

*Egypt Centre Children's Workshop*

**Date(s) of Visit:**.....

Name of Child.....

**Please Print Clearly**

Date of birth..... Age.....

Address.....

.....Postcode.....Tel.....

EMAIL.....

School.....School Year.....

(The children will gain 10 credits with Children's University)

Does your child suffer from a medical condition? (eg. Asthma, epilepsy, or diabetes).....

Medication details.....

(Please clearly label your child's medication and indicate dosage).

Does your child have any learning disabilities we need to be aware of in order to plan activities effectively?.....

Any allergies?.....

Name of Doctor.....

Address.....

Tel.....

Details of two emergency contacts

**Contacts Must Be Available and Contactable!**

Name.....

Name.....

Address.....

Address.....

tel.....

tel.....

I give permission for photographs to be taken of my child for advertising/archive purposes  
YES/ NO

Signature of parent or guardian.....