Plan of Care for Autism

Child's Name: ________________________________ **Date of Birth:** __________________ **Age:** ________

AYS Program: ________________________________ **School Year:** ____________________

Physician child sees for Autism:

______________________________________ __________________________

Name (please print) (Physician's Phone Number)

Medications your child uses for his/her Autism:

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

Would medication(s) need to be given during normal program hours? ☐ YES ☐ NO

Would medication(s) need to be given during non-school days? ☐ YES ☐ NO

If **yes** to either question, an AYS Medication Consent form, completed by your child's doctor is required.

Have you returned this form to the AYS director? ☐ YES ☐ NO

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. Often, this is difficult for a child with Autism. Please list any ideas/suggestions that would help the AYS staff to care for and communicate with your child in this type of a setting.

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Habits/Behaviors

Are there any habits or behaviors that are particular to your child that would be helpful for the AYS staff to be aware of? ____

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Are there any situations that your child finds stressful? ____

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How do you soothe your child in these situations? ____

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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.

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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.?

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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?

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Review of above information and signatures for the ______________ school year in AYS *(1st year)*:

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

Review of above information and signatures for the ______________ school year in AYS *(2nd year)*:

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

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