Plan of Care –Impairments/Disabilities

(Please Check all that apply)

____***Hearing or Visual Impairments***
____***Learning Disabilities***
____***Physical Disabilities***
____ ***Diagnosed Anxiety Disorder***
____***Other:***_____

Student's Name:_____**Date of Birth:**_____**Age:**____

Physician Name:_____**Phone:**_____

Medications your student uses related to impairment/disability:

Name of Medication	Dosage	Time of day given

Are medications needed to be taken during program hours? ____ Yes ____ No
If yes, a medication form must be filled out by the physician and returned **before your student can receive any medication. Medication must be in original container with correct dosage instructions.*

Control of the Program Environment:
During program time, a wide variety of activities are offered, often in the same location. Please list any ideas/suggestions that would help us to care for and communicate with your student in this type of setting. _____
_____
_____

Are there any special procedures required of an adult regarding your student's care (i.e. assistance with dressing, eating, toileting, etc.) If yes, please list and describe:

_____

_____

Do you use special equipment with your student? If yes, please list and describe:

_____

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

_____

_____

_____

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

_____

_____

_____

Therapies

If your student 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 staff would find helpful in caring for your student?

_____

_____

_____

_____

_____ _____

Parent/Guardian Signature *Date*

_____ _____

Physician Signature (optional) *Date*

_____ _____

Program Director Signature *Date*

Updated 6/19