

Circles of Hope Family Programs - Six Week Workshop

Date: _____

PRE-REGISTRATION FORM - CHILDREN PARTICIPANTS

PARENT/CAREGIVER'S NAME: _____

Relationship to child/children being pre-registered: _____

Address: _____ City: _____ Zip Code: _____

Phone: _____ Email: _____

CHILD/CHILDREN'S INFORMATION:

1. Name: _____ Gender: Male Female

Birthdate _____ Grade: _____

2. Name: _____ Gender: Male Female

Birthdate _____ Grade: _____

3. Name: _____ Gender: Male Female

Birthdate _____ Grade: _____

4. Name: _____ Gender: Male Female

Birthdate _____ Grade: _____

5. Name: _____ Gender: Male Female

Birthdate _____ Grade: _____

Type of loss: (Please Circle) Parent Sibling Age of Sibling who died _____

Family/Friend: _____ Grandparent _____ Other: _____

Was it a sudden loss? Yes No Date loved one Died: _____

Cause of Death: Accident Heart Cancer Longterm Illness Stroke

Alzheimer's/Dementia Suicide Overdose Other: _____