EXPANDED MEDICAL PREPAREDNESS
APPENDIX C

SUPPLEMENTAL FORMS

Level I & Level II

County of Marin
Department of Health & Human Services
Division of Health Services
Emergency Medical Services Program
161 Mitchell Boulevard, Suite 100
San Rafael, CA 94903
415/ 499-6871

Appendix C
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First Aid Station Activity/Duty Log

Assignment/Name:			Page_____of_____Pages
From: (date/time)		To: (date/time)	
ITEM #	**TIME**	**INCIDENTS, MESSAGES, NOTES**	**ACTION TAKEN**

First Aid Station (FAS) Action Plan

FOR OPERATIONAL PERIOD:	PREPARED:
FROM: *Date* TO: *Date*	**Date**
Time *Time*	**Time**

GENERAL OBJECTIVES

OBJECTIVES should be stated in measurable terms to allow for evaluation of progress, such as incomplete, XX%, complete.
Each TASK assigned to Sections should address a specific OBJECTIVE.

WEATHER FORECAST FOR OPERATIONAL PERIOD

SAFETY MESSAGE

MANAGEMENT SECTION:

OPERATIONS SECTION:

PLANNING SECTION:

LOGISTICS SECTION:

FINANCE SECTION:

PREPARED BY (Planning Chief):	Approved by (FAS Director):

First Aid Station (FAS) Staffing List

FOR OPERATIONAL PERIOD:	PREPARED:
FROM: *Date* TO: *Date* *Time* *Time*	*Date* *Time*

MANAGEMENT SECTION	PLANNING SECTION
FAS Director	Planning Chief
Liaison Officer	Situation Status Unit Leader
Security Officer	Documentation Unit Leader
Safety Officer	Patient Record & Tracking Officer
	Registration Tracking
	Discharge Tracking
OPERATIONS SECTION	**LOGISTICS SECTION**
Operations Chief	Logistics Chief
Triage/Treatment Unit Leader	Communications Unit Leader
Triage Area Officer	Materials/Supplies Unit Leader
Treatment Area Officer	Food Service Unit Leader
Morgue Unit Leader	Facilities Unit Leader
Morgue Security	Staffing Unit Leader
Transport/Discharge Unit Leader	
Transport Area Officer	
Discharge Area Officer	
Agency Representatives/Other	**FINANCE SECTION**
	Finance Chief
	Prepared by:

Patient Care Record

PATIENT INFORMATION

Location | Date

Triage Classification | Time

☐ Green ☐ Yellow ☐ Red ☐ Black- Date/Time Pronounced _____

Name(Last, First, MI) | Sex | Age | Date of Birth

Mailing Address | City | State | Zip | Weight

History	Medications (Include dosage)	Allergies

ASSESSMENT

Narrative

(Check Mark Indicates Within Normal Limits)

☐ NEURO		☐ LUNGS	
☐ HEAD/FACE		☐ ABDOMEN	
☐ PUPILS		☐ BACK	
☐ NECK		☐ PELVIS	
☐ CHEST		☐ EXTREMS	

Time	Position	B/P	Pulse	Resp	Skin	SaO2	Eyes	Verb.	Motor	GCS

TREATMENT

IVs

Type	Time	Fluid	Gauge	Site	Rate
IV IO					
IV IO					

Blood Glucose

Time	Value	Time	Value

Oxygen

Nasal Cannula		Mask		Immob. Time	Immob. Type
Time	LPM	Time	LPM	Splint Time	Splint Type

Time	Treatment	Response	Time	Treatment	Response

DISPOSITION

Date

Time

☐ Treat & Released

☐ Transferred

5/02

TRANSPORT

Transport Type ☐ ALS _____ ☐ BLS _____ ☐ Other _____

Destination

PERSONNEL

Treatment Provider Name

Treatment Provider Signature

Other

Master Patient Tracking Record

Triage Tag #	Arrival Time	Name (Last First, MI)	Age	Triage Code	Complaint	Disch. Code	Discharge Location	Discharge Time

Triage Codes

G- green (Non-serious)

Y- yellow (Serious)

R- red (Critical)

B-black (Deceased)

Discharge Codes

1- released

2- transfer to higher level

3- morgue

4- AMA (Against Medical Advice)

Registration Tracking Record

Triage Tag #	Arrival Time	Name (Last First, MI)	Age	Triage Code	Complaint	Comments

Triage Codes

G- green (Non-serious)

Y- yellow (Serious)

R- red (Critical)

B-black (Deceased)

Discharge Tracking Record

Triage Tag #	Name (Last First, MI)	Age	Triage Code	Complaint	Disch. Code	Discharged to Location	Discharge Time

Triage Codes

G- green (Non-serious)

Y- yellow (Serious)

R- red (Critical)

B-black (Deceased)

Discharge Codes

1- released

2- transfer to higher level

3- morgue

4- AMA