Kids Go Further
AYS
AT YOUR SCHOOL

PLAN OF CARE FOR SPECIAL DIETARY NEED: DISABILITY/MEDICAL DIAGNOSIS

CHILD INFORMATION	
First Name:	Last Name:
Date of Birth: / /	Program Site:
This Plan of care is for: ☐ 2019-20 School Year ☐ 2019 Camp AYS	
Doctor's Name:	Doctor's Phone: ( )
Does your child take prescription medication for the prevention or treatment of their need? ☐ YES* ☐ NO	
If your child participated in an outside activity or field trip would they be required to take any medications with them for the treatment or prevention of an adverse reaction? ☐ YES* ☐ NO	
*If you answered **yes** to either question, an AYS Medication Consent form will also need to be completed by your child's doctor and provided to AYS.	

DESCRIBE THE MEDICAL CONDITION AND THE MAJOR LIFE ACTIVITIES THAT ARE AFFECTED

FOODS TO BE OMITTED	SUBSTITUTIONS

ADDITIONAL INFORMATION ABOUT THE DIET (including texture changes such as chopped, ground, pureed, etc.)

Physician/Physician Assistant/Nurse practitioner Signature	Date
Physician/Physician Assistant/Nurse practitioner Printed Name and Title	
Parent Signature	Date