An opportunity for siblings to connect with others experiencing similar circumstances.

Sibshops is a program for siblings who have a brother or sister with chronic health, mental health or developmental needs.

Please return this form to the Child Life Department via e-mail, mail, or in person.

Email: mayosibshop@mayo.edu

Mail: Child Life Program
Mayo Clinic Sibshops
1216 Second St. SW
Rochester, MN 55902
**Events**

Sibshops events are held multiple times throughout the year. Events are divided into the following groups:

- 6-13 Years
- 14-18 Years (Teen Edition)
- Family Event

**Goals**

Children who participate in Sibshops will have the opportunity to:

- Explore their experience of having a sibling with chronic health, mental health or developmental needs
- Express how they view their family and their role within it
- Relate to and have fun with kids facing similar circumstances
- Enhance their awareness of how important they are
- Have fun by playing games, doing crafts, and engaging in physical activities

**Contact Information**

For more information and registration, contact us at:

**Phone:** (507) 255-4091
**Email:** mayosibshop@mayo.edu

**Let us Contact You!**

Provide the following information and we will let you know about upcoming events.

**Child’s Name:** __________________________
Age: ______ Date of Birth: ________________
Any helpful information to know:
_________________________________________________________________
_________________________________________________________________

**Child’s Name:** __________________________
Age: ______ Date of Birth: ________________
Any helpful information to know:
_________________________________________________________________
_________________________________________________________________

**Parent’s Name:** _________________________
Mailing Address: _________________________
_________________________________________________________________
Phone Number: __________________________
E-mail Address: _________________________

**Brother/Sister’s Name:** _________________
Age: ______ Date of Birth: ________________
Briefly describe their medical need(s):
_________________________________________________________________
_________________________________________________________________