BRESCIA UNIVERSITY
SCHOOL OF EDUCATION
PERMISSION TO DIGITALLY VIDEO-RECORD

I hereby give permission for my child, _____, to participate in a class that is digitally recorded on video. I understand the recording will be created as part of the Brescia University Clinical Practice Experience. The sole purpose of the recording is in the professional development and assessment of the Teacher Candidate listed below. All rules of confidentiality apply.

Name of Teacher Candidate:

Signature of Parent/Guardian:	Date: