

**Parent Authorization Sheet**

**Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Program: Summer Courses 2019**

**Authorization to Release Information:**

I give The Maryland School for the Blind permission to release written reports from the above programs on my child to our local school system

🞏Yes

🞏No

**TVI Name & E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorization to Transport:**

During our Above Program there may be some opportunities for off-campus activities. We believe these activities are important to a well-rounded program. Sometimes they may be of an educational nature, such as field trips to a museum or place of business. Other activities of a recreational nature, but equally important, might involve a baseball game, trip to a theater, etc. I grant permission for my child to participate in all off-campus activities of which the School approves.

🞏Yes

🞏No

**Authorization to Utilize Image or Photograph:**

Many pictures are taken during the above program of various activities. These pictures are sometimes used, along with press releases, to provide public relations information to television stations, newspapers and other publications. I grant permission for my son/daughter to be photographed for the above purposes

🞏Yes

🞏No

**Authorization to Participate in Orientation and Mobility Experiences:**

During the Program your child will receive exposure to mobility concepts which will facilitate the awareness or development of skills needed to become a safe, independent traveler in the community. Training may include basic overview and instruction in crossing city streets, using public transportation, and various other activities in an attempt to reach the above-mentioned purpose. Your child will be transported in the MSB vehicles by the mobility specialist(s) or MSB staff to the various travel sites. All safety precautions will be observed during this training period to safeguard your child who will be under the direct supervision of one of the Mobility Specialist(s) or MSB staff. I grant permission for my child to receive these services.

🞏Yes

🞏No

**Legal Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_**