Spina Bifida Care Plan

for education and care

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| To be completed by the treating health professional and parent or legal guardian.  This information is confidential and will be available only to relevant staff and emergency medical personnel. | | | |
| Name of child/young person: |  | | |
| DOB: |  | Review date: |  |
| Allergies: |  | | |
| Education or care service: |  | | |  |

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| **BACKGROUND INFORMATION** |
| This can include information about spina bifida and how it affects the person (eg Carol was born with nerve damage which has led to lower limb paralysis, incontinence and loss of sensation below the lesion. Carol has spent a significant amount of time in hospital, undergoing surgery on numerous occasions. This hospitalisation and surgery is ongoing). |

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| **LEARNING ISSUES**  Indicate if learning difficulties may be noted in the following areas | | | | | |
|  | Memory |  | Fine motor skills |  | Problem solving |
|  | Attention |  | Organisation |  | Decision making |
|  | Mathematics |  | Other (specify) | | |
| Provide any further details / comments | | | | | |

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| **GENERAL INFORMATION** | | |
|  | Physical | eg tiredness, headaches, limitations, safety |
|  | Social | eg related to friendships, significant others |
|  | Behavioural | eg changes, coping strategies |
| Provide any further details / comments | | |

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| **EFFECTS ON CARE, LEARNING AND BEHAVIOUR** | | |
|  | Short-term | indicate timeframe if known |
|  | Long-term | indicate timeframe if known |
|  | Understanding and impact | provide information about the child or young person’s understanding of the condition and its impact |
|  | Surgery or therapy | provide information about any ongoing or anticipated surgery or therapy program(s) |
| Provide any further details / comments | | |

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| **AUTHORISATION AND AGREEMENT**  *(To be signed after form has been completed)* | | The following settings have been considered in the development of the health care plan and is appropriate for use in the following: | | | | |
|  | Children’s centre, preschool or school | | |  | Childcare, Out of School Hours Care | |
|  | Camps, excursions, special event, transport (incl. aquatics) | | |  | Work experience or other education placement | |
|  | Respite, accommodation | | |  | Work | |
|  | Transport | | |  | Other (specify) | |
| *Treating health professional* | | | | | | |
| *(print name & practice/hospital or stamp)* | | | Professional role | | |  |
| Email or signature | | |  |
| Telephone | | | Date | | |  |
| *Parent or legal guardian; or adult student* | | | | | | |
| * **I understand and agree with the care plan as indicated above** * **I approve the release and sharing of this information to supervising staff and emergency medical staff (if required).** * **I understand staff may seek additional information and/or advice regarding the medical information contained in the care plan from the Access Assistant Program (AAP) to inform duty of care.** | | | | | | |
| (name) | | | | | (relationship) | |
| (email or signature) | | | | | (date) | |