CARE PLAN

Start Date:

**Name of setting:**

**Child Name: DOB:**

**Address:**

**Tel No: Mobile No:**

**Main Carer’s Details – Name, Address and Contact Numbers:**

**GP’s Name:**

**Surgery Address:**

**Relevant Health Professionals:**

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| **Name**  | **Service** | **Contact Number** | **Hospital/Clinic** |
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**Identified requirements:**

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**ESSENTIAL INFORMATION:**

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| --- | --- |
| **Likes** |  |
| **Dislikes** |  |

**REQUIREMENTS**

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| **Religious/Cultural Requirements:** |  |

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| **Hearing/Vision:**Any results from recent Audiologist tests, history of ‘glue ear’, Grommets’, hearing impairment, uses aids…Any results from recent Ophthalmic tests, requires glasses, large print… |  |

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| **Speech, Language and Communication:**Preferred communication, language, signs, gestures, expression, listening, understanding |  |

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| --- | --- |
| **Personal/Intimate Care:**Self-care skills, independence; washing, dressing, nappy changing, toileting |  |

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| **Physical Development:**Fine motor skills, gross motor skills, lifting and handling, specific resources/equipment |  |

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| **Feeding/Eating/****Drinking:**Type of feed/drink, dietary requirements, feeding and drinking utensils/equipment |  |

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| **Any other requirements:** |  |

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| **Identified Risks:**  |

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| **Aim of Care Plan:** |

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| --- |
| **Summary of Tasks** |
| **Actions** | **By Whom** | **By When** |
|  |  |  |
| **Any staff training requirements:** |  |  |
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| **Contingency Arrangements:** |

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| --- | --- | --- |
| **Medication administered at home:** | **Dosage** | **Possible side effects** |
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| **Medication administered in the setting:** | **Dosage** | **Possible side effects** |
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**I agree with the above details/actions……………………..**

**Signature :…………………………………………................................(on behalf of setting)**

**Signature :……………………………………………………………………….(Parent/Carer)**

**Copies to:**

**Date completed: Date of review:**

 **To be reviewed by:**