SIBSHOP REGISTRATION FORM

This form with payment must be completed before your child(ren) can participate in SIBSHOP.

Name of Siblings Attending: ____ Grade: ____________

____ Grade: ____________

Parent/Guardian: ____

Address: ____

Email: ____

Phone: (H) _________________________ (W) _________________________

Sibling's Name with Special Needs: _____________________________________ Age: ______________

Sibling's Disability: ____

Ages of all other siblings: ____

What are your reasons for enrolling your child(ren) in the Sibshop program?

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Do you have any particular topics that you would like addressed at Sibshop?

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Does your child(ren) have any food allergies or other restrictions?

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Emergency Contact – Other than Parent: ____

In case of injury, I do hereby waive all claims, or legal actions, financial or otherwise against Advocates for Developmental Disabilities of Steele Co. Inc., their elected board members, facilitators or any volunteer connected with the Sibshop program. I give Advocates for Developmental Disabilities permission to obtain emergency medical treatment if your child(ren) has a medical emergency during Sibshop and neither you nor your emergency contact can be reached.

____ ______________________
Signature of Parent or Guardian Date

I give Advocates for Developmental Disabilities permission to use any photographs, videotapes or recordings of my child(ren) to be used for publicity purposes.

____ ______________________
Signature of Parent or Guardian Date