



REGISTRATION FORM

Please indicate the **location** where your child will be attending Sibshops and the **age group**:

\_\_\_\_\_

Date: _____
Child's Name: _____
Date of birth: _____ Age: _____ Gender: _____
School: _____
Does this child receive any special services (e.g. counseling, speech therapy, special education)? _____
Parent(s) name(s): _____ E-mail address: _____
Home address: _____
City: _____ Zip code: _____
Home telephone: _____

Name of brother/sister with special needs: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Nature of disability: \_\_\_\_\_

School: \_\_\_\_\_ (over →)

What type of related special education services (e.g. speech, occupational or physical therapy, counseling, etc.) does this child receive? \_\_\_\_\_

Other siblings:

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

Do you have concerns about enrolling your child in the Sibshops program?

\_\_\_\_\_

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

\_\_\_\_\_

Please list 3 adults who will be responsible for picking up your child after each session.		
<u>Name:</u>	<u>Date of birth:</u>	<u>Relationship to child:</u>
(1) _____	_____	_____
(2) _____	_____	_____
(3) _____	_____	_____
Does your child have any allergies to food products? _____		
Does your child have any special dietary needs? _____		

How did you hear about Sibshops? \_\_\_\_\_

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 the conduct of the program and release from responsibility any person providing transportation to and from activities. In case of injury, I do hereby waive all claims or legal actions, financial, or otherwise against Mt. Washington Pediatric Hospital, Abilities Network, Baltimore County Public Schools Office of Special Education, Baltimore County Infants and Toddlers Program/Family Support Network, The Arc of Anne Arundel County, The Arc of Howard County, The Family Support and Resource Center of the Howard County Public School System The Arc of Montgomery County, Partners for Success, MD School for the Deaf, Jewish Community Services, the Mitchell David Teen Center, The Arc Northern Chesapeake Region, Harford County Infants and Toddlers Program, Partners for Success Resource Center, Harford County Public Schools, Mt. Christian Church, NIH, The Children’s Inn at NIH, Johns Hopkins Bloomberg School of Public Health, Kennedy Krieger Institute, Villa Maria, Maryland Coalition of Families for Children’s Mental Health, their elected officials and employees, the organizers, sponsors, supervisors, or any volunteer connected with the program. In absence of a signature, payment of fees and participation in the program shall constitute acceptance of the conditions set forth in the release.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

Please return this registration form and the registration fee-- a check made payable to:  
*Mt. Washington Pediatric Hospital*- and mail to:

Mt. Washington Pediatric Hospital  
Child Life Department  
Attention: DOLLY MAGSINO/SIBSHOPS  
1708 West Rogers Avenue  
Baltimore, MD 21209-4596