Initials: _____ **WAIVER OF LIABILITY**

This agreement releases **Little Medical School** from all liability relating to injuries that may occur by using a stethoscope, mortal pestle, blood pressure cuff, or any equipment used in particular classes. By signing this agreement, I agree to hold **Little Medical School** entirely free from any liability, including financial responsibility for injuries incurred, regardless of whether injuries are caused by negligence.

Initials: _____ **USE OF STETHOSCOPE** *(where applicable for certain classes)*

I acknowledge the risks involved in using a stethoscope. These include but are not limited to ear infections, blown ear drums, wrapping stethoscope around neck, and yanking of stethoscope causing injury. I swear that I am participating voluntarily, and that all risks have been made clear to me. Additionally, I do not have any conditions that will increase my likelihood of experiencing injuries while engaging in this activity.

By signing below I forfeit all rights to bring a lawsuit against **Little Medical School** for any reason. In return, I will receive a stethoscope. I will also make every effort to obey safety precautions as listed in writing and as explained to me verbally. I will ask for clarification when needed.

Initials:_____ **CONSENT TO PHOTOGRAPH, INTERVIEW, AND/OR AUTHORIZE THE RELEASE OF INFORMATION**

I consent and authorize to take photographs, video, or other visual images of me and/or my child and/or to record me and/or my child's voice, the results of which may be published into the public domain in print, visual, or electronic media including, but not limited to: brochures, direct mail, advertisements, newspapers, newsletters, magazines, television, radio, presentations, web sites, and trade show displays. I understand that the visual images or audio recordings may make me and/or my child's identity recognizable.

I agree that all reproduction and all copyrights associated with the above described media shall remain the property of **Little Medical School**. I understand that the use of the communications efforts may directly or indirectly benefit the program financially. I agree that my child and/or I are not entitled and release any right to any claim my child and/or I may have related to use of my and/or my child's visual images and/or audio recordings, including but not limited to, any claim for payment or royalty in connection with distribution or publication of these communications.

I understand that I have the right to revoke this authorization in writing at any time by written request to Little Medical School. But the revocation will not be effective to the extent that Little Medical School already relied on my authorization; for example, the revocation will not apply to publications already in production nor will it apply to publications already distributed to the public. Otherwise, the authorization will remain in effect for 5 years or until the media utilizing the photograph(s) or interviews are no longer in use, whichever occurs later.

I understand that **Little Medical School** will not condition me and/or my child's participation on whether I sign this consent and authorization. I have read and understand the terms of this Consent.

My signature below evidences my voluntary consent and authorization for the publication of visual images and/or audio recordings of me and/or my child by **Little Medical School**.

Name of Participant(s):

1. _____
2. _____
3. _____
4. _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____

Participant(s)' Parent/Guardian Name: _____

Participant(s)' Parent/Guardian Signature: _____

Date:_____