



ASSOCIATION *of* PEDIATRIC
HEMATOLOGY/ONCOLOGY NURSES

PHOTO RELEASE (Minor)

Date: _____

I acknowledge that the Association of Pediatric Hematology/Oncology Nurses (APHON) is requesting permission, and through this release and in consideration of having the opportunity to have my minor child's photographic image utilized by APHON I am granting APHON such permission, to use my minor child's photograph in projects related to promoting the association and the profession of pediatric hematology/oncology nursing. These projects may include, but are not limited to, patient/family education booklets, educational CD-ROMs, textbooks, educational materials about the profession, and the APHON Web site.

I hereby give to APHON the right and permission to use my minor child's photographic image(s). I agree that all photographic images of my minor child used and taken by APHON are owned by APHON and that APHON may copyright material containing same. If I should receive any print, negative or other copy thereof, I agree not to authorize its public use by anyone else. I waive on my minor child's behalf any right to inspect or approve the finished copy, images, or printed matter that may be created in conjunction with this material. I also agree that APHON shall be without liability to me or my minor child for any distortion or illusionary effect resulting from the publication of my minor child's photographic image and that nothing in this Release requires APHON to make any use of the rights it is acquiring.

I represent that this agreement does not in any way conflict with any other existing commitment on my or my minor child's part and that I have not authorized, nor will I authorize, any other person or entity to use my minor child's photographic image in connection with the advertising or promotion of any product, service or other organization in any manner involved in or related to the pediatric hematology/oncology nursing profession.

I have read the forgoing release agreement before affixing my signature below and certify that I fully understand the contents of this release. I represent that I am the parent or legal guardian of the minor child identified below and that I have full authority to authorize the above Release. I hereby release and agree to indemnify APHON from and against any and all liability arising out of the exercise of the rights granted above.

Name of Minor Child

Name of Parent/Guardian

Date

Parent/Guardian Signature

Date

Witness Signature

Return to:

APHON
4700 W. Lake Ave.
Glenview, IL 60025
Fax: 847/375-6478