COVID and Flu Care Plan for Parents/Carers and Children

It's important to have a plan in case you or anyone in your household gets COVID-19 or the flu. If this happens, you will need to isolate at home.

Most people who are fully vaccinated and get COVID-19 or the flu will experience mild symptoms and can care for themselves at home. Others may need to contact their GP for advice and management (including medication) and a few will need to go to hospital.

Part A - Complete this section if you are a parent or legal carer of a child
It will help your health team who will look after you if you get COVID-19 or the flu to understand your health needs and decide on the best care for you.

Part B - Complete this section to share information about your child's needs and who will care for them
This plan will contain important information about your child, your child's needs and who will care for your child if you can't care for them whilst you're isolating or in hospital.

What is a COVID and Flu Care Plan?

It lists important information about you, your health, and the people in your household. You can share it with:

- your doctor
- other health workers
- hospital staff
- a friend or family member.

How to use this plan:

Step 1
Complete Part A of this plan if you are a parent or legal carer of a child/children. (If you don't care for children, complete the COVID and Flu Care Plan for Adults).

Step 2
Complete Part B of this plan and print one individual plan for each child.

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

Step 4
If you get COVID-19 or the flu, use this plan when you speak to anyone providing care.

Take a copy of this plan with you if you need to go to hospital.

COVID and Flu Care Plan

Part A - Complete this section if you are a parent or legal carer of a child

It will help your health worker or doctor who will look after you and your child if you or your child get COVID-19 or the flu to understand your health needs and decide on the best care for you.

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

Parent / Carer 1

Name:

Age Date of birth: Phone number:

Address:

Email:

Medicare number: Expiry: HRN if known:

COVID-19 vaccination status:

First dose: Second dose: Boosters: Medical exemption:

Last influenza dose:

Any medical conditions:

Current medications:

Allergies:

Part A

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

Do you have any health conditions?

Do you have a current care plan?
(this could include a mental health plan or care plan for treatment of an existing health condition)

Do you have a plan for managing COVID-19 or flu as discussed with your GP?
(e.g. are you eligible for COVID-19 or flu medications)

Add the contact details for your current health team

If you don't have a current health team consider which GP you would contact if you need health care.

GP/Clinic: 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 or the flu

Date your symptoms started:

Date you took your positive COVID-19 or flu test:

What kind of test/symptoms:

Part A

Next of kin: Relationship:

Their contact details:

Add the contact details for the health team who will look after you

If you test positive for COVID-19 or the flu, provide details of contacts you are given to help care for you if they are not your normal health care team.

Health team: Phone:

Address:

Email:

Parent / Carer 2

Name:

Age Date of birth: Phone number:

Address:

Email:

Medicare number: Expiry: HRN if known:

COVID-19 vaccination status:

First dose: Second dose: Boosters: Medical exemption:

Last influenza dose:

Any medical conditions:

Current medications:

Part A

Allergies:

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

Do you have any health conditions?

Do you have a current care plan?
(this could include a mental health plan or care plan for treatment of an existing health condition)

Do you have a plan for managing COVID-19 or flu as discussed with your GP?
(e.g. are you eligible for COVID-19 or flu medications)

Add the contact details for your current health team

If you don't have a current health team consider which GP you would contact if you need health care.

GP/Clinic: Phone:

Address:

Email:

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

Part A

Complete this section if you test positive for COVID-19 or the flu

Date your symptoms started:

Date you took your positive COVID-19 or flu test:

What kind of test/symptoms:

Next of kin:

Relationship:

Their contact details:

Add the contact details for the health team who will look after you

If they test positive for COVID-19 or the flu, provide details of contacts you are given to help care for you if they are not your normal health care team.

Health team:

Phone:

Address:

Email:

Part A

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

Name:

Age Date of birth: Phone number:

Address:

Email:

Medicare number: Expiry: HRN if known:

COVID-19 vaccination status:

First dose: Second dose: Boosters: Medical exemption:

Last influenza dose:

Any medical conditions:

Current medications:

Allergies:

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

Do you have any health conditions?

Part A

Do you have a current care plan?
(this could include a mental health plan or care plan for treatment of an existing health condition)

Do you have a plan for managing COVID-19 or flu as discussed with your GP?
(e.g. are you eligible for COVID-19 or flu medications)

Add the contact details for your current health team

If you don't have a current health team consider which GP you would contact if you need health care.

GP/Clinic: Phone:

Address:

Email:

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

Complete this section if this person tests positive for COVID-19 or the flu

Date this person's symptoms started:

Date this person took their positive COVID-19 or flu test:

What kind of test/symptoms:

Next of kin: Relationship:

Their contact details:

Add the contact details for the health worker or doctor who will look after this person

If they test positive for COVID-19 or the flu, provide details of contacts you are given to help care for you if they are not your normal health care team.

Health team: Phone:

Address:

Email:

COVID and Flu Care Plan

Part B - Complete this section to share information about your child's needs and who will care for them

This plan will contain important information about your child, your child's needs and who will care for your child if you can't care for them whilst you're isolating or in hospital.

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

Please list in order of preference, adult carers that your child can stay with if you need to go to hospital. Are these people aware that you have nominated them?

If you can't find a carer for your children a health worker will be able to help you keep your children safe and cared for.

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:

Name:	Reason:

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

☐ Yes

☐ No

If yes, please provide the custody agreement details below:

Part B

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:

Parent signature: Date:

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

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

(Print child's full name): Preferred name:

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

Important people in my child'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:

Part B

Important information about my child

Medicare number: Expiry: HRN if known:

Medications or special health care my child 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 has (this may include events which have previously happened in the child's life):

Any cultural, religious, spiritual, or language influences for your child:

Part B

Feeding

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 (eg. favourite toys, music, nursery rhymes, sleep imes, lighting etc):

Please record any additional information here:

Parent signature: Date:

Parent signature: Date:

Parent/Carer signature: Date:

Parent/Carer signature: Date: