Boothby Therapy Services
806 North Main Street • Laconia, NH 03246 • (603) 524-9090 • fax (603) 524-1497
www.boothbytherapy.com

Permission to video record

I,_____, hereby acknowledge the request for the use of video recording of my child,_____, for the intended purpose of evaluation and therapy by the special education team. I acknowledge that the video recordings will primarily be restricted to the special education team which, include the primary teacher/educator, speech and language therapists, occupational/physical therapists, principal/assistant principal, school psychologist, and case managers. I acknowledge and understand that the use of video recordings is to only be utilized for the benefit of my child's education and learning styles. I understand that the storage of these recordings is restricted to the special education team and will be destroyed when the content of the recording is no longer needed or appropriate.

_____ **I DO** give permission for my child to appear on a video recording.
_____ **I DO NOT** give permission for my child to appear on a video recording.

Permission granted/not granted via phone on: _____By _____

Parent signature_____ date: _____

Supplemental permission to share video recordings

From time to time, professionals meet to discuss the latest research, evidenced based practice, or current methods in the evaluation and treatment of children with speech and language impairments. The use of video recordings of children with speech and language impairments is one of the most beneficial tools for both providing optimal services for children as well as providing learning opportunities for other professionals. By allowing video recordings of your child to be shared with other professionals, it would allow for multiple professionals to weigh in on the administration of services potentially enhancing therapy for your child. Also, it would be providing optimal learning opportunities for other professionals working with children with similar speech and language impairments. By signing below, I acknowledge and understand that the use of video recordings is to only be utilized for the benefit of my child's education and learning styles. I acknowledge and understand that information shared about my child will be regarded as confidential information. I understand that the storage of these recordings is restricted to the speech and language pathologist and will be destroyed when the content of the recording is no longer needed or appropriate.

_____ **I DO** give permission for video recordings of my child to be shared with other professionals outside the special education team.
_____ **I DO NOT** give permission for video recordings of my child to be shared with other professionals outside the special education team.
Permission granted/not granted via phone on: _____By _____

Parent signature_____ date: _____