Plan of Care for
Hearing or Visual Impairments
Learning Disabilities
Physical Disabilities
(Please circle, which applies) (©AYS, Inc.)

Child's Name:_____**Date of Birth:**_____**Age:**_____
AYS Program: _____

Physician child sees for above:

_____
Name (please print) Phone Number

Medications your child uses:

Name of Medication(s)	Dosage	Time(s) of day given

Would medication(s) need to be given during program hours? ……YES/NO
Would medication(s) need to be given during all-day programs? …….YES/NO
If **yes** to either question, an AYS permission slip, completed by your child's doctor is required. Have you returned this permission slip to the AYS program director? YES/NO

Allergies: List any allergies i.e. foods, medications, the environment, etc. _____
_____

Control of the Child Care Environment
AYS programs are often located in the gym or cafeteria. During a program, a wide variety of activities are concurrently offered. Please list any ideas/suggestions that would help the AYS staff to care for and communicate with and to your child in this type of a setting. _____
_____
_____
_____

Are there any special procedures required of an adult regarding your child's care i.e. assistance with dressing, eating, toileting, etc.? YES/NO If so, please list and describe.

_____
_____
_____

Do you use special equipment with your child? YES/NO If so, please list and describe.
_____
_____
_____

Social/Family

All children have difficulty in peer interactions at times. Describe the types of difficulties your child experiences. Please offer ideas/suggestions on how the AYS staff might help your child through these times._____

_____
_____
_____
_____
_____

Is there any information regarding your family's situation, as it relates to your child's behavior, that would be helpful in the care of your child i.e. recent change in marital status, living situation, job change/loss, death of a loved one, etc.? _____

_____
_____
_____
_____

Therapies

If your child receives any types of therapy i.e. psychological, reading, speech, etc. please describe when therapy began and how often therapy is given. Are there goals or techniques used in therapy that the AYS staff would find helpful in caring for your child?

_____
_____
_____
_____
_____

Review of the above information & signatures for this school year in AYS:

_____	_____
Parent/Guardian Signature	AYS Program Director's Signature
_____	_____
Date	Date

Review of the above information & signatures for the next school year in AYS:

_____	_____
Parent/Guardian Signature	AYS Program Director's Signature
_____	_____
Date	Date