Point of Dispensing Manual

REVISED: JUNE 2020

Division of Emergency Preparedness

Toledo-Lucas County Health Department
635 North Erie Street
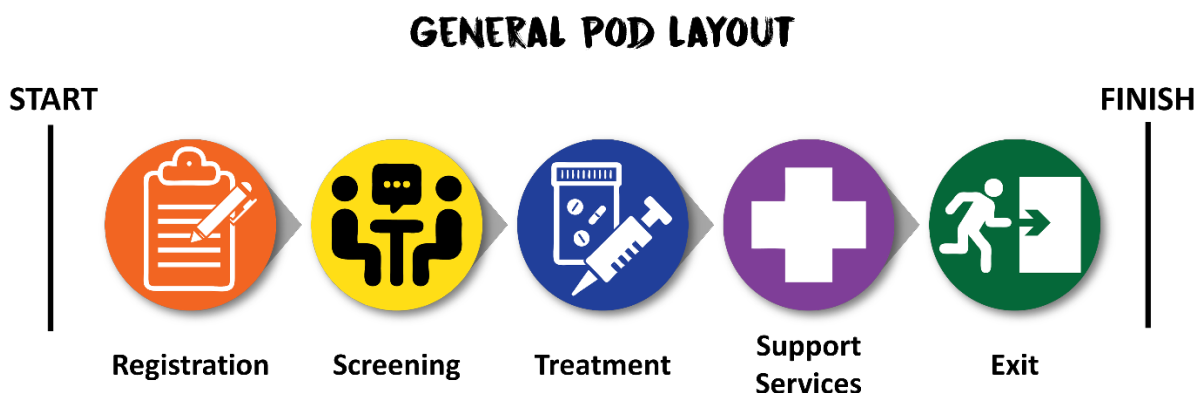Toledo, Ohio 43604

Public Health
Prevent. Promote. Protect.

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POINTS OF DISPENSING – THE 50,000 FOOT VIEW

A point of dispensing (POD) is a mechanism utilized by local public health officials during emergency situations to quickly and efficiently distribute medical countermeasures (testing or medications or vaccinations) to individuals. While the thought of providing medical countermeasures during a catastrophic emergency may seem like a daunting task, the process and system is simplistic and easy to execute. Five stations are utilized in a general POD layout:

GENERAL POD LAYOUT

START   **FINISH**

Registration   **Screening**   **Treatment**   **Support Services**   **Exit**

In Lucas County, the Toledo-Lucas County Health Department (known here after as 'public health') is responsible for all POD planning, training and logistics. During an emergency requiring mass distribution of medical countermeasures, public health will request assistance from both the State of Ohio and the Centers for Disease Control and Prevention. Once medical countermeasures arrive, public health will work to distribute these materials to locations and organizations throughout Lucas County.

When a large-scale emergency occurs, such as a pandemic or terrorist attack, local public health may request resources to better handle the situation at hand. Lucas County has a robust amount supplies on hand to include:

- N-95 respirators
- Sterile gloves
- Communication tools (radios, phones, etc.)
- Large moving equipment (large trucks, backhoes, earth moving equipment, etc.)
- Basic first aid tools
- Basic over the counter medications

Whenever an incident occurs when medication, vaccine, or testing is needed for the population, public health will generate a formal request with local officials, the State of Ohio, and the Centers for Disease Control and Prevention (CDC). After receiving the request, State and federal officials will provide assistance to Lucas County. Once these assets arrive, public health will break down the materiel by each POD location and will make it available for PODs to pick them up.

MEDICATION VS. VACCINATION VS. TESTING PODS

During a public health emergency, medical countermeasures are utilized to prophylaxis the public to either 1) help stop the spread of a certain disease once it has arrived in the community or 2) act as a proactive protective measure to create "immunity" in the general population before the event occurs. Medical countermeasures will come as either medications, vaccinations, or test kits. Regardless of what types of countermeasure arrives to Lucas County, the flow and process for conducting a POD is similar.

POINTS OF DISPENSING – NUTS AND BOLTS

We have looked at what a POD is from a 50,000-foot view. Now, let us look at the details of the operation. Each of the sections and descriptions below is accompanied by a job action sheet. Job action sheets are located in your POD Squad Box.

REGISTRATION SECTION

The registration section is the first section of five that compose a POD. The registration section is responsible for getting POD patrons registered with their personal information and monitoring lines.

Line Monitors:
During a POD, the line to wait for medical countermeasures may be long. It is important that line monitors walk up and down lines to provide information about the POD, what the public health emergency is, and to dispel rumors that may be heard. Line monitors are also tasked with monitoring individuals who may be showing signs/symptoms of sickness.

Registration Section Staff:
Registration staff greet POD patrons and provide them with a POD registration form. The registration form will vary based on if a medication POD or vaccine POD is in operation. Regardless of whether it is a medication, vaccine, or testing POD, the registration section provides patrons with a form that needs to be completed to receive medical countermeasures. Examples of these forms are found in Appendix A: Medication POD Registration Form and Appendix B: Vaccination POD Registration Form.

SCREENING SECTION

The screening section is the second section of five that compose a POD. The screening section is responsible for reviewing all registration forms that have been brought into the POD.

Screeners:
The screening section is solely tasked to review the registration form completed by POD patrons. At this point in the POD, POD staff members discuss what medication, vaccine, or test individuals will

receive, discuss medication/vaccine/test information sheet, and discuss any/all fact sheets relevant to the public health emergency.

All registration forms must be signed before anyone may receive medical countermeasures.

TREATMENT SECTION

The treatment section is the third section of five that compose a POD. The treatment section is responsible for providing medication, vaccine, or test distribution to POD patrons, and to manage/inventory all medical countermeasures that are at the POD.

Dispensing Section:
The dispensing section is solely responsible for distributing medical countermeasures to POD patrons. Staff in the dispensing section will utilize the countermeasures provided, accurately account for, and distribute to POD patrons.

Materiel Management:
The materiel management section is responsible for keeping an accurate inventory of all supplies and medical countermeasures given to the POD at activation. Certain forms are required to be completed by material management. Appendix C provides the forms utilized by the treatment section.

SUPPORT SECTION

The support section is the forth section of five that compose a POD. The support section is responsible for providing medical and logistical support to the POD. **This section is elective for POD patrons but is necessary for POD operations**. Not all patrons who go through the POD will need medical assistance or mental health services.

First Aid:
Provide basic first aid to POD staff members and any POD patron. First aid kits and training are the responsibility of the hosting organization.

Mental Health:
Provide mental health services to both POD staff and POD patrons who are in need. This section is critical for anyone who is having a difficult time with whatever situation is currently at hand.

Security:
Individuals who are able to provide security to the POD site as well as to the medical countermeasures at the facility.

Logistics:
Logistics will help get additional materials to the POD if and when they are needed.

EXIT SECTION

The treatment section is the final section of a POD. The exit section is responsible for providing any last minute information to POD patrons who may need them. In addition, they are also seeking feedback in surveys as well as inputting information into computers or databases for the incident.

Information/Referral:

Provides information to POD patrons (fact sheets, public health brochures, etc.) in regards to the public health incident or disease at hand. An important component of this is any adverse reporting instruction sheets. POD patrons may either provide adverse reaction sheets to individuals or direct them to the appropriate website.

Data Management:

This is simply data entry into either a local or statewide database on current POD conditions, inventory, etc.

POD STRUCTURE AND STAFFING REQUIREMENTS

We have looked at the details of how a POD flows. Now, let us look at the general structure of the POD and the staff needed to successfully execute POD activation.

Staffing requirements are dependent on the size of an organization and the employee census. A streamlined organizational structure will be utilized at all POD locations throughout Lucas County:

Point of Dispensing (POD) Command Structure

Toledo-Lucas County Health Department
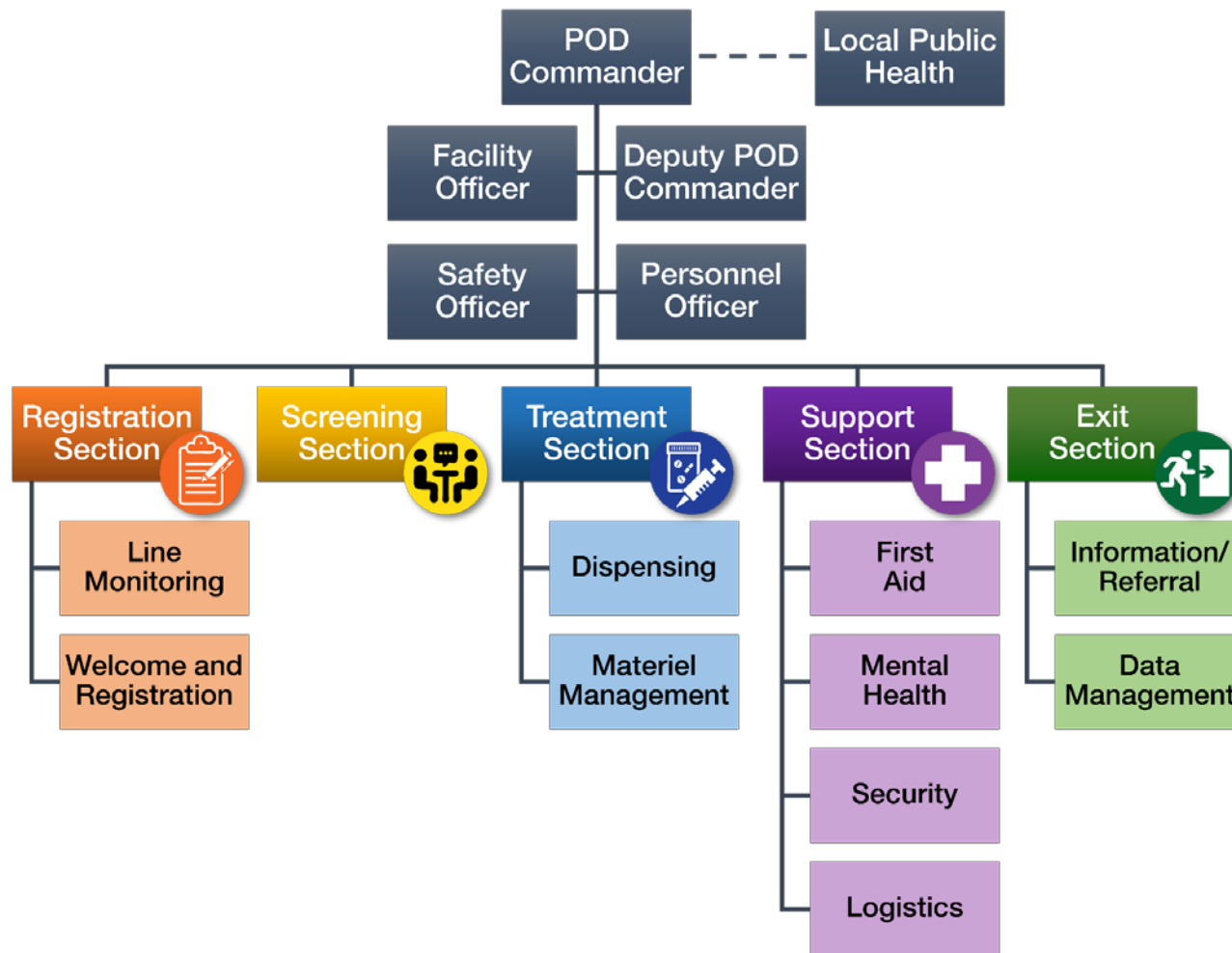
The organization chart mirrors incident command structure (ICS) format that is used by many different first response organizations. Keep in mind the following characteristics of the POD organizational chart:

- The POD Commander is responsible for all POD operations
- The chart is modular and scalable to accommodate small or large PODs
- Not all of the positions are required to be filled
- All positions not filled by an individual will be assumed by the section and POD commander
- The deputy POD commander must be able to assume command of a POD if the POD commander is not able
- While not directly at your POD site, "local public health" acts as a liaison for your POD operation

Note the sections listed on the organizational chart. Each of the sections corresponds to the specific POD station discussed in the 50,000-foot view. Additionally, each section is color coded to make flow easy for both POD staff and patrons.

CORE MANAGEMENT TEAM

The core management team is responsible for maintaining continuity and authority at a POD site. On the organization chart, the core management team is the very top tier of positions as well as all section chiefs.

The core management team is the primary group of individuals who are trained and will be the most knowledgeable about POD operations and logistics. The core management team is comprised of the following positions:

1) POD Commander
   a. Oversees and manages all POD operations
2) Deputy POD Commander
   a. Assists POD Commander to oversee and manage all POD operations
3) Facility Officer
   a. Provides assistance with facility usage and assists with facility needs
4) Safety Officer
   a. Ensures all aspects of POD operations are done safely
5) Personnel Officer
   a. Oversees all human resources at POD
6) Registration Section Chief
   a. Manages welcoming, registration and line monitors
7) Screening Section Chief
   a. Manages review and verification of all registration paperwork
8) Treatment Section Chief
   a. Manages medical countermeasure distribution and maintains medical countermeasure inventory status
9) Support Section Chief

a. Manages first aid, mental health, security, and logistics
10) Exit Section Chief
a. Manages information/referral and data management

JUST IN TIME TRAINING AND BRIEFINGS

Just in time training is completed to educate individuals of their job responsibilities and tasks at hand soon after an incident has occurred. Two just in time training sessions will occur before a POD is to be activated:

1) POD commander to the Core Management Team
   a. POD commander will provide briefing of situation and discuss talking points on just in time training sheet
2) Core Management Team to all POD Staff
   a. Core management team will provide a summary of the POD commanders briefing to all working POD staff members
   b. All POD staff will review job action sheets and completed supervisor and tasks box

A basic situational report will be provided by local public health to each POD site.

CREDENTIALING

All treatment section individuals must be licensed medical professionals with the State of Ohio and have up-to-date credentials in their field.

Verification of credentials can be done with the State of Ohio eLicense Center.

GENERAL OPERATIONS

INITIAL NOTIFICATION

Local public health will notify all POD squad members of an impending public health threat to discuss what the threat is, what actions will be done to combat and mitigate the threat, and how to recover from the threat. More likely than not, a POD will not be opened unless the threat is of grave danger to the public's health, highly communicable, and/or has high mortality.

Once a POD has received the initial notification, the POD needs to begin call out's and organizing the designated space to conduct POD operations.

ACTIVATION

POD operations need to become mobilized and running once the initial notification has been received. All materials needed for the incident are in the POD Squad Training Box as well as from public health. It

is local public health's responsibility to provide any/all necessary information and materials (fact sheets, incident action plans, basic information, etc.) to all POD squad members.

Appendix D contains a checklist for POD activation. Additional appendices at the end of this manual provide resources for POD operations.

OPENING AND SUSTAINMENT

Now that the POD has been mobilized, the POD can now be opened to provide medical countermeasures. By this time, all staff members have been briefed and job action sheets have been distributed. Transportation arrangements should be in place to collect and sign off on medical countermeasures at the Lucas County distribution site at the SeaGate Convention Centere in downtown Toledo.

The following should be considered and through of when opening:

- All of the sections should be clearly labeled with signage,
- Flow through the POD should be clear and easy to follow,
- Medical countermeasures are secured within the building, and
- Communication is open between the POD location and local public health

The sustainment and continuation of POD operations will be easy to maintain. The initial flow of patrons through the POD will be difficult until staff are comfortable and able to perform their job assignments. Appendix E will provide a checklist to maintain POD operations during each operational period.

Any additional questions or issues should be relayed through the POD Commander to local public health.

DEMOBILIZATION

When the public health threat has ceased, the POD can now begin the demobilization phase. Demobilization is a process that gradually shuts the POD down. In general, all POD staff will begin wrapping up all job duties and gradually shutting down their sections. All medical countermeasures are to be inventoried and sent back to the local distribution center. Appendix F provides a POD demobilization checklist.

CLOSED POD OBLIGATIONS

PRELIMINARY PAPERWORK

To be recognized as a closed POD site in Lucas County, the follow documents are needed by public health:

1) Point of Dispensing Memorandum of Understanding (MOU)
    a. A basic memorandum of understanding between public health and the closed POD member

2) Core Management Team Roster
   a. Roster of staff members that will be first to respond to the POD complete with name and contact information
3) State of Ohio Security Site Assessment
   a. Security site assessment to review POD location by local public health and law enforcement official
4) Lucas County POD Registration Form
   a. Formal registration form to sign POD site up with Toledo-Lucas County Health Department
5) Exercise and Training Agreement
   a. Agreement to be signed explaining obligations and requirements for POD exercises and training

TRAINING REQUIREMENTS

As a POD site, your organization is required to do annual training with both public health and your staff. These training sessions are critical to ensure your organization and core management team are properly trained and are competent to stand up a POD. In addition, training requirements are needed by public health to verify contact information and successful training of the Lucas County POD Squad.

Below are the training requirements for all closed POD sites:

	Frequency	
Training Requirement	Quarterly	Annually
Phone call verification of primary points of contact with local public health	X	
Review internal policies and procedures for POD activation with core management team and all POD staff		X
Face-to-face POD refresher training for core management team with local public health		X
Conduct one (1) POD activation full-scale exercise at organization with core management team and all POD staff		X

APPENDIX A:

MEDICATION POD REGISTRATION FORM

Medication Registration Form
Toledo-Lucas County Health Department Point of Dispensing (POD) Program
FOOMKA MAGACA CAAFIMAADKA DADWEYNAHA, CINWAANKA IYO TAARIIKHDA QOFKA (NAPH) (La baddalay 5/2017)

Section A				Section below completed by POD staff	
Magaca Buuxa Qofka Qaada Daawada				**Location:**	
Cinwaanka	Magaalada, Gobolka	Zip			
				Time In:	
Taariikhda Dhallashada	Telefoonka	Taariikhda		**Time Out:**	

Section B	A	B	C	D	Shaded section completed by POD staff
Bixi magaca iyo da'da qof kasta oo qaata daawo. Ku jawaab HAA ama MAYA su'aalaha A, B, C iyo D qof kasta aad u soo qaadi doontid daawo.	Qofka xasaasiyad miyuu ku qaabaa: Doxycycline ama Tetracyclines	Qofka xasaasiyad miyuu ku qaabaa: Ciprofloxacin ama Quinolones Ama ma qaataa: Tizanadine (Zanaflex) Ama ma haystaa: Myasthenia Gravis	Qofta ma tahay: Hooyo Naas Nuujiso ama Xaamilo	Qofkaan miisaankiisa ma ka yar yahay 76 bound (lbs): Haddii ay haa tahay, tilmaan miisaanka	**Medication Inventory Label**
1 Magaca: _____ Da'd: ___ Lab / Dhedig	Maya / Haa	Maya / Haa	Maya / Haa	Maya / Haa _____ lbs.	
2 Magaca: _____ Da'd: ___ Lab / Dhedig	Maya / Haa	Maya / Haa	Maya / Haa	Maya / Haa _____ lbs.	
3 Magaca: _____ Da'd: ___ Lab / Dhedig	Maya / Haa	Maya / Haa	Maya / Haa	Maya / Haa _____ lbs.	
4 Magaca: _____ Da'd: ___ Lab / Dhedig	Maya / Haa	Maya / Haa	Maya / Haa	Maya / Haa _____ lbs.	
5 Magaca: _____ Da'd: ___ Lab / Dhedig	Maya / Haa	Maya / Haa	Maya / Haa	Maya / Haa _____ lbs.	

>>>> REVIEW AND SIGN BACK OF FORM >>>>

Medication Registration Form
Toledo-Lucas County Health Department Point of Dispensing (POD) Program

| Section D | Medication Consent Form (to be completed by primary individual/household contact) |

Review the following statement. Sign and date the form when finished.
- I have been informed of the reasons why I and/or my household are receiving medication.
- I have received a medication information sheet indicating the following:
  - Risk and benefits of the medication
  - Medication side effects
  - How to report adverse health effects should any develop
- I have received information about the current public health emergency.
- I am picking up medications for myself, others in my household, and/or others who are unable to pick up their own medications. I have been given permission to sign for all of the individuals listed on this form and agree to provide medications/instructions to all of them. None of the individuals listed have received emergency medications from any other point of dispensing site.
- I understand that the medication may or may not be in a child-safe container.
- I will properly dispose of the medication no later than one (1) year from the date of dispensing, unless otherwise indicated.
- I understand that I and/or the individuals listed on this form may need to receive additional medication at the direction of a licensed medical professional.

I understand that the decision to take medications is voluntary. All of the information I have provided to the point of dispensing staff is true, correct and complete to the best of my knowledge. I consent to the recommendation of the listed medications for myself and those listed. Medications will not be dispensed unless form is signed and dated.

Primary Individual Signature (below):	Taariikhda:

POD Staff Member Signature (below):	Date (below):

Formulario de registro de medicamentos
Programa de Punto de Distribución del Departamento de Salud del Condado de Toledo-Lucas

Sección A | Información Personal / Cabeza del Hogar	Esta sección debe ser diligenciada por el personal POD

Sección A \| Información Personal / Cabeza del Hogar

Nombre completo de la persona que recoge los medicamentos

Dirección	Cuidad, Estado	Código postal
Fecha de nacimiento	Teléfono	Fecha

Esta sección debe ser diligenciada por el personal POD

Location:

Time In:

Time Out:

Sección B \| Información sobre Medicamentos: Personal / Cabeza del Hogar

Esta sección debe ser diligenciada por el personal POD

	A	B	C	D	Medication Inventory Label
Escriba el nombre y la edad de cada persona que reciba medicamentos. Responda Si o No a las preguntas A, B, C y D para todas las personas para las que vaya a recoger medicamentos.	¿Es la persona alérgica a?: Doxiciclina o tetraciclinas	¿Es la persona alérgica a?: Ciprofloxacino o quinolonas O está tomando: Tizanidina (Zanaflex) O tiene: Miastenia grave	Es la persona: Una madre lactante o embarazada	¿Pesa esta personamenos de 76 libras (34.5 kg)?: En caso afirmativo, indique el peso	Medication Inventory Label
1 Su Nombre (abajo): Edad: ___ Sexo: M / F	No / Sí	No / Sí	No / Sí	No / Sí _____ libras	
2 Nombre (abajo): Edad: ___ Sexo: M / F	No / Sí	No / Sí	No / Sí	No / Sí _____ libras	
3 Nombre: Edad: ___ Sexo: M / F	No / Sí	No / Sí	No / Sí	No / Sí _____ libras	
4 Nombre (abajo): Edad: ___ Sexo: M / F	No / Sí	No / Sí	No / Sí	No / Sí _____ libras	
5 Nombre (abajo): Edad: ___ Sexo: M / F	No / Sí	No / Sí	No / Sí	No / Sí _____ libras	

>>>> REVISIÓN Y REGISTRO DEL FORMULARIO >>>>

Formulario de registro de medicamentos
Programa de Punto de Distribución del Departamento de Salud del Condado de Toledo-Lucas

Sección D	Formulario de Consentimiento de Medicamentos (debe ser completado por la cabeza de hogar)

Revise la siguiente declaración. Firme y ponga la fecha en este formulario al finalizar.

• Me han informado de las razones por las que yo y/o mi familia estamos recibiendo la medicación.

• He recibido una hoja de información del medicamento que indica lo siguiente:

  -Riesgos y beneficios del medicamento.

  -Efectos secundarios del medicamento.

  -Como reportar efectos secundarios del medicamento.

  -He recibido información sobre la actual emergencia de salud pública.

• Estoy recogiendo medicamentos para mí, otros miembros de mi casa, y/o otras personas que no pueden recoger sus propios medicamentos. Se me ha dado permiso para firmar por todas las personas que figuran en este formulario y estoy de acuerdo en proporcionar los medicamentos / instrucciones a todos ellos. Ninguno de los individuos anteriormente mencionados ha recibido medicamentos de emergencia de otro punto de dispensación de medicamentos.

• Entiendo que el medicamento puede estar o no puede estar en un envase seguro para niños.

• Desecharé el medicamento a más tardar un (1) año a partir de la fecha de dispensación, a menos que se indique lo contrario.

• Entiendo que yo y/o los individuos listados en este formulario pueden necesitar recibir medicación adicional bajo la dirección de un profesional médico con licencia. Entiendo que la decisión de tomar medicamentos es voluntaria. Toda la información que he proporcionado al personal de distribución verdadera, correcta y completa a mi leal saber y entender. Yo consiento a la recomendación de los medicamentos enumerados para mí y los individuos listados en este formulario.

Los medicamentos no serán dispensados a menos que el formulario esté firmado y fechado.

Firma del Cabeza de Hogar (abajo):	Fecha (abajo):
Firma del miembro del personal POD (abajo):	Fecha (abajo):

Medication Registration Form
Toledo-Lucas County Health Department Point of Dispensing (POD) Program

Section A | Primary Individual / Household Contact Information | **Section below completed by POD staff**

First Name (Print)	Middle Name (Print)	Last Name (Print)

Location:

Street Address	City, State	Zip Code

Time In:

Date of Birth (MM/DD/YYYY)	Phone Number	Today's Date

Time Out:

Section B | Individual / Household Medication Information | **Shaded section completed by POD staff**

INSTRUCTIONS:
- Provide the name, age and gender of each person receiving medication.
- Answer columns A, B, C and D with either YES or NO.
- Review and sign back of form.

	Question A	Question B	Question C	Question D	
	Is this person allergic to: - Doxycycline or - Tetracyclines	Is the person allergic to: - Ciprofloxacin or Quinolones Or are they taking: - Tizanadine (Zanaflex) Or do they have: - Myasthenia Gravi	Is the person: - Breastfeeding - Pregnant	Does this person weigh less than 76 pounds (lbs): - If yes, indicate weight	Medication Inventory Label
1 Your Name (below): ___ Age: ___ Gender: M / F	No / Yes	No / Yes	No / Yes	No / Yes _____ lbs.	
2 Name (below): ___ Age: ___ Gender: M / F	No / Yes	No / Yes	No / Yes	No / Yes _____ lbs.	
3 Name (below): ___ Age: ___ Gender: M / F	No / Yes	No / Yes	No / Yes	No / Yes _____ lbs.	
4 Name (below): ___ Age: ___ Gender: M / F	No / Yes	No / Yes	No / Yes	No / Yes _____ lbs.	
5 Name (below): ___ Age: ___ Gender: M / F	No / Yes	No / Yes	No / Yes	No / Yes _____ lbs.	

>>>> REVIEW AND SIGN BACK OF FORM >>>>

Medication Registration Form
Toledo-Lucas County Health Department Point of Dispensing (POD) Program

Section D	Medication Consent Form (to be completed by primary individual/household contact)

Review the following statement. Sign and date the form when finished.

- I have been informed of the reasons why I and/or my household are receiving medication.
- I have received a medication information sheet indicating the following:
  - Risk and benefits of the medication
  - Medication side effects
  - How to report adverse health effects should any develop
- I have received information about the current public health emergency.
- I am picking up medications for myself, others in my household, and/or others who are unable to pick up their own medications. I have been given permission to sign for all of the individuals listed on this form and agree to provide medications/instructions to all of them. None of the individuals listed have received emergency medications from any other point of dispensing site.
- I understand that the medication may or may not be in a child-safe container.
- I will properly dispose of the medication no later than one (1) year from the date of dispensing, unless otherwise indicated.
- I understand that I and/or the individuals listed on this form may need to receive additional medication at the direction of a licensed medical professional.

I understand that the decision to take medications is voluntary. All of the information I have provided to the point of dispensing staff is true, correct and complete to the best of my knowledge. I consent to the recommendation of the listed medications for myself and those listed. Medications will not be dispensed unless form is signed and dated.

Primary Individual Signature (below):	Date (below):

POD Staff Member Signature (below):	Date (below):

APPENDIX B:

VACCINATION POD

REGISTRATION FORM

Formulario de Registro de Vacunación
Programa de Punto de Distribución del Departamento de Salud del Condado de Toledo-Lucas

Sección A | Información sobre la persona que recibirá la vacuna				
Apellido (escriba con letra impresa)	**Primer nombre** (escriba con letra impresa)	**Inicial del Segundo Nombre**	**Fecha de Hoy** (mes/día/año)	Esta sección debe ser diligenciada por el personal POD
Apellido de soltera de la madre	**Fecha de nacimiento** (mes/día/año)	**Edad**	**Sexo**	Ubicación:
			M / F	
Dirección				Hora de llegada:
Ciudad	**Estado**	**Código postal**	**Número de teléfono durante el día**	Hora de salida:

Sección B | Evaluación para la elegibilidad del paciente para la vacuna		SI	NO
Responda las siguientes preguntas sobre la elegibilidad de la vacuna con un (X) para SI o NO			
1.	¿Estás enfermo hoy?		
2.	¿Tiene usted una alergia grave a los huevos?		
3.	¿Tiene alguna alergia grave aparte de los huevos? Por favor enumere.		
4.	¿Alguna vez ha tenido una reacción grave a una dosis anterior de la vacuna contra la influenza?		
5.	¿Alguna vez ha tenido síndrome de Guillain-Barré? (El síndrome de Guillain-Barré es un tipo de debilidad muscular severa temporal)		

Sección C | Evaluación para la Administración de Vacunas		SI	NO
Responda las siguientes preguntas sobre la elegibilidad de la vacuna con un (X) para SI o NO			
1.	¿Ha sido vacunado con cualquier vacuna en los últimos 30 días? Vacuna: Fecha:		
2.	¿Tiene alguno de los siguientes: asma, diabetes (u otro tipo de enfermedad metabólica) o enfermedad de los pulmones, corazón, riñones, hígado, nervios o sangre?		
3.	¿Está usted en aspirina a largo plazo o terapia que contiene aspirina? (Régimen diario de aspirina)		
4.	¿Tiene un sistema inmune débil? (VIH, cáncer o medicamentos como los esteroides o los utilizados para tratar el cáncer)		
5.	¿Estas embarazada?		
6.	¿Tiene contacto cercano con una persona hospitalizada o en un ambiente protegido?		
7.	¿Está o ha estado tomando un medicamento antiviral en las últimas 48 horas?		
8.	¿Es la persona a vacunarse menor de 2 años de edad o mayor de 50 años?		

Sección D | Consentimiento informado para vacunación

Doy el consentimiento para ser vacunado con la vacuna de emergencia. He recibido y revisado la información sobre la vacuna de emergencia y entiendo los riesgos y beneficios. Entiendo que la información contenida en este registro es para monitorear las necesidades de inmunización con el fin de prevenir la enfermedad. Esta información es confidencial y sólo será compartida con organizaciones o personas autorizadas por la ley (el Departamento de Salud del Condado de Toledo-Lucas, proveedor de servicios de salud u organizaciones que prestan servicios en nombre de un niño (escuela de niños, cuidado de niños o cualquier persona autorizado por ley). Esta información se incluirá en el Registro de Inmunización de Ohio, un sistema web de registro seguro para los proveedores de atención médica. Si usted decide no compartir la información de su hijo con el registro por favor llame al 419-213-4100. La vacuna sólo se administrará con el consentimiento firmado.

Firma de la persona que recibe la vacuna -o- Padre/Tutor Legal (abajo):	Fecha (abajo):

Sólo para Uso Administrativo						
Vacuna	Fecha de administración	Vía de administracion	Dosis	Sitio de la inyección	Fabricante de la vacuna	Número de Lote
Nombre del Vacunador con Credenciales				Organización		

Vaccination Registration Form
Toledo-Lucas County Health Department Point of Dispensing (POD) Program

Section A	Information of Individual Receiving Vaccine			Section below completed by POD staff
Last Name (Print)	First Name (Print)	Middle Initial	Today's Date (MM/DD/YYYY)	Location:
Mother's Maiden Name (Last)	Date of Birth (MM/DD/YYYY)	Age	Gender M / F	Location:
Street Address				Time In:
City	State	Zip Code	Daytime Phone Number	Time Out:

Section B	Screening for Vaccine Eligibility	YES	NO
	Answer the following vaccine eligibility questions with an (X) for YES or NO	YES	NO
1.	Are you ill today?		
2.	Do you have a serious allergy to eggs?		
3.	Do you have any serious allergies other than eggs? Please list:		
4.	Have you ever had a serious reaction to a previous dose of influenza vaccine?		
5.	Have you ever had Guillain-Barré Syndrome? (Guillain-Barré Syndrome is a type of temporary severe muscle weakness)		

Section C	Screening for Vaccine Administration	YES	NO
	Answer the following vaccine eligibility questions with an (X) for YES or NO	YES	NO
1.	Have you been vaccinated with any vaccine within the past 30 days? Vaccine: Date:		
2.	Do you have any of the following: Asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
3.	Are you on long-term aspirin or aspirin-containing therapy? (Daily aspirin regimen)		
4.	Do you have a weak immune system? (HIV, cancer, or medications such as steroids or those used to treat cancer)		
5.	Are you pregnant?		
6.	Do you have close contact with a person who is hospitalized or in a protected environment?		
7.	Are you or have you been on an antiviral medication within the last 48 hours?		
8.	Is the person to be vaccinated younger than 2 years old or 50 years or older?		

Section D | Consent for Vaccination

I give consent to be vaccinated with the emergency vaccine. I have received and reviewed vaccine information statements for the emergency vaccine understand the risks and benefits. I understand that the information contained within this record is being maintained to monitor immunization needs in order to prevent disease. This information is confidential and will only be shared with organizations or persons who are authorized by law to receive it (includes the Toledo-Lucas County Health Department, health care provider or organization providing services on behalf of a child (child's school, childcare or anyone authorized under law to receive it.) This information will be included in the Ohio Immunization Registry, a secure web-based registry system for health care providers. If you choose not to have your child's information shared with registry please call 419-213-4100. Vaccination will only be administered with signed consent.

Signature Person Receiving Vaccination -or- Parent/Legal Guardian (below):	Date (below):

For Administrative Use Only						
Vaccine	Date Administered	Route	Dose	Injection Site	Vaccine Manufacturer	Lot Number

Name of Vaccinator with Credentials	Organization

APPENDIX C:

MATERIEL MANAGEMENT FORMS

Medical Countermeasure Chain of Custody

Toledo-Lucas County Health Department Point of Dispensing (POD) Program

From:

Agency:	
Address:	
Phone:	
Point of Contact:	

To:

Agency:	
Address:	
Phone:	
Point of Contact:	

Transfer of Custody:

Date: _____   Time: _____

Item Description:	Quantity:	Lot Number:

_____   _____
Shipper Signature   Recipient Signature

_____   _____
Date   Date

Resource Utilization Log
Toledo-Lucas County Health Department Point of Dispensing (POD) Program
Complete utilization log for each item within the SNS

POD Location	
Date Received	
Resource Name	
Quantity and Unity of Measure	

Date	Time	Quantity Taken	Initials	Comments

Form Completed By:		Submitted To:	
Name (Print)		Name (Print)	
Signature		Signature	
Date		Date	
Total Number of Pages			

Completed Resource Utilization Log to be sent to POD Commander or Local Public Health Official

APPENDIX D:
POD ACTIVATION CHECKLIST

POD ACTIVATION CHECKLIST

CONTACT INFORMATION

Write down who the primary and secondary POD contacts will be for your POD. The notification from public health will provide you with a primary and secondary contact name.

Primary POD Contact	
Name:	
Mobile Phone:	

Secondary POD Contact	
Name:	
Mobile Phone:	

Primary Public Health Contact	
Name:	
Mobile Phone:	

Secondary Public Health Contact	
Name:	
Mobile Phone:	

RECALL CORE MANAGEMENT TEAM

Recall all members of your POD's core management team.

POD Commander	
Name:	
Mobile Phone:	

Deputy POD Commander	
Name:	
Mobile Phone:	

Facility Officer	
Name:	
Mobile Phone:	

Personnel Officer	
Name:	
Mobile Phone:	

Registration Section Chief	
Name:	
Mobile Phone:	

Screening Section Chief	
Name:	
Mobile Phone:	

Treatment Section Chief	
Name:	
Mobile Phone:	

Support Services Section Chief	
Name:	
Mobile Phone:	

Exit Section Chief	
Name:	
Mobile Phone:	

PREPARE POD LOCATION

☐ Facility for POD is available

☐ Supplies are available and ready (pens, paper, clipboards, etc.)

☐ Tables and chairs are available and placed into pre designated POD layout pattern

☐ Lockable space available for medical countermeasures

☐ POD commander provides briefing to all core management team personnel

☐ Large POD signage is available and placed at different entrances, POD stations, etc.

RECEIVE MEDICAL COUNTERMEASURES

Send personnel and a vehicle to pick up medical countermeasures from the Lucas County Drop Site. County drop site location and instructions on where to park will be provided by local public health during initial notification call. Instructions on handling and storage requirements,

transfer of custody, and other paperwork will be provided by local public when you pick up the medical countermeasures.

FINAL REQUIREMENTS

☐ Ensure all POD personnel sign in with the personnel officer and complete all necessary paperwork prior to starting shift

☐ Provide all POD personnel with just in time training sheets

☐ The POD commander provides a general briefing to all POD personnel

☐ Section chiefs provide an additional briefing to all personnel working in their respective POD section

POD IS READY TO OPEN!

Checklist completed by:	
Name:	
Date and Time:	

APPENDIX E:

POD SUSTAINMENT CHECKLIST

POD SUSTAINMENT CHECKLIST

CONTACT INFORMATION

Write down who the primary and secondary POD contacts will be for your POD for this shift. Contact public health to get the latest primary and secondary contact names.

Primary POD Contact	
Name:	
Mobile Phone:	

Secondary POD Contact	
Name:	
Mobile Phone:	

Primary Public Health Contact	
Name:	
Mobile Phone:	

Secondary Public Health Contact	
Name:	
Mobile Phone:	

ESTABLISH CORE MANAGEMENT TEAM

Identify personnel for your POD's core management team's next operational period/shift.

POD Commander	
Name:	
Mobile Phone:	

Deputy POD Commander	
Name:	
Mobile Phone:	

Facility Officer	
Name:	
Mobile Phone:	

Personnel Officer	
Name:	
Mobile Phone:	

Registration Section Chief	
Name:	
Mobile Phone:	

Screening Section Chief	
Name:	
Mobile Phone:	

Treatment Section Chief	
Name:	
Mobile Phone:	

Support Services Section Chief	
Name:	
Mobile Phone:	

Exit Section Chief	
Name:	
Mobile Phone:	

POD OPERATIONS

- ☐ Identify and address any issues from previous POD commander in regards to POD operations

- ☐ Supplies are available and ready (pens, paper, clipboards, etc.)

- ☐ POD commander provides briefing to all core management team personnel for next operations period

FINAL REQUIREMENTS

- ☐ Ensure all POD personnel sign in with the personnel officer and complete all necessary paperwork prior to starting shift

- ☐ Provide all POD personnel with just in time training sheets

- ☐ The POD commander provides a general briefing to all POD personnel at the start of next operational period

- ☐ Section chiefs provide an additional briefing to all personnel working in their respective POD section

- ☐ Report any issues to local public health

POD IS READY TO KEEP RUNNING!

Checklist completed by:	
Name:	
Date and Time:	

APPENDIX F:
POD DEMOBILIZATION CHECKLIST

POD DEMOBILIZATION CHECKLIST

POD OPERATIONS

- ☐ Contact local public health that POD operations have been completed.
  - o Local public health will provide guidance on any additional relevant information as well as instruction on returning unused medical countermeasures and supplies.

- ☐ Clear tables of all medical countermeasures and supplies

- ☐ Collect all paperwork (registration forms, personnel sign in sheets, time logs, etc.)

- ☐ Take down all signage and return all tables/chairs to original room configuration (if applicable)

FINAL REQUIREMENTS

- ☐ Ensure all POD personnel have signed in with the personnel officer and completed all necessary paperwork prior to leaving POD

- ☐ Provide all POD personnel with a final briefing of the situation

- ☐ Report any issues to local public health

POD IS NOW SHUT DOWN!

Checklist completed by:	
Name:	
Date and Time:	