SIBSHOP: TEEN EDITION
This event is for teenagers (14–18) who have a brother or sister with a special health or developmental need.

Chanhassen Dinner Theater: The Music Man

APRIL 18, 2020 | 9:15AM–6PM

COST: $10
LUNCH & TRANSPORTATION WILL BE PROVIDED. SPACE IS LIMITED.

QUESTIONS:
Contact child life 507–255–4091 Ext. 1
mayosibshop@mayo.edu
Please complete registration form for your teen(s) to participate in Sibshops no later than March 13, 2020.

*Space is Limited*

**Participant(s) Information:**

Teen’s name: _____________________________________________________________________________________
Nickname: _______________________________________ Birthdate (m/d/y): ____________ Gender: ______________

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Nickname: _______________________________________ Birthdate (m/d/y): ____________ Gender: ______________

Parent(s) names: ___________________________________________________________________________________
Home address: ____________________________________________________________City: _____________________
State: _______ Zip: __________ E-mail: ________________________________________________________________
Home phone: (____) _______________________________Alternate phone: (____) ______________________________

☐ I have enclosed my payment of $10 for my enrolled teen to attend this Sibshops Program. Refunds for cancelations will not be given after March 13, 2020.
☐ I am interested in receiving information about scholarships available for my teen to attend this Sibshops Program.

Name of brother or sister with special needs: ___________________________________________________________
Name or description of disability or health concern: ______________________________________________________
Age: ____ Gender: ______
Has your teen ever attended a Sibshops Program before: ☐ Yes  ☐ No
If yes, can you please give us feedback about your teen’s experience: __________________________________________
__________________________________________________________________________________________________

Does your enrolled teen have any special needs, food allergies or other health restrictions of their own that we should know about? _______________________________________________________________________________________

I hereby give my child permission to participate in Sibshops. I also agree to hold Sibshops harmless for any and all liability incurred as a result of my child’s participation. Further, I grant full permission to use any photographs, videotapes, recordings or any other record of this program for the purpose of education and promotion of Sibshops.

Signature of parent or guardian____________________________________ (Date) ______________________________

Please mail registration form and payment of $10 to:
Mayo Clinic Sibshops
Child Life Program
1216 2nd St. SW
Rochester, MN 55902

(For more information contact us at 507-255-4091 or mayosibshop@mayo.edu)