PHOTO RELEASE FORM

I, ________________________________________________________, do hereby consent and agree that the Illinois Council of Health-System Pharmacists (ICHP) has the right to take photographs, video, or digital recordings of me and to use these in any and all media.

I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

ICHP intends to use such photographs and videos only in connection with ICHP official publications, media promotions, websites, or social media sites including but not limited to Facebook, Twitter, and YouTube, and that these images may be used without further notifying me.

I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent publication, transmission, or playback.

I represent that I am at least 18 years of age, or a parent/guardian of ____________, and have read and understand the foregoing statement, and am competent to execute this agreement.

☐ I do not consent.

Name: __________________________________________________________________________________

Parent/Guardian (if applicable): __________________________________________________________________________________

Signature: __________________________________________ Date: __________________________