Woodfords FAMILY SERVICES

Sibshops Child Registration Form

Child's Name: _____ Date of Birth: _____

Age: _____ Gender: _____ School: _____ Grade: ____

Parent(s)/Guardian(s) Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Alternate Phone Number: _____

Name of sibling with disability and/or illness: _____

Age of sibling: _____ Gender of Sibling: _____

Nature of disability and/or illness: _____

_____

_____

_____

Please list other siblings (if applicable):

Name	Age	Gender

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

_____

_____

_____

_____

_____

_____

_____

_____

Main Office
15 Saunders Way, Ste. 900
Westbrook, ME 04092
(207) 878-9663

Central Maine Office
747 Western Ave., #2
Manchester, ME 04351
(207) 680-4790

Southern Maine Office
5 Fletcher St., Ste. 2
Kennebunk, ME 04043
(207) 878-9663

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Is there any additional information that you feel we should know about your child? Please provide any information that you feel would make Sibshops a more enjoyable and education experience for your child:

_____
_____
_____
_____
_____
_____
_____
_____

In case of injury, I do hereby waive all claims or legal actions, financial, or otherwise against Woodfords Family Services, their elected officials and employees, the organizers, sponsors, supervisors or any volunteer (s) connected with the program. In the absence of a signature, payment of the fees and participation in the program shall constitute acceptance of the conditions set forth in the release.

_____

Signature of Parent or Guardian Date

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Sibshops Emergency Information & Authorization Form

Emergency Contact Name: _____

Relationship to Child: _____ Phone: _____

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Does your child have any known medical conditions? Yes ____ No ___
If yes, please list:

_____
_____
_____

Is WFS staff training required for these medical conditions? Yes ____ No ___
If yes, please explain:

_____
_____
_____

Is your child currently taking any medications? Yes ____ No ___
If yes, please list:

_____
_____
_____

Does your child have allergies: Yes ____ No ___
If yes, please list:

_____
_____
_____

Does your child have any physical limitations? Yes ____ No ___
If yes, please list:

_____
_____
_____

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I, _____give authorization for Woodfords Family Services to obtain emergency medical treatment for my child, _____in case of sudden illness or injury. In the event I can't be reached, I also give consent for them to seek medical treatment for my child to be billed to myself/my insurance.

_____

Signature of Parent or Guardian Date

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