

## EYH Medical and Photo Release Form

Student Name \_\_\_\_\_

Phone (in case of emergency) \_\_\_\_\_

I give permission for my child to receive emergency medical treatment and care. I give permission for my child to be photographed and videotaped and for the images to be published in newspapers, magazines, and on the Internet for the purpose of promoting the EYH Conference.

**Parent/Guardian Signature and Date**

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