



REGISTRATION FORM Ages 14 - 17

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Date of Sibshop: \_\_\_\_\_  
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: \_\_\_\_\_

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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? \_\_\_\_\_

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**Other Siblings**

Name	Date of birth	Age	Gender
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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

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

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

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Parents are encouraged to attend the last hour of the Young Sibshop to eat lunch with their child and participate in afternoon activities. Registration fees cover lunch for both the child and parent or guardian/caregiver.

Does your child have any food allergies or restrictions? \_\_\_\_\_

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

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*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