Dear Parent/Guardian:

Thank you for considering services from the Brent Woodall Foundation for Exceptional Children. In order for your application to be processed, please provide ***all*** of the information listed below:

___ 1) Intake Form Packet
- ___ Child and Family Information
- ___ List of the child's strengths and areas of concern as per parent's/guardian's opinion
- ___ Client Information
- ___ School / Therapy Information
- ___ Family and Birth History
- ___ Medical / Emergency Contact
- ___ Waiver and Indemnity Agreement
- ___ Signed and Notarized Policy form
  (Deposit information can be left blank until a therapy schedule has been set)
- ___Filming/ Photography Participation

___ 2) Medical History Documents
___ 3) Copies of previous Educational Testing (e.g. IQ tests or school evaluations)
___ 4) Copies of previous Assessments or Evaluations
(e.g. skills assessment, speech assessment, diagnostic assessment etc.)
- If you are waiting for your evaluation, please have the Doctor forward it to us.

___ 5) Copies of the most recent Individualized Education Plan (if previously/currently in a Special Education Program) or Individualized Family Support Plan (if previously/currently receiving ECI services)

***** We will be unable to process your application and schedule**
an appointment with you and your child until ALL information listed above is received***
*****Please send copies only; originals will not be returned*****

Please call 972-756-9170 or email at info@woodallkids.org with any questions or concerns regarding your application.

Turn in completed application to:

Brent Woodall Foundation for Exceptional Children
ATTN: Jennifer Chen
3021 Gateway Drive, Suite 295
Irving, Texas 75063

Fax: 214-614-4650
E-mail: Jennifer@woodallkids.org

INTAKE PACKET

CHILD AND FAMILY INFORMATION
PLEASE PRINT

Programs of interest: ☐ABA Therapy ☐Social Group

CHILD INFORMATION

Last Name:_____ First Name:_____ Middle:_____

Date of Birth: _____ Age:_____ Gender: _____

Address:_____ City: _____

State:_____ Zip: _____ Phone #(home): _____

Race/Ethnicity:_____ Language spoken by child: _____

REFERRAL DOCTOR INFORMATION

Child Referred by: _____ Phone #: _____

Doctor's Address:_____City: _____ State:_____ Zip: _____

Reason for Referral: _____

PARENT/GUARDIAN INFORMATION

Child Resides With: ☐Both Parents ☐Mother ☐Father ☐Guardian

If guardian: Is this the legal guardian? ☐Yes ☐No Relationship to child: _____

Primary Caretaker: _____

Parent/Guardian Full Name: _____

Cell #:_____Work #: _____

Home # (if different):_____E-mail: _____

Parent/Guardian Full Name: _____

Cell #:_____Work #: _____

Home # (if different):_____E-mail: _____

HOUSEHOLD MEMBERS

Name: _____ Age:_____ Relationship_____

Name: _____ Age:_____ Relationship_____

Name: _____ Age:_____ Relationship_____

Name: _____ Age:_____ Relationship_____

CHILD'S STRENGTHS AND AREAS OF CONCERN

Please list or explain areas of strengths:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list or explain areas of concern:

_____

_____

_____

_____

_____

_____

_____

_____

_____

CLIENT INFORMATION

Medical Diagnosis: _____ Date of Diagnosis: _____

Please check any of the following behaviors that your child displays:

☐Hyperactivity ☐Self-injurious behaviors ☐Echolalia (vocal repetition of others)

☐Anxiety (control/transition/coping difficulties) ☐Aggressive behaviors (toward others or objects)

☐Self-stimulatory behaviors (repetitive movements and/or sounds)

Please explain: _____

_____

_____

The above information will only be used for assessment and evaluation purposes.
It will not affect your child's eligibility to enter our program.

Does your child…	Never	Seldom	Occasionally	Often	Always
Use gestures (bye-bye, pointing, ect.)	0	1	2	3	4
Babble	0	1	2	3	4
Use single words	0	1	2	3	4
Use single words to request	0	1	2	3	4
Use phrases	0	1	2	3	4
Use phrases to request	0	1	2	3	4
Ask questions	0	1	2	3	4
Play with toys appropriately (independently)	0	1	2	3	4
Plays interactively w/ siblings	0	1	2	3	4
Plays interactively w/peers	0	1	2	3	4

Additional Info (specific words, toys, number of words in a phrase, comprehension, ect.):

_____

_____

_____

_____

_____

_____

_____

SCHOOL / THERAPY INFORMATION

Schools Attended

Name: _____ Date: _____

Name: _____ Date: _____

Name: _____ Date: _____

Therapy Services Provided By School

Speech Therapy: ☐Yes ☐No Hours per week: _____

Occupational Therapy: ☐Yes ☐No Hours per week: _____

Physical Therapy: ☐Yes ☐No Hours per week: _____

Other Therapy:_____ Hours per week: _____

Other Therapy:_____ Hours per week: _____

Other Therapy:_____ Hours per week: _____

Therapy Services NOT Provided By School

Speech Therapy: ☐Yes ☐No Hours per week: _____

Occupational Therapy: ☐Yes ☐No Hours per week: _____

Physical Therapy: ☐Yes ☐No Hours per week: _____

Other Therapy:_____ Hours per week: _____

Other Therapy:_____ Hours per week: _____

Other Therapy:_____ Hours per week: _____

Assessments : IQ tests, Basic Skills Assessments, Developmental Checklists
(e.g. WISC, WPPSI, Stanford-Binet, ABLLS, HELP, DAYC)

Assessment: _____ Date: _____

Assessment: _____ Date: _____

Assessment: _____ Date:_____

FAMILY HISTORY

Biological Mother

Education: ☐ Did Not Graduate ☐ GED ☐ High School ☐ Some College

☐ 2 year university ☐ 4 year university ☐ Advanced

Mother's Occupation: _____

Biological Father

Education: ☐ Did Not Graduate ☐ GED ☐ High School ☐ Some College

☐ 2 year university ☐ 4 year university ☐ Advanced

Father's Occupation: _____

Parent's Marital Status/Visitation

Child's Parents Are: ☐Never Married ☐Separated ☐Divorced ☐Married to Each Other

If separated or divorced, how often does the child see the non-custodial parent?

☐Regularly ☐Sometimes ☐Rarely ☐Never

Siblings

Number of siblings in the home: _____

Do any biological siblings have learning, speech, behavior, or other problems? ☐Yes ☐No

If Yes, please describe: _____

Family History

Please indicate if the mother, father, or anyone on either side of the family has a history of:

☐Mental Retardation ☐Genetic Syndromes ☐Autism/PDD-NOS ☐Asperger Syndrome

☐Schizophrenia ☐Bipolar Disorder ☐Anxiety ☐Seizures

☐Attention Problems ☐Depression ☐Drug Abuse ☐Alcoholism

☐Speech/Language Disorders ☐Learning Disabilities/Dyslexia ☐Neurological Problems

Stressors

☐Parent Separation/Divorce ☐Moves to Different Homes ☐Loss/Death of Friend or Pet

☐Family Financial Difficulties ☐Moves to Different Schools ☐Loss/Death of Family Member

☐Social Problems or Bullying ☐Multiple Absences/Tardies

BIRTH HISTORY

Was this child adopted? ☐Yes ☐No

Age when taken home: _____ Length of pregnancy: _____ weeks

Birth weight: _____lbs.

Was there trauma associated with the birth of the child? ☐Yes ☐No

If yes, please explain here:

_____

_____

_____

_____

_____

_____

MEDICAL/ EMERGENCY CONTACT

Doctor Information

Doctor's Name:_____

Address: _____City: _____ State: _____ Zip: _____

Medical Information

Medical Diagnosis: _____

Diet Specifications: _____

Allergies: _____

_____

Medications: _____

_____

Please check if your child has a history of:

☐Seizures ☐Sleep difficulties ☐Ear infections ☐Drooling

☐Staring episodes ☐Headaches ☐Chewing problems ☐Motor/vocal tics

☐Vision problems ☐Swallowing difficulties ☐Bowel problems ☐Hearing problems

☐Bladder problems

Previous hearing test results: ☐ Normal ☐Abnormal

Previous vision test results: ☐Normal ☐Abnormal

Medical History (Frequency of those checked above, if your child was sent to the hospital for anything, if your child has concurring issues, or if your child takes medication for any problem:

_____

_____

_____

Emergency Contact

In case of emergency, please contact:

Name: _____ Relationship to child: _____

Phone: _____

Name: _____ Relationship to child: _____

Phone: _____

I give the Brent Woodall Foundation permission to administer First Aid/CPR on my child if an emergency situation arises.

Parent/Guardian Signature:_____ Date: _____

WAIVER AND INDEMNITY AGREEMENT

We, _____ (mother) and _____ (father) acknowledge and agree to receive educational training from representatives of the BRENT WOODALL FOUNDATION FOR EXCEPTIONAL CHILDREN ("Indemnitee"), a Texas 501©3 corporation with its principal office located at 3021 Gateway Drive, Suite 295, Irving, Texas, 75063 (the "Company") pursuant to the following terms:

1. I understand that this Agreement does not create an obligation by the Company of its consultants to work with me or my family on an ongoing basis.
2. I understand that selected representatives from Indemnitee will work with me or designated representatives of my family regarding the training of Applied Behavior Analysis ("ABA"). I recognize that the designated representatives are trained in ABA work, and are NOT TRAINED MEDICAL PHYSICIANS. THEY ARE NOT TRAINED OR LICENSED TO PROVIDE A MEDICAL DIAGNOSIS OF ANY KIND OR TYPE.
3. I and my family shall indemnify, defend, and hold harmless Indemnitee, the subsidiaries and parent corporations of Indemnitee, each director, officer, employee, consultant, and agent of Indemnitee or any of its subsidiaries or parent corporations, and each affiliate of Indemnitee and its subsidiaries and parent corporations, and their respective heirs, legal representatives, successors, and assigns (collectively, the Indemnitee Group"), from and against any and all claims, actions, causes of action, demands, assessments, losses, damages, liabilities, judgments, settlements, penalties, costs, and expenses (including reasonable legal fees and expenses), of any nature whatsoever, whether actual or consequential (collectively, "Damages"), asserted against, resulting to, imposed upon, or incurred by any member of the Indemnitee Group, directly or indirectly, by reason of or resulting from receiving educational training for my child or children.

   Any suggestions made to seek other services are simply suggestions. If the client chooses to follow the suggestions, the client assumes full responsibility for all charges and/or damages resulting from services. The client will hold the clinician, and all associated individuals, harmless for any and all obligations, damages, and charges resulting from services rendered by others.

   Counseling/therapy is not a "quick fix" or a "cure all." It may or may not produce desirable results and, for some, may be detrimental. If at any time, you are not satisfied with the progress, approach, or techniques, you are encouraged to address this with the counselor, and you or the counselor may consider if services are still serving your needs at any time. Persistent lack of response to intervention may necessitate termination of treatment and/or referral to another healthcare provider for further treatment.

4. This Indemnity Agreement shall insure to the benefit of and be binding upon the respective heirs, executors, administrators, successors, and assigns of the Indemnitee and the undersigned.
5. This Agreement contains the entire agreement between the parties. No modification or amendment of this Agreement shall be of any force or effect unless made in writing and executed by the parties.
6. This Agreement, and the rights and obligations hereunder, may be assigned by Indemnitee to any of its affiliates at any time without the consent of the undersigned.
7. I agree that exclusive venue and jurisdiction of any dispute arising hereunder shall be in Dallas County, Texas, and that the terms and provisions of this Agreement shall be governed by and construed in accordance with the laws of the State of Texas without reference to its choice of law rules.
8. Except as expressly set forth herein, all disputes and claims relating to or arising out of this Agreement, including but not limited to all federal and state laws pertaining to the relationship, rights and obligations of the parties hereunder shall be settles totally, finally, and exclusively by binding arbitration in the City of Dallas, Dallas County, Texas, in accordance with the Federal Arbitration Act and the Commercial Arbitration Rules of the American Arbitration. Notice of such claim must be served on the other party within sixty (60) days of its inception to be valid. The decision of the Arbitrator(s) shall be final, and the judgment upon the award rendered by the Arbitrator may be entered in any court having jurisdiction thereof. This agreement to arbitrate shall survive the termination of this Agreement for any reason. The parties further agree that they may use alternate dispute resolution, including mediation, to resolve any differences and disputes between them.

AGREED TO BY:

Name (father)_____ Name (mother)_____

Address_____ Address_____

Signature_____ Signature_____

Date_____ Date_____

ACKNOWLEDGED BY:

BRENT WOODALL FOUNDATION FOR EXCEPTIONAL CHILDREN

By _____

Name _____

Title _____

Date _____

Brent Woodall Foundation for Exceptional Children
Client Policies
Revised March 2013
Please keep the policies so you may refer back to them.

Duplication of Services

The Brent Woodall Foundation does not allow for a duplication of services, meaning that if your child is receiving ABA from another therapist or therapeutic center, the Foundation will not provide ABA therapy. The BWF offers many other services that are complimentary to ABA therapy and would incorporate the principles of Applied Behavior Analysis while targeting specific areas of development. In order to have a successful ABA program it is important there are not competing programs in place. It can become confusing and impede your child's progress to have two ABA providers.

Billing Policy

Billing occurs at the beginning of each month for the month you will receive services. You will be charged for the set number of therapy hours as agreed upon with Tracy. For example, on October 1st you will be billed for the services you will receive for the month of October. We will notify you 30 days in advance of any holidays or closing the BWF has scheduled. Therefore, you will not be charged for those days. *Please note, the BWF may close unexpectedly due to inclement weather or other emergency in order to provide the safest environment for your children.* These days will not be refunded.

Payment Policy

The BWF requires a deposit equal to the amount of one month's invoice. A deposit can be made in the form of a cashier's check, cash, money order, check, or credit card. Any credit cards used for a deposit will be charged. These deposits will be deposited into your account and can be used for the last month of services. If payment is not made by the 5th business day of the month, the deposit may be used to pay for that month's invoice. If that occurs, you will be responsible for providing another deposit before the child can resume therapy. Your deposit may also be used to pay your bill in the event of a returned check. Additionally, you will be responsible for paying any returned check fees (currently our bank charges $35).

Bill payments can be made in the form of cash, personal check, cashier's check, money order, or credit card. If you would like to pay by credit card, you will need to complete a credit card processing form. You may keep a credit card on file to be charged automatically on the 5th business day of the month.

Once you have a schedule set for therapy, you will receive an email with your deposit amount and the first month's invoice. The deposit and the first month's invoice is due before the child begins their first therapy session.

Absence Policy

If you have alternative plans, in which you will not be attending the BWF during your scheduled sessions you must provide notice 30 days in advance in order for your account to be prorated. For example, if you are aware of specific observed holidays, vacation plans, or doctors' appointments, please let us know 30 days in advance and you will not be charged for those missed days. If you wish to reduce your scheduled number of hours or discontinue services, those changes must be made 30 days in advance in order to prorate your account. If you reduce the schedule number of hours or cancel services without 30 days notice, you will be financially responsible for the final 30 days of services, no exceptions. If you wish to increase your number of hours, those changes can be made at any time and those charges will be added to the following month's bill (note, we will always do our best to accommodate any additional sessions).

Sick Policy

Each month you will be given one (1) free sick day in which we will credit your next bill for that day's services. After that, credit or reimbursement will not be given for absences without email notice to Tracy 30 days prior to the services. If your child is sick, you must call the office (972)756-9170 and leave a message or email Tracy tracy@woodallkids.org by 7 am. If we do not hear from you by 7 am you will forfeit any reimbursement for that day's services. Cases of extended illness will be dealt with on a case by case basis through communication with Tracy.

Children must be fever, diarrhea, and vomit free for 24 hours without the use of fever reducing medication before returning to the office after being ill. If your child becomes ill while at our office, we will call you to pick him/her up immediately.

Nut Free Environment

The Brent Woodall Foundation is a nut-free zone. Please do not send food with your child that contains nuts of any kind. If those items containing nuts are brought into the office, we will be required to discard them immediately. If you eat or handle any nut products prior to entering our office, please wash your hands and/or use hand sanitizer.

Medications and Supplements Policy

We are unable to administer medications/supplements to any client. Parents may issue medications/ supplements to your child, but the medication/supplements cannot remain with the BWF staff. Parents must keep medication with them at all times. Medications or supplements cannot be put into a child's food or drinks. If you have any questions regarding this policy, please speak with Tracy.

Communication Policy

If you do not already have an email address, please set one up. Email is our main point of contact with each family. You will be receiving your monthly invoice and important notifications through email. It is also the most efficient way for you to communicate with us. All appointments, schedule changes, and meeting requests must be made to Tracy via email at tracy@woodallkids.org. We will still call if there are urgent cancellations. Please make sure your email will accept email from the following: info@woodallkids.org, development@woodallkids.org, carley@woodallkids.org, tracy@woodallkids.org, irina@woodallkids.org, bethany@woodallkids.org. In the event of inclement weather, we will give information regarding closing on our outgoing voicemail. If you are unsure if we are open, you can call 972-756-9170 to get that information. We will also do our best to post closings with the major news stations. You should also check out facebook page for up to the minute updates at www.facebook.com/woodallkids.

Open Door Policy

Observation of ABA therapy in the main therapy room is welcomed as a time for the parent to observe their child's progress and take notes on therapeutic procedures/programs. You are welcome to observe your child's entire session or observe only a part of the session. A waiting room is available when you are no longer observing your child or you may leave and return to pick your child up when his/her session is finished. Please plan to make arrangements for your other children when you are observing. It is distracting to the other children learning to have siblings in the therapy room. Please, do not leave children of any age unattended in the waiting room. Cell phones must be put away and turned to silent while in the therapy room.

Observation of the CALS & TIES programs is always welcomed; unfortunately not quite as accommodating for visitors. The CALS room is small and children in this program must be as mobile as their specific programming intends. This may mean that chairs are not always available for you to observe and standing is sometimes the only option when observing your child's programming. This is also the case in the small TIES room where the furniture and materials are set up to accommodate a specific number of children and adults in the room at a time. Because of this, it is difficult to be as flexible with TIES "drop-in" observation. While parents can observe their child through the room window at any time, Parents who would like to observe/take notes on their child's TIES programming should set up an appointment. We want to keep the number of people in the room at an appropriate number for the best rate of learning to take place at all times. Again, the door is always open for observation of your own child's programming, but if you would like to talk or read please move to the waiting room we have provided for you.

Observation of social groups is by appointment only. Some of our children are sensitive to major changes in their environment or schedule, such as a new adult in the room, and such a change may need to be introduced rather than spontaneous. Thank you for understanding.

Please note that our open door policy remains as a time for you to observe your child and take notes. Unless you have set up an appointment for a session with your child's Case Manager, please do not ask the therapist working with your child questions during this time. If you have a question about the programming or procedure please wait and email your child's Case Manager and he/she will be able to help you.

Late Policy

Therapy sessions have a specified start and end time. We cannot accommodate children left past their scheduled therapy sessions. If you are late picking up your child, you will be charged one dollar ($1) for every minute you are late. The charge will be added to your next invoice regardless of your grant status. Additionally, it is important your child be on time for their session or group. It is disruptive for children to arrive late and they miss out of their therapy time. There will be no proration or make-ups for late arrivals.

Required Parent Involvement

Parent involvement is essential to the success of our students. All BWF parents are required to attend at least one (1) meeting per month with their child's case manager for a minimum of fifteen (15) minutes. This meeting will be scheduled during your child's regularly scheduled session. This will give you the opportunity to be informed on the programs your child is working on. In addition to parent meetings, Tracy Pierce Bender holds Coffee Chat every Friday at either 11:00am, 1:00pm, or 4:00pm. Please check the website for dates and times. This is an open forum chat session which allows parents to ask questions about their child or share experiences. Tracy requests each parent to attend at least one (1) Coffee Chat per month. It is recommended parents attend the Parent Workshop held once per year. Additionally, it is required that parents attend at least one of our bi-monthly Mini-Workshops. Please check the website for dates and times.

Rates

Quality of service is of the utmost importance to the staff of the BWF. Our team of Case Managers and Assistant Case Managers has been and will continue working toward becoming certified by the Behavior Analysis Certification Board. The board of directors has set a standard billing rate for each level of therapist employed by the BWF. As a non-profit foundation, we rely on donations, grants, and fundraising in order to provide quality services at an affordable rate. The following rates apply to families who pay for services out of pocket. These rates are set by the board of directors as a way to assist families in accessing the necessary therapy for their child.

GROUP THERAPY	
Language Groups	**$15.00-$20.00/hour**
Social Groups	**$10.00-$20.00/hour**
ABA THERAPY	
Behavioral Consultation Services	**$75.00/ 2 hours** **$100.00/ 3 hours**
Behavioral Language Intervention Program (BLIP)	**$20.00/hour**
Communication and Life Skills (CALS)	**$22.50/hour**
Intensive Intervention Program	**$20.00/hour**
Practice for Advanced Language and Social Skills (PALS)	**$20.00/hour**
Targeted Intervention for Elementary Students (TIES)	**$20.00/hour**
OUTREACH	
Remote Consultation Services	**$75.00/ 2 hours** **$100.00/ 3 hours**
Family FIRST	**Free**
Supply Fee	**6% of all monthly bills**

Client Policy Acknowledgement

Please fill out completely and return to the Brent Woodall Foundation.

I, _____ and _____ have read, understand and agree to the policies of the Brent
(parent 1) (parent 2)

Woodall Foundation for Exceptional Children (last updated 3/2013).

Please initial next to each policy you have read and agree to.

Policy	Parent 1's Initials	Parent 2's Initials
Duplication of Services		
Billing Policy		
Payment Policy		
Absence Policy		
Sick Policy		
Nut Free Policy		
Medication and Supplement Policy		
Communication Policy		
Open Door Policy		
Late policy		
Required Parent Involvement Policy		
Service Rates		

_____ _____ _____
Parent/Guardian 1 Signature Date

_____ _____ _____
Parent/Guardian 2 Signature Date

Family Address: _____

_____

Email Address: _____

Both parents/guardians must sign this form:

State of_____ County of_____

on_____, before me, _____,
(date) (notary)

personally appeared, _____, & _____.
(signer #1) (signer #2)

_____ _____
Seal Notary Signature

Credit Card Processing Form

If you would like to keep a credit card on file, please provide you card information. Card information is stored in a secured and encrypted site and the paper copy will be shredded.

Credit Card Number:_____

Expiration Date:_____ CVC Code (3 digits on back of card):_____

Name on Card:_____

Billing Address_____

City:_____State:_____ Zip:_____

Child's Name:_____

☐ **Please keep this card on file for automatic payment of invoices.**

☐ **I would like to receive a receipt via email.**

Signature:_____

Filming and Photography Participation Consent Form

Introduction:

The Brent Woodall Foundation for Exceptional Children is requesting consent to film and photograph your child during various activities. These activities include: therapy, summer camps, Preschool Readiness Education Program (PREP), Communication and Life Skills program (CALS), Targeted Intervention of Elementary-Aged Students (TIES), etc.

The videos and pictures taken will be used on the Brent Woodall Foundation's websites and brochures, and will assist in promoting and advertising the services we provide to children and their families. This includes the appearance of your child's image (under a pseudonym) to appear in newspaper, magazine, and/or article publications promoting the BWF services. Several of our videos will involve clients demonstrating teaching skills and techniques and the photos may appear in our Facebook albums to demonstrate the success of our programs. Pictures and videos may be used for parents and professional workshops. All film and photography will be taken during your child's regularly scheduled sessions at the BWF.

Voluntary Participation:

Participation is voluntary. Your decision regarding whether or not to allow your child to participate will in no way affect your relationship with the BWF.

Procedures for Maintaining Confidentiality of Research Records:

If you give permission for your child to participate in photography and/or filming procedures, any relevant footage may be used for the BWF website or advertisement purposes. No identifiable information about your child will be provided. The confidentiality of your child's individual information may be maintained in any publications or presentation.

Questions about the Video or Pictures:

If you have any questions about photography and/or filming procedures, you may contact Executive Director Tracy Pierce Bender at Tracy@woodallkids.org.

Your Child's Rights:

Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- The filming process was explained to you and all of your questions were answered.
- You understand that you do not have to allow your child to take part in the filming/pictures, and your refusal to allow your child to participate will involve no penalty or loss of rights or benefits.
- You understand why the filming and photography are being conducted and how it will be performed.
- You understand your rights as the parent/guardian of your child and you voluntarily consent to your child's participation in filming/photography.
- You have been told you will receive a copy of this form.

Please fill out the below.

____ I hereby give permission for my child to be captured in filming and photography for the Brent Woodall Foundation. I understand that my child's confidentiality will be respected and I can withdraw this consent at any time.

____ I hereby give permission for my child's image and voice to be recorded for the Brent Woodall Foundation conference, but request his/her name remain confidential. I understand that my child's confidentiality will be respected and I can withdraw this consent at any time.

____ I am not willing for my child to be captured in photography and filming for the Brent Woodall Foundation. I understand that my child's confidentiality will be respected.

_____
Printed full name of child

_____ _____
Printed name of Parent/Guardian Signature of Parent/Guardian

_____
Date