



**Presented by Family Support Network
of Wake County**

Sibshop Information Form
**(This information must be completed for all
who wish to participate in Sibshops.)**

Date: _____

Child's Name: _____

Birth Date: _____ Age: _____ Gender: M or F

School: _____ Grade: _____

Parent(s) Name(s): _____

Home Address: _____

City: _____ Zip: _____

Home Phone: (____) _____

Alternate Phone: (____) _____

E-mail: _____

Name of brother or sister with special needs: _____

Age: _____ Gender: M or F

School: _____ Type of Class: _____

Name or description of disability or health concern. _____

Other Siblings:

Name:	Age:	Gender:

What do you hope your child will gain from our Sibshop? Are there any particular topics you would like addressed? _____

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

Please provide any other information that you feel would make Sibshops a more enjoyable and educational experience for your child: _____

Would you like your name placed on a list to be distributed to siblings and their families: ____ Yes ____ No.

Would you like your phone number included? ____ Yes ____ No

Comments: _____

____ I hereby give my child permission to participate in Sibshops.

____ I grant full permission to use any photographs, videotapes, recordings or other record of this program for the purpose of education and promotion of Sibshops.

Signature of Parent or Guardian

Date