



**Baltimore 8-13**

**Harford County 6-12**

**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 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](mailto: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**