Information on the recording of personal data and declaration of consent

Place, Date

Address

Address

Address

Address

Dear parents and legal guardians,

A student from the FHNW university of teacher education is carrying out an internship in early curative education / speech therapy in your child's class.

For the training of students, parts of lessons / support / therapy are recorded on video using an audio recording device. It may be possible that you or your child might be recorded. The FHNW university of teacher education assures you that these data will be handed confidentially, the personal rights of all parties ensured, all data protection guidelines strictly complied with and no information or data shall be passed onto any external third parties. The data shall only be used for post-processing in the scope of the internship and thus shall expressly not be published. All data which are not anonymised shall be deleted after completion of the accompanying course. During the semester, the data shall be kept by the student. After the end of the semester, the data shall be deleted.

I ask you to agree to the collection of data by signing the enclosed confirmation. Please contact us should you have any questions.

(simone.kannengieser@fhnw.ch)

We thank you for your support.

Yours faithfully,

|  |  |
| --- | --- |
| University of Teacher Education FHNWInstitute for Special Education and PsychologyProf. Practical Studies and ProfessionalisationSimone Kannengieser\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Student's name and signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

----------------------------------------------------------------------------------------------------------------------------------------------------------

# Declaration of parents/legal guardian, patient

Surname and first name of pupil / child / patient:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surname and first name of the legal representative:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please tick the applicable box:

* I consent to the collection of the data for the described purpose. The declaration of consent is valid until revoked.

or

* I do NOT consent to the collection of the data.

Place, date Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please hand over the form to the student.**