

# GET COVID READY



## 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](http://www.healthywa.wa.gov.au)



Scan the code to see  
where else you can get  
help and more  
information



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## 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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### Part A

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:

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## Adult / Carer 1

## Part A

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

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Health worker name:  Phone:

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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:

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

## Part A

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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## Part A

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Health worker name:  Phone:

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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.				<input type="checkbox"/> Yes
2.				<input type="checkbox"/> Yes
3.				<input type="checkbox"/> 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:



**Part B**

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:	<input type="text"/>	Phone:	<input type="text"/>
Family member/significant other:	<input type="text"/>	Phone:	<input type="text"/>
School:	<input type="text"/>	Teacher:	<input type="text"/>
Other:	<input type="text"/>	Relationship to my child:	<input type="text"/>
Other:	<input type="text"/>	Relationship to my child:	<input type="text"/>
		Phone:	<input type="text"/>
		Phone:	<input type="text"/>



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## Part B

### 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:

- |   |  |
|---|--|
| <input type="checkbox"/> feeding/eating | <input type="checkbox"/> sleeping      |
| <input type="checkbox"/> dressing       | <input type="checkbox"/> communicating |
| <input type="checkbox"/> toileting      |  |

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:



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## Part B

### Other information about my child

Babysitter:	<input type="text"/>	Phone:	<input type="text"/>
Child care centre/family day care centre:	<input type="text"/>	Phone:	<input type="text"/>
After School care:	<input type="text"/>	Phone:	<input type="text"/>

### 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 times, lighting etc):

### Please record any additional information here:

Parent Signature:	<input type="text"/>	Date:	<input type="text"/>	Parent signature:	<input type="text"/>	Date:	<input type="text"/>
Parent/Carer Signature:	<input type="text"/>	Date:	<input type="text"/>	Parent/Carer Signature:	<input type="text"/>	Date:	<input type="text"/>