

CYS SERVICES SNAP GENERAL MEDICAL ACTION PLAN

Child/Youth's Name	Date of Birth	Date		
Sponsor Name				
Health Care Provider Name	Health Care Provider Phone			
List ALL Diagnoses for this Child/Youth				
What physical/mental/behavior limitations would interfere with the child/youth attending CYSS?				
Would environmental modifications need to be made by the CYSS staff?				
Is the child/youth's condition/diagnosis stable? YES NO please explain:				
List significant medical history (ER visits, surgeries, chronic conditions).				
Current Medications (please indicate if requesting medication administration in the CYSS program)				
Medication	Dose/Amount	Route	How Often Given	Given in CYSS Program
1.				
2.				
3.				
4.				
5.				
6.				
7.				
Describe, if any, the exact interventions the CYSS providers would need to make on a daily/weekly basis to provide safe and appropriate care for this child. (Please attach any patient education/ training materials.(i.e. feeding tubes, positioning procedure, toileting procedure)				
EMERGENCY RESPONSE: What constitutes an emergency for this child/youth? Parent/guardian and 911 will be called if:				
I agree with the plan outlined above				
Printed Name of Parent/Guardian	Parent/Guardian Signature	Date (YYYYMMDD)		
Stamp of Health Care Provider	Health Care Provider Signature	Date (YYYYMMDD)		
Printed Name of Army Public Health Nurse	Army Public Health Nurse Signature	Date (YYYYMMDD)		