



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



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



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



GET COVID-READY





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 nu	imber:	
Address:							
Email:							
Medicare	e number:			Expiry:		ID number:	
COVID-1	9 vaccinati	ion status:					
First dose	e:	Second dose:		Booster:		Medical exemption	ו:
Current r	nedical cor	nditions:					
Current o	care plan (t	his could include a menta	l health plan oi	r care plan for treatr	ment of an existi	ng health condition)	
Current	medicatior						
Current	nealcation	15.					

Allergies:	
Do you have a disabili	ty? (if yes, please provide the
	ils for your current health wo rrent health worker or doctor
Health worker name:	
Address:	
Email:	
Are you currently recei	ving care for cancer? (if yes,
Complete this se	ection if you test posit
Date your symptoms s	started:

Date you took your positive COVID-19 test:	
Next of kin:	Relationship:
Their contact details:	



Part A

he details of your carer or support services)						
worker or doctor for you don't need to fill this out.						
Phone:						
es, what type of cancer?)						

itive for COVID-19







ge: Date of birth: Phone number: Add the contact detail if you don't have a current if	lt / Carer 1			Part A	
ddress: mail: Iedicare number: Expiry: ID number: ist dose: Second dose: Booster: Medical exemption: Interiment medical conditions: Surrent medications: Complete this sec Course plan. (this could include a mend health plan or core plan for treatment of an existing health condition) Course plan. (this could include a mend health plan or core plan for treatment of an existing health condition) Course plan. (this could include a mend health plan or core plan for treatment of an existing health condition) Course plan. (this could include a mend health plan or core plan for treatment of an existing health condition) Course plan. (this could include a mend health plan or core plan for treatment of an existing health condition) Course plan. (this could include a mend health plan or core plan for treatment of an existing health condition) Course plan. (this could include a mend health plan or core plan for treatment of an existing health condition) Course plan. (this could include a mend health plan or core plan for treatment of an existing health condition) Course plan. (this could include a mend health plan or core plan for treatment of an existing health condition) Course plan. (this could include a mend health plan or core plan for treatment of an existing health condition) Course plan. (this could include a mend health plan or core plan for treatment of an existing health condition) <td>ie:</td> <td></td> <td></td> <td></td> <td>Do you have a disability</td>	ie:				Do you have a disability
Add the contact details If you don't have a current Health worker name: Address: Add	Date of birth:	Phone n	number:		
In the second dose: Expiry: ID number: Address: Second dose: Booster: Medical exemption: Email: Address: Email: Are you currently receiving the second dose: Are you to a second dose are you to a s	ress:				
Address: COVID-19 vaccination status: Address: Email: Current medical conditions: Complete this sector of an existing health condition Complete this sector of the status	ıil:				
is to dose: Booster: Medical exemption: Email: Are you currently receiving for the or an existing health condition. Email: Are you currently receiving for the or an existing health condition. Complete this sector Date your symptoms state Date your symptoms state COVID-19 test: Next of kin: Their contact details:	licare number:	Expiry:	ID number:		Health worker name:
urrent medical conditions: Are you currently receiving current care plan (this could include a mental health plan or care plan for treatment of an existing health condition) Complete this sec current medications: Date you rook your positic COVID-19 test: current medications: Next of kin:	/ID-19 vaccination status:				Address:
Are you currently receiving current care plan (this could include a mental health plan or care plan for treatment of an existing health condition) Current medications: Current medications: Curre	dose: Second dose:	Booster:	Medical exemption:		Email:
Current care plan (this could include a mental health plan or care plan for treatment of an existing health condition) Complete this sec Date your symptoms sta Date you took your posit COVID-19 test: Next of kin: Their contact details:	ent medical conditions:				Are vou currently receivi
Complete this sec Date your symptoms sta Date you took your posit COVID-19 test: Next of kin: Their contact details:					
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Complete this sec Date your symptoms sta Date you took your posit COVID-19 test: Next of kin: Their contact details:					
Current medications: Date you took your position of kin: Their contact details:	ent care plan (this could include a mental health pl	n or care plan for treatment of an exit	isting health condition)		Complete this sec
Current medications: COVID-19 test: Next of kin: Their contact details:					Date your symptoms sto
Current medications: Next of kin: Their contact details:					
	rent medications:				
Allergies:					Their contact details:
	arcies:				



Part A

se provide the details of your carer or support services)

ent health worker or doctor ker or doctor you don't need to fill this out.

Phone:

Incer? (if yes, what type of cancer?)

test positive for COVID-19

GET COVID-READY





Other adult	Other adult household members. Print one copy for each adult. Part					Part A		
Name:								
Age:		Date of birth	:		Phone nu	umber:		
Address:								
Email:								
Medicare nu	umber:			Expiry:			ID number:	
COVID-19 v	vaccinati	ion status:						
First dose:		Second dose:		Booster	:	Medi	ical exemption:	
Current med	dical coi	nditions:						
Current car	e plan (t	his could include a mental	health plan c	r care plan for trec	atment of an exist	ing health c	condition)	
Current medications:								
Allergies:								

Do you have a disability? (if yes, please provide the
Add the contact details for your current health wor If you don't have a current health worker or doctor y
Health worker name:
Address:
Email:
Are you currently receiving care for cancer? (if yes, w

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

ne details of your carer or support services)

orker or doctor

or you don't need to fill this out.

Phone:

s, what type of cancer?)



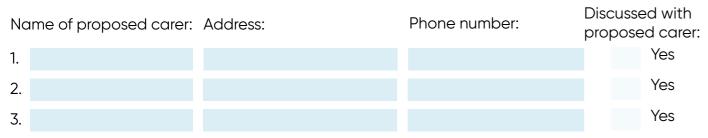




COVID-Ready Plan for Children / Dependent Adults

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:



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:

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

	Regular photos/videos of my child to be se						
	To speak to my chil	To speak to my child regularly by phone wh					
	My child to be show	My child to be shown photos of me regular					
Othe	er:						
Pare	nt Signature:	Date:	Po				

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):

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:

Family member/significant other:					
School:		Teacher:			
Other:		Relations	hip to my child		
Other:		Relations	hip to my child		



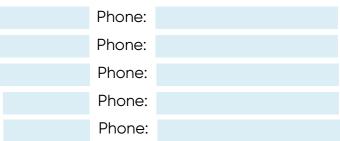
Part B

- ent to me
- hen I'm well enough
- ly

arent signature:

Date:

Preferred name:











	Part B
nportant information about my child/dependent adult	
edicare number: Expiry: Card ID:	
edications or special health care my child/dependent adult requires (include medico ame, dose and times to be given etc):	ation
anne, dose drid times to be given etc).	
accination due dates and details:	
accination due dates and details.	
lergies:	
ny specific concerns or worries that your child/dependent adult has (this may include	avents
hich have previously happened in their life):	events
ny cultural, religious, spiritual, or language influences:	



Part B

sleeping communicating

w often, if the bottle is heated, are there any

ow much, how often):





Other information about my child	Part B
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 times, lighting etc):

Please record any additonal information here:

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