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What Are the Individual Preparations for Children with Special Health Care Needs in the Event of an Emergency?

Karen Sue Barcelo

Wright State University - Main Campus

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What are the Individual Preparations for Children with Special Health Care Needs in the Event of an Emergency?

Karen Sue Barcelo

The Wright State University

June 6, 2008
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Abstract

Children with special health care needs are one of the most vulnerable groups in the event of an emergency. Natural and manmade disasters or emergency events occur on a daily basis. Government agencies, schools and day care centers have begun developing emergency disaster plans; fewer plans have been developed for children with special needs. One explanation for the lack of specific planning for children is that agencies may believe that plans for adults are not different from plans for children. There may be many reasons why parents who have children with special needs may not have an emergency plan in place. Parents are overwhelmed with the care of their child with special needs and they may have few specific resources to guide them in developing a plan. To identify relevant information on emergency preparedness for parents who have a child with special needs, this researcher conducted a MEDLINE search via PUBMED. The search included the years 1995 to 2008 using the key words children with special needs, disaster planning for children with disabilities, disaster planning, emergency preparedness and parent’s preparation for disasters. Sixty articles and studies were reviewed. Seventeen met the criteria of providing information regarding parent’s preparations and agency’s plans. The results of the research indicate agencies are beginning to develop plans, however, they are lacking for children with special needs. This researcher developed specific guidelines to complement the agency’s plans and to assist parents in creating emergency plans to ensure an improved outcome for their child with special needs. Parents planning through compilation of information, construction of an emergency kit and purchase of a medical alert identification will empower them with the feeling of being prepared for events that may occur and help to reduce the potential catastrophic consequences of an emergency for their child with special health care needs.
Introduction

The numbers of human designed and natural disasters have increased over the last twenty to thirty years. Regardless of where individuals live, there is a good likelihood that there will be an occurrence that will disrupt the normal daily routines of families. Since the events of September 11, 2001, domestic terrorism has become more of a perceived threat which has made disaster and emergency planning take on a new meaning. Emergency preparedness and training have become more prevalent concerns among federal, state, county, city and public health planning committees. There has been attention directed toward emergency planning in general but there has been a lack of any focused attention on individuals with disabilities; particularly, the pediatric population with special health care needs.

One explanation for the lack of information and details about meeting the needs of children when planning for disasters may be that children are frequently not looked at as being different from adults, as a separate concern or at a separate stage of growth (Ginter et al., 2006). The belief during disasters is that the care for children will be the same as for adults.

Regardless of the events of September 11, 2001, Hurricane Katrina and the tsunami in Asia, families are still not equipped for emergencies or disasters (Kubicek et al., 2008). Parents, who attempt to put an emergency plan into place, will likely compile a generic plan for the entire family. If they have a child with a health concern, however, it is imperative that they develop a plan specific to that child’s needs. The questions that the parents need to answer are: 1) if my child is displaced from home, what supplies will be needed to sustain him/her for at least 24 hours, 2) if my child is nonverbal, what can be done to ensure that individuals in a shelter can communicate effectively enough with my child in order to meet his/her needs.
Statement of Purpose

The purpose of this paper is to assist parents who have children with special health care needs develop an emergency plan for home and away from home, to emphasize to parents the importance of developing a plan of care specific to their child’s needs to assure that anyone temporarily caring for the child will have a sufficient understanding of those needs, including information about equipment and medications, to ensure that they can provide the care necessary to sustain the child for at least 24 hours. Federal, state and local agencies have written much about disaster and emergency planning. Very little of this direction, however, has been incorporated at the local level in schools, day care facilities, physician practices and hospitals. Similarly, little has been explored regarding parents’ planning specifically for their child with special health care needs. The purpose of this research is to condense the information that has been published about disaster preparedness and develop a simplified, concise plan to assist parents in the emergency preparations for their child with special needs.
Literature Review

The terms emergency and disaster take on many definitions and frequently are used interchangeably. Natural disaster is a term used to define an event that has the capability of displacing, causing death and property damage to many people. According to the Federal Emergency Management Agency (FEMA) there are many types of natural disasters:

- Earthquake
- Excessive Heat
- Thunderstorm
- Volcano
- Fire or Wildfire
- Hurricane
- Tornado
- Winter Storm
- Flood
- Landslide
- Tsunami

Other disasters or hazards, as defined by FEMA include:

- Chemical
- Dam Failure
- Hazardous Material
- Nuclear Power Plant Emergency

Man-made disasters are often defined as events which are the result of terrorism, intentional or unintentional explosions or bioterrorism. For the purpose of this review the term
emergency will be used to include all of the above definitions (Texas Department of State Health Services, 2006).

In the last 100 years, the number of natural disasters in the United States (U.S.) and the world has significantly increased with 91% of all natural disasters in the U.S. occurring in the last 54 years. Manmade disasters world-wide such as chemical spills, building collapses, fires, poisonings and transportation accidents have increased from 266 during the 1970’s decade to 2051 in the 1990’s decade. In the U.S., manmade disasters have increased during the same time frame from 42 to 86 (Ginter et al., 2006).

Emergency planning should be an essential factor of everyday living. It is a topic that individuals typically think about for a brief moment when they hear the term and then put out of their minds. Even though people know that some sort of emergency may happen, they don’t really believe that it will happen to them. It is a topic that must be taken seriously by every person, every business, and every school.

Public health, emergency personnel, volunteers and other agencies join together to provide emergency assistance to help protect the health of the public, ensure safety and provide assistance in meeting human needs. In the event of an emergency that requires assistance beyond the scope of the local agencies, the governor can declare a state of emergency and invoke the state’s emergency plan which indicates that federal assistance may be needed. When requesting federal assistance under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, the governor must declare the severity and extent of the disaster in order to certify that federal assistance indeed is necessary (FEMA, 2008).

The declared disasters from 1953 to present are listed in Table 1. The number of declared disasters has progressively increased since 1953. The year with the most disasters was 2004; the
years with the least were 1958 and 1959 (excluding 2008). Table 2 indicates the number of disasters by state since 1953. To date, Texas has the largest number of declared disasters.

Table 1. Declared Disasters by year

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Disaster Declarations</th>
</tr>
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<tbody>
<tr>
<td>2008</td>
<td>15</td>
</tr>
<tr>
<td>2007</td>
<td>63</td>
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<td>2006</td>
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### Table 2. Declared Disasters by state

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<tbody>
<tr>
<td>1 Texas</td>
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</tr>
<tr>
<td>2 California</td>
<td>73</td>
</tr>
<tr>
<td>3 Florida</td>
<td>59</td>
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<tr>
<td>4 New York</td>
<td>56</td>
</tr>
<tr>
<td>5 Oklahoma</td>
<td>54</td>
</tr>
<tr>
<td>6 Louisiana</td>
<td>53</td>
</tr>
<tr>
<td>7 Kentucky</td>
<td>46</td>
</tr>
<tr>
<td>8 Alabama</td>
<td>46</td>
</tr>
<tr>
<td>9 Missouri</td>
<td>44</td>
</tr>
<tr>
<td>10 Illinois</td>
<td>44</td>
</tr>
<tr>
<td>11 Ohio</td>
<td>43</td>
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<tr>
<td>12 Arkansas</td>
<td>43</td>
</tr>
<tr>
<td>13 Pennsylvania</td>
<td>42</td>
</tr>
<tr>
<td>14 Mississippi</td>
<td>42</td>
</tr>
<tr>
<td>15 Washington</td>
<td>41</td>
</tr>
<tr>
<td>16 West Virginia</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>State</td>
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<tr>
<td>17</td>
<td>Minnesota</td>
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<td>18</td>
<td>Virginia</td>
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<td>19</td>
<td>Tennessee</td>
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<td>20</td>
<td>Iowa</td>
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<tr>
<td>21</td>
<td>Kansas</td>
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<tr>
<td>22</td>
<td>North Dakota</td>
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<tr>
<td>23</td>
<td>Nebraska</td>
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<tr>
<td>24</td>
<td>North Carolina</td>
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<td>25</td>
<td>Indiana</td>
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<tr>
<td>26</td>
<td>Georgia</td>
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<tr>
<td>27</td>
<td>Wisconsin</td>
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<td>28</td>
<td>Maine</td>
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<tr>
<td>29</td>
<td>Alaska</td>
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<tr>
<td>30</td>
<td>South Dakota</td>
</tr>
<tr>
<td>31</td>
<td>Oregon</td>
</tr>
<tr>
<td>32</td>
<td>Vermont</td>
</tr>
<tr>
<td>33</td>
<td>New Jersey</td>
</tr>
<tr>
<td>34</td>
<td>Michigan</td>
</tr>
<tr>
<td>35</td>
<td>Federated States of Micronesia</td>
</tr>
<tr>
<td>36</td>
<td>Hawaii</td>
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<tr>
<td>37</td>
<td>Massachusetts</td>
</tr>
<tr>
<td>38</td>
<td>Puerto Rico</td>
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<tr>
<td>39</td>
<td>New Mexico</td>
</tr>
<tr>
<td>40</td>
<td>Idaho</td>
</tr>
<tr>
<td>41</td>
<td>Arizona</td>
</tr>
<tr>
<td>42</td>
<td>New Hampshire</td>
</tr>
<tr>
<td>43</td>
<td>Maryland</td>
</tr>
<tr>
<td>44</td>
<td>Nevada</td>
</tr>
<tr>
<td>45</td>
<td>Montana</td>
</tr>
<tr>
<td>46</td>
<td>South Carolina</td>
</tr>
<tr>
<td>47</td>
<td>Colorado</td>
</tr>
<tr>
<td>48</td>
<td>Northern Mariana Islands</td>
</tr>
<tr>
<td>49</td>
<td>US Virgin Islands</td>
</tr>
<tr>
<td>50</td>
<td>Connecticut</td>
</tr>
<tr>
<td>51</td>
<td>Guam</td>
</tr>
<tr>
<td>52</td>
<td>Delaware</td>
</tr>
<tr>
<td>53</td>
<td>American Samoa</td>
</tr>
<tr>
<td>54</td>
<td>Wyoming</td>
</tr>
<tr>
<td>55</td>
<td>Utah</td>
</tr>
<tr>
<td>56</td>
<td>Rhode Island</td>
</tr>
<tr>
<td>57</td>
<td>Marshall Islands</td>
</tr>
<tr>
<td>58</td>
<td>District of</td>
</tr>
</tbody>
</table>
Terrorism has increased the number of disasters. The targets for terrorists have not been restricted to adults. There have been numerous events where children were affected. In 1995 in Oklahoma City, Oklahoma, the Alfred P. Murrah Federal Building fell under attack. On that date, 19 of the victims were children who were in the day care center in that building. On September 11, 2001 there were a number of schools in close proximity to the Twin Towers. In September 2004, militants raided a school in Besian, Russia. At the end of this event, which lasted several days, there were 330 people killed, most of them children (Ginter et al., 2006).

An emergency may occur at any time and at any place. Children may be at home, in a child care setting, at school or a sporting event. Regardless of where the child is at the time an emergency occurs, advanced planning may help to decrease the negative outcomes for the child’s health.

The Federal Emergency Management Agency (FEMA) has developed numerous plans and policies for agencies, individuals and families. According to FEMA, “knowledge is power, and knowing what you are going to do when a disaster disrupts your life gives you the power to act, not react, during a time of chaos and confusion” (http://www.fema.gov/areyouready/emergencyplanning.shtm). Table 3 below lists suggestions given to assist individuals with disabilities or special needs.
### Table 3. FEMA Suggestions

<table>
<thead>
<tr>
<th>Disability/Special Need</th>
<th>Additional Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visually impaired</td>
<td>May be extremely reluctant to leave familiar surroundings when the request for evacuation comes from a stranger. A guide dog could become confused or disoriented in a disaster. People who are blind or partially sighted may have to depend on others to lead them, as well as their dog, to safety during a disaster.</td>
</tr>
<tr>
<td>Hearing impaired</td>
<td>May need to make special arrangements to receive warnings.</td>
</tr>
<tr>
<td>Mobility impaired</td>
<td>May need special assistance to get to a shelter.</td>
</tr>
<tr>
<td>Single working parent</td>
<td>May need help to plan for disasters and emergencies.</td>
</tr>
<tr>
<td>Non-English speaking persons</td>
<td>May need assistance planning for and responding to emergencies. Community and cultural groups may be able to help keep people informed.</td>
</tr>
<tr>
<td>People without vehicles</td>
<td>May need to make arrangements for transportation.</td>
</tr>
<tr>
<td>People with special dietary needs</td>
<td>Should take special precautions to have an adequate emergency food supply.</td>
</tr>
<tr>
<td>People with medical conditions</td>
<td>Should know the location and availability of more than one facility if dependent on a dialysis machine or other life-sustaining equipment or treatment.</td>
</tr>
<tr>
<td>People with intellectual disabilities</td>
<td>May need help responding to emergencies and getting to a shelter.</td>
</tr>
<tr>
<td>People with dementia</td>
<td>Should be registered in the Alzheimer’s Association Safe Return Program</td>
</tr>
</tbody>
</table>


Appendix B lists other suggestions by FEMA to assist families and individuals, including individuals with special needs when preparing for emergencies.
The American Red Cross is a humanitarian organization that helps millions of people each year prevent, prepare for, and cope with emergencies. Their belief is that “preparedness is an everyday task for everyday life and being prepared for emergencies is crucial at home, school, work and in your community” (www.redcross.org). Being prepared before a disaster occurs is the best way that individuals and families can remain safe. Red Cross volunteers are not available to assist everyone immediately following a disaster, but they encourage everyone to develop an emergency kit, make a plan and be informed. According to the Red Cross, there are six basic groups of items every home should have a stock of in the event of an emergency: water, food, first aid supplies, clothing and bedding, tools and emergency supplies and special items for medical conditions. The Red Cross recommends these items be placed in an easy to carry container such as a large covered trash container, a camping backpack or a duffle bag. Appendix B shows the suggested American Red Cross list of emergency items.

Preparedness of Schools to Respond to Emergencies in Children: A National Survey of School Nurses

Because children spend the major part of their day in the school setting, it would not be unlikely that an emergency could occur during this time frame. Olympia, Wan and Avner (2005) conducted a study to assess the preparedness of school nurses to respond to pediatric life-threatening emergencies, which included emergencies involving children with special needs. The study also assessed the preparedness of schools in the event of a mass disaster.

The participants were 1000 randomly selected members of the National Association of School Nurses. Of the 1000 surveys sent to nurses, 675 were returned and 573 were eligible for
analysis. They were given a two part questionnaire focusing on their clinical background, the demographic features of the school, self reported frequency of medical and psychiatric emergencies and the preparedness of schools to manage life-threatening emergencies. The second part of the questionnaire presented 10 clinical scenarios measuring the confidence level of the school nurse in managing a potential life-threatening emergency.

Sixty-eight percent (391 of 573) [95% confidence interval (CI): 64-72%] of the nurses verbalized that they had managed a life threatening emergency where the EMS had been activated during the last school year. Eighty-six percent (95% CI: 84-90%) of the schools had a Medical Emergency Response Plan (MERP), however 35% (95% CI: 31-39%) of the schools did not practice the plan. Thirteen percent (95% CI: 10-16%) of the schools did not have an assigned medical person to make medical decisions in an emergency.

Of the schools that had at least one child with special health care needs, 90% (95% CI: 86-93%) had an MERP, 64% (95% CI: 58-69%) had a nurse available during the entire school day, and 32% (95% CI: 27-38%) had an effective campus-wide communication system linked with EMS. In 12% (95% CI: 9-16%) of the schools with children with special needs there were no identified authorized personnel to make medical decisions when the school nurse was not present on the campus. When analyzing the confidence levels of the nurses to respond to life threatening emergencies in children with special health care needs, 67% (95% CI: 61-72%) of the nurses stated that they felt confident in managing seizures, 88% (95% CI: 84-91%) stated confidence in managing respiratory distress and 83% (95% CI: 78-87%) stated confidence in managing airway obstruction.

Even though it appeared schools were compliant with emergency preparedness issues, the recommendations from the survey were that the MERP should be practiced at least two times a
year in each of the schools, all areas of the school grounds should be linked with the EMS and when nursing staff is not present in the school, other authorized staff should be assigned and qualified to make medical decisions (Olympia et al., 2005).

Knowledge and Behaviors of Parents in Planning for and Dealing with Emergencies

School teachers and parents in two Los Angeles school districts were assessed to determine the parents’ level of emergency disaster preparedness and the challenges they face. The methods used were mixed method designs that included surveys, semi-structured interviews and focus groups in these two school districts (Kubickek, Ramirez, Limbos, & Iverson, 2008).

Parents generally stated that they did not feel prepared if a disaster or emergency should occur in their community. One of the questions asked parents to define preparedness for an emergency, in this case a natural disaster. Many of the parents spoke about having canned foods, extra water on hand, flashlights, batteries, extra cash, a first aid kit and important documents such as passports and home insurance. A much smaller group of parents discussed the importance of having home evacuation plans in place, a meeting place should the family be separated, and an emergency contact person for all of the family members.

Some of the parents stated they understood the importance of developing an emergency plan but recognized other things in life were currently more important. They thought however, they would get to it someday soon. Many of the parents in this study admitted they had very little knowledge as to what should be done if there was an emergency, in this particular case, an earthquake. Parents stated they discussed with their children the importance of avoiding strangers and other concerns but rarely if ever did they discuss what should be done if an emergency occurs. They believed the schools should educate the children on how to handle emergencies.
The Los Angeles County Office of Education collaborated with the University of California at Los Angeles along with the Children’s Hospital of Los Angeles to conduct a quantitative survey to evaluate parental involvement in emergency preparedness at schools (Kubicek et al. 2008).

The results of the study indicated parents are much more likely to participate in emergency preparedness activities when their children are in elementary school, less in middle school and even less when the children are in high school.

The conclusion from this article is that parents’ perception and knowledge of an event will directly affect their response to emergencies and disasters. School staff reported a large concern is if an emergency occurs, the school campus will be inundated by parents. In fact, when answering one of the questions on the survey, nearly all of the parents responded that they would go directly to the school to check on their child or offer assistance. This created a challenge for the school personnel who believed parents would not listen to them and would either send someone to pick up the child or would leave the school premises with their child without notifying the school. For that reason, it would be in the school’s best interest to encourage parents to make a plan and to advise the school with the names of friends or family who may be permitted to pick up the child in the event of an emergency. Preparedness by parents for emergencies or disaster planning for their special needs child had virtually not been explored (Kubickek, et al., 2008).

Public Health Emergency Preparedness in the Setting of Child Care

Over 13 million of America’s youngest children find a child care setting their second home. In a study conducted by Gaines & Leary, the authors discovered that because of the
complexity of developing an emergency preparedness plan for a child care center, many centers have not done so. The United States Department of Education has stressed to schools the importance of developing an emergency management plan (Gaines & Leary, 2004).

Child care regulatory agencies have not, however, stressed the same importance to child care centers. Information regarding how prepared child care centers are in the event of an emergency is lacking. However, a recent survey regarding child care safety and questions about training and planning for terrorism and other emergencies reflected more than 51% of the police officers who are school based stated that their school crisis plans were “inadequate”. More than 62% of the schools did not have emergency plans in place. Seventy-six percent of the school based police officers stated their schools were not prepared in the event of a terrorist attack and 71% of the school’s teachers, support staff and administrators in this study have never received training specific to terrorism. According to these authors, this same data may also apply to child care centers.

Both parents and child care centers have special concerns that impact emergency plans for a center. Parents ought to review their own family emergency plan and discuss their plan with the center. Appropriate questions parents could and should ask their child care center and ask themselves are: Does the center have the capability of transporting large numbers of children in the event of an emergency? Do the parents have a reunification plan with the school if an emergency should occur and the parents are separated from their child? Where will the child most likely go in the event of an emergency? Has the center developed an emergency plan? Have the parents developed a readiness kit for their child and provided the school with emergency phone numbers? (Gaines et al., 2004).
The authors of this study recommend discussing or rehearsing with the child what he/she should do if the parents are unable to get to the child. This should be done only if the parents believe that the child’s cognitive development is such that it would not disturb or frighten the child. The authors recommended that it be done in a non-threatening way so as to decrease anxiety or fear in the child. It is imperative that parents avoid developing fear in their child but present the scenario in a nurturing way.

Younger children, particularly, may display fear even when the parents appear to be calm. Children are able to detect stress and may respond accordingly. Parents need to understand their child’s perception as to what is occurring likely will influence the child’s response to the event, either good or bad.

Children in a child care setting or a school setting spend the majority of their days in the school which increases the likelihood that they will not be with their parents if an emergency should occur. Child care providers, as well as schools are responsible for a child’s emotional, physical and medical safety when the parent’s entrust them with their care. Therefore, it is imperative that parents assist the school or caregivers by providing an emergency form complete with any special needs of the child along with emergency contacts (Gaines et al., 2004).

*A National Survey of Terrorism Preparedness Training among Pediatric, Family Practice, and Emergency Medicine Programs*

Emergency medicine, family practice, and pediatric residency programs in the United States conducted a national survey, to “assess the current state of terrorism preparedness training, including child victims” and to “assess methods of training and barriers to establishing effective training” (Martin, Bush, & Lynch, 2006, p. e621). The survey measured the residents’
perceived risk of terrorist attack, the degree of training according to the type of attack, the extent of training regarding children and any identified barriers to training.

The surveys were electronically mailed to all pediatric, family practice and emergency medicine residency programs in the United States at three different times from September 2003 to January 2004. Twenty-five percent of the programs responded to the survey (46 of 182 pediatric, 75 of 400 family practice and 29 of 125 emergency medicine programs).

The results indicated emergency medicine programs were likely to have more in depth training, however when asked whether their training included the specific health concerns, vulnerabilities and/or supervision of children as victims, the residents stated comprehensive training was lacking. The family practice and pediatric residents reported they had a limited amount of terror response training incorporated into their program. There was concern over the lack of training for the management of children who were victims and training on pediatric specific issues. The residents received instructive classroom based lectures and when the residents were questioned about the training scenario exercises in which they participated, 94% stated that they “never” (40%) or only “sometimes” (54%) integrated child victims in the scenario. The barriers to valuable training in this particular study were time, financial funding, experts to instruct the residents and access to the material on the subject.

The limitations that children with special needs have, either physically or developmentally may preclude them from escaping an emergency situation quickly. If an emergency occurs, the likelihood increases that children will have a greater risk for exposure. These factors, in effect will impact their treatment needs such as decontamination, medications and equipment requirements. In light of the statistics regarding the preparation of medical
residents in an emergency situation, it becomes evident child casualties create an immense problem for logistic planning (Martin et al., 2006).

The authors of this study concluded that public health, disaster planning groups and medical education are in agreement that as a nation, the physician workforce has to be better trained and prepared for emergencies, including terrorist events. They also stated that children are a “precious national resource” but are especially at risk during emergencies (Martin et al., 2006).

**Assessing Emergency Preparedness of Families Caring for Young Children with Diabetes and other Chronic Illnesses**

Additional characteristics that make special needs children more vulnerable in an emergency are that they may not be able to verbalize their needs, share information or be communicative at all. With the increase number of children with special needs in the general population, it is likely that an increased number of children with special needs may be affected in an emergency situation. The use of some type of medical alert identification would be most beneficial for all individuals who have health concerns, but especially for children with special health care needs (Stallwood, 2006).

In medical preparation planning or literature regarding emergency planning little has been done to stress the importance of the medical alert identification program and its usefulness for individuals with allergies, diabetes and any number of conditions. A 2006 study showed only 22 out of 73 children who had type 1 diabetes wore any type of medical alert identification. This indicates the significance of medical alert identification continues to remain unappreciated. This
small device would be especially beneficial to younger children who may or may not be able to identify the warning signs associated with diabetes (Stallwood, 2006).

Children are not little adults, and likewise, children with special health care concerns, are not little adults who may have similar conditions. Based on the condition and the age of the child, treatment needs can vary significantly.

Due to the anatomic and physiologic differences between children and adults, children are likely to respond much differently than adults when exposed to hazards. They are more susceptible due to their smaller size; they have a higher respiration rate, which means that they are likely to inhale relatively larger proportions of the agent in the same amount of time as an adult. A child’s skin may be more vulnerable to chemical agents because their skin is thinner. When they are exposed to heat, they may have the tendency to dehydrate more quickly. Children are inclined to respond more quickly to medical interventions. Because of their size, they do require different medications and dosages than an adult and they require pediatric sized emergency equipment.

There are three levels of severity when describing children with special health care needs (Valluzzi, 1995). Level one children, are those who have a chronic health condition which requires dependence on 24 hours a day skilled health care supervision and availability of health care providers for survival. If this individual’s required mechanical support is interrupted or not made available, he/she may experience permanent damage or death. An example of an individual at level one is a child who is oxygen or ventilator dependent.

Level two children are those whose chronic health condition does not require 24 hour skilled health care but has a high potential for life threatening events. Without a health care provider consistently monitoring this child’s condition, the child could deteriorate to a
Individual Preparations

degree requiring intense medical intervention. Examples of children at level two are those who have feeding tubes, ostomies or require clean intermittent catheterization.

Level three children are those individuals whose chronic health conditions are more predictable, they are at a lower risk but require a health care provider for regular monitoring. Examples of children at this level are those with asthma and diabetes. These three levels, however, are fluid. A child may move back and forth between the levels depending upon the individual health care concerns and the individual response to the changes that may occur as a result of the emergency situation.

The general public may have difficulty grasping the intensity of the problem of planning for individuals with special needs, particularly if they do not know what portion of the population is involved when discussing children with “disabilities”. The 2006 U.S. Census Bureau Fact Finder (Table 4) shows the population of children from the ages of 5-15 was 44,696,789. The number of children with any type of disability was 6.3% (http://www.census.gov/).

Table 4. Disability Characteristics

United States
Data Set: 2006 American Community Survey
Survey: 2006 American Community Survey

<table>
<thead>
<tr>
<th>Subject</th>
<th>Total</th>
<th>Margin of Error</th>
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<tr>
<td>Population 5 to 15 years</td>
<td>44,696,789</td>
<td>+/-40,535</td>
</tr>
<tr>
<td>With any disability</td>
<td>6.3%</td>
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</tr>
<tr>
<td>With a sensory disability</td>
<td>1.2%</td>
<td>+/-0.1</td>
</tr>
<tr>
<td>With a physical disability</td>
<td>1.1%</td>
<td>+/-0.1</td>
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<td>With a mental disability</td>
<td>5.1%</td>
<td>+/-0.1</td>
</tr>
<tr>
<td>With a self-care disability</td>
<td>0.9%</td>
<td>+/-0.1</td>
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http://www.census.gov/
Likely, parents who have a child with special needs realize that they need to be better prepared for emergency situations, probably more so than families without the same challenges. The question is, however, are families prepared if an emergent event should happen? Do they have a family plan but also individual plans for not only each of their children, but particularly for their child with special needs?

Emergency planning for parents of children with special needs becomes an even larger task. The planning for a child with a special need involves a great deal of time for the parents, and may appear to be a daunting task for these parents who may already be consumed with the care of a chronically ill child. However, having a plan written out and distributed to the appropriate people may determine how well the child survives an emergency situation. For many children it may be imperative to have the right equipment, medications and/or other necessary medical supplies. It is essential to assure that parents have a clear understanding of what the specific recommendations are in planning for a disaster for a child with special needs (Romig, 2005).

Children with special health care needs may be especially susceptible to changes in environmental conditions. Children, who have asthma, may have an increased susceptibility to pollens or dust if they are outdoors for an extended period of time. Children who have sickle cell disease may experience long periods of exposure to excessive heat or the lack of water and may become dehydrated (Academy of Pediatrics 2002).

Bernardo and Veenema (2004) authored an article entitled *Pediatric emergency preparedness for mass gatherings and special event*. The authors discussed how important it is for parents to plan for their children’s health care needs, specifically at mass gatherings and special events. Bernardo and Veenema cited one of the most important reasons as:
Children seldom carry personal identification, making it difficult to establish the identity of an unconscious or lost child. Special medical information alert bracelets or other means of identifying a child’s health condition may not be worn. While emergency care is never withheld, the need to identify the child and parents or guardians still exists (Bernardo et al., 2004, p. 19).

The cross-disciplinary attempts for pediatric preparedness for emergencies are becoming more of a focus for schools, hospitals and physicians. Even though these initiatives are being addressed, certain aspects of preparedness are still lacking.

Emergency care of children with special health care needs is potentially difficult due to the lack of planning and concise information provided regarding their medical conditions. Essential information needs to be available and with the child at all times to help potential caregivers, in an emergency room, an emergency shelter or any type of emergency situation to help care for the child during an unplanned event. Parents may need to utilize the assistance of their child’s physicians to create an emergency plan with close attention to diagnoses, medications needed, allergies and equipment specific to their child (Bernardo et al., 2004).

The American Academy of Pediatrics (AAP) and the American College of Emergency Physicians (ACEP) have developed guidelines for creating emergency plans. Additionally, they have developed emergency forms which will assist parents along with their child’s pediatrician in knowing how to report the vital information regarding their child (Mulligan-Smith, 2000).

Parents should complete the Emergency Information Form for Children with Special Needs in collaboration with the child’s treating physicians. The AAP suggests that parents update their child’s emergency form on a regular basis with any changes of medications or
diagnoses, major procedures performed and any significant changes in the child’s plan of care or change in health care providers. The intent of this form (Appendix B) is to provide a summary of the child’s health status until the parents are contacted (American Academy of Pediatrics. 2002).

Parents are encouraged to have copies accessible to:

- the child’s school/day care
- all physicians associated with the child
- at home in a place where it can be easily accessed, such as the refrigerator door
- in each parent’s wallet, vehicle and workplace
- with the child at all times in a go kit or back pack
- emergency contact person
Methodology

Data Collection

To identify relevant information and studies on emergency preparedness for parents who have a child with special health care needs, I conducted a MEDLINE search via PUBMED. I submitted a search for the years 1995 to 2008, using the key words, children with special needs, disaster planning for children/individuals with disabilities and/or handicaps, disaster planning, emergency planning, emergency preparedness and parent’s preparation for disasters. There was one entry for parent’s preparation for disasters for children with special needs relating to the emergency preparedness of families caring for children with chronic illnesses. After researching other terms, 60 articles were selected and reviewed. Out of the 60 articles, 17 met the criteria of providing the results of research regarding the plans made by other agencies and providing information regarding the individual necessities required by children with special health care needs in the event of an emergency. Internet websites were used to gather data from the U.S. Census Bureau, The American Red Cross and Federal Emergency Management Agency (FEMA).

Data Analysis

Documents and materials obtained from research of the literature and the listed websites were reviewed to formulate best emergency preparedness practices for children with special needs. After analyzing the information, specific emergency guidelines were developed defining what equipment/medications are necessary during an emergency for children with particular conditions and/or diagnoses. The disease specific guidelines developed are for children with
diabetes, children who are tracheostomy dependent, children with hearing loss and children who have cerebral palsy or like conditions which may affect speech and mobility.

This research reviewed other agency’s disaster plans and discussed the importance of parents’ preparation for their child with special needs in the event of an emergency. The term children with special health care needs included those children who are fragile medically, technology dependent and “children who have, or are at risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount not usually required by typically developing children” (Mulligan-Smith, 2004, p. 87).
Results

Agencies are beginning to develop emergency plans for individuals with disabilities or special needs. The current disaster plans continue to be lacking, however, for children with special needs and for their families.

Schools, daycare centers, physicians and government agencies have developed generic emergency plans for families with some mention of individuals with disabilities or special needs. Parents, however, who have children with special needs, require specific information to help with planning for emergency situations.

Pediatricians can best educate parents who have children with special needs by encouraging them to:

- obtain information on how to get additional medication if needed during a disaster and/or how to obtain additional supplies of medication to keep on hand in an emergency kit
- update as needed the child’s emergency form so as to provide any health care workers the most recent diagnoses and treatments
- develop an emergency kit specific to the child’s needs and:
  - purchase medical alert identification listing the child’s diagnoses (Stallwood, 2006)

A vital part of parent’s planning for an emergency is the knowledge that they ultimately will be reducing the effects of the disaster on themselves but more importantly on their child. The following checklist will assist parents in making sure that they are as prepared as possible should a disaster occur. For the child with special needs:
• Has the emergency form been completed and/or updated with current diagnoses, treatments and medications and distributed to the appropriate individuals (the child’s school or day care center, physicians and the family’s emergency contact person)
• Is there at least a two-week supply of medications and/or supplies for the child?
• Are there back-up systems for equipment that requires electricity (generators, etc.)?
• Has the parent spoken with the child’s school or day care and given them a copy of the emergency form and reviewed the plan?
• Have the parents updated the child’s individualized education plan (IEP) to state that it is permissible and imperative that the child has the emergency kit available to the child at all times?
• Has there been an assessment of the supplies that will be necessary, both generic and specific for the child and the family?

For the family:
• Is there a disaster plan or evacuation plan?
• Is there a disaster supply kit for the entire family?
• Have the parents established a meeting place or a central location to meet if the family is displaced? (Texas Department of State Health Services 2006).

It will be important for the parents to call the local electric company if the child is dependent on equipment that requires electricity (ventilator, feeding pump, apnea monitor, etc.) and ask to be put on a priority list to restore power if there is a power failure. If the child is equipment dependent, the parents should contact the local fire department or the child’s durable medical equipment (DME) company to check about portable generators.
It appears that the critical issues in emergency planning for specific needs have been minimally addressed. There is a lack of specific information available for parents regarding emergency planning for their child with special needs. The American Red Cross has developed a list of supplies needed when planning for an emergency or disaster (Appendix C). It does not, however, provide a list of the necessary items for children with specific diagnoses. This research has developed literature-based best practices listed in Appendices D, E, F and G in order to assist parents in the process of emergency planning for children with diabetes, tracheostomy, hearing impairment and cerebral palsy respectively.
Discussion

What does being prepared really mean? Parents typically do not feel they are well prepared in general for emergencies or disasters that may occur in their home or away from their home. Generally, families say they are prepared because they have discussed what they should do, or perhaps they have developed a first aid kit, began gathering supplies such as water, nonperishable foods, flashlights, batteries and a radio. Some parents may have established a common location for the family to gather if they are separated. The reality is for many families, nothing has been firmly established in disaster planning.

Parents who have children with special needs may feel more of an urgency to plan for an emergency or disaster but may believe it to be such a daunting task that they put it off to another time. Parents reported that they knew that disaster planning, particularly for their child with special needs was something that they “should” do but stated that they did not know where to start or did not have the funds to do so (Kubicek et al., 2008).

A key goal of planning for any type of emergency is to keep the family members together. This is likely to occur with the assistance of a well constructed plan which takes into consideration an assessment of the needs of each family member. Without a plan, the family may scatter to several different sites until they are able to locate each other. When a child with special needs is displaced from the family without a well structured plan, the health of the child may be jeopardized.

Parents depend on schools and daycares to be safe places for their children. Parents believe when they take their child to this location for seven hours a day, five days a week and nine months out of a year, he/she will be well cared for by the staff. Although schools have begun emergency planning, the plan for children with special needs is lacking. The national
Individual Preparations

A survey of school nurses (Olympia et al., 2005) concluded that although the nurses in the study were compliant with the recommendations of the American Academy of Pediatrics and the American Heart Association, areas needing improvement remained. The authors highly recommended the nurses practice the Medical Emergency Response Plan several times a year; they also maintained that, all areas of the school campus should be linked with the local EMS and that the role of the nurse should be assigned to other school staff in the nurse’s absence. Unfortunately, at no point in the recommendations did the authors mention training or preparation in caring for the child with special health care needs.

Likewise, parents depend on the care, support and education from all of their primary care physicians, but particularly from the physician caring for their child with special needs. The national survey of physicians in residency programs concluded that the residents receive very limited training in terrorism. A greater concern is they spend even less time learning specifically about how to care for children in an emergency. The only discussion regarding a child with special needs referred to a child with “developmental limitations” and indicated that these children create “unique challenges” during an emergency situation. A key question for future examination is how disaster planning for children with special needs could be incorporated into medical training (Martin et al., 2006).

Families with young children consider their child’s pediatrician as the authority in many areas that concern the child. They expect the pediatrician to be knowledgeable regarding emergency planning, particularly, those parents who have a child with special needs. It is imperative that pediatricians educate themselves on the issues of emergency planning and discuss those issues with the families (Jacobsen, Johnson, Garcia, & Carlos 2006).
As addressed earlier, parents intend to prepare emergency plans but in most cases fail to follow through. As a part of anticipatory guidance, pediatricians should provide concrete information for parents on how to create such a plan and, when appropriate, address the unique requirements of the child with special health care needs.

The American College of Emergency Physicians and American Academy of Pediatrics developed and approved the use of the Emergency Information Form for Children with Special Needs (Appendix A). As part of educating parents, it will be beneficial for the pediatrician/specialist to review the form, assist the parents in completing it and encourage the parents to establish the much needed emergency plans. It is important to also list on the emergency form if the child is nonverbal so as to alleviate any questions as to why the child is not responding to questions. For the child who is nonverbal, cognitively delayed or uses a communication device, the American Red Cross recommends thinking about what a rescuer might need to know about the child. Be prepared to keep a written copy with the emergency kit. For example:

- "I communicate using an augmentative communication device. I can point to simple pictures or key words, which you will find in my wallet or emergency supply kit."
- "I may have difficulty understanding what you are telling me, please speak slowly and use simple language."
- "I forget easily. Please write down information for me."

http://www.redcross.org/services/prepare

The next step in emergency planning is to purchase a bag that is large enough to hold the basic supplies that the child will need but yet small enough to be carried or attached to the back
of a wheelchair. The bag should have zippers for storage and a pocket where information can be stored. The bag should either be with the child or accessible to the child at all times. Parents should store at least a three day’s supply of medications and/or necessary items in the emergency kit. To ensure freshness of medications and any food items, expiration dates should be recorded on a calendar or in a journal in the child’s emergency kit to remind parents to replace the items on an as needed basis or at the very least every three months. After the emergency kit is assembled, it is very important not to borrow items from it for everyday use with the intent of replacing items at a later date.

Rarely is it possible to anticipate when an emergency will occur, but preplanning can be helpful. What are the child’s specific needs in an emergency? Is it possible that extra medications and equipment could be stored at the child’s school? It may be difficult to obtain an extra supply of medications for the child so parents should speak to the child’s doctor about that. If the child is able to understand cognitively, parents may decide to discuss the emergency planning with the child. Children profit from concrete information when it is presented at the appropriate level of maturity and understanding. Parents must also teach the child to answer questions about his/her medical condition and current treatment.

The primary limitation to this study was the lack of research that has been done regarding parent’s preparedness for their child with special needs during emergency situations. Disaster management agencies, public health, schools, physicians and other groups are beginning to include individuals with disabilities in their emergency/disaster planning but only in generic terms. Due to the lack of information in the literature, the appendices are not as comprehensive as they could be; hence the development of Appendices D, E, F and G.
Conclusion

There will always be unplanned and unexpected events in life, some which may be life threatening or disastrous and ultimately out of our control. For one of the most vulnerable populations, children with special health care needs, any of these events may be devastating. Agencies’ plans will be beneficial, but parents’ planning through compilation of information, construction of an emergency kit and purchase of a medical alert identification will empower them with the feeling of being prepared for events that may occur and help to reduce the potential catastrophic consequences of an emergency for their child with special health care needs.
References


American Red Cross [sited March 1, 2008.] Available at
http://www.redcross.org/services/prepare.


Federal Emergency Management Agency [sited January 10, 2008]. Available from:


*Inf Young Children, 7(4):* 62-76.
Appendix A

FEMA Emergency Plans

- Have a communication plan.
- Know how you will get in touch with others if alone when a disaster strikes.
- Decide on a friend or relative that family members can contact in the event the family is separated during the disaster. Choose a person who lives in another town or state that won’t be affected by the same disaster.
- Contact your children’s school principal and learn what emergency plan is in place. Let your children know that in case of an emergency, they should remain calm and listen to their teacher or principal.
- Keep contact numbers, emergency numbers, medical numbers and insurance information taped inside binders, notebooks, book bags, wallets, etc. Write the list in waterproof ink.
- Find out what your community’s plans are in the event of evacuation.
- Keep specialized items ready, including extra batteries for hearing aids or electric wheelchairs, oxygen, catheters and medications.

http://www.fema.gov/areyouready/emergencyplanning.shtm
Appendix B

The following is a list of the recommended items needed to build a disaster supplies kit, according to the American Red Cross.

Water

- Store water in plastic containers such as soft drink bottles. Avoid using containers that will decompose or break, such as milk cartons or glass bottles. A normally active person needs to drink at least two quarts of water each day. Hot environments and intense physical activity can double that amount. Children, nursing mothers, and ill people will need more.
- Store one gallon of water per person per day.
- Keep at least a three-day supply of water per person (two quarts for drinking, two quarts for each person in your household for food preparation/sanitation).

Food

Store at least a three-day supply of non-perishable food. Select foods that require no refrigeration, preparation or cooking, and little or no water. If you must heat food, pack a can of sterno. Select food items that are compact and lightweight.

Include a selection of the following foods in your Disaster Supplies Kit:

- Ready-to-eat canned meats, fruits, and vegetables
- Canned juices
- Staples (salt, sugar, pepper, spices, etc.)
- High energy foods
- Vitamins
- Food for infants
- Comfort/stress foods
First Aid Kit
Assemble a first aid kit for your home and one for each car.

- (20) adhesive bandages, various sizes
- (1) 5" x 9" sterile dressing
- (1) conforming roller gauze bandage
- (2) triangular bandages
- (2) 3 x 3 sterile gauze pads
- (2) 4 x 4 sterile gauze pads
- (1) roll 3" cohesive bandage
- (2) germicidal hand wipes or waterless alcohol-based hand sanitizer
- (6) antiseptic wipes
- (2) pair large medical grade non-latex gloves
- Adhesive tape, 2" width
- Anti-bacterial ointment
- Cold pack
- Scissors (small, personal)
- Tweezers
- CPR breathing barrier, such as a face shield

Non-Prescription Drugs

- Aspirin or non-aspirin pain reliever
- Anti-diarrhea medication
- Antacid (for stomach upset)
- Syrup of Ipecac (use to induce vomiting if advised by the Poison Control Center)
- Laxative
- Activated charcoal (use if advised by the Poison Control Center)

Tools and Supplies

- Mess kits, or paper cups, plates, and plastic utensils
- Emergency preparedness manual
- Battery-operated radio and extra batteries
- Flashlight and extra batteries
- Cash or traveler's checks, change
- Non-electric can opener, utility knife
- Fire extinguisher: small canister ABC type
- Tube tent
- Pliers
- Tape
- Compass
- Matches in a waterproof container
- Aluminum foil
- Plastic storage containers
- Signal flare
Individual Preparations

- Paper, pencil
- Needles, thread
- Medicine dropper
- Shut-off wrench, to turn off household gas and water
- Whistle
- Plastic sheeting
- Map of the area (for locating shelters)

Sanitation

- Toilet paper, towelettes
- Soap, liquid detergent
- Feminine supplies
- Personal hygiene items
- Plastic garbage bags, ties (for personal sanitation uses)
- Plastic bucket with tight lid
- Disinfectant
- Household chlorine bleach

Clothing and Bedding

Include at least one complete change of clothing and footwear per person.

- Sturdy shoes or work boots
- Rain gear
- Blankets or sleeping bags
- Hat and gloves
- Thermal underwear
- Sunglasses

For Baby

- Formula
- Diapers
- Bottles
- Powdered milk
- Medications

For Adults

- Heart and high blood pressure medication
- Insulin
- Prescription drugs
- Denture needs
- Contact lenses and supplies
• Extra eye glasses

Special Items

• Remember family members with special requirements, such as infants and elderly or disabled persons

Entertainment (based on the ages of family members)

• Games (cards) and books
• Portable music device

Important Family Documents

• Keep these records in a waterproof, portable container:
  o Will, insurance policies, contracts deeds, stocks and bonds
  o Passports, social security cards, immunization records
  o Bank account numbers
  o Credit card account numbers and companies
• Inventory of valuable household goods, important telephone numbers
• Family records (birth, marriage, death certificates)
• Store your kit in a convenient place known to all family members. Keep a smaller version of the supplies kit in the trunk of your car.
• Keep items in airtight plastic bags. Change your stored water supply every six months so it stays fresh. Replace your stored food every six months. Re-think your kit and family needs at least once a year. Replace batteries, update clothes, etc.
• Ask your physician or pharmacist about storing prescription medications.

http://www.redcross.org/services/prepare
## Emergency Information Form for Children With Special Needs

**Appendix C**

### Name:

**Birth date:**

**Nickname:**

**Home Address:**

**Home/Work Phone:**

**Parent/Guardian:**

**Emergency Contact Names & Relationship:**

**Signature/Consent:**

**Primary Language:**

**Phone Number(s):**

### Physicians:

**Primary care physician:**

**Emergency Phone:**

**Fax:**

**Current Specialty physician:**

**Specialty:**

**Emergency Phone:**

**Fax:**

**Current Specialty physician:**

**Specialty:**

**Emergency Phone:**

**Fax:**

**Anticipated Primary ED:**

**Pharmacy:**

**Anticipated Tertiary Care Center:**

### Diagnoses/Past Procedures/Physical Exam:

1. **Baseline physical findings:**

2. 

3. **Baseline vital signs:**

4. 

**Synopsis:**

**Baseline neurological status:**

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*Consent for release of this form to health care providers*
### Diagnoses/Past Procedures/Physical Exam continued:

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### Immunizations

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<td>Varicella</td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td></td>
<td>TB status</td>
<td></td>
</tr>
<tr>
<td>HIB</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Antibiotic prophylaxis:**

<table>
<thead>
<tr>
<th>Indication:</th>
<th>Medication and dose:</th>
</tr>
</thead>
</table>

### Common Presenting Problems/Findings With Specific Suggested Managements

<table>
<thead>
<tr>
<th>Problem</th>
<th>Suggested Diagnostic Studies</th>
<th>Treatment Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments on child, family, or other specific medical issues:**

**Physician/Provider Signature:**

**Print Name:**

http://www.aap.org/advocacy/blankform
Appendix D

Emergency guidelines for the child with Diabetes

- Emergency supply bag with pockets and zippers
- Sealed plastic freezer bag(s) for storing documents
- Medical Alert Identification showing diagnoses and allergies
- Hand sanitizer
- Completed Emergency Information Form for Children with Special Needs – laminated*
- Picture identification with child’s name and address – laminated*
- Laminated copy of child’s insurance card*
- Disposable CPR key chain attached to outer zipper of supply bag
- Insulin or oral medication in original bottle (unopened bottles of insulin, except Lantus which needs to be stored in a refrigerator or kept below 86 degrees, can stay at room temperature for 30 days) check with pharmacist for additional information
- Syringe(s) or other insulin delivery supplies
- Alcohol swabs
- Cotton balls
- Lancets
- Test strips
- Glucometer for testing
- Travel size sharps container
- Quick acting source of glucose (ex. hard candies)
- Glucagon emergency kit
• 2-3 bottles of water or juice
• Small packages of crackers, dried fruits, nuts, peanut butter, cereal or other appropriate snacks
• 1 plastic spoon, fork and knife
• Disposable cups
• If insulin pump is used, extra batteries and extra infusion set
• Tape
• Record book to keep track of test results

*place in freezer bag
Appendix E

Emergency guidelines for the child who is Tracheostomy dependent

- Emergency supply bag with pockets and zippers
- Sealed plastic freezer bag(s) for storing documents
- Medical Alert Identification showing diagnoses and allergies
- Hand sanitizer
- Completed Emergency Information Form for Children with Special Needs – laminated*
- Picture identification with child’s name and address – laminated*
- Laminated copy of child’s insurance card*
- Disposable CPR key chain attached to outer zipper of supply bag
- Latex free gloves
- Extra diapers if needed
- Wet ones if needed
- 3 day supply of medications in original bottles if applicable
- Nutritional needs
- Flat 2 cup plastic sandwich size container for clean supplies
- Extra tracheostomy tube (removed from box but kept in wrapping)**
- 1 time use KY jelly packets**
- Extra tracheotomy tube holders (collars)**
- Sterile 2x2 i.v. sponges**
• Suction tubing (suction bag attached to wheelchair if available)

  * place in freezer bag

  ** place 1 in each plastic sandwich size container
Appendix F

Emergency guidelines for the child who is Hearing Impaired

- Emergency supply bag with pockets and zippers
- Sealed plastic freezer bag(s) for storing documents
- Medical Alert Identification showing diagnoses and allergies
- Hand sanitizer
- Completed Emergency Information Form for Children with Special Needs – laminated*
- Picture identification with child’s name and address – laminated*
- Laminated copy of child’s insurance card*
- Disposable CPR key chain attached to outer zipper of supply bag
- 3 day supply of medications in original bottles if applicable
- Extra batteries for hearing aid or cochlear implant
- Extra hearing aid if available
- Notepad and pencil for communication
- Communication device if used

*place in freezer bag
Appendix G

Emergency guidelines for the child who has Cerebral Palsy or conditions affecting Speech and/or Mobility

- Emergency supply bag with pockets and zippers
- Sealed plastic freezer bag(s) for storing documents
- Medical Alert Identification showing diagnoses and allergies
- Hand sanitizer
- Completed Emergency Information Form for Children with Special Needs – laminated*
- Picture identification with child’s name and address – laminated*
- Laminated copy of child’s insurance card*
- Disposable CPR key chain attached to outer zipper of supply bag
- 3 day supply of medications in original bottle if applicable
- Nutritional needs
- Extra battery and charger in emergency bag or stored under wheelchair if electric chair is used
- Latex free gloves
- Extra diapers if needed
- Wet ones if needed
- Additional information regarding physical limitations, i.e. Please do not attempt to straighten my legs
- Communication device if used
  *place in freezer bag
Appendix H

SUGGESTED WEBSITES

Disposable CPR Key chains

- [http://www.first-aid-product.com](http://www.first-aid-product.com)
- [http://www.nwmedicalsolutions.com](http://www.nwmedicalsolutions.com)
- [http://www.cpr-savers.com](http://www.cpr-savers.com)
- [http://www.whensecondscount.net](http://www.whensecondscount.net) (latex free)

Medical Identification

- [http://www.americanmedical-id.com](http://www.americanmedical-id.com)
- [http://www.mdbracelet.com](http://www.mdbracelet.com)
- [http://www.childrenwithdiabetes.com](http://www.childrenwithdiabetes.com)
- [http://www.911med411.com](http://www.911med411.com)

Additional Information

- [www.americandiabetes.com](http://www.americandiabetes.com) - Diabetes information
- [www.nobodyleftbehind2.org](http://www.nobodyleftbehind2.org)
- [www.readykids.org](http://www.readykids.org)
- [www.ready.gov/america/index](http://www.ready.gov/america/index) - Department of Homeland Security
- [http://www.redcross.org](http://www.redcross.org) – American Red Cross
- [http://www.nod.org/emergency](http://www.nod.org/emergency) - National Organization on Disability
## Appendix I

### Public Health Competencies

<table>
<thead>
<tr>
<th>Specific Competencies</th>
<th>Front Line Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain #1: Analytic Assessment Skill</strong></td>
<td></td>
</tr>
<tr>
<td>Defines a problem</td>
<td>Proficient</td>
</tr>
<tr>
<td>Selects and defines variables relevant to defined public health problems</td>
<td>Proficient</td>
</tr>
<tr>
<td>Identifies relevant and appropriate data and information sources</td>
<td>Proficient</td>
</tr>
<tr>
<td>Applies ethical principles to the collection, maintenance, use, and dissemination of data and information</td>
<td>Proficient</td>
</tr>
<tr>
<td>Makes relevant inferences from quantitative and qualitative data</td>
<td>Proficient</td>
</tr>
<tr>
<td><strong>Domain #2: Policy Development/Program Planning Skills</strong></td>
<td></td>
</tr>
<tr>
<td>Collects, summarizes, and interprets information relevant to an issue</td>
<td>Proficient</td>
</tr>
<tr>
<td>Identifies, interprets, and implements public health laws, regulations, and policies related to specific programs</td>
<td>Proficient</td>
</tr>
<tr>
<td><strong>Domain #3: Communication Skills</strong></td>
<td></td>
</tr>
<tr>
<td>Communicates effectively both in writing and orally, or in other ways</td>
<td>Proficient</td>
</tr>
<tr>
<td>Solicits input from individuals and organizations</td>
<td>Proficient</td>
</tr>
<tr>
<td>Advocates for public health programs and resources</td>
<td>Proficient</td>
</tr>
<tr>
<td>Leads and participates in groups to address specific issues</td>
<td>Proficient</td>
</tr>
<tr>
<td>Listens to others in an unbiased manner, respects points of view of others, and promotes the expression of diverse opinions and perspectives</td>
<td>Proficient</td>
</tr>
<tr>
<td><strong>Domain #4: Cultural Competency Skills</strong></td>
<td></td>
</tr>
<tr>
<td>Utilizes appropriate methods for interacting sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational, racial, ethnic and professional backgrounds, and persons of all ages and lifestyle preferences</td>
<td>Proficient</td>
</tr>
</tbody>
</table>
Identifies the role of cultural, social, and behavioral factors in determining the delivery of public health services | Proficient
---|---
Understands the dynamic forces contributing to cultural diversity | Proficient
Understands the importance of a diverse public health workforce | Proficient
**Domain #5: Community Dimensions of Practice Skills**

Establishes and maintains linkages with key stakeholders | Proficient
Utilizes leadership, team building, negotiation, and conflict resolution skills to build community partnerships | Proficient
Collaborates with community partners to promote the health of the population | Proficient
Identifies how public and private organizations operate within a community | Proficient
Identifies community assets and available resources | Proficient
**Domain #6: Basic Public Health Sciences Skills**

Defines, assesses, and understands the health status of populations, determinants of health and illness, factors contributing to health promotion and disease prevention, and factors influencing the use of health services | Proficient
Develops a lifelong commitment to rigorous critical thinking | Proficient
**Domain #7: Financial Planning and Management Skills**

Monitors program performance | Proficient
**Domain #8: Leadership and Systems Thinking Skills**

Creates a culture of ethical standards within organizations and communities | Proficient
Promotes team and organizational learning | Proficient
Applies the theory of organizational structures to professional practice | Proficient
Acknowledgements

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