THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

Media /Release Form

I _____

of _____

as parent/legal guardian of _____

hereby authorise the School of Medicine, and those acting pursuant to its authority to:

- Record the participation and image of the student named below on film, photograph, electronically or through any similar medium.
- Use his/her name, likeness, and any biographical material in connection with these recordings.
- Exhibit or distribute such recording in whole or part without restrictions or limitation for any educational and/or promotional purpose which the School of Medicine, and those acting pursuant to its authority, deem appropriate.

I understand that I will not receive any compensation or payment in consideration of the above educational and/or promotional materials.

I understand that the above terms and conditions will be in place for a period of up to five years from the date of signing this release form.

Activity/location/purpose: ExperienceMedicine@UQ
(UQ Rural Clinical School Work Experience Program)

Name of student: _____

School and year level : _____

Name of parent/guardian: _____

Signature of parent/guardian: _____

Date: _____

Please return completed form to:
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The University of Queensland Rural Clinical School
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Rockhampton Qld 4700
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E:kay.wolfs@uq.edu.au
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