



REGISTRATION FORM Ages 8 - 13

Child's Name: _____
Date of birth: _____ Age: _____ Gender: _____
School: _____
Does this child receive any special services (e.g. counseling, speech-language therapy, special education)? _____
Parent(s)/Caregiver(s) Name: _____
Home Address: _____
County: _____
Home Telephone: _____
Email Address: _____

Name of brother or sister with special needs: _____
Date of birth: _____ Age: _____ Gender: _____
Nature of disability or illness: _____

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

At what hospital does this child receive care? _____

Other Siblings			
Name	Date of birth	Age	Gender
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 my child's participation in Sibshop programs and activities sponsored by Riley Hospital for Children and Easter Seals Crossroads. I do hereby waive all claims or legal actions, financial or otherwise, against the sponsoring organizations, the Sibshop site, or their elected and appointed officials and employees, the organizers, sponsors, supervisors or any volunteer connected with the program. I grant full permission to use any photographs, videotapes, motion pictures, recordings, or any other record of this program for any purpose. In absence of signature, payment of fees and child's participation in the program shall constitute acceptance of the conditions set forth in the release.

Signature of Parent or Guardian

Date

Please return this form and the registration fee (a check for \$7 per child attending made payable to **Indiana University**) and mail to:

The Community Education and Child Advocacy Department
Riley Hospital for Children
575 West Drive Room 008
Indianapolis, IN 46202-5272
Attn: Sibshops