Circles of Life Sibshop Registration Form 2018

(There are 2 pages to this form.)

Sibshop is offered at the Circles of Life conference for typically-developing brothers and sisters of people with developmental disability, special health, or mental health concerns. Sibshop is open to ages 8-17. Younger children meet separately from teens. For more information about Sibshops, visit http://wisconsibs.org/what-we-offer/sibshops/

Complete and mail to: **WisconSibs, 211 E Franklin St, Appleton, WI 54911 by April 18.**

Today's Date:_____

Child's Name attending Sibshop: _____Nickname_____

Date of birth: _____ Male___ Female____ Grade in school _____ T-shirt size _____

Does this child receive any special services (eg. Counseling, speech-language therapy, special education)? __yes __no
If yes, describe:

Parent(s) or guardian(s) name(s): _____

Home address: _____City _____ Zip _____

Home telephone: _____ Cell phone:_____ Work phone: _____

Email address that you check regularly: _____
(VERY IMPORTANT: Email will be the primary method of communicating with parents prior to the Circles of Life event.

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

Do you have any concerns about enrolling your child in this Sibshop?

Please provide any other information that you feel will make this an enjoyable and valuable experience for your child:

SIBLING WITH SPECIAL NEEDS -

Name of brother or sister with special needs: _____

Date of birth: _____ Male __ Female ____ Nature of disability or illness: _____

How would you describe the relationship between this child and the sibling attending Sibshops currently?
(Close, Distant, Loving, Tolerant, Frustrating, Involved, Uninvolved,, etc.)

Does your child with special needs attend the same school as sibling attending Sibshop? ___ yes ___ no
Will your child with special needs be attending the Circles of Life conference? ___ yes ___ no

PERMISSION FORM – for child(ren) attending Sibshop.

Child's Full Name _____

I understand that in case of serious injury or illness, the person that I identified as the emergency contact will be notified, but if it is impossible to contact us, we give permission for emergency treatment or surgery as recommended by the attending physician.

Name of person to contact in an **emergency**; _____

Emergency phone(s):_____ _____ Relationship to child: _____

MEDICAL INFORMATION FOR THIS CHILD

In the case that medical information is required, the following information must be available:

Child's Physician: _____ Phone Number: (_____) _____

Insurance provider: _____ Policy or group number _____

Is this child subject to or bothered frequently with any of the following: (Please explain)

YES	NO		YES	NO		YES	NO	
		Headaches			Bee/Bug Stings			Sore throat
		Sinusitis			Heart trouble			Diarrhea
		Epilepsy			Hernia			Fainting spells
		Allergies			Ear Infection			Attention Deficit
		Constipation			Upset Stomach			Mental Illness
		Asthma/Hay fever			Tonsillitis			Other_____

*List any FOOD allergies or diet restrictions: _____

I further understand that In case of injury, I do hereby waive all claims or legal actions, financial or otherwise, against WisconSibs, Inc, the Circle of Life organizers, sponsors, supervisors or any volunteer connected with the program.

_____ _____
Signature of Parent of Guardian Date

PHOTO PERMISSION

I grant full permission to use any photographs, videos, or recordings or any other record of this program for the purpose of community education and awareness. (Child's full name will not appear on WisconSibs website even if you sign this form.)

_____ _____
Signature of Parent or Guardian Date