Parent/Guardian Consent Form
Junior Volunteer Program

Date _____

I give my consent for my son/daughter _____to participate in the Junior Volunteer Program at Stony Brook University Hospital.

I will assume responsibility for my son/daughter's transportation to and from Stony Brook University Hospital.

_____
(Parent/Guardian Name Printed)

_____
(Parent/Guardian Signature)

_____
(Parent/Guardian Address)

_____

CONSENT TO INTERVIEW, PHOTOGRAPH, FILM, VIDEOTAPE OR RECORD

I, _____ , hereby give my consent and permission to
(Parent/Guardian Print Name)
University Hospital at Stony Brook and to its employees and authorized agents to interview, take photographs, motion pictures, videotape and/or sound recordings of me or of _____ for whom I am legally responsible.
(Jr. Vol. Print Name)

The purpose of this activity has been clearly explained to me and I release University Hospital, State University of New York at Stony Brook, and the State of New York from any claim that I may have against each by reason of this interview, recording photography or videotaping. I also waive any claims to payment or royalties derived therefrom.

University Hospital reserves the right to grant or deny permission to patients or their authorized agents to interview, photograph, film, videotape or record patients while in the hospital. The patient or authorized guardian agrees to indemnify University Hospital, State University of New York, and/or the State of New York against any and all damages or losses they may sustain as a result of taking such recordings.

Interviews, photographs, films, videotapes or recordings obtained by University Hospital may be used for any or all of the following purposes, with or without names or other identification:

a. Clinical documentation of current patient condition
b. Educational purposes
c. Health care research
d. Publicity for Hospital programs
e. Staff recruitment and training
f. Fund raising and development
g. Other (specify) _____

_____ X_____
Date Parent/Guardian Signature

KK/rbc

Medical Authorization
Junior Volunteer Program

Date _____

I, _____, the parent/guardian of _____, give my consent to Stony Brook University Hospital and to is medical and nursing staff to examine or treat my son/daughter in the event of accident or illness that may occur in the course of performing duties as a volunteer at Stony Brook University Hospital.

I also give my consent to Stony Brook University Hospital to perform health assessments/screenings as required by hospital policy.

_____
(Parent/Guardian Name Printed)

_____
(Parent/Guardian Signature)

_____
(Parent/Guardian Address)

_____