary to the fundamental tenet of medical ethics which require voluntary and informed consent for any procedure, or drug that imposes a medical risk to an individual. "A person may freely choose to accept medical risks for the benefit of others . . . we don't harvest organs without consent, even if doing so would save many lives. Those who make such sacrifices for others must truly be volunteers, not conscripts drafted by college administrators." Aaron Kheriaty and Gerard V. Bradley, *University Vaccine Mandates Violate Medical Ethics*, WALL STREET JOURNAL (June 14, 2021, 12:47 PM), https://www.wsj.com/articles/university-vaccine-mandates-violate-medical-ethics-11623689220.

77. In some circumstances, our society has resolved this medical ethics quandary in favor of mandatory vaccines. But it is critical to look at the specific contexts in which this has occurred.

78. In elementary schools, pediatric vaccines are mandatory for illnesses that *pose significant medical risks to those children*, like polio or measles. *See id.* Likewise, colleges usually require its students to have been vaccinated against these illnesses.

79. The risks of side effects and serious complications from these types of mandatory vaccines are generally known due to long-time use and years of research on the specific population in question. The risks of serious illness or death due to the diseases far outweighs the known risks of the vaccines to those same diseases.

80. Here, the risk of serious morbidity and mortality from COVID for those under 30 are close to zero. *See* Part I.C.2. The known and unknown risks associated with COVID vaccines, particularly in those under 30, outweigh the risks to that population from the disease itself, by any rational measure. *See* Part I.D.2.

81. For instance, "a June 10 review by the FDA's Vaccines and Related Biological Products Advisory Committee indicated an excess risk for heart inflammation, especially in men 30 and younger." Kheriaty*, supra.*

82. Forced COVID vaccinations are also imposed on "populations that were deliberately excluded from clinical trials," such as patients who have recovered from COVID, as well as pregnant and breast-feeding women. *Id.* Thus, any risks to them were completely unknown.

83. People with higher risks of serious COVID complications, such as individuals over 60 and people with underlying health conditions, are not required to be vaccinated and can choose to take the vaccine to protect themselves, if they wish.

84. The much smaller subset of people who are at higher COVID risk and who cannot safely receive the vaccine can mitigate their risks by practicing social distancing and wearing a mask.

85. "Protection of others," especially in the COVID context, does not relieve our society from the central canon of medical ethics requiring voluntary and informed consent.[9]

86. The FDA requirement of voluntary and informed consent is based on the medical ethics.

[9] Additionally, "protection of others" interest fails for another significant reason—vaccines do not prevent spread or transmission of the virus. *See* Part I.D.1.

However, history is replete with societies which violated this central tenet of medical ethics. In 1932, the United States did not receive voluntary and informed consent from African Americans for a study in conjunction with the Tuskegee Institute on syphilis. The Tuskegee Study intentionally refused to reveal to the participants that they had syphilis, intentionally withheld widely available treatments, like penicillin, from them and intentionally failed to get their informed consent to participate in the study. *U.S. Public Health Service Syphilis Study at Tuskegee Timeline*, Centers for Disease Control and Prevention, https://www.cdc.gov/tuskegee/timeline.htm.

87. It took *forty years* for the U.S. government to put an end to the Tuskegee Study. *Id.* The Tuskegee Study prompted then-President Bill Clinton to state, "with [scientific and technical changes] we must work harder to see that as we advance we don't leave behind our conscience. No ground is gained and, indeed, much is lost if we lose our moral bearings in the name of progress." Pres. Bill Clinton, *Apology For Study Done in Tuskegee,* The White House Office of the Press Secretary (May 16, 1997), https://clintonwhitehouse4.archives.gov/textonly/New/Remarks/Fri/19970516-898.html.

88. Of course, the historical example of the Tuskegee Study differs from the Mandate because CU has no intent to risk harm to its students and they are not conducting a "study." And Students do not claim otherwise. However, the Mandate does not provide for voluntary and informed consent to the taking of the vaccine, a fundamental tenet of medical ethics, which the Tuskegee Institute also failed. Thus, the Mandate is contrary to modern medical ethics.

4. The Mandate is Contrary to the Common Law Right of Informed Consent

89. Individuals have a common-law right to informed consent for medical treatments, which stems from a person's right to bodily integrity. *Cruzan by Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 269 (1990).

90. In discussing bodily integrity, the Supreme Court has observed, "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Id*. at 269 (citing *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251, (1891)).

91. This notion is not limited to unwanted touching or the right to be left alone. Instead, the notion of bodily integrity is "embodied in the requirement that informed consent is generally required for medical treatment." *Id*. at 269.

92. The informed consent doctrine has been described as follows: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *Id*. (citing *Schloendorff v. Soc'y of New York Hosp.*, 105 N.E. 92, 93 (1914)).

93. Given its importance, the doctrine of informed consent has become "firmly entrenched in American tort law." *Id*. (citation omitted). But Courts have also continued to base a right to refuse medical treatment on the common-law right to informed consent. *Id*. (citing *inter alia Matter of Quinlan*, 355 A.2d 647 (S. Ct. NJ 1976), *Matter of Storar*, 420 N.E.2d 64, 68 (Ct. App.

NY 1981)).

94. But while informed consent gives rise to the notion that a patient has a right to consent to medical treatment, a logical and necessary corollary of the doctrine "is that the patient generally possesses the right not to consent, that is, to refuse treatment." *Id*. at 270.

95. Accordingly, "the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment." *Id*. at 277.

96. Under the common-law right to informed consent, every adult of sound mind has the right to determine what shall be done or not done with his own body, including whether to receive or refuse a medical treatment or vaccination.

5. The Mandate is Contrary to CDC's Recommendations

97. The CDC has acknowledged that adults in the eighteen to twenty-five years old demographic have a very low risk of adverse effects due to a COVID infection. *See infra* ¶ 142, Tables B and C.

98. The CDC guidelines for unvaccinated people remain largely unchanged from when the pandemic officially began on March 11, 2020. Currently, the CDC's guidance for unvaccinated people is to wear a mask, social-distance at least six feet apart from other individuals, avoid any sort of crowd whether it be outside or inside, get tested, sanitize often, and monitor health. *See Guidance for Unvaccinated People: How to Protect Yourself and Others*, Center for Disease Control (updated Nov. 29, 2021), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html. Furthermore, the CDC suggests that people get vaccinated, but does *not* require it. *Id*.

99. The Mandate is contrary to CDC recommendations, as the CDC simply suggests that individuals get vaccinated and use other protective measures. The CDC does not recommend *requiring* any individual to be vaccinated.

6. The Mandate is Contrary to Colorado State Requirements.

100. The current guidelines for Colorado were established in Governor Polis's recent executive orders. *See e.g., 2021 Col. Exec. Order D 124* (July 30, 2021), https://www.colorado.gov/governor/sites/default/files/inline-files/D%202021%20124.pdf; *see also 2021 Col. Exec. Order D 132* (Oct. 10, 2021), https://drive.google.com/file/d/1e2DNzf-zPb3JVtiGA3xc3kCr4RJJC0an/view; *2021 Col. Exec. Order D 139* (Nov. 29, 2021), https://drive.google.com/file/d/1n9-yVPWyJE72Rl0Pt s4xK9gRXXDYBnRz/view.

101. In *Order D 124*, the Governor stated (in regard to COVID-19) that "the moment for extraordinary executive action has passed," and he therefore rescinded "all previous Executive Orders issued due to COVID-19." *Id*. Subsequent measures have been taken, but none mandating vaccination. *See, e.g. 2021 Col. Exec. Order D 132*, *2021 Col. Exec. Order D 139*.

102. Requirements for all Coloradan's generally follow CDC guidelines. Colorado Department of Public Health and Environment, *Guidance for wearing masks* (Sept. 1, 2021), https://covid19.colorado.gov/mask-guidance.

103. Colorado's standing public health order requires unvaccinated individuals to wear a mask in certain settings, including medical facilities, homeless shelters, and prisons/jails. *Tenth Amended Public Health Order 20-38: Limited COVID-19 Restrictions*, Colorado Department of Public Health and Environment (Nov. 30, 2021), https://drive.google.com/file/d/1ZXHwIn976j

oblTQGjXYbv_KvnXGSHDhO/view.

104. The State encourages anyone who has not obtained a vaccine to do so. *Guidance for wearing masks*, Colorado Department of Public Health and Environment (Sept. 1, 2021), https://covid19.colorado.gov/mask-guidance.

105. Those who have not obtained a vaccination are still encouraged to socially distance themselves and wear a mask in public places, but there is no requirement to do so. *Id.*

106. The State of Colorado has not issued a vaccination mandate for the general public. *See generally Vaccine laws and regulations*, Colorado Department of Public Health & Environment (updated Sept. 17, 2021), covid19.colorado.gov/vaccine-laws-regulations.

107. Colorado has implemented a requirement that all state employee be fully vaccinated against COVID-19 *or participate in twice-weekly testing*. *Id*. Unlike the mandates in the CU system, the state mandate has no penalties for those refusing to be vaccinated so long as they complete the twice-weekly testing. *Id*.

108. Colorado does not require its citizens show proof of vaccination. *Id*.

109. The Mandate is contrary to Colorado recommendations, going significantly further than any recommendations from the State.

7. The Mandate is contrary to Boulder County, El Paso County, Adams County, and Denver County's Recommendations

110. CU's campuses are located in Boulder County, El Paso County, Adams County, and Denver County. The recommendations for these counties are discussed in turn.

111. Boulder County has no COVID vaccine requirements for its residents. *Boulder*

County Current Status, Boulder County, https://www.bouldercounty.org/families/disease/covid-19/boulder-county-status/. While Boulder County is currently requiring residents to wear masks indoors, it is not requiring its residents or county employees to get vaccinated. *Id*. And it is not requiring any proof of vaccination status. *Id*.

112. El Paso County does not appear to have any public health orders in place in regard to COVID-19. Accordingly, El Paso County is not requiring its residents or county employees to get vaccinated, and it is not requiring any proof of vaccination status. *Id*.

113. While Adams County recommends that people get vaccinated and wear masks in public, it has no vaccine requirement. *Coronavirus Disease 2019 (COVID-19)*, Tri-County Health Department, https://www.tchd.org/818/Coronavirus-COVID-19. Adams County is not requiring its residents or county employees to get vaccinated, and it is not requiring any proof of vaccination status. *Id*.

114. Of the four counties that the CU has campuses in, only Denver County has issued a vaccine mandate for county employees. Vaccination Info for Employees, Denver, https://www.denvergov.org/Government/COVID-19-Information/Frequently-Asked-Questions#section-8. However, Denver County has not issued a vaccination mandate for the general public. *Id*. Additionally, the employee mandate contains a medical exemption for those who cannot receive the vaccine based on a medical condition and a religious exemption for those with a sincerely held religious belief that conflicts with the vaccine. *Id*.

115. No local governments in Colorado have issued a vaccination mandate for their residents.

116. The Mandate is contrary to applicable county requirements—going significantly further than any of the relevant counties' recommendations and requirements.

C. Current Risk to CU Students of COVID Infection and Adverse Outcomes

1. Current State of the Pandemic

117. The CDC recently reported low COVID numbers—significantly lower than the peak of the pandemic. Centers for Disease Control and Prevention, *Daily Trends in Number of COVID-19 Cases in The United States Reported to CDC*, https://covid.cdc.gov/covid-data-tracker/#trends_dailycases.

118. In Colorado, Governor Polis recently stated that Colorado "has made tremendous progress in terms of containing and treating infection and distributing the COVID-19 vaccine." 2021 *Col. Exec. Order D 132* (Oct. 10, 2021), https://covid19.colorado.gov/public-health-executive-orders. And that "the [time] for extraordinary executive action has passed." *Id.* at 2.

119. Additionally, many places are reaching herd immunity.

120. Herd immunity "occurs when a high percentage of the community is immune to a disease (through vaccination and/or prior illness), making the spread of this disease from person to person unlikely." *Herd immunity*, Association of Professionals in Infection Control and Epidemiology, https://apic.org/monthly_alerts/herd-immunity/.

121. The percentage level to qualify for herd immunity differs depending on the disease, ranging from as low as 60% for influenza to 95% for measles (which is one of the most transmissible infections and so requires a higher number of persons immune to reach herd immunity). *See id*; *see also Understanding herd immunity*, Mayo Clinic (May 4, 2020),

https://newsnetwork.mayoclinic.org/discussion/understanding-herd-immunity/.

122. For COVID-19, the estimate for herd immunity is around 70%. *Id.*; *see also* Tracey, Kevin, *Covid vaccines won't provide herd immunity. We need to look for additional treatments*, Think (Aug. 11, 2021), https://www.nbcnews.com/think/opinion/covid-vaccines-won-t-provide-herd-immunity-we-need-look-ncna1276512; Berg, Sara, *What doctors wish patients knew about COVID-19 herd immunity*, AMA, (Aug. 27, 2021), https://www.ama-assn.org/delivering-care/public-health/what-doctors-wish-patients-knew-about-covid-19-herd-immunity. Some suggest that 70%-85% may be needed to reach herd immunity for COVID. *Id*.

123. In light of these estimates from leading experts, herd immunity has been reached at CU.

124. CU, as a whole, has an average vaccination rate of 92.9%, well above any relevant range for COVID herd immunity.

125. CU Anschutz has a vaccination rate of 99.5% and CU Denver has a vaccination rate of 94.3%. *Successful Vaccine Verification, Events, Remote Work Agreements, Flu Shots, Breaks & Meals, Parking Options*, University of Colorado Anschutz Medical Campus (Sept. 15, 2021), https://www.cuanschutz.edu/coronavirus/updates/archives/successful-vaccine-verification-more-updates, *COVID-19 Dashboard*, University of Colorado Denver (updated Dec. 7, 2021), https://www.ucdenver.edu/coronavirus/testing/covid-19-dashboard.

126. These numbers do not include those who have natural immunity, so those immune from the virus is actually much higher.

127. As the numbers continue to decline and herd immunity is reached, such draconian

measures, requiring all students to be vaccinated, is not reasonable.

2. Risk to the College-Age Group from a COVID Infection

128. The current risk of COVID to college age students is extremely low.

129. According to the CDC the survivability of COVID-19 is extraordinarily high. Survival rates for ages 0-17 is 99.99%, 18-29 is 99.95%, 30-49 is 99.8%, 50-64 is 98.6%, and 65 and older is 90%. These figures calculate the percentage of confirmed COVID infected patients who survive. *Demographic Trends of COVID-19 cases and deaths in the US reported to CDC*, CDC Covid Data Tracker, https://covid.cdc.gov/covid-data-tracker/#demographics.

130. By comparison, the smallpox epidemic of the early 1900s had a fatality rate of roughly 30%. Centers for Disease Control and Prevention, *History of Smallpox*, https://www.cdc.gov/smallpox/history/history.html.

131. The hospitalization rate of College Age Students with COVID has never been more than 3 per 100,000 (or .003%) in Colorado, which falls in line with the rate for the U.S. as a whole. *Coronavirus in the U.S.: Latest Map and Case Count*, The New York Times, https://www.nytimes.com/interactive/2021/us/covid-cases.html.

132. As of early December, in Colorado, the college age range had a *total* of just 57 deaths involving COVID-19, which the CDC states as Deaths with "confirmed or presumed COVID-19."[10] *Weekly Updates by Select Demographic and Geographic Characteristics*, Centers for Disease Control and Prevention,

[10] Accordingly, this number includes co-morbidities.

https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#A geAndSex. Because this number includes both confirmed and presumed COVID-19, it is extremely likely that the amount of deaths *caused by* COVID-19 is much lower for this age group.

133. That death rate accounts to less than .6% of the total number of deaths in Colorado.

134. The lack of so called "super spreader events" further highlights the low risk to college students. "Super spreader events" generally occurs where large masses of people gather in close quarters and the virus spreads rapidly and easily. With COVID, however, large gatherings are not the problem. Epidemic spread of COVID, like all other respiratory viruses, notably influenza,[11] is driven by symptomatic persons; asymptomatic spread is trivial and inconsequential.

135. A meta-analysis of contact tracing studies published in The Journal of the American Medical Association showed asymptomatic COVID spread was 0.7%. Zachary J. Madewell, PhD; Yang Yang, PhD; Ira M. Longini Jr, PhD; M. Elizabeth Halloran, MD, DSc; Natalie E. Dean, PhD, *Household Transmission of SARS-CoV-2: A Systematic Review and Meta-analysis*, JAMA Network Open, https://jamanetwork.com/journals/jamanetworko pen/fullarticle/2774102.

136. Accordingly, a rational and ethical prevention measure to reduce the spread of COVID is a simple requirement, as part of formal policies, that persons with active symptomatic, febrile (feverish) respiratory illnesses, like COVID, should isolate themselves. Indeed during the H1N1 influenza A pandemic, fully open, unmasked college campuses were advised by federal health officials, *"Flu-stricken college students should stay out of circulation"* and *"if they can't*

[11] Eleni Patrozou & Leonard A. Mermel, *Does Influenza Transmission Occur from Asymptomatic Infection or Prior to Symptom Onset?*, 124 Pub. Health Rep. 193 (2009).

avoid contact they need to wear surgical masks." Great Falls Tribune, *Advice: Flu-stricken college students should stay out of circulation*, August 21, 2009, page 5, section A, available at https://www.newspapers.com/image/243611045.

137. Despite a high frequency of COVID infections, as determined by standard testing, serious COVID cases among college and graduate students is a rare event. Brown University physician epidemiologist, Andrew Bostom, MD, MS, compiled data from 100 major university and college COVID data dashboards, in conjunction with national and local news reports of campus-related hospitalizations, August 2020 through the November 2020, Thanksgiving holiday break (11/22/20).

138. The COVID positive tests and related hospitalizations from 100 universities/ colleges, from August 2020–November, 2020 are detailed in **Table A**, Pls. Ex. 4.

139. As depicted in Table A, among students on campus during this period, even though there were 139,000 positive COVID tests, there were a mere 17—typically short-term—reported COVID hospitalizations. This was driven by a cluster of seven hospitalizations from Dayton University, i.e., only 0.012% of total positive tests resulting in hospitalization.

140. Within this large sample, there were zero medically-confirmed, albeit one possible, COVID related death. This very reassuring data accrued in the absence of any COVID vaccination of the student population.

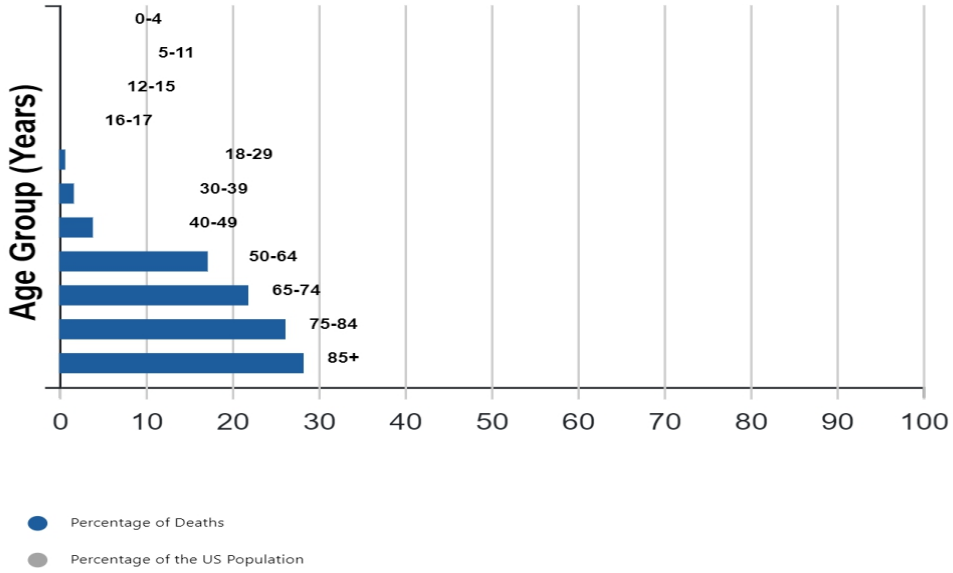
141. The risks for this age group to developing serious side effects from COVID is also extremely low.

142. Further, the CDC has released charts depicting the risks by age, as shown below.

Table B.

Deaths by Age Group:

Data from 670,145 deaths. Age group was available for 670,048 (99%) deaths.



Show Percentage of the US Population that is in this demographic category

Table C.

Risk for COVID-19 Infection, Hospitalization, and Death By Age Group

Updated Nov. 22, 2021 Print

Rate compared to 18-29 years old[1]	0-4 years old	5-17 years old	18-29 years old	30-39 years old	40-49 years old	50-64 years old	65-74 years old	75-84 years old	85+ years old
Cases[2]	<1x	1x	Reference group	1x	1x	1x	1x	1x	1x
Hospitalization[3]	<1x	<1x	Reference group	2x	2x	4x	5x	8x	10x
Death[4]	<1x	<1x	Reference group	4x	10x	25x	65x	150x	370x

All rates are relative to the 18- to 29-year-old age category. This group was selected as the reference group because it has accounted for the largest cumulative number of COVID-19 cases compared to other age groups. Sample interpretation: Compared with 18- to 29-year-olds, the rate of death is four times higher in 30- to 39-year-olds, and 370 times higher in those who are 85 years and older. (In the table, a rate of 1x indicates no difference compared to the 18- to 29-year-old age category.)

143. These charts (Tables B and C) show the minimal risk 18-29 year olds face across the United States. For example, for every one 18-29 year old that dies from COVID, 4 30-39 year olds die, 10 40-49 year olds die, 25 50-64 year olds die, 65 65-74 year olds die, 150 75-84 year olds die, and 370 over 85 die.

144. These studies do not take into account pre-existing conditions and co-morbidities, which greatly increase the likelihood of death in COVID patients. The people who are at the highest risk and have the greatest need for the vaccine are those over the age of fifty. The risk for young people is near minuscule with the achievement of herd immunity and highly effective treatments.

145. According to the CDC, as of early mid-December, only 33 18-29 year olds had died from COVID in 2021 in Colorado. Centers for Disease Control and Prevention, *Provisional COVID-19 Deaths by Sex and Age,* https://data.cdc.gov/NCHS/Provisional-COVID-19-Deaths-by-Sex-and-Age/9bhg-hcku/data.

146. Accordingly, the extremely low risk associated with catching and treating COVID make the Mandate unreasonable.

147. Further, college students are not the spreaders of the virus to the community. There was a recent study from Dr. Arnold and colleagues that reported the results of a longitudinal serosurvey (blood sampling) of community residents in Centre County, Pennsylvania, home to Pennsylvania State University, University Park campus. *See* Callum R K Arnold, Sreenidhi Srinivasan, Catherine M Herzog, Abhinay Gontu, Nita Bharti, Meg Small, Connie J Rogers, Margeaux M Schade, Suresh V Kuchipudi, Vivek Kapur, Andrew Read, Matthew J Ferrari,

SARS-CoV-2 Seroprevalence in a University Community: A Longitudinal Study of the Impact of Student Return to Campus on Infection Risk Among Community Members, medRXiv (Feb. 19, 2021), available at https://pubmed.ncbi.nlm.nih.gov/33619497/.

148. The return of approximately 35,000 students to the campus in August 2020 increased the county population size by nearly 20%. *Id*. Over 4,500 cases of COVID infections were detected among the student population during the Fall 2020 term (before and just after student return). *Id*. Between August 7, 2020, and October 2, 2020, these investigators enrolled community residents and tested their serum for the presence of anti-Spike Receptor Binding Domain (S/RBD) IgG (a class of immunoglobulin "antibodies"), to confirm prior COVID exposure. *Id*. This was repeated in the same community during December 2020 (after the departure of students), and seroprevalence for both sampling waves was recorded and analyzed. Moreover, returning students were enrolled in a longitudinal cohort, and IgG seroprevalence results were reported from the first wave of sampling (between October and November 2020, prior to the end of the term). Here is how Arnold and colleagues summarized their findings:

> Of 345 community participants, 19 (5.5%) were positive for SARS-CoV-2 IgG antibodies at their first visit between 7 August and 2 October. Of 625 returning student participants, 195 (31.2%) were positive for SARS-CoV-2 antibodies between 26 October and 23 November. 28 (8.1%) of the community participants had returned a positive result by 9 December. Only contact with known SARS-CoV-2-positive individuals and attendance at small gatherings (20-50 individuals) were significant predictors of IgG antibodies among returning students (adjusted odds ratio, 95% Confidence Interval: 3.24, 2.14-4.91, $p<0.001$; and 1.62, 1.08-2.44, $p<0.05$; respectively).

They concluded:

> Despite high seroprevalence observed within the student population, seroprevalen-

> ce in a longitudinal cohort of community residents was low and stable from before student arrival for the Fall 2020 term to after student departure, implying limited transmission between these cohorts…The demographic shift associated with student return to campus was not associated with increased SARS-CoV-2 seroprevalence in this cohort of community residents.

Id.

149. College students face little chance of actually catching COVID and little chance of spreading it to the greater community.

150. Even if students catch the virus, the treatment of the virus has improved tremendously since the advent of COVID. *See Does 1–3 v. Mills*, No. 21A90, 2021 WL 5027177, at *3 (U.S. Oct. 29, 2021) (Gorsuch, J. dissenting) (stating that we have additional treatments available that were not available last year, and that other new treatments appear near.). Studies have shown several different treatment methods, which have proven effective. A combination of medications for a minimum of five days and acutely administered supplements used for the initial ambulatory patient with suspected and or confirmed COVID-19 (moderate or greater probability) has proven effective. Brian C Procter, Casey Ross, Vanessa Pickard, Erica Smith, Cortney Hanson, Peter A McCullough, *Clinical outcomes after early ambulatory multidrug therapy for high-risk SARS-CoV-2 (COVID-19) infection*, Reviews in Cardiovascular Medicine (December 30, 2021), available at https://rcm.imrpress.com/EN/10.31083/j.rcm.2020.04.260.

Table D

Agent (drug)	Rationale
Zinc	Inhibits SARS-CoV-2 RNA synthesis
Hydroxychloroquine 200 mg po bid	Inhibits endosomal transfer of virions, anti-inflammatory
Ivermectin (200 mcg/kg) usual dose 12 mg po qd x 3 days	Attenuates importin α/β-mediated nuclear transport of SARS-CoV-2 into nucleus
Azithromycin 250 mg po bid	Covers respiratory bacterial pathogens in secondary infection
Doxycycline 100 mg po bid	Covers respiratory bacterial pathogens in secondary infection
Inhaled budesonide, Dexamethasone 8 mg IM	Treats cytokine storm
Folate, thiamine, vitamin 12	Reduce tissue oxidative stress
Intravenous fluid	Intravascular volume expansion

151. This study, conducted by Dr. McCullough, evaluated patients between the ages of 12 and 89 years. The average age was 50.5 and 61.6% were women. The study found that primary care physicians can treat COVID patients with low hospitalization and death. The study showed that administration of the medicines and supplements shown in table produces a less than 2% chance of facing hospitalization or death. As this study was done with mainly higher risk patients at the peak of the pandemic, this is a highly successful treatment plan and just one of the many new treatments that have been used in the last year. *Id.*; *see also* National Institutes of Health, *Therapeutic Management of Adults With COVID-19* (Updated Aug. 25, 2021), https://www.covid19treatmentguidelines.nih.gov/management/therapeutic-management/.

152. As shown, there is an extremely minimal risk of COVID to CU students, college students don't generally spread COVID to the community, and treatments have improved drastically, making the Mandate irrational and unreasonable.

3. Risks to the College-Age Groups for other Causes.

153. Table E shows the numbers of deaths for Colorado residents between the ages of 15 - 24 in 2019, for various non-COVID causes:

Table E

Cause of Death	Number of Colorado Residents, Ages 15 - 24
Suicide	186
Road Traffic Accidents	107
Poisonings	84
Homicide	61
Other Injuries	20
Congenital Anomalies	10

World Life Expectancy, Colorado *Health Rankings*, https://www.worldlifeexpectancy.com/colorado-cause-of-death-by-age-and-gender (citing recent data from the CDC, NIH, and individual state and county databases for verification and supplementation for USA data). This data shows that the risk of death for college-age students from any number of causes unrelated to COVID far exceeds the risk of death from COVID.

D. Current Benefits and Risks of COVID Vaccinations to CU Students

1. Benefits of COVID Vaccination for CU Students

154. While the vaccine is 95% effective at preventing severe illness and death (Thompson, Mark G., *Interim Estimates of Vaccine Effectiveness of BNT162b2 and mRNA 1273 COVID-19 Vaccines in Preventing SARS-CoV-2 Infection Among Health Care Personnel, First Responders, and Other Essential and Frontline Workers–Eight U.S. Locations, December 2020-March 2021*, https://www.cdc.gov/mmwr/volumes/70/wr/mm7013e3.htm), it does not prevent infection or transmission of the virus. It simply lessens the symptoms. *Id.*

155. Indeed, the efficacy data from trials was based solely upon lessening symptoms, not transmission. Dr. Corey who oversaw the vaccine trials for the NIH COVID-19 Prevention Network said "the studies aren't designed to assess transmission. They don't ask that question and there's no information on this at this point in time." Alicia Ault, *Can a COVID-19 Vaccine Stop the Spread? Good Question*, Medscape Medical News, (Nov. 20, 2020), https://www.medscape.com/viewarticle/941388.

156. Even the CDC admits that vaccinated people can still become infected and that "[f]ully vaccinated people who do become infected can transmit it to others." Centers for Disease Control and Prevention, *Interim Public Health Recommendations for Fully Vaccinated People* (Updated Oct. 15, 2021), https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html.

157. Additionally, the current strain is the Delta strain, which the CDC estimates is more than 99% of cases currently. Centers for Disease Control and Prevention, *Variant Proportions*, https://covid.cdc.gov/covid-data-tracker/#variant-proportions. Yet, the COVID vaccines are ineffective against the Delta strain of COVID.

158. Indeed, the CDC Director acknowledged that the vaccines do not stop the transmission of the Delta strain. *See* Madeline Holcombe, *Fully vaccinated people who get a Covid-19 breakthrough infection can transmit the virus, CDC chief says*, CNN (Updated Aug. 6, 2021), https://www.cnn.com/2021/08/05/health/us-coronavirus-thursday/index.html ("Our vaccines are working exceptionally well," [said Walensky] "They continue to work well for Delta, with regard to severe illness and death -- they prevent it. But what they can't do anymore is prevent transmis-

sion."

159. And Dr. Fauci admitted that they have not proven whether the vaccine is effective against the new Omicron variant. Hannah Bleau, *Fauci: We Haven't Proven that Vaccines, Boosters Protect Against Omicron Variant* (Dec. 3, 2021), https://www.breitbart.com/politics/2021/12/03/fauci-we-havent-proven-if-vaccines-and-boosters-protect-against-omicron-variant/.

160. Other researchers have found that the Omicron[12] variant is making existing vaccines and boosters even less effective. Ronny Reyes, *Omicron 'greatly compromises' ability of ALL Covid jabs to prevent infection including boosters, lab study finds - but third doses should still give high protection against hospitalization and death*, DailyMail.com (Dec. 16, 2021), https://www.dailymail.co.uk/news/article-10318991/Columbia-study-finds-Omicron-markedly-resistant-vaccines-boosters-not-help.html. In some cases, certain vaccines offered no protection against Omicron. *Id*.

161. The head of the World Health Organization ("WHO") and WHO's chief scientist admitted that the Omicron variant is spreading even faster that the Delta variant was and is much better at evading the antibodies generated by the COVID-19 vaccines. *Omicron spreading and infecting the vaccinated - WHO*, Reuters (Dec. 20, 2021), https://www.aol.com/news/1-omicron-spreading-infecting-vaccinated-172033826-184810325.html.

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[12] Researchers have found Omicron causes more mild illness than previous strains and is significantly less risky than Delta—with a 70% lower risk of severe illness and 80% less hospitalizations—even with the vaccines offering no protection against it. Gabrielle Reyes, *Study: South African Omicron Patients 80 Percent Less Likely to Be Hospitalized*, Breitbart (Dec. 23, 2021), https://www.breitbart.com/africa/2021/12/23/study-south-african-omicron-patients-80-percent-less-likely-to-be-hospitalized/.

162. Likewise, on November 12, 2021, CU admitted that "[y]ou can still acquire a COVID-19 infection and be infectious even if you are fully vaccinated." CU Anschutz COVID-19 Vaccination Email (Nov. 12, 2021), Pls. Ex. 5. CU's Senior Associate Dean for Clinics and Professional Practice went on to say:

> Vaccination means that you have received the vaccine; it does not mean that you are fully immunized to COVID-19. Remember, the vaccine is approximately 95% effective and the response varies in individuals. The vaccine does not prevent you from being infected and being infectious. It assists with the quality of your immune response and hopefully keeps you from becoming severely ill and shortens the time you may be infectious.

Id.

163. Even though CU Anschutz has a vaccination rate of 99.5% (*see infra* ¶ 125), CU also admitted that "[w]ith the number of patients who come to the school and the current infection rate in the community there is every reason to believe there are patients and possibly faculty, staff, students and residents in the school who are infectious with COVID-19." CU Anschutz COVID-19 Vaccination Email (Nov. 12, 2021), Pls. Ex. 5.

164. Studies also show the Delta strain passes easily amongst vaccinated persons. The Lancet, Transmission of SARS-CoV-2 Delta Variant Among Vaccinated Healthcare Workers, Vietnam (August 10, 2021) https://ssrn.com/abstract=3897733.

165. The CDC Director Wolensky also admitted that immunity from the vaccine decreases over time. White House Press Briefing by Covid-19 Response Team, Aug. 18, 2021 at 10 mins. And numerous studies have shown how vaccine effectiveness decreases and wanes over time. Arjun Puranik et al. *Comparison of two highly-effective mRNA vaccines for COVID-19 during periods of Alpha and Delta variant prevalence*, MedRxiv, Aug. 8, 2021; Ariel Israel et al.,

Large-scale study of antibody titer decay following BNT162b2 mRNA vaccine or SARS-CoV-2 infection, medRxiv, Aug. 22, 2021; *see also* Mary Keketos, Risk of COVID-19 infection more than DOUBLES 90 days after the second dose of the Pfizer vaccine, Israeli study finds (Nov. 24, 2021), https://www.dailymail.co.uk/health/article-10240501/Risk-COVID-19-infection-DOUBLES-90-days-second-dose-Pfizer-vaccine.html (highlighting a study which found that after 90 days, the risk of infection doubles, and after 150 days +, the risk of infection is 10 to 18 times the risk at time of original vaccination.); Adriana Diaz, DailyMail.com, *Get your second J&J dose ASAP say health experts after FDA advisory committee recommended approval of booster: Protection fell from 88% to just 3% in six months, study finds* (Oct. 16, 2021), https://www.dailymail.co.uk/news/article-10099209/FDA-advisory- committee-recommended-approval-J-J-vaccine.html (effectiveness of vaccine fell from 88% in March to 3% in August).

166. Because effectiveness wanes over time, boosters are proving necessary for the vaccinated. *See, e.g., id.*

167. Not only does vaccination not prevent transmission, some data suggests that vaccinated individuals may be more likely to transmit the virus to others when they contract a new variant. Nguyen Van Vinh Chau, *Transmission of SARS-CoV-2 Delta Variant Among Vaccinated Healthcare Workers, Vietnam*, The Lancet (Oct. 11, 2021) (pre-print), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3897733. Or at the very least, vaccinated and unvaccinatedmay have similar viral loads, thereby having the same risk of transmitting the virus. Kasen K. Riemersma, et al., *Vaccinated and unvaccinated individuals have similar viral loads in communities with a high prevalence of the SARS-CoV-2 delta variant*, medRxiv (pre-print),

https://www.medrxiv.org/content/10.1101/2021.07.31.21261387v1.

168. Finally, the vaccines do not promote the public health.

169. The American Public Health Association explains, "Public Health promotes and protects the health of people and communities where they live, learn, work and play. While a doctor treats people who are sick, those of us working in public health try to prevent people from getting sick or injured in the first place." American Public Health Association, *What is Public Health?*, https://www.apha.org/what-is-public-health.

170. Thus, public health professionals promote vaccines for "vaccine-preventable diseases that can be a threat to our health."American Public Health Association, *Vaccines*, https://www.apha.org/Topics-and-Issues/Vaccines.

171. This understanding of public health is long-standing. For instance, in 1920, public health was defined as:

> the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygience, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the scoial machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.

Office of Teaching & Digital Learning, Boston University School of Public Health, *What is Public Health?*, Boston University Medical Campus (Oct. 21, 2015), https://sphweb.bumc.bu.edu/otlt/MPH-Modules/PH/PublicHealthHistory.

172. As shown above, prior to August of this year, the CDC described vaccination in conformance with the traditional understanding that vaccines are a public health measure: "the act

of introducing a vaccine into the body to produce immunity to a specific disease." However, the CDC recently changed the definition to "the act of introducing a vaccine into the body to produce protection to a specific disease." *See supra* ¶ 58.[13]

173. Despite the CDC's efforts to re-define "vaccine" and "vaccination," the COVID "vaccines" cannot qualify as a public health measure because they do not prevent transmission, sickness, illness, or produce immunity.

174. Accordingly, the COVID "vaccines" are properly understood as a medical treatment.

175. Even assuming the Mandate is constitutional, which Students do not concede, the only ethical and constitutional justification for the Mandate would be the protection of others in the face of overwhelming danger to public safety. That is simply not the case here. The vaccines offer some protection from serious illness and death for the person who receives the vaccine. But the vaccine does not prevent the person who received the vaccine from contracting COVID or transmitting it to others, nor protect the public health. The Mandate is no longer about the broader public health, but about overriding an individual's choice of bodily integrity, autonomy, and of medical treatment choice without a countervailing, and substantial, danger to others to justify such an intrusion.

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[13] Likewise, the definition of "vaccine" was changed from "a product that stimulates a person's immune system to produce immunity to a specific disease, protecting the person from that disease[]" to "[a] preparation that is used to stimulate the body's immune response against diseases." Centers for Disease Control and Prevention, *Immunization: The Basics*, July 18, 2021, archived at https://web.archive.org/web/20210718162209/https://www.cdc.gov/vaccines/vac-gen/imz-basics.htm; Centers for Disease Control and Prevention, *Immunization: The Basics* (Sept. 1, 2021), https://www.cdc.gov/vaccines/vac-gen/imz-basics.htm.

2. Known Risks of COVID Vaccination for CU Students

176. Even if COVID was a significant risk for College Age Students, it is unreasonable for students to get a risky, relatively untested vaccine.

177. There are emerging trends showing that the vaccine is especially risky for those 18-29.

178. Increasingly the medical community is acknowledging the possible risks and side effects including myocarditis, Bell's Palsy, Pulmonary Embolus, Pulmonary Immunopathology, and severe allergic reaction causing anaphylactic shock. *See* Table G.

179. For example, 19-year-old Simone Scott at Northwestern University died from complications of myocarditis after receiving her second dose of the Moderna COVID vaccine. Megan Redshaw, *19-Year-Old College Freshman Dies From Heart Problem One Month After Second Dose of Moderna Vaccine*, Children's Health Defense, (June 15, 2021) https://childrenshealthdefense.org/defender/19-year-old-dies-heart-problem-moderna-vaccine/.

180. Also, a 21-year-old in New Jersey who was required to get the vaccine to attend college in the fall developed myocarditis after receiving the vaccine and had to be hospitalized. Megan Redshaw, *Exclusive: Dad Says Life 'Not the Same' for 21-Year-Old Student Who Developed Myocarditis After Second Moderna Shot,* Children's Health Defense (June 15, 2021), https://childrenshealthdefense.org/defender/21-year-old-new-jersey-student-severe-heart-inflammation-moderna-covid-vaccine/.

181. The FDA released a document detailing the large amount of serious adverse events connected to the mRNA vaccine in just the first three months after the FDA granted an EUA for

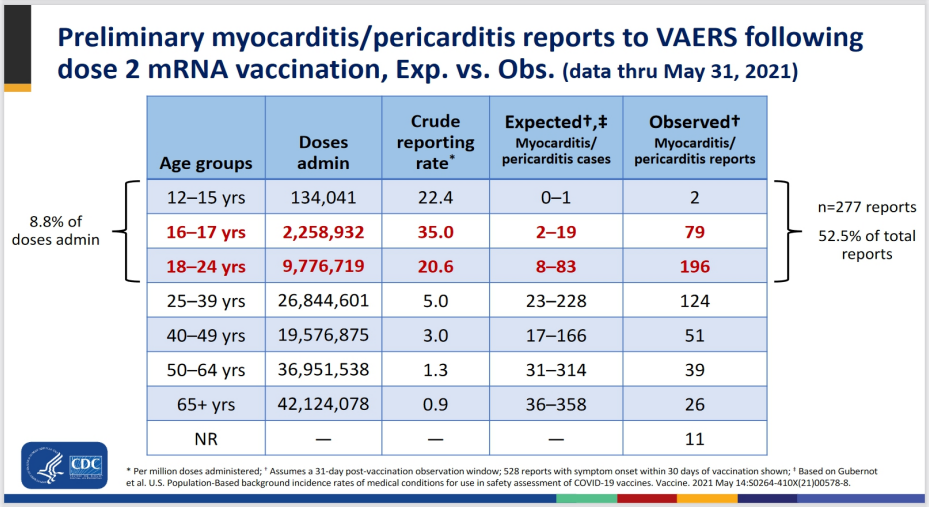
the shot. *FDA documents show over 150K serious adverse events in first 3 months of Pfizer jab approval*, LifeSiteNews (Dec. 3, 2021), https://www.lifesitenews.com/news/fda-releases-documents-showing-over-150000-serious-adverse-events-in-first-3-months-of-pfizer-jab-authorization/. These events range from blood and lymphatic disorders to cardiac, gastrointestinal, musculoskeletal, respiratory, and general disorders. *5.3.6 Cumulative analysis of post-authorization adverse event reports of PF-07302048 (BNT162B2) received through 28-Feb-2021,* Worldwide Safety (Apr. 30, 2021), https://phmpt.org/wp-content/uploads/2021/11/5.3.6-postmarketing-experience.pdf. At the time the report was completed 19,582 had recovered or were recovering, 520 recovered with sequelae, 11,361 had not recovered, 9,400 were unknown, and 1,223 of the events were fatal. *Id.*

182. Multiple recent studies and news reports detail people 18-29 dying from myocarditis after receiving the COVID vaccine. According to the CDC, 475 cases of pericarditis and myocarditis[14] had been identified in vaccinated citizens aged 30 and younger. *See* FDA, *Vaccines and Related Biological Products Advisory Committee June 10, 2021 Meeting Presentation*, https://www.fda.gov/media/150054/download#page=17.

183. The FDA found that people 12-24 accounted for 8.8% of the vaccines administrated, but 52% of the cases of myocarditis and pericarditis reported. *Id*.

[14] Myocarditis is inflammation of the heart muscle, whereas pericarditis is inflammation of the sac-like tissue around the heart called the pericardium.

Table F



Preliminary myocarditis/pericarditis reports to VAERS following dose 2 mRNA vaccination, Exp. vs. Obs. (data thru May 31, 2021)

Age groups	Doses admin	Crude reporting rate*	Expected†,‡ Myocarditis/ pericarditis cases	Observed† Myocarditis/ pericarditis reports
12–15 yrs	134,041	22.4	0–1	2
16–17 yrs	**2,258,932**	**35.0**	**2–19**	**79**
18–24 yrs	**9,776,719**	**20.6**	**8–83**	**196**
25–39 yrs	26,844,601	5.0	23–228	124
40–49 yrs	19,576,875	3.0	17–166	51
50–64 yrs	36,951,538	1.3	31–314	39
65+ yrs	42,124,078	0.9	36–358	26
NR	—	—	—	11

8.8% of doses admin

n=277 reports

52.5% of total reports

* Per million doses administered; † Assumes a 31-day post-vaccination observation window; 528 reports with symptom onset within 30 days of vaccination shown; ‡ Based on Gubernot et al. U.S. Population-Based background incidence rates of medical conditions for use in safety assessment of COVID-19 vaccines. Vaccine. 2021 May 14:S0264-410X(21)00578-8.

184. The CDC even has a warning on their website now, stating that myocarditis is a potential risk for young adults, but they believe the risks outweigh the benefits even though this is a surging problem and a risk with the vaccines. Centers for Disease Control and Prevention, *COVID-19 Vaccines for Children and Teens* (updated Oct. 21, 2021), https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/adolescents.html.

185. Additionally, a CDC panel is recommending that individuals not get the Johnson & Johnson shot after a rare side effect of blood clots which have caused nine deaths. *CDC warns Americans NOT to get J & J shot over blood clot risk following nine deaths: Panel unanimously recommends more effective Pfizer or Moderna vaccines instead - pharm-giant says it 'remains confident',* DailyMail.com (Dec. 17, 2021), https://www.dailymail.co.uk/news/article-10318751/CDC-panel-unanimously-recommends-Pfizer-Moderna-vaccine-instead-J-J.html.

186. Multiple medical studies are also starting to come out detailing this problem.[15]

187. Further, milder side effects from the vaccine include changes in hormone and menstrual cycles in women, fever, swelling at the injection site, etc. Jill Seladi-Schulman, Ph.D,, *Can COVID-19 or the COVID-19 Vaccine Affect Your Period?* (May 25, 2021), https://www.healthline.com/health/menstruation/can-covid-affect-your-period#covid-19-and-menstrual-cycles; Rachel K. Raw, et al., *Previous COVID-19 infection but not Long-COVID is associated with increased adverse events following BNT162b2/Pfizer vaccination*, Journal of Infection (May 29, 2021), https://www.journalofinfection.com/article/S0163-4453(21)00277-2/fulltext.

188. Additionally, there are a host of unknown side effects that may exist as the vaccine has only gone through human testing for a limited time.

3. Known Risk of Administering COVID Vaccinations to CU Students who have already had a COVID Infection.

189. There is also recent research on the fact that the COVID vaccine is dangerous for

[15] *See, e.g.,* Tommaso D'Angelo MD, Antonino Cattafi MD, Maria Ludovica Carerj MD, Christian Booz MD, Giorgio Ascenti MD, Giuseppe Cicero MD, Alfredo Blandino MD, Silvio Mazziotti MD, *Myocarditis after SARS-CoV-2 Vaccination: A Vaccine-induced Reaction?*, Pre-proof, Canadian Journal of Cardiology, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8187737/; Jeffrey Heller, *Israel sees probable link between Pfizer vaccine and myocarditis cases* (June 2, 2021), https://www.reuters.com/world/middle-east/israel-sees-probable-link-between-pfizer-vaccine-small-number-myocarditis-cases-2021-06-01/; Steven R. Gundry, *Abstract 10712: Mrna COVID Vaccines Dramatically Increase Endothelial Inflammatory Markers and ACS Risk as Measured by the PULS Cardiac Test: a Warning* (Nov. 8, 2021), https://www.ahajournals.org/doi/10.1161/circ.144.suppl_1.10712?fbclid=IwAR0HjaTZdIfsYEppQRd6-n5iaxM2olz1uFRfHvyXAjN8TSb97BErmb8SuSo (finding that mRNA vaccines "dramatically increase inflammation on the endothelium and T cell infiltration of cardiac muscle and may account for the observations of increased thrombosis, cardiomyopathy, and other vascular events following vaccination.").

those who have already had COVID.

190. A medical study of United Kingdom healthcare workers who had already had COVID and then received the vaccine found that they suffered higher rates of side effects than the average population. Rachel K. Raw, et al., *Previous COVID-19 infection but not Long-COVID is associated with increased adverse events following BNT162b2/Pfizer vaccination*, Journal of Infection (May 29, 2021), https://www.journalofinfection.com/article/S0163-4453(21)00277-2/fulltext. The test group experienced more moderate to severe symptoms than the study group that did not previously have COVID. *Id*.

191. These symptoms included fever, fatigue, myalgia-arthralgia and lymphadenopathy. *Id*.

4. Comparison of Immunity Conferred by a previous COVID Infection and by the COVID Vaccination.

192. Those who have previously had COVID do not even need the vaccine.

193. In a CDC document entitled "Questions & Answers: Vaccine Against 2009 H1N1 Influenza Virus," the CDC stated that: *"If you have had 2009 H1N1 flu, as confirmed by an RT-PCR test, you should have some immunity against 2009 H1N1 flu and CAN CHOOSE NOT (emphasis added) to get the 2009 H1N1 vaccine."* Centers for Disease Control and Prevention, *Questions & Answers: Vaccine Against 2009 H1N1 Influenza Virus*, https://www.cdc.gov/h1n1flu/vaccination/public/vaccination_qa_pub.htm.

194. Fast forward just over a decade later, and after intensive investigation for the past 16-months, both laboratory and real world clinical data demonstrate convalescent, unvaccinated

COVID immunity is just as (or more) robust as vaccine-acquired COVID immunity.

195. Indeed multiple laboratory studies conducted by highly respected U.S. and European academic research groups have reported that convalescent mildly or severely infected COVID patients who are unvaccinated can have greater virus neutralizing immunity—especially more versatile, long-enduring T- cell immunity—relative to vaccinated individuals who were never infected. *See* Athina Kilpeläinen, et al., *Highly functional Cellular Immunity in SARS-CoV-2 Non-Seroconvertors is associated with immune protection*, bioRxiv (pre-print), https://www.biorxiv.org/content/10.1101/2021.05.04.438781v1; Tongcui Ma, et al., *Protracted yet coordinated differentiation of long-lived SARS-CoV-2-specific CD8+ T cells during COVID-19 convalescence*, bioRxiv (pre-print), https://pubmed.ncbi.nlm.nih.gov/33948597/; Claudia Gonzalez, et al., *Live virus neutralisation testing in convalescent patients and subjects vaccinated against 19A, 20B, 20I/501Y.V1 and 20H/501Y.V2 isolates of SARS-CoV-2*, Emerging Microbes & Infections (June 28, 2021), https://www.medrxiv.org/content/10.1101/2021.05.11.21256578v1; Carmen Camara, et al. *Differential effects of the second SARS-CoV-2 mRNA vaccine dose on T cell immunity in naïve and COVID-19 recovered individuals*, Cell Reports (Aug. 3, 2021), https://www.biorxiv.org/content/ 10.1101/2021.03.22.436441v1; Ellie N. Ivanova, et al., *Discrete immune response signature to SARS-CoV-2 mRNA vaccination versus infection*, medRxiv (pre-print), https://www.medrxiv.org/content/10.1101/2021.04.20.21255677v1; Catherine J. Reynolds, et al, *Prior SARS-CoV-2 infection rescues B and T cell responses to variants after first vaccine dose*, (pre-print), https://pubmed.ncbi.nlm.nih.gov/33931567/; Yair Goldberg, et al., *Protection of previous SARS-CoV-2 infection is similar to that of BNT162b2*

vaccine protection: A three-month nationwide experience from Israel, medRxiv (pre-print), https://www.medrxiv.org/content/ 10.1101/2021.04.20.21255670v1; Nina Le Bart et al., *Highly Functional virus-specific cellular immune response in asymptomatic SARS-CoV-2 infection*, 218 J. Exp. Med. 2021 No.5 (March 1, 2021); Suhas Sureshchandra et al., *Single cell profiling of T and B cell repertoires following SARS-CoV-2 mRNA vaccine*, bioRxiv (pre-print), https://www.biorxiv.org/content/10.1101/2021.07.14.452381v1.

196. An enormous real world Israeli national follow-up study of ~6.4 million individuals, demonstrated clearly that naturally-acquired COVID convalescence immunity was equivalent to vaccine-acquired immunity in preventing COVID infection, morbidity, and mortality. Yair Goldberg, et al., *Protection of previous SARS-CoV-2 infection is similar to that of BNT162b2 vaccine protection: A three-month nationwide experience from Israel*, medRxiv (pre-print), https://www.medrxiv.org/content/10.1101/2021.04.20.21255670v1.

197. The Goldberg study showed those unvaccinated individuals who had previously tested positive for COVID ("Unvaccinated Previous Positives") fared at least as well as those who were vaccinated. *Id.* Through March 20, 2021, this study followed 187,549 Unvaccinated Previous Positives who tested positive between June 1, 2020, to September 30, 2020. *Id.* Of those, the study revealed 894 [0.48%] were reinfected, 38 [0.02%] were hospitalized, a mere 16 [0.008%] hospitalized with severe disease, and only 1 [one]/187,549 died—an individual over 80 years old. *Id*.

198. The Israeli investigators concluded, *"Our results question the need to vaccinate previously infected individuals." Id*.

199. Cleveland Clinic investigators have confirmed the Israeli findings in a study of their own employees. Nabin K. Shrestha, Patrick C. Burke, Amy S. Nowacki, Paul Terpeluk, Steven M. Gordon, *Necessity of COVID-19 vaccination in previously infected individuals*, medRxiv (pre-print), https://www.medrxiv.org/content/10.1101/2021.06.01.21258176v2. They found zero SARS-CoV-2 reinfections during 5-month follow-up among n=1359 infected employees who remained unvaccinated and concluded such persons are *"unlikely to benefit from covid-19 vaccination." Id*.

200. Unlike immunity from the vaccine, natural immunity does not wane over time. Jae Hyung Jung et al., *SAARS-CoV-2-specific T cell memory is sustained in Covid-19 convalescent patients for 10 months with successful development of stem cell-like memory T cells*, 12 Nature Communications (June 30, 2021), https://www.nature.com/articles/s41467-021-24377-1; Eamon O Murchu et al., *Quantifying the risk of SARS-CoV-2 infection over time*, Rev. Med. Virol. 2021 (May 27, 2021), https://pubmed.ncbi.nlm.nih.gov/34043841/; Kristen W. Cohen et al., *Longitudinal analysis shows durable and broad immune memory after SARS-CoV-2 infection with persisting antibody responses and memory B and T cells*, medRxiv (June 18, 2021) https://pubmed.ncbi.nlm.nih.gov/33948610/; Jackson S. Turner et al, *SARS-CoV-2 infection induces long-libed bone marrow plasma cells in humans*, Nature Vol 595 at 421 (July 15, 2021), https://www.nature.com/articles/s41586-021-03647-4.

201. Reinfection is not a common event, Eamon O Murchu et al, but is especially rare in the young population. Laith J Abu-Raddad et al., *SARS_CoV-2 antibody-positivity protects against reinfection for at least seven months with 95% efficacy,35* EclinicalMedicine (Apr. 6,

2021), https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(21)00141-3/fulltext.

202. Individuals who have been previously infected are unlikely to benefit from vaccination. Nabin K. Shrestha et al., *Necessity of COVID-19 vaccination in previously infected individuals,* medRxiv (pre-print), https://www.medrxiv.org/content/10.1101/2021.06.01.21258176v2; Jason Niedleman et al., *mRNA vaccine0induced SARS-CoV-2 specific T cells recognize B.1.1.7 and B.1.351 variants but differ in longevity and homing properties depending on prior infection status,* eLife (Oct. 12, 2021), https://www.biorxiv.org/content/10.1101/2021.05.12.443888v1. In fact, the second dose could even result in a reduction of immunity in previously infected individuals. Carmen Camara et al., *Differential effects of the second SARS-CoV-2 mRNA vaccine dose on T cell immunity in naive and COVID-19 recovered individuals*, Cell Reports (Aug. 3, 2021), https://www.biorxiv.org/content/10.1101/2021.03.22.436441v1.

203. In sum, those who recover from infection from COVID, roughly 99% of those who are infected, enjoy robust and durable natural immunity. Natural immunity is superior to vaccine-induced immunity resulting from the COVID shot-treatment, which does not prevent re-infection or transmission of COVID, and does not prevent infection, re-infection, or transmission of the current Delta or Omicron strains.

204. The risks of the vaccine and the fact that people who have already had COVID have at least equally strong protection from the virus makes the Mandate irrational and unnecessary.

5. Comparison of Risks of COVID Vaccinations with Vaccinations for other Infectious Diseases

205. The COVID vaccines cause a significantly higher incidence of adverse reactions,

injuries, reactions, and deaths than any prior vaccines on the market, and, therefore, pose a significant health risk to recipients, who are, by definition, healthy when they receive the COVID vaccines.

206. The vaccine is also far less safe than previous vaccines like the meningicoccal meningitis vaccine that is typically required on college campuses.

207. For example, the VAERS (Vaccine Adverse Event Reporting System) data from the CDC shows, for 18-29 year olds in Colorado, there had been one death associated with the meningitis vaccine.

208. The main side effects people reported were pyrexia, injection site pain, headache, dizziness and injection site swelling, and even these were limited as no more than seventy of each were reported. Centers for Disease Control and Prevention, WONDER data, https://wonder.cdc.gov/controller/datarequest/D8;jsessionid=6C89E97F1CA6547ADC87B54F2137?stage=results&action=sort&direction=MEASURE_DESCEND&measure=D8.M1.

209. However, in the brief time the COVID vaccines have been available, there have been many more serious symptoms for 18-29 year olds in Colorado. *See, e.g.,* Table G.

Table G

Vaccine Adverse Event Reporting System (VAERS) Data for Colorado 18 to 29 Year Olds, Comparing Covid-19 and Influenza Vaccines

Vaccine-Associated Adverse Events Among 18 to 29 Year Olds in Colorado	Covid-19 Vaccines Given in 2021[a]	Influenza Vaccines Given in >20 Years (2000-2021)[b]
Arthralgia	39	12
Hospitalizations	35	11
Life Threatening Events	14	4
Myocarditis/Myopericarditis	9	0
Anaphylaxis/Sever Allergic Reaction	3	0
Blindness	5	0
Bell's Palsy (Facial Paralysis)	2	0

[a,b] Using a very conservative comparison the denominator for the number of persons given influenza vaccines over 20 years would be at least 10-fold the denominator for the number of persons receiving covid-19 vaccines in 2021. Data accessed at the VAERS weblink, https://wonder.cdc.gov/vaers.html 8/26/21

210. Some research suggests that the level of adverse reaction to the COVID vaccine is similar to the levels of *all other vaccines* from 1990 to today. VAERS analysis, *VAERS Summary for COVID-19 Vaccines Through 8/27/2021*, https://vaersanalysis.info/2021/09/03/vaers-summary-for-covid-19-vaccines- through-8-27-2021/.

211. This includes levels such as life-threatening events, deaths, and birth defects which are even higher in the COVID vaccine then in all other vaccines from 1990 on. *Id.*

212. Since, according to the CDC, the COVID vaccines do not prevent the infection or transmission of COVID, while at the same time, Plaintiffs have shown that the COVID vaccine is nowhere near the level of safety as other vaccines and result in a significant number of adverse events and deaths, there is no legal basis for mandating them, and CU's mandate must therefore be struck down.

E. Factual Allegations of Students

213. Plaintiff Andrew Garlick is a Junior at CU. He is currently taking online classes through the CU Denver Campus.

214. Mr. Garlick objects generally to the Mandate. He objects to taking the Vaccine, given the known and unknown risks associated with it, the extremely minimal risk of COVID to his age group, the efficacy of the vaccines against infection and spread, and the natural immunity he has from a prior infection.

215. Mr. Garlick is particularly worried about the side effects of the vaccine including *inter alia* any heart issues, fertility issues, etc.

216. He also has a history of anaphylaxis from a peanut allergy, which gives him greater concerns and fears of the side effects.

217. Finally, Mr. Garlick believes that he has natural immunity from a prior COVID infection, making the vaccine unnecessary.

218. Mr. Garlick also has a sincerely held religious objection to receiving the COVID Vaccine. However, because Mr. Garlick could not get an exemption that would alleviate his harms—still requiring him to subject to the Extra Requirements—his only option to continue his education was to participate in a fully online program.

219. Despite being fully online, Mr. Garlick continued to receive multiple e-mails inquiring about his vaccination status. He was able to obtain an exemption from the Extra Requirements *only if* he was in a "fully online [program] and won't step on campus for any reason this semester[.]" CU Denver Vaccine Exemption Email (Sept. 28, 2021), Pls. Ex. 6.

220. Mr. Garlick's participation in a fully online program is causing significant harm to him.

221. First, Mr. Garlick transferred to CU in order to take advantage of the networking and connections present through participation in on-campus/in-person education at CU.

222. Unfortunately, as detailed above, Mr. Garlick is not permitted to be on campus without complying with the Mandate, so he is not permitted to engage in any networking or connections that form as result of on-campus/in-person education, despite this networking and connection opportunities being afforded to other CU students.

223. Second, being forced to participate in a fully online program is causing harm to his education.

224. Mr. Garlick considers himself to be a social learner, and thrives on the in person aspects of education. Mr. Garlick is more successful in the learning environment when he is able to interact with his teachers face-to-face, which helps him interpret and retain information better. Without that human connection and interaction, Mr. Garlick struggles to keep up with deadlines and absorb material.

225. As a result of the Mandate prohibiting him from enjoying this face-to-face education style without violating his views and choices, Mr. Garlick's grades have suffered and there has been significant added stress in keeping up with his coursework and deadlines.

226. Third, Mr. Garlick was forced to completely rework his course schedule, which had already been set before being forced to participate in the online program, and was prevented from taking specific classes he planned to take this semester.

227. Fourth, Mr. Garlick is unable to easily transfer to another college (without a vaccine mandate) at this point, given the significant time and money invested in his education at CU Denver.

228. Mr. Garlick misses the social interaction associated with in-person learning and wants to be able to take advantage of certain classes and experiences available in-person at CU. To alleviate his harms, Mr. Garlick desires to return to on-campus/in-person education as soon as possible. He would do so immediately, so long as his views, beliefs, and rights to bodily integrity, bodily autonomy, and medical treatment choice are respected.

229. Plaintiff Dr. Thomas Fow is a licensed dentist and a terminated student from the Graduate Periodontics Program at CU.

230. Dr. Fow objects generally to the Mandate. He objects to taking the Vaccine, given the known and unknown risks associated with it, the extremely minimal risk of COVID to his age group, the efficacy of the vaccines against infection and spread, and the natural immunity he has from a prior infection (making the vaccine unnecessary for him).

231. Dr. Fow further objects to CU dictating his medical treatment, despite not being his doctor or a medical professional.

232. Dr. Fow also has a sincerely held religious objection to receiving the COVID Vaccine. Accordingly, he applied for a religious exemption from CU, which was denied.

233. In early summer, Dr. Fow sought a religious exemption and appeared to have been granted said exemption. This original form simply required Dr. Fow to attest that his exemption request was "based upon a religious belief whose teachings are opposed to immunizations." Fow

Religious Exemption From COVID-19 Vaccination Requirement Form (July 8, 2021), Ex. 7.

234. Given his sincerely held religious beliefs which prevent him from getting the vaccine, Dr. Fow submitted this form on July 8, 2021. *Id*. He received no response or request for further information from the school and was permitted to continue his education.

235. However, on September 7, 2021, Dr. Fow received an e-mail from the school indicating that:

> The University only recognizes religious exemptions based on a religious beliefs whose teachings are opposed to all immunizations. The University has asked school administrators to speak with specific individuals to see if the policy is clear, and to confirm that all religious exemptions follow the prescribed criteria. You have been identified as a person who has submitted a religious exemption, and we would like to see if you are in compliance with the University's policy.

Email from Associate Dean for Student Affairs and Admissions to Dr. Fow (Sept. 7, 2021), Ex. 8.

236. In light of this request, Dr. Fow submitted another religious exemption request on September 8, 2021. This new form required him to "explain why your sincerely held religious belief, practice, or observance prevents you from getting a COVID-19 vaccination?" and state whether he has received "an influenza or other vaccine in the past? [and] How does this differ?" Fow Religious Exemption From COVID-19 Vaccination Requirement Form (Sept. 8, 2021), Ex. 9.

237. Dr. Fow submitted this new form, detailing his sincerely held religious objection and providing all relevant information and responses. *Id*.

238. On September 9, 2021, Dr. Fow received his official rejection from CU stating that:

> The University's mandatory vaccination policy offers exemptions based on a person's religious belief whose teachings are opposed to all immunizations, i.e., your religion teaches

> you and all other adherents that immunizations are forbidden under all circumstances. When asked to explain how your religious beliefs prevent you from receiving the COVID-19 vaccine, you responded that you object based on your belief that the COVID-19 vaccines were developed from human cell lines derived from abortion.
>
> The basis for your objection to vaccination against COVID-19 is of a personal nature and not part of a comprehensive system of religious beliefs.
>
> Having considered your exemption request and the campus COVID-19 vaccination policy, your request is not approved.

Exemption Denial (Sept. 9, 2021), Ex. 10.

239. In response to this denial, Dr. Fow was given the following options:

> Please submit verifiable documentation indicating you have received the first COVID-19 vaccine dose to the School's Associate Dean for Student Affairs and Admissions, and submit your verification via the campus portal by September 15, 2021. You will be allowed to continue attending school between the time you receive your first vaccination and the time you are fully vaccinated (two weeks after you receive the second dose of the Pfizer or Moderna vaccine or the single dose of the J&J vaccine). For any in-person activities, you will be required to follow campus safety protocols for unvaccinated individuals as set out in University policy, including, but not limited to, weekly testing, masking, and social distancing where possible.
>
> Alternatively, if you do not intend to submit documentation that you have received the first COVID-19 vaccine dose to the Associate Dean for Student Affairs and Admissions by September 15, 2021, you may request a Leave of Absence from the School or withdraw from the School by September 15, 2021. Your fall 2021 tuition and fees will be returned if you withdraw or go on a leave of absence. Please let the Associate Dean for Student Affairs and Admissions know if you would like more information about any of these options.

Id. "Failure to select any of these options will result in referral to the Student Performance Committee for further action, up to and including dismissal." *Id*.

240. On September 15, 2021, Dr. Fow requested an appeal of the denial of his religious exemption due to his sincerely held religious beliefs, but was informed that "University decisions regarding religious exemptions are final and not subject to appeal." Dr. Thomas Fow and

Associate Dean for Student Affairs and Admissions Correspondence (Sept. 15, 2021), Ex. 11.

241. On September 20, 2021, Dr. Fow received an e-mail from the Associate Dean for Student Affairs and Admissions stating:

> As you currently do not have an approved exemption, nor has the SDM received evidence of a Covid vaccination card from you, you are in violation of the university policy regarding the Covid-19 vaccination mandate.
>
> As a result, you are being referred to the Student Performance Committee for violating campus policy for continuing in an academic program; your program director has been included on this correspondence. *Effective 12:00 MST on Monday, September 20, 2021, your badge access to parking lots, axiUm, and SDM buildings will be revoked.*
>
> Should you have any questions, please contact me.

Email from Associate Dean for Student Affairs and Admissions to Dr. Fow (Sept. 20, 2021), Ex. 12 (emphasis added).

242. Dr. Fow was not permitted to attend the Student Performance Committee (SPC) meeting.

243. On September 22, 2021, Dr. Fow was notified that the SDM Dental SPC had reached a decision on his academic status stating the following:

> Given you are not in compliance with the Anschutz Medical Campus policies to allow participation in on-site campus activities, the SPC recommends placing you on Personal Leave until you are fully vaccinated for a period not to exceed one year. As Dean of the School of Dental Medicine, I concur with the recommendation of the SPC.
>
> Due to the structure of the Graduate Periodontics Program, the availability for a position in the CU SDM program is contingent on the allowable number of enrolled periodontics program students approved by the Commission on Dental Accreditation. Should you elect to remain unvaccinated, you will be reconsidered by the SPC for dismissal at the end of this academic year (2021-2022) in July 2022.

Letter from Dean of the CU School of Dental Medicine (Sept. 22, 2021), Ex. 13.

244. Just two days later, on September 24, 2021, Dr. Fow received a follow up e-mail from the Dean of the School of Dental Medicine, indicating that

> This letter is intended as a follow up to the communication I sent to you on September 22, 2021 regarding your noncompliance with the CU Anschutz Medical Campus COVID-19 policy related to the Campus requiring either an approved religious or medical exemption, or evidence of COVID-19 vaccination. In that letter I shared the recommendation of the School of Dental Medicine Student Performance Committee to put you on a leave of absence in the event you chose not to be vaccinated, and my concurrence with that recommendation as Dean.
>
> In this communication I would like to provide you with a date when you will be disenrolled if you fail to become vaccinated. If by Tuesday, September 28, 2021, you have not shared evidence of vaccination with a first dose of the COVID-19 vaccine, you will be disenrolled from all School of Dental Medicine course work in the Graduate Periodontics program, and patient care.

Email from Dean of the CU School of Dental Medicine (Sept. 24, 2021), Ex. 14.

245. At this time, Dr. Fow is unclear whether he has been disenrolled from the school or is on a one-year personal leave. Regardless of the phrasing of his termination, Dr. Fow has been, *inter alia*, **(1)** terminated from his program, **(2)** is not permitted to continue his education, **(3)** is not permitted to continue patient care, and **(4)** has been restricted from being on campus.

246. Dr. Fow desires and intends to continue his education in the Graduate Periodontics Program at CU, so long as his views, sincerely held religious beliefs, and rights to bodily integrity, bodily autonomy, and medical treatment choice are respected.

247. Plaintiff Rebekah Voelkelt is a deferred student of CU. She intends to continue her education at CU when and if the Mandate is lifted or enjoined.

248. Ms. Voelkelt objects generally to the Mandate. She objects to taking the Vaccine, given the known and unknown risks associated with it, the extremely minimal risk of COVID to

her age group, and the efficacy of the vaccines against infection and spread.

249. Ms. Voelkelt is particularly worried about the side effects of the vaccine including *inter alia* any heart issues, fertility issues, etc.

250. Ms. Voelkelt's family has a significant history of severe reactions to vaccines. Her grandfather suffered seizures from the swine flu vaccine, and her uncle had an extremely severe reaction to the pertussis vaccine. Ms. Voelkelt is worried that she may suffer similar reactions.

251. She also has asthma and fears that the vaccine could exacerbate those issues.

252. Ms. Voelkelt also has a sincerely held religious objection to receiving the COVID Vaccine, given the use of aborted fetal tissue used to make the vaccines. However, because Ms. Voelkelt could not get an exemption that would alleviate her harms—still requiring her to subject to the Extra Requirements—and because the exemption required the disclosure of her private information, she felt that her only option was to defer her education for the year.

253. In accordance with her deferment, Ms. Voelkelt will remain active in the CU system for three semesters. If she is not re-enrolled for the fall 2022 semester, CU will consider her inactive and she would need to re-apply and be re-admitted.

254. Ms. Voelkelt had received the Provost's Scholarship for this year but as a result of being forced to defer, it appears that Ms. Voelkelt may have lost that scholarship.

255. She has inquired about the status of her scholarship for future semesters, but has not received any commitments from CU to honor that scholarship for future semesters.[16]

[16] After Ms. Voelkelt deferred, the school issued her a "refund" for her scholarship. Ms. Voelkelt was confused by this since she did not want a refund, but a commitment to honor her scholarship for future years. The "re-funded" amount is now showing up as being due to CU by

256. Miss Voelkelt intends to continue her education at CU, so long as her views, sincerely held religious beliefs, and rights to bodily integrity, bodily autonomy, and medical treatment choice are respected.

257. For all of the reasons shown above (*see generally* ¶¶ 213-256), all Students object to the Mandate.

258. All Students also object to the Vaccine on the basis that all but one of the vaccines have only received Emergency Authorization from the FDA. None are willing to take the Vaccine while it is only approved under that Emergency Authorization.

259. Students should not be required to put their health at risk (given the known and unknown risks of the Vaccine) in order to comply with the Mandate and object to doing so.

260. Students are irreparably harmed by the Mandate.

261. Students have no adequate remedy at law.

Count I
The Mandate Violates Students' Liberty Interests Protected by the Fourteenth Amendment to the United States Constitution.

262. Students re-allege and incorporate by reference all of the allegations contained in all of the preceding paragraphs.

263. It is well established that "the government may not deny a benefit to a person because he exercises a constitutional right." *Regan v. Taxation With Representation*, 461 U.S. 540, 545 (1983). This principle "vindicates the Constitution's enumerated rights by preventing the

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Ms. Voelkelt.

government from coercing people into giving them up." *Koontz v. St. Johns River Water Mgmt. Dist.*, 570 U.S. 595, 604 (2013) (collecting cases). Put simply, this doctrine stands for the premise that the government cannot do indirectly what it is not permitted to do directly under the Constitution.

264. Here, CU is doing exactly that—trying to indirectly control students' medical treatment choices and religious liberties, which it would not be allowed to do directly—by coercing students to give up their rights to bodily integrity and autonomy, and to medical treatment choice and their religious rights in exchange for the discretionary benefit of matriculating at CU.

265. Even if "someone refuses to cede a constitutional right in the face of coercive pressure, the impermissible denial of a governmental benefit is a constitutionally cognizable injury[.]" *Id*. at 607. The U.S. Supreme Court has "often concluded that denials of government benefits were impermissible under the unconstitutional conditions doctrine," *id*. at 606, even where there is "no entitlement to that benefit." *Id*. at 608.

266. This is the situation here. The Mandate violates the liberty protected by the Fourteenth Amendment to the U.S. Constitution, which includes rights of personal autonomy and bodily integrity, *see, e.g.*, *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905), and the right to reject medical treatment, *Cruzan*, 497 U.S. 261.

267. Our constitutional history and heritage have repeatedly indicated that rigorous scrutiny must be applied when bodily integrity, autonomy, and medical treatment choice is involved. "'[N]o right is held more sacred, or is more carefully guarded,…than the right of every

individual to the possession and control of his own person.'" *Cruzan*, 497 U.S. at 269 (quoting *Union Pac. R. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

268. Historically, many have understood *Jacobson v. Commonwealth of Massachusetts*. 197 U.S. 11 (1905), to authorize near *carte blanche* for government to mandate vaccinations in response to a pandemic on the basis that such individual liberty must yield to the common good—all with great deference to legislatures and little or no evidence contrary to their choice reviewed. *See also Zucht v. King*, 260 U.S. 174, 176-177 (1922). So cases entitled to higher scrutiny have instead received the highly deferential *Jacobson* analysis.

269. In *Calvary Chapel Dayton Valley v. Sisolak*, Justice Alito dissented, joined by Justices Thomas and Kavanaugh, noting that "at the outset of an emergency, it may be appropriate for courts to tolerate very blunt rules," "[b]ut a public health emergency does not give . . . public officials *carte blanche* to disregard the Constitution as long as the medical problem exists." 140 S. Ct. 2630, 2605 (2020) (Mem. Op.). Rather, "[a]s more medical and scientific evidence becomes available, and as States have time to craft policies in light of that evidence, courts should expect policies that more carefully account for constitutional rights." *Id.* That dissenting view was essentially adopted by *Roman Catholic Diocese of Brooklyn v. Cuomo*. 141 S. Ct. 63 (2020) (per curiam). In other words, "blunt rules" may be permitted initially, but fine-tuning to actual scientific evidence is then required—requiring an *evidence-focused* inquiry in judicial review.

270. Likewise in *Does 1-3 v. Mills*, Justice Gorsuch dissented, joined by Justice Thomas and Justice Alito, noting that while the Court acknowledged 11 months before that stemming the spread of COVID was a compelling interest, "this interest cannot qualify as such forever." 2021

WL 5027177, at *3 (Gorsuch, J. dissenting). Instead, he noted that:

> Back when [the Court] decided *Roman Catholic Diocese*, there were no widely distributed vaccines. Today there are three. At that time, the country had comparably few treatments for those suffering with the disease. Today we have additional treatments and more appear near. If human nature and history teach anything, it is that civil liberties face grave risks when governments proclaim indefinite states of emergency.

Id.

271. *Calvary Chapel, Roman Catholic Diocese*, and *Does 1-3* support adopting—not abandoning—normal levels of constitutional jurisprudence when a court is faced with a constitutional question involving COVID-related measures.

272. At first glance, *Jacobson* and *Zucht* seem directly on point to the question in front of this Court. However, relying on these precedents here presupposes that the underlying reason why the Court affirmed the states' police powers in those cases is equivalent to the attainable outcome if CU retains similar police powers. This presupposition fails, which means that the controlling precedent is not *Jacobson* and *Zucht*, but rather *Cruzan*, which controls on questions involving forced medical treatment.

273. Competent individuals have a "constitutionally protected liberty interest in refusing unwanted medical treatment." *Cruzan*, 497 U.S. 261 at 278. *Jacobson* and *Zucht* both involved the state's use of its police power to implement public health measures to control the spread of deadly diseases among the population subject to the vaccination mandates.

274. Thus, the Court's jurisprudence, in *Jacobson* and *Zucht*, concerns vaccines used as a public health measure to prevent the transmission of a disease. As the American Public Health Association explains, "Public Health promotes and protects the health of people and communities

where they live, learn, work and play. While a doctor treats people who are sick, those of us working in public health try to prevent people from getting sick or injured in the first place." *Supra* ¶ 169. Thus, public health professionals promote vaccines for "vaccine-preventable diseases that can be a threat to our health." *Supra* ¶ 170.

275. The CDC recently changed the definition of "vaccine" to "[a] preparation that is used to stimulate the body's immune response against diseases," eliminating the public health component previously included of producing "immunity to a specific disease, protecting the person from that disease." *Supra* ¶ 172 n.13. As a result, the CDC's revised definition of vaccine no longer conforms with the understanding that *Jacobson* and subsequent cases assumed, that a vaccine is a public health measure, which is why the court afforded the government great deference. The evidence supports that COVID vaccines should not be viewed as a public health measure to prevent the spread of disease, but as a medical treatment designed to provide therapeutic benefits to the individual who contracts COVID. *Supra* Part I.B.1.

276. And for constitutional review, the difference between a public health measure and a medical treatment is critical. Constitutional jurisprudence over the last century shows that courts historically grant higher deference (and rational basis review) to decisions to mandate vaccines that are public health measures, but not to forced medical treatments.

277. The reasons for this different treatment is rooted in the differences in purpose behind such mandates. A personal decision to refuse a "vaccine" that is a medical treatment does not create a risk to other people to whom the disease might spread. *See Jacobson*, 197 U.S. at 35 (holding deference applies to those requirements "adapted to prevent the spread of contagious

diseases"). Instead, declining medical treatment impacts only the health of the individual making refusing the medical treatment.

278. The COVID vaccine appears to be effective at mitigating symptoms, hospitalizations and deaths, as all medical treatments and prophylactics do, but it does not prevent individuals from either getting or transmitting the COVID virus. According to CDC Director Rochelle Walensky, "what [the COVID vaccines] can't do anymore is prevent transmission." *Supra* ¶ 158. Likewise, CU admits that the vaccines do not prevent transmission. *Id*. ¶¶ 162-163.

279. Using *Jacobson*, and its deferential standard, as controlling precedent requires this Court to base its analysis on the supposition that these products would be effective in meeting CU's goal of slowing the spread of the COVID virus and thereby protecting the public at large. However, that presupposition is inaccurate, and the COVID vaccines are properly understood as a medical treatment.

280. When medical treatment has been **mandated** by the government, contrary to the decision of the person, such mandates uniformly require heightened scrutiny.[17] *See, e.g., Cruzan,* 497 U.S. at 278 (right to consent to or refuse medical treatment for incompetent person); *Humphrey v. Cody*, 405 U.S. 504 (1972); *Vitek v. Jones*, 445 U.S. 480 (1980) (involuntary commitment of mentally ill patients for medical treatment); *Riggins v. Nevada*, 504 U.S. 127, 135 (1992); *Sell v. United States*, 593 U.S. 166, 186 (2003) (pre-trial forced administration of

[17] Students refrain from exclusively using the term strict scrutiny because the medical treatment cases did not always specifically define the scrutiny level applied. However, this line of jurisprudence makes clear that rational basis is not applied in this context, and the Court most often applies a strict scrutiny analysis regardless of label.

antipsychotic drugs).[18] Further, the Court's recent constitutional jurisprudence gives greater weight to the protection of bodily integrity and autonomy, and of medical treatment choice than it did a century ago.[19]

281. The only exception to the application of heightened scrutiny is in the context of convicted inmates in prison—in this context alone, the Court's precedent supports the application of rational basis review. Even within the prison context, the Court recognized that inmates still "possess a significant liberty interest in avoiding the unwanted administration of…drugs," *Washington v. Harper*, 494 U.S. 210, 222 (1990), but recognized these rights must be balanced with the "legitimate penological interest." *Id.* at 223. Consequently, the Court applies only rational basis review for inmates in prison, but nowhere else.

282. The inescapable understanding derived from these cases is that this Court must require a heightened level of scrutiny where, as here, Students are not prisoners. It cannot be the case that prisoner rights are equal with or greater than rights possessed by free citizens. *Wolfe v. McDonnell*, 418 U.S. 539, 555 (1974) (holding that "[l]awful imprisonment necessarily makes unavailable many rights and privileges," and that a prisoner's rights "may be diminished by the needs and exigencies of the institutional environment"). As the Supreme Court's decisions in the

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[18] During modern times, the Court has also applied heightened scrutiny when an important personal choice has been **prohibited** by the government. *See, e.g.*, *Griswold v. Connecticut*, 381 U.S. 479 (1965) (contraception); *Roe v. Wade*, 410 U.S. 113 (1973), modified by *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833 (1992) (abortion), and *Obergefell v. Hodges*, 576 U.S. 644 (2015) (same-sex marriage). Students do not analyze these cases further but acknowledge their importance in constitutional jurisprudence tangentially relevant here.

[19] *See* Weiler, *Bodily Integrity: A Substantive Due Process Right to Be Free from Rape by Public Officials*, 34 Calif. West. L. Rev. 591, 596-604 (1998) (compilation and analysis of modern bodily integrity and autonomy cases).

medical treatment mandate cases, and in *Harper* and *Wolfe,* make clear: rational basis scrutiny is only applied to rights concerning bodily integrity and autonomy, and of medical treatment choice within the prison context. Outside this context, the Constitution demands a higher level of scrutiny.

283. Since the COVID vaccines do not prevent transmission and acquiring of the COVID disease, but treats its effect, the CU Mandate must analyze its constitutionality as a forced medical treatment. That analysis requires heightened scrutiny. The following problems reveal CU does not have a compelling interest in Mandating a vaccination to college students because:

- University students have very low risk for serious COVID illness, Part I.C.2.;
- Naturally acquired immunity from COVID is as robust as vaccine-acquired immunity, Part I.D.4.;
- Given natural and vaccine immunity, Colorado has de facto COVID herd immunity, Part I.C.1.;
- The COVID vaccines do not prevent transmission of COVID, so "protection of others" cannot be used to justify the Mandate, Part 1.D.1.;
- University students have a higher adverse-reaction risk from COVID vaccinations versus those for influenza, *see* Parts I.D.2-I.D.5.;

CU has no compelling interest in mandating student COVID vaccination.

284. The same evidence establishes that, even if there were a compelling interest in mandating vaccinations, the Mandate is not narrowly tailored to such an interest. A Mandate that applies to all ignores individual factors that increase (age, co-morbidities) or decrease (previous

COVID infection) students' risks to themselves or to others. Mandating vaccines for all is the sort of blunt rule perhaps appropriate with a more deadly disease such as small pox, or at the beginning of a new pandemic when much less is known about the risks of both the disease and treatments. This blunt tool is not justified here, when much more is known about those risks. *See also, e.g.*, *Does 1-3 v. Mills,* 2021 WL 5027177, at *4 (Gorsuch, J. dissenting) (stating that the State's "decision to deny a religious exemption in these circumstances doesn't just fail the least restrictive means test, it borders on the irrational.").

285. The Mandate fails modern rational basis scrutiny or a *Jacobson* analysis, since the Mandate is "unreasonable" and "has no real or substantial relation" "to protect[ing] the public health." 197 U.S. at 31, *i.e.*, it goes "beyond what [i]s reasonably required for the safety of the public," *id.* at 28. The same evidence that shows there is no compelling interest or narrow tailoring with the Mandate shows that it fails even under *Jacobson*.

286. CU's Mandate is internally illogical and therefore fails rational basis review. In some situations CU mandates masks and distancing. For that to be rational, it must be presumed that those work for preventing virus spread. But if those work, there is no need for vaccination. CU's Mandate does not distinguish between the following Groups:

(1) those who had COVID, who need no vaccination for their sake or others';

(2) those who have COVID, who can and should be quarantined to protect others, after which these will have natural immunity; and

(3) those who haven't had and don't have COVID and are unvaccinated.

No protection is needed against the first two groups, other than quarantining those now

affected, so a vaccine mandate is irrational. Others can protect themselves against the third group by obtaining a vaccination, if they wish, or by masking and distancing. Mandating vaccination in the present state of knowledge has no real, substantial relation to protecting public health and is irrational.

287. The Supreme Court has found rights to bodily integrity, autonomy, and of medical treatment choice to be "fundamental" rights protected by the Fourteenth Amendment. Outside of the context of prisons, infringements on such rights are subject to heightened scrutiny. Because college students have a very low risk of serious illness or death from COVID, many have robust natural immunity due to previous infection, the vaccines do not prevent transmission of COVID, and the risks to college-age students from the vaccines are higher and not inconsequential, CU has no compelling interest in its Mandate. Even if its interest was compelling, CU's Mandate makes no attempt to narrowly tailor it—the Mandate does not take into account underlying risk factors of either COVID or the vaccines to this age group or natural immunity.

288. Students' have fundamental liberty interests in their right to bodily integrity, autonomy, and of medical treatment choice. The government must justify an infringement upon such rights. Because CU's Mandate is neither narrowly tailored to serve a compelling government interest nor rationally related to serve an important government interest, it violates Students' Fourteenth Amendment liberty interests and is unconstitutional.

Count 2
The Mandate's Exemption Policies Violate the Establishment Clause of the First Amendment to the United States Constitution

289. "'[I]t is too late in the day to doubt that the liberties of religion and expression may

be infringed by the denial of or placing of conditions upon a benefit or privilege' as opposed to a right." *Dahl v. Bd. of Trustees of W. Michigan Univ.*, No. 21-2945, —— F.4th ——, 2021 WL 4618519, at *2 (6th Cir. Oct. 7, 2021) (quoting *Sherbert v. Verner*, 374 U.S. 398, 404 (1963)). The government is, in all cases, required to afford "at a minimum, . . . equal treatment [to] all religious faiths without discrimination or preference." *Colorado Christian Univ. v. Weaver*, 534 F.3d 1245, 1257 (10th Cir. 2008).

290. The state may not purport to determine which denominations—that is, *subsets* of belief *within a given faith*—are acceptable and which are not. *Larson v. Valente*, 456 U.S. 228, 245 (1982) ("Free exercise . . . can be guaranteed only when" the government affords *all* "religions the very same treatment given to small, new, or unpopular denominations.").

291. The state may not do indirectly what it is prohibited from doing directly. It may not directly discriminate between religions, and it may not "effectively distinguish" between religions by instituting rules directly contemplating religion but distinguishing based not on credal content, but other criteria. *Id.* at 246 n. 23 (explaining that a statute providing an exemption only to religious organizations receiving over half of their total contributions from members or affiliated organizations implicated Establishment Clause); *see also Barghout v. Bureau of Kosher Meat & Food Control*, 66 F.3d 1337, 1348 (4th Cir. 1995) (Luttig, J., concurring) (noting that the "statute at issue in *Larson* did not even mention a particular religion by name," but the Court nonetheless "summarily" found that it "clearly grant[ed] denominational preferences"); *Colorado Christian Univ.*, 534 F.3d at 1259 (rejecting argument that a religiously discriminatory law "distinguishe[d] not between types of religions, but between types of institutions"; stating that law discriminating

based on "pervasiveness" of religiosity was even more problematic than law at issue in *Larson*).

292. First Amendment protections flow not only to the denominational level, but to even the furthest iteration, the individual. *Frazee v. Illinois Dept. of Employment Sec.*, 489 U.S. 829, 834 (1989) (one need not "be responding to the commands of a particular religious organization" in order to claim First Amendment protection).

293. Thus, it is simply "a sincerely held religious belief . . . [that] entitle[s] one to invoke First Amendment protection." *Id.*; *see also, e.g.*, *Colorado Christian Univ. v. Weaver*, 534 F.3d 1245, 1266, 1269 (10th Cir. 2008) (holding that "interdenominational discrimination" is a "[v]iolation of the Equal Protection and Free Exercise Clauses," therefore finding that Colorado statute that provided "scholarship money to students who attend sectarian—but not 'pervasively' sectarian—universities," was "explicit[] discriminat[ion]" that "could not be justified" "on any plausible level of scrutiny"); *Thomas v. Rev. Bd. of Indiana Emp. Sec. Div.*, 450 U.S. 707, 715–16 (1981) (reversing finding that plaintiff's beliefs constituted "personal," rather than "religious," belief on the basis that another person of the same religion had differing beliefs: "Intrafaith differences . . . are not uncommon among followers of a particular creed . . . . [T]he guarantee of free exercise is not limited to beliefs which are shared by all of the members of a religious sect."); *Ford v. McGinnis*, 352 F.3d 582, 590 (2nd Cir. 2003) ("the question whether Jackson's beliefs are entitled to Free Exercise protection turns on whether they are 'sincerely held,' not on the 'ecclesiastical question' whether he is in fact a Jew under Judaic law") (quoting *Jackson v. Mann*, 196 F.3d 316, 321 (2nd Cir. 1999)).

294. While the First Amendment does not absolutely prohibit every burden on the

exercise of religion, "[a] law burdening religious practice that is not neutral or not of general application must undergo the most rigorous of scrutiny." *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 546 (1993).

295. Certain violations, however, may be immediately resolved without a strict scrutiny analysis. The state may not engage in "excessive entanglement" with religion—that is, it may not "monitor[] or second-guess[] . . . religious beliefs and practices, whether as a condition to receiving benefits . . . or as a basis for regulation or exclusion from benefits." *Colorado Christian Univ.*, 534 F.3d at 1261. Such violations of the Establishment Clause are "flatly forbidden without reference to the strength of governmental purposes" and must be declared "unconstitutional without further inquiry," *id.* at 1266 (citing *Corp. of Presiding Bishop of Church of Jesus Christ of Latter-Day Saints v. Amos*, 483 U.S. 327, 339 (1987)). *See also Walz v. Tax Commission*, 397 U.S. 664, 672–675 (1970).

296. Because "[t]he clearest command of the Establishment Clause is that one religious denomination cannot be officially preferred over another," *Larson,* 456 U.S. at 244, such distinctions (if not unconstitutional without further inquiry) trigger strict scrutiny due to lack of neutrality, *Colorado Christian Univ.,* 534 F.3d at 1266.

297. This rigorous scrutiny applies even if a discriminatory policy is "in fact executed" in a seemingly neutral way, such as refusing to grant *any* exemptions. *See Dahl*, 2021 WL 4618519 at *4.

298. Under this rigorous scrutiny, which applies both to First Amendment claims and parallel Equal Protection claims, "discrimination can be justified only if it is narrowly tailored to

achieve a compelling state interest." *Colorado Christian Univ.*, 534 F.3d at 1266.

299. The interest served by a governmental rule subject to strict scrutiny must be "of the highest order." *Fulton v. City of Phila.*, 141 S. Ct. 1868, 1881 (2021); *United States v. Hardman*, 297 F.3d 1116, 1127 (10th Cir. 2002). Such a rule must be narrowly tailored to achieve that interest, *Fulton,* 141 S. Ct. at 1881, which requires a government "showing that [the rule] is the least restrictive means" of achieving that interest, *Thomas*, 450 U.S. at 718.

300. Nor is preferential treatment of one religion or another vindicated by the claim that the disfavored religion is no religion at all: one need not "be responding to the commands of a particular religious organization" in order to claim First Amendment protection. *Frazee*, 489 U.S. at 834.

301. Accordingly, states that afford a vaccine exemption to those sincerely holding certain religious beliefs, while denying the same benefit to others sincerely holding disfavored religious beliefs, violate the protection of the Establishment Clause. *E.g.*, *Dahl*, 2021 WL 4618519 at *1, *5 (Oct. 7 decision applying strict scrutiny and finding that "defendants likely violated plaintiffs' First Amendment rights," therefore denying a motion to stay a preliminary injunction prohibiting state university "officials from enforcing [a COVID] vaccine mandate against plaintiffs" who made Free Exercise claim); *Davis v. State*, 294 Md. 370, 381 (1982) (finding unconstitutional an exemption that failed to "encompass personal religious beliefs . . . which are not associated with any church") (citing *United States v. Seeger*, 380 U.S. 163, 180); *Kolbeck v. Kramer*, 202 A.2d 889, 893 (N.J. Super.Ct.1964), modified on other grounds and "preserved," 46 N.J. 46, 214 A.2d 408 (1965) ("[m]embership in a recognized

religious group cannot be required as a condition of exemption from vaccination.").

302. In the present case, CU's discrimination under its original policy for granting exemptions ("**Original Exemption Policy**") "is expressly based on the . . . religiosity of the [students]," meaning the "Colorado [University rule] seems even more problematic than the Minnesota law invalidated in *Larson*," which "at least was framed in terms of secular considerations." *Colorado Christian Univ.*, 534 F.3d at 1259. And in the updated policy announced on September 24, 2021 ("**September 24 Exemption Policy**")[20], under which religious accommodations are not available to students but are available to employees, *supra* ¶ 46, CU disfavors those religions practiced by students while favoring those practiced by employees, "effectively distinguishing" between the two sets of religions. *See Larson*, 456 U.S. at 246 n. 23. And both Exemption Policies discriminate against religion by denying religious exemptions while broadly permitting medical exemptions.

303. Under the Original Exemption Policy, CU students had to have a religiosity of a very specific sort to qualify: it required students to adhere to a denomination whose "teachings are opposed to *all* immunizations." Email from Associate Dean for Student Affairs and Admissions to Dr. Fow (Sept. 7, 2021), Ex. 8 (emphasis added).

304. This is true despite the fact that the very existence of denominations within Christianity demonstrates that different Christians have different Christian beliefs, such as Dr. Fow's belief that the Bible teaches that "all abortion is an abomination" and that receiving

[20] Collectively, the Original Exemption Policy and the September 24 Exemption Policy will be referred to as the "**Exemption Policies**."

abortion-aided vaccines is therefore "a direct opposition and violation of the word of God." Fow Religious Exemption From COVID-19 Vaccination Requirement Form (Sept. 8, 2021), Ex. 9. Colorado University determined, under the Original Exemption Policy, not only that certain denominations need not apply, but that denominations themselves were not worthy of consideration at all: the only worthy whole *religion* was one rejecting *all* immunizations.

305. Nor mind the fact that different immunizations have different characteristics and thus may be subject to different religious considerations: CU determined that a belief that different immunizations should be considered differently is not worthy, could not possibly be religious rather than merely "personal."

306. And CU determined that only religions with recognized "teachings" were permissible—which is to say that it provided exemptions only to those "responding to the *commands* of a *particular* religious organization," *Frazee*, 489 U.S. at 834 (emphases added).

307. Dr. Fow received no notice of the implementation of the September 24 Exemption Policy, nor did CU communicate to him any indication that the denial of his exemption request had been or would be rescinded or reconsidered in light of CU's adoption of the September 24 Exemption Policy. Thus, the harm done to him remains—and is equal under the equally problematic September 24 Exemption Policy.

308. As such, CU violates the Establishment Clause in shocking and numerous ways.

309. "The University's mandatory vaccination policy offers exemptions based on a person's religious belief whose teachings are opposed to all immunizations, i.e., your religion teaches you and all other adherents that immunizations are forbidden under all circumstances."

Exemption Denial (Sept. 9, 2021), Ex. 10; *see also* Email from Associate Dean for Student Affairs and Admissions to Dr. Fow (Sept. 7, 2021), Ex. 8 (same: "The University only recognizes religious exemptions based on a religious beliefs [sic] whose teachings are opposed to all immunizations," and describing this once more as "the University's policy").

310. This description of the Original Exemption Policy could not be more clear: only adherents to religions with recognized, particular teachings qualify, and further, only adherents to religions whose teachings are opposed to *all* immunizations qualify.

311. The Original Exemption Policy violates the Establishment Clause's prohibition on requiring exemption-seekers to "be responding to the commands of a particular religious organization" in order to claim its protection, *Frazee*, 489 U.S. at 834. And the September 24 Exemption Policy, which gives preference to employees' religions over students' religions, *and* the Original Exemption Policy, violate its "clearest command," "that one religious denomination cannot be officially preferred over another." *Larson,* 456 U.S. at 244, whether by directly distinguishing or "effectively distinguishing" by establishing criteria other than credal content that is nonetheless aimed at religion, *see id*. at 246 n.23.

312. The Original Exemption Policy also violates the Establishment Clause's prohibition against excessive entanglement. In its attempt to delve into—rather, to answer—the "ecclesiastical question" of which religions are true religions to which believers may adhere and thus qualify for an exemption, CU "monitors . . . religious beliefs and practices," "second-guessing" those that (in its view) do not oppose *all* immunizations, "as a basis for . . . exclusion from benefits." *Colorado Christian Univ.*, 534 F.3d at 1261.

313. Indeed, Dr. Fow advised CU that he is "a faithful, practicing Christian" who believes the Bible, which he views as "the inerrant word of God," teaches that "all abortion is an abomination" and that, as such, "any vaccine containing aborted human fetal cells or tissue, . . . any vaccine having origins from a human aborted fetus, or . . . any vaccine in which its protein was tested using the cell line from an aborted human fetus" "is a direct opposition and violation of the word of God." Fow Religious Exemption From COVID-19 Vaccination Requirement Form (Sept. 8, 2021), Ex. 9.

314. To this, CU responded, "The basis for your objection to vaccination against COVID-19 is of a personal nature and not part of a comprehensive system of religious beliefs," Exemption Denial (Sept. 9, 2021), Ex. 10, thereby purporting to have monitored Christian religious beliefs and practices deeply enough to be able to conclusively determine that there is no Christian denomination that holds the beliefs espoused by Dr. Fow.

315. This is precisely the sort of "trolling through a person's or institution's religious beliefs" that the rule against excessive entanglement prohibits. *Colorado Christian Univ.,* 534 F.3d at 1261. The entanglement presented here—with CU essentially questioning the good faith of Dr. Fow's claim that his objection was religion, and into this claim's relationship with the Christian faith—is exactly what the Court warned against in *Catholic Bishop*, in which it found that NLRB oversight of Catholic schools would result in "significant risk" of excessive entanglement whenever the schools claimed that "challenged actions were mandated by their religious creeds" because such oversight would then "involve *inquiry into the good faith of the position asserted* by the clergy-administrators *and its relationship to the school's religious mission*."

NLRB v. Catholic Bishop of Chicago, 440 U.S. 490, 502 (1979).

316. The Exemption Policies are neither generally applicable nor neutral. *See Fulton*, 141 S. Ct. at 1879 ("[t]he creation of a formal mechanism for granting exceptions renders a policy not generally applicable"); *Colorado Christian Univ.,* 534 F.3d at 1266 (a rule affording preferential treatment to some denominations over others is not neutral).

317. Accordingly, to the extent the Original Exemption Policy did *not* create excessive entanglement, strict scrutiny must be applied to it due to its violation of the Establishment Clause.

318. But the Original Exemption Policy *did* create excessive entanglement. It permitted CU to discriminate "on the basis of *intrusive judgments* regarding *contested questions* of religious belief or practice," *Colorado Christian Univ.*, 534 F.3d at 1261 (emphasis added), that is, "excessive entanglement," *Walz v. Tax Commission*, 397 U.S. 664, 672–675 (1970). "Under the First Amendment, the government is not permitted to . . . second-guess the ecclesiology espoused by our citizens." *Colorado Christian Univ.*, 534 F.3d at 1261. "It is not only the conclusions reached by [CU's second guessing] which . . . impinge on rights guaranteed by the Religion Clauses, but also the very process of inquiry leading to findings and conclusions." *Catholic Bishop*, 440 U.S. at 502.

319. As such, because it authorized government actors to "troll[] through a person's [such as Dr. Fow's] or institution's [such as Christianity's] religious beliefs," *Mitchell v. Helms*, 530 U.S. 793, 828 (2000) (plurality), to determine whether those beliefs were legitimately "Christian," the Original Exemption Policy permitted "the *exact* kind of questioning into religious matters which *Catholic Bishop* specifically sought to avoid," *University of Great Falls v. NLRB*, 278 F.3d

1335, 1353 (D.C.Cir. 2002), *as cited by Colorado Christian Univ.*, 534 F.3d at 1264 (emphasis in original).

320. On this ground alone the Original Exemption Policy is "unconstitutional without further inquiry," *Colorado Christian Univ.*, 534 F.3d at 1266 (citing *Corp. of Presiding Bishop of Church of Jesus Christ of Latter-Day Saints v. Amos*, 483 U.S. 327, 339 (1987)).

321. Even if this were not the case, the Original Exemption Policy would still be subject, along with the September 24 Exemption Policy, to strict scrutiny, due to Establishment Clause violations. The Exemption Policies cannot survive strict scrutiny.

322. The Exemption Policies utterly fail the "compelling interest" prong. "The University adopted its COVID-19 Vaccination Policy for the purpose of protecting the health and safety of the campus community." Exemption Denial (Sept. 9, 2021), Ex. 10. And "[t]he purpose of th[e] [September 24 Exemption] [P]olicy is to protect the health and safety of the University of Colorado Anschutz Medical Campus . . . community, including all faculty, staff, students, [and others associated with the campus]." *COVID-19 Vaccination Requirement and Compliance*, University of Colorado Anschutz Medical Campus (Sept. 24, 2021), https://www.ucdenver.edu/docs/librariesprovider284/default-document-library/3000-facilities-management/3012---covid-19-vaccination-requirement-and-compliance.pdf?sfvrsn=3e48cbba_2. But CU has a high vaccination rate and a higher number of those immune from the virus. *Supra* ¶¶ 124-126. And the survivability of COVID for college-age students is almost 100%. *Supra* ¶ 129. For these and other reasons, it is not reasonable to require all students to be vaccinated.

323. For these reasons alone, the Exemption Policies do not serve an interest "of the

highest order," *Lukumi,* 508 U.S. at 2234; *Mills*, 2021 WL 5027177 at *3–4 (Gorsuch, J. dissenting) ("[C]ivil liberties face grave risks when governments proclaim indefinite states of emergency," and therefore where there were already high vaccination rates in the fields affected by vaccination mandate, the state's "decision to deny a religious exemption . . . doesn't just fail the least restrictive means test, it borders on the irrational").

324. But the Exemption Policies fail under the "compelling interest" prong for a simpler reason, because we must also ask the more specific question of "whether [CU] has . . . an interest *in denying an exception*," *Fulton*, 141 S. Ct. 1868, 1871, to those of unworthy religions. *See also Mills*, 2021 WL 5027177 at *3 (Gorsuch, J. dissenting) (the Supreme "Court has made plain that only the government's . . . asserted interests as applied to the parties before it count," rather than the interests as expressed at an "artificially high," "society-wide level of generality") (emphasis removed) (citation omitted).

325. "[A] law cannot be regarded as protecting an interest 'of the highest order' when it leaves appreciable damage to that supposedly vital interest unprohibited." *Id.* Here, the Exemption Policies do just that by providing exemptions for medical and *some* religious reasons. There is no reason to believe that the "damage" caused by those who *are* exemption-eligible under the Exemption Policies would be less than that caused by those of disfavored religions if they were granted exemptions, and CU can "offer[] no compelling reason" for doing precisely what the First Amendment prohibits. *Fulton*, 141 S. Ct. at 1882; *see also Does 1–3 v. Mills*, No. 21A90, 2021 WL 5027177, at *2 (U.S. Oct. 29, 2021) (Gorsuch, J. dissenting) (where state provided broad medical exemption from vaccination requirement, but no religious exemption, "[t]hat kind of

double standard is enough to trigger at least a more searching (strict scrutiny) review").

326. For the government to successfully show its "interest in reducing the spread of COVID," "it must show that the religious exercise at issue is more dangerous than" other permitted activities when the same precautions are applied to both. *Tandon v. Newsom,* 141 S. Ct. 1294, 1297 (April 9, 2021); *see also United States v. Friday*, 525 F.3d 938, 958 (10th Cir. 2008) ("Underinclusiveness suggests that the government's 'supposedly vital interest' is not really compelling.").

327. In this case, that means CU must show that the "activity" (being on campus) of an unvaccinated adherent of an "unworthy" religion is more dangerous than the "activity" (being on campus) of an unvaccinated person granted an exemption for a medical or "worthy" religious reason.

328. No such fantasy can be conjured: CU cannot make such a showing. Those of "unworthy" religions are not more diseased or more contagious than those permitted exemptions. *See Mills*, 2021 WL 5027177, at *2 (Gorsuch, J. dissenting) (government may not "blithely assume those claiming" an exemption for a favored reason "will be more willing to wear protective gear, submit to testing, or take other precautions than someone seeking" an exemption for a disfavored reason).

329. There is not even a rational basis for such discrimination. Nothing about "the characteristics" of adherents of unworthy religions "rationally justify denying to [them] what would [and has already been] permitted to [individuals] occupying the same site" for the same purposes. *Cleburne*, 473 U.S. at 450 (holding that zoning ordinance excluding group home for the

intellectually disabled was not rationally related to a legitimate interest since such homes would not pose a special threat to the City's interest).

330. The Exemption Policies likewise fail under the "narrow tailoring" prong, which asks whether CU's "conduct is narrowly tailored to achieve" its purported "interest in denying exception[s]" to some religious adherents but not to others. *Fulton*, 141 S. Ct. at 1881.

331. CU must "demonstrate that [its] policy is the 'least restrictive means' of achieving its objective." *Agudath Israel of Am. v. Cuomo*, 983 F.3d 620, 633 (2d Cir. 2020) (quoting *Thomas*, 450 U.S. at 718). This requires showing "that it 'seriously undertook to address the problem with less intrusive tools readily available to it.'" *Id.* (quoting *McCullen v. Coakley*, 573 U.S. 464, 494 (2014)).

332. CU cannot adequately explain why the exemptions permitted for medical or *some* religious reasons cannot similarly be extended to all with sincere religious objections. Nor can it show that it gave "sufficient weight to rules in other jurisdictions" in order to arrive at a properly tailored path forward. *See Mast v. Fillmore Cnty., Minnesota*, 141 S. Ct. 2430, 2433 (2021) (Gorsuch, J., concurring) ("It is the government's burden to show [such] alternative[s] won't work; not the [challenger's] to show [they] will"); *McCullen v. Coakley,* 573 U.S. 464, 494 (2014) (government must "show[] that it considered different methods that other jurisdictions have found effective").

333. Finally, as with the "compelling interest" analysis, underinclusiveness is an important consideration in the "narrow tailoring" analysis. "Underinclusiveness undermines the [government's] claim of narrow tailoring." *Colorado Christian Univ.*, 534 F.3d at 1268 (citing

Friday, 525 F.3d at 958).

334. CU cannot show that the "activity" (being on campus) of an unvaccinated adherent of an "unworthy" religion is more dangerous than the "activity" (being on campus) of an unvaccinated person granted an exemption for a medical or "worthy" religious reason, and the Exemption Policies are therefore not narrowly tailored according to the "underinclusiveness" test.

335. Because the Exemption Policies are neither neutral nor generally applicable, but run afoul of the Establishment Clause on multiple grounds (including excessive entanglement, which renders it unconstitutional without further inquiry), and cannot survive strict scrutiny, they are unconstitutional under the Establishment Clause of the First Amendment to the United States Constitution.

Count 3
The Mandate's Exemption Policies Violate the Free Exercise Clause to the First Amendment to the United States Constitution

336. Students re-allege and incorporate by reference all of the allegations contained in all of the preceding paragraphs.

337. "Th[e] constitutional prohibition of denominational preferences is inextricably connected with the continuing vitality of the Free Exercise Clause." *Larson*, 456 U.S. at 245; *see also Lukumi*, 508 U.S. at 532–33; *Larson*, 456 U.S. at 246 (citing *Abington School District v. Schempp*, 374 U.S. 203, 305 (1963) (Goldberg J., concurring)).

338. While the government "establishes" a religion by giving it preferential treatment, it burdens the free exercise of religion by coercing those of a given religion to forego that religion or its commands as the cost of a benefit.

339. As with the Establishment Clause, the Free Exercise Clause's protections are not limited to religions that possess a certain degree of "religiosity." Instead, the Supreme Court has adopted "a more subjective definition of religion, which examines an individual's inward attitudes towards a particular belief system." *Int'l Soc. for Krishna Consciousness, Inc. v. Barber*, 650 F.2d 430, 439 (2d Cir. 1981) (citing *United States v. Ballard*, 322 U.S. 78, 86 (1944) and *Thomas v. Rev. Bd.*, 101 S. Ct. 1425, 1429 (1981)).

340. Therefore, because "[t]he free exercise of religion promotes the inviolability of individual conscience . . . *private choice,* not official coercion, should form the basis for religious conduct and belief." *Id.* at 438 (citing *Walz v. Tax Comm'n*, 397 U.S. 664, 694 (1970) (Harlan, J., concurring)); *see also id.* at 439 (noting that First Amendment's goals "can best be satisfied if any belief that is *arguably religious* is considered 'religious' for the sake of free exercise analysis") (emphasis added).

341. When the state picks and chooses between favored and disfavored systems of belief, even if it does not "directly" burden religious freedom in the same way that (for example) criminalization of "a particular faith or religious practice" would, *Dahl*, 2021 WL 4618519 at *2 (citing *Smith,* 494 U.S. at 877–78), it nonetheless impermissibly imposes "indirect coercion or penalties on the free exercise of religion," *id.* (quoting *Trinity Lutheran Church of Columbia, Inc. v. Comer,* 137 S. Ct. 2012, 2022 (2017)).

342. "[A] policy that forces a person to choose between observing her religious beliefs and receiving a generally available government benefit for which she is otherwise qualified burdens her free exercise rights." *Id.* (citing *Fulton*, 141 S. Ct. at 1876; *Trinity Lutheran,* 137 S.

Ct. at 2023).

343. Such "[v]iolations of the . . . Free Exercise Clause[] are generally analyzed in terms of strict scrutiny." *Colorado Christian Univ.*, 534 F.3d at 1266.

344. CU infringes the Free Exercise Clause in multiple ways.

345. In a case of this nature, Free Exercise Clause violations go hand-in-hand with Establishment Clause violations. Specifically, by offering religious exemptions only to those whose religions it deems worthy—whether under the Original Exemption Policy's acceptance only of religions that prohibit *all* vaccinations or the September 24 Exemption Policy's distinguishing between religions practiced by students and religions practiced by employees, under which students continue to suffer the same harm—CU violates "[t]he free exercise [clause's] promot[ion of] the inviolability of *individual conscience*" by failing to "recogniz[e] that *private choice* . . . should form the basis for religious conduct and belief." *Int'l Soc. for Krishna Consciousness*, 650 F.2d at 438 (citation omitted).

346. Furthermore, in attaching a benefit to the religions it deems worthy and no others—whether by discriminating between religions that prohibit *all* vaccines and those that do not, or between the religions of students and those of employees—the Exemption Policies are not neutral. And they violate the Free Exercise Clause's prohibition on "indirect coercion or penalties on the free exercise of religion," *Dahl*, 2021 WL 4618519 at *2 (quoting *Trinity Lutheran*, 137 S. Ct. at 2022), forcing students to "choose between their religious beliefs and receiving a government benefit," *Trinity Lutheran*, 137 S. Ct. at 2023.

347. The Exemption Policies are not generally applicable. The Exemption Policies

provide exemptions for medical reasons and *some* religious reasons. Even if these discriminatory policies were "in fact executed" in a seemingly neutral way (i.e., granting no religious exemptions), *see Dahl*, 2021 WL 4618519 at *4, "[t]he creation of a formal mechanism for granting exceptions renders a policy not generally applicable," *Fulton*, 141 S. Ct. at 1879 (2021).

348. Accordingly, the Exemption Policies' violation of the Free Exercise Clause means they are subject to strict scrutiny. As explained above, they fail in numerous ways under both the "compelling interest" prong and the "narrow tailoring" prong.

349. Because the Exemption Policies are neither neutral nor generally applicable, but run afoul, on multiple grounds, of the Free Exercise Clause, and because they fail both the "compelling interest" and "narrow tailoring" prongs of strict scrutiny on multiple grounds and therefore cannot survive strict scrutiny, the Exemption Policies are unconstitutional under the Free Exercise Clause of the First Amendment to the United States Constitution.

Count 4
The Mandate's Exemption Policies Violate the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution

350. Students re-allege and incorporate by reference all of the allegations contained in all of the preceding paragraphs.

351. "Th[e] constitutional prohibition of denominational preferences is inextricably connected with the continuing vitality of the Free Exercise Clause," *Larson*, 456 U.S. at 245, and "the Equal Protection Clause's requirement is parallel." *Colorado Christian Univ.*, 534 F.3d at 1257.

352. "[I]nterdenominational discrimination" is therefore a "[v]iolation of the *Equal*

Protection and Free Exercise Clauses." *Colorado Christian Univ.*, 534 F.3d at 1266 (emphasis added).

353. Just as "law[s] burdening religious practice that [are] not neutral or not of general application must undergo the most rigorous of scrutiny," *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 546 (1993), so must violations of the Equal Protection Clause's similar requirement "that all persons similarly situated should be treated alike," *City of Cleburne, Tex.v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985). *See also Colorado Christian Univ.*, 534 F.3d at 1259, 1266 ("explicit and deliberate distinctions between different religious organizations" burden the Equal Protection Clause, triggering strict scrutiny due to lack of neutrality).

354. Because CU infringes on Establishment and Free Exercise Clause protections in multiple ways, it likewise infringes on the parallel protections of the Equal Protection clause.

355. By violating the Establishment Clause's prohibition on the government requiring those holding religious beliefs to "be responding to the commands of a particular religious organization" in order to claim its protection, *Frazee*, 489 U.S. at 834, and by violating the "the clearest command of the Establishment Clause," "that one religious denomination cannot be officially preferred over another," *Larson,* 456 U.S. at 244, and by the excessive entanglement it permits, the Exemption Policies violate the "parallel" protections of the Equal Protection Clause, *Colorado Christian Univ.*, 534 F.3d at 1257.

356. By violating the Free Exercise Clause's promotion of "the inviolability of individual conscience" and engaging in "official coercion . . . [in] religious conduct and belief," *Int'l Soc. for Krishna Consciousness*, 650 F.2d at 438 (citations omitted), the Exemption Policies

"[v]iolat[e] . . . Equal Protection." *Colorado Christian Univ.*, 534 F.3d at 1266.

357. Regardless of whether the discriminatory Exemption Policies were "in fact executed" in a seemingly neutral way (i.e., granting no religious exemptions), *see Dahl*, 2021 WL 4618519 at *4, "[t]he creation of a formal mechanism for granting exceptions renders a policy not generally applicable," *Fulton*, 141 S. Ct. at 1879 (2021). Nor is the Exemption Policy neutral.

358. Accordingly, the Exemption Policies' violation of the Equal Protection Clause means they are subject to strict scrutiny. As explained above, they fail in numerous ways under both the "compelling interest" prong and the "narrow tailoring" prong.

359. Because the Exemption Policies are neither neutral nor generally applicable, but run afoul, on multiple grounds, of the Equal Protection Clause, and because they fail both the "compelling interest" and "narrow tailoring" prongs of strict scrutiny on multiple grounds and therefore cannot survive strict scrutiny, the Exemption Policies are unconstitutional under the Equal Protection Clause.

Prayer for Relief

Wherefore, Students request the following relief:

360. Declare the Mandate unconstitutional on its face;

361. Declare the Mandate unconstitutional as applied to each Plaintiff;

362. Enjoin CU from enforcing the Mandate on its face or as applied;

363. Require CU to re-enroll terminated and deferred students into their prior programs and at the same matriculation status they previously attained;

364. Grant Students their costs and attorneys fees under 42 U.S.C. Section 1988 and any

other applicable authority; and

365. Grant any and all other such relief as this Court deems just and equitable.

Dated: January 4, 2022

Respectfully Submitted,

/s/ James Bopp, Jr.

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