

Release Form

Agreement to confer rights to use photographs or videos to the University of Kansas

I hereby give my consent for my image to be recorded during KU School of Pharmacy Summer Camp to be used by the University of Kansas in any way related to the publicity programs of this organization.

Date: _____

Name (please print): _____

Email: _____

Grade level: _____

Hometown: _____

Signature: _____

By checking this box, I understand that the KU School of Pharmacy will continue to stay in touch with me via email and that I may opt out of those emails at any time.

If the participant is 17-years-old or younger, a signature from a parent or guardian is required.

Name of parent or legal guardian (please print) : _____

Signature of parent or guardian: _____

KU School of Pharmacy | 2010 Becker Drive, Lawrence, KS 66045
pharmacy@ku.edu | 785-864-3591

