



# SIBLING SPECIAL NEEDS - INFORMATION FORM

*(Please complete one form for each sibling/family member attending)*

**Name of Sibling of Child who is DeafBlind:** \_\_\_\_\_

**Name of Parent/Guardian(s):** \_\_\_\_\_

**Cell Phone #:** \_\_\_\_\_ **Texting: Yes / No** *(please circle)*

**Medical Concerns:** *(health challenges, seizures/triggers, positioning options, feeding precautions, etc.)*

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**Is it alright to give your child water while in childcare?** \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**

Allergies:	Reactions:
Additional information to know about your child(ren):	
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