Plan of Care for Autism

Student's Name:______________________________Date of Birth:________Age:___
Physician Name:_________________________________ Phone:_____________

Medications your student uses for treatment of Autism*:

Name of Medication	Dosage	Time of day given

Are medication(s) needed 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.

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

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

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Social/Family
All students have 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.____

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