Plan of Care for Autism

Child's Name:______________________________Date of Birth:__________Age:____
Physician Name:___________________________________ Phone:________________

Medications your child uses for his/her Autism*:

Name	Dosage	Time of day given

Would medication(s) need to be given during program hours? ( ) Yes ( ) No

*****If yes, a medication form must be filled out by the physician and returned **before** your child can receive any medication. Physician may email to sharon@learnresourcecenter.org.*

Control of the Program Environment:
During program time, a wide variety of activities are offered, often in the same location. Often this is difficult for a child with Autism. Please list any ideas or suggestions that would help the staff to care for and communicate with your child in this type of setting:____
____

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

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 staff might help your child through this times.____
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____

Is there any information regarding your family's situation, as it relates to your child's behavior, which 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 type 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 staff would find helpful in caring for your child?____
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________________________________ ________________________________
Parent/Guardian Signature & Date *Physician Signature (Optional) & Date*

____
Site Director Signature & Date

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