

**Workshops for brothers and sisters of kids with developmental disabilities!**

**For more information call: The Arc of Frederick County • 301-663-0909 • www.arcfc.org**



**SIBSHOP REGISTRATION FORM**

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

How did you hear about Sibshop? \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Does this child receive any special services (e.g., counseling, speech therapy, special education)?  
\_\_\_\_\_  
\_\_\_\_\_

Parent(s) Name(s): \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Name of brother or sister with special needs: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ School: \_\_\_\_\_

Nature of disability or illness: \_\_\_\_\_  
\_\_\_\_\_

What kind of related special education services (e.g., speech, occupational, or physical therapy, counseling, etc.) does this child receive?

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

Other Siblings:

| <u>Name</u> | <u>Date of Birth</u> | <u>Age</u> | <u>Gender</u> |
|-------------|----------------------|------------|---------------|
| _____       | _____                | _____      | _____         |
| _____       | _____                | _____      | _____         |
| _____       | _____                | _____      | _____         |

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

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

---

---

---

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

---

---

---

Does your child have any food allergies or restrictions?

---

---

---

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

---

---

---

I assume all risks and hazards of the conduct of the program and release from responsibility any person providing transportation to and from activities. In case of injury, I do hereby waive all claims or legal actions, financial, or otherwise against The Arc of Frederick County, their elected officials and employees, the organizers, sponsors, supervisors or any volunteer connected with the program. In absence of a signature, participation in the program shall constitute acceptance of the conditions set forth in the release.

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

\_\_\_\_\_  
Date

I grant full permission to use any photographs, videotapes, motion pictures, recordings, or any other record of this program for any purpose.

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

\_\_\_\_\_  
Date



**Please return this form to:**  
The Arc of Frederick County  
Attn: Colette Hough  
620-A Research Court  
Frederick, MD 21703