



Plan of Care for **Autism**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

AYS Program: \_\_\_\_\_

**Physician child sees for Autism:**

\_\_\_\_\_  
Name (please print) 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 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, ie. 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. 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. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How do you help your child in situations that he/she might find stressful? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**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 the current year in AYS:**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
AYS Program Director’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**Review of the above information & signatures for the subsequent year in AYS:**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
AYS Program Director’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date