

**Photography Consents
Valid One Year**

Child's Name: _____

Date: _____

Parent/Guardian Signature: _____

INTERNAL

I consent to the taking of photographs in which my child appears as indicated below. I will make no claim for payment for my child being photographed. I understand that for purposes other than so stated below, photographs in which my child may appear will only be taken if I choose to give additional photo release for each individual photo session.

Please circle a response for each INTERNAL photograph option

Displayed in classroom and/or center.	Yes	No
Visible in Procure by my family only.	Yes	No

EXTERNAL

I consent to the taking of photographs of my child by staff of Longwood Medical Area Child Care Center ("LMACCC") and/or their designees. I give my permission for the photographs to be used as indicated below. I release both the LMACCC and Longwood Collective from any responsibility for any claim that could arise as a result of the use of these photographs. I will make no claim for payment for my child being photographed.

Please circle a response for each External photograph option

LMACCC and Longwood Collective websites, newsletters, presentations, or other publications.	Yes	No
Visible in Procure by other families (e.g. photos of classmates together)	Yes	No
Available for staff memories (e.g. completion of internships, last-day recognitions, etc.)	Yes	No
Available as gifts to families (e.g. moving away memories, graduation events, etc.)	Yes	No