Consent to Photograph/Videotape

Child's Name: ___________________________________

By signing this form I give permission to Laughing Giraffe Therapy and any of its therapists/professionals to photograph/videotape my child's therapy sessions for the following purpose(s):

(Please initial your choice for each selection)

Yes _____ No _____ For review by therapists/professionals of Laughing Giraffe Therapy for the purpose of tracking progress, treatment planning and providing parent feedback

Yes _____ No _____ For educational purposes; to teach theory and intervention techniques to parents and therapists/professionals of Laughing Giraffe Therapy and professionals in other health-related fields

Yes _____ No _____ For use on website

Yes _____ No _____ For use in brochures

Yes _____ No _____ For use in social media

I understand I may withdraw my permission at any time.

Parent/Guardian Name: _______________________________________

Parent/Guardian Signature: ____________________________________

Date: ___________________

100 O'Connor Drive #14, San Jose, CA 95128 408.753.0106 www.laughinggiraffetherapy.com