PO Box 28036 Oakridge R.O
London, ON N6H5E1
www.kidskickingcancer.ca

Student Permission Form

Student Information

Student Last Name:_____ First Name: _____

Known allergies or other medical conditions:_____

Parent or Legal Guardian Information

Primary Legal Guardian

Last Name:_____ First Name:_____

Address: Street_____City_____Prov___Postal Code_____

Contact Information

Home:_____ Cell:_____

Work:_____ Other:_____

Email:_____

Permission Form

Must be completed for patient and all *participating* siblings.

1. I grant full permission to Kids Kicking Cancer Corp., their agents, representatives and appointees to photograph and/or videotape my child(ren) and to use, publish and release for publication such photos relating to the Heroes Circle program. The name(s) of my child(ren) may be used in connection with the above-stated photographs with the understanding that there will be no exploitation of my child(ren) and that any photographs and/or videos will conform to good standards of taste.
2. Please list below all child(ren) participating in the Heroes Circle programs. Include the patient's name and any siblings *that will be participating*.

Patient Name:_____ Date of Birth:_/_/_____

Participating Sibling:_____ Date of Birth:___/___/_____ _____

Participating Sibling:_____ Date of Birth:___/___/_____ _____

Participating Sibling:_____ Date of Birth:___/___/_____ _____

Participating Sibling:_____ Date of Birth:___/___/_____ _____

Participating Sibling:_____ Date of Birth:___/___/_____ _____

Participating Sibling:_____ Date of Birth:___/___/_____ _____

Please Sign below-Thank you!

Parent/Guardian Signature:_____ Date___/____/_____

Print Name:_____

Relationship to Patient:_____ Relationship to other children:_____