MONTESSORI OF FRANKFORT
12 West Sauk Trail
Frankfort, IL 60423
815.469.3030
www.montessorioffrankfort.com
linda@montessorioffrankfort.com

MEDICAL AUTHORIZATION

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

____

of the above minor(s), also residing at the aforementioned address, do hereby appoint The Montessori of 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.

For the below mentioned minor(s):

Minor(s) Name	Birthdate	Allergies/Conditions	Medications

Physician Name	Address	Phone

Parent(s) Signature

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