MEDICAL PLAN (ICS 206), Adapted for COVID

1. Incident Name: COVID-19	2. Operational Period: Date From: Date To: Time From: Time To:

3. Medical Aid Stations including screening sites:

Name	Location	Contact Number(s)/Frequency	Paramedics on Site?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

4. Transportation:

Ambulance Service	Location	Contact Number(s)/Frequency	Level of Service
			☐ ALS ☐ BLS
			☐ ALS ☐ BLS
			☐ ALS ☐ BLS
			☐ ALS ☐ BLS

5. Hospitals:

Hospital Name	Address	Contact Number(s)	Distance	Trauma Center	Isolation Unit	Helipad
				☐ Yes Level:_____	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes Level:_____	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes Level:_____	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes Level:_____	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes Level:_____	☐ Yes ☐ No	☐ Yes ☐ No

6. Special Medical Emergency Procedures:

1) All patients, unless deemed extremely critical, will be screened in tents outside the facility to assess: (a) CDC risk factors; (b) presenting symptoms; (c) exposure risk[s]; and (d) need for isolation and/or quarantine
2) All staff performing triage will have and use proper PPE as per the AHJ
3) All staff performing triage and/or working in the triage area(s) will have their vital signs, including temperature taken at least twice (2X) per shift.
4) Any staff having a temperature >100.3 will be relieved of duty and sent for further assessment to include testing.
5) Any actual or potential occupational exposures in the triage areas will be documented and reported as per AHJ.
6) All staff will implement the AHJ's Infection Control protocols for handwashing, disinfection, site management, and patient isolation
7) Patients will be limited to no more than two (2) visitors at a time for no more than 30 minutes at a time – four (4) hour intervals between visits – NO VISITS AFTER 8 P.M.

7. Prepared by (Medical Unit Leader)**:** Name: _____ Signature: _____

8. Approved by (Safety Officer)**:** Name: _____ Signature: _____

ICS 206	IAP Page _____	Date/Time: _____

Updated by FDA 2/2011

ICS 206
Medical Plan

Purpose. The Medical Plan (ICS 206) provides information on incident medical aid stations, transportation services, hospitals, and medical emergency procedures.

Preparation. The ICS 206 is prepared by the Medical Unit Leader and reviewed by the Safety Officer to ensure ICS coordination.

Distribution. The ICS 206 is duplicated and attached to the Incident Objectives (ICS 202) and given to all recipients as part of the Incident Action Plan (IAP). Information from the plan pertaining to incident medical aid stations and medical emergency procedures may be noted on the Assignment List (ICS 204). All completed original forms must be given to the Documentation Unit.

Notes:

- The ICS 206 serves as part of the IAP.
- This form can include multiple pages.

Block Number	Block Title	Instructions
1	**Incident Name**	Enter the name assigned to the incident.
2	**Operational Period** • Date and Time From • Date and Time To	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	**Medical Aid Stations**	Enter the following information on the incident medical aid station(s):
	• Name	Enter name of the medical aid station.
	• Location	Enter the location of the medical aid station (e.g., Staging Area, Camp Ground).
	• Contact Number(s)/Frequency	Enter the contact number(s) and frequency for the medical aid station(s).
	• Paramedics on Site? ☐ Yes ☐ No	Indicate (yes or no) if paramedics are at the site indicated.
4	**Transportation**	Enter the following information for ambulance services available to the incident:
	• Ambulance Service	Enter name of ambulance service.
	• Location	Enter the location of the ambulance service.
	• Contact Number(s)/Frequency	Enter the contact number(s) and frequency for the ambulance service.
	• Level of Service ☐ ALS ☐ BLS	Indicate the level of service available for each ambulance, either ALS (Advanced Life Support) or BLS (Basic Life Support).

Block Number	Block Title	Instructions
5	**Hospitals**	Enter the following information for hospital(s) that could serve this incident:
	• Hospital Name	Enter hospital name
	• Address	Enter the physical address of the hospital
	• Contact Number(s)/ Frequency	Enter the contact number(s) and/or communications frequency(s) for the hospital.
	• Distance	Enter the distance in miles to the hospital.
	• Trauma Center ☐ Yes Level:_____	Indicate yes and the trauma level if the hospital has a trauma center.
	• Isolation Units ☐ Yes ☐ No	Indicate (yes or no) if the hospital has an Isolation Unit.
	• Helipad ☐ Yes ☐ No	Indicate (yes or no) if the hospital has a helipad.
6	**Special Medical Emergency Procedures**	Note any special emergency instructions for use by incident personnel, including (1) who should be contacted, (2) how should they be contacted; and (3) who manages an incident within an incident due to a rescue, accident, etc. Include procedures for how to report medical emergencies.
7	**Prepared by** (Medical Unit Leader) • Name • Signature	Enter the name and signature of the person preparing the form, typically the Medical Unit Leader. Enter date (month/day/year) and time prepared (24-hour clock).
8	**Approved by** (Safety Officer) • Name • Signature • Date/Time	Enter the name of the person who approved the plan, typically the Safety Officer. Enter date (month/day/year) and time reviewed (24-hour clock).

Updated by FDA 2/2011