



### Sibshop Registration Form

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

*There is a limit of 20 children for each session of Sibshop. A minimum of 8 children is required to hold a Sibshop. Sign up today!*

**Child's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

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

Heritage:  African American  Asian  Caucasian  Hispanic  Native American  Other

Household Income: *Please check appropriate family annual income. This will assist our agency in providing feedback to our funding sources.*  \$0—\$11,999  \$12,000—\$14,999  
 \$15,000—\$24,999  \$25,000—\$49,999  \$50,000—\$74,999  More than \$75,000

Does this child receive any special services (e.g., counseling, speech-language therapy, special education)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Home Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

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? \_\_\_\_\_  
\_\_\_\_\_

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 Sibshops? \_\_\_\_\_

Do you have any particular topics that you would like addressed during 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:

How did you hear about us? (Please circle one)

Easter Seals Website      Autism Society of Southeastern Wisconsin      Email      Facebook  
Friend      Easter Seals Newsletter      School      Other \_\_\_\_\_

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 Autism Society of Southeast Wisconsin, their elected and appointed officials and employees, the organizers, sponsors, supervisors, or and volunteer connected with the program. In absence of signature, payment of fees and participation in the program shall constitute acceptance of the conditions set forth in the release. I grant full permission to use any photographs, videotapes, motion pictures, recordings, or any other record of this program for any purpose.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

Please complete this form and mail to:

Autism Society of Southeastern Wisconsin, 3270 N 124<sup>th</sup> St., Suite O, Wauwatosa, WI 53222

OR scan and email as an attachment to [Julie@assew.org](mailto:Julie@assew.org) with SIBSHOP in the subject line

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