



Copy of Care Plan given to parents

File No: _____

Date: _____

Updated: _____

Updated: _____

Care Plan Southside

Child's Name _____ D.O.B. _____

Home Address _____

_____ Postcode _____

Mother/Guardian _____

Address _____

_____ Postcode _____

Phone Home _____ Work _____

Mobile _____

Father/Guardian _____

Address _____

_____ Postcode _____

Phone Home _____ Work _____

Mobile _____

Siblings _____

Contact Person in Case of Emergency:

1. Name _____ Phone No. _____

Mob. No. _____

2. Name _____ Phone No. _____

Mob. No. _____

Medicare No. _____

Health Care Card No. _____

Ambulance Member yes no

Private Health Insurance yes no

Family Doctor _____ Phone No. _____

Hospital attended _____

Allergies (drug, food) _____

Reaction _____

File No: _____ Child's Name: _____

D.O.B _____

HEALTH INFORMATION:

Has your child had any of the following?

Past Illnesses:

Immunisations:

Measles yes no Triple Antigen yes no

German Measles yes no Children's Diphtheria & Tetanus yes no

Mumps yes no Polio - Sabin yes no

Chicken Pox yes no Measles / Mumps / Rubella yes no

Whooping Cough yes no Hepatitis B yes no

Flu Vaccine yes no

Other:

General Health (colds, chest infections, ear aches)

NATURE OF DISABILITY

What is the nature of _____ 's disability / disabilities? (including medical diagnosis where possible)

What are _____ 's abilities and /or strengths?

File No: _____ Child's Name: _____ D.O.B _____

SOCIAL DETAILS:

What does your child like to do for recreation and fun?
(swimming, walks, dancing, TV, rough & tumble play, stories, music- which type, massage etc)

Favourite outings?

What assistance is required with swimming?

Is your child comfortable in crowds/shopping centres? _____

Are there any special/different behaviours to be aware of when on an outing? (i.e. child cries when the car stops, feels threatened in unusual places etc)

Are there any places we **shouldn't** take your child? (movies, beach etc.)

Does your child travel well? _____

Any other suggestions that will help your child enjoy their time?

File No: _____ Child's Name: _____ D.O.B _____

COMMUNICATION:

What is your child's preferred method of communication? (i.e. speech, smiling, makaton etc.)

Does your child have any special words or gestures for:

Yes No

Food _____ Bed _____

Discomfort _____ Toilet _____

Drink _____

How does your child relate to other children and adults?

Is there anything else that would be helpful for Carers to know?

Does your child have any hearing loss? yes no _____

Does your child wear hearing aids? yes no _____

If yes please provide the necessary details to ensure your child's needs are met.

Does your child have any visual impairment? yes no _____

Does your child wear glasses? yes no _____

If yes please provide the necessary information

File No: _____ Child's Name: _____ D.O.B _____

MOBILITY :

What is your child's mode of mobility (i.e. wheelchair, pram, walks)

Manual wheelchair yes no

Where is it used? _____

What assistance is required? _____

Walker yes no

Where is it used? _____

What assistance is required? _____

Electric wheelchair yes no

Where is it used? _____

What supervision is required? _____

Pram yes no

Where is it used? _____

Walks yes no

Where does he or she walk? _____

What assistance does he or she require? _____

File No: _____ Child's Name: _____ D.O.B _____

DIETARY INTAKE :

How does _____ eat & drink ? Orally Gastrostomy Naso-gastric tube

What does your child like for - (details please)

B'fast _____

M/tea _____

Lunch _____

A/tea _____

Dinner _____

Any Special Foods _____

Foods to Avoid _____

Preferred consistency of food _____

Special Eating Utensils _____

Assistance required _____

Drinks he/she likes _____

Drinks to avoid/ temperature _____

Times _____

Special Cup _____

Assistance Required _____

Formula _____

Additives _____

Amount _____

Times Given _____

Preparation _____

Extra Fluids (water, juice) _____

Kangaroo Pump (times & rate) _____

Are there any specific positioning needs at meal times ? _____

Any further information to assist us ? _____

File No: _____ Child's Name: _____ D.O.B _____

MOUTH CARE :

Please provide details of your child's mouth-care needs (toothpaste yes / no, toothbrush etc)

TOILETING :

How many times a day does your child usually pass urine? _____

Does _____ wear nappies? yes no

Does your child require toileting/changing overnight? yes no

How often does your child usually have bowel motions? _____

Does your child get constipated? yes no

Does your child require toileting/changing overnight? _____

What do you do for this? _____

After how many days would you be concerned if your child has not had a bowel motion?

Is there any other information about their hygiene needs?(i.e. specific cream for rashes)

File No: _____ Child's Name: _____ D.O.B _____

EPILEPSY :

Does _____ have Epilepsy? (seizures or fits) yes no

Are the seizures fully controlled? yes no

If no, how often do they occur? _____

Last date of seizure was? _____

Description of seizures _____

Frequency _____

The warning signs are _____

Particular things that trigger off a seizure _____

EPILEPSY EMERGENCY PROCEDURE:

Emergency Procedure to follow when _____ has a seizure

Step 1 _____

Step 2 _____

Step 3 _____

Step 4 _____

Further Information _____

IF YOUR CHILD BECOMES UNWELL WE WILL~

1. PHONE FAMILY ~ if unavailable
2. PHONE EMERGENCY CONTACTS LISTED ON CARE PLAN
3. CONTACT R.N. ON CALL
4. IF DEEMED NECESSARY SEEK MEDICAL ADVICE.

IN AN EMERGENCY SITUATION WE WILL ~

1. RING 000 for an Ambulance ~ your child will be transported to the NEAREST Hospital.
2. CONTACT FAMIYY OR EMERGENCY CONTACTS
3. CONTACT R.N. ON CALL & CO ORDINATOR

Is there any other relevant information? _____

File No: _____ Child's Name: _____ D.O.B _____

SAFETY & BEHAVIOUR:

Are there any particular behaviours that Carers should be aware of? yes no

How would you like us to respond to these behaviours?

Are there any particular fears, not already mentioned, that we should know about?

TRANSPORTING:

If travelling by car/bus how is your child restrained? _____

(legal restraints must be used at all times)

SCHOOLING DETAILS:

School attended? _____

Address _____

_____ Phone _____

AUTHORITY TO CONSENT

If you are unable to be contacted, PLEASE ensure that the Emergency Contacts listed on the front of this document have permission to consent to medication and/or treatment beyond that listed on Care Plan and Medication Form.

AS YOUR CHILDS' CARES CHANGE, IT IS THE PARENT/S OR GUARDIANS RESPONSIBILITY TO PROVIDE REGULAR UPDATES TO THE CARE PROVIDER

Date _____

Signature/s _____

Name _____

Relationship _____

