VERNON TOWNSHIP SCHOOLS
EMERGENCY AUTHORIZATION

Student Name:

Last___________________________________ **First**__________________

Student's Last Name: ____________

To the Board of Education, Principal, Designated Teacher-in-charge and School Nurse:
In the event, in your opinion, my child requires emergency medical treatment, you have my permission, and I hereby designate you my agent, to call the following doctor(s) after you have tried to telephone me and have been unsuccessful.

Doctor(s) ____
Address ____
Telephone ____

In the event the doctor(s) cannot be reached, you have my permission, and I hereby designate you my agent, to call any regularly licensed physician of the State of New Jersey.
I hereby release you from any claim arising out of the doctor's actions, and I assume and agree to pay the doctor's charge for services and any charges incurred at the doctor's direction.

Parent/Guardian Name (print) ______________________________________
Parent/Guardian Signature ____
Home Address ____
Home Telephone ____
Cell phone ____
Business Telephone ____

Grade: ________

Parent/Guardian Name (print) ______________________________________
Parent/Guardian Signature ____
Home Address ____
Home Telephone ____
Cell phone ____
Business Telephone ____

During the course of the year there may be times when a child may have to be sent home due to illness, etc. The school has no facilities for transporting children to the home at these times. Please list below the names of neighbors, relatives, or friends who may be contacted at these times if the parent/guardian is not available.

Name __________________________ Name __________________________
Address ________________________ Address ________________________
Phone __________________________ Phone __________________________

Name __________________________ Name __________________________
Address ________________________ Address ________________________
Phone __________________________ Phone __________________________