Montessori
PLAINFIELD | FRANKFORT

MEDICAL AUTHORIZATION

I/we, being the parent(s) or legal guardian(s), residing at _____

_____

of the below minor(s), also residing at the aforementioned address, do hereby appoint The Montessori of Plainfield/Frankfort staff to act on my/our behalf in authorizing hospitalization, surgical, medical or dental care for the named minor(s) during my/our absence. This authorization is effective for the entire time that below minor(s) are attending/enrolled with Montessori of Plainfield/Frankfort.

For the below mentioned minor(s):

Minor(s) Name	**Birthdate**	**Allergies/Conditions**	**Medications**

_____

Physician Name	**Address**	**Phone**

Parent(s) Signature

_____ Date: _____

_____ Date: _____