

**OKLAHOMA STATE DEPARTMENT  
OF HEALTH**

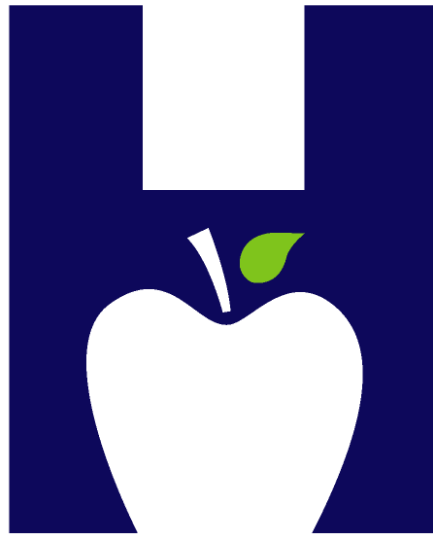
**Resource Guide for  
Access & Functional  
Needs of Children and  
Youth in Disaster  
Planning**

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Children and youth (0-18 years of age) are a highly vulnerable segment of the population in times of disaster. Children in this age category comprise nearly 25 percent of the U.S. population and have important and often complex planning and emergency response needs.

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# Creating a State of Health

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## **Introduction**

**Children (0-18 years of age)** are a highly vulnerable segment of the population in times of disaster. Children in this age category comprise nearly **25 percent** of the U.S. population and have important and often complex planning and emergency response needs. Under normal conditions, there are components at the governmental, private and non-profit level which together form the networks on which children depend to support their development and protect them from harm. In addition to these systems, children fall under the supervision of their parents, guardians and/or primary caregivers. Once a disaster occurs, however, most or all of these foundations in a child's life may suddenly collapse.

The childcare centers and schools to which they were enrolled may be damaged, destroyed or used for shelters. Their parents or guardians may be stretched between caring for the needs of their children and addressing the needs of the whole family's recovery. The child victims, who are generally incapable of managing their own needs, can suffer disproportionately and fall behind their peers in development, and education. Additionally, the physical and psychological damage sustained by children can far outweigh the same effects inflicted on fully-grown members of society, often requiring years of physical, psychological, and other therapeutic treatments to address.

## **General Information**

### **Unique Needs of Children in Disasters**

**The American Academy of Pediatrics** has established that children have unique physical and emotional needs when a disaster strikes. In addition to being placed at an increased risk of physical harm, children respond to illness, injury, and treatment differently than adults do. They also rely on stable routines in their daily lives, and when a disaster occurs, the drastic changes to their known world not only endanger their safety, but also greatly frighten them. To ensure the physical security and emotional stability of children in disasters, communities must modify their emergency planning efforts to include children's unique needs during disasters.

Children have unique needs that must be addressed in emergency preparedness, mitigation, response and recovery operations. Examples of needs specific to children are the following:

- a. Children require different dosages of medications and different forms of medical and mental health interventions than those used to treat adults.
- b. Different approach to mental health evaluation and treatment is necessary to accommodate children's specific mental health needs.
- c. Decontamination of children is more time and resource intensive than decontamination of adults.
- d. Children's developmental and cognitive levels may impede their ability to escape danger, evacuate, and self-identify. Young children may not be able to communicate enough information to be identified and reunited with parents, guardians, or caregivers.
- e. Communication formats such as the following: non-verbal, American Sign Language (**ASL**), usage of communication devices, and foreign languages will be utilized throughout their stay in the shelter.
- f. Professional language interpreters will be provided by the shelter staffing for functional needs and care of the children in the shelter.
  - i. ASL interpreters certified by the Oklahoma state Quality Assurance Screening Test (**QAST**) **Levels IV** and **V** will be used in the shelters.
  - ii. **QAST certification Level V** will be used in all medical examinations both (mental and physical).
  - iii. ASL interpreters will be used for the parent and/or child as requested and needed by either individual.
- g. Children may experience increased psychological effects as they may have difficulty comprehending disasters within the context of normal every day events. This may leave children unable to cope long after disasters and result in later consequences including depression, lack of focus and poor school performance
- h. Critically sick or injured children may have specialized transportation needs.
- i. Children with mobility disabilities may also require specialized transportation care to and from the shelter.
- j. Children's safety in a disaster and their individual recovery is dependent on the preparedness, response and recovery capabilities and resources of a



network of institutions, including schools, childcare providers and other congregate care settings.

### **Purpose**

This guide was created to help local and state agencies, and for profit and non-profit organizations in their efforts to develop and maintain Children's Disaster Planning. **This Resource Guide for Children & Youth is meant to assist in the disaster planning process.** There is no single format that can adequately fit every community or facility. Developing this resource guide is meant to assist organizations and communities in their efforts of whole community disaster planning.

### **Critical Components of a Child's World**

Because stable routines are critical to the physical and emotional well-being of a child, an Emergency Operations Plan must consider ways to prevent or minimize disruption to a child's routine during and after a disaster. Much of a child's everyday routine is shaped by:

- Childcare providers
- Before and After school programs
- Child social services
- Classmates and friends
- Families
- Schools

### **Family as Critical Infrastructure for Children**

The primary means of accounting for children in disasters is through the family. Family leaders will make the decisions about whether to evacuate in the face of an impending disaster, whether to seek shelter, and how to provide safety, and care for the children.

Families come in all shapes and sizes in today society. An emergency planner should be familiar with the various legal and societal definitions of a family. In today's society, children live in families that are headed by:

- A single parent
- Foster parent(s)

- Grandparent(s)
- Guardian(s)
- Sibling(s)
- Two parent(s)

Also, some children may be homeless, with or without parental supervision. Whatever the family unit, emergency planners must consider ways to keep families together when planning for disasters. Maintaining family unity will ensure the continuity in a child's life and increase the chances the child is properly cared for.

### **Family Reunification**

Being separated from loved ones during an emergency is a frightening situation for anyone, but it is especially traumatic and dangerous for children. Planning for ways to preserve family unity is the most important step you can take to provide for the physical safety and emotional stability of children in disasters. Children can become separated from their families in many situations, including:

- a. During an evacuation.
- b. At emergency shelters.
- c. While at school or a childcare facility.
- d. While on a school trip out of town.
- e. While at summer camp or after-school activities.
- f. While being treated at a hospital or medical clinic.
- g. While visiting friends or relatives away from home.
- h. While at the store, at the movies, or other location.
- i. Death of their parent/guardian/foster parent/sibling.

**The Emergency Operations Plan** for your community or organization should include procedures for identifying children who have been separated from their families and reuniting the families as soon, and as carefully, as possible.

### **Reunification Stations**

There are **five** very important stations when setting up an alternate location and reunification plan.

1. The **check-in gate** staff should be the first to greet the parents/guardians/emergency contacts upon arrival.

2. The **Childcare Area** is where staff will care for all the children still in their care. Staff will need to ensure the child's needs are being met and they are being entertained. **Note:** This can be very traumatic for the children and they will need more to do than sit and wait for parents.
3. The **Release Gate** will be one of the last places the adult and children see. This is where the childcare staff/emergency staff/or designee's will finish filling forms which state they are the "proper individuals" to pick up the child or children from this facility.
4. The **Command Post** is where the commander and support staff of the alternate care site will work during the disaster. The commander may be the director or designee, or it may be the most qualified staff member on hand. The command post is not usually accessible to parents.
5. A **Private Area** not visible to children and parents is necessary for the commander, director, or designee to bring a parent or guardian to tell them if their child or children are missing, injured, or deceased. It offers privacy and prevents other parents from becoming more agitated during chaotic circumstances.

### **Release Procedure**

For the safety of staff and children, parents/guardians are restricted to the **check-in** and **release gates**. A runner should be assigned to get the child or children when the parent/guardian arrives to the location.

- The release procedure begins at the **check-in gate**, where a parent/guardian or emergency contact begins filling out the child release form. (See **Appendix A** Post Disaster Child Release Form)
- A runner, if available, will then take the form titled Post Disaster Child Release Form to the childcare area to pick up the child.
  - The form is then signed by the staff assigned to the childcare area, releasing the child.
  - The runner will then take the child and form to the **release gate**.
    - Staff at the **release gate** and parent/guardian/emergency contact will complete the form together.

- The completed forms will be filed at the Release Gate.
- The release designee will fill out the Post Disaster Childcare Situation/Conversation Log (**See Appendix A** Post Disaster Child Release Form and **Appendix B-** Post Disaster Childcare Situation/Conversation Log)

❖ **Note:** If the child is injured/missing/deceased the process stops and the runner will take the form to the **command post or designee**. Someone from the **command post or designee** will contact the family/guardian away from the public and explain the situation to the individuals.

### **Preserve Family Unity**

**The Centers for Disease Control and Prevention (CDC)** has developed five critical steps to help shelters, hospitals, and medical clinics prevent separation of children from their families and identify those who have already been separated. These steps have also been adopted by **Save the Children**.

### **Five Critical Steps to Preserve Family Unity during Emergencies**

1. Survey all children to identify children who are not accompanied by an adult who is supervising them.
2. Place an identification bracelet on the child that matches a supervising adult, if available.
3. Report all unaccompanied children to the emergency operations center and the **National Center for Missing and Exploited Children (NCMEC)**.
4. Send a complete list of unaccompanied children to local emergency management officials.
5. Have a physician, preferably a pediatrician; conduct a social and health screening of the child and the supervising adult.

## **Shelters in Disasters**

### **Children Needs in Emergency Disaster Shelters**

This section will provide guidance and suggestions to shelter managers and staffs that ensure children have a safe, secure environment during and after a disaster. The information below will include appropriate support suggestions and access to essential resources that can be used in the planning process for children and youth in disasters.

## Standards and Indicators for All Shelters

Under most circumstances a parent, guardian, or caregiver is expected to be the primary resource for their children, **age 18 and younger**.

- a. In cases where parents or guardians are not with their children, local law enforcement personnel and local child protective/child welfare services must be contacted to assist with reunification.
- b. Children are sheltered together with their families or caregivers.
- c. Every effort is made to designate an area for families away from the general shelter population.
- d. Family areas should have direct access to bathrooms.
- e. Parents, guardians, and caregivers are notified that they are expected to accompany their children when they use the bathrooms.
- f. Every effort is made to set aside space for family interaction:
  - i. This space is free from outside news sources thereby reducing a child's repeated exposure to coverage of the disaster.
- g. If age-appropriate toys are available they will be in this space, with play supervised by parents, guardians or caregivers.
- h. Shared environmental surfaces in shelters that are frequently touched by children's hands or other body parts should be cleaned and disinfected on a regular basis.
  - i. High contact areas may include diaper changing surfaces, communal toys, sinks, toilets, doorknobs and floors. These surfaces should be cleaned daily with a **1:10 bleach solution** or a commercial equivalent disinfectant based on the manufacturer's cleaning instructions.
  - ii. Local health department authorities may be consulted for further infection control guidance.
- i. When children exhibit signs of illness, staff will refer children to on-site or local health services personnel for evaluation and will obtain consent from a parent, guardian or caretaker whenever possible.
- j. When children exhibit signs of emotional stress, staff will refer children to on-site or local disaster mental health personnel and will obtain consent from a parent, guardian or caretaker whenever possible.
- k. Children in the shelters come in all ages and with unique needs. Age appropriate and nutritious food (including baby formula and baby food) and

snacks are available, as soon as possible after needs are identified. Diapers are available for infants and children as soon as possible after needs are identified.

- i. General guidelines suggest that infants and toddlers need up to 12 diapers a day. (See **Appendix C** for Guidelines for Establishing and Maintaining a Diapering Station in an Evacuation Center) (See **Appendix I-J** for Infection Control Guidelines)
- l. Age-appropriate bedding, including folding, portable cribs or playpens are also available.
- m. Mothers who are breastfeeding should be hydrated and encouraged to breastfeed as the safest form of infant feeding.
  - i. A safe space for breastfeeding women is provided so they may have privacy and a sense of security and support (this can include a curtained off area or providing blankets/ personal covering for privacy).
  - ii. A private area with electrical outlet for breast pumps and containers for collecting milk should be available.
  - iii. Mothers should have access to certified lactation consultants who have been previously credentialed to provide staff training on breastfeeding and to assist in shelters during emergencies. More info available from:  
<http://www.usbreastfeeding.org/LinkClick.aspx?link=Publications%2fBF-Emergency-Response-2009-USBC.pdf&tabid=70&mid=388>
- n. Basins and supplies for bathing infants are provided as soon as possible after needs are identified.
- o. Food and snack selections that is healthy and safe for infants and children with food allergies.

### **Standards and Indicators for Temporary Respite Care for Children**

**Temporary Respite Care for Children** provides temporary relief for children, parents, guardians, or caregivers. It should be a secure, supervised and supportive play experience for children in a Disaster Recovery Center (DRC), assistance center, shelter, or other service delivery site. When placing their child or children in this area parents, guardians, or caregivers are required to stay on-site in the

disaster recovery center, assistance center or shelter. A designee to the family may be responsible for their child or children and will also be required to stay on-site.

In cases where temporary respite care for children is provided in a DRC, assistance center, shelter, and other service delivery site, the following Standards and Indicators shall apply:

- a. Temporary respite care for children is provided in a safe, secure environment following a disaster.
- b. Temporary respite care for children is responsive and equitable. Location, hours of operation and other information about temporary respite care for children is provided and easy for parents, guardians, and caregivers to understand.
- c. All local, state, and federal laws, regulations, and codes that relate to temporary respite care for children are followed.
- d. The temporary respite care for children area should be free from significant physical hazards and/or architectural barriers and remains fully accessible to all children.
- e. The temporary respite care for children area should have enclosures or dividers to protect children and ensure that children are supervised in a secure environment.
- f. The temporary respite care for children area is placed close to restrooms and a drinking water source; hand washing and or hand sanitizer stations are available in the temporary respite care for children area.
- g. Procedures are in place to sign children in and out of the temporary respite care for children area and to ensure children are only released to the parent(s), guardian(s), caregiver(s), or designee(s) listed on the registration form.
- h. All documents---such as attendance records and registration forms (which include identifying information, parent, guardian or caregiver names and contact information), information about allergies and other access and functional needs, injury and/or incident report forms; are provided, maintained, and available to staff at all times.
- i. Ensure all toys and materials in the temporary respite area are safe and age appropriate.

- j. Prior to working in the temporary respite care for children area, all shelter staff members should receive training and orientation. In addition, such staff must successfully complete a criminal and sexual offender background check. Spontaneous volunteers are not permitted. When inside the temporary respite area, staff shall visibly display proper credentials above the waist at all times.
- k. When children are present, at **least two adults** should be present at all times in the respite area. **No child should be left alone with one adult who is not their parent, guardian, or caregiver.**
- l. All staff members must be **18 years or older**. Supervision of the temporary respite care for children area is provided by a staff person at least **21 years of age**.
- m. An evacuation plan will be developed with a designated meeting place outside the center. The evacuation plan will be posted and communicated to parent(s), caregiver(s), and guardian(s) when registering their child.
- n. The child to staff ratio is appropriate to the space available and to the ages and needs of the children in the temporary respite care at all times.

### **Child-Friendly Spaces**

Child-Friendly Spaces is Save the Children's signature emergency response program in the United States and around the world, meeting a Common Standard of Mass Care Disaster RESponse that helps ensure children are safe and protected in shelters and other locations, such as recovery centers where families congregate during disasters.

Child-Friendly Spaces are a critical component in providing support to children and families in temporary locations following a disaster. The program's structured, supervised activities offer comfort to children who are used to daily routines, strengthen children resilience, and help them begin to cope. These Spaces also provide a forum for sharing valuable child safety and recovery information with families when they need it most.

### **The Child-Friendly Spaces Program:**

- Gives children a sense of normalcy and community when their lives are disrupted by disasters.



- Provides children with a safe, designated area where they can play, socialize, and express themselves under the supervision of caring, trained and background-checked adults.
- Helps children interact with peers, build self-esteem, and begin the recovery process by working through their emotions and building upon their natural resilience.
- Enables parents to have time to register for emergency assistance and start to re-establish their lives.

### **Child-Friendly Kits**

In partnership with the American Red Cross, Save the Children has pre-positioned Child-Friendly Spaces kits in high-risk areas across the United States to support the Child-Friendly Spaces program. Kit materials include age-appropriate, fun activities items such as jump ropes, books, toys, arts and craft supplies and board games.

### **Training**

Save the Children offers Child-Friendly Spaces training that supports emergency leaders, organizations and communities in meeting the needs of children in disasters. The training includes best practices on site selection, organization and set-up of the space, gives guidance for addressing children's unique needs, and promotes child safety and well-being while in temporary locations. The Child-Friendly Spaces program, also referred to as temporary respite care for children, helps communities meet the Common Standards of Mass Care in Domestic Emergency Response.

For more information concerning this program contact **Tim Lovell at 918-632-0044** or **Vanessa Price at 405-514-9198**.

. For more information concerning Child-Friendly Kits go to [www.savethechildren.org/GetReadyGetSafe](http://www.savethechildren.org/GetReadyGetSafe).

### **Disaster Agencies that Assist in Children Responses**

- Children's Crisis Centers (statewide)
- Children First (statewide)
- WIC (statewide)
- Oklahoma State Department of Health (OSDH)

- Oklahoma City County Health Department (OCCHD)
- Tulsa Health Department (THD)
- Oklahoma Department of Human Services/Children Protection Services (OKDHS) (statewide)
- Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) (statewide)
- Children Special Recovery Center, Norman OK
- Children Disaster Services
- Save the Children

### **Important Issues in Child Disaster Responses**

#### **Tips Concerning Children Who Have Access and Functional Needs**

All children benefit from concrete information presented at the proper level of understanding and maturity. Helping all children to stop and think about their reactions and behavior, especially with regard to anger and fear, is recommended and often necessary in order for them to make “good choices.” For some children with behavioral disorders, training in anger management, coping and conflict resolution skills are important additions to a comprehensive intervention program. The following information addresses specific, additional considerations for children with access and functional needs.

**Autism:** Children with autism pose very difficult challenges to caregivers. It is difficult to know how much information a nonverbal child is absorbing from television and conversations. It is important to pay close attention to the cues they may provide regarding their fears and feelings and provide them with ways to communicate. Remember that any change in routine may result in additional emotional or behavioral upset. If the child’s environment must be changed (e.g., an evacuation, the absence of a parent), try to maintain as much of the normal routine (e.g., meals, play, bedtime) as possible—even in the new environment. In addition, try to bring concrete elements from the child’s more routine environment (**e.g., a toy, blanket, doll, and eating utensils**) into the new environment to maintain some degree of “sameness” or consistency.

Many children with autism can be helped to comprehend behavior they observe but poorly understand through the use of “social stories.” The parent or teacher’s

explanation of what is happening can be reduced to a social story. A storybook can then be kept by the child to help reinforce the information on a concrete, basic level. For further information on the use of social stories visit the Autism Homepage at <http://members.spree.com/autism/socialstories.htm>.

**Verbal** children with autism may state a phrase repeatedly, such as, “we are all going to die.” This type of statement will serve to isolate the child socially from his peers and other adults. To help the child avoid such statements, it will be necessary to provide very concrete information about the situation and appropriate ways to react and respond that are within the child’s skill level.

**Cognitive Limitations:** Children with developmental or cognitive disabilities may not understand events or their own reactions to events and images. Teachers and caregivers need to determine the extent to which the child understands and relates to the traumatic event. Some lower functioning children will not be able to understand enough about the event to experience any stress, while some higher functioning children with cognitive disabilities may understand the event but respond to it like a younger child without disabilities.

Overall, children with cognitive limitations may respond to traumatic events based more on their observations of adult and peer emotions rather than the verbal explanations that they may receive. Discussions with them need to be specific, concrete and basic; it may be necessary to use pictures in explaining events and images. These children will need concrete information to help them understand that images of suffering and destruction are in the past, far away (if true) and that they are not going to hurt them. A parent may offer words of reassurance such as, “We are lucky to have the Red Cross in our community to help all the families who were hurt by the flood;” “The boys who brought the guns to school are in jail, they can’t hurt anyone else now.”

**Learning Disabilities:** Children/youth with learning disabilities (LD) may or may not need supports that are different from children without disabilities, depending upon their level of emotional maturity and ability to understand the concepts discussed. Many children with LD are able to process language and apply abstract concepts without difficulty, while others have specific deficits in these skills. In

particular, some children with LD interpret very literally; therefore teachers and parents need to choose their words carefully to ensure the child will not misinterpret. For example, even referring to terrorism as “acts of war” may confuse some children who interpret language literally; they may envision foreign soldiers, tanks and fighter planes attacking America.

If your child or student appears to have difficulty following the news reports and class discussions of the traumatic events and their aftermath, reinforce verbal explanations with visual materials; use concrete terms in discussion; check for understanding of key vocabulary. Remember that some children with LD have difficulty with time and space concepts, and may be confused by what they see on television-- they may have difficulty understanding what happened when, what is likely to happen next, etc. They may also be uncertain as to where these events took place and might benefit from looking at simple maps.

Some children with LD have difficulties with social skills and self-management, and may need additional instruction in anger control, tolerance of individual differences and self-monitoring. Additionally, some of the tips listed for children with cognitive disabilities may be applicable to some students with LD who, despite their higher cognitive ability, have similar difficulties with verbal learning, memory, and communication.

**Visual (low vision or blindness), Hearing (low hearing) or Physical Limitations:** Children who do not possess developmental or cognitive disabilities but who have visual disabilities, hearing disabilities or have mobility disabilities will understand, at their level of development, what is happening and may become frightened by the limitations their disability poses on them. In your explanations, be honest but reassuring. Safety and mobility are major concerns for children challenged by visual, hearing and physical disabilities. As with all children, they need to know that they are going to be safe and that they can find a safe place in an emergency. Review safety plans and measures with them, provide lots of reassurance, and practice with them, if necessary. Explanations should be performed in a very simple and explicit manner. Children with visual disabilities will need to have the area carefully described to them. While the students challenged by physical or hearing disabilities may need visual aids as to what they

have to do and where they have to go. **Note:** The children who are deaf should have a certified sign language interpreter for all questions and concerns around their living area.

**Vision disabilities (low vision or blindness):** The child with visual disabilities (low vision or blindness) cannot pick up on visual cues such as facial expressions. Use verbal cues to reinforce what you are feeling and seeing. Many children have seen video clips of the disaster or traumatic event and are talking about them. The child or children with low vision or blindness may need a verbal description to reinforce what they have heard about the events. Ask questions to clarify their understanding of what has happened. Children with visual disabilities may have extraordinary concerns about their mobility and ability to move to safety during a crisis. Ask questions and provide additional orientation and mobility training if needed.

**Hearing disabilities (low hearing):** Children who have low hearing disability will generally not be able to keep up with the fast talking of adults during traumatic events. Caregivers will need to be aware of the child's frustration when trying to keep up with the conversation, if the child has sufficient hearing to participate. Not being able to understand will result in greater fear reactions. Children who have low hearing may not be familiar with all the new terminology used in describing or explaining the events that are occurring. Be aware of the language you use, be very concrete and check for understanding. Use visual materials in conjunction with any verbal or signed explanations. **Certified Sign Language interpreters can and should be requested as needed for clarification of information.**

**Deaf** Professional, Certified Sign Language Interpreters will be provided by the shelter staffing for access and functional needs and care of the children/youth in the shelter. All information will be interpreted by a certified sign language interpreter.

1. ASL (American Sign Language) interpreters certified by the Oklahoma state Quality Assurance Screening Test (**QAST**) **Levels IV** and **V** should be used in the shelters.

2. **QAST certification Level V** should be used in all medical examinations both (mental and physical).
3. ASL interpreters should be used for the parent and/or child as requested and needed by either individual.

**Total Communication Children's** procedures should include providing a certified signer near them. They need to know that someone will be there for them. For oral communicators distance may be an issue as they may experience difficulty with lip reading. Darkness such as blackouts or disaster drills in areas with poor lighting, presents problems for total and oral communicators. In helping them understand that they are safe, that you are going to keep them safe, be sure and show them a flashlight and let them know where they are going to be kept and that they are a part of the safety plan and available for them in case of a black out or a brown out.

**Severe Emotional Disturbance/Behavior Disorder:** Children who have serious emotional and behavioral problems are at high risk for severe stress reactions following a crisis. Typically these children can have limited coping skills to handle "normal" daily stress; they are likely to be overwhelmed by unexpected and traumatic events such as a terrorist attack or the loss of family member. Those who suffer from depression and anxiety disorders are likely to exhibit exaggerated symptoms-- greater withdrawal, heightened agitation, increased feelings of worthlessness and despair, increase in nervous behaviors such as thumb sucking, nail biting, pacing, etc. Children with a history of suicidal thinking or behavior are especially prone to increased feelings of hopelessness and need to come to the attention of school personnel following any serious event likely to trigger these feelings. Additional information on preventing suicide in troubled children and youth may be found on the National Association of School Psychologists (NASP) website (<http://www.nasponline.org/>).

Those children who experience conduct problems, noncompliance and aggression are also likely to exhibit more extreme versions of problem behaviors. The children may demonstrate higher levels of disruptive and oppositional behaviors more frequent or more severe acts of aggression, etc. These children thrive on the consistent, predictable routines that are difficult to maintain in an emergency or crisis situation.

## **Protecting Children during Disasters**

**The Emergency Operations Plan** for your community or organization must consider the physical and emotional dangers to children during a disaster and include appropriate prevention and mitigation methods.

**Save the Children**, a charitable organization dedicated to helping children in need, has identified that children in disaster areas require protection from:

### **Children's Safety in Disasters**

#### **Physical Harm in Disasters**

Because of the nature of disasters, children are at an increased risk for physical harm from many dangers:

- a. Injury from building collapse, motor vehicle crashes, or debris.
- b. Injury or assault in an evacuation shelter.
- c. Infection from spilled chemicals or pollutants in standing water.
- d. Ingestion of spoiled food or polluted water.
- e. Extended periods without proper nutrition or water.
- f. Exposure to inclement weather (**hot or cold**).
- g. Attack by feral animals.
- h. Existing or chronic illness aggravated by disruption in medical attention.
- i. Lack of access to appropriate health care professionals, medicine, and equipment.

#### **Exploitation and Gender Based Violence**

During emergency situations, children are especially vulnerable to sexual violence and other means of exploitation, particularly when they are separated from their families or otherwise displaced, such as when evacuated to a large shelter.

#### **Psychosocial Distress**

Because the physical needs of disaster victims are generally the focus of relief efforts, there is a danger of overlooking the emotional well-being of children who are subjected to stressful situations during an emergency. Communities must consider ways of reducing psychological and social distress during disasters, while fostering hope and confidence in children.

## **Family Separation**

When an emergency occurs, families are often separated because they cannot safely get to each other's location. In large disasters involving evacuation, families may be separated for extended periods.

## **Abuses Related to Evacuation**

Children placed in temporary homes may be subject to abuse at the hands of those who are supposed to be taking care of them. Children evacuated to shelters may be at risk of violence and emotional trauma due to the nature of the mixed population at the shelter. Besides these kinds of abuse, children may also suffer unintentional neglect of their medical needs because basic health services may not be available.

## **Denial of Children's Access to Quality Education**

Often during emergencies, even when a school building is left intact by the disaster, the building may be used as a temporary shelter, and other issues such as loss of power may prevent the school from operating.

## **Oklahoma's Infants and Children's Crisis Centers**

**Infant Crisis Services, Inc.** is a center that provides life-sustaining formula, food and diapers to babies and toddlers, blankets, clothing, and other basic necessities in times of crisis. Based on availability of items, the **Infant Crisis Services** will provide the baby or toddler with the following items:

- One week's supply of diapers
- Pack of baby food or toddler food, formula, and bottle
- Seasonal clothing (6 items of clothing)
- Sleeper, socks, blanket, and other miscellaneous items
- Age appropriate toy and book

## **The Infant Crisis Services**

4224 N. Lincoln Blvd.

Oklahoma City, OK. 73105

405-528-3663

[info@infantercrisis.org](mailto:info@infantercrisis.org)



**Children’s Crisis Centers** assist young people who are in need of crisis intervention and stabilization for trauma, emotional, behavioral, or substance abuse issues. The services are provided in a secure residential setting for up to five days, if needed. Program components include individual, group, and family therapy, along with medication management if deemed medically necessary. Admission Criteria is set by the Oklahoma Health Care Authority and applicable state law (Title 43 A).

**Children’s Crisis Centers** work with no insurance and Medicaid clients, and are in network with some private insurance companies. While the units are located in specific towns, they serve children across the state. The following Infant Crisis Centers are as follows:

**Red Rock**

4404 N. Lincoln Blvd.  
Oklahoma City, OK. 73105  
405-425-0333

[www.red-rock.com](http://www.red-rock.com)

**Serving Ages 10 to 17**

**CALM Center**

6126 E. 32<sup>nd</sup> Place  
Tulsa, OK. 74135  
918-394-CALM (2256)

[www.crsok.org](http://www.crsok.org)

**Serving Ages 10 to 17**

**Children’s Recovery Center**

320 12<sup>th</sup> Ave. N.E.  
Norman, OK. 73071  
405-364-9004

**Serving Ages 13 to 17**

**Supplies for Infants and Toddlers in Mass Care Shelters and Emergency Congregate Care Facilities**

This document was facilitated by the National Commission on Children and Disasters with guidance from subject matter experts in emergency management and pediatric care. The document identifies basic supplies necessary to sustain and support 10 infants and children up to 3 years of age for a 24 hour period. The

guidance is "scalable" to accommodate 10 or more children over a longer period of time. (See **Appendix D-G** for Recommended Perishable and Non-Perishable Supplies)

The National Commission on Children and Disasters recommends state and local jurisdictions provide caches of supplies to support the care of children in mass care shelters and emergency congregate care facilities for a minimum of 72 hours. The amount of supplies cached in an area should be based upon the potential number of children up to 3 years of age that could be populating the local shelters and facilities for a minimum of 72 hours, as determined by an assessment of current demographic data for the jurisdiction.

Depending on the nature of the event, a 24-72 hour supply of essential child-specific supplies should be on site prior to the opening of a shelter or facility. In situations where this is not possible, supplies should still be available for immediate delivery to the shelter, when children are sheltered, within 3 hours (for example, through local vendor agreements, supply caches, interagency mutual aid, etc.). (See **Appendix D-G** for Recommended Perishable and Non-Perishable Supplies) Such a level of preparedness is critical due to the high vulnerability of this population.

**Note:** Just-In-Time-Training (J-I-T-T) for children's food distribution will be provided by WIC, or a Pediatric RN/Pediatric Nurse Practitioner, or Infant Crisis Centers employees. (See **Appendix H** for Pediatric Services Unit Leader Job Action Sheet)

### **Mental Health Needs**

Children's mental health and resilience building are essential aspects of all phases of emergency preparedness including response, recovery, and mitigation. The following recommendations address the mental health needs of children before, during, and after a disaster.

### **Recommendations for Mental Health Preparedness in Children**

- a. Incorporate mental health needs of children in the preparedness planning of federal, state, and regional/local government agencies. Avoid separating planning for safety, security, and other health needs from planning for mental health needs. Reviewing and incorporating existing international

disaster preparedness guidelines could facilitate the improvement of planning in the United States.

- b. Recognize factors that place children at risk and act proactively to help improve the mental health infrastructure for those children and their families. This includes the creation of a network or system that improves referral mechanisms and information about available resources.
- c. Children need to be engaged as active participants during disaster preparedness and throughout the resiliency process. Issues related to age, cognitive development and current skill level need to be taken into account to increase the potential for empowering and educating children. Successfully engaging children throughout the resiliency process will increase their self-efficacy, coping, and overall resiliency to disaster.
- d. Risk communication needs to be more effectively implemented. Recognize and consider the mental health implications of announcements in the media and responsibly communicate messages to caregivers. This involves taking into account recipients' literacy level, access to resources and the assessment of the trust of public messages.
- e. Recognize limitations in preparedness that may impact preparedness activities. These limitations can be proactively addressed by requiring training for all medical and mental health professionals who will be working appropriately assess, treat and provide referrals.
- f. Create a national emergency mental health funding mechanism to pre-authorize generic crisis response plans that address the mental health needs of children and families.
- g. Disaster is not an isolated event and continues to affect people throughout their life. Due to the long range implications and effects of disaster, it is essential that all disaster plans include vast resources for assessing and treating child mental health issues and concerns throughout the child's lifespan.
- h. Professionals who care for children need to be trained to understand mental health issues impacting children post-disaster. This includes having a better understanding and practice with differential diagnosis for disorders such as **Post Traumatic Stress Disorder (PTSD)**, **Autism Spectrum Disorder (ASD)**, adjustment, anxiety and mood disorders. Implementing training

programs for graduate students can help to broaden the understanding of mental health issues that impact children for these future practitioners.

### **Mental Health Needs of Children during Disaster and Terrorist Events**

- a. Provide federal funding for mental health care of children and families after a disaster to include both screening and therapy. Funding must be sufficiently flexible to allow for a response tailored to the needs of local communities that does not exclude those with pre-existing mental health problems.
- b. Ensure that children with pre-existing mental health conditions are not excluded from eligibility for mental health care after a disaster or crisis. Such children may be especially vulnerable to post-traumatic stress reactions and a range of other mental health problems after the event.
- c. Set time limits on government funding for mental health intervention based on clinical evaluation. Mental health problems in children may present soon after a disaster or persist over long periods of time. Even children who do not meet full criteria for a mental health diagnosis may have significantly impaired functioning and need intervention.
- d. Provide public information about the immediate and long-term effects of disasters to help parents, teachers, pediatricians, and other community service providers identify children suffering from long-term effects in mental health.
- e. Commission mental health professionals in the media to provide information to caregivers on how to help children cope during times of stress (anniversaries of the event, holidays, life changes, threats, etc.).
- f. Recommend a family-centered approach that includes assessment, early intervention, and treatment with primary caregivers and other family members. Additionally, incorporate nonclinical approaches to treatment that may be effective with some child particular populations.
- g. Interventions should always be culturally and linguistically appropriate and would ideally engage the parent as a treatment collaborator.
- h. Support parents' mental health and concrete needs. Research has shown that appropriate parental functioning after a disaster is a protective factor for children's mental health functioning.

- i. Take into account cultural, socioeconomic, community, history, risk, and vulnerability factors when preparing and implementing interventions in particular communities. It is essential that **multicultural issues** are reviewed when developing intervention guidelines for different members of the community.
- j. Children and families heal as communities heal and find ways to cope with new realities. As such, it is important to keep in mind community recovery as essential and positively correlated to individual recovery.

### **Effects of Disaster on Children**

Understanding the emotional reactions of children and young people to a disaster such as a fire, drought, or hurricane is important when trying to provide support. The American Academy of Pediatrics Work Group on Disasters (1995) suggests that young people experience disasters depending on several factors:

- Proximity to the impact zone
- Awareness of the disaster
- Physical injury sustained
- Amount of disability
- Witnessing of injury or death of family member or friend
- Perceived or actual life threat
- Duration of life disruptions
- Family and personal property loss
- Parental reactions and extent of familial disruption
- Child's pre-disaster state
- Probability of recurrence

**The American Academy of Pediatrics Work Group on Disasters (1995)** further suggests that there are **five primary responses** seen in children resulting from loss, exposure to trauma, and disruption of routine:

1. Increased dependency on parents or guardians
2. Nightmares
3. Regression in developmental achievements
4. Specific fears about reminders of the disasters
5. Demonstration of the disaster via posttraumatic play and reenactments

## **Therapy or Emotional Support Animals**

Therapy dogs are typically pets that have been obedience trained, tested, and registered by Therapy Dog organization. Under the ADA, "comfort," "therapy," or "emotional support animals" do not meet the definition of a service animal. With or without a legal definition it is generally known that for patients or children who are anxious, apprehensive, or depressed Therapy Dogs have a calming effect. By rhythmically touching and patting them it has the same reassuring, comforting effect as a child hugging a special toy or nuzzling a favorite blanket.

The results are immediate as the dogs simultaneously raise spirits and lower blood pressure. They encourage interaction while making no demands of their own. Their indiscriminate acceptance of people and unconditional love are, indeed, just what the doctor ordered.

**A legal definition of a therapy dog does not exist at this current time.**

## **Recovery**

### **Children Reactions to Disaster by Age**

Below are common reactions in children after a disaster or traumatic event.

**Birth (ages 0- 2 years)** when children are pre-verbal and experience a trauma, they do not have the words to describe the event or their feelings. However, they can retain memories of particular sights, sounds, or smells. Infants may react to trauma by being irritable, crying more than usual, or wanting to be held and cuddled. The biggest influence on children of this age is how their parents cope. As children get older, their play may involve acting out elements of the traumatic event that occurred several years in the past and was seemingly forgotten.

### **Children First Program**

The Children First program is a community-based voluntary family resource program which offers home visitation to families expecting to deliver and/or parent their first child. The program encourages early and continuous prenatal care, personal development, and the involvement of fathers, grandparents, and other supporting persons in parenting. **Public Health Nurses provide home visitation services during pregnancy and the first two years of the child's life.** Activities are designed to be responsive to the developmental needs of mothers, children, and families during pregnancy and early parenthood.

**Women meeting the following enrollment criteria:**

- Pregnant woman less than 28 weeks gestation
- Families expecting to deliver and/or parent their first child
- Families with little financial or social support

The information above is from Sooner Care- Child Health Checkup Provider manual.

**OSDH Children First Program**

**Oklahoma State Department of Health (OSDH)** provides Children First services also in our state. The OSDH provides specially trained public health nurses that perform home visits. The nurses are prepared to answer questions and provide guidance that will promote the health, safety, and optimum development of child during the early stages of development and up to the **first two years** of the child's life. Children First services are **free** to all eligible mothers.

The following services are provided during visits:

- Brief health assessments
- Child growth and development evaluations
- Nutrition education
- Parenting and relationship information
- Links to other services such as childcare, education, and job training

These services are not intended to replace services provided by the mother or child's primary health care provider. Nurses will work collaboratively with such providers to assure the needs of the family are met.

**Women, Infants, and Children (WIC)**

The Women, Infants, and Children (WIC) program provides nutritious foods to supplement the diets of women, infants, and children. WIC foods are specifically chosen to provide the nutrients to women and their children need in their lives.

WIC provide information about healthy eating and promotes active lifestyles. For more information concerning WIC link on the Oklahoma State Department of Health website: <http://www.ok.gov/health> and search WIC.

**Preschool (ages 3 through 6 years)** children often feel helpless and powerless in the face of an overwhelming event. Because of their age and small size, they lack

the ability to protect themselves or others. As a result, they feel intense fear and insecurity about being separated from caregivers. Preschoolers cannot grasp the concept of permanent loss. They can see consequences as being reversible or permanent. In the weeks following a traumatic event, preschoolers' play activities may reenact the incident or the disaster over and over again.

**School (ages 7 through 10 years)** the school-age child has the ability to understand the permanence of loss. Some children become intensely preoccupied with the details of a traumatic event and want to talk about it continually. This preoccupation can interfere with the child's concentration at school and academic performance may decline. At school, children may hear inaccurate information from peers. They may display a wide range of reactions — sadness, generalized fear, or specific fears of the disaster happening again, guilt over action, or inaction during the disaster, anger that the event was not prevented, or fantasies of playing rescuer.

**Pre-adolescence to adolescence (ages 11 through 18 years)** as children grow older, they develop a more sophisticated understanding of the disaster event. Their responses are more similar to adults. Teenagers may become involved in dangerous, risk-taking behaviors, such as reckless driving, or alcohol or drug use. Others can become fearful of leaving home and avoid previous levels of activities. Much of adolescence is focused on moving out into the world. After a trauma, the view of the world can seem more dangerous and unsafe. A teenager may feel overwhelmed by intense emotions and yet feel unable to discuss them with others.

### **Helping Children Cope with Disasters**

Disasters can leave children feeling frightened, confused, and insecure. Whether a child has personally experienced trauma, has merely seen the event on television or has heard it discussed by adults, it is important for parents and teachers to be informed and ready to help if reactions to stress begin to occur.

Children may respond to disaster by demonstrating fears, sadness or behavioral problems. Younger children may return to earlier behavior patterns, such as bedwetting, sleep problems and separation anxiety. Older children may also display anger, aggression, school problems or withdrawal. Some children who



have only indirect contact with the disaster but witness it on television may develop distress.

### **Recognize Risk Factors**

For many children, reactions to disasters are brief and represent normal reactions to "abnormal events." A smaller number of children can be at risk for more enduring psychological distress as a function of three major risk factors:

- Direct exposure to the disaster, such as being evacuated, observing injuries or death of others, or experiencing injury along with fearing one's life is in danger.

### **Loss/grief: This relates to the death or serious injury of family or friends**

- On-going stress from the secondary effects of disaster, such as temporarily living elsewhere, loss of friends and social networks, loss of personal property, parental unemployment, and costs incurred during recovery to return the family to pre-disaster life and living conditions.

### **Vulnerabilities in Children**

In most cases, depending on the risk factors above, distressing responses are temporary. In the absence of severe threat to life, injury, loss of loved ones, or secondary problems such as loss of home, moves, etc., symptoms usually diminish over time. For those that were directly exposed to the disaster, reminders of the disaster such as high winds, smoke, cloudy skies, sirens, or other reminders of the disaster may cause upsetting feelings to return. Having a prior history of some type of traumatic event or severe stress may contribute to these feelings.

Children are coping with disaster or emergencies are often tied to the way parents cope. They can detect adults' fears and sadness. Parents and adults can make disasters less traumatic for children by taking steps to manage their own feelings and plans for coping. Parents are almost always the best source of support for children in disasters. One way to establish a sense of control and to build confidence in children before a disaster is to engage and involve them in preparing a family disaster plan. After a disaster, children can contribute to a family recovery plan.

### **Meeting the Children's Emotional Needs**

Children's reactions are influenced by the behavior, thoughts, and feelings of adults. Adults should encourage children and adolescents to share their thoughts and feelings about the incident. Clarify misunderstandings about risk and danger by listening to children's concerns and answering questions. Maintain a sense of calm by validating children's concerns and perceptions and with discussion of concrete plans for safety.

Listen to what the child is saying. If a young child is asking questions about the event, answer them simply without the elaboration needed for an older child, or adult. Some children are comforted by knowing more or less information than others; decide what level of information your particular child needs. If a child has difficulty expressing feelings, allow the child to draw a picture or tell a story of what happened. Try to understand what is causing anxieties and fears. Be aware that following a disaster, children are most afraid that:

- The event will happen again.
- Someone close to them will be killed or injured.
- They will be left alone or separated from the family.

### **Reassuring Children after a Disaster**

Suggestions to help reassure children after the disaster include the following:

- Personal contact is reassuring. Hug and touch your children.
- Calmly provide factual information about the recent disaster and current plans for insuring their safety along with recovery plans.
- Encourage your children to talk about their feelings.
- Spend extra time with your children such as at bedtime.
- Re-establish your daily routine for work, school, play, meals, and rest.
- Involve your children by giving them specific chores to help them feel they are helping to restore family and community life.
- Praise and recognize responsible behavior.
- Understand that your children will have a range of reactions to disasters.
- Encourage your children to help update your family disaster plan.

If you have tried to create a reassuring environment by following the steps above, but your child continues to exhibit stress, if the reactions worsen over time, or if

they cause interference with daily behavior at school, at home, or with other relationships, it may be appropriate to talk to a professional. You can get professional help from the child's primary care physician, a mental health provider specializing in children's needs, or a member of the clergy.

### **Check List for Helping Your Young Child's Health**

Young children, toddlers, and preschoolers- even babies – know when bad things happen, and they remember what they have been through. After a scary event, we often see changes in their behavior. They may cry more, become more clingy and not want us to leave, have temper tantrums, hit others, have problems sleeping, become afraid of things that did not bother them before, lose skills... Changes like these are a sign that they need help. Here are some ways you can help them.

#### **Safety- Focus on safety first- Your young child feels safe when you...**

- Hold them or let them stay close to you.
- Tell them you will take care of them when things are scary or difficult. With children who are learning to talk, use simple words, like saying "Mother, Daddy, or Grandmother is here."
- Keep them away from frightening TV images and scary conversations.
- Do familiar things, like sings a song you both like or telling a story.
- Let them know what will happen next (to the degree that you know).
- Have a predictable routine, at least for bedtime: a story, a prayer, cuddle time.
- Leave them with familiar people when you have to be away.
- Tell them where you are going and when you will come back.

#### **Allow expression of feelings**

- Young children often "behave badly" when they are worried or scared. Children can "act out" as a way of asking for help. Remember! **Difficult feelings= Difficult behavior.**
- Help your child name how she feels: "scared," "happy," "angry," "sad". Tell them it's ok to feel that way.
- Help your child express anger in ways that won't hurt, using words, play, or drawings.

- Talk about the things that are going well to help you and your child feel good.

### **Follow your child's lead**

- Different children need different things. Some children need to run around, others need to be held.
- Listen to your child and watch their behavior to figure out what they need.

### **Enable your child to tell the story of what happened during and after the disaster.**

- Having a story helps your child make sense of what happened and cope better with it.
- Children use play to tell their story. For example, they may throw blocks to show what the disaster was like. They may separate toy animals to show how they were separated from you.
- Join your child in showing and telling not only what happened, step by step, but also how you both felt.
- As you tell the story, follow your child's lead. When the story is difficult, your young child may need breaks: running around, being held, playing something else. This is ok. They will come back to the story when they are ready.
- It can be hard to watch your children's play or listen to their stories. Get support if it is too hard for you to listen without becoming upset.

### **Ties—Reconnect with supportive people, community, culture, and rituals**

- Simple things like a familiar bedtime story, a song, and family traditions remind you and your child of your way of life and offer hope.
- If you belong to a group, like a church, try to find ways of reconnecting with them.
- You can help your child best when you take care of yourself. Get support from others when you need it.

**Your Child Needs You! This is the most important fact to remember.**

- Reassure your child that you will be together.
- It is common for children to be clingy and worried about being away from you.
- If you need to leave your child, let her know for how long and when you are coming back. If possible, leave something that belongs to you, or a picture that you child can have.
- Just being with your child, even when you can't fix things, helps your child.

### **When Children Need More Help**

Programs may also be interested in knowing when they should suggest to parents their children may need more support than the program or parents can provide. Children may need the help of a mental health professional if:

- **There is not sign of any decrease in the child's emotional or physical reactions to the disaster.** Usually, children will return to their normal behavior in the days and weeks following a traumatic event. If, after a month, the intensity of the child's reactions has not lessened, the help of a counselor or psychologist may be needed.
- **There is an increase in the severity of the child's symptoms.** If the child's symptoms become more intense, this should alert providers the child is experiencing depression, post-traumatic stress disorder, or other mental health issues. Worsening symptoms are a signal the help of a mental health professional is needed.
- **The child's symptoms are distressing to the family.** After a disaster, relationships among a family can become increasingly complex. If a child's continued reaction to a traumatic event results in extreme concern or disruption within a family, mental health services for the child and/or the whole family may be warranted.
- **The child's reactions interfere with the child's normal activities, such as attending childcare, preschool, or school.** Parents can sometimes help children make these adjustments by staying with them in the childcare program or school for a period. This should only be done for a specific period of time and should not continue so long it creates dependency. If children are not able to engage in the routines in which they normally

participated after a few weeks, the help of a counselor or psychologist may be needed.

Parents and providers may be interested in how they can teach children to be resilient and how they can help them adapt well in the face of adversity, trauma, tragedy, threats, and significant sources of stress resulting from disasters and other events. Some tips on how to help children develop resiliency from the American Psychological Association found on their website.

## **Legal Information for Children and Youth Disaster Planning**

### **Rights**

A summary of the rights of the child under Article 5 of the UN Convention on the Rights of the Child is as follows: Article 5 clearly states that children have the right to a family and that families have the right to care for their children. These rights are just as applicable in emergency situations as in any other situation. Actions to support and reunite separated children may require a long-term commitment, involving not just the initial phase of an emergency or the first few months but possibly a number of years.

Currently, **three** Federal statutes already require states to take disabled children into account in disaster planning, including **(1) The American with Disabilities Act**, **(2) The Individuals with Disabilities Education Act**, and **(3) The Rehabilitation Act**. Above and beyond Federal law, **Federal Emergency Management Agency (FEMA)** has also pointed out that the broader population of access and functional needs children include infants and toddlers, who are immobile, trapped in cribs and playpens and who, in emergency situations, must rely on caregivers for evacuation and relocation.

The Americans with Disabilities Act of 1990, (Pub. L. 101-336, enacted July 26, 1990), codified as 42 U.S.C. § 12101 et seq. In Re: Childcare, Title II (Public); Title III (Center and Home-based). See Also:

1. “U.S. Department of Justice Civil Rights Division; Disability Rights Section- Commonly Asked Questions about Childcare Centers and The Americans with Disabilities Act, <http://www.ada.gov/childq%26a.htm>.

2. The Individuals with Disabilities Education Act of 1990, (Pub. L. 101-476 enacted October 30, 1990), codified as 20 U.S.C. 1400 et seq.
3. The Rehabilitation Act of 1973, (Pub. L. 93-112, enacted September 26, 1973), codified as 29 U.S.C. § 701.

## **Federal Emergency Management Agency and the American Red Cross**

### **FEMA**

**The Federal Emergency Management Agency's (FEMA) [National Emergency Family Registry and Locator System \(NEFRLS\)](#)** facilitate family reunification when individuals are separated during a disaster.

The system provides a secure Web-based environment where survivors and their loved ones can communicate their location as well as provide a personalized message. FEMA also has a call center to assist people who do not have Internet access.

To support the reunification of children under 21 years of age with their parent(s)/legal guardian, FEMA works in collaboration with the **National Center for Missing and Exploited Children (NCMEC)**. Individuals reporting or searching for a child missing as a result of a disaster should call the NCMEC National Emergency Child Locator Center at **1-866-908-9572**. NCMEC is staffed 24-hours a day.

### **American Red Cross**

**The American Red Cross (ARC)** maintains Safe and Well, a Web-based system that helps reunify friends and family displaced by a disaster. To speak with someone at the ARC concerning a missing friend or relative, please contact the local ARC chapter where you live or are staying (visit [www.redcross.org](http://www.redcross.org) to find a local chapter).

### **Animals in the Shelter**

Children in a shelter will need to maintain their routines as much as possible. Many times children will have a need for a “service animal” to maintain their daily routine. The federal government has strict guidelines for service animals and comfort animals in disaster responses and daily routines.

## **Definition of Service Animals**

**Service animals are defined as dogs that are individually trained to do work or perform tasks for people with disabilities.** Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties. Service animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person's disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under The Americans with Disabilities Act (ADA).

This definition does not affect or limit the broader definition of "assistance animal" under the Fair Housing Act or the broader definition of "service animal" under the Air Carrier Access Act. Some State and local laws also define service animal more broadly than the ADA. Information about such laws can be obtained from the State Attorney General's office.

## **Where Service Animals Are Allowed**

**Under the ADA,** State and local governments, businesses, and nonprofit organizations that serve the public generally must allow service animals to accompany people with disabilities in all areas of the facility where the public is normally allowed to go. For example, in a hospital it would be inappropriate to exclude a service animal from areas such as patient rooms, clinics, cafeterias, or examination rooms. However, it may be appropriate to exclude a service animal from operating rooms, ICU's, or burn units where the animal's presence may compromise a sterile environment.

## **Service Animals Must Be Under Control**

**Under the ADA,** service animals must be harnessed, leashed, or tethered, unless these devices interfere with the service animal's work or the individual's disability prevents using these devices. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls.

## **Other Specific Rules Related to Service Animals**

The following information states other specific rules, inquiries, charges, and exclusions that pertain to service animals:



- When it is not obvious what service an animal provides, only limited inquiries are allowed. Staff may ask two questions: **(1)** is the dog a service animal required because of a disability, and **(2)** what work or task has the dog been trained to perform. Staff cannot ask about the person's disability, require medical documentation, require a special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task.
- Allergies and fear of dogs are not valid reasons for denying access or refusing service to people using service animals. When a person who is allergic to dog dander and a person who uses a service animal must spend time in the same room or facility, for example, in a school classroom or at a homeless shelter, they both should be accommodated by assigning them, if possible, to different locations within the room or different rooms in the facility.
- A person with a disability cannot be asked to remove his service animal from the premises unless: **(1)** the dog is out of control and the handler does not take effective action to control it or **(2)** the dog is not housebroken. When there is a legitimate reason to ask that a service animal be removed, staff must offer the person with the disability the opportunity to obtain goods or services without the animal's presence.
- Establishments that sell or prepare food must allow service animals in public areas even if state or local health codes prohibit animals on the premises.
- People with disabilities who use service animals cannot be isolated from other patrons, treated less favorably than other patrons, or charged fees that are not charged to other patrons without animals. In addition, if a business requires a deposit or fee to be paid by patrons with pets, it must waive the charge for service animals.
- If a business such as a hotel normally charges guests for damage that they cause, a customer with a disability may also be charged for damage caused by himself or his service animal.
- Staff workers are not required to provide care or food for a service animal.

## **Types of Service Animals**

The list below contains the various types of service dogs or miniature horses that assist the access and functional needs populations. The service dog/miniature horse can be trained for all types of services for their owners. The list below should not be considered complete.

- Diabetes Alert Dog
- Guide Dog/ Miniature Horse
- Hearing Alert Dog
- Migraine Alert Dog
- Mobility Aid Dog/ Miniature Horse
- Narcolepsy Alert Dog
- Narcolepsy Response Dog
- Psychiatric Service Dog
- PTSD Service Dog
- Seizure Alert Dog/ Miniature Horse
- Seizure Response Dog/Miniature Horse

## **Differences between a Service Dog and a Therapy Dog**

The differences between service dogs and therapy dogs are very noticeable from the perspectives of services provided and legal perspectives. The terms, ‘service dog’ and ‘therapy dog’ are not meant to be used as equivalents and should not be used to mean the same thing; they are not the same type. According to Federal Law, **a service animal is not a pet**. The Americans with Disabilities Act (ADA) states that a service animal is any animal that has been individually trained to provide assistance or perform tasks for the benefit of a person with a physical or mental disability which substantially limits one or more of the person’s major life functions.

A therapy dog is one that is trained to provide comfort and affection to people in long-term care, hospitals, retirement homes, schools, mental health institutions, and other stressful situations such as disasters. Therapy dogs provide people with animal contact; these persons may or may not have a form of disability. Therapy dogs work in animal-assisted activities and animal-assisted therapy. The dog is commonly owned by the person handling it, who considers the dog to be a personal pet.

## **Therapy or Emotional Support Animals**

Therapy dogs are typically pets that have been obedience trained, tested, and registered by Therapy Dog organization. Under the ADA, "comfort," "therapy," or "emotional support animals" do not meet the definition of a service animal. With or without a legal definition it is generally known that for patients or children who are anxious, apprehensive, or depressed Therapy Dogs have a calming effect. By rhythmically touching and patting them it has the same reassuring, comforting effect as a child hugging a special toy or nuzzling a favorite blanket.

The results are immediate as the dogs simultaneously raise spirits and lower blood pressure. They encourage interaction while making no demands of their own. Their indiscriminate acceptance of people and unconditional love are, indeed, just what the doctor ordered.

### **A legal definition of a therapy dog does not exist at this current time.**

Under the U.S. Federal Laws, Emotional Support Animals (Therapy Dogs) cannot go into no-pets allowed places, but they are allowed to live in "no-pet" housing and in the cabins of airplanes when accompanied by a note from their handler's doctor.

## **Miniature Horses**

**In addition to the provisions about service dogs, the Department's revised ADA regulations have a new, separate provision about miniature horses that have been individually trained to do work or perform tasks for people with disabilities.** (Miniature horses generally range in height from 24 inches to 34 inches measured to the shoulders and generally weigh between 70 and 100 pounds). Entities covered by the ADA must modify their policies to permit miniature horses where reasonable. The regulations set out four assessment factors to assist entities in determining whether miniature horses can be accommodated in their facility. The assessment factors are **(1)** whether the miniature horse is housebroken; **(2)** whether the miniature horse is under the owner's control; **(3)** whether the facility can accommodate the miniature horse's type, size, and weight; and **(4)** whether the miniature horse's presence will not compromise legitimate safety requirements necessary for safe operation of the facility.

## **Pet Shelters**

When people evacuate it is important to remember that many may bring their “pets” and in today’s age, many of them are thought of as family members. When a child is in a shelter, the pet may bring comfort to them and decrease their anxiety. Making the “pet” accessible to the children will help with mental and physical wellbeing during times of crisis.

## **Household Pet**

A household pet is a domesticated animal, such as a dog, cat, bird, rabbit, rodent, or turtle that is traditionally kept in the home for pleasure rather than for commercial purposes. Normally these types of animals should be kept out of the mass shelter and in a nearby pet shelter for care. Household pets do not include reptiles (except turtles), amphibians, fish, insects/arachnids, farm animals (including horses), nor animals kept for racing purposes.

Many children seek comfort in their pets. Maintaining a pet shelter close to a mass care shelter or smaller shelter would help in the mental health of the child or teenager during an emergency response. Oklahoma provides a separate shelter for pet care for disaster responses as requested.

## **Oklahoma Laws**

### **Oklahoma Law on Child Abuse**

Oklahoma statutes define child abuse as harm or threatened harm to a child’s health or welfare by a person responsible for the child. This includes non-accidental physical or mental injury, sexual abuse or neglect (10 O.S. Section 7102). Instances of child abuse and/or neglect discovered through screenings and regular examinations are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the **Oklahoma Department of Human Services (OKDHS)**. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.

- a. Physical abuse is non-accidental physical injury to a child
- b. Mental injury is an injury to a child’s psychological growth and development. It is caused by a chronic pattern of behaviors, such as belittling, humiliating and ridiculing a child.

- c. Sexual abuse, in general terms, includes any sexual activity between an adult and a child for the purpose of sexually stimulating the adult, the child or others. Sexual abuse may also be committed by a person under the age of 18 when that person is either significantly older than the victim or is in a position of power or control over the child.
- d. Neglect is the failure of the parent or caretaker to provide a child with basic needs such as food, clothing, shelter, medical care, protection and supervision.
- e. Threatened harm means a substantial risk of harm to the child. It may include acts or expressions of intent to inflict actual harm presently or in the future.

### **Who Must Report?**

Every person, private citizen or professional, who has reason to believe that a child has been abused, is mandated by law to promptly report suspected abuse. Failure to do so is a misdemeanor. A person making a report in good faith is immune from civil or criminal liability. The name of the reporter is kept confidential.

### **When to Report?**

A report should be made when there is reasonable cause to believe that a child has been abused or neglected or is in danger of being abused. A report of suspected abuse is a request for an investigation. Investigation of child abuse reports is the responsibility of Child Welfare workers and, when a crime may have been committed, law enforcement officials.

If other incidents of abuse occur after the initial report has been made, another report should be made.

### **How Is Abuse Reported?**

A report may be made to any county office of the Oklahoma Department of Human Services or to the 24-hour statewide Child Abuse Hotline, 1-800-522-3511.

## **Childcare Information and Resources**

### **Childcare Centers**

Many families use childcare centers, daycare centers, before, and after school programs in their daily routines. The childcare centers, daycare, before, and after

school programs, and agencies must develop all hazard disaster plans. These plans ensure the safety of the children before, during, and after a disaster. Childcare workers must understand the policies of their agencies plans and demonstrate the procedures of the disaster plans.

Under the circumstances that a disaster occurs while children are present in the childcare, daycare, or before and after school program; the care providers must take the initial steps to keep their clients safe. The next step would be to contact the children's parents or guardian(s), so their families are aware of their situation and know their children are safe. Reunification of parents/guardians with their children is one of the key factors in emergency planning.

### **Child Comfort (Go-Bag) Contents**

Childcare providers will need to have a disaster supplies (go-bag) for themselves and for infants and small children under the age of 3 years old. Each child 3 years and above should have a child comfort go-bag supplies in a backpack. When disaster strikes, the child should be given his/her comfort kit to carry.

Each child's comfort go-bag should contain the following:

- Change of clothes
- Medium to large garbage sack for rain poncho
- Kleenex
- 3 juice boxes
- 3 small boxes of dry cereal
- 1 small container of meat such as Vienna sausages or beef jerky
- Small boxes of raisins or other dried fruit
- Family photo
- Reassuring letter from mom, dad, grandparent, or legal guardian
- Small book
- Something small to hug (stuffed animal, etc.)

### **Childcare Facility Disaster Supplies Kit**

Consider placing these items in a large wheeled trashcan. Place the trash can close to an entrance in a shed for easy access. Note that the size and complexity of this kit will be related to the size of the facility.

- Copy of the disaster plan
- Copy of all children's emergency records

- Three days' worth of food for each individual at the childcare facility
- Infant formula and bottles, if appropriate
- Whistle
- One gallon of water per person per day for three days
- Extra clothing
- Medication
- First Aid Kit
- NOAA Portable radio and flashlight including extra batteries or rechargeable emergency crank radio
- Large trash bags to act as rain ponchos or waste disposal
- Manual can opener
- Small amount of cash
- Lightweight, compact blankets, or space blankets
- Hygiene supplies, such as toilet paper, diapers, tooth brushes, tooth paste, diaper wipes, and feminine products

### **Childcare Initial Emergency Actions**

There are **five Initial Emergency Actions** defined in the resource book. Some agencies may create others for their specific function or agency policy. The appropriate action will depend on the emergency and the agency policy. The five initial actions are the following:

1. Drop-Cover-Hold
2. Evacuation
3. Isolation
4. Lock Down
5. Shelter-In-Place

**Note:** Lock Down and Shelter-In-Place actions can occur separately or at the same time in any emergency occurrences.

The facility administrator, or whoever is in charge at the facility, decides which action is appropriate and initiates the notice. Other pertinent information may follow the order, but the order itself must come first and be transmitted decisively.

**A 911 call may be correct, if the situation is critical for saving lives or other additional emergency responses are needed.**

As facts become known, and conditions change, the initial order may be amended by the facility administrator or senior staff member. In an earthquake, for instance, children and staff may be told to Drop-Cover-Hold until the shaking stops, and then be told to evacuate the building. An active shooter confrontation may begin with a Lockdown response, but later turn into a Shelter-in-Place, or an Evacuation.

First responders will help the facility administrator or senior staff member decide if, when, and how orders should be changed. Depending on the nature of the event, the facility administrator or senior staff member may be relieved as Incident Commander. Transfer of authority should be made clear to all staff.

Eventually, the order(s) will be rescinded. Staff should be certain the modifications or cancellations are being given by the proper authority, if the message is not coming from the facility administrator or person who began the operation.

The following paragraphs detail the Initial Emergency Actions which can be taken by a childcare facility. These actions describe the activities undertaken by children and staff in the **first minutes of an emergency**. Depending on the type, magnitude, and duration of the event, many other activities will likely be conducted per facility protocol.

### **Drop-Cover-Hold**

**This action may be appropriate for:**

- Earthquakes
- Explosions

As with each of the Initial Emergency Action orders, the Drop-Cover-Hold command is given by the staff member(s) in the location the agency/room. The need to drop-cover-hold is generally obvious; it is the first response to loud, kinetic, catastrophic events.

**Staff shall immediately ensure that children:**

- Drop to the floor
- Get under their desks or other heavy furniture
- Hold on to a table leg or other stable support
- Remain until the order is rescinded or revised by a recognized authority



Children and staff caught outdoors should be guided away from buildings or other structures that could collapse and told to get down and cover their heads in a safe area.

## **Evacuation**

**This action may appropriate for the following hazards:**

- Bomb threat
- Earthquake
- Explosion
- Fire
- Wildfire
- Intruder (depending on the situation)

Evacuation may be the Initial Emergency Action. It is always so in the case of a facility fire, for instance. An evacuation could be called as a secondary action, however. With earthquakes, for example, evacuation may follow a Drop-Cover-Hold and an inspection of the facility for damage. In an active attack, evacuation could be preceded by a brief lockdown period. Staff must adapt to changing conditions.

As with each of the Initial Emergency Action orders, the Evacuation command is given by the Facility Administrator or Senior Staff Member. This order is generally delivered via intercom, but may also originate from the fire alarm system.

**Staff shall immediately ensure the following actions:**

- Children remain calm and organized
- Posted evacuation routes are followed if conditions permit
- Disaster Emergency Go Bags are taken
- Children Comfort Go-Bags are collected and distributed to each child over 3 years of age
- Children/youth should assemble at pre-planned staging areas when possible
- Roll call is taken at the staging area

If there is an evacuation in association with an active shooter and/or after a lockdown, the following measures should also be taken:

- Responding police officers are immediately sought, and their instructions followed

- Vehicles parked on-site shall not be used or touched

### **Isolation**

#### **This action may be appropriate for the following:**

- Communicable Disease Outbreak

The isolation command is given by the facility administrator, senior staff, or faculty nurse. The ill child will be taken to a designated sick room or area for separation from other children or staff members. The child's parent/guardian will be notified that their child is sick. The parent/guardian will need to pick up their child as quickly as possible.

#### **Staff shall immediately ensure the following actions:**

- The child is as comfortable as possible
- The child stays hydrated (water and/or fruit juices)
- Hand washing hygiene will be observed by child and staff (**See Appendix J Hand Hygiene**)
- Cough etiquette will be observed by child. (**See Appendix K Cover Your Cough**)

### **Lock Down**

#### **This action may be appropriate for the following:**

- Active Shooter
- Intruder
- Police Order (burglary alert or intruder search in the area)

The lockdown command is given by the facility administrator or staff member(s) of the childcare facility. However, due to the relatively subtle nature of an Active Shooter (compared to, say, an earthquake), any staff member sensing an imminent threat to life should be authorized to call a Lockdown.

Staff shall immediately ensure that the following actions occur to for the safety of the staff and children.

- Children indoors report to the **nearest room**.
- Children outdoors report to the predetermined **off-site staging area**.
- Children are to get down and seek cover away from windows and doors.
- All doors and windows are closed and locked.
- All lights are turned off.
- Doors and/or windows are covered, as appropriate, based on the threat.
- Roll call is taken.

- This condition is maintained until the order is rescinded or revised by a recognized authority.

If an Active Shooter successfully gains entry to an occupied room, staff and children in the room should evacuate immediately, by any means, if possible.

### **Shelter –In-Place**

**This action may be appropriate for the following:**

- Bomb Threat
- Earthquake
- Explosion
- Flooding
- Hazardous Materials Incident (Includes Biological / Chemical Spills)
- Ice Storm
- Intruder (depending on the situation)
- Snow Storm
- Tornado
- Wildfire

Shelter-In-Place means to take immediate shelter where you are- at home, work, school, or in between. It may also mean “seal the room” in other words; take steps to prevent outside air from coming in. This direction is likely to come from local authorities may instruct you to “shelter-in-place if chemical, biological, or radiological contaminants are released into the environment.

### **How Do You Prepare to Shelter-In-Place**

Choose a room in advance for your shelter. The best room is one with as few windows as possible. A large room, preferably with a water supply, is desirable. A storm shelter or safe room is also an excellent place to shelter-in-place.

As with each of the Initial Emergency Action orders, the Shelter-in-Place command is given by the facility administrator or senior staff member. The order may be based on observations reported to the front office by third parties or local authorities. Shelter-In-Place can be used for various emergency responses (ice storm, snow storm, biological spills, chemical spills, intruder alert, tornadoes etc.)

## **Emergency Planning for Childcare Facilities**

Emergency planning requires attention not just for specific types of hazards but also to steps that increase preparedness for any types of hazards or incidents. In the state of Oklahoma, we have the following natural and human-made hazards and incidents that can affect the operations of childcare facilities:

- Abductions
- Communicable Diseases Outbreaks
- Earthquakes
- Explosions
- Field Trip Incidents
- Fires
- Floods
- Ice Storms
- Intruder Alerts
- Snow Storms
- Tornados
- Wildfires

### **Abduction**

**The selected initial emergency action is to place the facility on Lockdown.**

#### **Communicate:**

- **Call 911 immediately** and provide the following information:
  - Child's name and age
  - Address
  - Physical and clothing description of the child, including any distinguishing marks such as visual scars or birthmarks
  - Medical status, if appropriate
  - Time and location child was last seen
  - Person with whom the child was last seen

#### **Additional Actions:**

- Immediately search the facility again
- Have child's information and if possible, a picture of the child will be provided for the police upon their arrival

- Director/ Designee will notify parents of missing child to determine if the child is with family or if not- inform parents of situation and steps that being taken
- **Report incident to 911 immediately**

### **Communicable Disease Outbreak**

Communicable disease is defined as an infectious transmissible (as from person to person) by direct contact with an affected individual or the individual's discharges. Encourage all staff to receive annual immunizations to protect themselves and their families. Encourage parents to have their children immunized. Practicing hand hygiene will reduce the spread of germs in a childcare facility. Practicing infections control throughout their facility (cough etiquette, hand washing, and cleaning community play, sleep, and work surfaces) will help reduce the spread of viruses that can cause a disease outbreak. Note: Go to [CDC.gov](http://CDC.gov) for guidance and information on cough etiquette and hand washing protocol.

Make sure to keep emergency disaster supplies and emergency contact information available all year for each child and staff member. Encourage the parents to keep the staff informed of all changes in family contact information.

- Check all children upon arrival for illness symptoms before the parents leave the childcare facility.
- Any children who have disease or illness symptoms should not be permitted to stay at the childcare facility and should be asked to leave with the parent/guardian.
- All staff, parents, and children should wash their hands with soap and warm water upon entering the childcare facility/ apply hand sanitizer).
- If a child or staff member develops disease/illness symptoms (flu, measles, chicken pox, mumps, fever, or rash) while at the childcare, physically separate the sick child (isolation).
- Call the parent/guardian to arrange for pick-up of the ill child
  - Insist that they come immediately
- Send sick staff home.
- Sick children will stay in the isolation area located (indicate where)\_\_\_\_\_until a parent or guardian is able to pick them up.

- The person in charge of caring for the ill child in the isolation area is – name and title of person \_\_\_\_\_
  - This person will limit contact with the ill child to the greatest extent possible.
  - This person will observe hand washing etiquette.
  - **Note- This designated staff member should not take care of non-ill children.**
- **Children and staff with symptoms will be asked to wear a mask.**
- **The staff member caring for the ill child/children will wear a mask and gloves.**
  - **The staff member should change washing hands and change gloves between each child’s medical visits.**
- The ill child or staff member will be given plenty of fluids to prevent dehydration.
- All people at the childcare should carefully follow recommendations for hand hygiene (**See Appendix I-J** Infection Control and **Appendix K-** Cough Etiquette) after contact with an infected person or the environment in which the infected person was located.
- Those persons who are not involved in caring for the ill child will not enter the isolation area
- Place all used tissues in a bag and dispose of them with other waste. A bag will be placed next to the ill child in the isolation area for this purpose
- All parents/guardians will be notified of the all illnesses occurring in the childcare facility
- Sanitize the environment in which the sick child/staff had been located. Sanitize any toys or objects the sick child handled
  - Other cleaning and sanitizing activities should be done at the normal times
- Wash and sanitize any bedding that was used by the sick child.
  - Care should be taken when handling soiled laundry (i.e. avoid holding the laundry close to your body) to avoid self-contamination
  - Wash hands after handling the dirty laundry.
- Soiled dishes and eating utensils should be cleaned and sanitized as usual

## **Earthquake**

The selected initial emergency action is Drop-Cover-Hold.

### **Communicate:**

Do not call 911 to report an earthquake; call only after the shaking stops if there is a definite emergency.

### **Other measures to consider (assuming a catastrophic event):**

- Avoid glass and falling objects. Move away from windows where there are large panes of glass and out from under heavy suspended light fixtures
- Inspect facility after the shaking stops or as soon as it is safe; when damage is apparent, consider evacuation
- If you suspect structural damage, request a structural inspection by calling your insurance company.
- Give special consideration to exit routes; do not use routes that have heavy architectural ornaments over entrances/exits
- Warn all personnel to avoid touching electrical wires
- Log activities, decisions, and communications
- If Shelter-In-Place is selected, begin planning for food, shelter, and sanitation requirements; secure Disaster supplies Kit and distribute Comfort Go-Bag kits to children
- If evacuation is selected, secure disaster supplies kit and distribute Comfort Go-Bag to children; staff to take all personal items, including vehicle keys; change telephone message and post information on facility door or window
- Obtain available information on the magnitude of the disaster; try to determine if aftershocks, fires, hazmat incidents, etc. are expected that may affect personnel, children, and/or facility
- Consider staffing requirements and the employee's need to check on their families and homes
- Notify parents/ guardians of all children in your facility where you are evacuating the facility to for safety measures.
- **Note:** This action should be explained in your emergency planning that each parent/guardian should have a copy of for their personal reference.

### **If an earthquake occurs after business hours:**

- Inspect facility after the fact

- When damage is apparent, call your agency insurance company.
- If it is determined that the facility must remain closed; notify staff members, local schools in your area, and families of your clients

## **Explosion**

### **Select an Initial Emergency Action:**

- Drop-Cover-Hold
- Is Shelter-In-Place – (depending on the situation)

### **Communicate:**

- Announce
- **Call 911**

### **Other measures to consider (assuming a catastrophic event):**

- Consider event to be essentially an earthquake plus a fire; a crime scene may be also apparent. (an accident or a bombing)
- Avoid glass and falling objects. Move away from windows where there are large panes of glass and out from under heavy suspended light fixtures.
- Inspect facility if safe to do so: if structural damage is apparent, consider evacuation
- If evacuating, change telephone message and leave information posted on facility door or window; once at the evacuation point, contact parents
- Look for indications suggesting whether the explosion was accidental or intentional and do not touch any evidence of activity
- If bombing is suspected, watch for unexploded secondary devices and report: do not touch anything that appears suspicious
- Be wary of the possibility of biological/chemical dispersal
- Special consideration should be given to entrance/exit routes
- Do not use routes that have heavy architectural ornaments over entrances/exits
- Warn all personnel to avoid touching all electrical wires
- Log activities, decisions, and communications concerning the incident

## **Field Trip Incident**

### **Select an Initial Emergency Action:**

- Varies depending on the location of the field trip.
  - Lock Down
  - Evacuation



**Communication:**

- **Call 911**

**Additional Actions:**

- All children will be accounted for by vehicle list or classroom list
- Attend to any medical needs if there are injuries or complaints of pain
- Contact the childcare center and provide update and actions being taken
- The childcare center may consider deploying personnel to the scene, hospital, or to appropriate location(s)
- Facility designee will contact parents and give update of actions being taken; indicate meeting locations or pick up times at the childcare facility

**Fire-In Facility****Select an Initial Emergency Action:**

- Evacuation

**Communication:**

- Announce
- **Call 911**

**Additional Actions:**

- Confine the fire by closing the door to the area involved
- Keep access roads open for emergency vehicles
- Log all activities, decisions, communications, and do not touch anything that appears suspicious or hazardous
- Do not return to the facility until instructed by the fire department
- Maintain a list of persons removed by ambulance, including name of intended hospital and contact parents/guardians of injured children

**Flood****Select an Initial Emergency Action:**

- Shelter –In-Place
- Evacuation

The extent and imminence of the flood will dictate the course of action.

**Communicate:**

- **Call 911, if necessary**

**Additional Actions:**

- Log activities, decisions, and communications

- If evacuating, confirm, and communicate
- Do not return to the facility until it has been declared safe by the state emergency managers, local emergency managers, or the building department officials.
- If structural damage is suspected, request a structural inspection by calling your agency insurance company.

If the answer is yes, see above under evacuation; if the answer is no, continue with daily routine; notify parents/guardians if anything changes.

### **Intruder Alert**

#### **Select an Initial Emergency Action:**

- Shelter –In-Place
- Lockdown
- Evacuation

#### **Communicate:**

- Hand Signal or Announcement
- **Call 911**

#### **Definition of Intruder:**

An intruder is defined as any unauthorized individual who, through act or deed, poses a perceived threat to the safety and welfare of children and employees. If at any time you are dealing with a person you feel uncomfortable around or are fearful for your safety or the safety of others, then you may be faced with an intruder situation.

#### **Additional Actions:**

- If you are uneasy or suspicious of the person(s) in your facility immediately have someone call 911
- **If a weapon is present, or suspected, Do Not Confront** – give pre-determined hand signal or announcement to another staff member for them to call 911 immediately.
- Initiate Intruder Alert / Lockdown Procedure.
- If **no** weapon is suspected, **follow your agency guidelines** on how to confront the intruder.

**Note: Follow your agency guidelines for intruder in facility.**

### **Tornado**

#### **Selection an Initial Emergency Action:**

- Shelter –In-Place

- Drop-Cover–Hold

**Communicate:**

- **Call 911, if necessary**

**Additional Actions:**

- Log activities, decisions, and communications
- If evacuating (do so after the storm- if possible), confirm, and communicate
- Do not return to the facility until it has been declared safe by the state emergency managers, local emergency managers, or the building department officials.
- If structural damage is suspected, request a structural inspection by your agency insurance company.

**Other measures to consider:**

- The facility safe room or place is designated by the Facility Director/ staff designee
- All children will be moved to the designated location before the tornado
- Maintain flashlight and voice contact among the staff members at all times (walkie-talkies are great for this action)
- Direct all children to kneel down on their knees with their heads between their legs covering their head with their hands
- Advise all children to wear their shoes
- Make sure to do a head count before moving to a safe place, after arriving at a safe place or safe room, and after leaving the designated area

**After The Storm**

- Staff members should perform an head count
- Provide any necessary first aid and call 911 for any necessary response agencies
- Check the complete building for any damages such as fire, water, or structural damages
- Notify the Director as soon as possible with update of conditions
- Notify all agents that service are needed

**Wildfire- Near Facility**

- Determine if it is necessary to implement any action

- Stay in contact with first responders for instructions and updated information concerning the location and situation of the wildfire
- Have alternate place of evacuation notified of possible evacuation process

### **Children, Youth, and Families in Childcare or After School Care Programs**

Most childcare programs keep information on the children and families they serve and most licensing agencies require that some information be collected and available on each child reenrolled and his or her family. However, this information may not be enough if a disaster strikes an area in which a childcare facility is located. It may be impossible to reach parents at their work site if the facility has been evacuated or damaged. Parents may have been injured or killed or evacuated to an area where they do not have access to phone service. Land and cell phone service in the area may be disrupted or clogged with incoming and outgoing calls. To ensure a parent or other responsible person can be reached, programs should consider collecting and maintaining the following information for each child in their care:

- **Parents or Guardians**
  - Work phone number
  - Home phone number
  - Cell phone number
  - Home e-mail address
  - Work e-mail address
  - Supervisor's work phone number and e-mail address
- The names, cell phone numbers, home phone numbers, and e-mail addresses of two local emergency contacts (preferably individuals with whom the parents do not live or work).
- The name, work phone number and e-mail, and home phone number and e-mail of two emergency contacts who live outside the area (preferably individuals, such as grandparents, who would assume responsibility for the child if the parents were not able to do so).

In addition, the program should collect and keep updated information on the child's health, allergies, and medications. The program should also have a signed permission sheet from the parents to transport the child in the event of an

emergency and to seek medical care for him or her, if necessary, during an emergency or evacuation.

It may be difficult to get parents to provide the information needed for the program to be able to respond to disasters. Parents are busy and may resent the time required to fill in several forms. Some may not have the information the program needs readily available for their childcare facility. The director may have to explain the need for the information to parents and train the staff on how to encourage and support parents during the process. If parents know why the information is requested, they may be more willing to provide and keep it updated. They may also be more cooperative if they spend some time thinking about why their child's program needs to prepare for disasters.

### **Suggestion**

If the most critical information is put on an identification bracelet worn by the child while he or she is in the program, it will be more readily available during an emergency. Parents can provide the information needed for the bracelet when they enroll the child in the program. Identification bracelets can be purchased from medical supply companies. In some cases the information is enclosed in a clear acrylic cover that protects the information from moisture and soiling. Some bands are made from a tough durable paper-like sheet of spun bonded olefin.

The next section covers the ten questions parents should ask all childcare facilities concerning disaster preparedness.

### **Eleven Questions for Parents to Ask Their Childcare Program Before a Disaster Happens**

1. Does my childcare program have an emergency preparedness plan for the types of disasters that are likely to occur in our area?
2. Can the childcare staff evacuate my child to a safe, secure, predetermined location if required?
3. How and when will I be notified in the event of a disaster that affects the childcare program my child is attending?
4. Is there a designated emergency point of contact at the program for me to contact during or following an emergency?
5. If I cannot get to my child during and after a disaster, how will the childcare program continue to care for my child?

6. Has the staff received disaster response training, including how to best respond to my child's physical and emotional needs during a disaster?
7. Will the childcare program teach my child 3 years and older what to do during an emergency and how to follow the evacuation plan if required?
8. Does the childcare program have a disaster kit on-hand with enough items to meet my child's needs for as long as 72 hours?
9. Are state and local emergency management agencies and responders aware of the childcare program where child attends?
10. How might I assist my childcare program during and after a disaster?
11. After a disaster occurs, how will I be notified regarding my childcare program's plan to reopen?

### **Relocation of Childcare Facility**

In the event of a natural disaster or unscheduled closing of a childcare center, alternative childcare facility may be used for emergency evacuation or services. Always have a back-up plan for such emergency occurrences. Partnerships and planning in such actions are very important.

- Ensure the back-up facilities have room for such emergency evacuation of your clients
- Plan for back-up food, cots, and staffing during emergency evacuations
  - i. Keep infection control guidelines in the shelter (**See Appendix C** for Diapering Station Guidelines in an Evacuation Center) (**See Appendix I-J** for Infection Control Guidelines)
- Contact the children's parents or guardians when the evacuation is complete
- Child's record should be maintained on file at the facility and made available to the alternate childcare facility staff
- If the facility wishes to hire staff from the damaged facility temporarily to ensure adequate staff: child ratios, the staff records must be on site and available to alternate facility staff

### **Family Reunification**

Being separated from loved ones during an emergency is a frightening situation for anyone, but it is especially traumatic and dangerous for children. Planning for ways to preserve family unity is the most important step you can take to provide

for the physical safety and emotional stability of children in disasters. Children can become separated from their families in many situations, including:

- a. During an evacuation.
- b. At emergency shelters.
- c. While at school or a childcare facility.
- d. While on a school trip out of town.
- e. While at summer camp or after-school activities.
- f. While being treated at a hospital or medical clinic.
- g. While visiting friends or relatives away from home.
- h. While at the store, at the movies, or other location.
- i. Death of their parent/guardian/foster parent/sibling

**The Emergency Operations Plan** for your community or organization should include procedures for identifying children who have been separated from their families and reuniting the families as soon, and as carefully, as possible.

### **Reunification Stations**

There are five very important stations when setting up an alternate location and reunification plan.

1. The **Check-In Gate** staff should be the first to greet the parents/guardians/emergency contacts upon arrival.
2. The **Childcare Area** is where staff will care for all the children still in their care. Staff will need to make sure that the child's needs are being met and they are being entertained. **Note:** This can be very traumatic for the children and they will need more to do than sit and wait for parents.
3. The **Release Gate** will be one of the last places the adult and children see. This is where the childcare staff/emergency staff/or designee's will finish filling forms that state they are the "proper individuals" to pick up the child or children from this facility.

4. The **Command Post** is where the Commander and support staff of the alternative care site will work from during the disaster. The Commander may be the Director or Designee, or it may be the most qualified staff member on hand. The Command Post is not usually accessible to parents.
5. A **Private Area** not visible to children and parents is necessary for the Commander, Director, or Designee to bring a parent or guardian to tell them if their child or children are missing, injured, or deceased. It offers privacy and prevents other parents from becoming more agitated during chaotic circumstances.

### **Release Procedure**

For the safety of staff and children, parents/guardians are restricted to the Check-in and Release Gates. A runner should be assigned to go get the child or children when the parent/guardian arrives to the location.

- The release procedure begins at the Check-in Gate, where a parent/guardian or emergency contact begins filling out the child release form. (See **Appendix A-** Post Disaster Child Release Form and **Appendix B-** Post Disaster Childcare Situation/Communication Log)
- For more information on reunification of children after disasters see: Post-Disaster Reunification of Children: A Nationwide Approach  
<http://www.phe.gov/Preparedness/planning/abc/Documents/children-reunification.pdf>

### **Restoring Childcare after a Disaster**

Most childcare staff and family childcare providers will be eager to begin offering childcare to children and families as soon as possible after a disaster strikes. Sometimes, this may be a simple matter; however, if the disaster was severe and widespread, it may take considerable effort for a program to reopen. Restoring childcare services in a community as quickly and effectively as possible is important because childcare is an essential service.

Childcare contributes many short- and- long term benefits to the local economy. Parents need childcare so they can return to work. Businesses and corporations



need to have childcare available so their employees can perform their jobs. Child-care centers and family childcare homes are among the small businesses that contribute to the productivity and output of communities. Operating childcare programs enable parents to return to work, which helps fuel the supply of goods and services by other businesses. If childcare is not available in a community that has experienced a disaster, the damage assessment and repair process will be slowed and recovery period lengthened.

# Appendices

## Appendix A- Post Disaster Child Release Form

<b>Section 1: Complete by Parent/Guardian/Emergency Contact at Check in Gate</b>	
<b>To be completed by Parent/Guardian/Emergency Contact and returned to Check-in Gate Staff</b>	<b>Child's Name:</b> _____ <b>Teacher:</b> _____ <b>Classroom:</b> _____
<b>Section 2: Completed by Gate Staff at Check in Gate</b>	
<b>To be filled out by Gate Staff</b>  Upon completion, given to runner to get child or children  Adult will be escorted to release gate	Parent/Guardian/Emergency Contact name: _____  <b>Proof of ID:</b> _____  Confirmed that this person is on the Emergency Contact Sheet: <b>Yes</b> ____ <b>No</b> ____ <b>Staff Initials</b> ____
<b>Section 3- Complete by Childcare Area Staff at Childcare Area</b>	
<b>To be filled out by Childcare Area Staff</b>  If child is present, send with runner to the Release Gate  If child is absent, missing, or injured, send form with runner to Command Post	<b>Child's Status:</b>  <b>Present</b> ____ <b>Absent</b> ____  <b>First Aid</b> ____ <b>Missing</b> ____  Childcare Area staff will initial next to appropriate status
<b>Section 4- Completed by Release Gate Staff at Release Gate</b>	
<b>To be completed by staff at Release Gate</b>  Upon completion, give to parent/guardian/emergency contact to fill out <b>section 5</b>	Name of Parent/Guardian/Emergency Contact picking up child (Must match name at the top of the form) _____  Confirm that this person is on the Emergency Contact Sheet: <b>Yes</b> ____ <b>No</b> ____ <b>Staff Initials:</b> ____
<b>Section 5- Completed by Parent/Guardian/Emergency Contact at Release Gate</b>	
<b>To be completed by Parent/Guardian/Emergency Contact and returned to Release Gate Staff</b>	Parent/Guardian/Emergency Contact signature: _____  Destination: _____  Date: ____/____/____ Time: ____:____ am/pm

**Section 6- Completed by Release Gate Staff at Release Gate**

**To be completed by Release Gate Staff and file at release gate**

Signature of Release Gate Staff:

\_\_\_\_\_  
Date: \_\_\_/\_\_\_/\_\_\_\_\_ Time: \_\_\_:\_\_\_ am/pm

**Appendix B-Post Childcare Situation/Conversation Log**

**Date:** \_\_\_\_\_ **Incident/Situation:** \_\_\_\_\_

<b>Time</b>	<b>Situation</b>	<b>Response</b>	<b>Initials</b>

## **Appendix C -Guidelines for Establishing and Maintaining a Diapering Station in an Evacuation Center**

Maintaining a clean and healthy environment for children and adults is essential in any situation. In a disaster it becomes even more critical for the health children and young families to maintain a clean work area to stop the spread of germs. Below the [www.cdc.gov](http://www.cdc.gov) states guidelines that should be established for the prevention of spreading germs in an evacuation center.

1. One station should be available for every 12 diapered children.
2. Place the diapering station near hand washing facilities. If this is not possible, make a waterless had gel product available at the diapering station, but place it out of the reach of children.
3. Diaper changing surface should be made of non-porous material.
4. Ideally, a rail or similar barrier should surround the diaper changing surface to help children from falls.
5. Provide disposable materials, such as paper towels or butcher paper, to cover the diapering surface before each use.
6. Provide baby wipes for child and diapering station clean-up.
7. Place a covered trash receptacle, preferably with a foot-operated opening mechanism, near the diapering area.
8. Keep paper towels and a disinfectant solution in a spray bottle at the diapering station, but out of reach of children.
  - Disinfectant solution may be made by mixing  $\frac{1}{4}$  cup bleach in 1 gallon of water.
9. Post cleaning/disinfecting instructions at each station.
  - If evacuation center guests are responsible for cleaning and disinfecting the diapering stations after each use, train them in proper technique.

**Appendix D – Recommended Perishable Supplies for Immediate Delivery within Three Hours**

<b>Recommended Perishable Supplies For Immediate Delivery Within 3 Hours</b>		
<b>Quantity</b>	<b>Description</b>	<b>Comment</b>
200	Diaper wipes - fragrance free (hypoallergenic)	Minimum of <b>200 wipes</b>
40	Diapers - <b>Preemie Size</b> (up to 6 lbs.)	As needed for shelter population
40	Diapers - <b>Size 1</b> (up to 14 lbs.)	Initial supply should include one package of each size, with no less than <b>40 count</b> of each size diaper
40	Diapers - <b>Size 2</b> (12 - 18 lbs.)	
40	Diapers - <b>Size 3</b> (16 - 28 lbs.)	
40	Diapers - <b>Size 4</b> (22 - 37 lbs.)	
40	Diapers - <b>Size 5</b> (27 lbs. +)	
40	Pull Ups <b>4 T – 5 T</b> (38 lbs. +)	
320 oz.	Formula, milk-based, ready to feed (already)	
64 oz.	Formula, hypoallergenic-hydrolyzed protein, ready to feed (already mixed with water)	
64 oz.	Formula, soy-based, ready to feed (already mixed with water)	
1 Quart	Oral Electrolyte solution for children, ready-to-use, unflavored (e.g. Pedialyte) - <b>Dispensed by medical/health authority in shelter</b>	Do not use sports drinks. The exact amount to be given, and for how long, should be determined by an appropriate medical authority (doctor or nurse). To be used in the event an infant/child experiences vomiting or diarrhea, and the degree of dehydration.
	Nutritional Supplement Drinks for Kids/Children, ready-to-drink (e.g., Pedia Sure, Kids Essential/Kids Boost) - <b>Dispensed by medical/health authority in shelter</b>	<b>Not for infants under 12 months of age.</b> Requirement is a total of <b>40-120 fl. oz. per day</b> ; in no larger than <b>8 oz.</b> bottles.

## Appendix E- Non Perishable Supplies & Equipment

<b>Non-Perishable Supplies &amp; Equipment</b>		
<b>Quantity</b>	<b>Description</b>	<b>Comment</b>
25	Infant feeding bottles (plastic only)	<b>4 - 6 oz.</b> size preferred (to address lack of refrigeration). Should be BPA- and PVC-free.
30	Infant Feeding Spoons	Specifically designed for feeding infants with a soft tip and small width. Should be BPA- and PVC- free. Can be used for younger children as well.
50	Nipples for Baby Bottles (non-latex standard)	<b>2 per bottle.</b> Should be BPA- and PVC- free.
25	Diaper Rash Ointment (petroleum jelly, or zinc oxide based)	Small bottles or tubes
100	Disposable changing pads	At least <b>13 x 18</b> in size. Quantity is based on <b>8-10</b> diaper changes per infant per day
10	Infant bathing basin	Thick plastic non-foldable basin. Basin should be at least 12" x 10" x 4"
1 case	Infant wash, hypoallergenic	Either bottle(s) of baby wash (minimum 100 oz.), which can be "dosed out" in a disposable cup (1/8 cup per day per child) or 1 travel size (2 oz.) bottle to last <b>~48 hrs.</b> per child
10	Wash cloths	Terry cloth/cotton - at least one per child to last the <b>72 hr.</b> period
10	Towels (for drying after bathing)	Terry cloth/cotton - at least one per child to last the <b>72 hr.</b> period
2 sets	Infant hat and booties	Issued by medical/health authority in shelter



## Appendix F- Other Recommended Non-Perishable Supplies & Equipment

<b>Recommended Non-Perishable Supplies &amp; Equipment</b>		
<b>Quantity</b>	<b>Description</b>	<b>Comment</b>
10	Sip Cups (support for toddlers)	Should be <u>BPA</u> and <u>PVC</u> free
10	Infant slings or wraps	To support mothers who breastfeed
10	Hospital grade multiuser breast pump with battery capability	Available for lactating; in the event that the infant has difficulty feeding from the breast; sterilization is required after each use

## Appendix G -Supplemental Information for Supplies & Equipment

Supplemental Information	
Description	Supplemental Notes
Formula	<p><b>It is recommended that ready-to-feed formula should be ordered in bottles with nipples to avoid contamination with non-potable water.</b></p> <p>If using powdered preparation of the formula should be conducted by appropriately trained food preparation workers. Water used should be from an identified potable water source (bottled water should be used if there is any concern about the quality of tap or well water). Hypoallergenic hydrolyzed formula can be provided in powdered form—<b><u>(1) 400 gram can</u></b> but only if potable water is accessible</p>
Infant Feeding Bottles and Nipples	<p>Each time nutritional fluids, formula and/or other infant feeding measures (including breast milk in a bottle) are distributed by trained, designated shelter staff and/or medical professionals, clean, sterilized bottles and nipples must be used. <b>Note:</b> After use, bottles are to be returned to the designated location for appropriate sterilization (and/or disposal). Bottle feeding for infants and children is a <b>24/7</b> operation and considerations must be in place to provide bottle feeding as needed (On average, infants eat at minimum <b>5-8 times daily</b>).</p> <p><b>Note to staff: Sterilizing and cleaning</b> Sterilize bottles and nipples before you use them for the first time by putting them in boiling water for <b>5 minutes</b>. Nipples and bottles should be cleaned and sterilized before each feeding. If disposable bottles and nipples are not available and more durable bottles and nipples will be re-used they must be fully sterilized before each feeding. To the greatest extent possible bottles and nipples should be used by <b>only one child</b>.</p> <p>In the event parents want to use their own bottles and nipples, shelter staff should provide support for cleaning these items between feedings. Support such as access to appropriate facilities for cleaning (not public restrooms).</p>

<b>Supplemental Information</b>	
<b>Description</b>	<b>Supplemental Notes</b>
<p>Note: regarding all feeding implements for infant/children</p>	<p>There is a specific concern with cleaning and sanitizing of all feeding implements associated with infants and children (infant feeding bottles/nipples, spoons, sip cups, etc.). These items will require additional attention by food preparation staff to ensure they are sanitary as a means of reducing food borne illness. Staff medical/health staff should be consulted on best means of raising awareness among shelter residents and enlisting their support for these extra sanitary measures.</p> <p>Feeding implements such as spoons and sip cups should be cleaned using hot soapy water provided potable water is available. When the item is being cleaned to give to another child the item must be sterilized.</p> <p><b>Note:</b> Specialty feeding items will be distributed /available upon request by parent or guardian for the child's usage.</p>

<b>Supplemental Information</b>	
<b>Description</b>	<b>Supplemental Notes</b>
<p>For the following items: infant bathing basin, lightweight blankets, diaper rash ointment, wash cloths, and towels</p>	<p>Consider pre-packaging the listed items together and providing one package to each family with children. <b>Note:</b> additional blankets and towels will be necessary for families with more than one child.</p>

## Appendix H- HICS Job Action Sheet–Pediatric Services Unit Leader

### HICS Job Action Sheet–Pediatric Services Unit Leader

You report to: \_\_\_\_\_  
(Operations Chief)

Command Center: \_\_\_\_\_

**Mission:** To ensure that the pediatric treatment and holding areas are properly assigned, equipped, and staffed during an emergency.

#### **Immediate (Operational Period 0-2 Hours):**

- \_\_\_\_\_ Receive appointment from Unit Leader
- \_\_\_\_\_ Read this entire job action sheet
- \_\_\_\_\_ Obtain briefing from Unit Leader
- \_\_\_\_\_ Gather external information from Treatment Area Supervisor/ED Charge Nurse regarding:
  - \_\_\_\_\_ Number of expected pediatric patients and their conditions
  - \_\_\_\_\_ Current total number of ED patients
  - \_\_\_\_\_ Expected time of patient arrival
- \_\_\_\_\_ Determine number of available pediatric/crib beds [inpatient] and report to Operations Chief for planning purposes
- \_\_\_\_\_ Determine qualified, on-site pediatric staff members
- \_\_\_\_\_ Determine additional staff needed based on expected patient volume
- \_\_\_\_\_ Alert Discharge Unit Leader to institute early discharge/transfer of patients
- \_\_\_\_\_ Initiate Pediatric Response Team as per plan
- \_\_\_\_\_ Predetermined Physicians for Pediatric Response -  
Pediatric/Family/Practice/Staff/Community)
- \_\_\_\_\_ Predetermined Nurses (with pediatric experience and/ or PALS /  
ENPC certification)
- \_\_\_\_\_ Predetermined ancillary technicians with pediatric experience

- \_\_\_\_\_ Others as predetermined
- \_\_\_\_\_ Determine need for opening of a Pediatric Safe Area (dependent on expected number of unaccompanied children during the disaster)
- \_\_\_\_\_ Assign Pediatric Safe Area Coordinator
- \_\_\_\_\_ Communicate with Operations Chief to assure coordination of non- pediatric ancillary /support personal are assigned to each area
- \_\_\_\_\_ Assure preparation of a pre-designated Pediatric Disaster Care Area  
Clear area
- \_\_\_\_\_ Designate each specific area per plan and based on expected casualties
- \_\_\_\_\_ Assure support personnel are assigned to each area
- \_\_\_\_\_ Assure delivery of medical and non-medical pediatric equipment
- \_\_\_\_\_ Assure set-up of pediatric equipment by clinical staff
- \_\_\_\_\_ Receive pediatric patients
- \_\_\_\_\_ Communicate findings to Treatment Area Supervisor for dissemination as /disaster plan
- \_\_\_\_\_ Following triage of all children, move uninjured/unaffected children to pre-designated Pediatric Safe Area

**Intermediate (Operational Period 2-12 Hours):**

- \_\_\_\_\_ Assess ongoing staffing needs based on patient status report form:
  - \_\_\_\_\_ Pediatric healthcare personnel (emergency department, inpatient)
  - \_\_\_\_\_ Non-pediatric ancillary/support personnel
  - \_\_\_\_\_ Pediatric Safe Area Coordinator
- \_\_\_\_\_ Assess additional medical and non-medical equipment/supply needs
- \_\_\_\_\_ Communicate with Pediatric Logistics Unit Leader via Operations Chief to Logistics Chief
- \_\_\_\_\_ Assess Pediatric Response Team basic needs:
  - \_\_\_\_\_ Food

- \_\_\_\_\_Rest
- \_\_\_\_\_Psychological support
- \_\_\_\_\_Obtain status of pediatric casualties (discharges, admissions, transfers, and Pediatric Safe Area) and report of Operations Chief
- \_\_\_\_\_Hold information sessions with Public Information Officer as needed
- \_\_\_\_\_Obtain Child Survey Forms from all pediatric patient areas
- \_\_\_\_\_Report any unidentified or unaccompanied pediatric patients to Operations Chief

**Extended (Operational Period Beyond 12 Hours):**

- \_\_\_\_\_Debrief Pediatric Response Team and Pediatric Safe Area Coordinator regarding:
  - \_\_\_\_\_Summary of Incident
  - \_\_\_\_\_Review of areas of success
  - \_\_\_\_\_Identify opportunities of success
- \_\_\_\_\_Thank and congratulate team

## **Appendix I- Infection Control Guidelines for Evacuation Shelters**

### **Infection Control Guidance for Community Evacuation Centers Following Disasters**

These recommendations provide basic infection control guidance to prevent exposure to or transmission of infectious diseases in temporary community evacuation centers.

Community evacuation centers include medium and large-scale, organized, temporary accommodations for persons displaced from their homes (e.g., following natural disasters such as hurricanes, floods, and earthquakes). Evacuation facilities may be residential (e.g., dormitories or campsites) or non-residential (e.g., sports stadiums and churches), with varying degrees of sanitary infrastructure. Individuals in evacuation centers are required to share living spaces and sanitary facilities and may be exposed to crowded conditions. Evacuees may have health problems including traumatic injuries, infectious diseases, and chronic illnesses such as renal failure.

### **General Infection Prevention for Residential Evacuation Centers**

Use of appropriate infection prevention measures by all staff and evacuees can reduce the spread of infectious diseases.

- Staff and residents should wash their hands with soap and water frequently.
- Children should be assisted in washing their hands with soap and water frequently.
- Alcohol hand gels are an effective addition to hand washing and a reasonable temporary substitute when soap and clean water are not readily available.
- Alcohol hand gel should be positioned throughout the evacuation center, especially at the beginning of food service lines and outside of toilet facilities.
- Encourage good personal hygiene practices including the following:
  - Cover your cough with tissues, disposing tissues in the trash, or with your hands. Wash your hands or use alcohol hand gel after

coughing. If possible, tissues should be provided in evacuation center living areas.

- Follow good hygienic practices during food preparation.
- Do not share eating utensils or drinking containers.
- Do not share personal care items such as combs, razors, toothbrushes, or towels with anyone else.

**Note:** Evacuation shelters can also be used for temporary accommodations after ice storms, snow storms, flood, chemical or biological spills, wild fires, and tornadoes.



## **Appendix J- Hand Hygiene**

Keeping hands clean through improved hand hygiene is one of the most important steps we can take to avoid getting sick and spreading germs to others. Many diseases and conditions are spread by not washing hands with soap and clean, running water. If clean, running water is not accessible, as is common in many parts of the world, use soap and available water. If soap and water are unavailable, use an alcohol-based hand sanitizer that contains at least 60% alcohol to clean hands.

### **When Should You Wash Your Hands?**

- Before, during, and after preparing food
- Before eating food
- Before and after caring for someone who is sick
- Before and after treating a cut or wound
- After using the toilet
- After changing diapers or cleaning up a child who has used the toilet
- After blowing your nose, coughing, or sneezing
- After touching an animal or animal waste
- After handling pet food or pet treats
- After touching garbage

**For more information go to [www.cdc.gov](http://www.cdc.gov)**

## What Is The Correct Way To Wash Your Hands?

- **Wet your hands** with clean, running water (warm or cold) and apply soap.
- **Rub your hands** together to make lather and scrub them well; be sure to scrub the backs of your hands, between your fingers, and under your nails.
- **Continue rubbing** your hands for at **least 20 seconds**. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
- **Rinse your hands** well under running water.
- **Dry your hands** using a clean towel, paper towel, or air dry them.

## What If I Don't Have Soap and Clean, Running Water?

Washing hands with soap and water is the best way to reduce the number of germs on them. If soap and water are not available, use an alcohol-based hand sanitizer that contains at least 60% alcohol. Alcohol-based hand sanitizers can quickly reduce the number of germs on hands in some situations, but sanitizers do **not** eliminate all types of germs.

**Hand sanitizers are not as effective when hands are visibly dirty.**

**How do you use hand sanitizers?**

- Apply the product to the palm of one hand.
- Rub your hands together.
- Rub the product over all surfaces of your hands and fingers until your hands are dry.

**For more information go to [www.cdc.gov](http://www.cdc.gov)**

## Appendix K- Cover Your Cough

### Stop the spread of germs that can make you and others sick!

Influenza (flu) and other serious respiratory illnesses like respiratory syncytial virus (RSV), whooping cough, and severe acute respiratory syndrome (SARS) are spread by cough, sneezing, or unclean hands.

To help stop the spread of germs, follow the directions below:

- Cover your mouth and nose with a tissue when you cough or sneeze.
- Put your used tissue in the waste basket.
- If you don't have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands.
- You may be asked to put on a facemask to protect others.
- Wash your hands often with soap and warm water for **20 seconds**.
- If soap and water are not available, use an alcohol-based hand rub.

For more information go to [www.cdc.gov](http://www.cdc.gov)

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## **Acronyms**

ADA- Americans with Disabilities Act

ASL- American Sign Language

ARC- American Red Cross

ASD- Autism Spectrum Disorder

BPA – Bisphenol A

CDC- Centers for Disease Control and Prevention

DHS- Department of Human Services

DRC- Disaster Recovery Center

ED-Emergency Department

ENPC- Emergency Nurse Pediatric Course

EOP - Emergency Operations Plan

FEMA- Federal Emergency Management Agency's

Flu- Influenza

HICS- Health/Hospital Incident Command System

Hr. - Hour

ICS- Incident Command System

J-I-T-T- Just- In-Time-Training

LD- Learning Disabilities

MCC- Hospital/Medical Command Center

MD- Medical Doctor

NACCRRA- National Association of Childcare Resource & Referral Agencies

NASP- National Association of School Psychologist

NCMEC- National Center for Missing and Exploited Children

NCTSN- The National Child Traumatic Stress Network

NEFRLS- National Emergency Family Registry and Locator System

NOAA- National Oceanic and Atmospheric Administration

NP- Nurse Practitioner

OCCHD- Oklahoma City County Health Department

ODMHSAS- Oklahoma Department of Mental Health and Substance Abuse Services

OK- Oklahoma

OKDHS- Oklahoma Department of Human Services

OSDH- Oklahoma State Department of Health

O.S. - Oklahoma Statutes

PA- Physician Assistant

PALS- Pediatric Advanced Life Support

PIO- Public Information Officer

PNP- Pediatric Nurse Practitioner

PTSD- Post Traumatic Stress Disorder

PVA- Polyvinyl Alcohol

QAST- Quality Assurance Screening Test

RN- Register Nurse

RSV- Respiratory Syncytial Virus

SARS- Severe Acute Respiratory Syndrome

THD- Tulsa Health Department

TV- Television

UN- United Nations

WIC- Women's, Infants, and Children

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3. [Http://www.ARC.org](http://www.ARC.org)- American Red Cross
4. [Http://www.archive.ahrg.gov/prep/nccdreport/nccdrptapf.htm](http://www.archive.ahrg.gov/prep/nccdreport/nccdrptapf.htm) - Agency for Healthcare Research and Quality
5. [Http://www.cdc.org](http://www.cdc.org)- Centers for Disease Control and Prevention
6. [Http://www.crsok.org](http://www.crsok.org) -Infants Crisis Services, Inc.
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