Appendix C -

Shelter Material

Barren River District Health Department Shelter Contact Sheet

Dear Shelter Official:

Barren River District Health Department (BRDHD) is tasked with monitoring and maintaining the public's health. In congregated living situations the risk of spreading communicable diseases is increased due to the exposures some of the shelter residents may have experienced as well as the living conditions they now face. We want to help you in maintaining a safe and healthy living environment until the shelter residents can be placed in more permanent living situations. The following pages* detail some of the primary health issues that you need to be aware of and focused on during the days, weeks, or months to come. First and most importantly, however, if you have any health-related questions or in the case that you suspect a disease outbreak has started in your shelter population, please do not hesitate to contact the individuals listed below:

Primary contact: _____

Phone #: (____) _____ - _____

(____) _____ - _____

Secondary Contact: _____

Phone #: (____) _____ - _____

(____) _____ - _____

If you cannot reach the listed individuals, please do not hesitate to contact us at our 24-hour access number: (270) 202-5785

Especially be alert for symptoms including vomiting, diarrhea, severe rashes, coughing illnesses, and high fevers and let BRDHD know if you are seeing increasing numbers of these.

Thank you for your generous willingness to house those displaced by the _____.
It is through your efforts and generosity that many are being carried through this difficult time.
See Attached: Food Service Guidelines For Emergency Shelters, Infection Control Guideance for Community Evacuation Centers Following Disasters, and Identifying and Preventing TB in Shelters

FOOD SERVICE GUIDELINES FOR EMERGENCY SHELTERS

- All food products must be from an approved commercially prepared source. Home canned foods are prohibited and home prepared foods are discouraged due to unknown sanitary conditions in private homes.
- Wash hands with hot soapy water before handling food and after using the bathroom.
- Always wash hands; wash, rinse and sanitize cutting boards, dishes and utensils after they come in contact with raw meat, poultry and seafood.
- Wash, rinse and sanitize cutting boards, dishes, utensils and counter tops after preparing each food item and before starting on the next food. Proper cleaning and sanitizing may be achieved by washing in hot, soapy water, rinsing in a clear, hot rinse and immersing or spaying with a solution of 5.25% unscented household bleach and water (one tablespoon of bleach per 2 gallons of warm water equals approximately 100 parts per million chlorine). Cleaning may be accomplished using an automatic home dishwasher, but sanitization may not be adequate.
- All fruits and vegetables must be washed prior to slicing, cooking, or serving.
- No smoking in the food preparation, serving and utensil washing areas. Restrict activities of food handlers to food preparation and service functions (to prevent cross contamination, individuals involved in shelter sanitation and diaper changing should not serve as food handlers).
- Consider using paper towels to clean up kitchen surfaces and dispose of immediately. If cloth towels are used, wash them often in the hot cycle of a washing machine.
- Use a different cutting board for each raw meat product or, clean and sanitize between species.
- Never place cooked food on a plate which previously held raw meat, poultry or seafood.
- To assure proper INTERNAL product temperatures, a metal stemmed, dial-type thermometer should be obtained and used. Heat meat, pork and fish to at least 145 degrees F. for 15 seconds; cook poultry to 165 degrees F. for 15 seconds. Heat eggs until yolk and white are firm, 155 degrees F. for 15 seconds.
- When cooking in a microwave oven, make sure there are no cold spots in food where bacteria can survive. Cover food, stir and rotate for even cooking, if there is no turntable, rotate dish by hand once or twice during cooking to achieve an internal temperature of 165 degrees F.
- Keep hot foods hot (140 degrees F.) and cold foods cold (41 degrees or below) during transportation and serving. Serve foods promptly.
- Refrigerate (41 degrees F. or below) or freeze (0 degrees F.) perishables, prepared foods and leftovers within 2 hours. Food not refrigerated within the 2 hours should be discarded. Don't overcrowd the refrigerator. Cool air must circulate to keep food safe.
- Heat leftovers thoroughly to at least 165 degrees F. Divide large amounts of leftovers into small, shallow containers for quick cooling in the refrigerator. Rapid chilling may be achieved by placing food container in an ice bath and stirring; or ice may be added to food as an ingredient to speed cooling.

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 any one else.
- Facilities should be adequate to allow residents to bathe at least twice weekly.
- Laundry facilities should be available to allow appropriate laundering of clothes and bed linens.

Hand Hygiene

After an emergency, it can be difficult to find running water. However, it is still important to wash your hands to avoid illness. It is best to wash your hands with soap and water but, when water isn't available, you can use alcohol hand gels made for cleaning hands. Below are some tips for washing your hands with soap and water and with alcohol hand gel.

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When should you wash your hands or use an alcohol hand gel?

1. Before eating food.
2. After handling uncooked foods, particularly raw meat, poultry, or fish.*
3. After going to the bathroom.
4. After changing a diaper or cleaning up a child who has gone to the bathroom.
5. Before and after tending to someone who is sick.
6. Before and after treating a cut or wound.
7. After blowing your nose, coughing, or sneezing.
8. After handling an animal or animal waste.
9. After handling garbage.

*Food handlers should wash hands with soap and water before beginning work, and before returning to work from any toilet visit or break. Alcohol hand gel should not be substituted in food handlers.

Cleaning the Living Area

Keeping surfaces and items clean helps to reduce the spread of infections to residents and staff.

- Clean surfaces with a household detergent when visibly dirty and on a regular schedule:
  - Kitchens and bathrooms should be cleaned daily and as necessary.
  - Living areas should be cleaned at least weekly and more often if necessary.
  - Bed frames, mattresses and pillows should be cleaned/laundered between occupants.
  - Other furniture should be cleaned weekly and as needed.
  - Spills should be cleaned up immediately.

- Sanitize (i.e., reduce microbial contamination to safer levels) high-risk surfaces using a household disinfectant (e.g., a product with a label stating that it is a sanitizer) or a mixture of 1 teaspoon of household bleach in 1 quart of clean water (mixed fresh daily). High-risk surfaces include:
  - Food preparation surfaces.
  - Surfaces used for diaper changing.
  - Surfaces soiled with body fluid (e.g., vomitus, blood, feces).

Laundry

- Garments heavily soiled with stool should be handled carefully, wearing gloves, and placed in a plastic bag for disposal. If stool can easily be removed using toilet paper, the garment may be laundered as described below.
- Wash clothing in a washing machine using normal temperature settings and laundry detergent.
- Household bleach can be used at normal concentrations.
- Dry clothes completely in a dryer.
- There is no need to disinfect the tubs of washers or tumblers of dryers if cycles are run until they are completed.
- Make sure donated clothing is washed before distribution.

Garbage

- Waste disposal should comply with local requirements including disposal of regulated medical waste such as syringes and needles.
- Facilities should provide for proper disposal of syringes and needles used for medications. Containers designed for sharp waste disposal should be placed where sharp items are used. A heavy plastic laundry detergent bottle with a lid may be used if official sharps containers are not available.
- Use trash receptacles lined with plastic bags that can be securely tied shut.
- Trash bags should not be overfilled.
- Place trash in an area separated from the living spaces, preferably in trash bins.
- Have waste pick-ups scheduled frequently—daily, if possible.
- Separate medical waste from household waste for pickup; follow local guidelines for pickup of medical waste.

Special Considerations for Non-Residential Evacuation Centers

Non-residential evacuation centers such as stadiums and churches have limited capacity for providing sanitary and food preparation facilities. Bathing and laundry resources are also likely to be limited. In general, it is preferable for non-residential facilities to be used only for very short-term evacuation. Food-service and laundry should be provided from external sources rather than attempting to set up poorly controlled on-site alternatives or allowing residents to attempt these activities individually.

Because of the potentially high ratio of residents to toilets, non-residential facilities have a particular need for frequent and supervised cleaning and maintenance of sanitary facilities. Designated evacuation center personnel should staff each restroom, controlling the number of individuals using the facility at one time, ensuring that surfaces are wiped down with disinfectant at least hourly, and that basic supplies such as hand soap, paper towels, and toilet paper are maintained.

The ability to clean surfaces in non-residential settings may be limited by the size or other physical characteristics of the facility. This increases the importance of hand hygiene. However, such facilities are also likely to have limited availability of hand washing sinks. Thus, additional attention should be paid to positioning alcohol hand gel dispensers in convenient locations throughout the living areas and at the beginning of food service lines, and ensuring that all arriving residents are instructed on their use and availability.

Open sleeping areas should be set up to prevent crowding, ideally with at least 3 feet separating each cot from the next.

Management of Persons with Infectious Diseases in Evacuation Centers

The arrival of evacuees who may have open wounds, symptomatic infections, and unrecognized or incubating infectious diseases, combined with potential for crowding and limited sanitary infrastructure, increases the risk of infections spreading among residents and between residents and staff. In particular, respiratory infections, diarrheal diseases and skin infections or infestations are prone to spread under these conditions. Before entering an evacuation center, all residents should be screened for the following conditions:

- Fever
- Cough
- Skin rash or sores
- Open wounds

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- Vomiting
- Diarrhea

Persons with any of the above conditions should be admitted to the evacuation center only after appropriate medical evaluation and care. Residents of the center should be instructed to report any of the above conditions to the center staff. If a potentially infectious condition is identified in a person already residing at the evacuation center, the ill individual(s) should be separated from other residents or transferred to a special needs evacuation center (see below). A separate area or room should be identified in advance to be used to house potentially infectious residents awaiting evaluation or transfer. If several residents with similar symptoms are identified, they may be housed together in one area. However, cots should still be separated by at least 3 feet. A dedicated restroom should be identified if possible and reserved for use of the ill individuals only. More than one separate area may be needed if more than one illness is identified in the population, e.g., an area for people with diarrhea, and another area for people with a cough and fever. Such separate areas will need to have extra staff members dedicated to monitoring people housed there and ensuring that the area is kept clean and appropriately supplied.

Staff members with any of the above symptoms should not work in the evacuation center, but should seek medical evaluation for assessment and clearance prior to returning to work. Staff members working with residents who have symptoms of illness should use Standard Precautions (defined below) for any interactions that require potential contact with body fluids, and should place particular emphasis on hand hygiene.

Each evacuation center should have a clear plan for transferring individuals with potentially communicable diseases from the evacuation center to an appropriate healthcare facility. This includes plans for having ill individuals with respiratory symptoms wear a paper mask while awaiting evaluation or transfer. A waiting area should be designated that is separate from the main center living areas, but which can be closely monitored by center staff. A system for identifying and notifying the receiving facility must be in place.

Special-Needs Evacuation Centers

Special-needs evacuation centers are places that can provide safe refuge to those individuals who require supervision by a healthcare professional. They include:

- People with minor health or medical conditions that require professional observation, assessment, and maintenance beyond the capabilities of the general evacuation center staff or facility.
- People with infectious diseases whose care requires protective equipment or isolation that are not available at the general evacuation center.
- People who require assistance with activities of daily living or more skilled nursing care but do not require hospitalization.
- People who need medications or monitoring by health professionals.

Standard Precautions* should be used whenever working with ill individuals, to protect residents and staff from exposure to recognized and unrecognized sources of infection.
Transmission-Based Precautions, including personal protective equipment (e.g., gloves, masks, and gowns) and isolation of ill individuals in separate rooms or areas, are based on the type(s) of symptoms an ill individual has. These precautions should be used when appropriate in the special-needs evacuation center. If possible, special-needs evacuation center staff should have access to healthcare personnel who are trained in infection control.

Detailed guidance for Standard and Transmission-based Precautions can be found at http://www.cdc.gov/ncidod/dhqp/gl_isolation.html.

***Standard Precautions** (summary):
During the care of any ill individual, personnel should:

- Wear gloves if hand contact with blood, body fluids, respiratory secretions or potentially contaminated surfaces is expected.
- Wear a disposable gown if clothes might become soiled with a patient's blood, body fluids or respiratory secretions.
- Change gloves and gowns after each patient encounter and wash hands or use alcohol hand gel immediately after removing gloves.
- Wash hands or use alcohol hand gel before and after touching a patient, after touching the patient's environment, or after touching the patient's respiratory secretions, whether or not gloves are worn.
- When hands are visibly dirty or contaminated with respiratory secretions, wash hands with soap (either plain or antimicrobial) and water.

Related Links:

- Keep Food and Water Safe after a Natural Disaster or Power Outage (http://www.bt.cdc.gov/disasters/foodwater.asp)
- Cooking for Groups: A Volunteer's Guide to Food Safety (http://www.fsis.usda.gov/OA/pubs/cfg/cfg.htm#contents)
- Cover your cough information and posters (http://www.cdc.gov/flu/protect/covercough.htm)

For more information, visit www.bt.cdc.gov/disasters,
or call CDC at 800-CDC-INFO (English and Spanish) or 888-232-6348 (TTY).

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Identifying Persons in Your Mass Patient Care System/Shelter Who May Have TB

In your mass patient care system/shelter, you should actively assess two groups of persons:

- Persons who were under treatment for TB
- Persons who currently have symptoms of active TB disease

To assess these persons, you should ask the following questions:

1. Were you taking medicine for TB just before coming to the shelter? (If yes, go directly to **Management of Persons Who Were Under Treatment for TB**. If no, proceed with questions 2-5.)

2. Have you coughed up any blood in the last month?

or

3. Do you have a cough that produces mucous that has lasted for at least 2 weeks?

and

4. Have you felt feverish or had chills or profuse sweating (night sweats) for more than one or two weeks?

and

5. Have you lost a lot of weight recently? More than 10 pounds?

(If the person answer "yes" to question 2 or answers "yes" to each of the questions 3, 4, and 5, proceed to **Management of Persons with Symptoms of TB Disease.**)

Management of Persons Who Were Under Treatment for TB <u>BEFORE</u> coming to the shelter:

Suggested questions to ask persons who are identified as being treated for TB before coming to the shelter:

- Did you **take any medicine** for your tuberculosis?
    - When did you start this medicine? When did you stop? Are you out of medicine?
    - Do you remember the names of the pills? *(If they can't remember, try asking how many different types of pills they were taking for TB.)*
    - Who was giving you the medicine? (Did you go to the health department or pharmacy, or did someone come to you and give you each individual dose?)
- **When** was this diagnosis made?
    - Do you remember if you had to cough up sputum (phlegm from deep inside your lungs) into a cup for your doctor/nurse to send to the lab? *(This would be part of work-up for TB disease.)*
- **Who** prescribed your TB medicine?
    - **Very important: Try to get name/contact info for health department or private provider who prescribed anti-TB treatment (or at least get the county/parish in which person lived).**

- For persons whom you suspect as being under treatment for TB disease (not latent TB infection), immediate action is needed. This includes anyone in your shelter who was taking more than one medicine for TB or was receiving directly observed treatment for this disease. You should immediately notify the state TB Control Office, (502) 564-4276
    - Please be prepared to provide patient name, date of birth, state of origin. This basic information is needed to make contact with the referring state to obtain medical history.

<u>Management of Persons with Symptoms of TB Disease:</u>

If anyone in your shelter has symptoms of TB disease (that is, if the person answer "yes" to question 2 or answers "yes" to each of the questions 3, 4, and 5 above), a thorough medical evaluation is in order.

If BRDHD determines that a person with TB was potentially contagious while staying in the shelter, a contact investigation will be needed. This is the process for identifying persons who may have been exposed to this infectious disease and providing any needed follow-up care. The contact investigation is done by BRDHD in cooperation with the shelter staff.

Additional Measures You Can Take to Prevent the Spread of TB

TB is spread when people with TB in their lungs cough or sneeze. Keep plenty of tissues on hand and offer them to clients and staff to cover their cough. Open windows and turn on fans. Fresh air and sunlight will kill the TB germs. **But most importantly, contact your state or local TB program if you suspect someone has TB disease.**

Background Information on Tuberculosis (TB)

What is TB?

Tuberculosis (TB) is a disease caused by bacteria called *Mycobacterium tuberculosis*. The bacteria usually attack the lungs. But, TB bacteria can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal. TB disease was once the leading cause of death in the United States.

TB is spread through the air from one person to another. The bacteria are put into the air when a person with active TB disease of the lungs or throat coughs or sneezes. People nearby may breathe in these bacteria and become infected.

However, not everyone infected with TB bacteria becomes sick. People who are not sick have what is called latent TB infection. People who have latent TB infection do not feel sick, do not have any symptoms, and cannot spread TB to others. But, some people with latent TB infection go on to get TB disease.

People with active TB disease can be treated and cured if they seek medical help. Even better, people with latent TB infection can take medicine so that they will not develop active TB disease.

How is TB spread?

TB is spread through the air from one person to another. The bacteria are put into the air when a person with active TB disease of the lungs or throat coughs or sneezes. People nearby may breathe in these bacteria and become infected.

When a person breathes in TB bacteria, the bacteria can settle in the lungs and begin to grow. From there, they can move through the blood to other parts of the body, such as the kidney, spine, and brain.

TB in the lungs or throat can be infectious. This means that the bacteria can be spread to other people. TB in other parts of the body, such as the kidney or spine, is usually not infectious.

People with active TB disease are most likely to spread it to people they spend time with every day. This includes family members, friends, and coworkers.

The Difference Between Latent TB Infection and Active TB Disease	
A Person with Latent TB Infection (LTBI)	**A Person with Active TB Disease**

• Has no symptoms
• Does not feel sick
• Cannot spread TB to others
• Usually has a positive skin test
• Has a normal chest x-ray and sputum test
 	
May be taking medication to treat this condition (either isoniazid [INH] for 6-9 months or rifampin for 4 months)—these doses are usually self administered
	• Has symptoms that may include:
	  • a bad cough that lasts longer than 2 weeks
	  • pain in the chest
	  • coughing up blood or sputum
	  • weakness or fatigue
	  • weight loss
	  • no appetite
	  • chills
	  • fever
	  • sweating at night
	• May spread TB to others
	• Usually has a positive skin test
	• May have an abnormal chest x-ray, or positive sputum smear or culture
	
	Usually treated with four medicines (isoniazid, rifampin, pyrazinamide, and ethambutol) for at least 2 months, then isoniazid and rifampin for at least another 4 months—these doses are typically administered under directly observed therapy (DOT) by a health department worker

Shelter Resident Letter

Dear Shelter Resident:

Welcome to the Shelter! We are glad that you have reached our region safely. As the local health agency for this area, the Barren River District Health Department can help you make the proper contacts with various health and social service programs.

Staff from the Health Department will be visiting your facility shortly. Because you are now living with a large group of people, you may be more easily exposed to illnesses. The Health Department will work with the shelter operators and residents to make sure that you don't get sick while you are staying in the shelter. Please watch for symptoms of illness such as vomiting, diarrhea, severe rashes, cough and fever. If you or someone near you has one of the above symptoms, please tell a shelter official right away. The Health Department will also be monitoring for illnesses as well as monitoring food preparation and sanitation.

If you have any other health concerns, please do not hesitate to contact the Health Department at any time. A 24-hour information line is available to you by calling PHONE NUMBER_____. We are here to assist you while you are in our area.

Sincerely,

NAME

TITLE

Barren River District Health Department

Cabinet for Health and Family Services
Kentucky Helps System (Medical/Needs Assessment Form)

KHELPS

Department for Public Health
Evacuation Shelter Medical and Needs Assessment

This form is meant to be used in conjunction with the KHELPS Displaced Person Intake form for those identified with health, medication, psychological or other needs. The purpose of the Medical and Needs Assessment Form is to:

1) Provide shelter operations personnel information on who may need medical follow-up or special accommodations and
2) Provide the Kentucky Department for Public Health and local health departments with information we need to help meet the medical and psychological needs of the evacuees.

The form may be filled out by the evacuee or a family member, but a trained lay person should be available to assist. If a trained person (e.g., nurse, EMT, medical records or trained lay person) is available to oversee the completion of the form, then more complete and accurate information will be available.

At some point soon after the completion of the form, the information should be reviewed by health staff to determine special accommodations for shelterees such as equipment and medication needs or transfer to another facility like a hospital or special needs shelter.

The third page of the form is to be used by health staff in documenting further assessment and follow-up when the shelteree is ill or needs further assessment/evaluation.

Medical and Public Health Needs Assessment

Shelter Name: _____ **City:** _____

Last Name: _____ First Name: _____ MI: ___ Age: _____ SS #: _____

Race: _____ Marital Status: _____ Sex: ___ Cell phone: (___) _____

Home City _____ Home State _____ Home Zip: _____

Are you sick? Yes ☐ No ☐

***If yes,* (Check all the symptoms you have):**

☐ Fever ☐ Chills ☐ Cough ☐ Productive Cough ☐ Night Sweats ☐ Open wounds
☐ Coughing up blood ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Rash ☐ Dehydration
☐ Puncture Wound/Bite ☐ Broken Bones ☐ Other: _____

Comments: _____

Who else is staying with you at the shelter?

Name (first, middle initial, last)	Relationship Age	Sex

Do you have someone we can contact in case of an emergency: Yes ☐ No ☐

If yes: Name: _____ Phone: _____

Address: _____ City/St/Zip _____

CURRENT MEDICAL SITUATION

Were you exposed to "untreated" or "dirty" water at any time since the hurricane? Yes ☐ No ☐

If yes: Type of exposure: Drank ☐ Waded/walked in ☐ Submerged/partially submerged ☐

Did you come from a previous shelter or temporary housing situation? Yes ☐ No ☐

If yes: Location _____ _____
Name of Facility *City and State*

Can you walk without help? Yes ☐ No ☐ *If No:* Cane ☐ Walker ☐ Wheelchair ☐ Bedridden ☐

If bedridden can you be moved in a wheelchair? Yes ☐ No ☐

What are your transportation needs Ambulance ___ Van w/lift ___ Assistance walking ___
Regular car or van Other:

Check if you have any of the following immediate medical needs:

Foot care/podiatry _____ Dental care _____

Joint/bone pain _____ Vision care _____

Name of personal Doctor or Clinic: _____ Phone: (___) _____

Office Location (City and State):

MEDICAL INFORMATION (Check all disabilities/conditions that you may have)

__AIDS/HIV
__Anemia
__Anxiety / Nerves
__Arthritis, Severe
__Asthma
__Back Injury
__Blind (Guide Dog? Y N)
__Breathing Impaired
__Cancer
__Complete Paralysis
__Diabetes ____ Oral ____ Insulin
__Drug Dependency
Alcohol____ Other _____

___ Electrically dependent life support
___Hearing Impaired
___Heart Condition
___Hepatitis (circle all types that apply:
A B C D E)
___Hypertension (High Blood Pressure)
___Incontinence
___Kidney disease:
Dialysis Yes No
___Memory Impairment
___Ostomy
___Oxygen Supported: L/Min. ____
Tank ____ O2 Converter ___

__Partial Paralysis
__Pregnant
__Pulmonary Disease
__Psychological Disorder
Describe_____
__Seizures
__Skin Disease/Rash
__Transplant Recipient:
Describe_____
__Tuberculosis ____ Active Disease
____ Skin test positive only
__Wound

Other:

List any significant family history of medical conditions (e.g. heart disease, diabetes, asthma, psychiatric):

_____ _____

_____ _____

_____ _____

Have you had any recent Operation(s)? Yes ☐ No ☐
If Yes, when and what type of operation

IMMUNIZATION HISTORY:

Have you had a Tetanus shot in the last five years? Yes ☐ No ☐ Unknown ☐

Have you had a Hepatitis A vaccination? Yes ☐: *How many* No ☐ Unknown ☐

Have you had a Hepatitis B vaccination? Yes ☐: *How many* ___ No ☐ Unknown ☐

Have you had a Meningococcal vaccination? Yes ☐: *How many* ___ No ☐ Unknown ☐

Have you had a vaccination in the last month? Type(s):_____

Have you had a flu vaccination this year? Yes ☐: *Month* No ☐ Unknown ☐

CURRENT MEDICATIONS:

Pharmacy Name: _____ Location (City & State)_____

Please list all medications that you are currently taking:

Name/Type	Amount/ Dosage How often	Do you have any?			Prescription Bottle Number (If Known)
		Yes	How many	No	

CARE AND TREATMENTS:

What medical/psychological care or treatment are you currently receiving (be specific)	How often?

LIST ANY ALLERGIES (Medicine, Food, or Other)

Do you have special dietary needs? Yes ☐ No ☐
If Yes, list them:

RELEASE OF INFORMATION

I, _____, GIVE MY AUTHORIZATION FOR THE MEDICAL INFORMATION CONTAINED HEREIN TO BE RELEASED TO THE APPROPRIATE HEALTH AUTHORITY. I UNDERSTAND THAT THIS INFORMATION WILL BE USED SOLELY FOR THE PURPOSE OF EVALUATING MY NEEDS IN A TIME OF PRESIDENTIALLY DECLARED STATE OF EMERGENCY AND WILL BE MAINTAINED AS CONFIDENTIAL. I PROVIDE THIS INFORMATION ON A VOLUNTARY BASIS.

SIGNATURE: _____ DATE: _____/_____/_____

WITNESS: _____ DATE: _____/_____/_____

Medical Assessment

Shelter Name: _____ **City:** _____

Name: _____ Birth date: _____ Age: ____ SS #: _____

Race: _____ Sex: _____ City/State/Zip: _____ Cell phone: (_____) _____

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL:

VITAL SIGNS: T _____ **P** _____ **R** _____ **B/P** _____

Referred to: _____ **Date:** _____

Reason: _____

What was done to address current illness/condition(s):

Additional Comments:

_____ **Date:** _____

Health Care Professional Signature and Title

Discharge Date:
Discharged to: _____ other shelter _____ hospital _____ family residence other: _____
Name (shelter/hospital/family member): _____
Address: _____
City/State/Zip: _____
Telephone: (_____) _____

Natural Disaster Morbidity Report Form

For Active Surveillance in Shelters with Medical Staff

Form v1.6
Revised 09/02/2008

Part I: Visit Information	Location & Name of Facility	2-Letter State	Date of Visit	Time of Visit	Encounter: (circle one)
					First Visit Follow-up

Part II: Patient Information	Unique Identifier / Medical Record Number	Age	Sex	Pregnant	If pregnant, due date
				☐ Yes	

Race / Ethnicity ☐ White ☐ Black/African American ☐ Hispanic or Latino ☐ Asian ☐ Unknown

Part III: REASON FOR VISIT (Please check all categories related to patient's current reason for seeking care.)

☐ **INJURY**
- ☐ Bite/Sting
  - ☐ Animal
  - ☐ Insect
  - ☐ Snake
- ☐ Burn
  - ☐ Chemical
  - ☐ Fire, hot object or substance
  - ☐ Sun exposure
- ☐ Cold-related (e.g., hypothermia)
- ☐ Cut
  - ☐ Debris
  - ☐ Machinery (e.g., chainsaw)
- ☐ Drowning/Submersion
- ☐ Electrocution
- ☐ Fall **specify:**
  - ☐ From height
  - ☐ Same level
- ☐ Foreign Body (e.g. in eye, splinter)
- ☐ Heat-related
- ☐ Hit by object
- ☐ Poisoning **specify:**
  - ☐ CO exposure
  - ☐ Inhalation of fumes, dust, or gas
  - ☐ Ingestion
- ☐ Vehicle collision **specify:**
  - ☐ Driver/occupant
  - ☐ Pedestrian
- ☐ Violence / assault **specify:**
  - ☐ Sexual assault
  - ☐ Suicide / self-inflicted injury
  - ☐ Other assault
- ☐ Undetermined, nonspecific

☐ **ACUTE ILLNESS / SYMPTOMS**
- ☐ Abdominal Pain
- ☐ Cardiac emergency (e.g., pain, arrest)
- ☐ Conjunctivitis / eye irritation
- ☐ Dehydration
- ☐ Fever (i.e., >100.4°F or 36°C)
- ☐ Gastrointestinal **specify:**
  - ☐ Nausea / vomiting
  - ☐ Bloody diarrhea
  - ☐ Watery diarrhea
- ☐ Headache or migraine
- ☐ Jaundice
- ☐ Meningitis / encephalitis
- ☐ Musculoskeletal pain (including joint, back)
- ☐ Neurological (e.g., altered mental status or confused / disoriented, syncope, stroke)
- ☐ Oral / dental pain
- ☐ Respiratory **specify:**
  - ☐ Cough **specify:**
    - ☐ Dry
    - ☐ Productive
    - ☐ With blood
  - ☐ Wheezing in chest
  - ☐ Pneumonia, suspected
  - ☐ Shortness of breath, difficulty breathing
- ☐ Dermatologic **specify:**
  - ☐ Rash
  - ☐ Infection
  - ☐ Infestation (e.g., lice, scabies)
- ☐ Sore throat
- ☐ Urinary pain (e.g., U.T.I.)

☐ **EXACERBATION OF CHRONIC DISEASE**
- ☐ Cardiovascular **specify:**
  - ☐ Hypertension
  - ☐ Congestive heart failure
- ☐ Diabetes
- ☐ Immunocompromised (e.g. HIV, lupus)
- ☐ Respiratory **specify:**
  - ☐ Asthma
  - ☐ COPD
- ☐ Seizure

☐ **MENTAL HEALTH**
- ☐ Affective symptoms (e.g. overly anxious or depressed)
- ☐ Drug/alcohol intoxication or withdrawal
- ☐ Psychological evaluation
- ☐ Suicidal thoughts or ideation
- ☐ Violent behavior / threatening violence

☐ **OBSTETRICS / GYNECOLOGY**
- ☐ Complication of pregnancy (e.g. premature bleeding, abdominal pain, fluid leakage)
- ☐ GYN condition not associated with pregnancy or post-partum period
- ☐ In labor with/without complication
- ☐ Routine pregnancy check-up

☐ **OTHER**

☐ **ROUTINE / FOLLOW-UP**
- ☐ Medication refill
- ☐ Vaccination
- ☐ Blood sugar check
- ☐ Wound care
- ☐ Blood pressure check

Part V: WORKER/VOLUNTEER STATUS INFORMATION

☐ Did condition occur as a result of work (paid or volunteer) involving disaster response ore restoration efforts?

Occupation / response role

Activity at time of injury/illness

Part IV: DISPOSITION (circle one)

Discharge to self care

Refer to other care (e.g. clinic, physician)

Admit/refer to hospital

Left before being seen

Died

Aggregate Natural Disaster Morbidity Report Form

For Reporting Purposes

Submit completed form daily to KY Department for Public Health Operations Center via email (CHFSDPHDOC@ky.gov), Phone (888-398-0013) or Fax (502-564-0477)

Kentucky

Form v1.6
Rev.11/10/2007

CDC

Part I FACILITY INFORMATION

LOCATION:

STATE | ZIPCODE | NAME OF FACILITY

REPORTING PERSON/CONTACT:

PHONE | NAME

FAX | EMAIL

Part II REPORTING PERIOD

START: MONTH DAY YEAR HOUR AM PM

END: MONTH DAY YEAR HOUR AM PM (CIRCLE)

TOTAL SHELTER POPULATION AT START:

Part III PERSONS SEEN OR TREATED

TOTAL SEEN OR TREATED DURING CURRENT REPORTING PERIOD:

RACE / ETHNICITY	White	
	Black/African American	
	Hispanic or Latino	
	Asian	
	Unknown	
AGE	≤ 1 years	
	≥ 65 years	
	Pregnant females	

TOTAL REFERRED TO HOSPITAL:

Part IV TREATED PATIENTS

▶ Use categories that best describe patients' **current** reasons for seeking care. Complete the **Total** patient tallies for each syndrome category in the column to the right. Be as specific as possible. A single patient may be counted more than once.

SYNDROME CATEGORY	TOTAL
Injury – Total	
Unintentional injury (e.g., fall, burn, bite/sting, cut, foreign body, vehicle collision, poison-not CO)	
CO poisoning	
Violence / assault (e.g., sexual or other)	
Suicide / self-inflicted injury	
Cold- or heat-related illness	
Injury–*not specified above*	
Gastrointestinal illness – Total	
Nausea / vomiting	
Bloody diarrhea	
Watery diarrhea	
Respiratory Illness – Total	
Cough	
Pneumonia, suspected	
Shortness of breath or difficulty breathing	
Wheezing in chest	
Dermatologic Illness - Total	
Rash	
Infection	
Infestation (e.g., lice or scabies)	
Other Illness - Total	
Fever (i.e., >100.4°F or 38°C)	
Jaundice/viral hepatitis, suspected	
Meningitis/encephalitis, suspected	
Other illness – *not specified above*	

SYNDROME CATEGORY	TOTAL
Management of chronic disease – Total	
Cardiovascular disease	
Diabetes	
Immunocompromised	
Respiratory	
Seizure	
Mental Health – Total	
Affective symptoms	
Drug / alcohol intoxication or withdrawal	
Psychological evaluation	
Suicidal thoughts or ideation	
Violent behavior / threatening violence	
Obstetrics/gynecology – Total	
Complication of pregnancy	
GYN condition not associated with pregnancy or post-partum period	
In labor	
Routine pregnancy check-up	
Routine / follow-up care – Total	
Blood pressure check	
Blood sugar check	
Wound care	
Medication refill	
Vaccination	
OTHER REASON FOR VISIT, not listed above	

Immediate Needs Identified?
† Yes † No

Kentucky Department for Public Health
Environmental Surveillance Form for Shelters
Completed forms should be faxed to: DPH Operation Center
Fax: 502-696-1882

I. ASSESSING AGENCY Date: ___/___/___
Name of Inspector: _____ Inspector ID:_____ Phone: (_____)-_____-_____

PERMITTED FOOD FACILITIES:
Number affected due to situation: _____ Estimated time to recovery: _____ Number still in operation: _____

II. FACILITY IDENTIFICATION
Shelter Name: _____ Street Address: _____ City: _____
County Name or Number:_____

Name of Shelter Manager: _____ Phone: (___) _____ - _____
Name of Environmental Manager: _____ Phone: (___) _____ - _____
Name of Medical Station Contact: _____ Phone: (___) _____ - _____
Shelter Sponsoring/Managing Agency: _____

Type of Facility: School ____ Church ____ Convention/Arena/Expo Center ____ Other _____

Food Preparation: † **On-Site:** † **Off-Site** **Off-Site Preparation Location**_____

Water:† Municipal† Private **Sewage:**† Municipal† Private **Refuse Disposal:**† Municipal† Private
If private, type: _____ If private, type:_____

III. CENSUS
≤ 2 yrs _____ 3-17 yrs _____ 18-64 yrs _____ ≥ 65 yrs _____ Total of all age groups _____

Please mark ONLY those items needing correction or immediate attention with an "X" in the center column

IV. FACILITY	X	Immediate Needs / Comments
Structural damage (Roof, Walls, Windows, etc)		
Security/Law enforcement adequate		
Identification required for entry		
All outside doors adequately secured		
Adequate ventilation		
HVAC system operational		
Hot water available		
Electricity available		
Adequate space per person (30 ft²/person)		
Presence of pest /vector issues		
Acceptable level of cleanliness		
Designated smoking area		
Handicap accessibility		
V. FOOD SERVICE DEFICIENCIES		
Approved/Safe food source		
Safe food handling/prep		
Clean kitchen/prep area		
Adequate food holding temperatures (≤41°F or >135°F)		
Refrigeration adequate (≤41°F)		
Food storage separate from chemicals		
Dishwashing facilities available		
Mop sink/utility sink available		
Adequate hand washing station		
Adequate formula preparation & bottle cleaning area		
Clean baby food/bottle prep area		
VI. DRINKING WATER		
Approved/safe water source		
Adequate water supply (15 liters/person/day)		
Ice from approved source, protected from contamination		
Distilled water to prepare baby formula		
VII. WASTE WATER/SEWAGE		
Sewage system accessible & operational		
Portable Units: pumping & cleaning schedule		
Adequate ventilation		
Adequately cleaned		

Shelter Name_____ Date____/____/____

Handwashing facilities provided for portable units		

VIII. SANITATION	X	Immediate Needs / Comments
One hand washing station /20 persons		
One toilet/ 20 persons		
One shower/ 20 persons		
Acceptable level of cleanliness		
Adequate laundry services		
Covered containers in female toilets		
Adequate supply of toilet supplies		
Adequate hand towels		
Toilets maintained according to schedule		
Adequate diapering areas (one per 12 infants, clean)		
Adequate handicap facilities		
Adequate cleaning supplies		
IX. SOLID WASTE		
Approved waste containers		
Adequate number of waste containers		
Approved disposal		
Timely removal of trash and debris		
Adequate storage		
Storage area maintained, debris accumulation prevented		
X. SLEEPING AREA		
Separate area for families		
Adequate number of cots/beds/mats		
Adequate spacing of cots/beds/mats (2ft bed-to-bed, 6ft head-to-head)		
Adequate supply of bedding (one set per cot)		
Bedding changed according to schedule		
Acceptable level of cleanliness		
XI. HEALTH/MEDICAL CARE Yes ☐ No ☐ (If "No" skip this section)		
Type of medical services available		
Adequate handwashing station, accessible & nearby		
Medical supplies separate from food & chemicals		
Separate refrigeration for medicine		
Adequate security for medical supplies		
Biohazard bags & sharps containers available		
Acceptable level of cleanliness		
Adequate security for entry to patient areas		
XII. CHILDREN'S AREA Yes ☐ No ☐ (If "No" skip this section)		
Hand washing required for children & adults before entering & after leaving play area		
Provided toys easily cleaned, do not pose a choking hazard		
Toys cleaned/disinfected 3X daily		
Adequate child/caregiver ratio		
Adequate monitoring for security		
Acceptable level of cleanliness		
XIII. COMPANION ANIMALS PRESENT Yes ☐ No ☐ (If "No" skip this section)		
Animal care available		
Designated animal area		
Acceptable level of cleanliness		
Adequate food and water		
Adequate security for safety of animals		

Refer questions about the form or assessment procedures to:
Division of Public Health Protection & Safety
Phone # on Weekends: (502) 564-5459
Mon-Fri: (502)-564-7398

Environmental Surveillance Form

Health Shelter Assessment Form Instruction Sheet

immediate needs are present

I. ASSESSING AGENCY DATA

- Date Assessed: self-explanatory.
- Assessor Name/Title: self-explanatory
- Assessor ID: self-explanatory.
- Assessor Phone contact: self-explanatory.

II. FACILITY TYPE, NAME and DATA

- Location Name and Description. Example: "Rockville Elementary School - brown building next to the police station."
- Street Address: self-explanatory.
- City/County: self-explanatory.
- Shelter Manager: name and phone of responsible contact person, such as a facility manager or designated person in charge, and his or her title.
- Environmental Manager: name and phone of responsible contact for environmental issues.
- Medical Station: name and phone of responsible contact person for medical station
- Shelter Sponsoring Agency: Red Cross, etc.
- Type of Host Facility: School, Church, Arena, Convention Center, or Other
- Water Source, Sewage type and Refuse Disposal (municipal or private)

III. CENSUS

- Current Census: estimated number of persons, including workers, in shelter at the time of inspection.

IV. FACILITY

- Structural damage: note damage to physical structure (e.g., roof, windows, walls, etc).
- Security/law enforcement adequate: security guards or police officers available at facility site.
- Identification required for entry: self-explanatory
- Adequate ventilation: facility well-ventilated and free of air hazards such as smoke, fumes, etc.
- HVAC system operational: self-explanatory.
- Hot water available: self-explanatory.
- Electrical grid system operational: self-explanatory.
- Adequate space per person in sleeping area:
  - evacuation shelters, 20 ft² per person;
  - general shelters, 40 ft² per person;
  - special needs shelters, 60–100 ft² per person.
- Free of pest/vector issues: note presence of mosquitoes, fleas, flies, roaches, rodents, etc.
- Acceptable level of cleanliness: self-explanatory.
- Designated smoking area: self explanatory.
- Handicap accessibility: ADA Compliant.

V. FOOD

- Adequate supply: self-explanatory. Safe food source: source of the food from a licensed contractor or caterer.
- Preparation on site: self-explanatory.
- Safe food handling: food preparers are using gloves, avoiding cross contamination, using appropriate utensils, etc. – refer to local code.
- Clean kitchen area: self-explanatory.
- Appropriate temperatures: hot food kept above 135 ºF; cold food kept at or below 41 ºF. Or refer to local code or US Food Code.
- Appropriate storage: Adequate refrigeration to maintain food ≤41°F.
- Proper dishwashing facilities: Wash, rinse and sanitize.
- Dishwashing facilities available: place to wash, rinse and sanitize kitchen utensils and cooking equipment.
- Hand-washing facilities available: fixed or portable, as long as they are operational.
- Clean formula preparation and bottle cleaning area.

VI. DRINKING WATER AND ICE

- Safe water from an approved source.
- Adequate water supply: drinking water in the range of 1–2 gallons/per person/per day, for all uses 3-5 gallons/per person/per day.
- Safe ice from an approved source (permitted facility outside affected area) and protected from contamination.
- Distilled water provided for baby formula preparation: self-explanatory.

VII. WASTE WATER / SEWAGE

- Sewerage system accessible and operational: self-explanatory.
- Portable Units: Pumped and cleaned according to a set schedule.
- Adequate ventilation: bathrooms and portables well-ventilated and free of odors.
- Adequately cleaned: self-explanatory.
- Handwashing facilities provided for portable units: self-explanatory
- Mop sink/utility sink: self-explanatory.

VIII. SANITATION

- Adequate number of operational hand-washing stations: 1 per 20 persons.
- Adequate number of operational toilets: minimum 1 per 20 persons or as specified by sex.
- Adequate number of operational showers/bathing facilities: 1 per 20 persons.
- Acceptable level of cleanliness: self-explanatory.
- Adequate laundry services: provided with separate areas for soiled and clean laundry.
- Covered containers provided in female toilets.
- Toilet supplies available: toilet paper, feminine hygiene supplies, and diapers/pads for children and adults.
- Hand-washing supplies available: water, soap, and paper towels
- Toilets cleaned according to schedule: self-explanatory.
- Adequate diapering areas: 1 diapering station per 12 infants, covered waste containers, disposable cleaning wipes and surface coverings, & instructions for cleaning the station posted by the changing tables.
- Adequate handicap facilities: ADA compliant.
- Adequate cleaning supplies: self-explanatory.

IX. SOLID WASTE GENERATED

- Appropriate disposal and labeling in approved containers.
- Adequate collection receptacles: minimum 1 (30-gal) container for every 10 persons.
- Approved disposal: self-explanatory
- Timely removal of waste – collected regularly.
- Appropriate storage and separation from common areas.
- Storage area maintained: self-explanatory.

X. SLEEPING AREA

- Separate area for families: self-explanatory.
- Adequate cots/beds/mats for each resident/staff (2' bed to bed and 6' head to head).
- Adequate bedding for each cot, bed, or mat: self-explanatory.
- Clean bedding available: self-explanatory.
- Acceptable level of cleanliness: self-explanatory.

XI. HEALTH/MEDICAL

- Medical care services available: list type of care available in comments section. (?)
- Adequate handwashing stations available: self-explanatory
- Medical supplies separate from food and chemicals: self-explanatory.
- Adequate security for medical supplies: narcotics in a locked cabinet.
- Biohazard bags and sharps containers available: self-explanatory.
- Acceptable level of cleanliness: self-explanatory.
- Adequate security for entry to patient area: self-explanatory.

XII. CHILDCARE AREA

- Play area provided: self-explanatory.
- Hand-washing facilities available: for adults and children with paper towels, soap, and water.
- Toys easily cleaned and do not pose a choking hazard: self-explanatory.
- Adequate toy hygiene: toys cleaned (3X per day) with a nontoxic, approved disinfectant.
- Adequate child/caregiver supervision ratio:
  - a. <12 months (5:1),
  - b. 12–24 months (6:1),
  - c. 2-3 years (10:1),
  - d. 3-4 years (12:1),
  - e. 4–5 year olds (14:1),
  - f. 5–7 year olds (15:1),
  - g. 7 and older years (20:1).
  - Per 902 KAR 2:120
- Adequate monitoring or security: self-explanatory.
- Acceptable level of cleanliness: self-explanatory.

XIII. COMPANION ANIMALS

- Companion animals present: animals in facility.
- Animal care available: animals have clean, fresh water and food.
- Designated animal area: animals located away from people and separately housed.
- Acceptable level of cleanliness: self-explanatory.
- Adequate food and water: self-explanatory.
- Adequate security for safety of animals:

June 2014

Disaster-related Mortality Surveillance Form .Complete one form per decedent

Complete the form for all known deaths related to a disaster: This information should be obtained from a medical examiner, coroner, hospital, funeral home or DMORT (Disaster Mortuary Team) office. Please, complete one form per decedent.

Form v1.1
Rev.03/ 21/ 2007

Part I General information

1.Type of disaster:
☐ Hurricane (name_____) ☐ Heat wave
☐ Tornado ☐ Technological disaster
☐ Flood ☐ Terrorism
☐ Earthquake ☐ Other (specify)_____

2. Facility type (info source): Please check one that best applies.
☐ ME office ☐ Funeral home ☐ Nursing home
☐ Coroner office ☐ Hospital
☐ DMORT office ☐ Other (specify)_____

3. Facility address:
Street _____ County/parish_____
State_____ Z-code_____

4. Contact person (informant):
Name_____ Phone number_____
Email Address_____

Part II Deceased information

5. Case / medical record number: _____

6. Body identified? ☐ Yes ☐ No ☐ Pending

7. Date of Birth (MM/DD/YY) ___/___/_____ ☐ Unknown

8. Age in years: _____ ☐ < 1 yr ☐ Unknown

9. Residential address of decedent:
County/parish_____ City_____
State_____ Zip code___

10. Ethnicity:
☐ Hispanic
☐ Non Hispanic
☐ Unknown

11. Race:
☐ American Indian or Alaskan Native ☐ White
☐ Black or African American ☐ Asian
☐ Native Hawaiian or other Pacific Islander ☐ Other race

12. Gender:
☐ Male ☐ Female
☐ Undetermined

13. Date of Death:
(MM/DD/YY) ____/____/_____
☐ Unknown

14. Time of Death:
☐ _____(24 hr clock)
☐ Unknown

15. Date of body recovery:
(MM/DD/YY)
____/____/_____ ☐ Unknown

16. Time of body recovery:
☐ _____ (24 hr clock)
☐ Unknown

17. Place of death or body recovery:
☐ Decedent's home ☐ Evacuation Center/shelter ☐ Vehicle ☐ Hospital
☐ Hotel /motel ☐ Nursing Home / long term care facility ☐ Hospice facility ☐ Unknown
☐ Street/Road ☐ Prison or detention center ☐ Other (specify)_____

18. Location of death or body recovery:
State_____ county/parish_____
Intersection_____

19. Prior to death, the individual was a:
☐ Resident ☐ Non-resident-intrastate ☐ Unknown
☐ Foreign ☐ Non-resident-interstate ☐ Other_____

20. Was the individual paid or volunteer worker involved in disaster response?
☐ Yes ☐ No ☐Unknown

21. Body recovered by:
☐ Law enforcement ☐ Fire department ☐ DMORT ☐ Other (specify)_____
☐ EMS ☐ Search and rescue ☐ Family or individual ☐ Unknown

Part III Cause and Circumstance of death (check one that best applies)

22. Mechanism or cause of death— Injury
☐ Drowning
☐ Electrocution
☐ Lightning
☐ Motor Vehicle occupant/driver
☐ Pedestrian/bicyclist struck by vehicle
☐ Structural collapse
☐ Fall
☐ Cut/struck by object/tool
☐ Poisoning/ toxic exposure:
  ☐ CO exposure
  ☐ Inhalation of other fumes/smoke, dust, gases
  ☐ Ingestion of drug or substance
  ☐ Other (specify)_____
☐ Suffocation/asphyxia
☐ Burns (flame or chemical)
☐ Firearm/gunshot
☐ Extreme heat (e.g., hyperthermia)
☐ Extreme cold (e.g., hypothermia)
☐ Other (specify)_____
☐ Unknown cause of injury

23. Cause of death— Illness
☐ Neurological disorders
  ☐ Meningitis/encephalitis
  ☐ Seizure disorder
  ☐ Stroke (hemorrhagic or thrombotic)
  ☐ Other (specify)_____
☐ Respiratory failure
  ☐ COPD
  ☐ Pneumonia
  ☐ Asthma
  ☐ Pulmonary embolism
  ☐ Other (specify)_____
☐ Cardiovascular failure
  ☐ ASCVD
  ☐ Congestive heart failure
  ☐ Other (specify)_____
☐ Renal failure
☐ GI and endocrine
  ☐ Bleeding
  ☐ Hepatic failure
  ☐ Pancreatitis
  ☐ Diabetes complication
☐ Sepsis
☐ Dehydration
☐ Allergic reaction
☐ Other (specify)_____
☐ Unknown cause of illness

24. Cause of death:
☐ Confirmed ☐ Probable
☐ Pending ☐ Unknown

25. Relationship of cause of death to disaster:
☐ **Direct** ☐ **Possible**
☐ **Indirect** ☐ **Undetermined**

26. Circumstance of death: (free text)

☐ Accident ☐ Pending
☐ Homicide ☐ Undetermined

28. Who signed the death certificate?
☐ ME/coroner
☐ Physician
☐ Not signed

29. Date of report completed:
(MM/DD/YY) ___/___/_____

Disaster-related Mortality Surveillance. General Instruction for completion of mortality form

General Information	**Q1. Disaster type —** Destructive forces originating from natural environment, such as hurricanes and earthquakes or man made (i.e., terrorist attack, WMD, toxic chemical release, nuclear reactor accident). If it is hurricane, please, specify the name. **Q2. Facility type**— Center involved in dead body handling during disaster and provided the information. Please check one that best applies.

Deceased Information	**Q5. Case/ Medical record number**— As appears in facility record **Q6. Body identified**— Yes or No if personal identity (name, DOB or residency) was identified or not **Q7. Date of birth** — Date of birth in MM/DD/YY format **Q8. Age in years**— Age in years, if age is less than one year please check the appropriate box **Q9. Residential address of deceased**— Deceased's home address including county of residence **Q10. Ethnicity**— Hispanic or non-Hispanic category **Q11. Race**: Select one or more of the racial category. **Q12. Gender**— Male, female **Q13. Date of death**— Date of death in MM/DD/YY format **Q14. Time of death**—Enter the exact or estimated time and minute according to 24- hour clock **Q15. Date of body recovered** — Date body taken from place of death in MM/DD/YY format **Q16. Time of body recovered**— Enter the exact or estimated time and minute according to 24- hour clock **Q17. Place of death**— Place where deceased was physically located at the time of death **Q18. Location of death or body recovery**— State and county of death **Q19. Deceased status prior to death**: Deceased residential at the time of death **Q20**. **—** Refers to work related deaths, this include volunteers deployed for disaster response. **Q21. Body recovered by** — The entity name who recovered the body

Cause and Circumstance of Death	**Q22. Mechanism or cause of death/ injury**: Record the mechanism that best describes the death. Record other and specify if the cause is not listed, but is known. **Drowning**— Includes but not limited to accidental drowning while in natural/flood water or following fall into natural/flood water. **Electrocution**—Includes but not limited to exposure to electric transmission lines or other unspecified electric current. **Lightning**—Includes death related to thunder or lightning **Motor vehicle occupant/driver**—Includes collisions relating to land transport accidents (e.g., car, motorcycle) **Pedestrian/bicyclist struck by vehicle**—Includes collisions involved non-motorized road users with motorized vehicles during the disaster period. **Structural collapse**—Include but not limited to building or shelter collapse **Fall**—includes but not limited to falls on same level from slipping or tripping; falls involving ice and snow; falls from trees, bed, stairs, roofs, ladders, etc. **Cut/ struck by object/tool**—Includes but not limited to contact or collision with inanimate objects that results in a physical damage and causes death **Poisoning/ toxin exposure**— Includes accidental poisoning by and exposure to liquids or gases and ingestion of drugs or substances. **Suffocation**— Includes but not limited to mechanical or oxygen depleted environment **Burn-** Includes but not limited to chemical, fire, hot object or substances contact **Firearm/gunshot**— Firearm injuries, including self-inflicted **Heat related injury**—Includes excessive heat as he cause of heat stroke, hyperthermia or others **Cold related injury**—Includes excessive cold as the cause of hypothermia **Q23 Cause of death/ illness**— Record the cause that best describes the disease process. If other, please specify. **Neurological disorders**—Includes but not limited to CNS infectious disease, seizure disorder, intracerebral hemorrhage, cerebral infarction and stroke **Respiratory failure**—Includes but not limited to COPD, pneumonia, asthma and pulmonary embolism **Cardiovascular failure**—Includes but not limited atherosclerotic cardiovascular disease, heart failure **Renal failure**—Includes kidney failure and other disorders of the renal system **GI and endocrine**—Includes but not limited to upper and lower GI bleeding, jaundice, hepatoma and pancreas **Sepsis**—Includes systemic infection **Dehydration**—Include sensible and insensible fluid and electrolyte loses **Allergic reaction**— Topical or systemic reaction including anaphylactic shock **Q24. Cause of death**: **Confirmed**—If the cause of death was certain and confirmed by a ME/physician **Probable**—If there is uncertainty to confirm the case **Pending**—If the case is subject for further investigation **Q25. Relationship** **Direct** —refers to a death caused by the environmental force of the disaster (e.g., wind, rain, floods, or earthquakes) or by the direct consequences of these forces (e.g., structural collapse, flying debris). **Indirect**— refers to unsafe or unhealthy conditions, or conditions that cause a loss or disruption of usual services that contributed to the death. Unsafe or unhealthy conditions may include but are not limited to hazardous road conditions, contaminated water supplies, scattered debris. Disruptions of usual services may include but are not limited to utilities, transportation, environmental protection, medical care or police/fire. **Possible**— refers to a death that occurred in the disaster-affected area during the disaster period. The cause or manner of death is undetermined or pending and the informant believes that a possible relationship between the death and the disaster might exist. **Unrelated**— refers to a death with no relationship to the disaster

Guidance on Shelter Surveillance from DPH

BRIEF GUIDANCE ON THE SHELTER SURVEILLANCE PROCESS IN KENTUCKY

The Kentucky Department for Public Health (KDPH) would like to offer local health departments the following brief guidance on the process to conduct surveillance of shelters.

Two streams of data collection are needed in sheltering situations: Disease/Injury Surveillance and Environmental Shelter Assessment. We will address the disease, or *morbidity*, surveillance process first and then the environmental health assessment process. Hopefully, this will cover the basics you will need to understand and conduct necessary surveillance in shelters should the need arise.

Morbidity Surveillance

Use

Disease surveillance is conducted daily in shelters to track the number of illnesses/injuries arising in order to detect any emerging public health issues. The process and forms are not used to document burden of chronic disease, or as medical records for shelter inhabitants.

Forms

The disease surveillance forms currently in use in Kentucky have been sent to the Regional Epidemiologists but are also filed in the KY Health Alert Network (HAN) Document Library in the following file path: https://han.ky.gov/btrs/Documents/Shelter%20Surveillance/ *(Once in, look at the title under the bold document heading to see the document name corresponding to those that were emailed out).*

The three pertinent forms include:

1) Individual Morbidity Report Form (Natural Disaster Morbidity Report Form): can be filled out for each person who becomes ill or injured while in the shelter (each medical encounter basically).

2) Morbidity Tally Sheet (Natural Disaster Morbidity Tally Form): used at the end of the day to tally the number of each illness or injury seen that day – may or may not be useful in your operations.

3) Morbidity Summary Sheet (Aggregate Natural Disaster Morbidity Report Form): filled out once each day to submit to the state health department.

Completion of forms

The Regional Epidemiologist has overall responsibility to make sure that forms are completed and submitted daily for each shelter. This does not mean that the Regional Epidemiologist will necessarily fill the forms out themselves. In the case of any shelter, there is usually someone in charge of the shelter and that is who would be approached to assign someone to be responsible for filling out the forms each day. If there is medical staff, they would be the obvious choice to fill out the disease (morbidity) surveillance forms. Keep in mind, these forms are only used for

people who have an illness or injury of some sort *and are intended not to be filled out on every person in the shelter*.

If it isn't possible to identify a person at the shelter who can take responsibility for filling out the daily forms, then the Regional Epidemiologist will try to find another way to get the forms completed – either doing it themselves or arranging for others in the local public health network to do it. Obviously, if a lot of shelters open up or conditions make travel very difficult, the Regional Epi will not physically be able to do it themselves, so other local LHD personnel might be needed to take on this responsibility. In the case of small shelters (e.g., two families at a church), just a call each day would probably suffice to fill the Summary (Aggregate) Morbidity form out, if phone lines are up. Otherwise, an in-person check would be advisable.

The Regional Epi should go over these forms with whoever might be filling them out.

If the Regional Epi is coordinating surveillance at several shelters, the forms could be sent to them first and then they would forward on to the state, but that would be up to the local arrangements made with the Epi.

Note:
One temptation is to use the individual morbidity form as a medical record. That is not the intent but rather to get information only on emergent medical/mental health issues (instead of recording every chronic condition the patient has), so that we can stay on top of the potential arising public health problems. In the past, we have told medical staff in larger shelters that they can use the form as a medical record but need to have a method to clearly show why the patient was seen for medical services so that could be counted on the Summary Morbidity Form.

State Contact persons for Questions: Doug Thoroughman, TJ Sugg, Sara Robeson (502-564-7243)

Environmental Health Shelter Assessment

Use
Environmental Health Shelter Assessment is conducted daily to monitor the environmental conditions within each shelter to make sure that these conditions are safe for residents of the shelter.

Forms
The environmental assessment forms currently in use in Kentucky have been sent to the LHD Environmental Health Directors and Environmentalist listserves and are also filed in the KY Health Alert Network (HAN) Document Library in the following file path: https://han.ky.gov/btrs/Documents/Shelter%20Surveillance/ *(Once in, look at the title under the bold document heading to see the document name corresponding to those that were emailed out).*

There is only one pertinent form (Env_Hlth_EnviroShelterSurveillanceKY JAN_10 v1_Final.doc) with an associated companion instruction sheet (Environmental Health Assessment Form For Shelters).

Completion of forms

The Environmental Health program of the local health department with jurisdiction over the shelter has overall responsibility to make sure that forms are completed and submitted daily for each shelter. This usually requires direct daily visits by an Environmental Health Technician (or Sanitarian) to go through the check list. If food is being provided on-site, this is particularly crucial. This can be combined with picking up the disease surveillance form at the same time each day if that works. In smaller shelters, an initial inspection and then subsequent calls might suffice if it is difficult to get to the shelter or there are too many shelters for the environmental staff to cover in a day. The environmental staff people should be able to understand the forms but if they have difficulties, they can email or call to get direction (unless they are in a no-electricity situation, in which case they should use their best judgment on how to proceed).

State Contact persons for Questions: Kathy Fowler or Coleen Kaelin
(502) 564-4537

Disaster-related Injury Surveillance Form

Complete the form for all known injuries related to a disaster: This information should be obtained from hospitals, LTC, or shelter administration. **Please, complete one form per facility. Submit completed form daily to KY Department for Public Health via Fax (502-564-0477). For questions phone (502-564-3418).**

Part I General information

1.Type of disaster:

- ☐ Hurricane (name_____)
- ☐ Heat wave
- ☐ Tornado
- ☐ Winter Storm
- ☐ Technological disaster
- ☐ Flood
- ☐ Terrorism
- ☐ Earthquake
- ☐ Other (specify)_____

2. Facility type (info source): Please check one that best applies.

☐ Hospital ☐ LTC ☐ Shelter providing medical care

☐ Other (specify)_____

If Hospital or LTC: Is the facility operational?

☐ YES ☐ NO

Is the facility on Diversion?

☐ YES ☐ NO

Are there any unconscious/non-communicative patients that still need to be connected with family members?

☐ YES ☐ NO

Do you have any unidentified patients (John Smith/Jane Doe)

☐ YES ☐ NO

3. Facility:

Facility Name:_____

Street _____

County/parish_____ State_____

4. Contact person (informant) at facility:

Name_____

Phone number_____

Email Address_____

Part II Aggregate Injury Information

5. Total number of patients with disaster-related injuries: _____

6. Severity of Injuries Counts:

Life Threatening: _____
Serious: _____
Minor: _____
Deaths: _____

7. Number transferred to this facility _____

From:_____

8. Number transferred from this facility _____

To:_____

9. Number patients from out-of-state transported to facility _____

10. Breakdown of Mechanism or Cause of Injuries (number of patients in each category)

_____ Drowning _____ Electrocution _____Lightning _____Motor Vehicle occupant/driver

_____ Fall _____ Structural collapse _____Pedestrian/bicyclist struck by vehicle _____Firearm/gunshot

_____ Cut/struck by object/tool _____Suffocation/asphyxia

_____ Burns (flame or chemical) _____ Extreme heat (e.g., hyperthermia) _____ Extreme cold (e.g., hypothermia)

_____ Other (specify)_____

_____ Unknown cause of injury

Poisoning/toxic exposure: (If any, has facility had to activate decontamination equipment? ☐ YES ☐ NO)

_____ CO exposure _____ Ingestion of drug or substance

_____ Inhalation of other fumes/smoke, dust, gases _____ Other Poisoning (specify) _____

11. Date of report completed:

(MM/DD/YY) _____/_____/_____

Form v1.1
Rev.05/3/2012

12. Name of person submitting:

_____