Autism Society of Wisconsin Sibshop Registration Form 2017

(There are 3 pages to this form.)

Complete the form in its entirety and email to mvandevelden@asw4autism.org, fax to 920-278-1496 or mail to ASW, PO BOX 66, DE PERE, WI 54115. Completed forms must be received by January 25!

Today's Date:_____

Child's Name attending Sibshop: _____Nickname_____

Date of birth: _____ Male☐ Female☐ Grade in school _____

Does this child receive any special services (eg. Counseling, speech-language therapy, special education)? ☐ Yes ☐ No
If yes, describe:

Parent(s) or guardian(s) name(s): _____

Home address: _____City _____ Zip _____

Home telephone: _____ Cell phone:_____ Work phone: _____

Email address that you check regularly: _____
(VERY IMPORTANT: Email will be the primary method of communicating with parents prior to the event.

What are your reasons for enrolling your child in the Sibshop program?

Do you have any concerns about enrolling your child in this Sibshop?

Please provide any other information that you feel will make this an enjoyable and valuable experience for your child:

SIBLING WITH SPECIAL NEEDS

Name of brother or sister with special needs: _____

Date of birth: _____

Male ☐ Female ☐

How would you describe the relationship between this child and the sibling attending Sibshops currently?
(Close, Distant, Loving, Tolerant, Frustrating, Involved, Uninvolved, etc.)

Does your child with special needs attend the same school as sibling attending Sibshop? ☐ yes ☐ no

PERMISSION FORM – all children must have this completed.

Child's Full Name _____

I understand that in case of serious injury or illness, the person that I identified as the emergency contact will be notified, but if it is impossible to contact us, we give permission for emergency treatment or surgery as recommended by the attending physician.

Name of person to contact in an **Emergency:** _____

Emergency phone(s):_____ _____ Relationship to child: _____

MEDICAL INFORMATION FOR THIS CHILD

In the case that medical information is required, the following information must be available:

Child's Physician: _____ Phone Number: (_____) _____

Insurance provider: _____ Policy or group number _____

Is this child subject to or bothered frequently with any of the following:

Headaches ☐	Bee/Bug Stings ☐	Asthma/Hay Fever ☐	Sinusitis ☐	Heart trouble ☐
Ear Infection ☐	Epilepsy ☐	Hernia ☐	Sore throat ☐	Allergies ☐
Upset Stomach ☐	Diarrhea ☐	Constipation ☐	Fainting Spells ☐	
Attention Deficit ☐	Mental Illness ☐	Other_____		

Please explain:

*List any FOOD allergies or diet restrictions: _____

I further understand that In case of injury, I do hereby waive all claims or legal actions, financial or otherwise, against Autism Society of Central Wisconsin, St. Mark's Lutheran Church, WisconSibs Inc, the Autism Society of Wisconsin, organizers, sponsors, supervisors or any volunteer connected with the Sibshop program.

_____ _____
Signature of Parent of Guardian Date

PHOTO PERMISSION

I grant full permission to use any photographs, videos, or recordings or any other record of this program for the purpose of community education and awareness. (Child's full name will not appear on Autism Society of Wisconsin, Autism Society of Central Wisconsin, St. Mark's Lutheran Church, or WisconSibs website even if you sign this form.)

_____ _____
Signature of Parent or Guardian Date

PAYMENT- the cost to participate is $5 per child.

☐ **Check (Made out to Autism Society of Wisconsin):**

Check # _____

☐ **Credit Card: (select from the following)**

- ☐ **VISA**
- ☐ **MASTERCARD**
- ☐ **DISCOVER**

Cardholder's Name _____ Amount $_____

Card Number _____ Exp. Date _____ Security Code _____

Signature _____

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