



Position paper

## Adolescent Consent for Vaccination: A Position Paper of the Society for Adolescent Health and Medicine

The Society for Adolescent Health and Medicine

---

**A B S T R A C T**

Vaccines currently recommended for adolescents by the Advisory Committee on Immunization Practices have the potential to improve the health of youth by preventing conditions such as: tetanus, pertussis, meningococcal disease, influenza, and genital warts, as well as later adult outcomes such as cervical and other human papillomavirus–related cancers. Adolescent vaccine coverage lags behind that for younger age groups. A requirement to obtain parental consent for vaccination can present a significant barrier to improving adolescent vaccine uptake across all health care settings in which adolescents access care. The ability of minors to consent to vaccination can influence whether adolescents receive indicated vaccines during adolescent health care visits when parents are absent and when adolescents are seen for confidential services. State laws govern consent for the delivery of health care to minors. All states have some laws that allow minors to consent to health care based either on their status or on the services they are seeking. Some of these laws would allow them to consent to vaccination. It is the Position of the Society for Adolescent Health and Medicine that, within ethical and legal guidelines, it will be important to develop strategies that maximize opportunities for minors to receive vaccinations when parents are not physically present, including opportunities for them to give their own consent.

© 2013 Society for Adolescent Health and Medicine. All rights reserved.

**Positions**

1. Health care professionals who care for adolescents should be informed about all laws that are relevant to consent for vaccination of adolescents who are minors.
2. Public and private agencies and health care sites involved in the delivery of care to adolescents should develop clear policies and guidelines regarding consent for vaccination.
3. Health care sites should develop procedures for enabling minor adolescents who come to health visits for routine care without a parent present to receive recommended vaccines, based on minor consent or previously obtained parental consent, and consistent with legal requirements.
4. Health care sites should develop procedures for enabling minor adolescents who come to health care visits for confidential care to consent to vaccines, consistent with legal requirements.
5. Clinicians, public health personnel, and policy makers should explore all available legal options for allowing minor adolescents with capacity for informed consent to give their own consent for vaccinations.

**Background on Adolescent Vaccination**

The number of vaccines routinely recommended for adolescents continues to increase. As of January 2011, the United States Advisory Committee on Immunization Practices recommends that all teens receive one dose of the tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap); two doses of the quadrivalent meningococcal conjugate vaccine (MCV4); three doses of human papillomavirus vaccine (HPV); and annual doses of the influenza vaccine [1,2]. In total, between ages 11–17 years, adolescents in the United States are advised to receive at least 13 doses of four different vaccines. Furthermore, many adolescents also need catch-up doses of vaccines missed during childhood.

The currently recommended adolescent vaccines have the potential to greatly improve the health of youth and their contacts by preventing conditions such as: tetanus, pertussis, meningococcal disease, influenza, as well as cervical and other HPV-related cancers in adulthood, and genital warts. However, adolescent vaccine coverage lags behind that for younger children. According to the 2011 National Immunization Survey-Teen, among a cross-sectional sample of 13–17 year olds, 78% had received a single Tdap dose and 71% had received at least one dose of MCV4; approximately half of girls age 13–17 years (53%)

---

 Position paper approved by the Society for Adolescent Health and Medicine's Board of Directors, July 2013.

had received at least one HPV vaccine dose and only 35% had completed the three-dose vaccine series [3]. In contrast, at least 90% of children 19–35 months of age have received at least one dose of measles/mumps/rubella and varicella vaccine, as well as three doses of DTP/DT/Tdap, *Haemophilus influenzae* type B, hepatitis B, and pneumococcal conjugate vaccine [4]. For some vaccines, additional disparities in adolescent and young adult vaccine coverage by race, ethnicity, and poverty status are present [3]. It is clear that further efforts are needed to reduce barriers and promote vaccination for adolescents.

Barriers to vaccination include both individual (teen, parent, or provider) beliefs, such as concerns about vaccine efficacy and safety [5], and inadequate system-level practices that facilitate vaccination [6]. Although beliefs about vaccines may be modified through education, system-level barriers require changes in policies. One barrier to immunizing teens is that many do not present for identified routine preventive health care. For younger patients, vaccines are primarily administered during well-child check-ups. However, surveys have estimated that only 9%–15% of adolescents have an identified annual preventive health visit [7,8]. In addition, a recent study demonstrated that one third of adolescents with continuous enrollment in a large Midwestern health plan had no specifically designated preventive health visits between the ages of 13 and 17 years [9]. On the other hand, most adolescents do have contact with the medical system at least once a year [7–9]. Many teenagers present to their medical home for sports physicals (which can be used as preventive health visits) or for management of acute or chronic medical issues. In addition, teenagers may receive additional care in school-based health centers, family planning clinics, and public health clinics. A requirement to obtain parental consent for vaccination can present a significant barrier to improving adolescent vaccine uptake in both traditional and nontraditional health care settings [10].

Vaccination of adolescents is an issue of great importance globally as well as in the United States. Laws regarding consent for health care vary from one country to another. Comprehensive analysis of laws pertaining to adolescent consent for vaccination in countries other than the United States is beyond the scope of this position paper. Nevertheless, the Society for Adolescent Health and Medicine acknowledges that it would be desirable for barriers related to consent for adolescent vaccination to be reduced in all countries in which they exist.

### **Clinical Settings, Minor Consent, and Adolescent Vaccination**

The following common clinical scenarios demonstrate ways in which the ability of minors to consent to vaccination has an impact on whether adolescents receive indicated vaccines.

#### *Vaccination during routine adolescent health care visits when parents are absent*

Adolescents may present for routine health care alone. This is especially likely for older adolescents who have the skills and means to travel to health care settings independently. Adolescents with access to school-based health centers typically present without parents to be seen during the school day. Although parents in these situations are absent, parents may nonetheless be aware of routine health care visits and supportive of receipt of all indicated vaccines. When

adolescents are due for vaccinations in these clinical scenarios, health care professionals must make decisions about whether to offer and deliver vaccines without the parent being physically present to provide consent. In these cases, the potential barrier to vaccination is not concern about confidentiality, but whether and how parents can provide consent for vaccination when they are not physically present. Strategies to reduce this barrier to vaccination may include provisions for parents to provide written informed consent for vaccinations in advance, verbal informed consent over the telephone at the time of visit, use of technology to document receipt of information and consent such as via text or e-mail messaging, or strategies to allow minors to provide their own informed consent. Such policies must be developed consistent with state laws. To the extent that state laws can be interpreted to allow implementation of these and similar strategies, the potential exists to reduce barriers that impede vaccination of adolescents.

#### *Vaccination during confidential adolescent health care visits*

All states have laws that allow minors to consent on their own to evaluation and treatment for sexually transmitted infections [11]. Many states also have laws that allow minors to consent to reproductive health services to prevent pregnancy [11]. These state laws provide opportunities for minors to receive needed sensitive health care services confidentially that they might otherwise forego. When adolescents are seen for confidential health services, whether within the context of routine health care or specific sexual health-related visits, there may also be important opportunities to deliver needed vaccinations. In these situations, health care providers may not be able to discuss and obtain parental consent for vaccinations without risking a breach in physician–patient confidentiality by revealing the fact of or reason for the patient's visit. Strategies to reduce this barrier to vaccination may include, if feasible, provisions for parents to receive vaccination information and provide informed written consent for vaccinations in advance, particularly when adolescents are obtaining care, albeit confidential care, at their medical home or a site their parents know they visit. They may also include strategies to allow minors to provide their own informed consent for vaccination, consistent with applicable laws.

### **Legal Issues, Minor Consent, and Adolescent Vaccination**

Federal law does not contain any requirements with respect to consent for vaccination of minors. It is silent concerning both consent by parents and consent by minors. State laws govern the consent requirements for the delivery of health care to minors. As discussed in further detail in the following section, federal law does require that vaccine information statements (VIS) be distributed each time a vaccine is administered. The VIS itself, however, is not a consent form or documentation of informed consent. Rather it is a document containing information about a specific vaccination that federal law requires to be communicated to patients and/or their parents or legal representatives.

States generally do not have comprehensive statutes that specify consent requirements for vaccination of children or adults, although some states have statutes or regulations that apply in specific circumstances. However, vaccination typically would be covered under laws that more generally address

consent for health care. Based on statutes and/or court decisions, every state requires minors to have parental consent for most health care, including vaccination [12], although few states explicitly mention vaccination. When the parent is not available or does not have custody, depending on the specifics of an individual state's laws and the minor's particular circumstances, consent for health care may almost always be given by a legal guardian or a court, and may sometimes be given by related caretakers, foster parents, social workers, or probation officers, who have been accorded the appropriate authority. This would likely also be true for vaccination. With respect to vaccination, laws have generally been interpreted as requiring consent for each injection when more than one injection is required to complete a vaccination series [12].

The question of when adolescents may give consent for their own vaccination depends on an analysis of several factors: the age and capacity of the adolescent, the state in which the adolescent is seeking care, the legal status of the adolescent, the type of health care, and the disease for which vaccination is being administered. Several of these factors are addressed in the minor consent laws, contained in two types of statutes in every state: laws that allow minors to give consent based on their status and those that allow minors to give consent based on the services they are seeking [11]. Both types of minor consent laws may be used to determine whether an adolescent minor may consent for vaccination.

#### *Minor consent laws based on status*

Minors who are generally allowed to consent for their own health care based on their status (e.g., emancipation, marriage, living apart from parents) would likely be able to consent to their own vaccinations unless a specific law explicitly precluded them from doing so. The concept of the mature minor, which was developed in court decisions and is widely accepted by legal scholars and courts, enables certain older minors who have the capacity to give informed consent to do so for care that is within the mainstream of medical practice, not high risk, and provided in a nonnegligent manner. This doctrine also might provide a basis for a minor to give consent for vaccinations.

#### *Minor consent laws based on services*

Laws related to care for sexually transmitted infections and reportable diseases may also be relevant to whether an adolescent minor may consent to vaccination, depending on the type of vaccine to be administered. Every state has a law that allows minors to consent for diagnosis and treatment for sexually transmitted infections (although the terminology used in the statutes is usually "sexually transmitted disease" or "venereal disease") [11]. In addition, about one fourth of states explicitly allow minors to consent for diagnosis and treatment of reportable diseases [11]. Some state laws include the term *prevention* along with *diagnosis* and *treatment*, which could allow the law to cover vaccinations for sexually transmissible or reportable diseases (e.g., hepatitis B and HPV). Other states do not include the term *prevention* among the services explicitly covered, but use other terminology, such as services *related to* the diagnosis or treatment of a sexually transmitted disease or reportable disease, that might justify a minor giving consent for a vaccination.

## **VIS and Adolescent Vaccination**

The National Childhood Vaccine Injury Act is a federal law that requires the distribution of VIS when vaccines are administered. For specified vaccines, a VIS must be given either to the vaccine recipient or to a child's parent or legal representative before each administration of a vaccine [12]. According to the Centers for Disease Control and Prevention (CDC), a "legal representative" is a parent or other individual who is qualified under state law to consent to the immunization of a minor; there is not any other overriding federal definition [13]. This suggests that when a minor is authorized to consent to the administration of a vaccine under state law, it would be permissible to give the VIS to the minor rather than the parent. Specific requirements exist for the health care provider to document the provision of the VIS [14]. In this context, questions are common; many such questions are addressed by the CDC materials on VIS [13]. Consultation with experts familiar with state laws and local standards of adolescent health care also can provide guidance in these areas.

## **Current Challenges and Recommendations**

New adolescent vaccines provide an opportunity to improve adolescent and adult health, and more vaccines targeting this age group are anticipated. Strategies to increase the proportion of adolescents who receive vaccines will be important to assure that adolescent vaccination will lead to improvements in the health of populations [15]. Within ethical and legal guidelines, it will be important to develop policies and strategies that maximize opportunities for minors to receive vaccinations when parents are not physically present. As outlined in the Positions at the beginning of this paper, the Society for Adolescent Health and Medicine urges that the development of policies and strategies should include: increased awareness of applicable federal and state laws; clear policies and guidelines regarding consent for vaccination; procedures for enabling minor adolescents who come to health visits for routine care without a parent present to receive recommended vaccines based on minor consent or previously obtained parental consent within existing legal requirements; and legal options for allowing minor adolescents with capacity for informed consent to give their own consent for vaccinations. A broad range of organizations of health care professionals, adolescent health care clinicians, public health personnel, health care sites, and policy makers should undertake the development of the necessary policies and strategies.

Information about state laws relevant to vaccination of adolescents can be found from several sources. The Center for Adolescent Health & the Law produces a monograph that summarizes the minor consent laws of all states and Washington, DC, available as a complete document or individual state summaries at: <http://www.cahl.org/web/state-minor-consent-laws-a-summary-third-edition/>. The Center for Adolescent Health & the Law will publish a report containing information on state laws specifically relevant to the vaccination of adolescents that will be available in early 2014 at [www.cahl.org](http://www.cahl.org). The Guttmacher Institute produces State Policies in Brief that provide an overview of state consent laws related to specific topics, such as sexually transmitted disease, accessible at: <http://www.guttmacher.org/statecenter/adolescents.html>. The CDC provides

information about state laws specific to vaccines, accessible at: <http://www2a.cdc.gov/nip/StateVaccApp/statevaccsApp/default.asp>. The CDC also provides information about the VIS, accessible at <http://www.cdc.gov/vaccines/pubs/vis/vis-facts.htm>.

Amy B. Middleman, M.D., M.S.Ed., M.P.H.  
*Section of Adolescent Medicine*  
*Department of Pediatrics*  
*University of Oklahoma Health Sciences Center*  
*Oklahoma City, Oklahoma*

## Author Disclosures

Abigail English, J.D., was a co-investigator on a research project funded by GlaxoSmithKline, 2006-2009 and has spoken at Merck & Co., Inc. for Grand Rounds, 2012. Carol Ford, M.D., was a co-investigator on a research project funded by GlaxoSmithKline, 2006-2009. Jessica Kahn, M.D., is co-chair of two HPV vaccine clinical trials in HIV-positive individuals, for which Merck & Co, Inc. is providing vaccine and immunogenicity titers; she also chaired a grant review committee for the Society for Adolescent Health and Medicine evaluating public health demonstration project proposals to improve adolescent vaccination; grant funding for this program was from Merck & Co, Inc. Amy Middleman, M.D., has had research grant funding from Novartis and MedImmune, 2010-2012.

Prepared by:

Abigail English, J.D.  
*Center for Adolescent Health & the Law*  
*Chapel Hill, North Carolina*

Carol A. Ford, M.D.  
*The Children's Hospital of Philadelphia*  
*Philadelphia, Pennsylvania*

Jessica A. Kahn, M.D., M.P.H.  
*Division of Adolescent Medicine*  
*Cincinnati Children's Hospital Medical Center*  
*Cincinnati, Ohio*

Elyse Olshen Kharbanda, M.D., M.P.H.  
*HealthPartners Institute for Education and Research*  
*Bloomington, Minnesota*

## References

- [1] Centers for Disease Control and Prevention. General recommendations on immunizations: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 2011;60.
- [2] Centers for Disease Control and Prevention. Recommendations on the use of quadrivalent human papillomavirus vaccine in males – Advisory Committee on Immunization Practices (ACIP), 2011. *MMWR* 2011;60:1705–8.
- [3] Centers for Disease Control and Prevention. National and state vaccination coverage among adolescents aged 13 through 17 years – United States, 2011. *MMWR* 2012;61:671–7.
- [4] Centers for Disease Control and Prevention. National and state vaccination coverage among children aged 19–35 months – United States, 2010. *MMWR* 2011;60:1157–63.
- [5] Humiston SG, Rosenthal SL. Challenges to vaccinating adolescents: Vaccine implementation issues. *Pediatr Infect Dis J* 2005;24(6 Suppl):S134–40.
- [6] Ford CA, English A, Davenport AF, Stinnett AJ. Increasing adolescent vaccination: Barriers and strategies in the context of policy, legal, and financial issues. *J Adolesc Health* 2009;44:568–74.
- [7] Rand CM, Shone LP, Albertin C, et al. National health care visit patterns of adolescents: Implications for delivery of new adolescent vaccines. *Arch Pediatr Adolesc Med* 2007;161:252–9.
- [8] Dempsey AF, Freed GL. Health care utilization by adolescents on Medicaid: Implications for delivering vaccines. *Pediatrics* 2010;125:43–9.
- [9] Nordin JD, Solberg LI, Parker ED. Adolescent primary care visit patterns. *Ann Family Med* 2010;8:511–6.
- [10] Guajardo AD, Middleman AB, Sansaricq KM. School nurses identify barriers and solutions to implementing a school-based hepatitis B immunization program. *J Sch Health* 2002;72:128–30.
- [11] English A, Bass L, Boyle AD, Eshragh F. State minor consent laws: A summary. 3rd ed. Chapel Hill, NC: Center for Adolescent Health & the Law; 2010.
- [12] Gordon T, Zook E, Averhoff F, Williams W. Consent for adolescent vaccination: Issues and current practices. *J School Health* 1997;67:259–64.
- [13] Centers for Disease Control and Prevention. Fact sheet for vaccine information statements. <http://www.cdc.gov/vaccines/pubs/vis/vis-facts.htm>. Accessed January 5, 2012.
- [14] Centers for Disease Control and Prevention. Fact sheet for vaccine information sheets: Frequently asked questions. <http://www.cdc.gov/vaccines/pubs/vis/vis-facts.htm#faq>. Accessed January 5, 2012.
- [15] Middleman AB, Rosenthal SL, Rickert VI, et al. Adolescent immunization: A Position Paper of the Society for Adolescent Health and Medicine. *J Adolesc Health* 2006;38:321–7.