My Body, Your Choice: The Conflict Between Children's Bodily Autonomy and Parental Rights in the Age of Vaccine Resistance

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Across the United States, parents are increasingly refusing to vaccinate their children against harmful childhood diseases. Many of these parents utilize expansive exemptions to school-immunization laws to keep their children unvaccinated. Even as their children become teenagers and develop their own informed opinions about vaccines, most state and local laws provide these minors with no avenue to override their parents' objections and choose vaccination for themselves. However, this legal landscape may be changing, as creative laws like the District of Columbia's Minor Consent for Vaccination Amendments Act of 2020 (MCA) have emerged that do allow certain minors to consent to recommended vaccines without parent permission, provided that they can meet an informed-consent standard.

This Comment argues that minors possess a qualified autonomy right to consent to recommended vaccines. It outlines the legal background of this autonomy right by discussing the history of vaccination laws, parental rights, and children's rights in the United States. It also demonstrates how vaccine-resistant parents could attempt to challenge the exercise of this autonomy right by invoking the protections of highly restrictive religious-freedom laws like the Religious Freedom Restoration Act. Then, this Comment outlines the contours of the autonomy right itself. Finally, this Comment proposes a statutory solution, based in part on the District of Columbia's MCA, that can vindicate this autonomy right while appropriately including parents in the consent process.

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INTRODUCTION

In late 2014, some visitors to the Disneyland Resort Theme Parks in California brought home more than just souvenirs. Starting in mid-December, Disneyland became the epicenter of a measles outbreak that spread rapidly across state lines.[1] By January 19, 2015, health officials had identified fifty-two cases, nearly double the number from the previous week.[2] Just three

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[1] *See* Lisa Aliferis, *Disneyland Measles Outbreak Hits 59 Cases and Counting*, NPR (Jan. 22, 2015), https://perma.cc/5PY5-QB3S.

[2] *Measles Outbreak Spreads in California, Other States*, NBC NEWS (Jan. 19, 2015), https://perma.cc/HK9T-UQTX.

days later, that number was fifty-nine.[3] By late 2015, the Centers for Disease Control and Prevention (CDC) had linked the outbreak to 147 cases across seven U.S. states, Mexico, and Canada.[4] This outbreak was troubling for two reasons: First, measles is highly contagious—just one infected person can spread it to 90% of nonimmune people nearby.[5] Second, the federal government had declared measles eliminated in the United States, largely due to a robust nationwide vaccination program.[6] But since then, this life-threatening disease had proliferated into a "multi-state public health incident."[7]

Officials quickly identified two commonalities among many of these patients: they were unvaccinated, and they were young. Of the thirty-four California patients whose vaccination statuses were known by January 22, 2015, twenty-eight were not vaccinated against measles, and one was partially vaccinated.[8] Six of these unvaccinated patients were babies who were too young to receive the vaccine.[9] By April, the CDC found that about 83% of reported measles patients in the United States were either unvaccinated or had an unknown vaccination status.[10] The CDC study reported that the most cited reasons for refusing vaccines were "philosophical or religious objections."[11] But whose objections were these? Though the nation's measles vaccination program achieves high coverage in children, almost half of reported measles patients in 2015 were minors or young adults.[12] Many of these young patients likely did not have the opportunity to choose vaccination for themselves. Instead, the decision rested with their parents.

The Disneyland outbreak exemplifies a growing nationwide public health crisis: more parents are rejecting vaccination for

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3 *See* Aliferis, *supra* note 1.

4 *Year in Review: Measles Linked to Disneyland*, CTRS. FOR DISEASE CONTROL & PREVENTION: PUBLIC HEALTH MATTERS BLOG (Dec. 2, 2015), https://perma.cc/6FLL-LPKD [hereinafter CDC Year in Review].

5 *Id.*

6 *See id.*

7 *Id.*

8 *See* Aliferis, *supra* note 1.

9 *Id.*

10 Nakia S. Clemmons, Paul A. Gastanaduy, Amy Parker Fiebelkorn, Susan B. Redd & Gregory S. Wallace, *Measles*, CTRS. FOR DISEASE CONTROL & PREVENTION: MORBIDITY & MORTALITY WKLY. REP. (Apr. 17, 2015), https://perma.cc/PZA8-3Z7X.

11 *Id.*

12 *See id.* (finding that 45% of measles patients in 2015 were under the age of twenty); CDC Year in Review, *supra* note 4.

their children, and it is putting the health of children—and of the broader community—at risk.[13] Some parents cite religious objections to vaccines, but many are motivated by "safety concerns," "underestimates of vaccines' efficacy," "distrust of government and doctors," "preference for alternative medicine," or "concern that vaccination policies violate their civil rights."[14] Many vaccine-resistant parents simply want to protect their children.[15] However, antivaccine advocates reject evidence showing that vaccines are much less risky than the diseases they prevent.[16] This deep mistrust between parents and health officials divides communities and undermines health protocols.[17]

Even though minors face the risk of direct bodily harm from not receiving their recommended vaccines, state and local laws generally provide them no opportunity to choose vaccination for themselves. As Professor Brian Dean Abramson noted, "When minor children disagree with their parents' opposition to vaccination, they must look to statutes or case law for assistance, and may find it lacking."[18] At the same time, broad legal pathways allow parents to circumvent childhood immunization requirements without consulting their minor children.[19] Many

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13 *See* Nat'l Vaccine Advisory Comm., *Assessing the State of Vaccine Confidence in the United States: Recommendations from the National Vaccine Advisory Committee*, 130 PUB. HEALTH REP. 573, 576–77 (2015); *see also* Katie Berry, *Pumping the Brakes on Measles Outbreaks*, 52 TEX. TECH L. REV. 505, 510 (2020) ("In recent times, when disease levels have risen the majority of those affected were documented as intentionally un vaccinated. Moreover, this group largely consists of *children*." (emphasis in original)).

14 Dorit Rubinstein Reiss & Lois A. Weithorn, *Responding to the Childhood Vaccination Crisis: Legal Frameworks and Tools in the Context of Parental Vaccine Refusal*, 63 BUFF. L. REV. 881, 937 (2015); *see also* Frej Klem Thomsen, *Childhood Immunization, Vaccine Hesitancy, and Provaccination Policy in High-Income Countries*, 23 PSYCH. PUB. POL'Y & L. 324, 326 (2017) ("[N]umerous studies show that vaccine-hesitant parents justify their attitudes . . . by holding that vaccines are harmful, that non-vaccination will strengthen the child's immune system, and that the diseases against which the vaccine protects are not dangerous.").

15 *See* Erwin Chemerinsky & Michele Goodwin, *Compulsory Vaccination Laws Are Constitutional*, 110 NW. U. L. REV. 589, 594 (2016).

16 *See* Reiss & Weithorn, *supra* note 14, at 938.

17 *See, e.g.*, Brandy Zadrozny & Ben Collins, *Extremist Groups Battered by Jan. 6 Fallout Resurface in Their Own Backyards*, YAHOO (Jan. 4, 2022), https://perma.cc/AB4R-ZJF7.

18 Brian Dean Abramson, *Do US Teens Have the Right to Be Vaccinated Against Their Parents' Will? It Depends on Where They Live*, THE CONVERSATION (Aug. 31, 2021), https://perma.cc/85UZ-B4P7.

19 *See id.* (noting that parents "have primary legal authority" to make vaccination decisions on behalf of their children); *see also* Melissa Suran, *Why Parents Still Hesitate to Vaccinate Their Children Against COVID-19*, 327 J. AM. MED. ASS'N 23, 25 (2022) ("But what if a child wants the vaccine? Often, it comes down to parental consent for minors, although even that depends on state laws.").

vaccine-resistant parents utilize nonmedical exemptions to school-immunization statutes, which authorize parents to excuse their children from school vaccine mandates on religious or personal grounds.[20] Nonmedical exemptions give wide latitude to parents and dampen the effectiveness of immunization requirements.[21] Moreover, they almost always allow parents to act unilaterally and disregard their children's views.[22] And minors, especially teens, do not always agree with their parents' stances on vaccination.[23]

For years, all but two states (Mississippi and West Virginia) allowed for nonmedical exemptions in their school-immunization statutes.[24] However, since the 2015 measles crisis, several states have sprung into action to repeal their nonmedical exemptions. After the Disneyland outbreak, the California legislature swiftly enacted S.B. 277[25] to do just that. In the years since, New York,

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[20] *See, e.g.*, ARK. CODE ANN. § 6-18-702(d)(4)(A) (2019); 28 PA. CODE § 23.84(b) (1997); WIS. STAT. ANN. § 252.04(3) (2015). Some of these exemptions only encompass religious objections to vaccination, while others include both religious and secular objections. In recognition of this variation in statutory language, this Comment refers to these laws broadly as "nonmedical exemptions."

[21] *See* Clemmons et al., *supra* note 10 ("Exemptions from mandated immunizations have been shown to increase risk for acquiring disease as well as increasing the risk of a disease outbreak at the community level."); *see also* Eileen Wang, Jessica Clymer, Cecelia Davis-Hayes & Alison Buttenheim, *Nonmedical Exemptions from School Immunization Requirements: A Systematic Review*, 104 AM. J. PUB. HEALTH 62, 81 (2014).

[22] *See* Abramson, *supra* note 18 ("When a state legally allows parents to request exemptions for legally mandated childhood vaccinations, these laws universally require that the parents are the ones to take steps to obtain it."); *see also, e.g.*, ALA. CODE § 16-30-3 (1973) (stating that a nonmedical exemption may be obtained when "the parent or guardian of the child shall object thereto in writing"); ARIZ. REV. STAT. § 15-873 (2007) (stating that, to obtain an exemption, "[t]he parent or guardian of the pupil submits a signed statement to the school administrator"). Some laws allow emancipated students or adult students to submit exemptions on their own behalf. *See, e.g.*, COLO. REV. STAT. § 25-4-903(2)(b)(I) (2020) (requiring "a completed certificate of nonmedical exemption signed by one parent or legal guardian, an emancipated student, or a student eighteen years of age or older").

[23] For example, in testimony before the U.S. Senate, high school student Ethan Lindenberger described his conflict with his mother over the safety and efficacy of vaccines for measles, chickenpox, and other diseases. *Vaccines Save Lives: What is Driving Preventable Disease Outbreaks?: Hearing Before the Comm. on Health, Educ., Lab. & Pensions*, 116th Cong. 30–31 (2019) (statement of Ethan Lindenberger, Student, Norwalk High Sch., Norwalk, Ohio). As another example, Pennsylvania teenager Nicholas Montero disagreed with his parents about the COVID-19 vaccine and traveled to Philadelphia to obtain that vaccine without their consent. Nina Feldman, *Why a Suburban Teen Went to Philly to Get His COVID-19 Vaccine*, WHYY (Jan. 18, 2022), https://perma.cc/5A5A-G4U7.

[24] MISS. CODE. § 41-23-37 (2021); W. VA. CODE § 16-3-4 (2015).

[25] S.B. 277, 2015–2016 Reg. Sess. (Cal. 2015).

Maine, and Connecticut have all passed similar laws.[26] These newer legislative measures have faced staunch resistance from vaccine-resistant parents.[27] In some states, antivaccine advocates have blocked such bills altogether.[28]

As other jurisdictions consider their own solutions to promote vaccination and public health, parents are sure to remain a powerful force in these debates. However, only one group of people has (quite literally) skin in the game: the minors who do not receive vaccines due to their parents' objections. Any solution that does not meaningfully account for these minors' views is missing a crucial element of the childhood-vaccination story. This Comment analyzes an alternative approach that foregrounds a minor's autonomy and choice while creating space for parental input and involvement. This strategy expands upon preexisting laws, most notably one from the District of Columbia. In March 2019, a D.C. lawmaker became concerned about the prevalence of childhood measles and introduced new legislation to protect D.C. children.[29] In late 2020, the D.C. Council passed The District of Columbia Minor Consent for Vaccinations Amendment Act of 2020[30] ("Minor Consent Act" or MCA). The MCA did not repeal D.C.'s nonmedical exemption.[31] Instead, D.C. now allows minors aged eleven and older to consent to recommended vaccines if they can show that they are "able to comprehend the need for, the nature of, and any significant risks ordinarily inherent in the medical care."[32] The providers who administer the vaccines can then

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[26] These states' codes no longer contain nonmedical exemptions. *See* CONN. GEN. STAT. § 10-204a (2021); ME. REV. STAT. tit. 20-A, § 6355 (2019); N.Y. PUB. HEALTH LAW § 2164 (McKinney 2019).

[27] In California, for example, parents and religious liberty groups objected to S.B. 277 through multiple lawsuits and a repeal effort. Though these attempts were unsuccessful, they show that opponents of such laws are dogged in their efforts to overturn them. *See* Love v. State Dep't of Educ., 240 Cal. Rptr. 3d 861, 864 (Cal. Ct. App. 2018); Brown v. Smith, 235 Cal. Rptr. 3d 218, 220–21 (Cal. Ct. App. 2018); Sharon Bernstein, *Bid to Repeal California School Vaccination Law May Falter*, REUTERS (Sept. 30, 2015), https://perma.cc/58A6-8482.

[28] *See* Abramson, *supra* note 18 ("Not all efforts by states to pass laws expanding the ability of minors to seek vaccination have succeeded. Recently, these measures have met strong opposition from the antivaccination movement, and history suggests that this will only increase in the face of COVID-19 vaccination hesitancy.").

[29] *See* Debbie Truong, *Parents Take Aim at D.C. Law That Lets Minors Get Vaccinated Without Permission*, NPR (July 19, 2021), http://perma.cc/Q43S-FB6K; Deirdre Paine, *DC Paves Way for Permitting Vaccination of Kids Without Parental Consent*, DC POST (Oct. 21, 2020), https://perma.cc/SLN4-FB2Z.

[30] 67 D.C. Reg. 14774 (Mar. 16, 2021).

[31] *See* D.C. CODE ANN. § 38-506 (West 1979).

[32] D.C. Mun. Regs. tit. 22-B § 600.9(a)–(b) (2021).

only seek reimbursement directly from the insurer without consent from parents.[33]

The MCA is not the only local law allowing minors to independently consent to vaccines. California and Minnesota allow minors to consent to vaccines for certain sexually transmitted diseases.[34] Seven states have statutes permitting unemancipated minors [35] to consent to general medical treatments based on age or demonstrated maturity.[36] A Philadelphia municipal regulation, like the MCA, permits minor consent to vaccines under certain circumstances.[37] Philadelphia's law remained "little-known" until 2021, when it made headlines after a suburban teen traveled to Philadelphia to receive his COVID-19 vaccine without telling his parents.[38]

Because the MCA became law at a time when childhood vaccinations had become especially contentious, it has already received particular attention. Some state lawmakers have sought to follow the MCA's lead. A California legislator recently introduced the Teens Choose Vaccines Act, which would permit minors aged twelve and older to consent to all approved vaccines, not just those that protect against sexually transmitted diseases.[39] In August 2021, a Pennsylvania lawmaker introduced a similar bill with an age limit of fourteen.[40] Many other people were quick to criticize the MCA on parental rights grounds. It already faces two lawsuits, including one from four D.C. parents with children in D.C. public schools.[41] Though three of those four parents had

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33 D.C. Mun. Regs. tit. 22-B § 600.9(d)(1) (2021); *see also* D.C. CODE ANN. § 38-602(a)(2) (2021) ("[T]he health care provider shall leave blank part 3 of the immunization record, and submit the immunization record directly to the minor student's school.").

34 *See* CAL. FAM. CODE § 6926 (2012); MINN. STAT. § 144.3441 (1993).

35 For an explanation of what it means when a minor is "emancipated," see Sahra Nizipli, *Emancipation of Minors*, LEGAL INFO. INST. (Mar. 2020), https://perma.cc/Z44C-5D8Z.

36 *See infra* Part III.B.1.

37 CITY OF PHILA. DEP'T OF PUB. HEALTH, REGULATIONS GOVERNING THE IMMUNIZATION AND TREATMENT OF NEWBORNS, CHILDREN AND ADOLESCENTS § (4)(b) (2019).

38 Feldman, *supra* note 23.

39 *See* S.B. 866, 2021–22 Reg. Sess. (Cal. 2022); *Senate Bill 866*, SCOTT WIENER REPRESENTING SENATE DIST. 11 (2022), https://perma.cc/GWE5-JC86.

40 *See* H.B. 1818, 2021–22 Reg. Sess. (Pa. 2021); Dan B. Frankel, *Frankel Unveils Legislation to Protect Teen Health, Require Vital Vaccine Info*, PA. HOUSE DEMOCRATS (Aug. 30, 2021), https://perma.cc/B8DB-DV8X.

41 *See* Complaint at 2–3, Mazer v. D.C. Dep't of Health, 2021 WL 2798324 (D.D.C. July 2, 2021) (No. 1:21-cv-01782) (alleging that the MCA violates the rights of a Maryland parent whose daughter traveled to D.C. to receive a vaccine); Complaint at 34–47, Booth v. Bowser, 2021 WL 2935087 (D.D.C. July 12, 2021) (No. 21-1857) (alleging that the MCA violates the rights of four D.C. parents whose children attended public schools in D.C.).

allowed their children to receive vaccines as babies, all four expressed fears that school officials and others would pressure their children to receive the COVID-19 vaccine under the new law.[42] The complaint from D.C. parents includes both parental rights claims based on constitutional free exercise and a claim that the MCA violates parental rights under the Religious Freedom Restoration Act[43] (RFRA).[44] RFRA provides that the government "shall not substantially burden a person's exercise of religion even if the burden results from a rule of general applicability" unless the burden is both "in furtherance of a compelling governmental interest" and the "least restrictive means of furthering" that interest.[45]

So far, the D.C. parents' free exercise arguments have proven relatively successful. In March 2022, the D.C. District Court entered a preliminary injunction against the MCA, based in part on concerns that the law was not "narrowly tailored" enough to justify "target[ing] religious parents."[46] However, RFRA (and its state analogues) could prove an even more formidable foe for minor consent laws like the MCA. Scholars and advocates have argued that RFRA is more restrictive of government actions than any other religious freedom standard before it, including the constitutional standard for free exercise rights.[47]

This Comment examines one of the MCA's central tensions. In an implicit recognition that parents have a legitimate legal interest in whether their children receive vaccines, the D.C. Council chose not to repeal D.C.'s nonmedical exemption. However, the law's primary intention was to protect children's bodily autonomy interest (or, as this Comment argues, autonomy *right*) in consenting to vaccines, even if that meant overriding parents' rights to

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42 Complaint at 36–38, 40, Booth v. Bowser, 2021 WL 2935087 (D.D.C. July 12, 2021) (No. 21-1857).

43 Religious Freedom Restoration Act of 1993, Pub. L. No. 103-141, 107 Stat. 1488; *see also generally* City of Boerne v. Flores, 521 U.S. 507, 536 (1997) (invalidating RFRA's application to state governments).

44 Complaint at 2, Booth v. Bowser, 2021 WL 2935087 (D.D.C. July 12, 2021) (No. 21-1857).

45 42 U.S.C. § 2000bb-1(a), (b).

46 Booth v. Bowser, No. 21-cv-01857, at 36 (D.D.C. Mar. 18, 2022) (order granting preliminary injunction).

47 *See, e.g.*, Marci A. Hamilton, *The Case for Evidence-Based Free Exercise Accommodation: Why the Religious Freedom Restoration Act Is Bad Public Policy*, 9 HARV. L. & POL'Y REV. 129, 138–39 (2015); Ira C. Lupu, *Of Time and the RFRA: A Lawyer's Guide to the Religious Freedom Restoration Act*, 56 MONT. L. REV. 171, 195 (1995) (arguing that RFRA could "over-restore" religious liberty because the law, if "literally construed, would thus insulate religious exercise far beyond its most stringent protection in the prior law").

refuse them.[48] Parents often know their children's needs better than almost anyone. Therefore, this Comment conceives of parents as primary fact finders in their children's lives: when it comes to their children's health needs, parents' input matters greatly, but it should not always be dispositive. And while the legal system generally recognizes that adults possess a greater capacity for decision-making than minors, a minor acting in support of personal and communal health should still be able to go against a parent's decision.

Part I of this Comment provides an overview of vaccine laws across the United States and of how these laws impact both public health and the relationships between parents and their children. While courts have generally shown deference to local vaccine mandates, nonmedical exemptions have given wide latitude to antivaccine parents. Part II describes the doctrine of parental rights and analyzes how RFRA claims could strengthen antivaccine arguments. Part III discusses how Supreme Court and lower court opinions support a qualified autonomy right for minors to consent to vaccines without parent permission. Finally, Part IV outlines a revised version of the MCA that could preserve this right for minors while respecting religious parental rights and the parent-child relationship. This solution maintains the basic structure of the MCA but adds a provision requiring school officials to elicit relevant information from parents after they file their nonmedical exemptions but before their children potentially seek to receive vaccines under the law. Ultimately, this Comment argues that, while parents are important fact finders and stakeholders regarding their children's health and wellbeing, minors have an overriding right to follow public health guidance and choose vaccination.

I. VACCINATION AND SCHOOL-IMMUNIZATION LAWS ACROSS THE UNITED STATES

Since 1905, the Supreme Court has generally upheld local vaccine mandates against both religiously motivated and secular challenges. Lower courts have often upheld the decisions of local legislatures to repeal their jurisdictions' nonmedical exemptions. However, recent opinions signed by several Supreme Court Justices indicate that this deference to mandates—particularly

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[48] *See* Truong, *supra* note 29 (quoting Councilmember Mary Cheh, who said that the MCA allows children to exercise "agency in their body and their health and their lives").

those without nonmedical exemptions—may be waning. Meanwhile, the vast majority of states and territories in the United States continue to recognize expansive exemptions to school-immunization laws. Increasing lobbying pressure from antivaccine groups in the age of COVID-19 may ensure that this legislative trend continues.[49] Part I.A begins with an overview of vaccine jurisprudence in the Supreme Court and lower courts, and then it considers the potential impacts of the Supreme Court's recent vaccine decisions. Then, Part I.B provides a brief discussion of nonmedical exemptions in U.S. states and territories, as well as the practical effects of these exemptions on parents and teenagers who disagree with each other about vaccines.

A. Vaccine Jurisprudence from the Early Twentieth Century to the Present

From 1905 to 2021, the Supreme Court repeatedly recognized the authority of local jurisdictions to mandate vaccines. In its seminal 1905 case *Jacobson v. Massachusetts*,[50] the Court rejected a challenge to a municipal regulation and a state law requiring citizens to receive the smallpox vaccine.[51] The Court found that a state's police powers include "reasonable regulations" that "protect the public health and the public safety."[52] Such regulations, according to the Court, become increasingly justified when the targeted disease is prevalent and spreading through the community.[53] The Court reasoned that an adult could potentially claim exemption from immunization by showing that vaccination would "seriously impair" her health or safety.[54] Nevertheless, it held that Jacobson, who was "in perfect health and a fit subject of vaccination," could not ignore the requirement.[55] Ultimately, the Court found that a community-wide health and safety interest outweighed Jacobson's individual liberty interest.

Seventeen years later, the Court applied similar logic to school vaccination mandates in *Zucht v. King*.[56] Fifteen-year-old

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[49] *See* Lauren Gardner, *Anti-Vax Groups Rack Up Victories Against Covid-19 Push*, POLITICO (June 14, 2021), https://perma.cc/4HH9-5F3H.

[50] 197 U.S. 11 (1905).

[51] *See id.* at 37–39.

[52] *Id.* at 25.

[53] *See id.* at 27.

[54] *Id.* at 39.

[55] *Jacobson*, 197 U.S. at 39.

[56] 260 U.S. 174 (1922).

high school student Rosalyn Zucht challenged a San Antonio ordinance requiring that every child present a certificate of vaccination before attending school.[57] Zucht claimed that she "never has been vaccinated, nor is she willing to be vaccinated, nor are her parents willing, because she and her parents fear that vaccination will endanger her health."[58] The Court tersely rejected this challenge and held that the ordinance violated neither Zucht's due process rights nor her equal protection rights under the Fourteenth Amendment.[59]

After *Zucht*, the Court continued to recognize, in dicta, state power to mandate childhood vaccines. In *Prince v. Massachusetts*[60] (further discussed in Parts II and III), the Court noted that vaccine mandates constitute a reasonable limitation on religious parental rights. The *Prince* Court wrote that a parent "cannot claim freedom from compulsory vaccination for the child more than for himself on religious grounds" because "[t]he right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death."[61] The Court found that both the community and the individual child had an interest in avoiding disease that, together, could outweigh parents' individual religious liberties.[62]

Lower courts have generally found that nonmedical exemptions are not constitutionally required in school-immunization statutes. Mississippi's school-immunization law previously included a nonmedical exemption only for parents who "are bona fide members of a recognized denomination whose religious teachings require reliance on prayer or spiritual means of healing."[63] In 1979, the Mississippi Supreme Court heard a First Amendment challenge to the law from a father who, despite his "sincere religious beliefs" against vaccination, had been denied a nonmedical exemption for his son.[64] In response, the court invalidated the exemption altogether, finding that it violated the Equal Protection Clause of the Fourteenth Amendment by "requir[ing] the great body of school children to be vaccinated and at the same

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57 *Id.* at 175; Zucht v. King, 225 S.W. 267, 269 (Tex. Civ. App. 1920).
58 *Zucht v. King*, 225 S.W. at 270.
59 *Zucht*, 260 U.S. at 176–77.
60 321 U.S. 158 (1944).
61 *Id.* at 166–67.
62 *Id.*
63 Brown v. Stone, 378 So. 2d 218, 219 (Miss. 1979).
64 *Id.* at 220.

time expos[ing] them to the hazard of associating in school with children exempted under the religious exemption."[65]

The Mississippi Supreme Court expressed concern for how nonmedical exemptions could harm both children's rights as individuals and the state's interest in protecting children's health.[66] Put succinctly, "a [parent's] right to exhibit religious freedom ceases where it overlaps and transgresses the rights of others"—namely, those of the child and the community.[67] This decision has dramatically impacted public health in Mississippi, even as social norms in that state have changed. At one point in the summer of 2021, 99% of Mississippi's population had received the vaccine for measles, mumps, and rubella (MMR)—the highest rate in the country—but Mississippi also had the *lowest* rate of COVID-19 vaccine uptake of any state.[68] In other words, even while vaccine resistance took hold in the state with regard to immunization against COVID-19, Mississippians remained highly compliant with the school-immunization rules that had been in place since the 1979 decision.[69]

In 2011, the Fourth Circuit upheld West Virginia's school-immunization statute, which lacks a nonmedical exemption, in *Workman v. Mingo County Board of Education*.[70] Citing *Jacobson* and *Prince*, the court found that the statute did not violate the plaintiff's free exercise rights.[71] In 2015, the Second Circuit responded to a lawsuit challenging New York's school-immunization statute, which contained a nonmedical exemption but allowed for the temporary exclusion of unvaccinated children from school during outbreaks of vaccine-preventable diseases.[72] In ruling that this temporary exclusion was constitutionally sound,

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65 *Id.* at 223.

66 *See id.*

67 *Id.* at 222.

68 Nina Shapiro, *Mississippi Has the Lowest Covid-19 Vaccination Rate but the Highest Childhood Vaccination Rate: Here's Why*, FORBES (July 10, 2021), https://www.forbes.com/sites/ninashapiro/2021/07/10/mississippi-has-the-lowest-covid-19-vaccination-rate-but-the-highest-childhood-vaccination-rate-heres-why/?sh=79dee6a119ab.

69 This compliance is directly attributable to the Mississippi Supreme Court's decision. *See* Larrison Campbell, Mississippi, *First in School-Age Vaccines, Lags in Immunization Rates for Teens, Adults*, MISS. TODAY (Oct. 8, 2019), https://perma.cc/73YN-7S88 ("The reason for the state's success [in childhood immunization] is a 40-year-old law that . . . has remained impenetrable to the loopholes requested by the anti-vaccine movement.").

70 419 F. App'x 348 (4th Cir. 2011).

71 *Id.* at 353–54.

72 *See* Phillips v. City of New York, 775 F.3d 538, 540 (2d Cir. 2015) (per curiam).

the Second Circuit also noted that New York was not constitutionally required by either substantive due process or the Free Exercise Clause to include a nonmedical exemption in its school-immunization statute at all.[73] When the New York legislature later removed the exemption, a state appeals court rejected a claim that the repeal was motivated by religious animus, finding instead that it was a neutral law of general applicability and was supported by a rational basis.[74] Additionally, California's S.B. 277, which removed the state's nonmedical exemption, has been upheld in both state and federal court as permissible under free exercise and substantive due process.[75]

Until recently, *Prince* was the last time that the Court meaningfully considered the issue of childhood vaccines, even as vaccine litigation continued in the lower courts. However, the COVID-19 vaccines have brought a new wave of vaccine litigation to the Supreme Court. In August 2021, Justice Amy Coney Barrett, who reviews emergency appeals from the state of Indiana, declined a request to block Indiana University's vaccine mandate.[76] Notably, the university's rule included both medical and nonmedical exemptions.[77] In October 2021, Justice Sonia Sotomayor rejected a similar request to block a vaccine mandate for employees in New York City's Department of Education.[78] Like the Indiana University mandate, this rule allowed for both medical and nonmedical exemptions.[79]

While this deference to local vaccine mandates is longstanding, recent divisions within the Supreme Court suggest that change may be on the way. Justices nominated by presidents from both political parties have indicated continued deference to vaccine mandates, but several Justices have expressed unwillingness

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73 *See id*. at 542–43.

74 *See* F.F. v. State, 143 N.Y.S.3d 734, 740–43 (N.Y. App. Div. 2021).

75 *See* Whitlow v. California, 203 F. Supp. 3d 1079, 1086 (S.D. Cal. 2016) ("[T]he right to free exercise does not outweigh the State's interest in public health and safety."); Love v. State Dep't of Educ., 240 Cal. Rptr. 3d 861, 868 (Cal. Ct. App. 2018) ("Plaintiffs' substantive due process claim fails under either [strict scrutiny or rational basis review]."); Brown v. Smith, 235 Cal. Rptr. 3d 218, 225 (Cal. Ct. App. 2018) ("[P]laintiffs' free exercise claim has no merit.").

76 Amy Howe, *Barrett Leaves Indiana University's Vaccine Mandate in Place*, SCOTUSBLOG (Aug. 12, 2021), https://perma.cc/LGQ9-ADRF.

77 *See id*.

78 Bruce Haring, *New York School Teachers Rejected on Petition to US Supreme Court on Vaccine Mandate*, DEADLINE (Oct. 2, 2021), https://perma.cc/7U4G-KKHG.

79 *COVID-19 Vaccination Mandate*, NYC DEP'T OF EDUC. (Dec. 23, 2021), https://perma.cc/CCP5-Q3GF.

to uphold mandates that do not include a nonmedical exemption. In October 2021, the Court denied an appeal challenging a vaccine mandate, this time with no nonmedical exemption, for Maine healthcare workers.[80] Justice Neil Gorsuch dissented, joined by Justice Clarence Thomas and Justice Samuel Alito, writing that the law must contain an exemption for religious objectors.[81] While Justice Gorsuch found "that 'stemming the spread of COVID-19' qualifies as 'a compelling interest,'" he asserted that the rule was not the least restrictive means of achieving that interest.[82] In December 2021, the Court denied a similar challenge from New York healthcare workers, and the same three Justices objected.[83] Again, Justice Gorsuch wrote that the New York law was not narrowly tailored to achieve the state's interest in lessening COVID-19 transmission because "New York has presented nothing to suggest that accommodating the religious objectors before us would make a meaningful difference to the protection of public health."[84] Though Justice Gorsuch acknowledged the urgency of the ongoing pandemic, he noted the Court's prior recognition that "the Constitution is not to be put away in challenging times."[85] Justices Gorsuch, Alito, and Thomas were in the minority, but their objection to these rules represents a growing belief that states must limit their public health initiatives to avoid burdening religious rights. At least in some circumstances, the prevailing judicial philosophy regarding vaccines may be moving away from the principles underlying *Jacobson*. Though Reverend Henning Jacobson's objection to vaccines may have been religious in nature, his 1905 claim against Massachusetts had to be secular because the First Amendment had not yet been incorporated against the states.[86] Some commentators have suggested that if Jacobson were to bring a religious claim against vaccines today, he might be more

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80 David Sharp & Jessica Gresko, *Supreme Court Declines to Block Maine Vaccine Mandate*, AP NEWS (Oct. 30, 2021), https://apnews.com/article/us-supreme-court-healthmaine-6f246ae1c1dd501e40ceb470f0cc2366.

81 *See* Does 1–3 v. Mills, 142 S. Ct. 17, 22 (2021) (order denying application for injunctive relief) (Gorsuch, J., dissenting).

82 *Id.* at 20–21 (quoting Roman Cath. Diocese of Brooklyn v. Cuomo, 141 S. Ct. 63, 67 (2020) (per curiam)).

83 *See generally* Dr. A. v. Hochul, 142 S. Ct. 552 (2021) (order denying application for injunctive relief) (Gorsuch, J., dissenting).

84 *Id.* at 557.

85 *Id.* at 559.

86 *See* Reiss & Weithorn, *supra* note 14, at 898.

likely to succeed.[87] In fact, if a modern-day Jacobson wanted to exempt his child from vaccination, he may not even need to sue—almost every jurisdiction in the United States would allow him to exempt his child from required immunizations by claiming religious or personal objection.

B. Nonmedical Exemptions in State Laws and Their Impacts

Though courts have generally upheld strict local vaccine mandates, forty-nine of fifty-six states and territories provide broad nonmedical exemptions that undercut school-immunization requirements.[88] Most nonmedical exemptions designate the parent as the primary decision maker by requiring that the parent—not the minor child—write, sign, or submit the exemption.[89] Moreover, nonmedical exemptions are typically extremely deferential to parents. In many jurisdictions, parents can secure exemptions based on "conscientiously held," "philosophical," "personal," or "moral" beliefs.[90] Louisiana's law simply requires "a written dissent."[91] Of the exemptions that apply only

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87 *See id.* at 900–01 ("In those states with a RFRA, vaccine opponents may again find a basis for arguing that heightened scrutiny must be applied."); *see also* Daniel Farber, *The Long Shadow of* Jacobson v. Massachusetts*: Public Health, Fundamental Rights, and the Courts*, 57 SAN DIEGO L. REV. 833, 857–58 (2020).

88 California, Connecticut, Maine, Mississippi, New York, the Northern Mariana Islands, and West Virginia do not currently recognize a nonmedical exemption. *See* CAL. HEALTH & SAFETY CODE § 120335 (2016); CONN. GEN. STAT. § 10-204a (2021); ME. REV. STAT. tit. 20-A, § 6355 (2019); MISS. CODE. § 41-23-37 (2021); N.Y. PUB. HEALTH LAW § 2164 (McKinney 2019); 3 N. MAR. I. CODE § 2105 (2021); W. VA. CODE § 16-3-4 (2015).

89 *See, e.g.*, ALA. CODE § 16-30-3 (1973); ARIZ. REV. STAT. § 15-873 (2007); COLO. REV. STAT. § 25-4-903(2)(b)(I) (2020).

90 *See, e.g.*, MINN. STAT. ANN. § 121A.15(3)(d) (2014) (allowing an exemption for "conscientiously held beliefs" of the parent, guardian, or emancipated person); WASH. REV. CODE ANN. § 28A.210.090(1)(c) (2019) (allowing an exemption for a parent or legal guardian's "philosophical or personal objection to the immunization of the child"); 28 PA. CODE § 23.84(b) (1997) (allowing an exemption for a parent, guardian, or emancipated child's "strong moral or ethical conviction similar to a religious belief").

91 LA. STAT. ANN. § 17:170(E) (2020).

to religious belief, many do not require that the parent be a member of a recognized church or denomination.[92] Only Puerto Rico's law requires verification from a religious leader.[93]

Agreement between parents and children, especially older children, on the question of vaccination is by no means guaranteed.[94] In particular, the COVID-19 pandemic has created or exacerbated such disagreements between parents and their children.[95] Despite this, none of these laws allows minor students to object to these exemptions, and none authorizes minors to opt back in to school-immunization requirements following parental objection. They prioritize parental decision-making power over children's health and community safety, inverting the Supreme Court's priorities in *Jacobson* and *Prince*.[96] One mother in Florida, who refused to allow her seventeen-year-old daughter to receive the COVID-19 vaccine, provided an astute summary of the legal landscape: "[My daughter] said, 'It's my body.' And I said, 'Well, it's my body until you're 18.'"[97] As this mother correctly realized, nonmedical exemptions often ensure that a minor has neither her own body nor her own choice.

So long as these legal loopholes exist, outbreaks and revivals of vaccine-preventable diseases may become increasingly common. In July 2022, New York reported that a young adult in the

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92 *See, e.g.*, 16 R.I. GEN. LAWS § 16-38-2(a) (allowing an exemption via "a certificate signed by the pupil, if over eighteen (18) years of age, or by the parent or guardian stating that immunization . . . is contrary to that person's religious beliefs"). *But see* ALASKA ADMIN. CODE tit. 4, § 06.055(b) (3) (2018) (allowing an exemption if "immunization conflicts with the tenets and practices of the church or religious denomination of which the applicant is a member").

93 P.R. LAWS ANN. tit. 24, § 182d (2021) ("The sworn statement must indicate the name of the religion or sect and must be signed by the student, or his parents, and by the minister of the religion or sect.").

94 *See, e.g.*, *Vaccines Save Lives: What is Driving Preventable Disease Outbreaks?: Hearing Before the S. Comm. on Health, Educ., Lab. & Pensions*, 116th Cong. 30–31 (2019) (statement of Ethan Lindenberger, Student, Norwalk High Sch., Norwalk, Ohio); Feldman, *supra* note 23; *see also* Natasha L. Herbert, Lisa M. Gargano, Julia E. Painter, Jessica M. Sales, Christopher Morfaw, Dennis Murray, Ralph J. DiClemente & James M. Hughes, *Understanding Reasons for Participating in a School-Based Influenza Vaccination Program and Decision-Making Dynamics Among Adolescents and Parents*, 28 HEALTH EDUC. RSCH. 663, 667–68 (2013) (discussing conversations between parents and their adolescent children about participation in a school-based influenza vaccination program).

95 Timothy M. Smith, *COVID-19 Vaccination: What to Do When Teens, Parents Disagree*, AM. MED. ASS'N (Aug. 25, 2021), https://perma.cc/H9T2-HMGN ("The dispute over COVID-19 vaccines . . . [is] creating disagreements between parents and their kids."); Jan Hoffman, *As Parents Forbid Covid Shots, Defiant Teenagers Seek Ways to Get Them*, N.Y. TIMES (June 26, 2021), https://perma.cc/6237-NXJK.

96 *See Jacobson*, 197 U.S. at 39; *Prince*, 321 U.S. at 166–67.

97 Hoffman, *supra* note 95.

state had contracted polio, a disease associated with paralysis and other debilitating neurological symptoms.[98] This marked the first recorded polio case in the United States since 2013.[99] And though both the CDC's standard child immunization schedule and New York's required school-immunization schedule include the polio vaccine, the young adult who contracted the virus was unvaccinated.[100]

Recognizing the urgency of the moment, some teenagers have sought ways to circumvent parental consent requirements and choose vaccination for themselves. One option for minors seeking vaccination is to visit VaxTeen, a website founded by then–high school student Kelly Danielpour.[101] She initially created VaxTeen to "provid[e] a reliable and easy-to-understand source" for the growing number "of teenagers turning to [the internet] to figure out if they could consent to vaccinations in their states."[102] To that end, the website includes a hyperlinked list of minor consent laws in U.S. states and D.C.[103] Danielpour hopes that the website will become "a platform to advocate for straightforward legislation allowing teenagers to consent to all vaccinations"—legislation like the MCA.[104] As minors continue to seek vaccination for their own safety and community health, minor consent laws like the MCA, the Philadelphia regulation, and the proposed legislation in California and Pennsylvania will become increasingly important.

Parts II and III further explore the tension between parental rights and the health of both children and the broader community. Part II discusses the doctrine of parental rights, particularly religious rights, and their RFRA protections. Then, Part III discusses the doctrine surrounding children's interests and bodily autonomy.

II. THE DOCTRINE OF PARENTAL RIGHTS

For decades, the Supreme Court has repeatedly protected the parental right to exert control over the upbringing of one's child. In the twentieth century, the Court decided a line of cases that

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98 George Citroner, *Polio Case Detected in New York, First Case in U.S. Since 2013*, HEALTHLINE (July 25, 2022), https://perma.cc/5GNS-CXEW.

99 *Id.*

100 *Id.*

101 *See About VaxTeen*, VAXTEEN (2020), https://perma.cc/8ZLQ-6EYS [hereinafter VaxTeen About Page].

102 *Id.*

103 *Minor Consent Laws by State*, VAXTEEN (2020), https://perma.cc/5Q4K-8NTJ.

104 VaxTeen About Page, *supra* note 101.

fortified especially strong protections for parental rights based on substantive due process and free exercise rights.[105] More recent cases have been decided in a purely secular context. However, RFRA and its state-level counterparts could provide powerful tools for modern antivaccine plaintiffs to secure protections even more stringent than those currently recognized by the Court's religious parental rights cases. Moreover, a majority of sitting Supreme Court Justices have indicated an interest in incorporating RFRA-like protections into their free exercise analysis.

This Part discusses the past, present, and future of parental rights protections in the legal system. Part II.A provides a history of the Supreme Court's parental rights jurisprudence from the early twentieth century to the turn of the twenty-first century. Then, Part II.B explains how RFRA and similar state laws can bolster a parental rights claim against a statute like D.C.'s Minor Consent Act.

A. The Supreme Court's Parental Rights Protections

U.S. law recognizes the state as a "parental" figure toward all its citizens, from young children to mature adults. When the state enters a lawsuit to represent the interest of its citizens, it is said to be acting as *parens patriae*, or "parent of the country."[106] However, the state shares control over its youngest citizens with the children's parents or guardians. This tension between parents and states-as-parents underlies the Supreme Court's parental rights jurisprudence, which has, by some accounts, positioned children as property—either "resource[s] of the state" or "private asset[s] of the parent."[107]

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[105] *See* Jay S. Bybee, *Substantive Due Process and Free Exercise of Religion:* Meyer*,* Pierce *and the Origins of* Wisconsin v. Yoder, 25 CAP. U. L. REV. 887, 890–91 (1996); *see also* Diarmuid F. O'Scannlain, *From* Pierce *to* Smith*: The Oregon Connection and Supreme Court Religion Jurisprudence*, 86 OR. L. REV. 635, 637 (2007) (explaining that, though the plaintiffs in *Pierce* were concerned with religious upbringing, they "did not explicitly invoke the federal Free Exercise Clause, for that clause would not be incorporated against the states until 1940").

[106] *See* Jim Ryan & Don R. Sampen, *Suing on Behalf of the State: A Parens Patriae Primer*, 86 ILL. B.J. 684, 684 (1998).

[107] Barbara Bennett Woodhouse, *"Who Owns the Child?":* Meyer *and* Pierce *and the Child as Property*, 33 WM. & MARY L. REV. 995, 999 (1992).

The Supreme Court has characterized parental rights as "perhaps the oldest of the fundamental liberty interests recognized by this Court."[108] In *Meyer v. Nebraska*[109]—a 1923 case concerning a school instructor who violated a Nebraska statute that outlawed the teaching of foreign languages before the ninth grade—the Court recognized a right to "establish a home and bring up children."[110] After *Meyer*, the Court expounded upon this right in a series of three influential cases: *Pierce v. Society of Sisters*,[111] *Prince*, and *Wisconsin v. Yoder*.[112]

In *Pierce*, the Court struck down an Oregon statute requiring parents to send their children to public schools instead of private schools.[113] Though the ruling applied to both religious and secular schools, the parental right at issue nevertheless had religious undertones. The Society of Sisters, a corporation that ran parochial schools, asserted that the statute violated parents' rights "to choose schools where their children will receive appropriate mental *and religious* training."[114] To justify its ruling against the state, the Court wrote that "[t]he child is not the mere creature of the State; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations."[115] *Pierce* has since come to stand for the broad principles that people have the right "to make decisions about child-bearing free of state intervention . . . [and] that parents have a right to inculcate their children with moral values."[116]

In *Prince*, the Court indicated that religious parental rights deserve greater deference than purely secular ones. Here, the Court upheld the conviction of a woman who had defied the state's child labor law by bringing her young niece to the streets to distribute religious pamphlets.[117] While the Court ruled in favor of the state, it nevertheless wrote that a parent or guardian's "conflict with the state over control of the child . . . becomes [more serious] when an element of religious conviction enters."[118]

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[108] Troxel v. Granville, 530 U.S. 57, 65 (2000).

[109] 262 U.S. 390 (1923).

[110] *Id.* at 399.

[111] 268 U.S. 510 (1925).

[112] 406 U.S. 205 (1972).

[113] *See Pierce*, 268 U.S. at 530–31, 536.

[114] *Id.* at 532 (emphasis added).

[115] *Id.* at 535.

[116] Barbara Bennett Woodhouse, *Child Abuse, the Constitution, and the Legacy of* Pierce v. Society of Sisters, 78 U. DET. MERCY L. REV. 479, 481 (2001).

[117] *See Prince*, 321 U.S. at 160, 169–70.

[118] *Id.* at 165.

In *Yoder*, the Court allowed Amish parents to remove their children from school after eighth grade, despite a Wisconsin law requiring that children remain in school for two additional years.[119] To reach this result, the Court conducted a "balancing process" between "a State's interest in universal education" and "the traditional interest of parents with respect to the religious upbringing of their children."[120] The majority indicated that a combined parental rights and free exercise claim merited a heightened standard of review.[121] While the Court recognized that both the state and the parent have an interest in a child's welfare, it expressed considerable deference to the parent's determination of the child's best interests.[122] Notably, the evidence before the Court suggested that the plaintiffs' children agreed with their parents and wished to forgo the final two years of compulsory schooling.[123] Both Justice Potter Stewart's concurring opinion and Justice William Douglas's dissenting opinion indicated that, had the children disagreed with their parents, the Court could have reached a different result.[124] *Prince* and *Yoder* together suggest that a religious parental rights claim is more likely than a secular one to overcome an otherwise-overriding state interest in child welfare.

Two Supreme Court cases have provided further protections for parental rights and reaffirmed the Court's commitment to privileging a parent's determination of her child's best interest over the state's contrary view. In *Parham v. J.R.*,[125] decided seven years after *Yoder*, the Court held that parents could institutionalize their children for mental health care without adversarial proceedings.[126] The *Parham* Court recognized a presumption that "parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions . . . [and] that natural bonds of affection lead parents to act in the

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119 *See Yoder*, 406 U.S. at 207, 231–32.

120 *Id.* at 214.

121 *See id.* at 233.

122 *See id.* at 218–19.

123 *See id.* at 237 (Stewart, J., concurring). *But see* Emily Buss, *What Does Frieda Yoder Believe?*, 2 U. PA. J. CONST. L. 53, 67–70 (1999) (suggesting that the "series of leading questions" in Frieda Yoder's court testimony may not have led to an accurate account of her true beliefs).

124 *See Yoder*, 406 U.S. at 237 (Stewart, J., concurring); *id.* at 242 (Douglas, J., dissenting).

125 442 U.S. 584 (1979).

126 *Id.* at 620.

best interests of their children."[127] Furthermore, the Court wrote that even though a parent's decision may be risky or "not agreeable to a child," this "does not automatically transfer the power to make that decision from the parents to some agency or officer of the state."[128]

In 2000, a plurality of the Court held in *Troxel v. Granville*[129] that parents can limit the visitation rights of grandparents or other third parties.[130] The *Troxel* plurality noted that a parent's decision need not align with a judge's priorities: "[T]he Due Process Clause does not permit a State to infringe on the fundamental right of parents to make child rearing decisions simply because a state judge believes a 'better' decision could be made."[131] In sum, a parent's determination of her child's best interest may outweigh the state's contrary determination; in other words, the state does not have grounds to intervene in the parent-child relationship simply because it disagrees with the parent.

While the Court has recognized the state's interest in regulating children's lives, it often defers to the choices that parents make for their children. The legal system presumes that parents act in service of their duty to raise their children and that they have their children's best interests at heart. When two different outcomes for a child both pose benefits and harms, a court prioritizes the opinion of the child's parent. Moreover, in cases like *Yoder* and *Pierce*, the Court has shown particular respect for parental rights claims that are bolstered by strong religious rights arguments. This suggests that the Court may be receptive to a parental rights claim, particularly a *religious* parental rights claim, that challenges a state law mandating or even facilitating vaccines for children. However, as Part III explains, this line of cases has also indicated the nascent recognition of a right previously left out of these discussions: the child's own right to bodily integrity.

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127 *Id.* at 602 (first citing 1 WILLIAM BLACKSTONE, COMMENTARIES *447; and then citing 2 JAMES KENT, COMMENTARIES ON AMERICAN LAW *190).

128 *Id.* at 603.

129 530 U.S. 57 (2000).

130 *Id.* at 60, 75.

131 *Id.* at 72–73.

B. RFRA as a Tool for Parental Rights Litigants

The Religious Freedom Restoration Act and its state-level counterparts could provide additional strength to modern parental rights claims, particularly antivaccine claims. This Part discusses the relevant history of RFRA and outlines some of the arguments that parental rights advocates might make against statutes like D.C.'s Minor Consent Act.

Congress enacted RFRA in 1993 as a response to *Employment Division v. Smith*,[132] in which the Supreme Court had ruled that neutral, generally applicable laws can be applied in a manner that burdens religious practice without violating constitutional free exercise rights.[133] Designed to repudiate *Smith*'s approach and return to an especially expansive interpretation of free exercise, RFRA outlines a strict test: no government action, even a generally applicable law, may substantially burden a plaintiff's religious practice unless it constitutes the least restrictive means of achieving a compelling government interest.[134] Just four years after the law's enactment, the Supreme Court invalidated RFRA as applied to state laws in *City of Boerne v. Flores*.[135] Finding that the statute exceeded Congress's power under the Fourteenth Amendment, the Court ruled that RFRA could only apply at the federal level, including in federal territories and D.C.[136]

However, *City of Boerne* did not mark the end of state-level RFRA protections. Twenty-two states have since enacted their own religious freedom restoration laws, most recently South Dakota and Montana in 2021.[137] As a result, RFRA-style restrictions still apply across much of the United States. Additionally, a majority of the Court has suggested a willingness to reconsider *Smith*, and three Justices have made the more forceful claim that they are ready to overturn it.[138] This means that any

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[132] 494 U.S. 872 (1990).

[133] *Id.* at 881–82.

[134] *See* Lupu, *supra* note 47, at 172–73.

[135] 521 U.S. 507 (1997).

[136] *See id.* at 536.

[137] *See* Wyatt Ronan, *South Dakota Governor Kristi Noem Signs Religious Refusal Bill, Creating First Major RFRA Law in Six Years*, HUM. RTS. CAMPAIGN (Mar. 13, 2021), https://perma.cc/J3G7-M2SB; Seaborn Larson, *Gianforte Signs Religious Freedom Bill*, HELENA INDEP. REC. (Apr. 22, 2021), https://perma.cc/GP6F-K684.

[138] In *Fulton v. City of Philadelphia*, 141 S. Ct. 1868, 1924 (2021), Justice Alito's concurring opinion, joined by Justice Thomas and Justice Gorsuch, simply stated that "*Smith* was wrongly decided." *Id.* at 1924 (2021) (Alito, J., concurring). Justice Barrett's concurring opinion, joined by Justice Brett Kavanaugh, noted that "the textual and structural

law that burdens free exercise could soon be subject to a RFRA-like test. With this in mind, it is important for public health purposes that any future vaccine regulation be able to withstand RFRA's strict scrutiny test.

In jurisdictions subject to the federal RFRA or one of its state-level counterparts, a statute like the MCA would need to satisfy the law's strict test to survive a parental rights challenge. The RFRA inquiry begins by determining whether a challenged government action "substantially burden[s]" a plaintiff's right to religious exercise.[139] Under the federal RFRA, religious exercise includes "any exercise of religion, whether or not compelled by, or central to, a system of religious belief."[140] To meet this standard, it may simply be enough that the law interferes with parental control over their children's upbringing in accordance with religious principles.

The second element of the RFRA test requires the government to demonstrate that its challenged action furthers a "compelling governmental interest."[141] The Supreme Court has ruled that the government's compelling interest must be particularized to the "claimant whose sincere exercise of religion is being substantially burdened."[142] This means that the government must show that its compelling interest in public health requires burdening the particular plaintiff-parent—in other words, that the state's interest in public health requires that the plaintiff's child in particular be permitted to consent to vaccines. This may require a balancing of interests between religious rights and public health, or it may require the state to point to a particularized interest in the health and safety of the plaintiff's child. Regardless, the government would be relatively likely to succeed in proving a compelling interest, especially in the midst of a pandemic or series of frequent outbreaks; in 2020, the Supreme Court found that "[s]temming the spread of COVID-19 is unquestionably a compelling interest."[143]

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arguments against *Smith* are more compelling" than those in its favor. *Id.* at 1882 (Barrett, J., concurring).

139 42 U.S.C. § 2000bb-1(a).

140 42 U.S.C. § 2000cc-5(7)(A).

141 42 U.S.C. § 2000bb-1(b)(1).

142 Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal, 546 U.S. 418, 431 (2006).

143 Roman Cath. Diocese of Brooklyn v. Cuomo, 141 S. Ct. 63, 67 (2020) (per curiam). *But see* Does 1–3 v. Mills, 142 S Ct. 17, 21 (2021) (order denying application for injunctive relief) (Gorsuch, J., dissenting) (suggesting that a compelling interest in preventing

Finally, the third component of the RFRA test requires the government to demonstrate that its challenged action constitutes "the least restrictive means of furthering that compelling governmental interest."[144] To meet this "exceptionally demanding" standard, the government must show that it "lacks other means of achieving its desired goal without imposing a substantial burden."[145] This third component is likely to be the most difficult for a minor consent statute to overcome, as the government would need to show that it has no other avenue to achieve its public health goals without restricting parents' religious liberties. Against the MCA, plaintiffs might argue that the government could still encourage vaccination at school without undermining parental authority, destabilizing parental religious interests, and bypassing parental consent.

Though the Supreme Court has generally shown deference to measures that safeguard public health, the parental rights cases suggest that the Court may be especially sympathetic to an anti-vaccine claim if it is couched in religious terms. However, focusing exclusively on the interests of parents and the government fails to tell the whole story. In Part III, this Comment discusses the third—and arguably most important—interest implicated in debates over childhood vaccination: the child's own.

III. THE DOCTRINE OF CHILDREN'S INTERESTS

Though the legal system provides strong protections for parental rights, it also accounts for children's autonomy and the state's interest in raising healthy and productive citizens. Part III.A recontextualizes *Prince* and *Yoder* to show how they interact with these other two concepts. Then, Part III.B considers the mature minor doctrine and courts' prior approaches to minor consent for medical treatments, particularly abortion and contraception. Finally, Part III.C uses the logic of these cases to illustrate that children hold a qualified autonomy right to consent to vaccines.

COVID-19 transmission has a temporal limit and is weakened by the presence of vaccines and effective treatments).

144 42 U.S.C. § 2000bb-1(b)(2).

145 Burwell v. Hobby Lobby Stores, 573 U.S. 682, 728 (2014).

A. The Role of Children's Interests in the Parental Rights Cases

While parental rights cases largely position children as passive participants in conflicts between parents and states, several also recognize that children have rights and interests independent of their parents. These can be divided into two categories: autonomy interests (asserted by the child) and well-being interests (asserted by the state). When these two interests align—for instance, when the child and the state want the same thing—they become a powerful autonomy right.

The first category, autonomy interests, describes what children say they want. In contrast, a child's well-being interests, which are shared between the child and the state, do not depend on the child's stated desires and are instead defined by the government. The state, as a quasi-parental figure, identifies interests that it believes will support a child's growth into a healthy and productive citizen who will contribute positively to the community. Even if the child does not express a desire to exercise these well-being interests, the state can claim them on her behalf. To provide a simplistic example, a child's autonomy interest might be to eat candy for public school lunch. The state, recognizing that vegetables and rice will provide more nutrients for the child to grow healthy and strong, asserts the child's well-being interest and orders stir fry from the caterer instead of chocolate bars.

Bellotti v. Baird,[146] further discussed in Part III, explains why courts allow the state to override a child's freedom of choice in this way. Children, in the Supreme Court's view, have a reduced capacity to make decisions and may not know what will be beneficial or detrimental to them in the future, thereby justifying prioritization of the well-being interest over the autonomy interest.[147] Additionally, because the well-being interest relates to a child's ability to contribute to her community, it necessarily implicates the state's desire to support and protect all its citizens. Autonomy interests are highly individualistic, looking inward to what a child thinks; well-being interests are more communal, focusing not only on children's futures but also on how children fit into a thriving community.

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[146] 443 U.S. 622 (1979).

[147] *See id.* at 635–36.

Prince demonstrates a conflict between a child's autonomy interest and her well-being interest. Here, the child's autonomy interest aligned with her guardian's wishes—she wanted to hand out religious pamphlets with her guardian, even if it meant she would miss school.[148] However, the Court instead prioritized her well-being interest, which the state asserted on her behalf through the passage of a child labor law. The Court wrote that "[i]t is the interest *of youth itself*, and *of the whole community*, that children be both safeguarded from abuses and given opportunities for growth into free and independent well-developed men and citizens."[149] Though the child did not express a desire to stop working, the Court identified the prohibition of child labor as a shared interest between the "youth itself" (the child) and "the whole community" (the state).[150] The protections provided by the child labor law would give the child the opportunity to rest and engage in other activities that would contribute to her growth as a citizen. Therefore, the child labor law meaningfully benefitted both the child and her community. For this reason, the state's assertion of the child's well-being interest through the child labor law was able to outweigh both her autonomy interest and her guardian's parental rights.

Yoder demonstrates that states cannot always override parental rights simply by asserting that their laws protect children's well-being interests. As in *Prince*, the Court found that the children's autonomy interests aligned with their parents' desires—they wished to exit the public school system before high school.[151] Instead of finding these autonomy interests to be dispositive, the *Yoder* Court also considered the children's well-being interests. Here, the Court used the children's future well-being as a metric to weigh the state's preferred outcome against the parents' preferred outcome. The Court evaluated whether two additional years cloistered in Amish society would "impair the physical or mental health of the child, or result in an inability to be self-supporting or to discharge the duties and responsibilities of citizenship, or in any other way materially detract from the welfare of society."[152] The state asserted that the children could become

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[148] *See Prince*, 321 U.S. at 162–63 (acknowledging excluded testimony showing that the child wanted to go hand out pamphlets and "believed it was her religious duty" to do so).

[149] *Id.* at 165 (emphasis added).

[150] *Id.*

[151] *Yoder*, 406 U.S. at 237 (Stewart, J., concurring).

[152] *Id.* at 234 (majority opinion).

healthy citizens and carry out their duties to society only if their families adhered to the compulsory schooling law, but the children's parents—and the Court—disagreed.

When the *Yoder* Court ultimately granted an exemption to the Amish parents, it was not influenced by the children's views; rather, the Court expressed a belief that the Amish lifestyle adequately supported the children's well-being.[153] Because, in the Court's view, the children could grow to become healthy, functioning citizens within the Amish community, the state's assertion that the child's well-being interest could *only* be served by compulsory schooling carried little weight. Therefore, the Court deferred to parental rights.

Despite their contrary results, both *Prince* and *Yoder* recognized that state actions can override religious parental rights if the exercise of parental rights undermines children's well-being interests. The *Prince* Court noted that a parent could not rely on free exercise rights to avoid childhood immunizations because "[t]he right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death."[154] Citing *Prince*, the Court in *Yoder* wrote that a parent's religious freedom "may be subject to limitation . . . if it appears that parental decisions will jeopardize the health or safety of the child."[155] The statement in *Prince*, implicitly endorsed by *Yoder*, expressed dual concerns: first, the Court wanted to safeguard each child's health, and second, it wanted to ensure that the infection of that one child will not spread disease to the community. Instead of allowing a child to grow into a positive member of her community, this would lead to the ultimate marker of poor citizenship: harm to the community. If a parent's decision would actively harm both child and community, the child's well-being interest is especially likely to override the parental right.

If well-being interests and autonomy interests align, there might be an even greater argument for limiting parental rights. While the majority opinions in *Yoder* and *Prince* recognized the existence of the children's autonomy interests, they did not find them very relevant. The holdings in those cases instead represented a balancing of the children's well-being interests, as expressed by the state, against their parents' religious rights.

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153 *Id.*

154 *Prince*, 321 U.S. at 166–67.

155 *Yoder*, 406 U.S. at 233–34.

However, in his famous *Yoder* dissent, Justice Douglas, who "had often asserted the supremacy of free exercise in other contexts,"[156] expressed that a child's autonomy interest might change the outcome of parental rights litigation.[157]

Justice Douglas identified three factors that can each lend strength to a child's autonomy interest, such that it becomes an autonomy *right* that can outweigh parental rights. This framework reflects the varied considerations that courts take into account when they utilize the mature minor doctrine, further discussed in Part III.B., to assess minor consent to medical care. The first factor was maturity: Justice Douglas's dissent explained that when a mature child disagrees with her parents, courts should alter their parental rights calculus to account for the child's views.[158] The second was subject matter: Justice Douglas noted that the child's opinion should hold particular weight for matters that directly pertain to her life and future, such as education.[159] The third factor was agreement between child and state. Put simply, "if an Amish child desires to attend high school, and is mature enough to have that desire respected, the State may very well be able to override the parents' religiously motivated objections."[160] This means that when a child's well-being and autonomy interests align, those interests become especially strong and may outweigh religious parental rights.

As a dissenter, Justice Douglas did not speak for the Court, and his words provide no binding precedent. However, he articulated an influential framework for recognizing children's interests that has generated robust scholarly discussion. In the years since *Yoder*, several commentators have found Justice Douglas's dissent to have continued relevance outside of the education context, including as applied to medical decisions.[161]

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156 John W. Whitehead, *The Conservative Supreme Court and the Demise of the Free Exercise of Religion*, 7 TEMP. POL. & CIV. RTS. L. REV. 1, 2 (1997).

157 *See Yoder*, 406 U.S. at 242 (Douglas, J., dissenting).

158 *Id.*

159 *Id.* at 244.

160 *Id.* at 242.

161 *See* Ann MacLean Massie, *The Religion Clauses and Parental Health Care Decisionmaking for Children: Suggestions for A New Approach*, 21 HASTINGS CONST. L.Q. 725, 770 (1994) ("Justice Douglas's cogent arguments apply with much greater force to an exemption permitting parents to choose spiritual treatment over conventional medical care for their severely ill minor children."); Buss, *supra* note 123, at 54 ("[T]he questions Douglas raises are applicable in any case in which parents seek to avoid the application of a law to their children on the basis of the parents' religious convictions."); Jennifer E.

Together with the mature minor doctrine and the Court's reproductive rights decisions, this opinion helps define the contours of a minor's right to consent to vaccines.

B. Medical Decisions and the Mature Minor Doctrine

Jurisdictions have long grappled with questions of when and how minors can consent to medical treatments. Local statutory and judicial solutions have developed into a framework known as the mature minor doctrine, under which older competent minors can provide valid consent to beneficial medical treatments ("minor consent").[162] The federal courts have used a similar framework to assess minor consent to abortion and contraception.[163] The logic that undergirds these cases also suggests that minors possess a qualified autonomy right in the vaccine context. Part III.B.1 begins with a discussion of the mature minor doctrine across states, and then Part III.B.2 analyzes federal jurisprudence concerning minors' reproductive rights. Part III.B.3 analogizes minors' reproductive rights to the autonomy right to consent to vaccines. Together, these cases set the stage for a statutory framework, outlined in Part IV, that expands on D.C.'s Minor Consent Act to successfully vindicate this autonomy right.

1. The mature minor doctrine across states.

The mature minor doctrine appears in case law and "targeted statutes" that address minor consent to specific medical treatments, such as treatments for sexually transmitted diseases, substance abuse, mental health concerns, and pregnancy.[164] Seven states have statutes permitting unemancipated minors to consent to general medical treatments based on age or demonstrated maturity,[165] but, of those, "[o]nly a few states have incorporated the

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Chen, Comment, *Family Conflicts: The Role of Religion in Refusing Medical Treatment for Minors*, 58 HASTINGS L.J. 643, 663 (2007).

[162] *See* Elizabeth S. Scott, *The Legal Construction of Adolescence*, 29 HOFSTRA L. REV. 547, 567 (2000).

[163] *See infra* Part III.B.2.

[164] *See* Scott, *supra* note 162, at 567–68.

[165] ALA. CODE § 22-8-4 (1971) (allowing minors to legally consent at ages fourteen and older); IDAHO CODE § 39-4503 (crediting consent from any person "who comprehends the need for, the nature of and the significant risks ordinarily inherent in any contemplated hospital, medical, dental, surgical or other health care, treatment or procedure"); 410 ILL. COMP. STAT. 210/1.5(a)(1) (crediting consent when "the health care professional reasonably believes that the minor seeking care understands the benefits and risks of any proposed primary care or services"); KAN. STAT. ANN. § 38-123b (2012) (crediting consent from

mature minor doctrine into a statute."[166] Initially adopted to reduce tort liability for medical professionals who treat minors without parental consent, the doctrine now reflects more normative justifications based on the idea that removing the "obstacle" of parental consent "encourages adolescents to seek treatment that may be critically important to their health."[167] The mature minor doctrine has not yet found widespread or consistent adoption across the United States.[168] However, even where the mature minor doctrine has not been officially adopted, its "principles . . . seem to be influential."[169]

When judges make decisions under the mature minor doctrine, they typically use "a case-by-case assessment of an individual minor's circumstances."[170] Some opinions focus on a minor's capacity to consent. In the seminal case of *Cardwell v. Bechtol*,[171] the Tennessee Supreme Court found that the relevant factors for minor consent include "the age, ability, experience, education, training, and degree of maturity or judgment obtained by the minor, as well as upon the conduct and demeanor of the minor at the time of the incident involved."[172] In *Younts v. St. Francis Hospital and School of Nursing, Inc.*,[173] the Kansas Supreme Court also focused on the child's capacity to consent, finding that the key factor was the child's comprehension of the medical treatment itself.[174] This approach from *Cardwell* and *Younts* focuses exclusively on autonomy interests. Once the child's desire was made clear, each court asked if the child was mature enough for that desire to be honored by the law.

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minors who are sixteen or older "where no parent or guardian is immediately available"); OR. REV. STAT. § 109.640 (2022) (crediting consent from minors fifteen and older); 23 R.I. GEN. LAWS § 23-4.6-1 (2018) (crediting consent from minors sixteen and older); S.C. CODE § 63-5-340 (2008) (crediting consent from minors sixteen and older).

166 ABIGAIL ENGLISH, LINDSAY BASS, ALISON DAME BOYLE & FELICIA ESHRAGH, STATE MINOR CONSENT LAWS: A SUMMARY 3 (3d ed. 2010).

167 Scott, *supra* note 162, at 568; *see* Lois A. Weithorn & Dorit Rubinstein Reiss, *Providing Adolescents with Independent and Confidential Access to Childhood Vaccines: A Proposal to Lower the Age of Consent*, 52 CONN. L. REV. 771, 810–11 (2020).

168 *See* Jalayne Arias, *A Childs' Voice in Pediatric Cancer Treatment: A Minor's Role in the Informed Consent Process*, HEALTH L. 39, 40 (2011); Weithorn & Reiss, *supra* note 167, at 810.

169 Scott, *supra* note 162, at 567 n.79.

170 B. Jessie Hill, *Medical Decision Making by and on Behalf of Adolescents: Reconsidering First Principles*, 15 J. HEALTH CARE L. & POL'Y 37, 42 (2012).

171 724 S.W.2d 739 (Tenn. 1987).

172 *Id.* at 748.

173 469 P.2d 330 (Kan. 1970).

174 *See id.* at 337.

Other courts have used additional situational or subject matter factors as part of the mature minor calculus, including whether an emergency was present, whether the child's parents were readily available, and whether the care was demonstrably beneficial.[175] This approach incorporates both categories of interests by asking if a child's well-being interest would be advanced by honoring her autonomy interest. For example, in *Bonner v. Moran*,[176] the D.C. Circuit wrote that "in all such cases the basic consideration is whether the proposed operation is for the benefit of the child and is done with a purpose of saving his life or limb."[177] Rather than considering only whether the minor wanted the operation and had the capacity to consent to it, the *Bonner* court emphasized the importance of the operation to the child's well-being.

Some state statutes codifying the mature minor doctrine take an approach that similarly balances autonomy interests and well-being interests by allowing care providers to consider external factors, such as parental availability or the presence of an emergency, rather than only the minor's age and demonstrated capacity.[178] For example, Alaska's statute allows consent "if the parent or legal guardian of the minor cannot be contacted or, if contacted, is unwilling either to grant or withhold consent,"[179] and Maryland's statute allows consent "if, in the judgment of the attending physician, the life or health of the minor would be affected adversely by delaying treatment to obtain the consent of another individual."[180]

2. Judicial approaches to minor consent for abortion and contraception.

The Supreme Court has previously employed its own version of the mature minor framework in its jurisprudence concerning

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[175] *See, e.g.*, Sullivan v. Montgomery, 155 Misc. 448, 449–50 (N.Y. City Ct. 1935) (finding that the mature-minor calculus changes when a physician conducts a medical procedure in emergency circumstances); *see also* Rowine Hayes Brown & Richard B. Truitt, *The Right of Minors to Medical Treatment*, 28 DEPAUL L. REV. 289, 290–91 (1979) (finding that courts have been more likely to recognize a mature minor exception for beneficial medical procedures when there is an emergency, the child is emancipated, the parents are far away or otherwise unavailable, or the child is near the age of majority).

[176] 126 F.2d 121 (D.C. Cir. 1941).

[177] *Id.* at 123.

[178] *See, e.g.*, NEV. REV. STAT. § 129.030(1)(d) (allowing consent if a physician determines that the minor is "in danger of suffering a serious health hazard if health care services are not provided").

[179] ALASKA STAT. § 25.20.025(a)(2).

[180] MD. CODE ANN., HEALTH–GEN. § 20-102(b).

minors' reproductive decisions. While the Court no longer recognizes the constitutional right to abortion,[181] the line of cases concerning minors' reproductive rights provides the most robust discussion of minor autonomy rights and can offer a useful analogue for how future courts might approach minors' exercise of other bodily autonomy rights. In *Planned Parenthood of Central Missouri v. Danforth*,[182] the Court asserted that "[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights."[183] Because the Supreme Court's decision in *Roe v. Wade*[184] had already established abortion as a constitutional right for adults,[185] the Court recognized a similar right for minors and "essentially constitutionalized" the mature minor doctrine for reproductive decisions.[186]

In *Bellotti v. Baird*, the Court defined the contours of a minor's constitutional right to seek an abortion. As a threshold matter, the Court agreed with *Danforth* that "[a] child, merely on account of his minority, is not beyond the protection of the Constitution."[187] However, the *Bellotti* Court identified three factors that could allow a state to limit a minor's ability to exercise constitutional rights: "[T]he peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing."[188] The first factor entitles the state to "adjust its legal system" in recognition of children's unique sensibilities; the second allows the state to limit children's freedom of choice; and the third requires states to "defer[ ] to parental control" when minors seek to make important decisions.[189] To address these concerns while still vindicating the minor's reproductive rights, the Court ruled that a minor seeking an abortion must be given the opportunity

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[181] Dobbs v. Jackson Women's Health Org., 142 S.Ct. 2228, 2317 (2022) (Breyer, Sotomayor & Kagan, JJ., dissenting) ("Today, the Court . . . says that from the very moment of fertilization, a woman has no rights to speak of. A State can force her to bring a pregnancy to term, even at the steepest personal and familial costs.").

[182] 428 U.S. 52 (1976).

[183] *Id.* at 74.

[184] 410 U.S. 113 (1973).

[185] *See id.* at 153.

[186] Hill, *supra* note 170, at 62.

[187] *Bellotti*, 443 U.S. at 633.

[188] *Id.* at 634.

[189] *Id.* at 635–37.

to obtain permission from a court "without first consulting or notifying her parents."[190] That court would then determine whether the minor met a certain maturity threshold:

> If she satisfies the court that she is mature and well enough informed to make intelligently the abortion decision on her own, the court must authorize her to act without parental consultation or consent. If she fails to satisfy the court that she is competent to make this decision independently, she must be permitted to show that an abortion nevertheless would be in her best interests.[191]

The Supreme Court later reaffirmed its support for this procedure, known as a judicial bypass, in the landmark abortion case *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[192]

In cases concerning contraception, lower federal courts have considered another limiting factor: state coercion. Essentially, a state cannot utilize compulsion or coercion to force a minor to receive contraception. On this principle, the Third and Sixth Circuits have upheld state laws that *allow* but do not *compel* minors to access contraception without parent permission. In *Anspach ex rel. Anspach v. City of Philadelphia, Department of Public Health*,[193] the Third Circuit found that the voluntary provision of contraceptives to a minor did not violate parental rights.[194] The key factor in this inquiry was state compulsion, as "[c]ourts have recognized the parental liberty interest only where the behavior of the state actor compelled interference in the parent-child relationship."[195] Similarly, the Sixth Circuit found that Michigan's decision to distribute contraceptives to minors at a voluntary clinic did not violate parental rights because the state was not "requiring or prohibiting some activity," and the minors' parents "remain[ed] free to exercise their traditional care, custody and control over their unemancipated children."[196] So long as a state only furnishes an opportunity for a minor to voluntarily obtain contraception, that state action is acceptable and does not unduly interfere with the domain of parental control.

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190 *Id.* at 647.
191 *Id.* at 647–48.
192 505 U.S. 833 (1992).
193 503 F.3d 256 (3d Cir. 2007).
194 *Id.* at 269–71.
195 *Id.* at 262.
196 Doe v. Irwin, 615 F.2d 1162, 1168 (6th Cir. 1980).

3. Applying the logic from the reproductive rights decisions to the context of minor consent to vaccines.

The reproductive rights cases provide a useful corollary for a minor's autonomy right to consent to vaccines. These cases, though no longer in force, provide the most in-depth discussions of children's exercise of constitutional rights contrary to their parents' wishes.[197] The autonomy frameworks that they establish can be transferred to the vaccine context without reliance on abortion as a recognized right.

Some commentators have argued that minors' reproductive rights should encompass a right to consent to the HPV vaccine, "which prevents certain cancers caused by the [sexually transmitted] Human Papillomavirus."[198] However, the logic of minors' reproductive rights can further extend to any vaccine that impacts children's health. Professor B. Jessie Hill argued that the right of minors to make decisions related to their own bodies should not be confined to the reproductive context but rather expanded to any decision "with profound long-term effects on the minor's future—a decision that cannot, moreover, be delayed until the minor reaches maturity."[199] Certainly, a highly damaging disease like measles could have profound impacts on any minor's future,[200] and increasingly frequent outbreaks among young people underscore the urgency of receiving MMR vaccines as soon as possible. Therefore, minor consent to vaccines falls within this autonomy framework.

There are also important differences between vaccination, which affects an entire community, and abortion, which does not have as widespread an effect. Reproductive rights concern a choice that goes both ways—the Court in *Roe* framed the right to abortion as a right to choose "whether or not" to terminate that pregnancy.[201] Similarly, an argument could be made that a minor

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[197] *See* B. Jessie Hill, *Constituting Children's Bodily Integrity*, 64 DUKE L.J. 1295, 1305 (2015).

[198] Jennifer Rosato, *What Are the Implications of* Roper*'s Dilemma for Adolescent Health Law?*, 20 J.L. & POL'Y 167, 186 (2011); *see also* Danielle M. Costello, Comment, *The Right to Make Informed Reproductive-Health-Care Decisions Regardless of Age: Maintaining the Focus on the "I" In "I Want to Be One Less"*, 2008 WIS. L. REV. 987, 1004 (2008).

[199] Hill, *supra* note 197, at 1314.

[200] Serious complications of measles can include blindness, extreme dehydration, pneumonia, ear infections, and encephalitis (swelling of the brain). Rajiv Bahl, *What Parents Should Know About the Long-Term Effects of the Measles Virus*, HEALTHLINE (Dec. 11, 2018), https://perma.cc/AGU4-J4UE.

[201] *Roe*, 410 U.S. at 153.

should have a right to choose whether or not to receive a vaccine. However, a pregnancy only affects the health of the pregnant person and the growing fetus. The choice not to vaccinate, as explained above, can harm the whole community. Thus, a minor's vaccination right can be asymmetrical in a way that reproductive rights are not—it can be a right to consent to vaccines but not a right to avoid them.

Additionally, a vaccine, which typically only requires an injection, presents a much more limited intrusion on bodily autonomy than does state interference with reproductive choices.[202] An asymmetrical right to vaccines—a right to opt into a vaccination program but not to opt out of it—does not infringe on bodily integrity in the same way that an asymmetrical reproductive right would. Because vaccines "are low risk/high benefit health care interventions" that "promote the welfare of the vaccinated minor and the public's health, both parent and competent child should possess the legal right to consent, even over the objection of the other."[203] When the parent and the state agree on a positive, minimally intrusive public health measure, the child does not have the right to override them.

The reproductive rights cases, particularly *Bellotti*, also offer well-founded concerns about allowing minors to make potentially life-changing decisions about their own bodies.[204] Due to their unique vulnerability, minors may be susceptible to coercion by peers or authority figures who wish for them to consent to vaccines. Additionally, some minors may not possess the maturity necessary to discern whether they truly want to make such an important decision without parental guidance. As explained in the remainder of this Comment, a statutory framework based on the MCA can address these concerns while still allowing minors to exercise their right to consent to vaccines.

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[202] *See Adams & Boyle, P.C. v. Slatery*, 956 F.3d 913, 926 (6th Cir. 2020) ("[A]sking a person to get a vaccination, on penalty of a small fine, is a far cry from forcing a woman to carry an unwanted fetus against her will for weeks, much less all the way to term."), *vacated on other grounds,* 141 S. Ct. 1262 (2021).

[203] Weithorn & Reiss, *supra* note 167, at 853.

[204] *See Bellotti*, 443 U.S. at 634; *see also* Hodgson v. Minnesota, 497 U.S. 417, 444 (1990) ("The State has a strong and legitimate interest in the welfare of its young citizens, whose immaturity, inexperience, and lack of judgment may sometimes impair their ability to exercise their rights wisely.").

C. A Minor's Qualified Autonomy Right to Consent to Vaccines

The current case law offers little direct guidance on the increasingly urgent issue of minor consent to vaccines. Using ideas and principles from the parental rights cases, the reproductive rights cases, and the mature minor doctrine, this Section asserts that minors hold a qualified autonomy right to consent to vaccines—qualified, because a child does not have a right to *refuse* vaccines against the wishes of parent and state. Part III.C.1 situates this qualified autonomy right within the principles of the parental rights cases. Part III.C.2 then describes how local statutory solutions like D.C.'s MCA can vindicate this right while addressing the concerns that courts have expressed in granting consent rights to minors in other contexts.

1. The qualified autonomy right comports with the principles of the parental rights cases.

The Supreme Court has recognized that parental rights are strong but not unlimited. Children's autonomy interests (what they say they want) and well-being interests (what the state has concluded they need) play important roles in the limitation of parental rights. In *Prince* and *Yoder*, the Court found that certain well-being interests can override parental rights. This holds true across sectors; for example, "compulsory schooling and child labor laws exhibit paramount intrusion upon parental discretion yet are followed by parents and society at large."[205] Justice Douglas's influential *Yoder* dissent suggested that a child's autonomy interests can override parental rights when they align with her well-being interests. Minor consent to vaccination falls squarely within this carveout.

When a state mandates that a child be vaccinated, the state is asserting a well-being interest on the child's behalf. Receiving a vaccine undoubtedly advances a well-being interest. It lowers the child's risk of contracting diseases that could hinder the child's ability to progress into adulthood, and it allows the child to participate fully in civic activities (like going to school) without exposing the community to widespread risk. *Prince* and *Yoder* contemplated the idea that this well-being interest alone could override a parent's free exercise right to refuse vaccination, thus

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[205] Berry, *supra* note 13, at 514. *But see generally* Milton Gaither, *Why Homeschooling Happened*, 86 EDUC. HORIZONS 226 (2008) (describing the rise of homeschooling movements in the United States).

rendering nonmedical exemptions unacceptable. More recent scholarship has generally found that nonmedical exemptions pass constitutional muster.[206] Nevertheless, commentators also agree that nonmedical exemptions are not constitutionally *required*, meaning that parental rights do not per se overpower a child's well-being interest in receiving vaccines.[207]

When a minor wishes to consent to vaccines, her autonomy interest aligns with an already-powerful well-being interest. As Justice Douglas noted, a child's views are most compelling when they align with the state and when the subject matter relates directly to the child's life. An autonomy interest in receiving vaccines aligns with the state's public heath goals, and vaccines have a direct impact on a child's body and health. Therefore, if a child can demonstrate suitable maturity, that child's desire to receive vaccines constitutes an interest strong enough to override a parent's right to refuse them on her behalf. As discussed above, the Court's more recent reproductive rights framework provides a useful corollary to analyze a minor's autonomy right to consent to vaccines. However, this right is qualified, meaning that it does not extend to a minor's decision to refuse vaccines against the wishes of her parents and the state. As in the mature minor context, it is the alignment of the child's wishes with the state's assessment of the child's interests that justifies deferring to the child's choice to receive a vaccine.

When a child wants to *refuse* a vaccine, her autonomy interest conflicts with her well-being interest. The choice to forgo vaccination, as the Court recognized in *Prince*, can harm the child herself and spread disease through the community, contravening both the state's interest in the child's personal well-being and its more general interest in the well-being of all its citizens. The Court suggested in both *Prince* and *Yoder* that even strong individual rights do not justify harm to the community. Furthermore, the *Prince* Court wrote that when the state seeks to protect the child and community, its "authority over children's activities is

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[206] *See, e.g.*, Ross D. Silverman, *No More Kidding Around: Restructuring Non-medical Childhood Immunization Exemptions to Ensure Public Health Protection*, 12 ANNALS HEALTH L. 277, 281–82 (2003); Megan Joy Rials, Comment, *By the Pricking of My Thumbs, State Restriction This Way Comes: Immunizing Vaccination Laws from Constitutional Review*, 77 LA. L. REV. 209, 228–32 (2016).

[207] *See, e.g.*, Reiss & Weithorn, *supra* note 14, at 927–29; Rials, *supra* note 206, at 232–34; Silverman, *supra* note 206, at 281. *See generally* Chemerinsky & Goodwin, *supra* note 15.

broader than over like actions of adults."[208] If the state can use its authority to prohibit an adult from inflicting harm on others, then it expresses even greater such authority over a child. A child's autonomy interest in consenting to vaccines gains the status of a right capable of overriding even powerful religious rights because it aligns with her well-being interests and the health of the community. At the same time, a child's autonomy interest in refusing vaccines loses legal force because it contravenes her well-being interests and the health of the community. Therefore, this right is asymmetrical: a right to opt in but not to opt out.

2. Local solutions can vindicate the qualified autonomy right while addressing the concerns from *Bellotti* and the mature minor doctrine.

The structure of D.C.'s MCA includes a bypass procedure that addresses several of the *Bellotti* Court's concerns. To address children's vulnerability and limited decision-making capacity, the MCA includes two safeguards ensuring that a minor seeking immunization can demonstrate suitable maturity. First, it includes a lower age limit of eleven years old.[209] Second, it requires that the minor meet an informed-consent standard showing comprehension of the necessity and risks of medical care.[210] In this bypass procedure, a physician, rather than a judge, makes the informed-consent determination.[211] This means that a minor can secure a professional maturity assessment without the inconvenience of going to court.

The MCA also comports with the logic of the mature minor doctrine. Vaccines are both important and beneficial. Health authorities have determined that vaccines provide strong health benefits to children in almost every case.[212] Increasing outbreaks

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[208] *Prince*, 321 U.S. at 168.

[209] D.C. Mun. Regs. tit. 22-B, § 600.9(a) (2021).

[210] D.C. Mun. Regs. tit. 22-B, § 600.9(a)–(b) (2021).

[211] *See* Truong, *supra* note 29.

[212] *See, e.g.*, *Why Childhood Immunizations Are Important*, STAN. CHILD.'S HEALTH (2021), https://perma.cc/TQX6-CZAT ("Vaccinations not only protect your child from deadly diseases, such as polio, tetanus, and diphtheria, but they also keep other children safe by eliminating or greatly decreasing dangerous diseases that used to spread from child to child."); *Vaccines for Your Children, Common Questions About Vaccines, What Are the Risks and Benefits of Vaccines?*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 14, 2019), https://www.cdc.gov/vaccines/parents/FAQs.html; *see also* Kathleen A. Gould, *Vaccine Safety: Evidence-Based Research Must Prevail*, 36 DIMENSIONS OF CRITICAL CARE NURSING 145, 147 (2017) ("Experts agree that the benefit of vaccines is not a matter of opinion but a matter of scientific fact.").

of communicable diseases arguably constitute an emergency that gives minors increased ability to consent. Additionally, the law is not compulsory—it simply gives minors the option of confidentially receiving vaccines. These factors all support the legality of the MCA and the framework it establishes to recognize the minor consent right.

The MCA falters in its treatment of the third *Bellotti* limitation: deference to parental control. On one hand, because the MCA does not repeal the state's religious exemption, parents can still exercise their religious rights by sending their children to school unvaccinated. Moreover, the statute does not simply empower the state at the expense of parents—instead, it furnishes minors with the opportunity to exercise their qualified autonomy right by making the choice themselves. On the other hand, parents could still argue that their religious rights are substantially burdened by their children's ability to override them at any time. This makes the law vulnerable to a RFRA challenge and, further, to the argument that it overextends children's rights by usurping parental control. In response to this dilemma, Part IV discusses a potential solution that builds on the MCA to protect both the minor's right to consent and the parent's religious rights while honoring the parent-child relationship.

IV. A POTENTIAL SOLUTION FOR MATURE MINORS AND CONCERNED PARENTS

This Part puts forward a statutory solution that would furnish competent minors with an opportunity to exercise their right to consent to vaccines. D.C.'s Minor Consent Act remains vulnerable to challenges from parental rights advocates, who may claim that their religious objections to vaccinations should afford them greater control over their children's immunizations. Moreover, the parent-child relationship is an especially important one that deserves recognition in any state action that implicates both the rights of minors and parents.[213] A stronger version of the MCA can

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[213] *See* Pamela Laufer-Ukeles, *The Relational Rights of Children*, 48 CONN. L. REV. 741, 769–72 (2016) (arguing for a conception of children's rights as "relational" rather than "individualistic"). While this Comment conceptualizes a minor's right to consent to vaccines as an individual autonomy right, this perspective also embraces Professor Laufer-Ukeles's idea that "any conception of individualized rights of children that does not also consider the interests of parents and society in providing care for children does not appropriately reflect the nature of childhood, parent-child relationships, and children as rights-holders." *Id.* at 769.

incorporate parents into the decision-making process, thereby honoring their religious rights and important relationships with their children while retaining the confidentiality that is so central to the law's public health goals.

First, Part IV.A explains why a statutory solution based on the MCA is preferable to other methods of vindicating a minor's autonomy right to consent to vaccines. Like the MCA, the ideal statutory solution should be noncoercive, and it should account for each minor's individual maturity level. Specifically, minors aged eleven and older should still have the opportunity to consent to vaccines without parental notice or permission, provided they can meet an informed-consent standard, and each minor's decision to seek a vaccine should remain confidential. Then, Part IV.B advocates for the addition of a parental communication provision within the MCA and similar minor consent statutes. To include parents in the decision-making process without sacrificing confidentiality, this provision would require school officials to contact all parents who file nonmedical exemptions and elicit relevant information from them that would be used if their children later sought vaccines under the statute. Finally, Part IV.C discusses how the addition of this provision would strengthen a statute like the MCA against legal challenges based on RFRA or constitutional parental rights.

A. Developing a Statutory Solution Based on the MCA

A statutory solution based on the MCA comes with a number of benefits that make it preferable to other potential solutions. As a general matter, a statutory solution is preferable to a judicial one. Statutes offer permanence and consistency for families who may be affected by the law. They also provide clear expectations for the physicians and health officials subject to the law. Additionally, legislatures have the competency to engage in the necessary research prior to enactment and develop "clear, specific language and criteria" for community stakeholders to follow.[214]

A judicial solution (likely a form of judicial bypass similar to that in *Bellotti*) would also provide some relative benefits. It may be difficult to pass a statutory solution in states with resistant legislators or particularly strong parental-rights lobbyists. Additionally, a judicial solution allows a judge to make a facts-driven,

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[214] Weithorn & Reiss, *supra* note 167, at 850–51.

case-by-case inquiry based on input from the children, their parents, and the state. Still, the costs of requiring litigation to achieve a solution are substantial and outweigh the benefits that come from this approach.[215] According to Professor Rachel Rebouché, "In only a few places can the judicial bypass system be described as a functional process in which most minors, from any part of a state, can seek a bypass without significant delay, cost, or embarrassment."[216] Litigation would require a significant expenditure of time and resources. A young person would need to navigate an unfamiliar legal system. Moreover, the adversarial process could strain or even sever the important relationship between parent and child while increasing the distrust between vaccine-resistant parents and the state.[217]

A statutory solution avoids many of these pitfalls. Children would not need to go to court to receive vaccines; they could simply speak to a qualified doctor or school official. Parents could be involved in the process without being pitted against their children as opposing litigants. Therefore, this Comment puts forward a single statutory solution.

Specifically, the MCA itself provides the ideal baseline for an effective statutory solution. In its current form, the MCA allows any minor aged eleven or older to consent to receive recommend vaccines, so long as that minor is able to satisfy an informed-consent standard.[218] Neither the official who administers the vaccine nor the insurance provider may notify the minor's parents.[219] This confidentiality provision is central to the functioning of the law, as it ensures that a minor who receives a vaccine against her family's wishes will not fear anger or retaliation from family members. Unlike other minor consent statutes, the MCA both covers a range of vaccines and includes numerous safeguards to address the judiciary's concerns with minor decision-making. Also, while straightforward proposals like eliminating nonmedical exemptions or lowering the age of consent offer compelling public

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[215] *See* Rachel Rebouché, *Parental Involvement Laws and New Governance*, 34 HARV. J.L. & GENDER 175, 189–93 (2011) (describing how a minor seeking a judicial bypass procedure to consent to abortion may face a lack of sufficient information, monetary obstacles, and high emotional costs); Alexandra Rex, Note, *Protecting the One Percent: Relevant Women, Undue Burdens, and Unworkable Judicial Bypasses*, 114 COLUM. L. REV. 85, 118–22 (2014).

[216] Rebouché, *supra* note 215, at 177.

[217] *See Parham*, 442 U.S. at 610.

[218] D.C. Mun. Regs. tit. 22-B, § 600.9(a)–(b) (2021).

[219] D.C. Mun. Regs. tit. 22-B, § 600.9(d)(1) (2021); D.C. CODE ANN. § 38-602(a)(2) (2021).

health justifications,[220] such solutions do little to account for the views of parents, which may make these laws vulnerable to a RFRA or free exercise challenge.

Professors Lois Weithorn and Dorit Rubinstein Reiss, who have written extensively on childhood vaccination, explain that the preferable solution would be "the least coercive approach that is feasible and effective [and] helps strike the best balance among the public's health, the well-being of the children who would receive vaccinations, and the interests of parents to make decisions about their children's healthcare."[221] The MCA, which does not compel parents to vaccinate their children, meets almost all of these qualifications but largely does not account for the interests of parents. To address this issue, Part IV.B recommends a stronger solution.

B. Improving the Minor Consent Act to Better Include Parents

Though the MCA provides a useful baseline, it is not the full solution. The MCA does preserve parental religious rights by keeping the nonmedical exemption in D.C.'s school-immunization statute, but it cuts parents entirely out of the minor consent process by allowing minors to override the exemption without any parental input. This lack of parent involvement creates two concerns. First, it opens the door to legal challenges that could have far-reaching implications. If a judge were to rule against a statute like the MCA, lawmakers in other jurisdictions may feel reluctant to pursue similar paths. A second concern involves the relationships between parents, their children, and school districts. The relationship between parents and children is an important one that is worthy of consideration and respect.[222] Moreover, framing parents as adversaries of the state could deepen the growing distrust of authority that has fueled the antivaccine movement over the past decade. Opponents of minor consent laws have already leveled a similar criticism. For example, a California legislator opined that the state's proposed Teens Choose Vaccines Act is simply an attempt to "remove parents from the equation" when "parents are vital to these decisions."[223]

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220 *See* Weithorn & Reiss, *supra* note 167, at 831–32.

221 Reiss & Weithorn, *supra* note 14, at 956 (emphasis removed).

222 *See* Laufer-Ukeles, *supra* note 213, at 769.

223 Don Thompson, *Preteens Can Get Vaxxed Without Parent Under California Bill*, AP NEWS (Jan. 21, 2022), https://apnews.com/article/coronavirus-pandemic-business-health-scott-wiener-san-francisco-1878f7be2355e82c1885754fc53514c0.

Instead of cutting parents out of the process, an ideal solution should instead seek to promote dialogue with parents and leverage their unique knowledge of their children. Each child's case should be assessed by those with the relevant expertise in understanding their level of maturity and ability to consent—including parents. Parents have years of experience with their children that physicians and school officials do not. While parents often do not share the public health expertise of physicians and health officials—a fact that justifies approaching their views on vaccination with reasonable skepticism—they do have a wealth of information about their children's maturity levels, how their children react to different situations, and why their children may or may not wish to be vaccinated. In many ways, they are the most qualified fact finders for their children and cutting parents out of the vaccination-decision process removes a set of experts from the calculation.

Herein lies a difficulty. Confidentiality is a cornerstone of the MCA. If students must disclose to their parents that they intend to be vaccinated, they will likely refuse to seek vaccination out of fear of punishment or disapproval.[224] This could entirely undermine the public health goals of the law. To avoid this outcome, school officials should engage parents ex ante. Minor consent statutes should include a requirement that, within a set time period after a parent files a nonmedical exemption to school immunization, a physician or health official from the school must reach out to the parent to let them know about the existence of the statute and elicit relevant information. This would be a routine component of filing a nonmedical exemption—every parent who filed such an exemption would receive a call. To account for each parent's changing beliefs and each minor's evolving viewpoints, officials should plan to make such calls once a year.

First, the official should give the parent an opportunity to explain their objection to vaccination, particularly if those concerns are religious in nature. Then, the official should ask for insights about the child's maturity level or tendency to succumb to peer pressure. The official may ask if the child has a tendency to act rashly or make reckless decisions. Jurisdictions could provide a set of specified questions for officials to ask, but any policy should also make space for parents to speak freely and ask questions of their own. This would ensure that the parent feels heard

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[224] *See* Weithorn & Reiss, *supra* note 167, at 849.

and understood. Above all, officials should make clear to parents that they are calling because they value their concerns—religious or otherwise—and consider parents to be important stakeholders in this process. In a focus group convened by the National Vaccine Advisory Committee's Vaccine Confidence Working Group to discuss parental confidence in childhood vaccines, parents expressed that they "want[ed] to be viewed and treated as individuals by health-care providers."[225] According to one mother, "First and foremost, knowing my physician is listening to my concerns (is important) whether or not [my physician] already knows [he or she is] right—to see me and my child as unique human beings with unique concerns."[226] Though it would provide greater effort from both parents and school officials than most nonmedical exemptions currently require, this sort of respectful communication could build much-needed trust between parents and health authorities.

The information from this conversation should go in the child's file and be sent to the child's primary care physician, if applicable. Then, any qualified official with access to that information and the ability to assess the child's capacity for consent could administer vaccines to the child if the child wants them. If the child seeks vaccination at a location other than her school or pediatrician's office (such as a drugstore), the official at that location may not administer the vaccine without contacting the school and receiving the file. This could be set up through an online appointment portal, similar to how people currently upload insurance information for vaccine appointments: the child would enter the name and phone number of her school, and the official would contact the school to receive the relevant information. This caveat does reduce flexibility for the child; while the child could still seek a vaccine from her school or pediatrician at any time, she would need to set an appointment before seeking a vaccine from another location. However, the caveat is necessary to ensure that the provision is evenly applied.

If the child decides to seek vaccination, the overseeing health official must account for her parent's insights when deciding whether the child meets the informed-consent standard. The official must also communicate any religious beliefs to the child that the parent wished to share. After reminding the child that the

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[225] Nat'l Vaccine Advisory Comm., *supra* note 13, at 584.

[226] *Id.* (alterations in original).

vaccination will remain confidential, the official should also relay the parent's concerns or religious beliefs about vaccination, making it clear that these are the views of the parent and not of the official. Once the child has heard the parental input and the official has determined that the child has the capacity to consent, the official may ask the child one more time if she still wishes to consent. This gives parents the opportunity to voice their concerns (through the official) at the time of vaccination.

This proposal may limit the scope of minor consent laws, as only minors whose parents had been contacted by local school officials would be able to access vaccines on their own. At present, neither the MCA nor Philadelphia's law requires minors to prove D.C. or Philadelphia residency to access these statutory protections—and both cities have seen minors travel from other jurisdictions to seek vaccines.[227]

There are two ways to resolve this issue, and both depend on buy-in from surrounding jurisdictions. The first is for most or all jurisdictions to enact their own minor consent laws so that minors would not have to travel to receive their vaccines. Alternatively, surrounding jurisdictions that do not wish to enact their own minor consent laws could instead enact only the parental communication provision. School officials would still call a parent who filed a nonmedical exemption, and they would still add that information to the child's files—it just wouldn't become relevant unless the child traveled to another jurisdiction for a vaccine. Officials would need to tell parents that this information may be released to medical authorities outside the jurisdiction if the child seeks a vaccine somewhere else. That way, the location administering the vaccine would still have access to relevant information from the parent. This could require a sizeable amount of administrative work from surrounding jurisdictions, but those governments could provide officials with materials to streamline and standardize the process. Additionally, it would increase communication between health officials and vaccine-resistant parents, helping to build toward mutual respect and trust.

Adding these parental communication provisions to the MCA or another minor consent statute would include parents as stakeholders in the process while preserving necessary confidentiality.

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[227] *See* Complaint at 3, Mazer v. D.C. Dep't of Health, 2021 WL 2798324 (D.D.C. July 2, 2021) (No. 1:21-cv-01782) (describing a teenager who traveled from Maryland to D.C. to receive a vaccine); Feldman, *supra* note 23 (describing a teenager who traveled from a suburban Pennsylvania town to Philadelphia to receive a COVID-19 vaccine).

The statute would both protect a minor's right to consent to vaccination and honor the unique relationship between parents and their children. So long as school officials approach parents with understanding and respect, this statute could also work to build a stronger relationship between parents and schools. It would include several safeguards to ensure that parents are involved to the greatest possible extent and provide space and flexibility for lawmakers to customize the law as needed.

C. Surviving Legal Challenges

The proposed solution not only comports with policy arguments in favor of parental involvement. It also strengthens minor consent statutes against potential legal challenges based on RFRA and constitutional parental rights.

1. This proposed solution could overcome a RFRA challenge from antivaccine parents.

This revised MCA would be much more likely to survive a RFRA challenge. Parents might still argue that providing a way for children to undercut their religious exemption imposes a substantial burden on their religious practice, but the revised law includes several safeguards to meet the least restrictive means standard.

The revised law would create space for parent involvement at every step of the decision-making process—from filing the exemption, to sharing their views with an official, to having their beliefs relayed to the child before vaccination. The only less restrictive alternative, notifying parents when a child seeks vaccination, would undercut the law's central confidentiality provision and severely inhibit the law's compelling interest in protecting the child's health.[228] In this way, the revised MCA would fortify a unique, innovative law against difficult legal challenges, providing a model for local governments to protect children within their jurisdictions.

While state RFRA statutes largely mirror the federal statute, they are not uniform. But this does not mean that a minor consent

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[228] *Cf.* Kaemmerling v. Lappin, 553 F.3d 669, 679 (D.C. Cir. 2008) (finding that the government's extraction and storage of the plaintiff's DNA information satisfied the least restrictive means test because "no alternative forms of regulation would [accomplish the compelling interest] without infringing [religious exercise] rights" (alterations in original) (quoting Sherbert v. Verner, 374 U.S. 398, 407 (1963))).

statute would necessarily be more vulnerable to RFRAs at the state level. For example, state RFRAs require different thresholds for plaintiffs. Though many require that a plaintiff demonstrate a substantial burden to her religious practice, some find that any burden is sufficient.[229] Jurisdictions with stricter RFRAs may further modify this statutory solution to meet local needs; this proposal does not require an exact statutory language to be effective. Some other state RFRAs contain coverage exclusions that disallow RFRA challenges for certain issues.[230] These laws may be helpful to drafters of a minor consent statute. For example, Pennsylvania's Religious Freedom Protection Act[231] does not apply to any provisions of the state's Human Services Code, which concerns child welfare and juvenile justice.[232] Even if a state's RFRA is more deferential to healthcare laws, lawmakers creating a minor consent statute should still provide opportunities for parent involvement. As explained above, policy arguments—including the important role of parents as fact finders for their children's welfare—favor parent involvement.

Should the Supreme Court overturn *Smith*, which held that neutral, generally applicable laws may be applied in a manner that burdens religious practice without violating constitutional free exercise rights,[233] RFRA-like protections could be constitutionalized once more. This means that it is especially important for a minor consent law to be able to survive a RFRA challenge. The D.C. District Court has already indicated that the present version of the MCA may not be able to survive a free exercise claim unless *Smith* applies. In March 2022, the court entered a preliminary injunction against the MCA based partly on a finding that the law in its current form would not be likely to survive a free exercise challenge.[234] The court found that the MCA targeted religious parents and was therefore not "facially neutral" under *Smith*.[235] After finding that *Smith* did not apply to the MCA, the

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229 *See* Christopher C. Lund, *Religious Liberty After* Gonzales*: A Look at State RFRAs*, 55 S.D. L. REV. 466, 477–78 (2010) (explaining that eleven states require a plaintiff to demonstrate a "substantial burden," two states require a "burden," and three states require only that the plaintiff show a "restriction[ ] on religious liberty").

230 *Id.* at 491.

231 2002 Pa. Laws 1701, No. 214 (codified at 71 PA. STAT. ANN. § 2401–2407).

232 *See* 71 PA. STAT. ANN. § 2406(b)(4) (2002).

233 *See Smith*, 494 U.S. at 884–85.

234 Booth v. Bowser, No. 21-cv-01857, at 30–36 (D.D.C. Mar. 18, 2022) (order granting preliminary injunction).

235 *Id.* at 33 n.17.

court then applied a RFRA-like strict scrutiny test to the law and found that it was not "narrowly tailored" enough to justify burdening parents' religious practice.[236] The revised statutory solution outlined in this Comment would achieve this narrow tailoring by lessening the law's burden on parents' religious exercise.

2. This proposed solution could survive a constitutional parental-rights challenge.

A minor consent statute may face not only a RFRA challenge but also a constitutional parental rights challenge. Such challenges may carry ever-increasing legal force, as the Supreme Court has expressed interest in lending renewed strength to free exercise rights.[237] As discussed in Part III, a minor's right to consent to vaccination should overcome even a strong presumption of protection for parental rights.

A minor's qualified autonomy right to consent to vaccines marries two strong interests. The right is only triggered when a minor asserts her autonomy interest in receiving vaccines. The right also relates to her well-being interest, since her decision will protect herself and her entire community. When the minor and the state agree on the minor's exercise of a right, that right takes on particular strength. By the same token, a parent's right to refuse vaccination is limited because it goes against the child's well-being interest and creates an active risk of harm for both child and community. Therefore, this especially strong minor consent right faces an especially weak parental refusal right.

Furthermore, the physician-bypass procedure vindicates the minor consent right without eliminating parental rights. The physician-bypass procedure is far from a free-for-all; it is a carefully crafted solution that accounts for the importance of the parental role. By including safeguards to ensure parent participation, this solution still allows parents to exercise their rights, albeit in a more limited way. Conversely, existing nonmedical exemptions make almost no provision for minors' autonomy rights. To be fully realized, the minor consent right must supersede the parental right, as the alternative is for minors not to have this right at all.

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[236] *Id.* at 36.

[237] *See* Kennedy v. Bremerton Sch. Dist., 142 S.Ct. 2407, 2432–33 (2022). For a discussion of the Court's recent concern with local vaccine mandates' infringement on religious rights, see Part I.A.

CONCLUSION

In 2021, sixteen-year-old Nicolas Montero traveled to Philadelphia by himself to receive his COVID-19 vaccine.[238] Though his parents were opposed to the COVID-19 vaccine, he felt that remaining unvaccinated would leave him "unprotected and vulnerable."[239] He wrote in his school newspaper, "I must be able to make this decision myself."[240] This Comment has argued that Montero and other adolescents have the right to protect themselves and their communities by consenting to vaccines.

The debates around childhood vaccination have occurred against a complicated legal backdrop. Courts have generally upheld local vaccine mandates, but widespread nonmedical exemptions allow parents to easily avoid vaccinating their children. Courts have developed strong protections for parental rights, but they have also honored children's decisions, particularly in the medical context.

Jurisdictions have developed different solutions to keep communities safe. Some, like California, have opted to remove nonmedical exemptions to school immunizations. Others, like D.C., have attempted to account for religious parental rights by preserving nonmedical exemptions but giving some minors the option to override them. Even though these solutions align with public health guidance, they have deepened mistrust between local parents and scientific authorities, and they remain vulnerable to legal challenges from antivaccine parents.

A minor's qualified autonomy right to consent to vaccines derives from the logic of the Supreme Court's parental-rights cases, federal reproductive-rights cases, and the mature minor doctrine. Though this right to consent can override parental religious rights, this does not mean parents should be cut out of the process entirely. To protect a minor's right to consent while also honoring parental rights, this Comment has forwarded a modified version of D.C.'s Minor Consent to Vaccinations Amendment Act of 2020. Under this revised law, school officials would engage parents ex ante to solicit their viewpoints on both vaccination and their children's needs.

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238 Nicolas Montero, *The PA Legislature Must Pass HB1818*, THE PLAYWICKIAN (Nov. 4, 2021), https://perma.cc/J4RR-WGMD; *see also* Feldman, *supra* note 23.

239 Montero, *supra* note 238.

240 *Id.*

This solution would preserve the parent-child relationship, honor parental rights, and build trust between parents and state officials. Most importantly, it would empower minors to protect themselves and their communities. As Montero put it, "we must work as a team, we must work as communities that value each other's existence, and for this reason, we must all get vaccinated."[241] It is his right to make that choice.

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[241] *Id.*