Government of **Western Australia**
Department of **Health**

COVID-19

COVID-19 Care Plan for parents or carers and children

This plan can be used if you are a parent or carer of children. Complete a Care Plan for every child in your care.

It is important to plan in case you or anyone in your household gets COVID-19 and needs to stay at home.

Most people with up to date vaccination who get COVID-19 experience only mild symptoms and can care for themselves at home, with support from their GP. Other people may need to go to hospital.

A COVID-19 Care Plan (Care Plan) includes important information about you, your health and the health of children in your household. It also details your plans for the care of your children and pets, should you need to go to hospital.

You can share your plan with:

- your GP
- your family or support person
- hospital staff and other healthcare workers.

Care Plans for Adults can be found on the HealthyWA website (healthywa.wa.gov.au)

How to use this plan

- Complete Part A of this plan if you are a parent or legal guardian of a child or children (if you don't care for children, complete the COVID-19 Care Plan for Adults).
- Complete and print a Care Plan for each child in your household. Keep the plans somewhere easy to find, such as on your fridge or near your bed.
- If you get COVID-19, use this plan.

COVID-19

Part A – Complete this section if you are a parent or legal guardian of a child

It will help your doctor if you get COVID-19 and need to go to hospital

COVID-19 Care Plan

Parent/carer 1

*Your personal information is private. GPs and other health care workers must keep your personal information private

Full name

Age | Date of birth (DD/MM/YYYY)

Phone number

Address

Email address

Medicare number | Expiry | ID number

Private health insurance provider

Card number | ID number

COVID-19 vaccination status

☐ First dose ☐ Second dose ☐ Third dose ☐ Booster ☐ Winter booster ☐ Medical exemption

Medical conditions

(e.g. are you pregnant, do you have diabetes, or a heart or lung condition)

Are you currently receiving treatment for cancer?
(if yes, what type of cancer, and what type of treatment?)

Current medications

Medication name		Dose		Times to be given	
Medication name		Dose		Times to be given	
Medication name		Dose		Times to be given	
Medication name		Dose		Times to be given	
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Allergies

Allergy name	
Medication or treatment	
Allergy care plan provided	
Allergy name	
Medication or treatment	
Allergy care plan provided	
Allergy name	
Medication or treatment	
Allergy care plan provided	

Do you have a disability? (if yes, provide details and consider completing the COVID-19 Care Plan for people with disability)

Do you have a current health care plan? ☐ Yes ☐ No

(e.g. a mental health care plan or plan for the treatment of an existing health condition)
If yes, record the details of the plan and healthcare agency you consult

Do you have any other health conditions?

Complete this section if you test positive to COVID-19

Date your symptoms started

Date you took your positive COVID-19 test

Next of kin (closest relative)

Relationship

Next of kin's phone number

Next of kin's address

Next of kin's email address (if relevant)

GP, specialist or healthcare worker who will help look after you

If you test positive for COVID-19, you may need seek support from your GP, treating specialist or health worker. Provide their contact details below.

Name

Title (e.g. GP, cardiologist)

Phone number

Address

Email address

Name

Title (e.g. GP, cardiologist)

Phone number

Address

Email address

Monitor my COVID-19 symptoms

To monitor your COVID-19 symptoms, print the symptoms diary here

Other healthcare (such as WA COVID-19 Care at Home)

If you test positive for COVID-19 and have been enrolled in the free service **WA COVID Care at Home**, record advice and treatment provided by the program below

Do you have pets/livestock in your care?

☐ Yes ☐ No

If I need to go to hospital with COVID-19, I would like the following people to care for my pets/livestock (list in order of preference)

1. Name

Address

Phone number Discussed with carer? ☐ Yes

Email address

2. Name

Address

Phone number Discussed with carer? ☐ Yes

Email address

3. Name

Address

Phone number Discussed with carer? ☐ Yes

Email address

Parent/carer 2

Full name

Age | Date of birth (DD/MM/YYYY)

Phone number

Address

Email address

Medicare number | Expiry | ID number

Private health insurance provider

Card number | ID number

COVID-19 vaccination status

☐ First dose ☐ Second dose ☐ Third dose ☐ Booster ☐ Winter booster ☐ Medical exemption

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(e.g. Are you pregnant, do you have diabetes, or a heart or lung condition)

Are you currently receiving treatment for cancer?
(if yes, what type of cancer, and what type of treatment?)

Current medications

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Medication or treatment	
Allergy care plan provided	
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Relationship

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Next of kin's address

Next of kin's email address (if relevant)

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Name

Title (e.g. GP, cardiologist)

Phone number

Address

Email address

Name

Title (e.g. GP, cardiologist)

Phone number

Address

Email address

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☐ Yes ☐ No

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1. Name

Address

Phone number Discussed with carer? ☐ Yes

Email address

2. Name

Address

Phone number Discussed with carer? ☐ Yes

Email address

3. Name

Address

Phone number Discussed with carer? ☐ Yes

Email address

COVID-19 Care Plan for children

Part B – Complete this section to share information about your child's needs and who will care for them if you can't because you're unwell or in hospital with COVID-19.

Complete and print a COVID-19 Care Plan for each child in your care.

If I/we need to go to hospital for COVID-19, I/we consent to my/our child staying with the following people

List in order of preference the adult carers that your child can stay with if you need to go to hospital, and whether these people have agreed to care for your child

1. Name of carer

Address

Phone number

Carer agreed? ☐ Yes

2. Name of carer

Address

Phone number

Carer agreed? ☐ Yes

3. Name of carer

Address

Phone number

Carer agreed? ☐ Yes

I/we DO NOT wish the following people visit or care for my child

Name

Reason

Name

Reason

Name

Reason

Is there a court-ordered or legal custody agreement in place? ☐ Yes ☐ No

If yes, provide the custody agreement details below

If I am hospitalised, I would like the following to occur, if possible

- ☐ Photos of my child brought/sent to the hospital to have with me
- ☐ Regular photos/videos of my child to be sent to me
- ☐ To speak to my child regularly by phone when I'm well enough
- ☐ My child to be shown photos of me regularly

Other

Parent signature _____ Date (DD/MM/YYYY) _____

Parent signature _____ Date (DD/MM/YYYY) _____

Complete this section and share with the person you have nominated to care for your child if you are unable to or have to go to hospital

This plan contains information to be used in the care of my/our child, should I/we be temporarily unable to due to COVID-19

Child's name (print) _____

Preferred name _____

Important people in my child's life who may need to be contacted

Doctor's name

Phone number

Doctor's name

Phone number

Family member/significant other name

Phone number

School name

Teacher name

Phone number

Other name

Relationship with my child

Phone number

Other name

Relationship with my child

Phone number

Important information about my child

Medicare number | Expiry | ID number

Private health insurance provider

Card number | ID number

Medications that my child needs

Medication name		Dose		Times to be given	
Medication name		Dose		Times to be given	
Medication name		Dose		Times to be given	
Medication name		Dose		Times to be given	
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Medication name		Dose		Times to be given	
Medication name		Dose		Times to be given	
Medication name		Dose		Times to be given	

Vaccination due dates and details

Vaccination name		Details		Due date	
Vaccination name		Details		Due date	
Vaccination name		Details		Due date	

Allergies

Allergy name	
Medication or treatment	
Allergy care plan provided	
Allergy name	
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Allergy care plan provided	
Allergy name	
Medication or treatment	
Allergy care plan provided	
Allergy name	
Medication or treatment	
Allergy care plan provided	
Allergy name	
Medication or treatment	
Allergy care plan provided	

Concerns or worries that my child has (e.g. scared of dogs or dark)

This could include events that happened in the child's life

Cultural, religious, spiritual or language influences for my child

Feeding

My child is currently (tick all that apply)

Breastfed ☐ Yes ☐ No

Details

Bottle-fed ☐ Yes ☐ No

Details (e.g. how much, how often, if heated, if there are additives to the bottle?)

Introducing solid foods ☐ Yes ☐ No

Details (e.g. what foods, how much, how often?)

Full diet ☐ Yes ☐ No

Food and drink dislikes

Other information about my child

Babysitter

Phone number

Childcare/family day care centre

Phone number

After school care

Phone number

Regular activities/commitments (e.g. playgroup, sport, music lessons)

Activity		Day		Time	
Activity		Day		Time	
Activity		Day		Time	
Activity		Day		Time	
Activity		Day		Time	
Activity		Day		Time	
Activity		Day		Time	
Activity		Day		Time	

Bedtime and other routines, including setline routines

(e.g. favourite toys, music, nursery rhymes, bedtime books, sleep time, lighting)

COVID-19

Additional information

Parent signature

Date (DD/MM/YYYY)

Parent signature

Date (DD/MM/YYYY)

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This document can be made available in alternative formats on request.

healthywa.wa.gov.au

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