

Photography and Outing Authorization

Student Last Name	Student First Name	Birthdate	Gender	Allergies
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent/Guardian Name		Parent / Guardian Phone Number		Parent/Guardian Email Address

PHOTOGRAPHY

My signature indicates that I am giving permission for my student _____ to be photographed and/or videotaped. I understand that the photographs/videotapes will be used for educational purposes, and/or for publicity (Newspapers- Media). No last names are used. This authorizes releasing of student information and/or photographs and/or videotapes for educational and/or publicity purposes.

_____ **YES, I do give my permission for my child to be photographed and/or videotaped.**

_____ **NO, I do not give my permission for my child to be photographed and/or videotaped.**

Date _____

Parent/Guardian Signature & Printed Name

Outings and Aqua-Therapy

My signature indicates that I am giving permission for my student _____ to participate in the Community Outing Program with Marklund Day School. I understand that the Community Outing Program allows my child to participate in daily field trips, in and around the community. During community outings 911 will be called in the event of a medical emergency or if a student requires Professional Crisis Management.

My signature also provides permission for my student to participate in aqua-therapy (if applicable) at the Marklund Therapy Pool in our Geneva site, with qualified staff.

Please indicate if you give your child permission to participate in Community Outings and Aqua Therapy

Yes, I do give permission for my child to participate in

- Community outings**
- Aqua-therapy**

NO, I do not give permission for my child to participate in

- Community outings**
- Aqua-therapy**

Date _____

Parent/Guardian Signature & Printed Name