



## 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

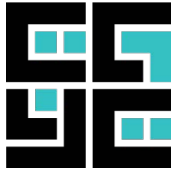
Are medications needed to be taken during program hours?  Yes  No

*\*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:

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

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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.

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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.)?:

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### **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?

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

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Physician Signature (optional)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Program Director Signature*

\_\_\_\_\_  
*Date*