*A Program JUST for **Brothers & Sisters** of Kids with Special Needs*

Celebrating the many contributions made by brothers & sisters

Meet other kids ages 8-13, who have a sibling with special health or developmental needs

*Connect with kids who have a sibling with special needs

*Meet friendly kids in a safe, fun environment

*Play fun, high-energy, exciting games

*Talk about the good and not-so-good parts of having a sib with special needs

Sibshops are offered in Montgomery County for siblings ages 8-13

Sundays from 1-5 pm

September 18, October 9, November 20, 2016

$30*/3 sessions (snack included)

Join us for all sessions for the most rewarding experience

Registration Deadline: September 6, 2016

Program Location: The Arc Montgomery County,
10611 Tenbrook Drive, Silver Spring, MD 20901

For more information, please visit: www.thearcmontgomerycounty.org and http://www.mwph.org/programs/pm-rehabilitation/services/sibshops, call 410-578-5169, or email Sibshops@mwph.org

**Limited number of scholarships available. Donations welcome.*

Sponsored by: Mt. Washington Pediatric Hospital • The Arc Montgomery County

Registration Form

Baltimore 8-13 **Montgomery County 8-13** **Special Families Unite**

Today's Date:_____

Child's Name:_____

Date of birth:_____ **Age:**_____ **Gender:**_____

School:_____

Does this child receive any special services (ie- counseling, speech therapy, special education)?

_____

Parent(s) name(s):_____

E-mail address:_____

Home address:_____

City:_____ **Zip code:**_____

Contact number: ( )Home or ( )Cell phone_____

Name of brother/sister with special needs:_____

Date of birth:_____ Age:_____Gender:_____

Nature of disability:_____

School:_____

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.

Name: ***Date of birth:*** ***Relationship to child:***

(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 additional information that you feel will make this an enjoyable 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, Baltimore County Public Schools Office of Special Education, The Arc of Montgomery County, Partners for Success, The Arc Northern Chesapeake Region, Partners for Success Resource Center, Harford County Public Schools, Mt. Christian Church, 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

Email or mail completed forms to : sibshops@mwph.org

Mt. Washington Pediatric Hospital
Child Life and Therapeutic Recreation Department
Attention: SARAH BEALE/SIBSHOPS
1708 West Rogers Avenue
Baltimore, MD 21209-4596

STANDARD RELEASE for Sibshops Participants

I, _____, give my consent to the
Parent/ Caregiver's Name

Sibshop Interagency Team to:

_____ Use my likeness or my child's likeness in ***print materials*** for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs
(ie- photos in Newsletters, for Sibshops presentations, etc).

_____ Use my likeness r my child's likeness in ***television news stories or television commercials*** for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs.

_____ Use my child's ***artwork*** in print materials for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs.

_____ Use my child's ***likeness and/or artwork on the World Wide Web*** for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs.

_____ Provide my ***child's email and/or home address and phone number*** to all Sibshops participants

_____
Child's Name

_____
Date

_____
Parent/Caregiver's Signature

_____

Witness

Sibshop Interagency Team:

Mt. Washington Pediatric Hospital | The Arc Montgomery County

Revised February 2011

SIBSHOPS
Parental Release for:

EMERGENCY MEDICAL TREATMENT

I, _____, parent or guardian or
Parent's Name

_____ , give permission to the Sibshops staff to
Child's Name
Staff to secure, if necessary, emergency medical treatment for my child. I realize the Sibshops staff will make every effort to contact me, or any additional local emergency contacts that are named here, after securing emergency medical care, including calling 911 if necessary. This permission is granted for the Sibshops offered from:

___March 1 2016_____ to ___March 1 2017_____.
Date Date

Sibshops of Maryland is an interagency consortium involving:
Mt. Washington Pediatric Hospital and The Arc Montgomery County, and their staff, volunteers and sponsors.

Parent/Guardian _____
Name

Signature _____

Date _____

Revised February 2011

SIBSHOPS

Participant EMERGENCY MEDICAL TREATMENT Information

Child's Name _____ **Date of Birth** _____

Address _____

City _____ **Zip Code** _____

Allergies (Include Food & Medications) _____

_____

Medications taken _____

Primary Doctor ***Name*** _____

Phone _____

Emergency Phone _____

Health Insurance ***Name*** _____

Phone _____

Policy # _____

Mother's Name _____

Contact # _____

Father's Name _____

Contact # _____

Additional Emergency Contacts:

Name: _____ ***Phone #*** _____

Name: _____ ***Phone #*** _____

Revised February 2011