

AUDIO/VIDEOTAPE RECORDING CONSENT FORM
PROGRAM IN SCHOOL COUNSELING

I understand that the counseling sessions provided to my child, _____
(First & Last Name)

by his/her counselor trainee, _____ will be recorded
(First & Last Name)

via audio/video tape in order to supervise and evaluate the counselor trainee. I further understand that confidentiality of all recorded sessions will be maintained. Only the counselor trainee and his/her supervisor and/or faculty instructor will have access to the recorded sessions. I understand that the recorded sessions may be reviewed by other counselor trainees for instruction purposes only.

My signature below indicates my understanding of and consent for recording sessions with my child:

Parent/Guardian's signature

Date

Student's Assent/ Consent

Date

Counselor trainee's signature

Date