SIBSHOP REGISTRATION FORM

Saturday, October 17, 2015 10:00 a.m. – 1:00 p.m.

Aurora Mental Health Alameda Center 10782 E. Alameda Ave. Aurora CO 80012

(PLEASE PRINT)

Date: _____

Child's Name: _____

Birthdate: _____ Age: _____ Gender: _____

School: _____ Grade: _____

Parent (s) Name(s): _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: (_____) _____ Cell phone: (_____) _____

Emergency Contact Name: _____

Emergency Contact Phone Number: (_____)_____

Has your child ever attended a Sibshop before: (Circle one) Yes No

If yes, where? _____

Name of brother or sister with special needs: _____

Age: _____ Gender: _____

Description of mental health concern: _____

What do you hope your child will gain from the Sibshop? Are there any particular topics you would like addressed?_____

_____

_____

_____

Does your enrolled child have any special needs, food allergies, or other health restrictions of his or her own that we should know about?

_____

_____

Would you like your name and number placed on a list to be distributed to siblings and their families?
___Yes ___No

Comments:

_____

_____

_____

_____

_____

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_____

I hereby give my child permission to participate in Sibshops. I also agree to hold Aurora Mental Health Center, their staff, and volunteers harmless for any and all liability incurred as a result of my child's participation. If my child is enrolled in Sibshops for brothers and sisters of children with mental health needs, I understand that Aurora Mental Health Center provides funding for this program.

_____ _____

Signature of Parent or Guardian Date

****Please return the completed form to Leah or Edie via email at Coloradosibshop@yahoo.com, via mail to Aurora Mental Health Center c/o Cindy Baca 11059 E. Bethany Dr. Ste #200 Aurora CO 80014 or fax to 303-617-2475.**