

Mayo Clinic Sibshop

Please complete this form for all who wish to participate in Mayo Clinic Sibshop program on Saturday April 30, 2011.

Participant Information:

Childs Name: _____

Birth Date: _____ Age: _____ Gender: _____

School: _____ Grade: _____

Parents Names: _____

Home address: _____ City: _____

State: _____ Zip: _____ E-mail _____

Home phone: (____) _____ Alternate phone: (____) _____

Sibling Information:

Name of brother or sister with special needs:

Name or description of disability or health concern:

Birth Date: _____ Age: _____ Gender: _____

Ever attended a Sibshop program before: Yes No

I hereby give my child permission to participate in Sibshop. I also agree to hold Sibshop harmless for any and all liability incurred as a result of my child's participation. 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 Sibshop.

Signature of Parent or Guardian

Date:

Please mail registration form to:

Cindy Oftedahl

Mayo Clinic, Lobby 64-W

200 First Street SW

Rochester, MN 55905

**If you know of a child that could benefit,
please give them the flyer and registration form.**

Thank you.

Sibshops

A program for children and teens
who have a sibling with
a chronic illness
or life-long health concerns.

Saturday, April 30, 2011

9:00 a.m. to 12:00 p.m.

Jester Hall

Rochester Methodist Hospital

Rochester, MN

Activities and fun for
kids and teens!