Sibshop of the Rappahannock

The disAbility Resource Center
Spotsylvania County Public Schools' Parent Resource Center
Stafford County Public Schools' Parent Resource Center
540-373-2559

Registration Form

Date: _____

Child's Name: _____ Birthday: _____ Age: _____

Gender: _____ Current Grade or Grade Completed: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Email: _____

Does your child have any special needs, food allergies, or other health restrictions of their own that we should be aware of? If yes, what are they? Are there any specific directions we need to follow with regards to any concerns?

_____

_____

Are there any specific medical issues that the disAbility Resource Center (dRC) staff should be aware of?

_____

_____

Parent(s)/ Guardian's Contact Information

Father: _____ Home #: _____ Cell: _____

Mother: _____Home#: _____ Cell: _____

Emergency Contact Information (Other than parent(s)/guardians)

Emergency Contact #1: _____ Relationship to Child: _____

Home phone: _____ Cell phone: _____

Emergency Contact #2: _____ Relationship to Child: _____

Home phone: _____ Cell phone: _____

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Sibling Information

Name of brother or sister with special needs_____

Birth Date: _____ Age: _____ Gender: _____

Name or description of sibling's disability:
_____
_____

What kind of related special education services (e.g. speech, occupational or physical therapy, counseling, etc.) does this child receive?
_____
_____

Other siblings:

NAME	AGE	GENDER

Additional Information

What do you hope your child will gain from Sibshops? Are there any particular topics you would like to see addressed?
_____
_____
_____

Please provide any other information that you feel would make Sibshops a more enjoyable and educational experience for your child:
_____
_____
_____

Would you like your name placed on a list to be distributed to siblings and their families? ___YES ___ NO

Would you like your phone number included? ___YES ___ NO

Would you like your email address included? ___YES ____NO

******Healthy snacks will be provided!!***

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Confidentiality Statement/Release of Information

I hereby give my child permission to participate in Sibshops. I also agree to hold the disAbility Resource Center, Spotsylvania County Public Schools, and Stafford County Public Schools harmless for any and all liability incurred as a result of my child's participation.

All information concerning your child from the Sibshop of the Rappahannock Area is confidential without exception.

Occasionally the disAbility Resource Center (dRC) and Spotsylvania and Stafford Parent Resource Centers use photos of their activities, including Sibshops, in their newsletter, flyers, and webpage. **Please initial your response:**

_____ I do not give dRC and the Spotsylvania and Stafford Parent Resource Centers permission to use my child's name or picture in any publication.

_____ I give permission to dRC Spotsylvania and Stafford to use my child's name and/or photograph in presentations or other publicity if I am notified in advance of the event and have the opportunity to decline.

Signature: _____Date: _____

*****Please return form and payment (checks made out to disAbility Resource Center) a minimum of one week prior to the workshop. Please send to:**

disAbility Resource Center
ATTN: Linda Galloway
409 Progress Street
Fredericksburg, VA 22401