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

Sibshops is for kids who have a brother or sister with a chronic medical condition or developmental needs.

For more information and registration contact us at:

507-255-4091
mayosibshop@mayo.edu

An opportunity for siblings to connect with others experiencing similar circumstances.
Events
Sibshops are for kids who have a brother or sister with special health or developmental needs.

Sibshops events are held multiple times throughout the year. Events are divided by age groups:

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

Here's what kids say about Sibshops:
“At Sibshops you get to meet other brothers and sisters of kids with special needs.”

“At Sibshops you can talk about the good and not-so-good parts of having a brother or sister who has special needs.”

“Sibshops are fun!”

Goals
Sibshops gives siblings the chance to talk about their issues with others who “get it.” Children who participate in Sibshops will have the opportunity to:

- Explore their feelings regarding how having a sibling with special health or developmental needs affect them
- Express how they view their family and their place in 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 physical activities.

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: _____
Briefly describe their medical need(s):

________________________________________

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