**ATHLETE REGISTRATION FORM**

National Special Olympics Program: **USA - Texas, AREA 10**  
Delegation: **10.CAR**

Are you a new athlete to Special Olympics or Re-Registering?  
- [ ] New Athlete  
- [ ] Re-Registering

### ATHLETE INFORMATION

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Middle Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td>Preferred Name:</td>
</tr>
</tbody>
</table>
| Date of Birth (dd/mm/yyyy): | □ Female  
□ Male |
| Race/Ethnicity (Optional): |
| Language(s) Spoken in Athlete's Home (Optional): |
| Street Address: | City: |
| State/Province: | Country:  
Postal Code: |
| Phone: | E-mail: |
| Sports/Activities: |

Does the athlete have the capacity to consent to medical treatment on his or her own behalf?  
- [ ] Yes  
- [ ] No

### PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship:</td>
</tr>
</tbody>
</table>
- [ ] Same Contact Info as Athlete

<table>
<thead>
<tr>
<th>Street Address:</th>
<th>City:</th>
</tr>
</thead>
</table>
| State/Province: | Country:  
Postal Code: |
| Phone: | E-mail: |

### EMERGENCY CONTACT INFORMATION

- [ ] Same as Parent/Guardian

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
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<tbody>
<tr>
<td>Phone:</td>
</tr>
</tbody>
</table>

### PHYSICIAN INFORMATION

<table>
<thead>
<tr>
<th>Physician Name:</th>
</tr>
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<tbody>
<tr>
<td>Physician Phone:</td>
</tr>
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</table>
ATHLETE RELEASE FORM

I agree to the following:

1. Ability to Participate. I am physically able to take part in Special Olympics activities.

2. Likeness Release. I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, words, and biographical information to promote Special Olympics and raise funds for Special Olympics.

3. Risk of Concussion and Other Injury. I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

4. Emergency Care. If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:

   - I have a religious or other objection to receiving medical treatment. (Not common.)
   - I do not consent to blood transfusions. (Not common.)

   (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

5. Overnight Stay. For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.

6. Health Programs. If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.

7. Personal Information. I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").
   - I agree and consent to Special Olympics:
     - using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
     - sharing my personal information with (i) researchers, business partners, public health agencies, and other organizations that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
   - I understand Special Olympics is a global organization with headquarters in the United States of America. I acknowledge that my personal information may be stored and processed in countries outside my country of residence, including the United States. Such countries may not have the same level of personal data protection as my country of residence, and I agree that the laws of the United States will govern your processing of my personal information as provided in this consent.
   - I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.
   - Privacy Policy. Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy-Policy.

<table>
<thead>
<tr>
<th>Athlete Name:</th>
<th>E-mail:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATHLETE SIGNATURE (required for adult athlete with capacity to sign legal documents)</td>
<td></td>
</tr>
<tr>
<td>I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.</td>
<td></td>
</tr>
<tr>
<td>Athlete Signature:</td>
<td>Date:</td>
</tr>
<tr>
<td>PARENT/GUARDIAN SIGNATURE (required for athlete who is a minor or lacks capacity to sign legal documents)</td>
<td></td>
</tr>
<tr>
<td>I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

A3 Athlete Registration – Updated October 2018
WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION AGREEMENT FOR COMMUNICABLE DISEASES
(“Agreement”) for SPECIAL OLYMPICS

In consideration of being allowed to participate in any way in Special Olympics sports training, competition or fundraising activities, the undersigned acknowledges, appreciates, and agrees that:

1. Participation includes possible exposure to and illness from infectious and/or communicable diseases including but not limited to MRSA, influenza, and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and,

2. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and,

3. I willingly agree to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, I observe and any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and,

4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Special Olympics, Inc, Special Olympics Texas their officers, officials, agents, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event (“RELEASEES”), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IF FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Name of Participant: ____________________________

Participant Signature: ____________________________

Date signed: ____________________________

FOR PARTICIPANTS OF MINORITY AGE (UNDER AGE 18 AT THE TIME OF REGISTRATION)

This is to certify that I, as parent/guardian, with legal responsibility for this participant, have read and explained the provisions in this waiver/release to my child/ward including the risks of presence and participation and his/her personal responsibilities for adhering to the rules and regulations for protection against communicable diseases. Furthermore, my child/ward understands and accepts these risks and responsibilities. I for myself, my spouse, and child/ward do consent and agree to his/her release provided above for all the Releasees and myself, my spouse, and child/ward do release and agree to indemnify and hold harmless the Releasees for any and all liabilities incident to my minor child/’s/ward’s presence or participation in these activities as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE, to the fullest extent provided by law.

Name of parent/guardian: ____________________________

Parent guardian/signature: ____________________________

Date signed: ____________________________
Athlete Medical Form – HEALTH HISTORY
(To be completed by the athlete or parent/guardian/caregiver and brought to exam)

Athlete First & Last Name: ___________________________ Preferred Name: ___________________________
Athlete Date of Birth (mm/dd/yyyy): ___________________________ ☐ Female ☐ Male ☐ Other Gender Identity

STATE PROGRAM: USA - Texas, AREA 10 E-mail: ___________________________

ASSOCIATED CONDITIONS - Does the athlete have (check any that apply):
☐ Autism ☐ Down Syndrome ☐ Fragile X Syndrome
☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome
☐ Other Syndrome, please specify: ___________________________

ASSISTIVE DEVICES - Does the athlete use (check any that apply):
☐ Brace ☐ Colostomy ☐ Communication Device
☐ C-PAP Machine ☐ Crutches or Walker ☐ Dentures
☐ Glasses or Contacts ☐ G-Tube or J-Tube ☐ Hearing Aid
☐ Implanted Device ☐ Inhaler ☐ Pacemaker
☐ Removable Prosthetics ☐ Splint ☐ Wheel Chair

ALLERGIES & DIETARY RESTRICTIONS
☐ No Known Allergies ☐ Latex
☐ Medications: ___________________________
☐ Insect Bites or Stings: ___________________________
☐ Food: ___________________________

List any special dietary needs:

SPORTS PARTICIPATION
List all Special Olympics sports the athlete wishes to play:

Has a doctor ever limited the athlete’s participation in sports?
☐ No ☐ Yes If yes, please describe:

SURGERIES, INFECTIONS, VACCINES
List all past surgeries:

Does the athlete currently have any chronic or acute infection?
☐ No ☐ Yes If yes, please describe:

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? If yes, describe date and results
☐ Yes, had abnormal EKG ___________________________
☐ Yes, had abnormal Echo ___________________________

Has the athlete had a Tetanus vaccine in the past 7 years?
☐ No ☐ Yes

EPILEPSY AND/OR SEIZURE HISTORY
Epilepsy or any type of seizure disorder
☐ No ☐ Yes If yes, list seizure type: ___________________________
If yes, had seizure during the past year?
☐ No ☐ Yes

MENTAL HEALTH
Self-Injurious behavior during the past year
☐ No ☐ Yes Depression (diagnosed) ☐ No ☐ Yes
Aggressive behavior during the past year
☐ No ☐ Yes Anxiety (diagnosed) ☐ No ☐ Yes

Describe any additional mental health concerns:

FAMILY HISTORY
Has any relative died of a heart problem before age 50?
☐ No ☐ Yes
Has any family member or relative died while exercising?
☐ No ☐ Yes

List all medical conditions that run in the athlete’s family:

Medical Form for US Programs – updated April 2021

Special Olympics Medical Form | 1 of 4
**Athlete Medical Form – HEALTH HISTORY**
(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)

**Athlete's First and Last Name:**

<table>
<thead>
<tr>
<th>HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Consciousness</td>
</tr>
<tr>
<td>Dizziness during or after exercise</td>
</tr>
<tr>
<td>Headache during or after exercise</td>
</tr>
<tr>
<td>Chest pain during or after exercise</td>
</tr>
<tr>
<td>Shortness of breath during or after exercise</td>
</tr>
<tr>
<td>Irregular, racing or skipped heart beats</td>
</tr>
<tr>
<td>Congenital Heart Defect</td>
</tr>
<tr>
<td>Heart Attack</td>
</tr>
<tr>
<td>Cardiomyopathy</td>
</tr>
<tr>
<td>Heart Valve Disease</td>
</tr>
<tr>
<td>Heart Murmur</td>
</tr>
<tr>
<td>Endocarditis</td>
</tr>
</tbody>
</table>

If female athlete, list date of last menstrual period:

Describe any past broken bones or dislocated joints (if yes is checked for either of those fields above):

List any other ongoing or past medical conditions:

---

**Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability**

<table>
<thead>
<tr>
<th>Difficulty controlling bowels or bladder</th>
<th>No</th>
<th>Yes</th>
<th>If yes, is this new or worse in the past 3 years?</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbness or tingling in legs, arms, hands or feet</td>
<td>No</td>
<td>Yes</td>
<td>If yes, is this new or worse in the past 3 years?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Weakness in legs, arms, hands or feet</td>
<td>No</td>
<td>Yes</td>
<td>If yes, is this new or worse in the past 3 years?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet</td>
<td>No</td>
<td>Yes</td>
<td>If yes, is this new or worse in the past 3 years?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Head Tilt</td>
<td>No</td>
<td>Yes</td>
<td>If yes, is this new or worse in the past 3 years?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Spasticity</td>
<td>No</td>
<td>Yes</td>
<td>If yes, is this new or worse in the past 3 years?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Paralysis</td>
<td>No</td>
<td>Yes</td>
<td>If yes, is this new or worse in the past 3 years?</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW**
(includes inhalers, birth control or hormone therapy)

<table>
<thead>
<tr>
<th>Medication, Vitamin or Supplement Name</th>
<th>Dosage</th>
<th>Times per Day</th>
<th>Medication, Vitamin or Supplement Name</th>
<th>Dosage</th>
<th>Times per Day</th>
<th>Medication, Vitamin or Supplement Name</th>
<th>Dosage</th>
<th>Times per Day</th>
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</tr>
</tbody>
</table>

Is the athlete able to administer his or her own medications?  No  Yes
# Athlete Medical Form – PHYSICAL EXAM

*(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)*

**Athlete’s First and Last Name:**

**Date of Birth:**

## MEDICAL PHYSICAL INFORMATION

*(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)*

<table>
<thead>
<tr>
<th>Height (cm)</th>
<th>Weight (kg)</th>
<th>Temperature</th>
<th>Pulse</th>
<th>O₂ Sat</th>
<th>Blood Pressure (in mmHg)</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>BP Right:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Right Vision 20/40 or better</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Left Vision 20/40 or better</td>
</tr>
</tbody>
</table>

- **Right Hearing (Finger Rub):** Responds | No Response | Can't Evaluate
- **Left Hearing (Finger Rub):** Responds | No Response | Can't Evaluate
- **Right Ear Canal:** Clear | Cerumen | Foreign Body
- **Left Ear Canal:** Clear | Cerumen | Foreign Body
- **Right Tympanic Membrane:** Clear | Perforation | Infection | NA
- **Left Tympanic Membrane:** Clear | Perforation | Infection | NA
- **Oral Hygiene:** Good | Fair | Poor
- **Thyroid Enlargement:** No | Yes
- **Lymph Node Enlargement:** No | Yes
- **Heart Murmur (supine):** No | 1/6 or 2/6 | 3/6 or greater
- **Heart Murmur (upright):** No | 1/6 or 2/6 | 3/6 or greater
- **Heart Rhythm:** Regular | Irregular
- **Lungs:** Clear | Not clear
- **Right Leg Edema:** No | 1+ | 2+ | 3+ | 4+
- **Left Leg Edema:** No | 1+ | 2+ | 3+ | 4+
- **Radial Pulse Symmetry:** Yes | R=L | L>R
- **Cyanosis:** No | Yes, describe
- **Clubbing:** No | Yes, describe

## SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) *(Select one)*

- Athlete shows **NO EVIDENCE** of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.
- OR

## ATHLETE CLEAREANCE TO PARTICIPATE *(TO BE COMPLETED BY EXAMINER ONLY)*

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

- This athlete is **ABLE to participate in Special Olympics sports without restrictions.**
- This athlete is **ABLE to participate in Special Olympics sports WITH restrictions. Describe ➔**
- This athlete **MAY NOT participate in Special Olympics sports at this time & MUST be further evaluated by a physician for the following concerns:**
  - Concerning Cardiac Exam
  - Concerning Neurological Exam
  - Other, please describe:
  - Acute Infection
  - Stage II Hypertension or Greater
  - O₂ Saturation Less than 90% on Room Air
  - Hepatomegaly or Splenomegaly

## Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

- Follow up with a cardiologist
- Follow up with a vision specialist
- Follow up with a podiatrist
- Follow up with a neurologist
- Follow up with a hearing specialist
- Follow up with a physical therapist
- Follow up with a primary care physician
- Follow up with a dentist or dental hygienist
- Follow up with a nutritionist

### Signature of Licensed Medical Examiner

**Name:**

**E-mail:**

**Phone:**

**License #:**

Medical Form for US Programs – updated April 2021
Athlete Medical Form – MEDICAL REFERRAL FORM
(To be completed by a Licensed Medical Professional only if referral is needed)

Athlete’s First and Last Name: __________________________________________

This page only needs to be completed and signed if the physician on page three does not clear
the athlete and indicates further evaluation is required.
Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner’s Name: ______________________________________________________

Specialty: ____________________________________________________________

I have been asked to perform an additional athlete exam for the following medical concern(s) - Please describe:
☐ Concerning Cardiac Exam ☐ Acute Infection ☐ O₂ Saturation Less than 90% on Room Air
☐ Concerning Neurological Exam ☐ Stage II Hypertension or Greater ☐ Hepatomegaly or Splenomegaly
☐ Other, please describe:

In my professional opinion, this athlete MAY now participate in Special Olympics sports (indicate
restrictions or limitations below):
☐ Yes ☐ Yes, but with restrictions (list below) ☐ No

Additional Examiner Notes/Restrictions:

Examiner E-mail: ______________________________________________________

Examiner Phone: ______________________________________________________

License: _____________________________

Examiner’s Signature ___________________________ Date ____________

This section to be completed by Special Olympics staff only, if applicable.

This medical exam was completed at a MedFest event? ☐ Yes ☐ No

The athlete is a Unified Partner or a Young Athlete Participant? ☐ Unified Partner ☐ Young Athlete
Field Trip - Permission, Waiver and Release Form

Carrollton-Farmers Branch ISD is proud to offer the opportunity for our students to participate in field trips. Participation in this Field Trip is voluntary, and we ask that you read and sign this form as a condition of participation.

As parent/guardian, I desire that my child or ward to participate in the Field Trip and grant permission to attend. This participation includes travel to and from the Field Trip activity.

Student Code of Conduct and Student Handbook

I acknowledge that I have received a copy of, and that I have made my child/ward adequately aware of, the Carrollton-Farmers Branch ISD's Student Code of Conduct and the Student Handbook. I understand, and have made my child/ward aware, that the Field Trip and the events, activities and experiences related to it are school-related functions, and that all the rules and regulations from the Student Code of Conduct and the Student Handbook apply. I understand and agree that if my child/ward violates these rules and regulations, I may be required to pick-up my child/ward early from the Field Trip location.

Transportation

I understand and recognize that transportation of my child/ward will be provided by either vehicles owned and operated, or vehicles not owned or operated, by the Carrollton-Farmers Branch ISD. I hereby release and discharge the Carrollton-Farmers Branch, its employees, officers, agents and assigns from all claims, which I may have or claim to have against the Carrollton-Farmers Branch ISD, its employees, officers, agents and assigns for all personal injuries, known or unknown, and from all known or unknown injuries to property, caused by or arising out of, the above-described transportation.

Permission and Release

I agree to assume any and all liability stemming from my child/ward's participation on this Field Trip. I further agree to hold the Carrollton-Farmers Branch ISD, its Trustees, employees, and agents harmless from all claims or actions which I or my child have, or may have in the future, including any liability for injuries or damages which occur to my child or me as a result of his or her participation in this Field Trip. I agree to indemnify and hold harmless the Carrollton-Farmers Branch ISD, its Trustees, employees, and agents from all claims made by third parties against it or them on behalf of my child/ward or which may result from my child's action on the trip.

Student Name


Student ID#


Student Grade Level


Student Class


Consent to Medical Treatment *
☐ I Agree
I hereby authorize the sponsors for this event, on behalf of Carrollton-Farmers Branch ISD, in the case of a medical emergency during the event, to consent to medical treatment of my child or ward.

Consent to Administration of Medications *
☐ I Agree
I hereby request the sponsors for this event to administer to my child the medications listed on this form. I recognize that the school does not thereby undertake any ongoing duty to administer drugs or medicine, or to supervise or participate in any self-medication, all of which remain my responsibility. I understand that the school is not legally obligated to store or administer medication for students and will not do so, either on a temporary or ongoing basis, except by special agreement. Before any medication is given by the school, I will provide those medications in their original pharmacy containers, with the child’s name and doctor’s instructions on the label, and I will provide a written, signed authorization from a physician, including complete instructions.

Student Date of Birth *

Name of Health Insurance Company *

Insurance Company Subscriber ID Number *

Insurance Company Phone Number *

I will provide a written, signed authorization from a physician, including complete instructions.

My child/ward is allergic to *

My child/ward has the following special medical conditions *

My child/ward takes the following prescription medications *
I have read this Permission, Waiver and Release Form and understand all of its terms and conditions. I execute this Permission, Waiver and Release Form voluntarily and with full knowledge of its significance.

☐ I give my permission for my child to participate in the above mentioned activity.

☐ I deny permission for my child to participate in the above mentioned activity.

Parent/ Guardian Name

Parent/ Guardian Email

Parent/ Guardian Phone

Information entered on this form will be visible to the post author and ParentSquare admins

Signature

Date
PHOTO/VIDEO WEB SITE RELEASE FORM

Dear Parent/Guardian:

On occasion, representatives from and/or employees of the Carrollton Farmers Branch Independent School District or its affiliates wish to photograph, videotape, and/or interview individuals in connection with school programs, projects, or events. In order to release photographs, video footage, and/or comments, and/or to post on district or school web sites, we need written permission. To give your consent, please complete the form below.

I, __________________________, parent/guardian of __________________________, give permission for my child to be photographed, videotaped, and/or interviewed by representatives from and/or employees of the Carrollton Farmers Branch Independent District or its Affiliates for educational or public relations purposes. I authorize the use and reproduction by the Carrollton Farmers Branch Independent District or anyone authorized by the Carrollton Farmers Branch Independent District or its Affiliates of any and all photographs and/or videotapes taken of my child, without compensation to me/my child. All these photographs/video recordings shall be the property, solely and completely, of the Carrollton Farmers Branch Independent District or its Affiliates. I waive any right to inspect or approve the finished photographs/videotapes, and the sound track, script or printed matter that may be used in conjunction with them.

Signature of Parent and/or Guardian: __________________________ Date: __________

Address: _____________________________________________________________

OR

I am 18 years of age or older and I give my consent without reservations to the foregoing on my own behalf.

Signature of Subject: _____________________________________________ Date: __________

Address: _____________________________________________________________