CHAPTER 2

Medical Consents

Giving medical consent is agreeing to and understanding the risks and benefits of the medical or health services to be provided. Such consent is generally required to release medical and mental health records, provide treatment, and prescribe medication or tests, such as psychiatric medications and testing for HIV. For some medical or health decisions, persons under 18 years of age are unable to provide consent for their own treatment. As a result, the law generally requires that consent from the parent or guardian be obtained and documented for key medical activities and conditions. Additionally, because of their placement in out-of-home care, children in foster care need special oversight and consideration regarding medical consent.

This chapter covers the issues of consent as related to medical and mental health records, information, and treatment for children in foster care.

Sections in this chapter include:

Medical Consent

The term "medical consent" in this chapter refers to several kinds of consent:

1. Consent for release of prior health records.
2. Consent/authorization for routine evaluation and treatment.
3. Informed consent for non-routine health care.

1. Consent to Obtain Health Records

Consent from the parent is required to obtain health records for a child who enters foster care.[1] Actions to obtain the child's health records include:

- Diligent efforts to obtain records of any previous medical, mental health, or dental treatment.
- Asking the parent or guardian for written consent to release the child's past health records no later than 10 days after placement (emergency or Article 3, 7, 10 or 10-C court-ordered) or before accepting a child into care (voluntary placement).
- When consent cannot be obtained from the parent/guardian, obtaining the LDSS commissioner's consent to release the records or a court order if appropriate.
- Sending written requests with the appropriate consent to known medical providers who have treated the child for the child's treatment history and records.
- For any preschool child, making diligent efforts to obtain the child's birth record from the hospital where the child was born or from another hospital in possession of the record.

Consent for Family Health History

In addition to the child's health history, efforts should be made to learn the health status of birth family members, as this information will be helpful for the child. It is preferable to obtain documentation from the family member's medical provider to verify any condition reported. The person to whom the record pertains must give written consent for the medical provider to release records to you.

There is no prescribed time frame for requesting consent to obtain the family's health records, nor are family members compelled to consent to the release of their records, though the assistance of the court may be requested in serious circumstances. If you have received health information that you believe is credible and important for the child's medical provider to know, this information may be provided with the caveat that you are not able to verify it (see Chapter 5 for more information on health history).

2. Consent/Authorization for Routine Evaluation and Treatment

Consent is required for routine evaluation and treatment of a child in foster care. Prior to accepting a child into care or within 10 days after a child enters care, written consent must be requested from the child's parent or guardian for routine medical and/or psychological assessments, immunizations, and medical treatment, and for emergency medical or surgical care in the event that the parent or guardian cannot be located at the time such care becomes necessary. Authorization from the child's parent/guardian must be included in the child's health record. If written consent cannot be obtained from the child's parent or guardian in cases of involuntary placements (Article 10 and 10-C court-ordered and Article 10 emergency placements), the LDSS commissioner may provide written consent where authorized in accordance with section 383-b of the Social Services Law.[2]

[1] 18 NYCRR 441.22(e); 90 ADM-21, *Foster Care: Medical Services for Children in Foster Care.*
[2] *18 NYCRR 441.22(d), FCA §355.4(2).*

➔ Remember to give a copy of the signed consent form for routine evaluation and treatment to the child's primary care provider and any other providers treating the child. It is recommended that staff document any specific discussions about medical consent in the child's health record.

When Consent Form Is Not Available

Medical Emergency

➔ In a medical emergency, children in foster care should receive treatment even if a signed consent form is not available.[3]

Absence of written consent should not delay emergency or urgent health care

Legal Authority

The chart below outlines the required actions that should be taken depending on the legal authority under which the child is placed in foster care and when parental consent is not obtained.

Consent for Routine Medical Services for Children in Foster Care[4]

Placement Authority	LDSS/VA Actions	Parental Consent Not Obtained
Article 10 (Child Protective)	Request authorization in writing from the child's parent/guardian within 10 days of entry into foster care.	If a child has been removed or court-ordered into LDSS custody pursuant to Article 10, the LDSS commissioner or designee may provide consent.
Article 10-c (Destitute Children)	Request authorization in writing from the child's parent/guardian within 10 days of entry into foster care.	If child is in the temporary care of the LDSS commissioner and has been found to be a destitute child pursuant to Article 10-C, commissioner or designee may provide consent.
Article 7 (Persons in Need of Supervision)	Request authorization in writing from the child's parent/guardian within 10 days of entry into foster care.	Seek a court order.
Article 3 (Juvenile Delinquents)	Request authorization in writing from the child's parent/guardian within 10 days of entry into foster care.	If the child is in the custody of the OCFS or LDSS commissioner, the court's placement order constitutes consent for routine medical, dental, and mental health services and treatment.
Voluntary Placement	Include written consent to medical services in the voluntary placement agreement signed by the parent/guardian and LDSS, prior to accepting the child into foster care.	The LDSS/VA has no authority to consent to medical services. Seek a court order or initiate Article 10 action, where appropriate.
Surrender (Both parents)	LDSS commissioner or VA to which the child was surrendered provides written authorization for medical services.	Consents signed by the parent/guardian are no longer required or valid.
Termination of Parental Rights (Both parents)	LDSS commissioner provides written authorization for medical services.	Consents signed by the parent/guardian are no longer required or valid.

[3] *PHL §2504.4.*
[4] *18 NYCRR 441.22(d), SSL §§383 and 384-b, FCA §355.4.*

When a parent/guardian refuses to provide needed consent for treatment of a child, this may lead to an evaluation of whether the case should be referred to child protective services (CPS) as a possible medical neglect case. This may be considered even when the situation is not life-threatening but there is risk of serious harm if the child is not treated. Consult with an appropriate medical practitioner about the implications of the child not receiving medical care.

Note: LDSS commissioners may delegate specific staff on an administrative level within the agency or in a contract agency to provide written consent on behalf of the commissioner in appropriate cases. Make sure that you know who has this authority. Be familiar with the policies of your LDSS/VA regarding medical consent for each child under your care.

Consent and Foster Parents

➔ **Foster parents, including kinship foster parents, are not authorized to give consent.** Instruct foster parents to contact the agency for consent if the consent form is not available (e.g., if a prescription for psychiatric medication changes or surgery is being planned). Agencies should establish protocols for giving health care providers a copy of the original signed consent form for their files. The only exception is when foster parents serve as surrogate parents for children in the New York State Early Intervention Program, described in section 4 of this chapter. Then the foster parent can consent to early intervention services.

Communicate to foster parents the following information:

1. As a foster parent, you cannot provide consent for medical or mental health treatment for a foster child in your care. Keep a copy of the signed consent forms provided by the agency with you.
2. If a signed consent form is not in the health care provider's file and the child needs routine treatment, the provider should contact the agency for consent.
3. In an emergency, the health care provider or emergency room staff may treat the child even if consent is missing, but they should seek consent from the agency as soon as possible. Always have the agency phone number with you.

Consent and Relatives/Fictive Kin

There are different circumstances under which children involved with Family Court may come to reside with relatives or another person not related to the child but have a strong or significant relationship with the child or the child's family (often referred as fictive kin). In these cases, it is recommended that agency staff explain consent and custody/guardianship to the child's health care provider(s).

Relatives may be approved as kinship foster parents for a specific child. For the purpose of approval of a kinship foster home, a relative includes an adult who is related to the parent(s) or stepparent(s) of a child through blood, marriage, or adoption to any degree of kinship, or an adult with a positive relationship to the child or the child's family, including, but not limited to, a child's godparent, neighbor, family friend, or an unrelated person where such placement allows half siblings to remain together in an approved foster home, and the parents or stepparents of one of the half-siblings is a relative to such person.[5]

- Kinship foster parents may **not** give consent for medical care because they lack legal authority to do so.

When the child is not in foster care, relatives/fictive kin may be able to consent for medical services if:

- the relative/fictive kin has an order of custody for the child and is authorized by court order to do so or is designated in writing as a person in parental relationship to the child by the parent;[6] or
- the relative/fictive kin has been granted legal or permanent guardianship.[7]

[5] *18 NYCRR 443.1(h).*
[6] *GOL §5-1551.*
[7] *FCA §661(b)].*

The relative/fictive kin also has the right to enroll the child in school and enroll the child in their employer-based health insurance plan.[8]

3. Informed Consent for Non-Routine Health Care

If the child requires non-routine health care, such as elective or mental health care not provided as a part of primary care, medical providers generally will seek a higher level of consent, known as informed consent. Informed consent implies that the parent or guardian has had the opportunity to ask the medical provider questions and understands all the risks, benefits, and alternatives of treatment. The LDSS or VA should attempt to get consent from the child's parent/guardian for both routine and non-routine care.

If the child's parent/guardian will not or cannot consent, as with consent for routine medical care, the authority of the LDSS to provide informed consent is dependent upon the legal authority under which the child was placed into foster care. Informed consent is usually required for the following:

- Hospitalization.
- Dispensing of any psychiatric medication.
- Any procedure that requires anesthesia.
- Surgery.
- Invasive diagnostic procedures or treatments.

If Parent/Guardian Does Not Give Consent for Psychiatric Medication[9]

As a general rule, prior to the administration of psychiatric medication to children in placement, informed consent must be requested from the parent or guardian. If the parent or guardian and the treatment team cannot agree on the use of psychiatric medication, the LDSS or VA may wish to seek legal counsel to determine if court intervention is advisable.

Consent may be provided in accordance with the legal placement authority if the parent or guardian is unavailable or does not respond to repeated requests to provide informed consent. The chart below outlines who has authority to provide informed consent when it cannot be obtained by the parent or guardian.

[8] *FCA §657(c).*
[9] *08-OCFS-INF-02, The Use of Psychiatric Medications for Children and Youth in Placement; Authority to Consent to Medical Care.*

Informed Consent for Psychiatric Medication for Children in Foster Care	
Placement Authority	**Informed Consent When Parental/Guardian Consent is Unavailable**
Article 10 (Child Protective)	The LDSS commissioner or their designee can provide consent.
Article 7 (Persons in Need of Supervision)	A court order must be obtained to authorize medication.
Article 3 (Juvenile Delinquents)	If psychiatric medications were part of an existing health care plan at the time the youth was admitted to OCFS or LDSS custody, the placement order authorizes OCFS or the LDSS to continue treatment without additional consent. A court order must be obtained to authorize the introduction of new psychiatric medication.
Voluntary Placement	Include consent to such services in the voluntary placement agreement signed by the parent/guardian and LDSS. Otherwise, a court order is required.
Surrender (Both parents)	The LDSS commissioner with guardianship of the child provides consent. Parental consent is not required.
Termination of Parental Rights (Both parents)	The LDSS commissioner with guardianship of the child provides consent. Parental consent is not required.

The LDSS commissioner or designee and the court, if applicable, must also receive information on the medication to provide an informed consent.

4. Minors' Capacity to Consent for Specific Health Services

Minors (persons under the age of 18) may give consent[10] to health care when they have the legal right to consent and if it has been determined that they have the capacity to consent. Capacity to give consent means an individual's ability to understand the nature and consequences of a proposed health care service, treatment, or procedure.[11] These two aspects of consent together are prerequisites to the treatment of minors based on their own decisions. If either of these is missing, the consent of a legally responsible adult will be necessary.

New York Law[12] allows certain minors the legal right to consent to their own health care if the minor is:

- Married.
- The parent of a child.
- Pregnant.
- A homeless youth.
- Receiving services at an approved runaway and homeless youth (RHY) program.[13]
- Incarcerated[14]

[10] *For more information, see: Teenagers Health Care and the Law: A Guide to Minors' Rights in New York State.*
[11] *PHL Article 27-F; 18 NYCRR 360-8.1(a)(8) & 441.22.*
[12] *PHL §2504.*
[13] *EXC §532-a*
[14] *Correction Law § 140.*

Minors with capacity to consent can make choices regarding testing and treatment for the following types of health services:

- Reproductive health services/family planning services.
- Certain outpatient mental health services.
- Inpatient psychiatric services.
- Substance use treatment services in certain situations.
- HIV risk assessment and testing.

Although a minor with capacity to give informed consent may consent for the specific health services, health care providers and agency staff may wish to encourage the youth to talk over the situation with a parent or supportive adult. Even a minor who understands the risks and benefits and can make the decision alone may benefit from support and discussion with a trusted adult.

Reproductive Health Services/Family Planning Services

Minors may give consent to receive reproductive health services and family planning services.[15] This includes gynecological exams, pap tests, contraceptives (including emergency contraceptives), pregnancy testing, pregnancy options counseling, counseling on sexual decision-making, and treatment for vaginal infections.

Minors may consent to their own testing and treatment for sexually transmitted diseases (STDs).[16]

Minors may choose to continue or terminate their own pregnancy.[17] The youth has no obligation to report the pregnancy or the termination to the agency, parent/guardian, or foster parent.

Outpatient Mental Health Services

Mental health services are considered part of routine health care, and consent is provided pursuant to the parent's/guardian's authorization obtained when the child enters care. Parental consent is required, except as noted below.[18]

Minors may consent to outpatient mental health services if the youth knowingly and voluntarily seeks services and the mental health practitioner determines that 1) the minor is knowingly and voluntarily seeking such services, 2) the provision of such services is clinically indicated and necessary for the minor's well-being, and 3) either (a) the parent/guardian has refused consent and a physician determines that treatment is necessary and in the best interests of the minor, (b) the parent/guardian is not reasonably available to consent, or (c) requiring consent or involvement of the parent or guardian would have a detrimental effect on the course of outpatient treatment.[19]

Inpatient Psychiatric Services

A patient who is a minor may be provided treatment over their objection if the patient's parent, legal guardian, or other legally authorized representative has consented to the treatment, and the treatment is not one for which the consent of a minor would be legally sufficient. One exception is when an independent review process is required if the minor is a patient in a state-operated psychiatric center and objects to psychiatric medication.[20]

[15] *18 NYCRR 463.1; 431 U.S. 678: 1977 U.S. Supreme Court decision in Carey vs. Population Services International.*
[16] *PHL Article 23, § 2305(2).*
[17] *PHL Article 25, 2504.*
[18] *MHL 33.21.*
[19] *Ibid.*
[20] *14 NYCRR 527.8(2) (a).*

Regarding the right to object, a patient under the age of 18 in a hospital or secure treatment facility operated by the New York State Office of Mental Health is considered an adult rather than a minor if that person is married, the parent of a child, or has made a voluntary application for admission.[21]

Substance Use Disorder Treatment Services

Substance use disorder (SUD) treatment services are considered part of routine health care, and consent is provided pursuant to the parent/guardian's authorization obtained when the child enters care. Parental consent is required, except as noted below.[22]

Minors may consent to SUD services if in the judgement of a physician: 1) a parent or guardian involvement and consent would have a detrimental effect on the course of treatment of the minor or 2) if a parent or guardian refuses to consent to such treatment and the physician believes that such treatment is deemed necessary for the child's best interests.[23] Minors may also consent where the provider of services is unable to locate the parent or guardian of the minor seeking treatment after employing reasonable measures to do so. This includes SUD services provided on an inpatient, residential, or outpatient treatment basis.

Admission to SUD residential rehabilitation services for youth is voluntary. A patient is free to discharge themself from the service provider at any time.[24]

5. Consent and HIV/AIDS[25]

Considering the extent of the HIV/AIDS epidemic and the lack of a vaccine or cure for the disease, agencies must take preventive measures, including risk assessment, counseling, and testing and arrange for medical care when needed. As noted in Chapter 5, Initial Health Evaluation, all children entering foster care must be assessed for risk of HIV. Who can give consent for HIV risk assessment and testing and how consent is obtained are important issues. The agency must have protocols as to who is the LDSS commissioner's designee in this matter and a consent document that addresses HIV to present to the health care provider. General consent forms do not address consent for an HIV test (See Chapter 3, Confidentiality of Health Information).

It is recommended that designated staff who are informed about HIV, foster care, and developmental stages make the determination as to whether a child has the capacity to consent. Designated staff may include health staff, social work staff, and medical providers.

Children in foster care may consent for HIV testing and family planning procedures if it has been determined that they have the capacity to consent. ➔ **No one other than the child can consent to an HIV test if the child has the capacity to consent.**

HIV Testing

Amendments to the Public Health Law and state Department of Health regulations have removed the requirement of obtaining written or oral informed consent for an HIV test. At a minimum, patients must be orally informed that HIV testing is going to be conducted and have the right to refuse an HIV test.[26]

[21] *14 NYCRR 527.8(a) (5).*
[22] *MHL §22.11.*
[23] *MHL §22.11.*
[24] *14 NYCRR 817.3 (e)(5).*
[25] *18 NYCRR 441.22 (b).*
[26] *PHL §2781.*

The Public Health Law allows for individuals to consent to an HIV test regardless of age. Minors 13 years of age or older, if there is evidence or indication of risk activity, seeking medical care shall be offered an HIV-related test, unless the health care practitioner providing services reasonably believes that: a) the minor is being treated for a life threatening emergency; or b) the minor has previously been offered or has been subject to an HIV-related test, except that a test shall be offered if otherwise indicated; or c) the minor lacks capacity to consent to an HIV-related test. [27]

When an infant or child is in foster care, special rules apply. Consent for an HIV test must be obtained from the child's parent or guardian, if possible, or from the LDSS commissioner with legal custody of the infant or child or from designated representatives where such LDSS commissioner has the legal authority to consent to health care for such infant or child only if the child does not otherwise have the capacity to consent to an HIV test. If the child has capacity to consent, only the child may give effective consent to the HIV test.

Please note as previously addressed, the LDSS commissioner does not have legal authority to consent to medical care for all categories of children in foster care. The LDSS commissioner has a legal right to consent for the following: (1) children who are freed for adoption and in the custody and guardianship of the LDSS commissioner; (2) children found by the Family Court to be abused, neglected or destitute and placed in the care and custody of the LDSS commissioner; or children taken into protective custody or placed into the legal custody of the LDSS commissioner in accordance with SSL 417 or FCA 1022, 1024, 1027, 1094, or 1095; (3) children whose parent has delegated the right to consent to the LDSS commissioner; or (4) children where the authority to consent has been granted by court order. OCFS and the LDSS commissioner may also consent to routine medical care for a youth in foster care who was adjudicated as a juvenile delinquent.[29] In New York City, the Administration for Children's Services has this responsibility. Neither the foster parents nor the VA can legally give consent for an HIV test for a child in foster care.

Blood Donations

Any person aged 17 or over can consent to donate blood in any voluntary and non-compensatory blood program.[30]

6. Consent and Early Intervention Program

The New York State Early Intervention Program (EIP) is part of the national EIP for infants and toddlers with disabilities, as well as their families. To be eligible for services, a child must be under the age of three and have a confirmed disability or established developmental delay as defined by the State in one or more of the following areas of development: cognitive, physical (including vision and hearing), communication, social/emotional, and/or adaptive.

The Federal Child Abuse Prevention and Treatment Act (CAPTA) requires state child protection agencies to establish provisions and procedures for referral of a child under the age of three who is involved in a substantiated case of child abuse and neglect to the EIP for developmental screening through the Child Find Program.[31,32] Parental consent is not required; however having a conversation with the parent to inform them of the referral is beneficial. A parent may object to the referral to the EIP. If a parent objects to a referral, then the objection must be documented, and the caseworker must make reasonable efforts to follow up with the parent within two months. Section 424(13) of the Social Services Law requires that each child protective services staff coordinate, provide, arrange, and monitor rehabilitative services for children and families. Accordingly, LDSSs must inform parents of children under the age of 3 who are subjects in an indicated report of child abuse or maltreatment about EIP and refer them to the county's EIP.[33]

When a child in foster care is referred to the EIP for a suspected disability or developmental delay, the early Intervention official/designee (EIO/D) will work in conjunction with the local commissioner of social services or their designee, regarding the availability and willingness of the child's parent to participate in the EIP. This also provides an opportunity

[27] *PHL §2781-a.*
[28] *SSL §383-b.*
[29] *FCA §355.4.*
[30] *PHL §3123.*
[31] *EIP Memorandum 2005-02. 42 U.S.C. 5106a(b)(2)(B)(xxi).*
[32] *04-OCFS-LCM-04.*
[33] *10 NYCRR 69-4.16.*

to share information and identify any potential barriers to parental consent and participation. Per EIP regulation, the EIO is responsible for the determination of the need for a surrogate parent.[34]

If a parent is unable to participate due to termination of parental rights, voluntarily surrendered rights, or a parent is unavailable and/or chooses not to patriciate, the EIO/D must appoint a surrogate parent for the purposes of the EIP. The surrogate parent per EIP regulation cannot be an employee of the lead agency or any other public agency or provider involved in the provision of early intervention or education, care or other services to the child, provided however that a person who otherwise qualifies to be a surrogate parent is not considered an employee solely because such person is paid by a public agency to serve as a surrogate parent.[35]

The surrogate parent is only able to make decisions for the child related to the EIP and represents the child in all matters related to screening, multidisciplinary evaluation (MDE), individual family service plan (IFSP) creation and implementation, provision of early intervention services, six-month IFSP review and IFSP annual review, and due process procedures. The EIO/D may designate the child's foster parent or an available relative as the child's surrogate parent whenever possible and appropriate. A parent who wishes not to patriciate in the EIP may appoint a surrogate for their child in collaboration with the EIO/D.

Unless parental rights have been terminated or surrendered, the EIO/D and foster care systems should take steps to encourage the parent/guardian involvement in the EIP, including attending the multidisciplinary evaluation (MDE), creating and implementing the individualized family service plan (IFSP), attend the six-month and annual review of the IFSP, be informed of any services the child will receive, and have the opportunity to participate when and where appropriate. *Protocol: Children in Foster Care Who Participate in the Early Intervention Program*[36] issued by the NYS Department of Health is a helpful tool to assist LDSSs in collaborative efforts to implement the new Individuals with Disabilities Education Act (IDEA) and CAPTA requirements.

[34] *10 NYCRR 69-4.16.*
[35] *10 NYCRR 69-4.16.*
[36] *Protocol: Children in Foster Care Who Participate in the Early Intervention Program.*