

**“Superheroes Need Help, Too: A Grief Workshop for Children”**

**27 August 2016**

Registration

Child's Full Name \_\_\_\_\_ Nickname \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_ Sex: Male Female Grade in school \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Your Name and telephone number: \_\_\_\_\_

Your relationship to the registrant: \_\_\_\_\_

Emergency Contact during Workshop: \_\_\_\_\_


People living in the home	Age	Relationship to child
Name		
_____		
_____		
_____		
_____		

Name of Person who Died \_\_\_\_\_ Date of Death \_\_\_\_\_

Person's Relationship to Child \_\_\_\_\_ Cause of Death \_\_\_\_\_ Age \_\_\_\_\_

How has your child expressed their grief?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe other significant losses your child has experienced within the past year (e.g. deaths, moves, divorces, illness)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**THE GRIEF  
CENTER**  
at Circle of Life  
NWA's Resource for Grief and Loss

Does your child have any allergies or medical conditions?

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Does your child require any additional accommodations?

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How did you learn about the "Superheroes Need Help, Too" Workshop?

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What would you like us to know about your child?

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Following receipt of completed registration, a member of the Grief Center will contact you by telephone to confirm registration.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Please return to:  
Circle of Life Hospice  
c/o Angela Kathman, Grief Counselor  
901 Jones Rd.  
Springdale, AR. 72762  
Phone: (479) 872-3364  
Fax: (479) 872-3371 ATTN Angela Kathman