6 Self Permission Form

YP/SM 2010

PL ID#

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 and 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 INFORMATION

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.

PERMISSION TO PARTICIPATE IN THE KALEIDOSCOPE RESEARCH PROJECT

AFS is working with an independent research group to conduct a worldwide study named the Kaleidoscope Project. The aim of this project is to improve understanding of the impact of intercultural exchange programs. Participants will be invited by email from the research group to participate in a number of online questionnaires. At the end of the project, each participant will receive personalized feedback on their results. In the rare event of an early termination of the program, AFS will be contacted by the research group and asked to indicate one or more of seven broad reasons for the participant's early termination of the program, (e.g. "Participant has broken AFS rules"). Information provided by participants will be anonymously aggregated into the results and participant email addresses and other personally identifiable information will only be kept as long as necessary for purposes of conducting the study. We understand that if we do not want our son/daughter to be invited to take part in this study, we may indicate this with our initials below and our child's contact information will not be shared with the independent group conducting the study and they will not be invited to participate. We understand that if we do not initial below, our child will be invited to participate in this survey. More information on the study may be found at: http://www.kaleidoproject.org/

☐ Initial here if you DO NOT give permission for AFS to invite your child to participate in the worldwide research study.

AGREED AND ACCEPTED:

Signature of participant

Participant's Birthdate: day month (spell word) year

Name of emergency contact Relationship

Work phone Home phone

Address