SIBSHOPS REGISTRATION FORM TO BE RETURNED TO Community Options:

I am registering for a single session on: (date _____) fee $_____
I am registering for the 2025-2026 term (8 sessions) fee $_____
I would also like to make a donation of: $_____

SIBSHOP PARTICIPANT (s)

First Name:		Last Name:	
First Name:		Last Name:	

PARTICIPANT 1 INFORMATION:

Birthdate _____ School_____ Grade_____

PHN: (medical #) _____ Health Care Provider: _____

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

PARTICIPANT 2 INFORMATION:

Birthdate _____ School_____ Grade_____

PHN: (medical #) _____ Health Care Provider: _____

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

Name of sibling with support needs: _____

Nature of sibling's support needs:

_____

_____

PARENT (S) / Legal Guardian

First Name _____ LastName _____

First Name _____ LastName _____

Mailing Address: _____

_____

Phone: Work: Home:

Email 1
Primary _____ Email 2 _____

EMERGENCY CONTACT: (other than a parent)

First Name: _____ Last Name: _____

Relationship: _____

Phone: _____

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:

For office use only:

Date: _____ Payment received: ☐ Amount: $_____ cash ☐ e-transfer ☐ cheque ☐ #_____

Receipt issued: # _____

Fee Waived: ☐ Approved by: _____