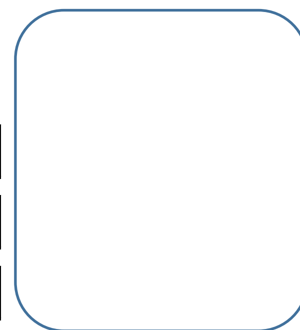
GOVERNMENT OF SINDH
DEPARTMENT OF EMPOWERMENT OF PERSONS WITH DISABILITES

STUDENT REGISTRATION FORM



REGISTRATION NUMBER	
NAME OF CHILD	

DATE OF BIRTH		GENDER		DISABILITY	

FATHER'S NAME			
C.N.I.C #			
QUALIFICATION		PROFESSION	

MAILING / CORESPONDENCE ADDRESS	

PHONE / CELL NUMBERS	

PHYSICAL / CELL INFORMATION (CHILD)

S.No	Description	Yes	No	Remarks
1	Does your Child have any Difficulty in Hearing ?	☐	☐	
2	Does your Child have any Difficulty in Vision ?	☐	☐	
3	Does your Child have any Physical Problem ?	☐	☐	
4	Does your Child have any Learning Problem ?	☐	☐	
5	Does your Child take any Medicine Regularly ?	☐	☐	
6	Is Your Child Vaccinated ?	☐	☐	

REMARKS	