



\_\_\_\_\_  
Name of participant Date

\_\_\_\_\_  
AFS Program of participation

**PERMISSION TO USE PHOTOGRAPHS AND VIDEO FOOTAGE**

I understand that photographs and film and video footage (the "images") of current and former participants are occasionally used by AFS in promotional materials. By signing this Agreement, I grant to AFS the right to use, publish and/or reproduce for any lawful and legitimate purpose excerpts from interviews and letters, images and audio recordings and any other still or moving images of me taken during my involvement with AFS and to use my name in this connection. I understand that if I do not wish my images to be so used, I must mark the following box and initial the space beside it. By leaving this box blank, I understand that I will be deemed to have consented to such use.

Initial here if you DO NOT give permission for AFS to use such letters, images & audio recordings of yourself.

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

Should any medical emergency arise, if time permits, AFS will communicate with the person(s) I have designated below as the emergency contact(s) through the National Office and request permission for surgery or other necessary treatment; however, if in the sole judgment of AFS, time and circumstances do not permit communication with them, I authorize AFS to consent to medical treatment, the administration of x-ray examination, anesthetics, blood transfusion, medical or surgical diagnosis or treatment and hospital care and to make medical evacuation arrangements and transport, if required, which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon.

I am aware that some local government may require certain vaccinations in order for myself to participate in community responsibilities. I understand that I am responsible for any costs related to these requirements.

**AUTHORIZATION FOR RELEASE OF MEDICAL TREATMENT**

I hereby authorize AFS, and/or its duly authorized medical consultant, to obtain all medical records relating to examinations or treatments for me while I am on the program and any other information concerning such examinations or treatments..

**AGREED AND ACCEPTED:**

\_\_\_\_\_  
Signature of participant

\_\_\_\_\_  
Name of emergency contact Relationship

\_\_\_\_\_  
Work phone Home phone

\_\_\_\_\_  
Address