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3B - CRISALIDA VIDEO CONSENT AGREEMENT

I, ______________________________, parent/carer of ______________________, give written
please print full name please print full name

consent for ______________________ to video or photograph my son/daughter during the
Crisalida Practitioner

Friendship Group Program. I understand and agree that some of the footage for the group sessions may be used by the above therapists for educational/training purposes. That is, some small amounts of footage may be shown to other professionals at a conference/training session to demonstrate the elements and processes involved in group work.

I understand that names will not be used and any personally identifying information will be kept confidential.

____
please print full name

____
sign date