SUNY NEW PALTZ

DEPARTMENT OF TEACHING AND LEARNING

LITERACY CLINIC

EDUCATIONAL RECORDING AND CONSENT RELEASE FORM

So as to provide the best possible service to the person requesting tutoring in the Literacy Clinic, the following regulations are necessary and require the agreement of the client, parent, or legally responsible party.

The Department of Elementary Education Literacy Clinic accepts the responsibility of utilizing practices that maintain the welfare of the tutored students as being paramount. By the acceptance of a student for tutoring in Literacy, the Department of Elementary Education Literacy Clinic does not guarantee the results of tutoring or literacy intervention.

In recognition of the Department of Elementary Education Literacy Clinic’s responsibility to provide clinical experience for Candidates for the MS Degree in Literacy Education, I understand that:

1. Candidates for the Master’s Degree in Literacy Education will observe, assess, participate, and organize clinical activities, under supervision.
2. The Department of Elementary Education Literacy Clinic may make customary and constructive use, exercising due discretion for educational, scientific, and professional purposes of information, photographs, sound recordings, films, video recordings, and other records or materials pertaining to my minor child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .
3. I am aware that my child may be taken out of the classroom building for instructional purposes under the supervision of the Graduate Candidate and/or the supervising instructor.
4. To the maximum extent permitted by law, I release and indemnify the State of New York, the State University of New York, Department of Elementary Education Literacy Clinic, and their officers, employees, agents and volunteers, from and against any present or future claim, loss or liability for injury to person or property which my child may suffer, or for which my child may be liable to any other person, during or as a result of my child’s participation in the program.
5. I further consent to the release of relevant confidential material to qualified professional personnel in furtherance of clinical services, on my behalf or of the above named child.

Name: (Print) \_\_\_\_\_\_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your relationship to the child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_