



**SIBSHOP INFORMATION FORM**

This information form must be completed for all who wish to participate in Sibshops.  
(Please print)

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

Child's name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Gender: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Does *this* child receive any special services (counseling, speech-language therapy, special education, etc)? \_\_\_\_\_  
\_\_\_\_\_

Parent(s) name(s): \_\_\_\_\_

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

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

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

Name of sibling with special needs: \_\_\_\_\_

Birth date: \_\_\_\_\_ Gender: \_\_\_\_\_

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

School: \_\_\_\_\_

**Other siblings:**

Name	Birth date	Age	Gender
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does the child enrolled for Sibshops have any food allergies or health restrictions that we should know about? \_\_\_\_\_

What do you hope your child will gain from Sibshops? Do you have any specific topics you would like addressed? \_\_\_\_\_

Please provide any information that will enhance your child's enjoyment of Sibshops:

I assume all risks and hazards of this program and release from responsibility any person who provides transportation to and from activities. In case of injury, I do hereby waive all claims or legal actions, financial or otherwise, against Family Support Network and any employees, organizers, sponsors, supervisors or volunteers connected with the program. In case of injury, I authorize a Sibshops supervisor to obtain needed medical care for my child.

Parent signature: \_\_\_\_\_

Private insurance company: \_\_\_\_\_

Policy number: \_\_\_\_\_ Policy holder: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

**Photo release:**

I grant full permission to use any photographs of this program to promote the activities of the Family Support Network of Greater Forsyth.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

*Please return completed form to:*

Family Support Network of Greater Forsyth  
4505 Shattalon Drive  
Winston-Salem, NC 27106  
Or FAX to 336.924.0388

added to mailing list \_\_\_\_\_

