Egypt Centre Children's Workshop
Gods and Goddesses – May 2014

Date(s) of Visit:..

Name of Child.. **Please Print Clearly**

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

Address..
......................Postcode………………………Tel...EM
AIL………………………………………………………………………………

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...
Address...
....
tel...
……………………………………

Name...
Address..
....
tel...
……………………………………

Name of adult that will be collecting child(ren) at the end of the workshop 3 pm

....
I give permission for photographs to be taken of my child for advertising/archive purposes
YES/ NO
Signature of parent or guardian...

If you would like to be informed about upcoming workshops and events please PRINT your email
address...