Media Release

PERMISSION FOR PARTICIPATION OF CHILD'S MEDICAL INFORMATION AND/OR PHOTOS IN MEDIA OR OTHER PUBLICATIONS

Child's Name ____

Child's Date of Birth ____

CONSENT TO PARTICIPATE -- CHILD

The purpose of this consent is to allow for participation of my child's medical information and records (photos, and medical records) to be used for media and/or research purposes. I agree that my child's medical information and/or photos may be used in future medical publications and/or media distributions.

I understand that my child's participation is voluntary. I also understand that my decision to have my child participate/or not participate will not affect the health care my child receives, now or in the future.

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Signature of Parent or Legal Guardian Date Signature of Witness Date

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Relationship to Child (Legal Guardian Only)

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