CARE PLAN SOUTHSIDE

File No.

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
Name: ____________ Age: ______ Name: ______________ Age: ______
Name: ____________ Age: ______ Name: ______________ Age: ______

Contact Person in Case of Emergency:

1. Name ______________________ Phone No. ______________
Relationship: _________________ Mobile No. ______________

2. Name ______________________ Phone No. ______________
Relationship: _________________ Mobile No. ______________

Medicare No. ______________________

Healthcare Card No. ______________________

Ambulance Member Yes ☐ No ☐

Private Health Insurance Yes ☐ No ☐

Family Doctor ______________________ Phone No. ______________

Hospital Attended ____

Height ____________________ Weight ____________________

Allergies (drug, food) ___________________________________

Reaction ____

Xavier Medication Chart in Use Yes ☐ No ☐

Copy of Care Plan given to Parents Date: ☐	Date: ______	Signature: ______
	Updated: ______	Signature: ______
	Updated: ______	Signature: ______

1. HEALTH INFORMATION:

Has your child had any of the following?

Past Illnesses:

Measles	Yes	☐	No	☐
German Measles	Yes	☐	No	☐
Mumps	Yes	☐	No	☐
Chicken Pox	Yes	☐	No	☐
Whooping Cough	Yes	☐	No	☐

Immunisations:

Triple Antigen	Yes	☐	No	☐
Children's Diphtheria & Tetanus	Yes	☐	No	☐
Polio – Sabin	Yes	☐	No	☐
Measles / Mumps / Rubella	Yes	☐	No	☐
Hepatitis B	Yes	☐	No	☐
Flu Vaccine	Yes	☐	No	☐

Other:

____

____

General Health (colds, chest infections, earaches)

____

____

____

____

NATURE OF DISABILITY

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

____

____

____

____

What are your child's abilities and/or strengths?

____

____

____

____

2. 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?

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).

Does your child travel well? ____

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

What is your child's daily routine? (Please describe a usual day)

3. 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 have grommets? 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.

4. MOBILITY:

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

Pram Yes ☐ No ☐

Where is it used? ____

____

____

Manual wheelchair Yes ☐ No ☐

Electric Wheelchair Yes ☐ No ☐

Walker Yes ☐ No ☐

Standing Frame Yes ☐ No ☐

Where is it used? ____

____

____

What assistance does he or she require? ______________________________

____

____

Walks Yes ☐ No ☐

Where does he or she walk? ____

____

What assistance does he or she require? ______________________________

____

____

5. DIETARY INTAKE:

How does your child take nourishment?

☐ Orally ☐ Gastrostomy ☐ Naso-Gastric Tube ☐ Combination

Oral

Preferred consistency of food: ☐ Pureed ☐ Mashed ☐ Cut ☐ Finger Food

Time ____________ Food/Drink: ____________________

Time ____________ Food/Drink: ____________________

Time ____________ Food/Drink: ____________________

Time ____________ Food/Drink: ____________________

Time ____________ Food/Drink: ____________________

Food/Drinks to Avoid ____________________

Preferred Temperature of Fluids ____________________

Special Eating Utensils ____________________

Special Cup/Teat ____________________

Assistance Required ____________________

Gastrostomy/Naso Gastric Type ____________ Size ____________

☐ Bolus ☐ Continuous ☐ Combination Pump Type ____________

Time	Type of food/formula/fluid	Amount	Temperature	Rate	Flush Amount

Are there any specific positioning needs at meal times? ____________________

Any further information to assist us? ____________________

6. SLEEPING:

☐ N/A – Go to Question 7

Usual bedtime? ____

How do you settle your child for the night (i.e. music, bath) ______________________________

____

Does your child usually sleep through the night? Yes ☐ No ☐ ______________________________

____

If your child wakes during the night, what do you do?

____

____

____

Preferred sleeping position? ____

Does your child sleep in a ☐ bed ☐ bed with rails ☐ cot?

Is there any other information that would be helpful? (i.e. lights on/off; door open/shut; with/without a pillow; favourite toy; music?)

____

____

____

Are there any behaviours to be discouraged at bedtime or through the night?

____

____

____

Usual waking time? ____

Does your child have a daytime rest? If yes, please give details.

____

____

____

7. HYGIENE NEEDS:

Xavier staff do not cut nails without seeking permission from parents. Do you give Xavier staff permission to cut/trim your child's nails? Yes ☐ No ☐

BATHING:

Does your child prefer a bath or shower? ____________________

Morning or evening? ____________________

Long or short? ____________________

Special equipment? (type of chair, bath aide) ____________________

Any particular fears? (i.e. hair washing, etc) ____________________

Is there any other relevant information? (i.e. allergic to soap, grommets, etc) ____________________

____

MOUTH CARE:

Please provide details of your child's mouth care needs (toothpaste, toothbrush, etc)

____

____

____

GASTROSTOMY CARE: TYPE: ____________________ SIZE: ____________________

Please provide details of the routine you follow at home in regards to cleaning and dressing button sites. (i.e. specific creams you may use).

____

TOILETING:

How many times a day does your child require changing? ________ ☐ N/A Go to Question 8

What types of incontinence aids are used?

Day ____________________ Night ____________________

How often does your child usually have a bowel motion? ____________________

Does your child get constipated? Yes ☐ No ☐

What do you do for this?

____

Does your child require toileting at specific times? Yes ☐ No ☐

If so, when?

Does your child require any special equipment? (e.g. chair, commode, rail)

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8. EPILEPSY:

Does ____________________ have Epilepsy? (seizures or fits) Yes ☐ No ☐ N/A ☐
Go to Question 9

Are the seizures fully controlled? Yes ☐ No ☐

If no, how often do they occur? ______________________________

Description of seizures ______________________________

Frequency ______________________________

The warning signs are ______________________________

Particular things that trigger off a seizure ______________________________

Last date of seizure was? ______________________________

EPILEPSY EMERGENCY PROCEDURE:

Emergency Procedure to follow when your child has a seizure

Step 1 ______________________________

Step 2 ______________________________

Step 3 ______________________________

Step 4 ______________________________

Further Information ______________________________

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9. 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?

10. TRANSPORTING: N/A – Go to Question 11

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

(legal restraints must be used at all times)

11. SCHOOLING DETAILS: N/A – See Below

School attended? ____________________

Address ____________________

What days does your child attend? ____________________

Phone: ____________________

12. XAVIER PROCEDURES:

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 FAMILY OR EMERGENCY CONTACTS;
3. CONTACT R.N. ON CALL & COORDINATOR.

In most circumstances, a Xavier staff member will accompany a child to the hospital.

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 CHILD'S CARES CHANGE, IT IS THE PARENT/S OR GUARDIANS RESPONSIBILITY TO PROVIDE REGULAR UPDATES TO THE CARE PROVIDER.

Date ______________________ ______________________

Signature/s ______________________ ______________________

Name ______________________ ______________________

Relationship ______________________ ______________________

Copy sent to Respite Provider Yes ☐ Date: ______________ N/A ☐

This Care Plan has been read by the relevant Support Worker	Date:	Signature:
	Date:	Signature:
	Date:	Signature:

XAVIER CHILDREN'S SUPPORT NETWORK
Community Team Daily Plan

Child's Name:

Age:	DOB:	Register No:

Environment	In Home	Out of Home
Resources Available in Environment (e.g. toys, community facilities, etc)		

What needs to be done:

Feeding ☐

Sleep ☐

Bathing ☐

Medication ☐

Ideas of things to do (check with parent)

Contingency	**Alternative Arrangements/Things to Do**
Poor Weather	
Illness	

Parent's Signature ______________________________ Date: ______________________