SPECIAL NEEDS CHILD WATER EXERCISE, DOCTOR'S RELEASE FORM

FOR

TEXAS HEALTH HARRIS HEB PHYSICAL MEDICINE AND REHABILITATION
251 West Park Way, Euless, TX 76040
PHONE: 817-257-3308 FAX: 817-267-0207

TEXAS HEALTH RESOURCES PRESBYTERIAN HOSPITAL CVC CENTER
5721 Phoenix Drive, Dallas, TX 75231
PHONE: 214-345-4625 FAX: 214-345-4689

To be filled out and signed by a Physician

Physician Name: _____

Phone Number:_____

Special Needs Child's Name:_____

Date of Birth:_____ Age:_____

Address:_____

City:_____State:_____Zip Code:_____

Parent's/Guardian's Phone:_____

Diagnosis:_____

Precautions: _____

_____

_____

This release is valid for 12 months, unless there is a change in medical status which requires a new release. If the participant drops from the program for a period longer than 30 days/1 month, they will need a new release and to re-register.

_____ Date:_____

Physician Signature

Texas Health Resources®

Consent to be Photographed, Filmed, Videotaped
and/or Interviewed and Release of Liability

I, the undersigned, hereby consent to be photographed, filmed, videotaped and/or interviewed while a patient, employee, volunteer, physician or visitor of Texas Health Resources (THR) or any wholly owned or controlled member organization or an event sponsored by THR or one of its respective member organizations).

I agree that Texas Health Resources or any THR member organization may use or permit other persons to use the negatives, prints or video prepared from my photographs, words or written materials reflecting my interview for any purposes and in such manner as they may choose, including but not limited to use in informational or promotional materials about THR or any THR member, including:

- News coverage by television, newspaper, radio, internet or other media
- Video news releases
- Marketing materials
- internal and external communication, including newsletters and video productions
- Social media

I understand that I will not be paid or reimbursed in any way for current or future use of my likeness, words or ideas. I hereby give up any right to inspect or approve the finished product or products that may be used in connection therewith or the use to which it may be applied.

I HEREBY RELEASE AND AGREE TO HOLD HARMLESS TEXAS HEALTH RESOURCES (THR), ITS MEMBER ORGANIZATIONS AND THEIR TRUSTEES, OFFICERS, EMPLOYEES, AGENTS, PATIENTS, AND REPRESENTATIVES AND MEDICAL STAFFS OF THE THR HOSPITALS FROM ANY INJURY ANDIOR DAMAGES SUSTAINED AS A RESULT OF SUCH PHOTOGRAPHING, FILMING, VIDEOTAPING ANDIOR INTERVIEWING INCLUDING BUT NOT LIMITED TO, CLAIMS FOR PERSONAL INJURY, PROPERTY DAMAGE, INVASION OF PRIVACY ANDIOR BREACH OF CONFIDENTIALITY.

I have read and understand this consent prior to signing.

Signature _____ Date _____

Please Print:

Name _____ Phone _____

Address _____

City _____State ___ Zip _____

Email Address _____

Staff member name and signature completing the form (or witness)

Name _____

Signature _____ Date _____