

WHOLE KIDS THERAPY

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CONSENT TO VIDEOTAPE

I give permission for Moira Sullivan, MS, OTR/L, to videotape sessions for the following purpose(s):

_____ For review by me, Moira Sullivan, MS, OTR/L, only for purpose of tracking progress and providing feedback.

_____ For educational purposes to teach theory and techniques of intervention to parents and professionals in health related fields, (mental health, pediatrics, education, occupational therapy, physical therapy, speech and language therapy).

I understand that I may withdraw my permission at any time.

Child's Name _____

Parent or Guardian

Date _____

Parent or Guardian

Date _____