GET COVID READY

SHIRE OF MANJIMUP

COVID-Ready Plan for Households

It's important to have a plan in case you or a household member get COVID-19. If this happens, you will need to isolate at home.

PART A – Complete this section for all adults in your household.

PART B – Complete this section for any children or dependent adults in your household. This plan will contain important information about your child or dependent adult's needs and who will care for them if you are unable to.

What is a COVID- Ready Plan?

It lists important information about you, your health and the people in your household. You can share the Plan with the following people who may be helping you while you have COVID-19

- Your doctor and other health/hospital workers
- Support services
- Friends or family members
- Carers

How to use this plan:

Step 1
Complete Part A for all adults in your household.

Step 2
Complete Part B for any children or dependent adults in your household.

Step 3
Keep the Plan somewhere easy to find like your fridge, near your phone charger or bed.

Step 4
If you get COVID-19, refer to the information in this plan when speaking with:

- Your doctor and other health/hospital workers
- Support services
- Friends or family members
- Carers

For current information on COVID-19

13 COVID - 13 26843
www.healthywa.wa.gov.au

Document credit: City of Albany

COVID-Ready Plan for Households

Part A - Complete this section for adults in the household.

*Your personal information will be safe. Under the law, all health workers MUST keep your private information confidential.

Adult / Carer 1

Name:

Age: Date of birth: Phone number:

Address:

Email:

Medicare number: Expiry: ID number:

COVID-19 vaccination status:

First dose: Second dose: Booster: Medical exemption:

Current medical conditions:

Current care plan (this could include a mental health plan or care plan for treatment of an existing health condition)

Current medications:

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Allergies:

Do you have a disability? (if yes, please provide the details of your carer or support services)

Add the contact details for your current health worker or doctor
If you don't have a current health worker or doctor you don't need to fill this out.

Health worker name: Phone:

Address:

Email:

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

Complete this section if you test positive for COVID-19

Date your symptoms started:

Date you took your positive COVID-19 test:

Next of kin: Relationship:

Their contact details:

Part A

Adult / Carer 2

Name:

Age: Date of birth: Phone number:

Address:

Email:

Medicare number: Expiry:ID number:

COVID-19 vaccination status:

First dose: Second dose: Booster: Medical exemption:

Current medical conditions:

Current care plan (this could include a mental health plan or care plan for treatment of an existing health condition)

Current medications:

Allergies:

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Part A

Do you have a disability? (if yes, please provide the details of your carer or support services)

Add the contact details for your current health worker or doctor
If you don't have a current health worker or doctor you don't need to fill this out.

Health worker name: Phone:

Address:

Email:

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

Complete this section if you test positive for COVID-19

Date your symptoms started:

Date you took your positive COVID-19 test:

Next of kin: Relationship:

Their contact details:

Part A

Other adult household members. Print one copy for each adult.

Name:

Age: Date of birth: Phone number:

Address:

Email:

Medicare number: Expiry: ID number:

COVID-19 vaccination status:

First dose: Second dose: Booster: Medical exemption:

Current medical conditions:

Current care plan (this could include a mental health plan or care plan for treatment of an existing health condition)

Current medications:

Allergies:

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Part A

Do you have a disability? (if yes, please provide the details of your carer or support services)

Add the contact details for your current health worker or doctor
If you don't have a current health worker or doctor you don't need to fill this out.

Health worker name: Phone:

Address:

Email:

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

Complete this section if you test positive for COVID-19

Date your symptoms started:

Date you took your positive COVID-19 test:

Next of kin: Relationship:

Their contact details:

COVID-Ready Plan for Children / Dependent Adults

Part B - Complete this section for each child and/or dependent adult in your household.
This plan will contain important information about your child or dependent adult's needs and who will care for them if you are unable to.

If I/we need to go to hospital for COVID-19. I/we consent to my/our child or dependent adult staying with the following people:

	Name of proposed carer:	Address:	Phone number:	Discussed with proposed carer:
1.				☐ Yes
2.				☐ Yes
3.				☐ Yes

I/we DO NOT wish the following people to visit or care for my/our child/dependent adult:

Name	Reason

Is there a court-ordered or legal custody agreement in place?

☐ Yes
☐ No

If yes, please provide the custody agreement details below:

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

☐ 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: Parent signature: Date:

Please complete this form and share this with the person you have nominated to care for your child/dependent adult if you have to go to hospital

This plan contains information to be used in the care of my/our child/dependent adult

(Print child's/dependent adult's full name): Preferred name:

should I/we be temporarily unable to care for him/her.

Important people in my child's/dependent adult's life who may need to be contacted:

Doctor name: Phone:
Family member/significant other: Phone:
School: Teacher: Phone:
Other: Relationship to my child Phone:
Other: Relationship to my child Phone:

Important information about my child/dependent adult

Medicare number: Expiry: Card ID:

Medications or special health care my child/dependent adult requires (include medication name, dose and times to be given etc):

Vaccination due dates and details:

Allergies:

Any specific concerns or worries that your child/dependent adult has (this may include events which have previously happened in their life):

Any cultural, religious, spiritual, or language influences:

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Part B

Support Needs

My child/dependent adult needs support with:

- ☐ feeding/eating
- ☐ dressing
- ☐ toileting
- ☐ sleeping
- ☐ communicating

My child is currently (tick all that apply):

☐ Breastfed – Details:

☐ Bottle-fed - Details (including how much, how often, if the bottle is heated, are there any additives to the bottle?):

☐ Introducing solid foods - Details (including how much, how often):

☐ Full diet

Food and drink likes/dislikes:

Part B

Other information about my child

Babysitter: Phone:

Child care centre/family day care centre: Phone:

After School care: Phone:

Regular activities/commitments (eg. playgroup, sports etc) (include days, times etc):

Bedtime and other routines including settling routines

Please record any additional information here:

Parent Signature: Date: Parent signature: Date:

Parent/Carer Signature: Date: Parent/Carer Signature: Date: