CENTRE FOR DISBALITY STUDIES

POOJAPURA, THIRUVANANTHAPURAM

(A unit under LBS Centre for Science and Technology)

PARENT NETWORK PROGRAMME

REGISTRATION FORM

Name : ……

Address:……...

……

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Occupation :……Education Qualification……...

Phone (Home) :…….. Phone (Mobile)…….

Email : ……

Name of the Child : ……..

Date of Birth and Age of the child : ……

Child's Specific Challenges : Autism/ ADHD/ Visual/ Hearing/Speech/Locomotor/ Intellectual / Learning Disability /Cerebral Palsy/Dyslexia/Autism/Downs Sydrome/ Dyspraxia/ Behaviour Disorder / Others.

Is the child currently enrolled in any school? Yes/ No

Name of the School/ Institute the child currently attending

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_ **I plan to attend the workshop.**
_ **I am a parent/relative /sibling of a child who has disability.**

Place

Date Signature