**GENESIS MONTESSORI PRESCHOOL**

**AUTHORIZATION FOR EMERGENCY MEDICAL CARE**

(I)(We), the undersigned, parent(s)of_____

Date of Birth:_____

a minor(s), do hereby authorize The Genesis Montessori Preschool and/or its employees as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any duly licensed physician and surgeon on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain effective until _____, 20_____, unless sooner revoked in writing delivered to said agent(s).

The designated physician to call is_____

Address_____Phone_____

Preferred Hospital_____

Address_____Phone_____

Attention:

My child is allergic to_____

My child has no known allergies_____

Date_____

_____
Father

_____
Mother

_____
Legal Guardian

STATE OF MISSOURI )
) ss.
COUNTY OF JACKSON)

Subscribed and sworn to before me, a notary public, this _____

day of_____ , 20_____.

_____ _____
Notary Public Commission Expires