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: _____

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

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)

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 _____

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: _____

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

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: _____