Registration Form

MAC Sibling Support Group
2010

CHILD INFORMATION

Full Name: ____
Mailing Address: ____
City: ________________________________ **State:** ______________________ **Zip:** _________________

PARENT INFORMATION

Full Name: ____
Mailing Address: ____
City: ________________________________ **State:** ______________________ **Zip:** _________________
Telephone: (______)__________________
Email: ____

DATES (Please check which days you would like to attend)

No Fee (complimentary pizza and beverage will be provided)

___ Tuesday, January 12th
___ Tuesday, February 9th
___ Tuesday, March 9th
___ Tuesday, April 13th
___ Tuesday, May 11th
___ Tuesday, June 8th
___Tuesday, July 13th
___Tuesday, August 10th
___Tuesday, September 14th
___Tuesday, October 12th
___Tuesday, November 9th
___Tuesday, December 14th

TIME: 6:30pm–8:00pm

Please mail completed registration form with payment to:
Minnesota Autism Center
5710 Baker Road
Minnetonka, MN 55345
Phone: (952) 767-4201