HU School of Pharmacy Summer Pharmacy

Enrichment Program Information and Photo Release Authorization

Name _____ Age _____ High School _____

Address _____ Zip _____

Student Cell _____Student's email _____

Parent/Guardian Name _____ Phone _____

Parent/Guardian Name _____ Phone _____

Parent email address _____

Emergency Contact _____ Phone _____

Name(s) and phone number of person(s) other than parents allowed to pick up your child

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

**All persons picking up students will have to present identification at time of pick-up. **

Special notes:

_____

_____

_____

**SPECIAL WAIVER: I hereby authorize Hampton University School of Pharmacy and those acting in pursuant to its authority to record the student's likeness and voice on a video, audio, photographic, digital, electronic or any other medium for University publication or social media.

☐ **Yes**, I give Hampton University permission to photograph my child for University Publication.

☐ **No,** I do not give Hampton University permission to photograph my child University Publication.

Signature _____

Signature _____ Date _____