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From Human Papillomavirus to COVID-19: Adolescent Autonomy and Minor Consent for Vaccines

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Adolescent minors in every state can give their own consent for some health care. Although parent consent is generally required for vaccination, there are exceptions in some states. Completion rates are low for recommended adolescent vaccines; allowing adolescents to consent may improve coverage, although more study is needed on barriers to vaccine completion and the feasibility of changes in consent laws. The COVID-19 pandemic highlights the importance of vaccines and related challenges. This policy brief reviews laws governing adolescent consent for health care, including vaccines, and recommends advocacy to support increased adolescent access to vaccines and improved public health. *J Pediatr Health Care.* (2022) 36, 607–610

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Minimizing barriers to adolescent health care serves important public health needs. Allowing adolescent minors to consent to their care is one strategy to further this goal. Adolescents in every state can consent to diagnosing and treating sexually transmitted infections (STIs; [Guttmacher Institute, 2022](#)). This approach to STIs recognizes public health risks posed by infectious disease and public interest in encouraging adolescents to seek care. Allowing adolescents to consent to vaccines can meet similar goals by preventing the transmission of preventable diseases. However, state and local policies that explicitly allow adolescent consent for vaccines are rare ([Zimet, Silverman, Bednarczyk, & English, 2021](#)). Although parental consent is generally required for vaccination, there are exceptions. Some states and localities already allow adolescents to consent for specific vaccines, such as human papillomavirus and hepatitis B, integrating them with treatment and prevention of STIs, for which young people in those locations can already consent, or allow self-consent for vaccines because of an adolescent's status ([Zimet et al., 2021](#)).

The COVID-19 pandemic has clarified the public health importance of vaccines, the impact of vaccine hesitancy for the pandemic, political divisions about vaccine mandates, and divisions within families about vaccinating children ([Hoffman, 2021](#); [Lewis, 2020](#)). Some adolescents may wish to be vaccinated or refuse the vaccine, contrary to parental views ([Yang, Olick, & Shaw, 2019](#)), and may rely more on their provider's vaccine recommendations than their parents' recommendations ([Griffin, Muhlbauer, & Griffin, 2018](#)). A policy may be needed to resolve such differing views. Below we explore the laws and rationale underlying adolescent consent for health care, views on adolescent vaccine consent

during the COVID-19 pandemic, and recommendations for increasing access to vaccines.

CONSENT FOR HEALTH CARE BY ADOLESCENT MINORS

Until the mid-twentieth century, minors in the United States did not have legal rights independent of their parents (Schaapiro & Mejia, 2018). Beginning in the 1960s, court decisions recognized that minors have constitutional due process, First Amendment, and privacy rights. States simultaneously enacted laws allowing minors to consent to their health care. These laws, which vary significantly from state to state, allow adolescent minors to consent for health care either because they have a specific status (e.g., married) or living situation (e.g., homeless) or are seeking a specific service (English, Bass, Boyle, & Eshragh, 2010). For example, adolescent minors in every state can consent to the diagnosis and treatment of STIs (Guttmacher Institute, 2022).

The ethical concept of autonomy supports the right to consent to or refuse health care once the adolescent has the mental capacity to understand the implications of alternatives and make a voluntary choice (Beauchamp & Childress, 2013). Researchers, using a well-established tool that assesses adult competence, have estimated that children reach intellectual competence to consent autonomously to research by the age of 12 years (Hein et al., 2015), but opinions about the age at which adolescents may competently consent to either research or medical treatment vary (Groontens-Wiegers, Hein, van den Broek, & de Vries, 2017), as do state laws (English et al., 2010; Guttmacher Institute, 2022; Zimet et al., 2021).

CONSENT FOR VACCINATION OF ADOLESCENTS

Historically, parental consent has been required for vaccinations for children and for those adolescents aged < 18 years and legally minors. There are specific circumstances in which adolescent minors may legally be able to consent to their vaccinations. State laws allowing adolescent minors to consent for their care are based on their legal status, living

situations, or the services they seek. Laws in each of these categories—status and services—may be a source of support for minor consent to vaccination (Table 1).

Less clarity exists in state laws regarding whether and when adolescent minors may refuse care; however, it is often presumed that a minor can refuse care to which they could legally consent (Hartman, 2000). Even when the law is unclear or parental consent is required, ethically, clinicians should at minimum seek the assent of the adolescent minor. This has special relevance when a parent wants their adolescent child to be vaccinated, and the adolescent refuses (Hoff & Kao, 2021).

Overall, there are many legal and ethical reasons for allowing some adolescent minors to consent to their vaccinations, and both the American Medical Association and the Society for Adolescent Health and Medicine have advocated for expanded adolescent vaccine consent (Society for Adolescent Health and Medicine et al., 2013; Matshazi, 2019). As with other health care, authorizing minors to consent for vaccinations can serve both the public health goal of reducing the risk of transmission of infectious diseases and protecting adolescents' health. As important as legal and policy guidance, clinical and ethical guidance is needed for these situations in which an adolescent and parent do not agree about vaccination (Olick, Yang, & Shaw, 2022).

COVID-19 SPECIFIC ISSUES

The emergence of parental resistance to vaccines in recent years has contributed to outbreaks of measles, pertussis, and other contagious diseases (Olick et al., 2022). This resistance has been attributed to mistrust of government and health care systems, political affiliation, religious objections, concerns about vaccine safety and, for COVID-19, disagreements about the danger of the infection, and concerns about the speed with which the vaccines were developed and approved (Troiano & Nardi, 2021). Despite very effective COVID-19 vaccines (Olson et al., 2022), low vaccine uptake has contributed to the continued morbidity and mortality associated with COVID-19 (Table 2). The unique nature of the COVID-19 pandemic illuminated some distinctive

TABLE 1. Consent for vaccination by adolescent minors

Status that may allow minors to consent for general health care, including vaccination	Services for which minors may be allowed to consent that include vaccination
Minors who have attained a specific age "Mature minors" ^a	Prevention of sexually transmitted disease or infection Prevention of infectious, contagious, or communicable disease
Legally emancipated minors	
Minors living apart from parents, including homeless and runaway youth	
Married minors	
Minor parents (for self and/or child)	
Minors in military service	

Note. Data from English et al., 2010; Guttmacher Institute, 2022; and Zimet et al., 2021.
^aThe mature minor doctrine, defined in court decisions and incorporated into statute in a few states, allows minors to consent to care if they can give informed consent.

TABLE 2. COVID-19 vaccination rates in adolescents and adults as of June 9, 2022

Age group	At least one dose	Fully vaccinated ^a
Adolescents aged 12–17 years	69.6%	59.7%
Adults aged 18–24 years	78.6%	63.9%
Adults aged 25–39 years	80.3%	67.2%

Note. Data from the Centers for Disease Control and Prevention (updated June 14, 2022; <https://data.cdc.gov/Vaccinations/COVID-19-Vaccination-and-Case-Trends-by-Age-Group-/gxj9-t96j>).

^aDefined as one dose of Johnson & Johnson or two doses of Moderna or Pfizer.

reasons to facilitate adolescent receipt of vaccines. In particular, the need to balance immediate public health concerns with family and adolescent decision-making is unique to COVID-19 (Morgan, Schwartz, & Sisti, 2021). Herd immunity created by very high rates of previous childhood vaccine completion resulted in unvaccinated and vulnerable community members being protected from most contagious diseases (Centers for Disease Control and Prevention, 2021). In contrast, very high rates of circulating COVID-19 virus put unvaccinated youth at risk of being infected and spreading the virus to others (Willis, Presley, Williams, Zaller, & McElfish, 2021). Because both the virus and the vaccine were new, many families were particularly hesitant about vaccinating their children and adolescents (McGrew & Taylor, 2022).

Conflicts between parents, children, and adolescents around vaccines are not novel and have intensified as vaccines have become increasingly politicized (Mubarak & Firm, 2022). Public health messaging about the importance of COVID-19 vaccination—and rules requiring the COVID-19 vaccine for participation in school or other activities—led some adolescents to seek vaccination despite parental hesitation (Hoffman, 2021). In the context of the public health emergency, some states and local governments expanded adolescent rights to allow minors to consent specifically to COVID-19 vaccines (Olick et al., 2022; Singer, Kates, & Tolbert, 2021).

Although cogent arguments support allowing adolescents to consent to vaccines (Agrawal & Morain, 2018; Olick et al., 2022), it is unclear that expanding consent would lead to increased COVID vaccination rates. A study of young adults earlier in the pandemic found that concerns about safety and side effects were major reasons for slower vaccine uptake in this age group (Adams et al., 2021). A contemporaneous study of ninth graders found that most were either somewhat or very hesitant to get the vaccine themselves (Willis et al., 2021).

POLICIES TOWARD ADOLESCENT SELF-CONSENT IN THE UNITED STATES AND BEYOND

Although adolescent consent for vaccines is supported by the ethical principle of autonomy and developmental research on adolescents, in practice, self-consent for vaccines is not widespread, either in the United States or other countries (Fisher, Harding, Hickman, Macleod, & Audrey, 2019; World Health Organization, 2014). Fisher and

colleagues noted that one barrier to self-consent was that health care providers were concerned about its impact on the provider-parent relationship.

The World Health Organization (2014) noted that factors such as accessibility and cost for vaccines had more impact on vaccine uptake than consent. Making vaccines mandatory to participate in school and other activities have increased vaccine coverage in the United States and abroad (Cioffi, 2020). Many countries use schools as a location for vaccinating children and adolescents, increasing the accessibility of vaccines, and in these countries, the time needed to obtain written parental consent is seen as a barrier to wider implementation (Perman et al., 2017). Parents in the United States have supported schools as a site for health care services, including vaccines (Gargano et al., 2015), and advanced practice nurses can advocate for school-based vaccine clinics.

Adolescents often present alone for health care, either in school or freestanding clinic settings, including for services that require parental consent. In these circumstances, policies and procedures that facilitate obtaining and tracking parental consent for vaccines could increase the uptake of COVID-19 and other essential adolescent vaccines (Fisher et al., 2019; World Health Organization, 2014). Many health care systems have increased their use of electronic communication via cell phone and e-mail for a variety of forms during the COVID-19 pandemic (Wood et al., 2020). Expanding opportunities to obtain consent via electronic communication could ease the vaccine permission process and increase access for adolescents presenting alone. The Centers for Disease Control and Prevention guides obtaining permission for school-located vaccine programs (Box).

BOX. Additional information on minor consent and vaccines

Information

- Sexually transmitted services (Guttmacher Institute)
- School-located vaccination planning (Centers for Disease Control and Prevention)
- Considerations regarding consent in vaccinating children and adolescents (World Health Organization)
- Ethics talk: Should adolescents be able to consent for COVID-19 vaccinations? (*AMA Journal of Ethics*)

Conclusions

The COVID-19 pandemic highlighted challenges related to vaccine access and uptake for adolescents that have existed

for a long time. Overcoming these challenges requires understanding and addressing the complex interplay of many legal, ethical, and clinical factors related to parental consent and adolescent autonomy. We support clarifying the COVID-19 vaccine consent policy when minors qualify for expanded health care consent under status- or service-specific laws, and increasing flexibility of parent consent options. The full exploration of current controversies about parents' rights and adolescent privacy is beyond the scope of this article; however, they affect the feasibility of a greater expansion of adolescent consent for vaccines at this time. Increasing adolescent COVID-19 vaccine rates will require further research into the underlying reasons for the low uptake of all vaccines. In the meantime, health care professionals can play a key role in collaborative discussions with adolescent patients, their parents, and guardians about the importance and safety of vaccines, and the COVID-19 pandemic continues to provide an urgent incentive.

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