1Logo, company name

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**SIBSHOP REGISTRATION FORM – 2023-24**

Welcome to Community Options for Children and Families sibling support groups. This year, we are pleased to offer daytime Saturday Sibshops. Participants can register for single sessions or for the full term.

Please complete the attached registration forms and return pages 2 and 3 either by hand through the office mail slot, faxed or mailed to

Community Options Sibshops

1595 Bay Street Victoria, BC V8R 2B5

FAX #: 250-389-1110

Thanks to the generosity of our funders, we are able to offer this program to COCF members at no cost.

There is a nominal registration fee of $10 to secure your spot, and the cost of membership is $10 annually or $25 for three years.

Community Options is accepting e-transfers for payments which can be emailed to [billing@cocf.ca](mailto:billing@cocf.ca).

Please ensure the password note is clear: such as child’s first name, no caps, etc. Alternatively, send a second email with the password. Please do not include the password within the e-transfer email.

**2023-24 Sibkids: Ages 7-11**

**Registration fee: $10.00**

**Payment method:** e-transfer, cheque or cash

**Location:** Drop-off and pick-up at COCF offices (1595 Bay St).

**Session Time:** 10am - 3pm

**Dates:** Saturdays: September 30, October 21, November 25, January 27, February 24,

March 30, April 27, May 25 (*note*: *no meeting in December*)

Contact Margaret at 250-380-6363 ext 210 or via email at: [mtreleaven@cocf.ca](mailto:mtreleaven@cocf.ca) with any questions.

**SIBKIDS REGISTRATION FORM TO BE RETURNED TO Community Options:**

**I am registering for a single session on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I am registering for the 2023-24 term (8 sessions) \_\_\_\_\_\_\_**

**SIBSHOP: Participant(s)**

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name:** |  | **Last Name:** |  |
| **First Name:** |  | **Last Name:** |  |

**PARTICIPANT INFORMATION:**

**Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_**

**PHN: (medical #) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies, food, health or behaviour concerns our leaders should be aware of:**

**Name of sibling with support needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nature of Support needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT (S) / Legal Guardian**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name** | |  | | | | **Last Name** | |  | | |
| **First Name** | |  | | | | **Last Name** | |  | | |
| **Mailing Address:** | | |  | | | | | | | |
|  | | |  | | | | | | | |
| **Phone: Cell:** |  | | **Work:** | |  | | | | **Home:** |  |
| Email 1 Primary | |  | | Email 2 | | |  | | | |

**EMERGENCY CONTACT: (other than a parent)**

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name:** |  | **Last Name:** |  |
| **Relationship:**  **Phone: Cell:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **Work: Home:** | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Currently a Member of Community Options for Children and Families?** | YES |  | NO |  |
| **To become a member, please attach completed membership form \*** |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| * Registration cannot be guaranteed until registration form and fees are received.   I hereby agree to indemnify, release and save harmless Community Options, its employees or contractors  for any loss or damage through personal injury or otherwise and claims arising from any accident or  sickness to the participant. \*Including the transportation of your child in the event of an emergency. | | | |
| Signature: |  | DATE: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Photograph Permission to Release Form**  I understand and I am in agreement that the photograph(s) taken of my child during their participation in the Sibshop program may be used for promotion and publicity purposes for Community Options for Children and Families, including posting on the Community Options Website or Facebook page. | | | | | |
| YES, I give Consent | |  | NO, I do NOT give Consent | |  |
| Signature: |  | | | DATE: |  |

For office use only:

Date: \_\_\_\_\_ Payment received:  Amount: $\_\_\_\_\_\_ cash/e-transfer  cheque  #\_\_\_\_

I would also like to make a donation of: $\_\_\_\_\_\_\_\_\_\_ Receipt issued: # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*membership forms available here: [ARE YOU A MEMBER (cocf.ca)](https://cocf.ca/wp-content/uploads/2019/05/Membership-Application-Form.pdf)