

CENTRE FOR DISABILITY STUDIES
POOJAPURA, THIRUVANANTHAPURAM
(A unit under LBS Centre for Science and Technology)

WORKSHOP FOR DIFFERENTLY ABLED

REGISTRATION FORM

Name :

Address :

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Education Qualification :

Date of Birth :

Parents Name :

Phone (Office) : **Phone (Mobile) :**

Email :

Kindly mark the disability of the child : Autism / ADHD / Visual / Hearing /
Speech /Locomotor / Intellectual / Learning Disability / Cerebral Palsy / Dyslexia /
Autism / Downs Sydrome / Dyspraxia/ Behaviour Disorder / Others.

Place :

Date :

Signature of the Parent/-

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Recommended

Place:

Signature/-

