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# CARER INFORMATION BOOKLET

FOR

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| **CHILD NAME:** |
| **LIKES TO BE CALLED:** |
| **DATE OF BIRTH:** |
| **DIAGNOSIS:** |
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| MUMS NAME: |
| MUMS CONTACT NUMBERS: |
| DADS NAME: |
| DADS CONTACT NUMBERS: |
| SIBLINGS: |
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| **MEDICATIONS:** |
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| **IN CASE OF EMERGENCY:** |
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| **OTHER USEFUL NUMBERS** |
| Grandparents: |
| GP: |
| Physio: |
| OT: |
| Speech Therapist: |
| School: |
| Paediatrician: |
| Poison Info Hotline: |
| PMH Emergency Dept: |
| Local Hospital Emergency Dept: |

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**FEEDING INSTRUCTIONS:**

**COMMUNICATION:**

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**TOILETING:**

**PLAY (See Daily Activities Planner)**

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**SLEEP:**

**BATHING:**

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**EQUIPMENT:**

**DISCIPLINE:**

OTHER:

- Please read and follow our vision statement in all interactions with our child/ren