Dear Families:

As a student teacher in your child’s classroom, I will be presenting one or more lessons in your child’s classroom. These lessons will be evaluated by a professor at the University of Wisconsin at River Falls to ensure that my teaching meets the Wisconsin State standards for communicating with students. This evaluation of my teaching fills one of the requirements I must meet in order to receive a teaching certification from the state of Wisconsin.

The purpose of this assessment is to evaluate my teaching. In order to do this, the project will include short video recordings of lessons taught in your child’s class, as well as samples of student work. In the course of taping, with your permission, your child may appear on the video recordings.

The video recordings will be used only in order to evaluate my instruction. The only people who see them will be teachers at the school and university faculty and supervisors. The recordings will not appear on the Internet or in other public settings. Any samples of student work that I collect for this assessment will not contain the student’s last names.

If you choose not to give your permission, then your child will still participate in the classroom instruction as usual. However, your child will just be seated out of camera range. Also, I will submit anonymous samples of student work as evidence of teaching practice, and that work may include some of your child’s work (with his or her name removed).

Please use the form provided to say whether or not you agree to have your child appear on the video.

PERMISSION SLIP

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School/Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am the parent/legal guardian of the child named above. I have received and read the project description, and agree to the following:

(Please check the appropriate box below.)

◻ I DO give permission to you to include my child’s image on video recordings as he or she participates in a class conducted at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by

(Name of School)

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

(Teacher’s Name)

and/or to reproduce materials that my child may produce as part of classroom activities. No actual last names of any child will appear on any materials submitted by the teacher.

◻ I DO NOT give permission to video record my child or to reproduce materials that my child may produce as part of classroom activities.

Signature of Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_