



**Thursday, August 4<sup>th</sup> 2011**  
**Ironwood Springs Ranch**  
**8:00am – 4:30pm**

\*Please complete one of these registration forms by July 14<sup>th</sup> for each child who plans to participate in Sibshops.

**Participant Information:**

Child's Name: \_\_\_\_\_ Age (6-13yrs): \_\_\_\_\_ Gender: \_\_\_\_\_

Transportation Needed:  Yes  No (\*\*More information to follow upon registration.)

Parent(s) Names: \_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Alternate phone: (\_\_\_\_) \_\_\_\_\_

- I have enclosed my payment of \$10 for my enrolled child to attend this Sibshops program.  
 I am interested in receiving information about scholarships available for my child to attend this Sibshops program.

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

Name or description of disability or health concern: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_

*\*\*\*Sibshops are best described as opportunities for brothers and sisters of children with special health and developmental needs to obtain peer support and education within a recreational context. Sibshops are not therapy, although their effect may be therapeutic for some children.\*\*\**

Has your child ever attended a Sibshop program before:  Yes  No

If yes, can you please give us feedback about your child's experience: \_\_\_\_\_

What do you hope your child will gain from this Sibshop or future Sibshop opportunities? \_\_\_\_\_

Does your enrolled child have any special needs, food allergies or other health restrictions of their own that we should know about? \_\_\_\_\_

*I hereby give my child permission to participate in Sibshops. I also agree to hold Sibshops harmless for any and all liability incurred as a result of my child's participation, including use of transportation. Further, I grant full permission to use any photographs, videotapes, recordings or any other record of this program for the purpose of education and promotion of Sibshops.*

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)

**Please mail registration form and payment of \$10 to:**

Holli Johnson, L.I.C.S.W.  
St. Mary's Hospital, Dom. 1-254  
1216 2<sup>nd</sup> St. SW  
Rochester, MN 55902

(For questions or additional registration forms, contact Holli Johnson at (507) 284-6819 or johnson.holli@mayo.edu)