LEAPClinics
LIVING EVERYDAY AS PURPOSED

Consent To Treat Minor

Patient's Name _____

Patient's Date Of Birth: _____

I, _____, hereby give consent to **Leap Pediatrics, LLC** to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician, as well as any assistant on the staff of **Leap Pediatrics, LLC**.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required.

This consent is given to any and all such diagnoses, treatments and hospital care which a licensed physician at **Leap Pediatrics, LLC** recommends.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Signed: _____

Print Name: _____

Date: _____

Please specify relationship to minor:

- ☐ Parent with legal custody
- ☐ Guardian with legal custody

Leap Pediatrics LLC
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