

# U.S. Athlete Registration Form

**Special Olympics**



Required for all athletes participating in Special Olympics.

Local Special Olympics Program: 10.CAR

**Athlete Information - To be completed by the athlete or parent/guardian/caregiver.**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Middle name: \_\_\_\_\_

Date of birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Female  Male  Other

Email: \_\_\_\_\_ Phone number: \_\_\_\_\_  Mobile  Landline

Home address: \_\_\_\_\_

<b>Optional - Check all that apply:</b>			
Race / Ethnicity	<input type="checkbox"/> American Indian / Alaskan Native	<input type="checkbox"/> Asian American	
	<input type="checkbox"/> Black / African American	<input type="checkbox"/> Hispanic / Latino	
	<input type="checkbox"/> Middle Eastern / North African	<input type="checkbox"/> Native Hawaiian / Other Pacific Islander	
	<input type="checkbox"/> White / Caucasian	<input type="checkbox"/> Unknown	
	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Prefer not to answer	
Language(s) Spoken by Athlete	<input type="checkbox"/> English	<input type="checkbox"/> French	<input type="checkbox"/> Spanish
	<input type="checkbox"/> American Sign Language (ASL)		
	<input type="checkbox"/> Other (please list): _____		

**Parent/Guardian Information - Required if minor or otherwise has a legal guardian.**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Relationship to athlete: \_\_\_\_\_

Email: \_\_\_\_\_ Phone number: \_\_\_\_\_  Mobile  Landline

Home address: \_\_\_\_\_

**Emergency Contact**  Same as Parent/Guardian

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Phone number: \_\_\_\_\_  Mobile  Landline

Relationship to athlete:  Parent/guardian  Caregiver  Family member  Healthcare provider  Coach  Other

**Associated Conditions - Mandatory**

Associated Conditions	<input type="checkbox"/> Autism	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Fetal Alcohol Syndrome
	<input type="checkbox"/> Marfan Syndrome	<input type="checkbox"/> Spina Bifida	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Fragile X Syndrome
	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Unknown				
Please specify other known intellectual disability diagnoses: _____				

**Assistive Devices and Accommodations - Do you use any of the following? Check all that apply:**

Mobility	<input type="checkbox"/> Walker	<input type="checkbox"/> Braces or crutches	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Removable orthotics
	<input type="checkbox"/> Prosthetics	<input type="checkbox"/> None		
Lifestyle Aids	<input type="checkbox"/> CPAP	<input type="checkbox"/> Dentures	<input type="checkbox"/> Glasses, contact lenses, or protective eyewear	
	<input type="checkbox"/> None			
Communications	<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Communication devices	<input type="checkbox"/> Sign Language	<input type="checkbox"/> None
Medical Devices	<input type="checkbox"/> Implantable cardioverter defibrillator (ICD)	<input type="checkbox"/> Implantable device for seizure management		
	<input type="checkbox"/> VP Shunt	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> None	
Do you have a specific dietary requirement?	<input type="radio"/> Yes	<input type="radio"/> No	If yes, please specify: _____	
Do you use other assistive devices?	<input type="radio"/> Yes	<input type="radio"/> No	If yes, please specify: _____	

**General Health Questions**

Do you have a heart condition?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have asthma?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have diabetes that requires you to take insulin?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a vision impairment?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a hearing impairment?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a bleeding disorder?	<input type="radio"/> Yes	<input type="radio"/> No
Has a doctor ever limited your participation in sports?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have epilepsy or any type of seizure disorder?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have sickle cell disease?	<input type="radio"/> Yes	<input type="radio"/> No

Have you ever had a concussion?	<input type="radio"/> Yes	<input type="radio"/> No	If yes, please specify how many in your lifetime: _____ Date of last one (mm/yyyy): _____
Do you have behavioral, mental health, and/or sensory conditions?	<input type="radio"/> Yes	<input type="radio"/> No	If yes, please specify:
Do you have severe allergies that requires the use of an EpiPen?	<input type="radio"/> Yes	<input type="radio"/> No	If yes, please specify if it is to any of the following: <input type="checkbox"/> Insect stings <input type="checkbox"/> Medication/drugs <input type="checkbox"/> Food <input type="checkbox"/> Latex <input type="checkbox"/> Other (please specify): _____

**Medication and Treatment - Please list:**

Are you taking any prescription or over-the-counter medications or treatments? (Including birth control pills, insulin, multivitamins allergy shots or pills, EpiPen, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.)

Yes       No

**If yes, please list:**

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Name of person completing the form: \_\_\_\_\_

Today's date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this form being completed by someone other than the athlete?       Yes       No

If yes, please select the relationship to athlete:

Relationship to athlete:     Parent/guardian     Caregiver     Family member     Healthcare provider     Coach     Other

***Special Olympics encourages all participants to get a yearly physical examination.***

## WAIVERS, RELEASES, AND POLICIES

Please read the following information and check boxes fully before signing.

I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities, and will abide by all applicable rules, requirements and codes of conduct.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, Special Olympics accredited Programs (collectively "Special Olympics"), as well as official Special Olympics supporters and partners that have authorization from Special Olympics, to use my likeness, photo, video, name, voice, words, biographical information and similar or related material (my "likeness") to promote Special Olympics and raise funds for Special Olympics. I understand that my likeness may be used in all forms of media in local or global campaigns – including those by supporters and partners of Special Olympics – but understand that my likeness will not be used to endorse commercial products or services. I understand that I will not be compensated for the use of my likeness.
3. **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.
  - I do not consent to blood transfusions.

**(If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)**
4. **Overnight Stay.** For some events, overnight accommodations may be required. If I have questions, I will contact my Special Olympics Program.
5. **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 have the right to decline Health programming treatment (which is different from sideline or emergency medical care) at any time."
6. **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.
- using my contact information for communicating with me about Special Olympics.
- sharing my personal information confidentially with (i) researchers such as universities and public health agencies 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 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](http://www.SpecialOlympics.org/Privacy-Policy).

### SYMPTOMS FOR SPINAL CORD COMPRESSION and ATLANTOAXIAL INSTABILITY (For athlete with Down syndrome only)

If I (or the athlete) have been diagnosed with or experienced any of the following symptoms that have increased in severity over the past three years – difficulty controlling bowels or bladder; numbness or tingling in legs, arms, hands, or feet; weakness in arms, legs, hands or feet; burner/stinger/pinches nerve, pain in neck, back shoulders, arms, hands, buttocks, legs or feet; spasticity or paralysis – I must obtain a review and permission from a licensed medical practitioner to train and/or participate in Special Olympics activities.

**WAIVER AND RELEASE OF LIABILITY / ASSUMPTION OF RISK / INDEMNIFICATION**

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

- 1. While particular rules and personal discipline may reduce this risk, the risk of illness (including communicable diseases), injury (including concussion), disability, and death does exist;
- 2. If I observe 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 Special Olympics representative immediately; and,
- 3. **I understand the risks involved with participation in Special Olympics activities. I fully accept and assume all risks and all responsibility for losses, costs, and damages I may incur as a result of my participation. To the fullest extent of the law, I release and agree not to sue any Special Olympics organization, its directors, agents, volunteers, and employees, other participants, sponsoring agencies, sponsors, advertisers, and, if applicable owners and lessors of premises on which any Special Olympics activity is occurring ("Releasees") related to any liabilities, claims, or losses on my account caused or alleged to be caused in whole or in part by the Releasees even if arising from the negligence of the Releasees. I have read this release of liability and assumption of risk provision, fully understand its terms, acknowledge that I have given up substantial rights by signing it, and sign it freely and voluntarily without any inducement. I further agree that if, despite this release, I, or anyone on my behalf, makes a claim against any of the Releasees, I will indemnify and hold harmless each of the Releasees from any such liabilities, claims, or losses as the result of such claim. I agree that if any part of this form is held to be invalid, the other parts shall continue in full force and effect.**

Athlete Name: \_\_\_\_\_

**ATHLETE SIGNATURE**  
(required for adult athlete with capacity to sign legal documents)

I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.

Athlete Signature: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

**PARENT/GUARDIAN SIGNATURE**  
(required for athlete who is a minor or lacks capacity to sign legal documents)

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.

Parent/Guardian Signature: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**EVALUATION AND RESEARCH  
(Optional)**

Special Olympics wants to help our athletes and their families stay healthy and happy. We may take part in research studies and would share information for your potential participation. All studies will be checked by the Special Olympics Chief Health Officer.

Would you or your family be interested in learning about research studies?

- Yes
- No

# Special Olympics



## EMERGENCY MEDICAL CARE REFUSAL FORM – ATHLETE COMPLETION

(To be completed by adult athlete with capacity to sign legal documents)

**Instructions:** Only complete this form if you do not consent to emergency medical care on religious or other grounds and have marked a box under the Emergency Care provision on the Athlete Release Form.

**I am a Special Olympics athlete with capacity to sign documents on my own behalf and agree to the following:**

1. **No Consent to Emergency Medical Care.** I understand that Special Olympics' standard registration form requires athletes or their parents or guardians to consent to emergency medical care for the athlete if needed in an emergency. Based on religious beliefs or other reasons I am not consenting to emergency medical care.

**YOU MUST MARK THE BOX AND WRITE YOUR INITIALS NEXT TO ONE STATEMENT TO CONFIRM YOUR INTENT:**

- I DO NOT CONSENT TO ANY KIND OF MEDICAL TREATMENT, EVEN IN A LIFE-THREATENING EMERGENCY. INITIALS: \_\_\_\_\_
- I DO NOT CONSENT TO BLOOD TRANSFUSIONS, EVEN IN A LIFE-THREATENING EMERGENCY. I CONSENT TO ALL OTHER KINDS OF EMERGENCY MEDICAL CARE. INITIALS: \_\_\_\_\_
2. **Printed Instructions.** I agree to carry printed instructions that describe my religious or other objections to medical treatment and how I wish the person accompanying me to respond if I get sick or hurt and cannot speak for myself. I agree to carry these printed instructions with me at all times during my participation in any Special Olympics activity, including during meal times, in overnight accommodations, at training sessions and competitions, and during travel to and from Special Olympics activities.
  3. **Friend or Family Accompaniment.** I understand that I must be accompanied by an adult friend or family member in order for that person can take personal responsibility for me during a medical emergency where I am unable to speak for myself.
  4. **Emergency Medical Care If Athlete Is Not Accompanied.** I understand that, if I am not carrying the printed instructions or the accompanying adult is not present and actively taking personal responsibility for me during a medical emergency where I am unable to speak for myself, Special Olympics may seek emergency medical care for me as recommended by medical professionals responding to the emergency.
  5. **Liability Release.** I release Special Olympics, its employees, and its volunteers from all claims that may arise out of taking or failing to take measures to provide me with emergency medical care. I am agreeing to this release because I have refused, knowingly and voluntarily, to give Special Olympics permission to take emergency measures, and I am expressly withholding consent to emergency medical care on religious or other grounds. For this form, "Special Olympics" means all Special Olympics organizations.

<b>Athlete Name:</b>	<b>E-mail:</b>
<b>ATHLETE SIGNATURE</b>	
I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.	
<b>Athlete Signature:</b>	<b>Date:</b>
<b>SIGNATURE OF ACCOMPANYING ADULT</b>	
By signing, I agree to accompany the athlete during Special Olympics activities and take personal responsibility for the athlete during an emergency. I understand the extent to which the athlete does not consent to emergency medical care and agree to act in accordance with the athlete's wishes as I understand them.	
<b>Signature of Accompanying Adult:</b>	<b>Date:</b>
<b>Printed Name:</b>	<b>Relationship:</b>

**Special Olympics**



**EMERGENCY MEDICAL CARE REFUSAL FORM – PARENT OR GUARDIAN COMPLETION**

(To be completed by parent or guardian of athlete who is a minor or lacks capacity to sign legal documents)

**Instructions:** Only complete this form if you do not consent to emergency medical care on religious or other grounds and have marked a box under the Emergency Care provision on the Athlete Release Form.

**I am the parent/guardian of the athlete named below and agree to the following:**

1. **No Consent to Emergency Medical Care.** I understand that Special Olympics' standard registration form requires athletes or their parents or guardians to consent to emergency medical care for the athlete if needed in an emergency. Based on religious beliefs or other reasons I am not consenting to emergency medical care as follows.

**YOU MUST MARK THE BOX AND WRITE YOUR INITIALS NEXT TO ONE STATEMENT TO CONFIRM YOUR INTENT:**

- I DO NOT CONSENT TO ANY KIND OF MEDICAL TREATMENT, EVEN IN A LIFE-THREATENING EMERGENCY. INITIALS: \_\_\_\_\_**
- I DO NOT CONSENT TO BLOOD TRANSFUSIONS, EVEN IN A LIFE-THREATENING EMERGENCY. I CONSENT TO ALL OTHER KINDS OF EMERGENCY MEDICAL CARE. INITIALS: \_\_\_\_\_**
2. **Accompaniment of Athlete.** I understand that I must be present in order to take personal responsibility for the athlete if any medical treatment is to be refused on the athlete's behalf in a medical emergency arises. This includes during meal times, in overnight accommodations, at training sessions and competitions, and during travel to and from Special Olympics activities.
  3. **Emergency Medical Care If Athlete Is Not Accompanied.** I understand that, if I am not present and actively taking personal responsibility for the athlete during a medical emergency, Special Olympics may seek emergency medical care for the athlete as recommended by medical professionals responding to the emergency.
  4. **Liability Release.** On behalf of myself and the athlete, I release Special Olympics, its employees, and its volunteers from all claims that may arise out of taking or failing to take measures to provide the athlete with emergency medical care. I am agreeing to this release because I have refused, knowingly and voluntarily, to give Special Olympics permission to take emergency measures, and I am expressly withholding consent to emergency medical care on religious or other grounds. For this form, "Special Olympics" means all Special Olympics organizations.

<b>Athlete Name:</b>	<b>E-mail:</b>
<b>PARENT/GUARDIAN SIGNATURE</b>	
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. This release shall be binding upon me, the athlete and our respective heirs and legal representatives.	
<b>Parent/Guardian Signature:</b>	<b>Date:</b>
<b>Printed Name:</b>	<b>Relationship:</b>

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_)  
brachial blood pressure while sitting

Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected:  Y  N Pupils:  Equal  Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high participation and again prior to first and third years of high school participation. It **must** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. \* **Local district policy may require an annual physical exam.**

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

\*station-based examination only

**CLEARANCE**

Cleared  
 Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

*The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.*

Name (print/type) \_\_\_\_\_ Date of Examination: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Signature: \_\_\_\_\_

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or performance/games/matches.



**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**

<input type="text"/>	<input type="text"/>
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## 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: \_\_\_\_\_