



Department of Speech and Hearing Sciences
Roinn na nEolaíochtaí Urlabhra agus Éisteachta

Video Consent Form

I agree that I / my child (delete as appropriate) may be videoed for the purpose of educating Speech and Language therapy students and Speech and Language Therapists.

I understand that the video will be stored safely in the Brookfield clinic in UCC for up to 3 years and only used for the purpose stated below.

I give my permission for the video to be (tick as appropriate):

- (a) viewed by the student/s who are currently seeing me / my child
- (b) used for training other Speech and Language therapy students
- (c) used for training Speech and Language Therapists
- (d) other (please specify) _____

Signed: _____

Print Name: _____

Client's Name: _____

Relationship to Client: Parent/Carer/Spouse (delete as appropriate)

Date: _____



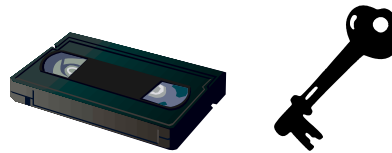
Department of Speech and Hearing Sciences
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Video Consent Form (Pictorial version)

I agree to being filmed



I understand that my video will be locked away



I agree to my video being used to teach people – Speech and Language Therapists and Students



Tick <input checked="" type="checkbox"/>

Signed: _____

Print Name: _____

Date: _____

Client's Name: _____

