



# MONTESSORI OF PLAINFIELD

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## 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 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
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_____	_____	_____	_____
_____	_____	_____	_____

Physician Name	Address	Phone
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_____	_____	_____
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Parent(s) Signature

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