
Mental Health Support Team
Workshop Application

Case Number: (office use only)
Date Received: (office use only)

Parent/Carer Details			
Name:			
Address:			
Postcode:			
Telephone Number:		Email Address:	
Gender:		Ethnicity:	
Child Details			
Name:			
School:		Year:	
Gender:		Ethnicity:	

Are you the child's:	<input type="checkbox"/> Parent <input type="checkbox"/> Carer
Relationship to child:	



Do you have a preferred time of day for the workshop?

- | | | |
|--|--|--|
| <input type="checkbox"/> Morning session | <input type="checkbox"/> Afternoon session | <input type="checkbox"/> Evening session |
| <input type="checkbox"/> Lunchtime session | Comments: | |

Topic interested in:

Have you/your child ever had mental health support in the past?

Yes No

(if yes) Details:

Any other details:
(eg. Physical health issues, housing issues etc.)

I confirm I have access to zoom:

Yes

Please complete and send this form to:
trailblazer@mindinwestessex.org.uk

