**SCHOOL OF HEALTH SCIENCES**

**SCHOLARSHIP PERMISSION/AGREEMENT FORM**

**Permission**

I hereby grant the Purdue University School of Health Sciences permission to send information about me (such as my academic record; contact information; scholarship application material; financial aid verification; recommendation letters; picture or news release to the media and our School web site) that might be useful to companies, individuals and/or other organizations for the purpose of scholarship or other award selection.

**Exception Clause**

I do not give permission to release my: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agreement**

I further agree that if selected to receive a scholarship or other award, I will:

1. prepare a thank you letter to the donor; and
2. attend any related receptions or events in which the donor(s) will be present.

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

Name

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

Signature

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

Date