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Administrator
System Administrator



NAVIGATION

Survey of Children with Disabilities in the Family

AWW Details

Name of the AWW *

Name of the Centre *

Family Details

State *

ODISHA

District *

-Select-



Sub-division *



Address Type *

-Select-



Block *

Aadhaar No

Description of Child/Children's Disabilities

Child's Name: *



DOB: *

dd/MM/yyyy



Age: *

Gender *

-Select-

Aadhaar No

Disability Type: *

- Select -

Attending School?: *

-Select-

Govt. Facilities: *

		Required	Provided
1.	Surgical Correction	<input type="checkbox"/>	<input type="checkbox"/>
2.	Medical Treatment	<input type="checkbox"/>	<input type="checkbox"/>
3.	Therapeutic Service	<input type="checkbox"/>	<input type="checkbox"/>

Fitment of Aids & Appliances: *

		Required	Provided
1.	Tricycle	<input type="checkbox"/>	<input type="checkbox"/>
2.	Walking Stick	<input type="checkbox"/>	<input type="checkbox"/>
3.	Wheel Chair	<input type="checkbox"/>	<input type="checkbox"/>
4.	Artificial Limb	<input type="checkbox"/>	<input type="checkbox"/>
5.	Caliper	<input type="checkbox"/>	<input type="checkbox"/>
6.	Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>
7.	Mobility Cane	<input type="checkbox"/>	<input type="checkbox"/>
8.	CP Chair	<input type="checkbox"/>	<input type="checkbox"/>
9.	Braille Slate	<input type="checkbox"/>	<input type="checkbox"/>
10.	DVR	<input type="checkbox"/>	<input type="checkbox"/>
11.	None of the Above	<input type="checkbox"/>	<input type="checkbox"/>

Finance Assistance: *

		Required	Provided
1.	Scholarship	<input type="checkbox"/>	<input type="checkbox"/>
2.	Pension	<input type="checkbox"/>	<input type="checkbox"/>
3.	Assistance from CMRF	<input type="checkbox"/>	<input type="checkbox"/>
4.	Others	<input type="checkbox"/>	<input type="checkbox"/>

Received Medical Board Certificate: *

-Select-

Any Emotional or Mental Health Issues (If any):

1.	Depression	<input type="checkbox"/>
2.	Self-harming	<input type="checkbox"/>
3.	Hyperactivity	<input type="checkbox"/>
4.	Behavioural problems	<input type="checkbox"/>
5.	Sleep problems	<input type="checkbox"/>
6.	Anxiety	<input type="checkbox"/>
7.	Learning/school problems	<input type="checkbox"/>

8.	Obsession & Compulsions	<input type="checkbox"/>
9.	Eating problems	<input type="checkbox"/>
10.	Difficulties with sibling relationship	<input type="checkbox"/>
11.	Other	<input type="checkbox"/>

Save

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