

Disaster Preparedness for Children

Protecting Kids Before, During, and After Disasters

LEARNER REFERENCE

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This reference supports, and does not replace, guidance from clinicians, schools, and local emergency management.

How to Use This Reference

This is what you take from the course: the principles, checklists, and decision tools you will want months or years from now, when a storm is forecast, a child is frightened, or your organization is planning an exercise. Open the section you need. Each module page lists its Essential Understanding, the key actions, and the terms that matter.

COURSE ESSENTIAL UNDERSTANDING

Children are not small adults, and most of a child's safety on the worst day is decided before it. Child-specific plans, practiced with children and connected across homes, schools, and health care systems, are what protect children through preparation, response, reunification, and recovery.

ACKNOWLEDGMENT

This course and reference draw on the curated resource libraries of the National Pediatric Disaster Coalition (NPDC), a nonprofit dedicated to improving disaster preparedness, mitigation, response, and recovery for infants, children, and their families. Explore its seven libraries at npdcoalition.org. Course content and any errors are the author's own.

Course Synthesis

Children are about one in five people in the United States, yet most disaster systems were designed around adults. Children breathe faster, dehydrate sooner, depend on adults to escape and to be identified, read safety from the adults around them, cannot consent or advocate for themselves, and need pediatric doses, equipment, and trained staff. Nearly one in five has a special health care need. Adult plans therefore do not automatically protect them.

The good news is that most of a child's safety on the worst day is decided before it. A family plan that names who picks up each child, a kit matched to each child, an Emergency Information Form that travels with a child who has special needs, a school that verifies custody before release, adults who know how to offer psychological first aid, action sheets for the hazards that are actually likely, and health systems with a named pediatric emergency care coordinator: each is ordinary work, done in advance, that changes outcomes.

Children are also capable partners. Give every child a role. Practice calmly, at least twice a year. And remember that recovery lasts months: distress in children can peak well after attention has moved on, and the helpers who support children need support themselves.

The Four Phases and Your Portfolio

Phase	What protects children	Portfolio product	Module
Prepare	Child-specific plans, kits, identity skills, EIF and care map, power and medication budgets	Family plan; EIF and care map	1, 2
Respond	Age-tiered protective actions for local hazards; shelter in place; pediatric triage and decontamination	Hazard action sheet	5, 6

Phase	What protects children	Portfolio product	Module
Reunify	Verified release: separate check-in from release; custody checks; safe areas	Program gap analysis and reunification flow	3
Recover	Psychological first aid; routines; referral for warning signs; helper care	PFA role-play	4
System	Readiness assessment; named PECC; surge plans; pediatric exercises	Readiness summary and tabletop plan	6

Module 1: Children Are Not Small Adults, and Family Readiness

ESSENTIAL UNDERSTANDING

After this module, the learner can explain how children's physical, developmental, emotional, and social differences change disaster risk, and can build a child-specific family plan that names who picks up each child, where the family meets, and how a child who is alone can identify themselves and get help.

Why This Matters

Children are about one in five people in the United States, yet most disaster systems are designed around adults. A plan that works for the adults in a household can fail the children in it: the child who cannot recite a phone number, the infant whose formula runs out on day two, the child at school when the roads close. Every professional who works with families, and every parent or caregiver, can close most of these gaps in an afternoon. This module gives you the reasons and the tools.

Key Insights

- Most of a child's safety on the worst day is decided before it, by the plans, kits, and practice adults put in place.
- An adult plan does not automatically protect a child. Bodies, development, and dependence change the risk and the response.
- Children are capable partners. A job in the plan builds their confidence and their family's readiness.

Questions to Carry With You

- If a disaster struck at 10:30 on a school morning, who would pick up each child in your care, and how would the school know that person is authorized?
- What would a 5-year-old in your life be able to tell a stranger about who they are and how to reach you?
- Which items that keep a specific child healthy (formula, medication, a device, a comfort object) would run out first if you could not leave home for three days?
- When was the last time the children in your household or program practiced a drill, and what did you learn from it?

Section Summaries

Why Children Are Different in Disasters. Children differ from adults in body, development, emotions, legal status, and health care needs, so adult plans do not automatically protect them. Children are also capable partners who should have a role in every plan.

Plan, Kit, Practice: Building the Family Plan. A family plan names an out-of-area contact, two meeting places, and authorized pickup adults for each child; a child-specific kit adds formula, medications, records, photos, and comfort items; and short, calm drills twice a year make the plan work under stress.

Key Terms

Term	Definition
Children are not small adults	The principle that children's anatomy, physiology, development, and dependence on caregivers create distinct disaster risks and require distinct protective actions, equipment, and doses.
Family communication plan	A written plan that names an out-of-area contact, two meeting places, and authorized pickup adults for each child, and is shared with every caregiver and school.
Child-specific go kit	Emergency supplies matched to each child: food and formula, medications with dosing, records and custody papers, a recent photo, comfort items, and a contact card.
Out-of-area contact	A relative or friend outside the local region whom every family member calls or texts to check in, because long-distance lines often work when local lines are jammed.
Plan, kit, practice	The three-part readiness cycle. A plan without supplies fails on day two, and a plan that is never rehearsed fails under stress.

Module 2: Children and Youth with Special Health Care Needs

> **ESSENTIAL UNDERSTANDING**
>
> *After this module, the learner can complete an Emergency Information Form and a care map for a child with special health care needs, and can build a plan that keeps that child safe when power, pharmacies, therapy, and routines are disrupted at the same time.*

Why This Matters

Nearly one in five U.S. children has a special health care need. Many depend on daily medications, special formulas, ventilators, oxygen, feeding pumps, suction, or predictable routines. In a disaster those supports fail together, and the clinicians who know the child may be unreachable. Rehabilitation professionals, nurses, care coordinators, teachers, and families are often the only people who know what the child needs. This module turns that knowledge into documents and plans that work without you in the room.

Key Insights

- For a child who depends on power, medication, or equipment, a disaster is the moment every support system stops at once.
- Families are the help until help arrives. Planning makes that help skilled instead of improvised.
- One page that travels with the child lets any clinician act safely.

Questions to Carry With You

- If a child you know arrived at an unfamiliar emergency department without a parent, what would the staff need to know in the first five minutes?
- Which single failure (power, one medication, one caregiver, one routine) would put that child at greatest risk?
- How long would the child's device batteries last, and what is the backup?
- What would a noisy, crowded shelter feel like to a child with autism, and what would help?

Section Summaries

The Emergency Information Form and the Care Map. The Emergency Information Form puts a child's baseline, medications, devices, and communication needs on one page that travels with the child, and a care map reveals the network and single points of failure that must be backed up before a disaster.

When Power, Pharmacies, and Routines Stop. Children who depend on power, medications, or routines need a registered, budgeted, backed-up power plan, a medication and supply buffer, sensory and communication supports, and an evacuation trigger set in advance.

Key Terms

Term	Definition
Children and youth with special health care needs (CYSHCN)	Children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services beyond those children generally need.
Emergency Information Form (EIF)	A one-page medical summary developed by the American Academy of Pediatrics and the American College of Emergency Physicians that travels with the child so any clinician can act safely.
Care map	A visual diagram of every provider, service, supply source, school contact, and support person in a child's life, used to rebuild the care network quickly after a disruption.
Power budget	A calculation of how long each powered device can run on available batteries or backup power, used to decide when to evacuate or seek a charging site.
Access and functional needs	Needs related to communication, maintaining health, independence, support and safety, and transportation that require accommodation in emergency planning and sheltering.

Module 3: Schools, Child Care, and Reunification

> **ESSENTIAL UNDERSTANDING**
>
> *After this module, the learner can judge whether a school, child care center, or camp is ready for an emergency, and can design or support a reunification process that verifies identity and custody before a child is released.*

Why This Matters

On a typical weekday about 57 million children are in K-12 schools and about 12 million more are in child care or pre-K, away from their parents. Disasters do not wait for the school day to end. After Hurricane Katrina more than 5,000 children were reported missing. Every parent depends on a school's plan, and every educator, school nurse, and emergency planner shares responsibility for it. This module shows you what a ready program looks like and how reunification works when it is done well.

Key Insights

- Separation is one of the greatest risks to children in disasters. Reunification must be planned before it is needed.
- Shared, standard language saves time when seconds matter.
- Release a child to the right adult, not the first adult.

Questions to Carry With You

- If your child's school or your program went into lockdown right now, what would parents be told, by whom, and when?
- How would staff know that the adult asking for a child is authorized to take that child?
- What happens to a child whose authorized adult cannot reach the site for 24 hours?
- How does the plan account for children with special health care needs, infants, and children who do not speak English?

Section Summaries

What a Ready School or Child Care Program Looks Like. A ready program has a multi-hazard plan, evacuation and relocation, verified reunification, plans for children with special needs, and calm, documented practice, uses plain shared language, and treats school nurses and parents as partners.

Planning Reunification Before It Is Needed. Safe reunification separates adult check-in from student release, verifies identity and custody before every handoff, escalates unresolved cases, tracks unaccompanied children in safe areas, and plans in advance for children who wait 24 hours or longer.

Key Terms

Term	Definition
Standard Response Protocol (SRP)	A set of shared action terms (Hold, Secure, Lockdown, Evacuate, Shelter) from the I Love U Guys Foundation that lets students, staff, parents, and responders understand the same instruction.
Standard Reunification Method (SRM)	A school reunification process that uses a controlled parent check-in, verification of identity and custody, and a separate supervised student release so a child is handed only to an authorized adult.
Unaccompanied minor	A child separated from parents and legal guardians and not in the care of an adult who is responsible for them.
National Emergency Child Locator Center	NCMEC's center, activated in federally declared disasters, that helps locate and reunify children separated from their families.
Pediatric safe area	A supervised, secured space in a hospital or shelter where unaccompanied children are held and tracked until they can be safely reunified.

Module 4: Psychological First Aid, Coping, and Recovery

ESSENTIAL UNDERSTANDING

After this module, the learner can offer psychological first aid to a child using Listen, Protect, Connect, recognize age-typical stress reactions and the warning signs that call for referral, and protect their own wellbeing as a helper.

Why This Matters

After earthquakes and floods, about one child in five shows post-traumatic stress in the first six months, rising to nearly one in three in the second six months, and depression is common. Children who receive no psychological support are at higher risk. You do not need to be a therapist to change those odds. Parents, teachers, coaches, nurses, therapists, and responders who know what to say and do in the first days and weeks are the first line of mental health care for children after a disaster.

Key Insights

- How adults respond after a disaster, calmly, honestly, and with routine, shapes how children recover.
- Most children recover well. The skill is supporting all of them and spotting the ones who need more.
- Helpers need help too. Compassion that is not sustained cannot be sustained.

Questions to Carry With You

- What do children learn from watching how the adults around them cope?
- How would you know whether a child's behavior after a disaster is a normal reaction or a sign that the child needs more help?
- What is the difference between protecting a child from frightening information and lying to a child?
- Who takes care of the helpers in your family, school, or workplace?

Section Summaries

Psychological First Aid: Listen, Protect, Connect. Psychological first aid strengthens caregiving relationships, coping, and stable routines in the first days after a disaster. Listen without probing, protect from harm and media overexposure with honest answers, and connect children to family, routines, and services.

Who Needs More: Reactions by Age, Referral, and Caring for the Helper. Most children recover with support, but distress can peak months later. Know typical reactions by age, use risk factors to decide who needs referral, treat statements about self-harm as urgent, support grief, and plan care for helpers.

Key Terms

Term	Definition
Psychological First Aid (PFA)	An evidence-informed approach for the first days and weeks after a disaster that promotes safety, calm, connection, self-efficacy, and hope through practical, non-intrusive support.
Listen, Protect, Connect	A simplified psychological first aid model for parents and teachers: listen to the child, protect from further harm and overexposure, connect to routines and supports.
Regression	A temporary return to earlier behaviors (such as bedwetting, clinging, or baby talk) that is a common stress reaction in young children.
Secondary stressors	Ongoing hardships after the event, such as moving, changing schools, parental job loss, or family conflict, that raise a child's risk of lasting distress.
Compassion fatigue	The emotional and physical depletion helpers experience from sustained exposure to others' suffering, which can reduce their capacity to help.

Module 5: Hazard-Specific Protective Actions for Children

> **ESSENTIAL UNDERSTANDING**
>
> *After this module, the learner can identify the two or three hazards most likely in their community and adapt protective actions for each hazard to the age and needs of each child.*

Why This Matters

A family in Tampa Bay, a family in the Sierra foothills, and a family near a chemical plant face different worst days. CORE's Relevant rule applies here: time spent on unlikely hazards is time not spent on likely ones. At the same time, children's bodies change what protective actions mean. Smoke, heat, floodwater, and chemicals reach children faster and harder than adults, so the threshold for action is lower. This module helps you choose your hazards and translate each one into age-tiered actions families can follow.

Key Insights

- Plan for the hazards that are likely where you live, not for every hazard on the list.
- The same hazard calls for different actions for an infant, a 7-year-old, and a teenager.
- Children receive a higher dose from air, water, and chemical hazards, so protective actions start sooner.

Questions to Carry With You

- Which two or three hazards are most likely where you live, work, or teach, and how do you know?
- At what air quality level should an outdoor recess or practice move indoors?
- What would you tell a 6-year-old to do when the ground starts shaking, and what would you tell a 15-year-old?
- How has climate change shifted the hazards your community faces in the last ten years?

Section Summaries

Your Local Hazards: Water, Wind, Heat, and Cold. Choose the two or three hazards most likely in your community, then adapt protective actions to children: early evacuation, carbon monoxide safety, no floodwater, helmets in tornado shelters, scheduled water and no hot cars in heat, and safe sleep and safe heat in cold.

Smoke, Shaking, Chemicals, and Violence. For smoke, keep children indoors in clean air guided by the AQI; for earthquakes, practice Drop, Cover, and Hold On; for chemical and radiological events, shelter in place and use warm, low-pressure, family-centered decontamination; and for violence, store firearms securely, use plain-language protocols, and limit replays.

Key Terms

Term	Definition
Hazard vulnerability analysis	A structured review of which hazards are most likely in a place and how severely they would affect a population, used to prioritize planning.
Shelter in place	Staying inside a building and sealing it against outside air during a chemical, radiological, or smoke hazard until officials say it is safe.
Air Quality Index (AQI)	A color-coded scale from AirNow that reports daily air pollution and the health actions recommended for sensitive groups, including children.
Drop, Cover, and Hold On	The recommended protective action during earthquake shaking: drop to hands and knees, cover head and neck under sturdy furniture, and hold on until shaking stops.
Pediatric decontamination	Removing hazardous material from children using warm water, low pressure, and attention to hypothermia, while keeping children with their caregivers.

Module 6: Health Care and Community System Readiness

> **ESSENTIAL UNDERSTANDING**
>
> *After this module, the learner can measure an organization's pediatric readiness with national tools, identify the highest-value gaps (starting with a named pediatric emergency care coordinator), and plan a pediatric exercise that tests surge, triage, reunification, and family needs.*

Why This Matters

Most children who need emergency care are treated in general emergency departments that see few children each day, by EMS agencies that rarely transport them. When a disaster sends many children at once, the gaps in everyday readiness become the gaps that cost lives. Research across hundreds of hospitals shows that children treated first in highly ready emergency departments are far more likely to survive. Clinicians, rehabilitation professionals, EMS leaders, school health teams, and emergency managers can each close part of that gap. Family track learners will finish this module knowing what questions to ask about the hospitals and EMS that serve their children.

Key Insights

- Pediatric readiness is a system property. Homes, schools, EMS, hospitals, and communities must connect.
- Where a child is first treated changes whether the child survives.
- Name a pediatric emergency care coordinator. Readiness that belongs to everyone belongs to no one.

Questions to Carry With You

- Who in your organization owns pediatric readiness today, and what happens when that person leaves?
- If 20 injured children arrived at your nearest emergency department in one hour, what would run out first?

- How would your facility feed infants, track unaccompanied children, and reunify families during a surge?
- What role could rehabilitation professionals play in the hours and days after a mass casualty event involving children?

Section Summaries

Measuring Pediatric Readiness. Children treated first in highly ready emergency departments are far more likely to survive, yet readiness is uneven. Measure it with national tools, name a pediatric emergency care coordinator, fix the highest-value gaps, drill, and build readiness into roles so it survives turnover.

Surge, Triage, Infant Feeding, and the Pediatric Exercise. Pediatric surge plans cover space, staff, supplies, and transfers; children need pediatric triage, decontamination, tracking, and safe infant feeding; rehabilitation professionals add essential skills; and pediatric tabletop exercises with measurable objectives and owned after-action items turn plans into readiness.

Key Terms

Term	Definition
Pediatric readiness	The degree to which an emergency department or EMS agency has the staff, training, equipment, policies, and quality processes to care for children, measured by national assessments.
Pediatric emergency care coordinator (PECC)	A designated physician, nurse, or EMS clinician responsible for pediatric readiness in an emergency department or EMS agency; the strongest modifiable factor in readiness scores.
Weighted Pediatric Readiness Score	The 0 to 100 score from the National Pediatric Readiness Project assessment of an emergency department's pediatric capabilities.
JumpSTART	A pediatric adaptation of START mass casualty triage that accounts for children's normal respiratory rates and their inability to walk or follow commands at young ages.
Pediatric surge	A sudden increase in pediatric patients beyond a facility's or region's usual capacity, requiring pre-planned space, staff, supplies, and transfer agreements.

Quick Tools

Family Communication Plan Checklist

- Out-of-area contact (name and number memorized or on a card for every family member; text if calls fail)
- Meeting place 1: right outside the home. Meeting place 2: outside the neighborhood
- Primary and backup pickup adult for each child, authorized in writing with every school, child care, camp, and activity
- Contact card in each child's backpack; wallet card for each adult
- Drill scheduled at the start of each local hazard season, followed by a debrief with the children

Identity Skills by Age

Age	Practice
3 to 5	Full name; a parent's first and last name; a parent's phone number (songs and rhymes help)
6 to 9	Add home address, the out-of-area contact's name, and when and how to call 9-1-1 (practice on a toy or disconnected phone)
10 and up	The full communication plan; text-to-911 where available; how to help a younger sibling

Child-Specific Kit Additions

- At least 3 days of formula (ready-to-feed avoids the need for clean water), baby food, diapers, wipes
- Medications with written dosing and prescriber contact; copies of prescriptions
- Copies of IDs, birth certificates, custody papers, insurance cards, immunization records (waterproof bag or secure cloud)
- A recent photo of each child
- Comfort items: stuffed animal, book, small game, something that smells like home
- Pet kit: food, water, medications, records, carrier, photo

Special Health Care Needs: Power Budget Worksheet

Device	Battery runtime (hours)	Spare batteries	Backup source	Total hours

Evacuation trigger: if expected restoration time is longer than the lowest total, leave early or move to a reliable charging site. Runtimes come from device manuals and suppliers. Generators run outdoors only, far from windows; use battery carbon monoxide alarms. Register with the utility and the county special needs registry, but do not rely on registration alone.

Emergency Information Form: Keep It Working

- Complete with the child's clinician; medical fields signed by the clinician
- Baseline status first: normal vital signs, communication, movement, behavior
- Devices with make, model, settings; transfers and positioning (therapists can help)
- Store three copies: go kit, child's bag or wheelchair, phone
- Update whenever a medication or device changes

Reunification: The Five Steps

Step	What happens
Notify	Families learn where reunification will happen through the channel they were told to expect
Check in	Adults show ID and complete a card; staff verify the release list and custody restrictions
Hold	Children stay supervised in a separate area, out of view of the check-in line
Release	A runner brings the child; adult and child are matched; the release is recorded and signed
Escalate	No authorized adult, custody conflict, injured or missing child: designated team, then law enforcement and child welfare as needed

Answer the 24-hour question in advance: who supervises, feeds, medicates, and tracks a child whose authorized adult cannot arrive for 24 hours or longer.

Psychological First Aid: Listen, Protect, Connect

Move	Do	Say
Listen	Eye level; let the child lead; accept feelings; notice play and drawing; do not probe for details	"You were really scared when the wind got loud."
Protect	Water, food, warmth, quiet; an adult nearby; turn off news replays; honest, simple answers; no false promises	"I don't know yet, but I will tell you when I find out."
Connect	Reunite with family; restore meals, bedtime, school, play; practical help; services when needed	"Let's find your mom, and then we'll get dinner."

Typical Reactions by Age

Age	Common reactions (usually ease with support and routine)
Infants and toddlers	Fussiness, sleep and feeding changes, clinging, startling
3 to 5	Regression (bedwetting, thumb sucking, baby talk), tantrums, fear of the dark or being alone, replaying events in play
6 to 12	Worries, stomachaches and headaches, poor concentration, school problems, irritability, repeated questions, guilt
13 to 18	Withdrawal, anger, risk taking, substance use, changes in friendships, guilt, sense of a shortened future

Refer Promptly When

- Reactions are severe, last more than a few weeks, or are getting worse
- The child cannot function at home or school
- The child talks about wanting to die or hurt themselves or others: act immediately (call or text 988 in the United States; 911 for immediate danger)
- The child seems detached, numb, or not there much of the time
- Caregivers are overwhelmed and cannot support the child
- Higher risk: direct exposure, loss, prior trauma or mental health conditions, ongoing secondary stressors (displacement, job loss, family conflict). Distress can peak 7 to 12 months after the event

Hazard Quick Reference

Hazard	Child-specific actions
Hurricane	Leave early for children with special needs; comfort items; generators outdoors only; CO alarms; keep children from debris and standing water
Flood	Never walk, swim, play, or drive in floodwater; wash hands and toys; check mold and yard contamination before play
Tornado	Lowest interior room; children under sturdy furniture or mattresses; helmets; practiced drill
Extreme heat	Water on a schedule; shade and cooler hours; watch for heat illness; never leave a child alone in a car
Winter and outages	Layers; infants on their backs in a crib without loose bedding; no fuel-burning heat indoors; flashlights not candles
Wildfire smoke	Check the AQI; children are a sensitive group; clean-air room; N95s do not fit young children; no ash cleanup with children
Earthquake	Drop, Cover, and Hold On; secure furniture in children's rooms; near the coast, strong or long shaking means go to high ground
Chemical or radiological	Shelter in place (close, turn off outside air, interior room, wait for all-clear); do not pick children up during the event; warm, low-pressure decontamination with families together
Violence	Locked, unloaded firearm storage with ammunition separate; plain-language school protocols; Stop the Bleed; limit replays; psychological first aid

Age-Tiered Action Sheet Template

Adults do	School-age children do	Adults do for young children

System Readiness Quick Reference

- Children first treated in the highest-readiness emergency departments had about 60 percent lower in-hospital mortality after injury and about 76 percent lower after medical illness (Newgard et al., 2023)
- Median ED readiness score was 69.5 of 100 in 2021; EDs with a pediatric emergency care coordinator scored a median of about 90 versus about 74 without (Remick et al., 2023)
- Tools: National Pediatric Readiness Project (EDs); Prehospital Pediatric Readiness checklist (EMS); AAP office guidance (clinics); program readiness elements (schools and child care)
- Cycle: assess, name a PECC, fix three high-value gaps, drill, reassess; write the PECC role into job descriptions
- Surge plans: space, staff (with just-in-time pediatric support), supplies (weight-based guides, pediatric equipment, cribs, ready-to-feed formula), transfer agreements
- Triage children with JumpSTART or SALT; plan pediatric decontamination, tracking, safe areas, and reunification
- Protect breastfeeding; avoid untargeted formula donations
- Include rehabilitation professionals: transfers, positioning, mobility devices, early mobilization, communication supports, accessibility

Pediatric Tabletop Exercise Checklist

- Two to four measurable objectives tied to known readiness gaps
- A scenario for your community's top hazard
- Whole-system participants: ED, EMS, schools, public health, emergency management, child welfare, rehabilitation, families
- Pediatric injects: unaccompanied infant, technology-dependent child, custody conflict, equipment shortage
- Hot wash, then an after-action report with an owner and a date for every improvement

Go Deeper: NPDC Resource Libraries

Library	Use with	Address
Children and Family	Module 1	npdcoalition.org/resources/children-family/
CYSHCN and At-Risk Youth	Module 2	npdcoalition.org/resources/cyshcn/
Schools and Childcare	Module 3	npdcoalition.org/resources/schools-childcare/
Mental Health	Module 4	npdcoalition.org/resources/mental-health/
Threats and Hazards	Module 5	npdcoalition.org/resources/threats-hazards/
Healthcare and EMS	Module 6	npdcoalition.org/resources/healthcare-ems/
National and International	Module 6, instructors	npdcoalition.org/resources/national-international/

Questions Families and Community Leaders Can Ask

- Does our hospital participate in the National Pediatric Readiness Project?
- Does our ED and our EMS agency have a pediatric emergency care coordinator?
- Where would children be sent if many were hurt at once?
- Where and how will my child's school or program reunify families?

Glossary

Term	Definition
Access and functional needs	Needs related to communication, maintaining health, independence, support and safety, and transportation that require accommodation in emergency planning and sheltering.
Air Quality Index (AQI)	A color-coded scale from AirNow that reports daily air pollution and the health actions recommended for sensitive groups, including children.
Care map	A visual diagram of every provider, service, supply source, school contact, and support person in a child's life, used to rebuild the care network quickly after a disruption.
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Pediatric emergency care coordinator (PECC)	A designated physician, nurse, or EMS clinician responsible for pediatric readiness in an emergency department or EMS agency; the strongest modifiable factor in readiness scores.

Term	Definition
Pediatric readiness	The degree to which an emergency department or EMS agency has the staff, training, equipment, policies, and quality processes to care for children, measured by national assessments.
Pediatric safe area	A supervised, secured space in a hospital or shelter where unaccompanied children are held and tracked until they can be safely reunified.
Pediatric surge	A sudden increase in pediatric patients beyond a facility's or region's usual capacity, requiring pre-planned space, staff, supplies, and transfer agreements.
Plan, kit, practice	The three-part readiness cycle. A plan without supplies fails on day two, and a plan that is never rehearsed fails under stress.
Power budget	A calculation of how long each powered device can run on available batteries or backup power, used to decide when to evacuate or seek a charging site.
Psychological First Aid (PFA)	An evidence-informed approach for the first days and weeks after a disaster that promotes safety, calm, connection, self-efficacy, and hope through practical, non-intrusive support.
Regression	A temporary return to earlier behaviors (such as bedwetting, clinging, or baby talk) that is a common stress reaction in young children.
Secondary stressors	Ongoing hardships after the event, such as moving, changing schools, parental job loss, or family conflict, that raise a child's risk of lasting distress.
Shelter in place	Staying inside a building and sealing it against outside air during a chemical, radiological, or smoke hazard until officials say it is safe.
Standard Response Protocol (SRP)	A set of shared action terms (Hold, Secure, Lockdown, Evacuate, Shelter) from the I Love U Guys Foundation that lets students, staff, parents, and responders understand the same instruction.
Standard Reunification Method (SRM)	A school reunification process that uses a controlled parent check-in, verification of identity and custody, and a separate supervised student release so a child is handed only to an authorized adult.
Unaccompanied minor	A child separated from parents and legal guardians and not in the care of an adult who is responsible for them.
Weighted Pediatric Readiness Score	The 0 to 100 score from the National Pediatric Readiness Project assessment of an emergency department's pediatric capabilities.

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