**ADULTS GREEK LESSONS REGISTRATION FORM 2015 –2016**

**Starting date 3rd October 2015**

# Contact Details

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| --- | --- |
| **Full Name/Ονοματεπώνυμο:** |  |
| **Profession/Επάγγελμα:** |  |
| **Place of birth (city or town and country)**  **Τόπος γέννησης (πόλη ή χωριό και χώρα):** |  |
| **Telephones/Τηλέφωνα: mobile/κινητό:** |  |
| **Email:** |  |

# Ability

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| --- |
| **How confident are you in the following skills?** (1 being not at all, 5 being well versed)  Please circle: |

|  |  |  |  |
| --- | --- | --- | --- |
| Speaking | Reading comprehension | Listening | Writing |
| 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 | 1 2 3 4 5 |

**What are your key objectives for taking Greek language lessons?**

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# Relationship with Goffs Greek School

**Please specify if you are the father or mother of one of Goffs Greek School students or you have other relationship with the school**

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| --- | --- | --- | --- |
| Father / Πατέρας | Mother / Μητέρα | Other (explain) |  |

**If you’re a parent of a student at the school please provide the class and personal details of your child**

Name of Child: ………………………………………………… Class: ……………………………

Name of Child: ………………………………………………… Class: ……………………………

Name of Child: ………………………………………………… Class: ……………………………

Name of Child: ………………………………………………… Class: ……………………………

# Medical Information / Πληροφορίες σχετικά με την υγεία

Do you suffer from any medical conditions or allergies, such as diabetes, asthma, epilepsy, nut allergies etc, or are you on medication? (All personal information will be treated as strictly confidential).

Νο Yes – please provide details

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Signature/Υπογραφή \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Ημερομηνία: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_