Chapter ON1: Disaster Preparedness and Response
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Introduction
Natural and man-made disasters have unfortunately been a part of human reality since the beginning of time. As people have moved into more condensed urban settings, and as air travel has allowed for relocation from one end of the globe to the other within a day, disasters that used to affect only small communities now can affect large and even global populations. Pediatricians have a responsibility to help ensure the safety and health of their patients and their families as well as respond to threats to child health and well-being around the globe. Disasters represent a meaningful public health concern for children in all communities; therefore, awareness of disaster preparedness principles, understanding the unique needs of children, and a commitment to personal readiness have become essential components of a pediatrician's knowledge base and general daily practice.

Background
A “disaster” is largely defined as an event that overwhelms a community’s ability to compensate and recover from the disruption caused by that event. Examples of disasters range from natural disasters like earthquakes and tornadoes to man-made disasters such as school shootings and acts of terrorism. Even a small event, such as a school bus rollover, can be a disaster that can potentially overwhelm a community’s resources. This is particularly so in rural areas with limited health care access.

There is rarely a disaster that does not affect children. Events like the 1995 Oklahoma City bombing, largely remembered for the destruction of a federal building, resulted in the deaths of 6 children with more than 100 additional children injured because there was a child care center on campus. Thousands of children lost parents and grandparents during the 9/11 attacks. School shootings such as the 2012 tragedy in Newtown, Connecticut, where 20 children were killed, or the Beslan (Russia) school hostage crisis in 2004, where 186 children were killed, serve as reminders that children can be specifically targeted. During Hurricane Katrina, more than 4,500 children were separated from family members and reported missing; after 2 weeks only 25% had been reunited.\(^1\) It took more than 6 months to reunite the last child with her family, a reminder of the challenges of caring for children.
during major disasters, but with a time delay that should not be accepted in any future event.

Despite the fact that 25% of the US population is children, who are affected at some level in every disaster, many disaster plans lack sufficient attention to pediatric issues. In addition, even if a plan does address pediatric needs, it may often lack details pertaining to particularly vulnerable groups, such as children and youth with special health care needs (CYSHCN) or children in the foster care or juvenile justice systems. Pediatric providers should advocate for these vulnerable populations and ensure that all children are considered in disaster planning.

**Pediatrics-Specific Vulnerabilities**

Children are especially vulnerable physically and emotionally across a range of disaster scenarios in part because of unique anatomic, physiologic, and developmental differences. Physiologic vulnerabilities include a large skin surface area to body mass ratio as well as thinner skin, leading to higher potential dermal exposure to burns and biochemical weapons. For the same reason, children also are at higher risk for hypothermia when exposed to the elements with loss of shelter. They require special attention during decontamination, such as ensuring warmer water, protecting the airway, and using lower pressure shower systems. Children are lower to the ground, increasing their exposure to certain heavy airborne biochemical weapons such as sarin and chlorine. Children have a higher baseline respiratory rate, meaning that they are at risk for increased inhalation of biochemical agents that can be aerosolized. With any biochemical agent or a natural disaster such as a cholera outbreak, loss of a safe water supply leaves children at higher risk for dehydration from vomiting and diarrhea. Young children are specifically vulnerable to head and multisystem organ injury from blunt trauma and debris during blast injuries or storm situations. With a smaller circulating blood volume, pediatric patients can experience exsanguination more quickly after trauma such as with blast injury. Because of the inherent social nature of children who largely spend their days in childcare programs and schools, infectious diseases can spread rapidly through the population when children bring those agents home to their families.

Developmental characteristics also set children apart from adults in a disaster. Children have less developed motor skills, and may be unable to escape a dangerous situation. Because of differing levels of cognitive skills across the pediatric population, younger children and those with developmental delays may not be able to recognize a dangerous situation; even if they do, they may not run away or may be unable to ask for help. Lack of fully developed language skills also adds to the challenge of reunification of families after a disaster if unattended children cannot provide identifying information. In addition, an injured child may not be able to vocalize symptoms of injuries or specific needs, including critical medical information such as medical history or medication allergies. Young children and CYSHCN will require constant adult supervision, unlike older teenage children and adults who can reliably accomplish basic self-care tasks such as feeding and toileting.

Pediatric disaster planning should also include attention to the specific developmental and psychological needs of children. Children require a developmentally appropriate explanation of what is occurring around them. Children will respond to a stressful event differently according to their
developmental level, and clinicians should be aware of these varying responses and be prepared to offer advice to families to help them cope. Children need careful protection from the media. To ensure that children are not taken advantage of in any way, their photographs should not be used without a guardian’s permission. In addition, after a stressful event, they should be protected from the media coverage of the event, because watching such coverage may cause added anxiety and increase risk for post-traumatic stress disorder (PTSD). In general, children exposed to stressful events early in life are at higher risk of developing PTSD and other long-term mental health conditions. Therefore, children need mental health attention as soon as possible after a major disaster disrupts their lives.6,8

Separation from family and loved ones is particularly stressful, and whenever possible, children should be kept with their caretakers. If a child and a parent are injured, if at all possible, they should be transported to the same medical facility. Any medical facility receiving an unaccompanied child should make every effort to document as much personal and/or identifying information as possible to expedite efforts to reunify the child with a family member. Schools and child care programs should establish reunification plans that are shared with all parents. Emergency management teams dealing with reunification can turn to the Federal Emergency Management Agency (FEMA) National Emergency Family Registry (www.fema.gov/recovery-directorate/national-emergency-family-registry-and-locator-system-fact-sheet) and the National Center for Missing and Exploited Children (www.missingkids.com/home) for help with reunification. However, these database tools rely on a minimum amount of identifying data on a child. Often, such data may not always be available. Other groups such as the American Red Cross have developed systems for tracking families (www.redcross.org/find-help/contact-family/register-safe-listing). Regardless, hospitals should address the management of unaccompanied minors and patient tracking as key components of their disaster plan, because patient tracking and reunification continue to pose major challenges in any large disaster event.

Preparation Specifics

Home Preparedness

Preparation for disasters begins at home. This policy applies to the pediatrician as well as the families in the pediatrician’s care. Ensuring their home and loved ones are safe and have the supplies and other resources needed during a disaster frees up clinicians to help the greater community in times of need. Pediatricians should incorporate disaster planning into anticipatory guidance during health maintenance visits; these discussions should include all aspects of family emergency planning (e.g., home evacuation, reunification, disaster supply kits, medications, emergency power, and equipment and medications for CYSHCN).9,10 It is easy to start these communications by asking the family how they are prepared for an emergency. Surprisingly, as many as 40% of families do not have an emergency plan, and approximately half of families express that they do not feel very prepared for a disaster.1

Every home should have a “disaster supply kit” with basic crucial supplies to allow a family to survive
for 72 to 96 hours in any circumstance. This includes water, age-appropriate nutrition, critical medications, blankets, comfort objects for children, flashlights, battery-operated radio, and infant needs such as diapers. Placing these objects in an easily moveable storage bin or bag is optimal. The bag can be quickly thrown into a vehicle if the family needs to leave the home or carried to an upstairs level in cases of flooding. It is prudent to include copies of important papers, such as birth certificates and social security cards, in the disaster supply kit. In addition, every able family member should know where the emergency water and gas shut-off valves are in case of an earthquake, fire, flooding, or any major structural damage to a home. Individuals are encouraged to always keep at least half a tank of gas in the car, because gasoline supplies may quickly become limited in the event of a major disaster. For an example of a disaster supply kit, see the American Academy of Pediatrics (AAP) Family Disaster Supplies List on the HealthyChildren.org (http://HealthyChildren.org) Web site (www.healthychildren.org/English/safety-prevention/at-home/Pages/Family-Disaster-Supplies-List.aspx (http://www.healthychildren.org/English/safety-prevention/at-home/Pages/Family-Disaster-Supplies-List.aspx)).

Every family should have an evacuation and reunification plan, and know where to meet and how to contact each other if they are not at home during a disaster. Young children should carry emergency cards with contact information in their school backpacks. In addition, pediatricians should ask parents if they are aware of their child’s school or child care program emergency protocols and reunification plans.

**Community Preparedness**

Pediatricians should take an active role in community preparation for disasters, because they possess unique insight into and understanding of children's needs. A pediatrician can become involved in numerous ways to prepare the larger community for an adequate pediatric disaster response. First, preparing the community to respond to any large-scale disaster includes ensuring that all hospitals are ready and capable to care for an influx of pediatric patients. Studies in the past decade have demonstrated significant deficiencies in pediatrics-specific equipment in ambulances and community hospital emergency departments. In one survey, only 13% of hospitals had pediatric mass casualty protocols, and only 28% of hospitals’ disaster plans included pediatrics-specific issues such as reunification of families. During Hurricane Katrina, even hospitals with disaster plans that included specific provisions for children found that these plans were not sufficient to respond to such an enormous disaster. Most recently, the National Pediatric Readiness Project found that less than half of US hospitals had pediatric considerations in their disaster plans. Having a designated physician or nurse pediatric emergency care coordinator has been linked with improved pediatric readiness in hospital emergency departments.

Efforts led by the Emergency Medical Services for Children program and other stakeholders have helped to improve prehospital and emergency preparedness for pediatric patients, but deficiencies still exist. Starting with emergency medical services (EMS) and the prehospital setting through care in emergency departments and hospital inpatient units, the medical community needs to have basic supplies for pediatric EMS and include pediatrics-specific considerations as part of the medical facility
disaster plan. Most hospitals could accommodate a small surge of pediatric patients, but the Task Force for Mass Critical Care recommends that pediatric intensive care units (PICUs) should carry adequate supplies, staff, and equipment to treat 3 times their usual patient capacity for a minimum of 10 days. Prehospital agencies, urgent care clinics, emergency departments, and general hospital inpatient facilities should anticipate a similar volume surge, if not more.

There are fewer than 4,000 PICU beds across the United States, with large areas of the country lacking immediate access to the level of care provided by PICUs. In the case of a major disaster, some children who would be admitted to the PICU or transferred to PICUs in regional medical centers may need to receive care in general hospital wards. Having adequate supplies available will be crucial to provide care for these patients. Pediatricians should take a lead role in advocating for pediatric preparedness. They can volunteer to participate on the local EMS or hospital advisory board for disaster planning to ensure that pediatric needs are considered and basic supplies are on hand in case of an influx of ill or injured pediatric patients.

Disaster preparedness in schools and child care programs represents another crucial area for planning. The vast majority of the pediatric population, 69 million children, will be attending school, Head Start, early education, or child care programs during any weekday event. The close proximity of children to each other in these settings also is pertinent to pandemic planning and infection control. In addition, schools and similar facilities often serve as places for community shelter and contact during disasters. There are no federal laws requiring all school districts to have emergency management plans. Although the majority of states do require some sort of plan, according to a 2015 annual readiness survey conducted by Save the Children, 18 states and the District of Columbia did not require all school and child care programs to have emergency plans. Pediatricians can help to advocate that local school boards, child care programs, and other locations where children spend time (e.g., camps) require disaster plans. These plans should include specifics about sheltering in place (e.g., active shooter scenarios) vs evacuation (e.g., earthquakes) as well as reunification so that parents will know where to arrive to find their child when the circumstances allow. These plans should also consider the unique needs of CYSHCN. These plans should be practiced and reviewed regularly so that students, parents, and teachers understand their roles.

Child care programs and schools should maintain a predetermined cache of crucial supplies for up to 72 hours should a need arise to shelter in place. Ideally, every child care facility, including schools, should have a parental notification plan. This could include phone calls, media outreach, text messaging, etc., to efficiently alert parents if a major disaster affects the community or the school. Each facility should keep an easily accessible and portable binder of critical information about each child (similar to an emergency contact card, with guardian’s name, phone number, and address, alternate caregiver, allergies, medical conditions, distinguishing physical characteristics (such as birthmarks, scars, etc). All CYSHCN should have individualized emergency care plans readily available.

A survey conducted in 2004 demonstrated that only 26% of EMS had a written disaster response agreement or plan with local school districts, and 50% had never met with school officials. Complete
and coordinated emergency plans should be developed in partnership with local law enforcement, firefighters, public health representatives, and community pediatricians. Pediatricians can serve as an advocate or liaison to unite these groups. Schools should have an alternative method of communication, such as a battery-powered radio, to receive information from law enforcement or other local emergency management authorities. In addition, local law enforcement personnel and fire fighters should have access to copies of floor plans at every school. These plans should identify locations where students and teachers would be expected to shelter in place. Pediatricians can help to reinforce school disaster plans by having the literature outlining the plans of area school districts in their waiting room and by addressing school readiness and emergency management as part of anticipatory guidance.

Office Preparedness

The presence of an accessible medical home is a vital component of the foundation on which healthy and resilient communities are built. In a report on resiliency, the US Department of Health and Human Services National Biodefense Science Board underscored the pivotal role of community health resiliency and the presence of accessible medical and mental health services as being key to resilient communities. During a disaster or pandemic, the availability and function of ambulatory primary and specialty care are crucial for both response and recovery. During a disaster, local hospitals and emergency departments will likely be overwhelmed with a surge of ill and/or injured patients as well as the “worried well.” The pediatrician can help by being prepared to care for a surge of affected and/or concerned patients and families. However, the ability to keep a practice functional during a disaster requires forethought and planning. Just like at home, the office should stock essential supplies (food, water, flashlights, diapers, etc) to last 72 to 96 hours. Also consider arranging an “office disaster kit” with critical medical supplies that can be easily transported from the office to a remote location, such as a school, to help with medical care if needed. The AAP Preparedness Checklist for Pediatric Practices offers items to consider including in an office disaster kit (www.aap.org/disasters/checklist). Certain disasters may have a direct impact on a health care facility. Pediatricians should work with office managers and staff to conduct a hazard vulnerability assessment to consider the most likely disaster scenarios for their particular community/region (tornado, flood, etc). Planners should assess the office setting and arrange furniture to minimize damage or injuries in case of a major disaster (eg, in flood-prone areas, place essential paper work and equipment at heights; in earthquake-prone areas, keep heavy or hanging objects away from seating areas used by families or patients). Offices should also evaluate and consider securing disaster-specific hazard insurance particular to their region (flood, fire, etc). Office readiness planning should also include an evacuation plan for practices that are in areas deemed unsafe. Pediatricians and other clinicians should have a list of critical office records, equipment, or supplies that would need to be evacuated and a plan to designate staff members to be in charge of specific tasks. Copies of critical documents should be made and stored in a secure manner. These considerations should also include electronic data stored on computers and back-up systems.
Each office should have an evacuation plan that includes removing critical data and equipment if necessary, taking the disaster supply kit and office disaster kit, and knowing how to shut off gas and water lines into the clinic to minimize further damage. Offices should maintain emergency contact information for all employees, so that in the event of a disaster affecting the clinic, staff can help to contact family and friends if needed. Also consider a phone tree whereby additional staff can be contacted to respond to local disasters or help to expand office capacity or hours of operation if needed.24

In the event of a disaster, vaccination status would be important information. Pediatricians must ensure that they continually input their vaccination records into the state or other registry so that this information on patients presenting for care outside the office is accessible and up to date. Knowing vaccination status for infectious diseases, such as influenza, would also be crucial during pandemics, when public health officials could use these records to identify those most at risk. In addition, offices should have an emergency plan for vaccine storage in the case of power outages, so that those vaccines remain viable. Options include a backup generator, storage cooler, and prearranged agreement to transport vaccine vials to another facility. For more information, see the AAP Practice Management: Storage & Handling Web page (www2.aap.org/immunization/pediatricians/storageandhandling.html).

Having a database of patients with special health care needs also would be helpful in the event of any disaster. Knowing which children rely on electrically powered equipment during prolonged power loss would be important for local emergency management and public health officials.24 Knowing which children have underlying neurologic and other conditions that place them at greatest risk for influenza-related morbidity and mortality could help identify those at greatest need for timely vaccination or antiviral agents.5,25 Pediatricians could also check in on patients who rely on daily medications, such as those with insulin-dependent diabetes, to ensure adequate medication availability during infrastructure disruption. All families with CYSHCN should keep an updated emergency information form with their child at all times as well as copies in their home, school, or child care center. Pediatricians should address and review this packet during office visits with these children and their families as part of anticipatory guidance.9,22

In times of disasters or pandemics, primary care physicians and specialists will be required to ease the burden placed on hospitals and other acute care facilities. Clinics may need to expand their operating hours to see more patients during these volume surges. As part of the office disaster plan, a patient flow plan for pandemics is needed, whereby children are screened on arrival and potentially ill children are separated from those who are not ill. Offices should provide adequate personal protective equipment for employees, masks for ill patients and family members, and an adequate amount of hand sanitizer that can be used throughout the facility. During a pandemic, consideration may be given to a pediatric nurse–staffed telephone triage line to screen patients who actually require medical evaluation. Such telephone triage lines have helped to decrease patient volumes in clinics and emergency departments as well as to prevent the spread of illness during past pandemics.18
Pediatricians will be critical in screening and providing care for mental health illnesses that can plague families and children for months and years after a crisis. Clinicians should incorporate mental health screening into the evaluation of all children potentially affected. The immediate goal of care during a disaster is medical stabilization and evaluation. However, shortly afterwards, pediatricians need to play an active role in ensuring that any affected child has a secondary mental health triage. Certain behavioral red flags can suggest the need for more in-depth mental health screening and care. For more information, see the AAP clinical report “Providing Psychosocial Support to Children and Families in the Aftermath of Disaster and Crises.” Pediatricians also should pay attention to signs and symptoms of caregivers struggling to cope after a disaster and recommend resources and mental health services for the entire family. It is important to recognize that mental health problems relating to the disaster may manifest in varied ways, such as PTSD, anxiety, depression, poor school performance, and somatization disorders. Attention to mental health services is crucial for long-term health recovery.

Finally, to provide adequate care for patients and the community, pediatricians must pay attention to self-care for themselves and their families. Being able to respond to the larger community in a disaster requires pediatricians to be well prepared at home, including having adequate supplies and an emergency plan for their families and loved ones. In addition, responding to any disaster scenario will be emotionally and physically exhausting. Clinicians and other disaster responders are at risk for “burnout” or “compassion fatigue,” which can lead to long-term personal and professional health implications. Responding to a disaster scenario often entails long hours with little rest, strained resources, and the possibility that a provider's family and friends are also directly affected by the crisis. The psychological stress of practicing in these situations can place pediatricians at risk for depression, anxiety, substance abuse, and poor coping responses. Pediatricians and other clinicians need to ensure that they make time for adequate rest, respite away from clinical duties, good nutrition, and time with family. They should consider forming informal support groups during the disaster response to cope with the stress of disaster response and possibly long-term mental health attention for symptoms of PTSD, depression, and anxiety.

Long-term Planning and Regional Preparedness

Pediatricians can help to prepare their community by getting involved in local or regional disaster planning. Pediatricians have subject matter expertise and a unique set of skills to ensure that children's needs are considered in advance. This planning can help to mitigate the effects and disruption of a disaster on the well-being of children, families, and pediatric health care delivery.

Pediatricians can get involved in local/regional disaster planning in various ways. Each AAP state chapter should identify at least 1 member to serve as the chapter contact for local and regional disaster preparedness planning. That person can join the AAP electronic mailing lists; participate in webinars, conferences, and other educational opportunities; and help distribute relevant information to other AAP members in his/her state to update chapter members about current disaster potential and planning. These chapter contacts can also ensure that each state has an action plan to address the needs of children (www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-
One of the most important challenges during a disaster is efficient and accurate distribution of information to the public. Establishment of a communication plan ahead of time is crucial. Ideally, information should come from a single trusted source involved directly with the disaster management, such as the communications officer who is part of the community's incident command team. The information should be distributed quickly to public health officials and clinicians, who can help to further disseminate the information to the public. This may be especially important in the face of conflicting information in traditional and social media. The goal is to limit conflicting information, provide a common message about a health crisis, and give a single communication message to the public with simple instructions, i.e., “one voice, one message.”

As trusted sources of information, pediatricians can ensure that their patients and families receive accurate information. Pediatricians can help to distribute this health message by posting updated information in their offices, having on-call staff who are up to date with the message, and having a plan to distribute the information to families when they call in with questions. During a pandemic or disaster, it would be helpful to have additional staff available to field calls. Diverse media outlets, such as Twitter, Facebook, and group texts, in addition to radio and television, can be used as well. Pediatricians should also ensure they have 2-way communication with public health officials, whereby they can distribute information including concern for potential new outbreaks of infectious diseases, medication shortages, and basic health needs of their patients and families (i.e., access to water, diapers, etc.).

The best time to establish effective 2-way communication is in advance of an event.

Most hospitals conduct regular disaster drills as part of the Joint Commission or state regulatory requirements to have an “all hazards” disaster plan. However, fewer than half of general hospitals routinely include pediatric patients in their drills. Pediatricians can join local hospital emergency management teams to help organize disaster drills and ensure that children are included as drill “victims.” This is critical for ensuring that hospitals have appropriate pediatric emergency equipment, medications, and supplies; plans for the evacuation of pediatric patients (i.e., nonambulatory children); and a plan for unaccompanied children, including secure tracking and reunification with their families.

Local school district representatives should also be included in drill planning. Along the same lines, pediatricians can help with hospital and prehospital preparedness in their communities by reviewing recommendations for standard pediatric equipment in all hospitals and EMS.

Few in the community are more in tune to the most vulnerable pediatric populations than pediatricians. They can partner with their state or local health department to organize a system to identify high-risk children during pandemics (flu vaccine registry, registry for CYSHCN). They can reach out to the foster care and juvenile justice systems to ensure that disaster plans are in place, including legal protection for this group of children (e.g., “Who will be medical guardians in case of need for medical treatment?” “Who will care for these children if their shelter/home is compromised?”).

Emergency shelters serve hundreds of people in times of disasters and disruptions of home
environments. However, shelters also hold potential dangers for children, such as allowing sex offenders into the same space as children and violence among stressed populations housed in a small location. Pediatricians can help local organizations that support disaster relief efforts, such as faith-based groups and Red Cross chapters, to be prepared to serve affected individuals of every age. They can ensure that these groups have appropriate supplies (diapers, cribs, formula), follow safety precautions to protect unaccompanied and other children from the media and potential predators, and identify local mental health resources available to families. The National Commission on Children and Disasters has compiled a guide to basic shelter management and essential supplies to serve as a reference.

In addition to providing immediate local care in times of disaster, pediatricians can respond at a state, regional, national, and even international level. There are several options for AAP members to volunteer on organized disaster medical assistance teams (www.phe.gov/preparedness/responders/ndms/teams/pages/dmat.aspx), pediatric strike teams, and or as part of the Medical Reserve Corps (www.medicalreservecorps.gov/HomePage). Becoming part of such a response team may help provide adequate care to children even when resources are stretched thin in a large-scale disaster. In medical tents staffed by disaster medical assistance teams after Hurricane Katrina, 12% of patients were children, and more than half of those were younger than 2 years. The types of injuries and illnesses ranged from lacerations and infected wounds to asthma and diabetes. Having pediatric expertise on disaster response teams is critical to ensure that children receive the specialized care they require.

Pediatricians can register their credentials ahead of time with their state Emergency System for Advanced Registration of Volunteer Health Professionals (www.phe.gov/esarvhp/pages/about.aspx) or with the Medical Reserve Corps (www.medicalreservecorps.gov/HomePage). In cases of disaster, clinicians with preestablished credentials may be able to respond to any local hospital to help provide pediatric care.

Basic Supportive Services and Psychological First Aid

Attention to the basic needs of individuals affected by a disaster is a top priority for immediate response. This includes food, shelter, safety, supervision, communication, and reunification with loved ones. Ensuring that these basic needs are addressed is the first step to providing emotional support.

In addition, all individuals directly affected by an overwhelming event should be provided psychological first aid. Psychoeducation and supportive services can accelerate the natural healing process and promote effective coping strategies. These services includes providing timely and accurate information to facilitate adjustment; offering appropriate (but not false) reassurance against misconceptions and misperceptions that might otherwise increase risk and fear; supplying information about likely reactions and practical strategies to facilitate coping with distress; and helping people identify support in their family and useful resources in their community. One such
model for psychological first aid that is readily accessible to those outside the mental health field is Listen, Protect, and Connect.\textsuperscript{30} Pediatricians and other pediatric clinicians should ensure that all staff in their practice setting, including front office and support staff, are familiar with psychological first aid and are ready to provide such support to children and adults in the aftermath of a disaster. Given that children and families who present to health care settings are often in distress, these are useful skills that can be practical on a daily basis even outside the context of a disaster. In addition, other adults who care for children, such as staff at child care facilities and schools, also should be familiar with these strategies; this is important to create resilient communities that are able to support children in the aftermath of a disaster.

**Conclusions**

Natural and man-made disasters are an unfortunate global reality. Increased attention has been given to disaster planning and medical advances to help to treat illnesses such as influenza. However, any disaster or new pandemic has the potential to significantly disrupt local infrastructure, overwhelm health care capacity, and cause long-term mental health problems for victims and health care responders. Children are an especially vulnerable population in any such scenarios. Without advanced planning and practice to specifically address the needs of children, morbidity and mortality rates among children will likely increase. Pediatricians have a unique perspective, knowledge, and skill set to ensure that their community is prepared to meet children's needs in a disaster. Pediatricians should ensure that they have prepared their home, family, self, and office staff for any potential disaster that could reasonably arise. They should be willing to assist on a local, regional, or even national level to care for a vulnerable population.

Table 1 includes a list of Web sites and resources that clinicians can review; some of these are appropriate for sharing with families.

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**AAP Policy**


References


Related Handouts

Four Steps to Prepare Your Family for Disasters (/handout.aspx?gbosid=166214)

Related Multimedia

AAP Policy

*Emergency Information Forms and Emergency Preparedness for Children With Special Health Care Needs* (http://pediatrics.aappublications.org/content/125/4/829.full)

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The Pediatrician and Disaster Preparedness (http://pediatrics.aappublications.org/content/117/2/560.full)

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