



# Policy Statement—Consent for Emergency Medical Services for Children and Adolescents

COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE AND  
COMMITTEE ON BIOETHICS

## KEY WORDS

informed consent, Emergency Medical Treatment and Active Labor Act, confidentiality, mature minor, emancipated minor, emergency medical condition

## ABBREVIATIONS

ED—emergency department  
AAP—American Academy of Pediatrics  
EMS—emergency medical services  
MSE—medical screening examination  
EMC—emergency medical condition  
IRB—institutional review board

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

[www.pediatrics.org/cgi/doi/10.1542/peds.2011-1166](http://www.pediatrics.org/cgi/doi/10.1542/peds.2011-1166)

doi:10.1542/peds.2011-1166

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2011 by the American Academy of Pediatrics

## abstract

FREE

Parental consent generally is required for the medical evaluation and treatment of minor children. However, children and adolescents might require evaluation of and treatment for emergency medical conditions in situations in which a parent or legal guardian is not available to provide consent or conditions under which an adolescent patient might possess the legal authority to provide consent. In general, a medical screening examination and any medical care necessary and likely to prevent imminent and significant harm to the pediatric patient with an emergency medical condition should not be withheld or delayed because of problems obtaining consent. The purpose of this policy statement is to provide guidance in those situations in which parental consent is not readily available, in which parental consent is not necessary, or in which parental refusal of consent places a child at risk of significant harm. *Pediatrics* 2011;128:427–433

## INTRODUCTION

Minors (persons under the age of legal consent as defined by state law) often require care in the prehospital environment and present to emergency departments (EDs) with medical concerns. Parental consent generally is required for the medical evaluation and treatment of minor children. In most cases, children will present to the ED with a parent or legally authorized decision-maker who can provide informed consent for evaluation and treatment. However, a number of well-recognized exceptions to this “general rule” have been outlined in common and statutory law to allow for the treatment of minors without parental consent in situations that frequently occur in EDs.<sup>1–14</sup> The purpose of this document is to provide guidance for those situations in which parental consent is not readily available, in which parental consent is not necessary, or in which parental refusal of consent places a child at risk of harm.

The American Academy of Pediatrics (AAP) supports the principle that all pediatric patients who present to any emergency medical services (EMS) provider or ED for evaluation and treatment should receive an initial evaluation or medical screening examination (MSE) regardless of ability to pay or presence of a legally authorized decision-maker who can provide consent. The AAP has written 2 previous versions of this document. The original document, “Consent for Medical Services for Children and Adolescents,” was published in 1993 and subsequently revised in 2003.<sup>15</sup> The recommendations made in the 2003 revision remain important and pertinent to current practice. In addition to reaffirming the 2003 recommendations, this policy statement attempts

to explore additional situations in which obtaining consent presents special challenges.

## EVALUATION AND TREATMENT OF THE UNACCOMPANIED MINOR

If a parent or legal guardian is present or available, the health care professional treating the child should make every reasonable effort to obtain and document informed consent. Children occasionally present to the ED unaccompanied by a parent or legal guardian. In some cases (discussed later in this statement), adolescents may have the legal authority to consent for treatment without a parent present. In most situations, however, the child or adolescent will either not have the authority to consent or will be unable to do so. Common and statutory law generally has supported the health care professional in evaluating these children and providing emergently needed care while attempts are made to locate a parent or legally authorized decision-maker. In addition, current federal law under the Emergency Medical Treatment and Active Labor Act (EMTALA) mandates an MSE for every patient seeking treatment in an ED of any hospital that participates in programs that receive federal funding, regardless of consent or reimbursement issues.<sup>16–19</sup> The purpose of the MSE is to determine if an emergency medical condition (EMC) exists, including life- or limb-threatening conditions, severe pain, or conditions with the potential for serious impairment or dysfunction if left untreated. The MSE might require the use of extensive ED resources, including laboratory testing, radiographic imaging, and subspecialty consultation, as needed for diagnosis. Although the ED should attempt to contact the unaccompanied patient's parent or legal guardian to seek consent for evaluation and treatment, the performance of the MSE and the stabilization of the patient with an

identified EMC must not be delayed. If an EMC is not identified, EMTALA regulations no longer apply, and the physician or health care professional generally should seek proper consent before further (nonemergent) care is provided. In cases of suspected abuse or neglect, child protective services or local law enforcement officers may have the authority to consent for evaluation and treatment, although the extent of this authority might differ from one jurisdiction to the next.

In situations in which a minor has a condition that represents a threat to life or health and a parent or legally authorized decision-maker is not readily available to provide consent, health care professionals may provide necessary medical treatment or transport the child for more definitive evaluation and stabilizing treatment. The ethical basis for this approach is based in the professional's duty to seek the best interest of the child. The legal basis for taking action in an emergency when consent is not available is known as the "emergency exception rule."

The emergency exception rule is also known as the doctrine of "implied consent." This emergency exception rule is based on the assumption that reasonable persons would consent to emergency care if able to do so and that if the legal guardian knew the severity of the emergency, he or she would consent to medical treatment for the child. Under the emergency exception rule, a medical professional may presume consent and proceed with appropriate treatment and transport if the following 4 conditions are met:

1. The child is suffering from an emergent condition that places his or her life or health in danger.
2. The child's legal guardian is unavailable or unable to provide consent for treatment or transport.

3. Treatment or transport cannot be safely delayed until consent can be obtained.
4. The professional administers only treatment for emergent conditions that pose an immediate threat to the child.

Any time a minor is treated without consent, the burden of proof falls on the professional who is evaluating, treating, or transporting the child to justify and document that the emergency actions were necessary to prevent imminent and significant harm to the child. In addition to actions necessary to save a person's life and prevent permanent disability or harm, the treatment of fractures, infections, pain, and other conditions may broadly be considered as emergent conditions that require treatment. As a general rule, health care professionals should always do what they believe to be in the best interest of the minor. The emergency exception exists to protect the health care professional from liability with the assumption that if the parents were present, they would consent to treatment.<sup>20</sup> The professional must clearly document in the child's record the nature of the medical emergency and the reason the minor required immediate treatment and/or transport and the efforts made to obtain consent from the patient's legal guardian, if unavailable.<sup>15</sup>

## EMANCIPATION AND THE MATURE MINOR DOCTRINE

There are 3 situations in which a minor, rather than his or her parents, has the legal authority to make decisions regarding his or her health care: emancipation; the mature minor exception; and exceptions based on specific medical conditions. In fact, every state has enacted minor consent statutes that address some or all of these exceptions to the "general rule."<sup>21,22</sup>

In general, an emancipated minor can function as an adult, independent from

his or her parents, with regard to consent for medical evaluation and treatment.<sup>23</sup> Children who are legally emancipated may give consent for medical treatment and transport. They may also refuse medical care and/or transport. Although emancipated minor laws vary from state to state, most states recognize minors to be emancipated if they are married, economically self-supporting and not living at home, or on active-duty status in the military. In some states, a minor who is a parent or who is pregnant might also be considered emancipated. Other states might require a court to declare the emancipation of a minor.

Most states also recognize a mature minor exception, in which a minor, usually 14 years old or older, displays sufficient maturity and intelligence to understand and appreciate the benefits, risks, and alternatives of the proposed treatment and to make a voluntary and reasonable choice on the basis of that information. States vary in terms of whether a physician can make this determination or whether a judicial determination is required.<sup>23</sup>

Finally, most states allow a minor to consent to evaluation and treatment of specific medical conditions without the consent of a parent, generally including mental health services, treatment for drug and alcohol addiction, pregnancy-related care, contraceptive services, and testing for and treatment of sexually transmitted diseases. The specific nature of these exceptions and the age at which they apply vary from state to state. Because state laws vary, it is important to be familiar with the specifics of emancipated and mature minor laws in the state in which care is being provided.

If none of the 3 scenarios described previously (emancipation, mature minor, or condition-specific exceptions) are applicable, then the minor has no legal authority to either provide con-

sent or refuse medical care. Regardless of whether a child has the legal authority to provide or withhold consent, it is always prudent to attempt to get the child's agreement or assent to treatment and transport. This approach respects the personal dignity and self-determination of the child/patient and minimizes confrontation. A willingness to provide the child with some control and some choice might allow for a compromise that allows transport personnel to achieve a safe transfer. Using force or restraint to evaluate, treat, or transport a child should be reserved only for those situations in which all efforts to negotiate respectfully with the child have failed and the child is at risk of serious harm if he or she is not restrained. In these unusual circumstances, appropriate measures should be taken to ensure the safety of the patient.

#### **CONSENT FOR NONURGENT PEDIATRIC CARE OF CHILDREN ACCOMPANIED BY SOMEONE WHO IS NOT AUTHORIZED TO PROVIDE LEGAL CONSENT**

Health care professionals should refrain from providing nonurgent testing and treatment to children who present to medical facilities unaccompanied by a custodial parent or legal guardian. An MSE should be performed to ensure that the child does not have a condition that requires emergent attention, and any treatment necessary to prevent immediate and serious harm to the child should be provided while an attempt is made to obtain consent from a legally authorized decision-maker. The AAP clinical report "Consent for Nonurgent Pediatric Care"<sup>24</sup> describes the issue of "consent by proxy" and provides practical steps that will help to balance a patient's ready access to medical care, family integrity, and the health care professional's need to limit his or her exposure to liability. Unless a minor's right to consent has

been legally established, health care professionals should attempt to notify parents or legal guardians of their intentions to test and/or treat the minor and consider delaying all nonurgent diagnostic and treatment decisions until the parent or legal guardian can be reached for informed permission or consent.<sup>24</sup>

#### **REFUSALS OF CONSENT FOR EMERGENT EVALUATION AND TREATMENT**

A particularly challenging situation occurs when the health care professional is faced with a legal guardian who refuses to give permission for treatment of a child in situations in which such treatment is considered essential to the child's well-being. Competent adult patients have the right to refuse evaluation and treatment, even for EMCs, unless they are determined to lack decision-making capacity. Under US law, minors are generally considered incompetent to provide legally binding consent regarding their health care; parents or legal guardians are empowered to make those decisions on their behalf, and those decisions are considered legally binding. Except for the exceptions cited previously, parental permission is required before the evaluation and treatment of a child. Parental authority is not absolute, however, and when a parental decision places a child at significant risk or serious harm compared with an alternative decision, the state may intervene to require intervention over the objections of the legal decision-maker.

As long as a child's legal guardian possesses medical decision-making capacity, he or she has the right to refuse medical care for the child. However, the guardian is required to act in the best interest of the child. When a legal guardian refuses to consent to medical care or transport that is necessary

and likely to prevent death, disability, or serious harm to the child, law enforcement officers may intervene under local and state child abuse and neglect laws. It is always preferable to negotiate with the legal decision-maker and attempt to achieve an agreeable plan for safely managing the child's medical condition.

When faced with a guardian who refuses to allow the provision of necessary medical care or transport of a child when it is necessary to save a child's life or prevent serious harm, it might be necessary to notify the police and enlist their assistance in placing the child in temporary protective custody. In a life-threatening emergency, it might be necessary to involve hospital security so that emergent evaluation and treatment can begin while child protective services and the police are notified. Likewise, when a legal guardian appears to be intoxicated or otherwise impaired, involvement of law enforcement officers might be necessary to place a minor in temporary protective custody. Once the professional has received authorization to treat from a state child protective agency or police, the emergency medical professional does not have the right to treat a minor for medical conditions that are not serious or life-threatening. Under these circumstances, a medical professional should provide medical treatment without consent only when the child has a medical condition that poses a risk of death or serious harm, when immediate treatment is necessary to prevent that harm, and when only those treatments necessary to prevent the harm are provided.<sup>25</sup>

### **INFORMED CONSENT AND THE LANGUAGE BARRIER**

If a language barrier exists, informed consent for medical treatment should, when clinical circumstances permit, be obtained through a trained medical

interpreter. Using an interpreter not only increases the likelihood of truly informed consent but also enhances the possibility of optimal medical treatment by allowing the professional to obtain accurate information about a child's underlying medical conditions, allergies, current medications, or other relevant and important information. Such interpretation may be performed in person, via videoconferencing, or by telephone, but a certified medical interpreter should be used. Using a family member as interpreter should be avoided unless absolutely necessary, and the medical professional should be aware that translation might not be accurate when a trained interpreter is not used.

### **CONSENT AND CONFIDENTIALITY**

State statutes that allow the consent of a minor do not all guarantee an adolescent protection from parental disclosure. However, some states explicitly require either confidentiality or parental notification. Other states require the health care professional to at least make a good-faith effort to involve the family of the minor in his or her treatment. The only federal law that requires confidentiality for minors is the Family Planning Act.<sup>26</sup> It is crucial that every health care professional be knowledgeable of his or her respective state and all federal laws relating to confidentiality and minors.<sup>27</sup>

The issue of adolescent confidentiality was addressed in the recently published AAP technical report "Patient and Family-Centered Care and the Role of the Emergency Physician Providing Care to a Child in the Emergency Department."<sup>28</sup> This report suggested that ED health care professionals be familiar with the limitations to and obligations for providing care to the unaccompanied older pediatric patient seeking care without the knowledge of his or her family<sup>15,24,29</sup> and make those

limits and obligations clear to the patient. For example, both the patient and the health care provider should identify a secure and confidential means of receiving follow-up information regarding pending laboratory results, return visits, and billing notification. In particular, confidentiality can only be reliably realized when attached to financial accountability. The child must be willing and able to pay the bill for the ED visit or risk a breach of confidentiality as a result of billing notification. Some professional organizations have formalized their opinions on the issue of confidentiality. The American Medical Association recommends a conservative approach to confidentiality and encourages parental involvement whenever possible.<sup>30</sup> The Society for Adolescent Medicine believes that health care professionals have an obligation to protect patient confidentiality when appropriate.<sup>31</sup>

As discussed previously, the lack of legal clarity provides health care professionals with some discretionary control over whether to provide testing and treatment to a minor without parental notification. That responsibility should not be taken lightly, and consideration for issues such as family dynamics (eg, will the child be punished if the parents are consulted?), developmental maturity (eg, is the child a runaway risk?), and the actual scope of testing and treatment must be taken into consideration before excluding or including parents in the discussion. In addition, health care professionals should be honest and consistent with their patients and families. A clinician should never promise a patient confidentiality if he or she might not be able to honor that promise.

### **PREHOSPITAL CONSENT**

EMS providers and EMS medical directors caring for minors might find it difficult or impossible to make real-time

contact with parents or legal guardians of patients, despite the increased availability of communication tools in the prehospital environment (eg, cell phones). Although most EMS systems promote a good-faith effort on the part of the prehospital provider to make contact with the parents and legal guardians of minors, many systems do not have formal policies addressing the lack of informed minor or parental consent. If at all possible, an assessment should be performed to determine if there is a medical emergency, and medical consultation should be sought if the emergency medical technicians are unclear about whether a threat to life or limb exists. If parents are present or accessible and refuse care for their injured or ill child, they must be informed of the risk of not transporting a sick or injured pediatric patient, which might include death or permanent disability. Regardless of religious beliefs or parental desires, every attempt should be made to treat and/or transport a child with a life-threatening emergency or if providers suspect child abuse. EMS providers should involve medical control early in these situations and use law enforcement resources as necessary to ensure that the patient receives the necessary emergency stabilization and transport.

### **CONSENT DURING A DISASTER**

Health care professionals evaluating and treating a minor during a disaster should always attempt to obtain consent from the parents or legally authorized decision-maker. The mere existence of a disaster event does not automatically authorize emergency medical professionals to evaluate and treat minors without parental consent unless the minor's life or health would be jeopardized by delay.<sup>32</sup> However, in an overwhelming disaster scenario, time pressures on medical providers, a chaotic environment, interruption of

normal communication methods, the inability to identify patients, and multiple casualties might make it impossible to seek timely informed consent for the evaluation and treatment of minors. In such a situation, medical professionals should act in the best interest of the patient and provide stabilizing care until consent can be obtained.

### **CONSENT FOR RESEARCH IN THE EMERGENCY SETTING**

For research protocols that enroll ED patients, informed consent will require a process separate from that of informed consent for evaluation and treatment. Whether to enroll a child in a research project can never be decided solely by a health care professional but must occur in accord with the requirements of an institutional review board (IRB). The IRB will determine the requirements for informed consent, including the content of the informed consent, who can obtain consent, and whether consent requires the agreement of 1 or both parents.

In some cases, research in the emergency environment is designed to investigate emergency procedures that offer the prospect of direct benefit to potential participants, and in these situations, enrollment must take place immediately, and parents might not yet be available to provide permission.<sup>33</sup> Such special situations are governed by special rules. Under these circumstances, the research can proceed without permission of the parents only under restricted guidelines outlined by federal regulation. These guidelines require that the subject be facing a life-threatening or permanently disabling situation for which the only known therapy is investigational, unproven, or unsatisfactory; that the child is incapable or unable to provide valid consent, and the parents cannot be reached for permission before the

time the investigational treatment must be started; and that there is no accepted therapy that is clearly superior to the experimental therapy. In addition, the research protocol must have received IRB approval that the experimental treatment has a realistic probability of benefit that equals or exceeds that of standard care, that the risks of the experimental therapy are reasonable in comparison to the patient's condition and standard therapy, that there is minimal added risk from participation in the research protocol, that there is no possibility of getting prospective consent from those who are likely to need the experimental therapy, that participants and/or parents will be provided with all pertinent information regarding the study as soon as possible, and that alteration or waiver of consent will not adversely affect the rights and welfare of the subjects. Once the legal decision-maker has been informed of the research, he or she might choose to discontinue participation at any time after being fully informed of the consequences of doing so. Finally, federal regulations require that input from community representatives be sought regarding the protocol before IRB approval to gain a form of "community consent" to proceed with the research and that public disclosure of the research and its risks and benefits be made to the community from which potential participants will be enrolled before initiation of the research. Public disclosure of study results is also required by law in this situation.

### **CONCLUSIONS**

A health care professional's decision to treat combined with parental consent and patient assent (when appropriate) is the preferred scenario encountered by the pediatrician working in the emergency medical environment. When any one of those factors is absent or unclear, the health care pro-

vider must be (1) knowledgeable of state and federal laws related to a minor's right (or lack thereof) to consent for testing and treatment and (2) prepared to confront the ethical challenges surrounding those same issues.

## RECOMMENDATIONS

1. An MSE and any medical care necessary and likely to prevent imminent and significant harm to the pediatric patient with an EMC should never be withheld or delayed because of problems with obtaining consent.
2. The physician or health care professional should document in the patient's medical record all informed-consent discussions, including the identity of the person providing consent (if the patient) or permission for treatment (if a parent or another adult with legal decision-making authority) and the efforts made to obtain consent from the patient's legal guardian, if unavailable.
3. The physician or health care professional should be familiar with Emergency Medical Treatment and Active Labor Act federal regulations, state laws concerning consent for the treatment of minors, and state laws enumerating the conditions under which minors can provide consent for their own care.
4. Unless a minor is allowed to consent under the law, health care professionals should consider delaying all nonurgent diagnostic and treatment decisions until the parent or legal guardian can be reached for informed permission or consent.
5. The physician or health care professional should seek patient assent for medical testing and treatment from the pediatric patient as appropriate for the patient's age, stage of development, and level of understanding.

6. If a language barrier exists, informed consent for medical treatment from health care professionals should be obtained through a trained medical interpreter.
7. Every EMS agency and ED should develop written policies and guidelines that conform to federal and state laws regarding consent for the treatment of minors, including specific guidelines on financial billing, parental notification, and patient confidentiality for the unaccompanied minor.
8. For research protocols, the decision to enroll a child in a research project must occur in accord with the requirements of an IRB.

## LEAD AUTHORS

Paul E. Sirbaugh, DO  
Douglas S. Diekema, MD, MPH

## COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE, 2010–2011

Kathy N. Shaw, MD, MSCE, Chairperson  
Alice D. Ackerman, MD, MBA  
Thomas H. Chun, MD, MPH  
Gregory P. Connors, MD, MPH, MBA  
Nanette C. Dudley, MD  
Joel A. Fein, MD, MPH  
Susan M. Fuchs, MD  
Brian R. Moore, MD  
Steven M. Selbst, MD  
Joseph L. Wright, MD, MPH

## LIAISONS

Kim Bullock, MD – *American Academy of Family Physicians*  
Toni K. Gross, MD, MPH – *National Association of EMS Physicians*  
Tamar Magarik Haro – *AAP Department of Federal Government Affairs*  
Jaclyn Haymon, MPA, RN – *EMSC National Resource Center*  
Elizabeth Edgerton, MD, MPH – *Maternal and Child Health Bureau*  
Mark A. Hostetler, MD, MPH – *American College of Emergency Physicians*  
Cynthia Wright-Johnson, MSN, RNC – *National Association of State EMS Officials*  
Lou E. Romig, MD – *National Association of Emergency Medical Technicians*  
Sally K. Snow, RN, BSN, CPEN – *Emergency Nurses Association*  
David W. Tuggle, MD – *American College of Surgeons*

Tasmeen Weik, DrPH, NREMT-P – *Maternal and Child Health Bureau*

## FORMER COMMITTEE MEMBERS

Steven E. Krug, MD, Immediate Past Chairperson  
Thomas Bojko, MD, MS  
Laura S. Fitzmaurice, MD  
Karen S. Frush, MD  
Patricia J. O'Malley, MD  
Robert E. Sapien, MD  
Joan E. Shook, MD  
Paul E. Sirbaugh, DO  
Milton Tenenbein, MD  
Loren G. Yamamoto, MD, MPH, MBA

## FORMER LIAISONS

Kathleen Brown, MD – *American College of Emergency Physicians*  
Andrew Garrett, MD, MPH – *National Association of EMS Physicians*  
David Heppel, MD – *Maternal and Child Health Bureau/EMSC Program*  
Dan Kavanaugh, MSW – *Maternal and Child Health Bureau/EMSC Program*  
Tommy Loyacono – *National Association of Emergency Medical Technicians*  
Cindy Pellegrini – *AAP Department of Federal Government Affairs*  
Tina Turgel, BSN, RN, C – *Maternal and Child Health Bureau*

## STAFF

Sue Tellez

## COMMITTEE ON BIOETHICS, 2010–2011

Mary Fallat, MD, Chairperson  
Armand H. Matheny Antommara, MD, PhD  
Ian R. Holzman, MD  
Aviva L. Katz, MD  
Mark Mercurio, MD  
Sally A. Webb, MD  
Kathryn L. Weise, MD

## FORMER COMMITTEE MEMBER

Lainie F. Ross, MD, PhD

## LIAISONS

Philip L. Baese, MD – *American Academy of Child and Adolescent Psychiatry*  
Douglas S. Diekema, MD, MPH – *American Board of Pediatrics*  
Steven J. Ralston, MD – *American College of Obstetricians and Gynecologists*  
Ellen Tsai, MD, MHSC – *Canadian Paediatric Society*

## CONSULTANTS

Jessica W. Berg, JD

## STAFF

Alison Baker, MS

## REFERENCES

- Bissett-Johnson A, Ferguson P. Consent to medical treatment by older children in English & Scottish law. *J Contemp Health Law Policy*. 1996;12(2):449–473
- Bernet W. The noncustodial parent and medical treatment. *Bull Am Acad Psychiatry Law*. 1993;21(3):357–364
- Dickenson D. Children's informed consent to treatment: is the law an ass? *J Med Ethics*. 1994;20(4):205–206, 222
- Henry PF. Judicial review of treatment consent issues for minors. *Nurse Pract Forum*. 1992;3(2):54–55
- Neinstein LS. Consent and confidentiality laws for minors in the western United States. *West J Med*. 1987;147(2):218–224
- Nypaver MM, Linakis JG, Klein BL. In the absence of consent. *Pediatr Emerg Care*. 1995;11(3):192–195
- Holder AR. Disclosure and consent problems in pediatrics. *Law Med Health Care*. 1988;16(3–4):219–228
- Rice MM. Medicolegal issues in pediatric and adolescent emergencies. *Emerg Med Clin North Am*. 1991;9(3):677–695
- Sigman GS, O'Connor C. Exploration for physicians of the mature minor doctrine. *J Pediatr*. 1991;119(4):520–525
- Siegel DM. Consent and refusal of treatment. *Emerg Med Clin North Am*. 1993;11(4):833–840
- Sullivan DJ. Minors and emergency medicine. *Emerg Med Clin North Am*. 1993;11(4):841–851
- Veilleux DR. Medical practitioner's liability for treatment given to child without parent's consent. *Am Law Rep*. 1989;67:511–534
- American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. Legal aspects of the provision of emergency care. In: Seidel JS, Knapp JF, eds. *Childhood Emergencies in the Office, Hospital, and Community*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2000:257–276
- Tsai AK, Schafermeyer RW, Kalifon D, Barkin RM, Lumpkin JR, Smith EE III. Evaluation and treatment of minors: reference on consent. *Ann Emerg Med*. 1993;22(7):1211–1217
- American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. Consent for medical services for children and adolescents. *Pediatrics*. 2003;111(3):703–706
- Emergency Medical Treatment and Labor Act, 42 USC §1395dd (1986)
- Solloway M. *EMSC White Paper Series: EMTALA and the Prudent Layperson in Emergency Medical Services for Children*. Washington, DC: EMSC National Resource Center; 2000:1–11
- American Academy of Pediatrics, Task Force on Interhospital Transport. Appendix B. EMTALA: an overview. In: MacDonald MG, Ginzberg HM, eds. *Guidelines for Air and Ground Transport of Neonatal and Pediatric Patients*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 1999:179–183
- Bitterman RA. The medical screening examination requirement. In: Bitterman RA, ed. *EMTALA: Providing Emergency Care Under Federal Law*. Dallas, TX: American College of Emergency Physicians; 2000:23–65
- American Academy of Pediatrics, Committee on Bioethics. Informed consent, parental permission, and assent in pediatric practice. *Pediatrics*. 1995;95(2):314–317
- English A, Simmons PS. Legal issues in reproductive health care for adolescents. *Adolesc Med*. 1999;10(2):181–194, v
- English A, Boburg E, Hersh CL, Morreale MC, Stinnett A. *State Minor Consent Statutes: A Summary*. 2nd ed. Chapel Hill, NC: Center for Adolescent Health and the Law; 2003
- Driggs AE. The mature minor doctrine: do adolescents have the right to die? *Health Matrix Cleve*. 2001;11(2):687–717
- Berger JE; American Academy of Pediatrics, Committee on Medical Liability. Consent by proxy for nonurgent pediatric care. *Pediatrics*. 2003;112(5):1186–1195
- Diekema DS. Parental refusals of medical treatment: the harm principle as threshold for state intervention. *Theor Med Bioeth*. 2004;25(4):243–264
- Public Health Service Act, Pub L No. 91-572, 1008 (codified at 42 USC 3001-6) (1970), supra note 44. Available at: [www.hhs.gov/opa/about/legislation/p191-572.pdf](http://www.hhs.gov/opa/about/legislation/p191-572.pdf). Accessed July 8, 2010
- McGuire AL, Bruce C. Keeping children's secrets: confidentiality in the physician-patient relationship. *Houst J Health Law Policy*. 2008;8(2):315–333
- American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Emergency Medicine Committee. Patient- and family-centered care and the role of the emergency physician providing care to a child in the emergency department. *Pediatrics*. 2006;118(5):2242–2244
- Derish MT, Vanden Heuvel K. Mature minors should have the right to refuse life-sustaining medical treatment. *J Law Med Ethics*. 2000;28(2):109–124
- American Medical Association. Opinion E-5.055: confidential care for minors. In: *Code of Medical Ethics*. Chicago, IL: American Medical Association; 1994 (updated 1996). Available at: [www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion5055.page?](http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion5055.page?) Accessed June 10, 2011
- Ford C, English A, Sigman G. Confidential health care for adolescents: position paper of the Society for Adolescent Medicine. *J Adolesc Health*. 2004;35(2):160–167
- Texas Department of State Health Services. Consent for emergency medical care of a minor in a disaster. Available at: [www.dshs.state.tx.us/comprep/ogc/ConsentMinor.doc](http://www.dshs.state.tx.us/comprep/ogc/ConsentMinor.doc). Accessed July 8, 2010
- Waiver of informed consent requirements in certain emergency research. *Fed Regist*. 1996;61:51531–51533

**Consent for Emergency Medical Services for Children and Adolescents**  
Committee on Pediatric Emergency Medicine and Committee on Bioethics  
*Pediatrics* 2011;128;427

DOI: 10.1542/peds.2011-1166 originally published online July 25, 2011;

**Updated Information & Services**

including high resolution figures, can be found at:  
<http://pediatrics.aappublications.org/content/128/2/427>

**References**

This article cites 24 articles, 5 of which you can access for free at:  
<http://pediatrics.aappublications.org/content/128/2/427#BIBL>

**Subspecialty Collections**

This article, along with others on similar topics, appears in the following collection(s):

**Current Policy**

[http://www.aappublications.org/cgi/collection/current\\_policy](http://www.aappublications.org/cgi/collection/current_policy)

**Committee on Bioethics**

[http://www.aappublications.org/cgi/collection/committee\\_on\\_bioethics](http://www.aappublications.org/cgi/collection/committee_on_bioethics)

**Committee on Pediatric Emergency Medicine**

[http://www.aappublications.org/cgi/collection/committee\\_on\\_pediatric\\_emergency\\_medicine](http://www.aappublications.org/cgi/collection/committee_on_pediatric_emergency_medicine)

**Emergency Medicine**

[http://www.aappublications.org/cgi/collection/emergency\\_medicine\\_sub](http://www.aappublications.org/cgi/collection/emergency_medicine_sub)

**Permissions & Licensing**

Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:

<http://www.aappublications.org/site/misc/Permissions.xhtml>

**Reprints**

Information about ordering reprints can be found online:

<http://www.aappublications.org/site/misc/reprints.xhtml>

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™





# PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

**Consent for Emergency Medical Services for Children and Adolescents**  
Committee on Pediatric Emergency Medicine and Committee on Bioethics  
*Pediatrics* 2011;128;427

DOI: 10.1542/peds.2011-1166 originally published online July 25, 2011;

The online version of this article, along with updated information and services, is  
located on the World Wide Web at:

<http://pediatrics.aappublications.org/content/128/2/427>

Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2011 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 1073-0397.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

