**STANDARD RELEASE for Sibshops Participants**

I, _____, give my consent to the
Parent/ Caregiver's Name

Sibshop Interagency Team to:

_____ Use my likeness or my child's likeness in ***print materials*** for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs
(ie- photos in Newsletters, for Sibshops presentations, etc).

_____ Use my likeness r my child's likeness in ***television news stories or television commercials*** for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs.

_____ Use my child's ***artwork*** in print materials for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs.

_____ Use my child's ***likeness and/or artwork on the World Wide Web*** for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs.

_____ Provide my ***child's email and/or home address and phone number*** to all Sibshops participants

_____
Child's Name

_____
Date

_____
Parent/Caregiver's Signature

_____

Witness

*Sibshop Interagency Team:*

Mt. Washington Pediatric Hospital | The Arc Montgomery County

*Revised February 2011*

SIBSHOPS
Parental Release for:

# EMERGENCY MEDICAL TREATMENT

I, _____, parent or guardian or
Parent's Name

_____ , give permission to the Sibshops staff to
Child's Name
Staff to secure, if necessary, emergency medical treatment for my child. I realize the Sibshops staff will make every effort to contact me, or any additional local emergency contacts that are named here, after securing emergency medical care, including calling 911 if necessary. This permission is granted for the Sibshops offered from:

___March 1 2016_____ to ___March 1 2017_____.
Date Date

*Sibshops of Maryland* is an interagency consortium involving:
Mt. Washington Pediatric Hospital and The Arc Montgomery County, and their staff, volunteers and sponsors.

Parent/Guardian _____
Name

Signature _____

Date _____

*Revised February 2011*

**SIBSHOPS**

# Participant EMERGENCY MEDICAL TREATMENT Information

**Child's Name _____ Date of Birth _____**

**Address _____**

**City _____ Zip Code _____**

**Allergies (Include Food & Medications) _____**

**_____**

**Medications taken _____**

**Primary Doctor** ***Name*** **_____**

***Phone*** **_____**

***Emergency Phone*** **_____**

**Health Insurance** ***Name*** **_____**

***Phone*** **_____**

***Policy #*** **_____**

**Mother's Name _____**

***Contact #*** **_____**

**Father's Name _____**

***Contact #*** **_____**

**Additional Emergency Contacts:**

***Name:*** **_____** ***Phone #*** **_____**

***Name:*** **_____** ***Phone #*** **_____**

*Revised February 2011*