



Please complete the registration form below for your child(ren) (ages 6-12 years) to participate.

Drop-off @ 8:00 am at Chip Shots

Pick-up following matinee showing at CMX Chateau Theater (Time TBD)

Must be e-mailed or postmarked by Saturday, February 1st, 2025.

Participant(s) Information:

Name of participant: _____ Birthdate (m/d/y): _____ Age: _____

Allergies, physical limitations or other health restrictions: _____

Name of participant: _____ Birthdate (m/d/y): _____ Age: _____

Allergies, physical limitations or other health restrictions: _____

Has your child(ren) ever attended a Sibshops Event? Yes No

Sibling Information:

Name of brother or sister with chronic health, mental health, or developmental needs: _____

Name or description of health concern: _____ Age: _____

Caregiver(s) Information:

Name of parent(s)/caregiver(s): _____

Home address: _____ City: _____

State: _____ Zip: _____ E-mail: _____

Home phone: (_____) _____ Alternate phone: (_____) _____

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: _____

\$10 registration fee enclosed

\$10 scholarship requested

Please mail the registration form/payment (checks are preferred and scholarships are available upon request) to:

Mayo Clinic Sibshops
Child Life Program
1216 2nd St. SW
Rochester, MN 55902

Questions? Contact us at: mayosibshop@mayo.edu