

AHA Sibshop™

Registration Form - Winter/Spring 2014

Child's Name: _____ Nickname: _____

Age: _____ Date of birth: _____ Grade: _____ Gender: _____

Home Address: _____

Parent #1 Name: _____ Parent # 2 Name: _____

Parent #1 cell #: _____ Parent # 2 cell #: _____

Parent #1 email: _____ Parent #2 email: _____

Best Contact Number and email address: _____

Emergency Contact (day of Sibshop): _____ Relationship to child: _____

Best Contact number (s) for day of Sibshop: _____

Current Medications: _____

Medical Conditions (e.g. asthma, allergies): _____

As part of the program, activities and projects are tailored to the needs of the group members. We attempt to engage each participant in at least one activity they will share at home. Please provide any information which may be beneficial for us to know in advance (e.g. If we know a sibling has a dairy allergy we will ensure that any food we make within the group will not contain dairy so that the youngster can bring the project home).

Siblings Name	Diagnosis (ie ASD)	Date of birth/age	Food Allergies - If yes please specify.

Please provide us with any additional information which you feel would be beneficial for us to know about your child who is attending the program

What would you like your child to gain from this program?
