



Special Education Technology Center
 Central Washington University
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 www.specialedtechcenter.org
 (509) 963-3350
 FAX: 509-963-3355

THIS PAGE FOR PARENT/LEGAL GUARDIAN TO COMPLETE

Permission for Video and Observation

I, _____, as parent or legal guardian of _____, grant permission to the Special Education Technology Center to do the following during the scheduled consultation at the Special Education Technology Center or as a result of the consultation:

CHECK THE FOLLOWING

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | To record video of my child while attending the consultation |
| <input type="checkbox"/> | <input type="checkbox"/> | To use pre-recorded video footage of my child during the consultation |
| <input type="checkbox"/> | <input type="checkbox"/> | To use video footage of my child for purposes of educator training or staff development |
| <input type="checkbox"/> | <input type="checkbox"/> | University faculty and staff may observe this consultation process |

I, the undersigned, understand that by giving permission for the Special Education Technology Center to use video footage of my child, that said video recording becomes the property of the Special Education Technology Center and will be used for educational purposes only.

Parent/Legal Guardian: _____

Date: _____