Students Working Against Tobacco (SWAT)
Registration and Participation Form
PINELLAS County

Name_____**Date**_____

Address_____**City**_____**Zip**_____

Home Phone_____ **Cell Phone**_____

Email address_____

School_____ **Graduation Year**_____

Date of Birth_____ **Sex**_____ **Ethnicity**_____

Parent/Guardian Permission:

I hereby grant permission for_____to participate in the Students Working Against Tobacco (SWAT) program of **PINELLAS** County for the period of time from July 1, 20___ through June 30, 20___. This may include various educational programs and field trips to sites around the state of Florida. I understand that we will be notified in advance of all field trips and be required to give permission for each individual event requiring transportation services. I understand that under present Florida law, if my child is riding in a private automobile that is involved in an accident, he/she will be primarily covered for bodily injury under my family automobile policy, and I agree to submit any medical bills incurred to my insurance company for payment. If my policy has been insured with a deductible clause relative to the personal injury protection, I understand that I have assumed that deductible amount when I purchased the policy.

I understand the following:

- My child or ward may be attending community events as a representative of Students Working Against Tobacco and the Bureau of Tobacco Free Florida.
- The activities/events are designed as a means to educate and update participating youth and community members on the latest techniques in tobacco prevention.
- My child or ward may be accompanied and transported by officials sponsoring these events or by their designated chaperone(s).
- I agree that no official or employee associated with the training will be held responsible for any injuries or damages occurring while my child is traveling to or from or participating in the training/meeting. I do hereby hold harmless the sponsoring agencies, their officials, divisions and agents against any and all liability, damage, loss, claims or demands which arise out of or are in any way connected with my child or ward's participation in the meeting.
- By signing this form I authorize my child to be transported to/from tobacco prevention and control activities within the county by tobacco staff personnel or a registered volunteer for the county's tobacco program.

Medical Treatment

- I hereby authorize any official of SWAT events or designated chaperone to consent to emergency medical treatment as necessary for the health and safety of my child. I further agree that no official or volunteer will be held responsible for injuries or damages arising from the provision of any such emergency medical treatment.
- I do hereby agree to indemnify and hold harmless the sponsoring agencies, their officers, divisions and agents from any and all liability, damage, loss, claims, or demands and actions of any nature whatsoever, including attorney's fees, which arise out of or are in any way connected with the provision of such emergency medical services.

Evaluation

- My child, or ward, may participate in evaluation projects facilitated by the Department of Health and others working for it or on its behalf. I give unlimited right and permission to use, distribute, publish, and reproduce the data from such projects.

Media Consent

- For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, I hereby grant to the Florida Department of Health and others working for it or on its behalf, and their respective licensees, successors, and assigns (collectively, "Client"), the unlimited right and permission to use, distribute, publish, exhibit, digitize, broadcast, display, reproduce, and otherwise exploit my child's or ward's name, picture, likeness, voice and biographical information, or any material based thereon or derived therefrom, or to refrain from so doing, in any manner or media whatsoever (whether now known or hereafter devised) anywhere in the world for the purposes of advertising or trade in promoting and publicizing Client and its products and services.
- I shall have no right of approval, no claim to compensation, and no claim (including, without limitation, claims should be based upon invasion of privacy, defamation, or right of publicity) arising out of any use, alteration, blurring, distortion, faulty reproduction, illusionary effect or use in any composite form of my child's or ward's name, picture, likeness, voice and biographical information.
- I have the full right and authority to grant the rights granted hereunder and I agree that this Consent and Release does not in any way conflict with any existing commitment on my part. I have not heretofore authorized (which authority is still in effect), nor will I authorize or permit the use of my child's or ward's name, picture, likeness, voice and biographical information in connection with the advertising or promotion of any product or service competitive to or incompatable with those of Client.

Parent/Guardian Signature _____ Date_____

Parent/Guardian Work Phone_____ Cell Phone_____

Other emergency number_____ Name of contact_____

Email address_____

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CONSENT, PERMISSION AND RELEASE FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to the Florida Department of Health (DOH) to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of (print name)_____, age (if minor) _____.

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by the DOH and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing.

I acknowledge that the DOH is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, Internet, intranet, or in other media once released.

The DOH has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold the DOH, its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: _____

Address: _____

Telephone Number/Email address: _____

Signature of Subject: _____ Date: _____

Required if Subject is under age 18:
Name of Parent/Legal Custodian: _____

Signature of Parent/Legal Custodian: _____

Witness Name: _____

Witness Signature: _____ Date: _____

☐ I am revoking this consent.
I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold the Department of Health responsible for instances of these violations.

Signature: _____ Date: _____