Sibling Workshop – 2016/2017
REGISTRATION FORM

Participants Name: _____ Parent / Guardian: _____

Date of Birth: _____ Age: ____ Telephone: _____ Cell: _____

Health Card #: _____ Address: _____

Does your child have any special needs we should be aware of (**i.e. allergies, special diet, seizures, etc)?** _____

_____

Does your child require an EpiPen? ☐ No ☐ Yes, please describe reaction / symptoms: _____

_____

Please indicate current agency involvement: ☐ Community Living ☐ Salvation Army
☐ Autism Ontario ☐ CPRI
☐ Other (Please indicate): _____

Emergency Contact: (in the circumstance that you can not be contacted)

Name: _____ Relationship to child: _____

Address: _____ Phone #: _____

Consent
I/we hereby give consent for The Salvation Army London Village, Community Living London, Autism Ontario and CPRI Sibshop personnel to share information, as necessary, while planning and implementing Sibling Workshops. Initial:_____

Liability Release
I/we will not hold The Salvation Army London Village, Community Living London, Autism Ontario, or CPRI Sibshop personnel liable, should any accident, illness, or injury while my /our child is participating in the Sibling Workshop. Initial:_____

Emergency Consent
I/we hereby give consent for my/our child to be transported to a medical facility and /or treated by a physician or qualified emergency medical staff should there be an emergency or accident. Initial:_____

Authorization for Photographs
I/we hereby give my authorization for photographs or videotapes to be taken of my/our child and to be released for print or display for promotional/educational or other purposes. Initial:_____

_____ _____
Signature of Parent / Guardian Date

_____ _____
Signature of Witness Date

Email address for future Sibshop mailings: _____ Initial for email Consent: _____

Thank you for completing

Sibling Workshop – 2016/2017
Family Background Information

Name of Sibling Attending Workshop: _____

Name of Sibling with Disability: _____

Sibling with Disability's Date of Birth: _____ Current Age: _____

Parent / Guardian(s): _____

Diagnosis / Information specific for sibling with special need(s):_____

_____

_____

_____

_____

_____

_____

Please indicate current agency involvement:

- ☐ Community Living
- ☐ CPRI
- ☐ Autism Ontario
- ☐ Salvation Army
- ☐ Other (Please indicate): _____

Positives / negatives of relationship between siblings or concerns: _____

_____

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This background information will assist in preparing for discussions and therapeutic activities.

Thank you for completing