Dear Parent or Guardian:

This year your child’s class will be working with ______________________________, a school counseling candidate from the Graduate School of Education at Portland State University. As part of his/her preparation as a counselor, he/she may be asked to make photo, video or audio recordings of his/her counseling work with students. The photo, video or audio recording is used to document their skills and interaction with children or clients, and share examples with their instructors or peers. While the focus of these recordings is the school counselor candidate, this may result in you/your child being recorded, so we are asking your permission to do so.

Candidates are required to store recordings securely and may only share them with faculty and peers as part of a course assignment or fieldwork. Recordings must be destroyed by two weeks after course grades are posted. If a candidate needs permission to use recordings for research or other purposes after that date, they will be required to request an additional release form from you with those details included.

Please review the attached permission slip, select your preference, then sign and return the form. If at any time you change your decision, please let us know in writing.

Sincerely,

Lisa Aasheim, PhD, School Counseling Program Coordinator
503.725.4253

Graduate School of Education
503-725-4619
615 SW Harrison Street, Portland OR 97201
Permission Slip

Student name: ___________________________________________  School/Teacher: ___________________________________________

I am the parent/legal guardian of the child named above. I have received and read your letter regarding a school counselor candidate from Portland State University recording audio/video or taking photos in the classroom and agree to the following:

   I DO give permission to you to include my child’s image and/or voice on video/audio recordings or photos as he/she participates in a class conducted at _________________ by ___________________ and/or to share these recordings with (Name of School) (school counselor candidate’s name) instructors or peers as part of classroom activities. No last names will appear on any materials or in discussions.

   I DO NOT give permission to make video/audio recordings or take photos of my child as he/she participates in a class activities.

Signature of Parent or Guardian ________________________________ Date: __________________________
Student/Client Consent Form

I have read, or have had this consent form read to me. I understand that it is possible that my picture or voice may become part of a recording. I also understand I am not the one being evaluated and that my last name will not appear or be used if the recording is shared with their instructors or in their classes. If I give permission and decide later that I don’t want to be included, all I need to do is tell the school counselor candidate.

I GIVE permission to you to include video/audio recordings or photos of me as I participate in class activities or counseling activities, and to share these recordings with instructors and peers as part of a class assignment.

I DO NOT GIVE permission to make video/audio recordings or take photos of me as I participate in a class activities or counseling activities

Signature of Student ____________________________ Date: _________ Date of birth: ___/___/____

MM DD YY