IMAGING CONSENT FORM

Child's First name:______________ Last name:______________ DOB:____________

I consent to photography &/or Video &/or Structured Light Imaging being made of me or the child/dependent named above whom is in my care for the purposes of evaluation, assessment and 3D design, if required.

Additionally, I agree that images may be:

	YES	NO
Retained on file for future treatment	________	________
Electronically transmitted to other care providers	________	________
Used for health-related education and training	________	________
Used in paper or electronic publications	________	________
Used in The Pediatric Headshape Clinic and Headstart Medical's website and/or social media content in conjunction with the childs scan dimensions	________	________

By signing below, I confirm that I understand this consent form.

____ ___________________

Signature of parent/guardian Date

____

Parent/guardian name (please print)

Pediatric Headshape Clinic