



State Of Ohio
EMS Health Crisis Planning
Awareness Essentials for Patient Care Delivery
by the EMS Provider

Course Handbook

Ohio Department of Public Safety
Division of Emergency Medical Services

EMS/Homeland Security Committee

Version 1.0

August 2006



Table of Contents

Introduction.....

Basic Definitions.....

START Triage.....

Jump START Triage.....

Treatment Area.....

Mandatory Actions during a Potential Health Crisis.....

WMD/NBC Agents with Antidotes for EMS Use in the
Prehospital Setting.....

Specialized Protocols.....

Informational Resources.....

Introduction

The Ohio Department of Public Safety has provided disaster management, incident command, and weapons of mass destruction awareness programs for personnel who protect and support the citizens of Ohio during mass casualty events. Health crisis planning requires coordination between EMS providers, hazardous materials (HazMat) teams, law enforcement, public health agencies, and health care facilities. In November 2004, the Ohio Department of Public Safety formed the EMS/Homeland Security Committee to identify and address health crisis needs that are specific to EMS providers and to reinforce existing network between EMS and our colleagues in crisis management.

The NIMS IS 700 and State of Ohio WMD Awareness courses address basic disaster management needs for first responders, EMS providers, and law enforcements personnel. The EMS/Homeland Security Committee has recognized that EMS providers will be the largest source of manpower in the prehospital setting with specialized responsibilities and capabilities for the provision of patient care. Furthermore, the EMS/Homeland Security Committee has recognized that there are critical actions that EMS providers are certified to perform in the prehospital setting with the appropriate training that will save and protect lives during an event that creates a health crisis.

The State of Ohio EMS Health Crisis Planning: Awareness Essentials for Patient Care Delivery by the EMS Provider course will provide basic awareness of the provision of medical care during a health crisis for our EMS providers. The information provided by this course is not meant to replace the resources and information available from the Emergency Management Agency, Department of Health, Department of Homeland Security, or HazMat agencies nor is it meant to be inclusive of all agents that may cause a health crisis. The information provided by this course is directed toward actions and utilization of resources, including antidotes that are available to EMS providers, in the prehospital setting during a health crisis. The course provides a baseline level of health crisis management awareness for all EMS providers functioning in the state of Ohio, and serves as a foundation upon which every EMS provider should build a greater knowledge base.

Basic Definitions

Disaster



Any disaster, whether it is natural, accidental, or covert act of terrorism, can trigger a health crisis. By definition, a **disaster** is defined as any event, regardless of size or expanse, that overwhelms the available resources.

Triage



Trier is a French verb that means “to sort”. **Triage** is the sorting and allocation of treatment to patients and especially to battle and disaster victims according to a system of priorities designed to maximize the number of survivors. Triage of victims is essential to the initial management of a disaster after scene safety has been secured.

START Triage



The State of Ohio has adopted the START triage system as the method of triage during a health crisis. **START** stands for **S**imple **T**riage **A**nd **R**apid **T**ransport and does not require any medical equipment such as stethoscopes, blood pressure cuffs, or monitors to perform.

The START triage system is based upon the assessment of the patient’s ambulatory status, respiratory status, pulse or perfusion, and mental status. As the EMS provider approaches the

scene, all patients should be asked to walk to a central location. This allows the providers to gather all of the ambulatory patients in one location and provides a quick triage for patients whose injuries are not immediately life threatening. Those patients that are unable or unwilling to walk promptly need further evaluation.

As the EMS provider approaches the remainder of the patients, he will initially determine if respirations are present. If not the patient is not breathing, the airway is repositioned and the patient is assessed again for the presence or absence of respirations. If respirations are absent, the patient is triaged as unsalvageable or dead, and no further patient assessment is indicated.

All non-ambulatory patients who are breathing will need prompt care. If respirations are present, the respiratory rate is measured and determined to be normal or abnormal (greater than 30 breaths per minute). Non-ambulatory patients with a respiratory rate greater than 30 breaths per minute need immediate care and do not need any further triage assessment.

If the non-ambulatory patient has respirations at a rate less 30 breaths per minute, the EMS provider should determine if the patient has a radial pulse or assess the patient's capillary refill. Lack of a radial pulse or capillary refill greater than 2 seconds is considered abnormal. Non-ambulatory patients with respirations less than 30 breaths per minute and abnormal capillary refill or absence of a radial pulse need immediate care and do not need further triage assessment.

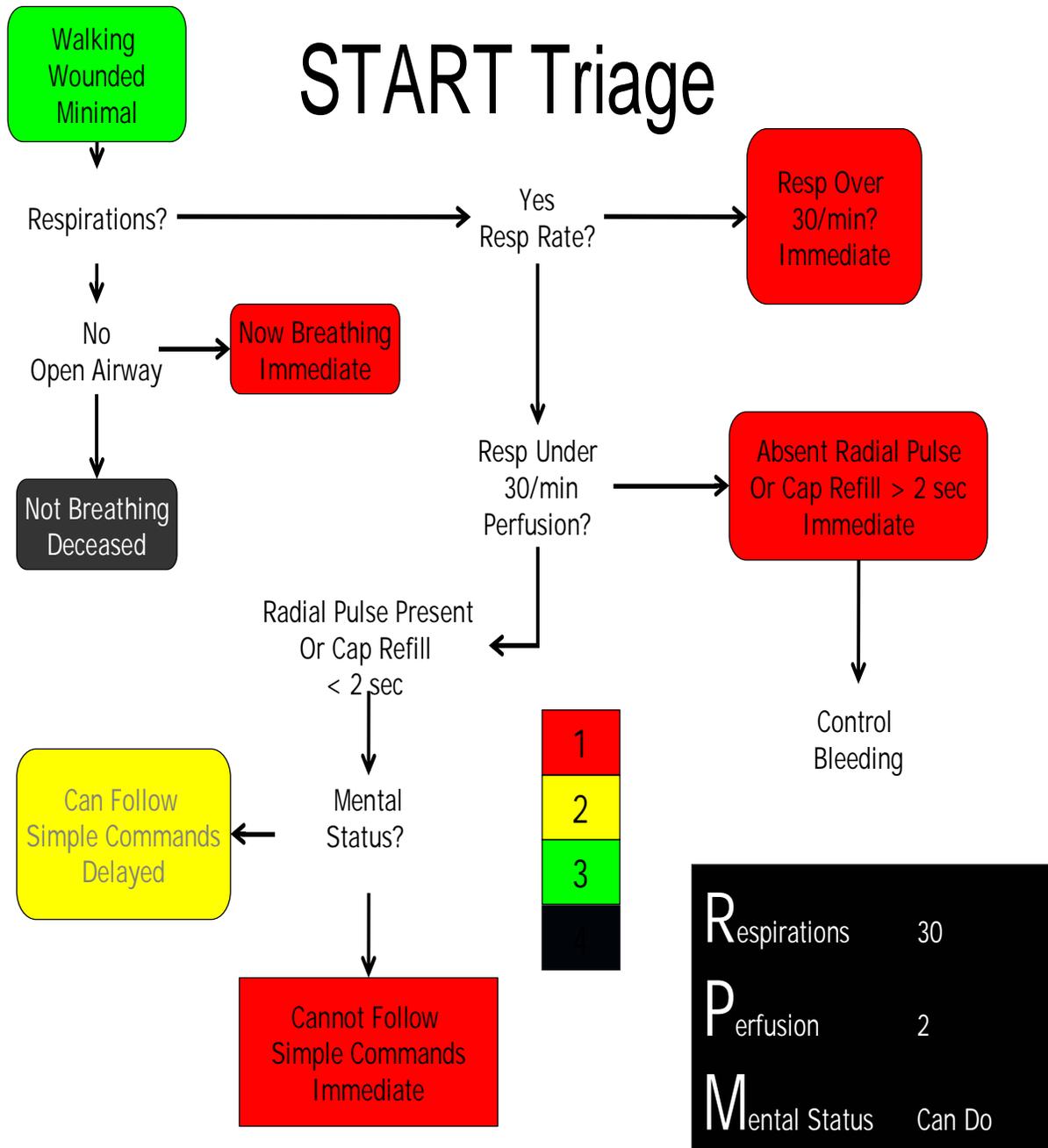
Lastly, the EMS provider determines if the patient's mental status is normal or abnormal (unable to follow simple commands). Non-ambulatory patients with a respiratory rate greater than 30 breaths per minute and presence of a radial pulse or normal capillary refill who can follow a simple command can receive delayed care. The non-ambulatory patient with a respiratory rate greater than 30 breaths per minute and presence of a radial pulse or normal capillary refill who cannot follow a simple command will need immediate care.

The START triage categories are based on four colors that match the color of triage tag that is attached to the patient. In addition to the START triage tags, many systems also use mass casualty triage ribbons whose colors match those used in the START triage system.

Patients who are ambulatory with minor injuries are tagged green and their transport to a health care facility can be delayed. Patients who have normal respirations, a pulse with normal capillary refill, and a normal mental status but are not ambulatory are tagged yellow and their transport to a health care facility should be completed urgently. Patients who required repositioning of their airway to initiate respirations, have a respiratory rate greater than 30 breaths per minute, delayed capillary refill, or are unable to follow commands are tagged red and should be transported to a health care facility immediately. Patients who have no respirations even after repositioning of the airway are considered dead or unsalvageable and are tagged black without assessment of pulse or mental status.

The key to management of a mass casualty incident (MCI) is the expeditious initiation of patient triage. With the exception of personal protective equipment, scene safety, and resources allocation, patient triage should be the highest priority and all available personnel should be assigned to this task. Using the START triage system, each patient contact should take no more than 15 to 30 seconds and facilitates an EMS provider to triage 40 patients in 10 to 20 minutes. The only patient care that should be delivered during the primary triage process is opening airways and controlling major bleeding in patients who are breathing. Dedication of

additional manpower, time, and resources during primary stages of triage to one patient will result in the loss of life for many others. Patient triage and the START triage system saves lives and provides focus. Following the completion of primary triage, the patients are moved to a treatment area for secondary and ongoing triage. Patients in the treatment area may have their triage categories upgraded or downgraded based upon their assessment.



Jump START



The START triage system will not apply to the pediatric population, yet EMS must also be prepared to triage these patients appropriately. The Jump START triage system was designed to address the needs of the pediatric population during crisis management.

In a crisis situation, it will be difficult, if not impossible, to accurately determine a patient's age. If the patient looks like an adult, use the START triage criteria. If the patient looks like a child, use the Jump START triage guidelines. Some pediatric patients who are minimally injured are developmentally unable to walk. The adult START triage system does not have provisions for these patients tagged green despite minimal or no injury.

A respiratory rate greater than 30 is normal in a young child and it would be inappropriate to triage these patients with red tags. The majority of cardiac arrests in the pediatric population are due to a respiratory arrest. Therefore, a slow respiratory rate is an ominous symptom in a child and should be addressed immediately (i.e. red tag).

Capillary refill in the pediatric population is a valuable patient assessment tool. However, in a crisis situation, the lighting and cool temperatures may make capillary refill difficult to assess.

The mental status assessment in the START triage system may not be applicable to a child who is developmentally too young to follow commands or comprehend speech.

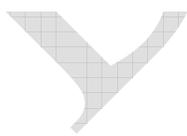
Pediatric patients who are ambulatory are tagged green, but must undergo a secondary triage to assess for further injuries as well as potential for rapid deterioration. If the child is unable to ambulate, the respiratory status should be assessed immediately. If the child is not breathing, reposition the airway. If respirations resume with repositioning, the child is tagged red and should be transported immediately. If the patient remains apneic with repositioning of the airway, assess the pulse. If the pulse is absent, the child is deceased and tagged black. If the apneic child has a pulse, five rescue breaths should be given. If respirations resume, the child is tagged red and transported immediately. If apnea persists, the child is unsalvageable and tagged black.

If the child is not ambulatory but has respirations, the respiratory rate should be measured and classified as normal (15-45 breaths per minute) or abnormal (less than 15 or greater than 45 breaths per minute). Non-ambulatory children with an abnormal respiratory rate are tagged red and require immediate transport. If the respiratory rate is normal, check for a pulse. A child with a normal respiratory rate and no palpable pulse is tagged red and transported immediately.

Non-ambulatory children with a normal respiratory rate and a palpable pulse are then assessed for responsiveness. Children who are unresponsive, respond inappropriately to pain, or are posturing are tagged red and transported immediately. The non-ambulatory child who is alert or responds appropriately to verbal or painful stimuli is tagged yellow and can be transported to a health care facility in a delayed fashion.

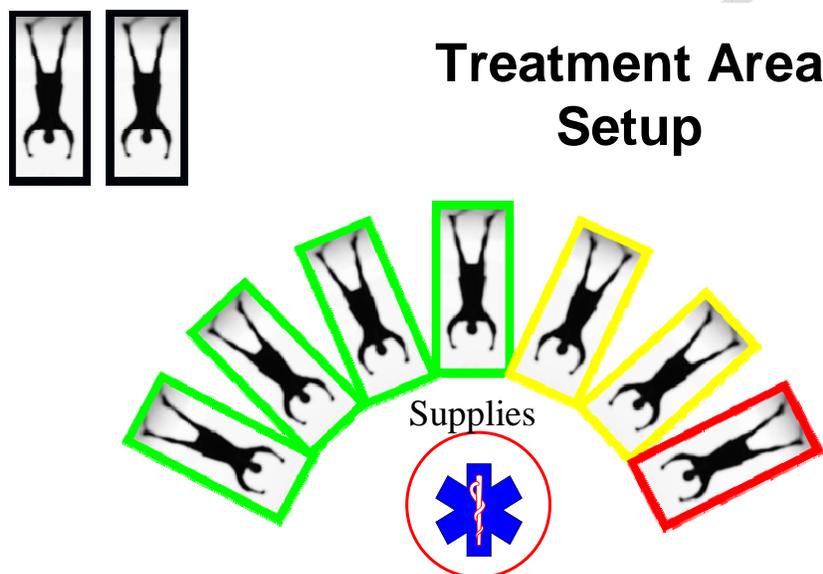
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Jump START



Treatment Area

The treatment area should be partitioned into areas that coincide with the START triage groups to facilitate appropriate patient transport. Deceased or unsalvageable patients who are tagged black should not be placed in view of the patients with red, yellow, or green tags, and preferably should be retained at a separate site. Ideally, the treatment area should be in a circle or semi-circle with the patient's head towards the center for ease of airway access by the EMS provider.



Form a semi-circle or circle for each treatment area with the patient's head towards the center of the circle

Mandatory Actions during a Potential Health Crisis

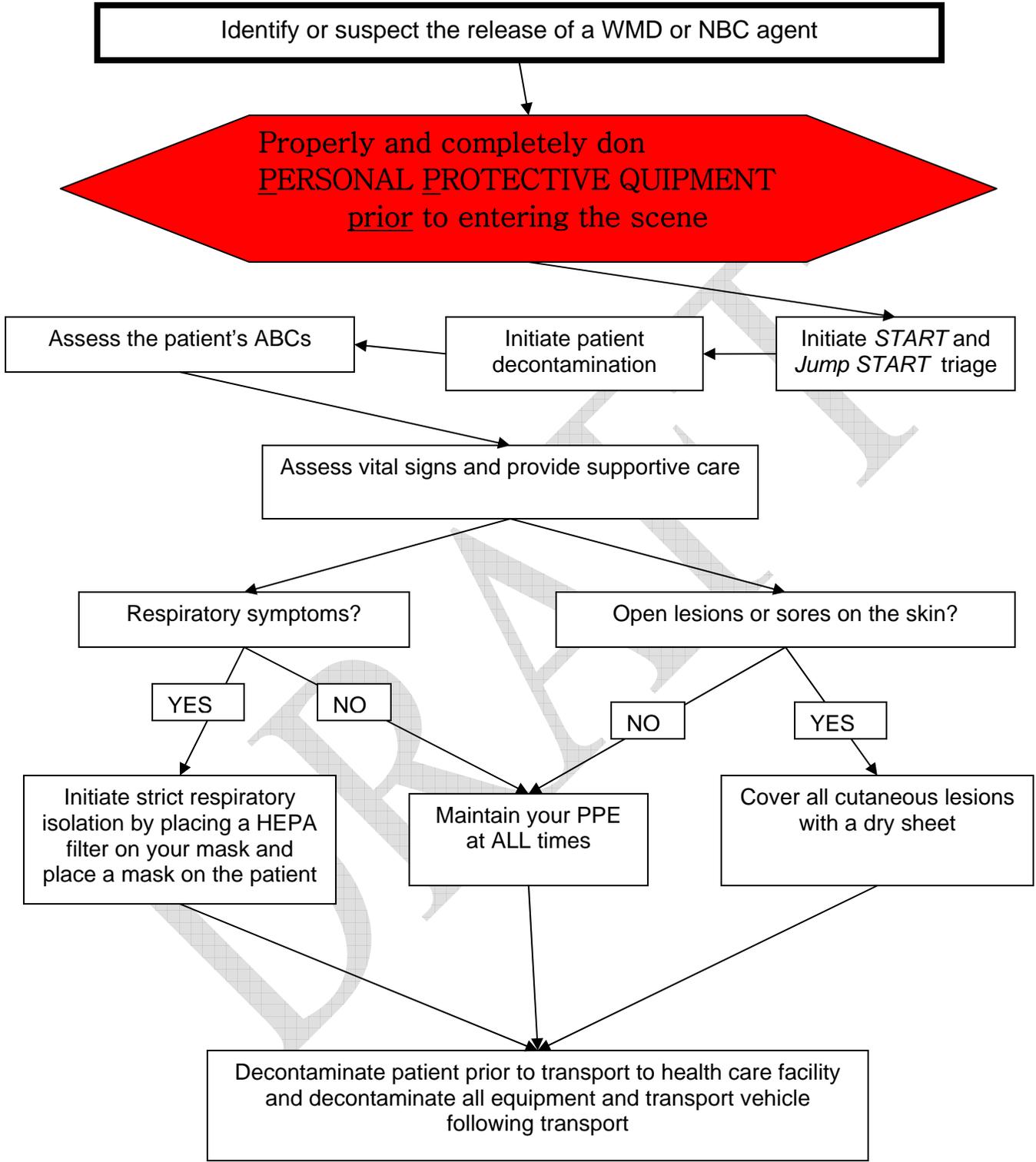


An EMS health crisis may result from the release of weapons of mass destruction (WMD) of nuclear, biologic, or chemical (NBC) agents. Although it may be impossible to identify the agent on the scene, the EMS provider must be aware that these agents exist and may present additional challenges to patient care delivery. There are a host of WMD and NBC agents; however, for the purposes of this course, we will concentrate on those agents which will require specific additional actions by the EMS provider.

It is mandatory that every EMS provider in the state of Ohio be proficient in donning and doffing personal protective equipment (PPE). This is the most important skill that an EMS provider must exercise during a disaster resulting in health crisis. You will be useless to your EMS team and to your patients if you fail to recognize the need for PPE or fail to don it properly. Despite the potential chaos that is inherent during a disaster, use of universal precautions is mandatory at all times just as they are during operations on an ordinary day.

When you arrive on scene, initiate START and Jump START triage. You can remove the clothing and begin decontamination of the patients until the hazardous materials support team arrives. In order to prevent further contamination, it is essential to decontaminate the patient prior to transport to a health care facility. Once the patients are triaged, continue to assess the airway breathing, and circulation as some patients may deteriorate prior to transport and require changing the color of their START triage tag.

You will most likely not be able to identify offending agent in the field. If a patient has respiratory symptoms, exercise strict respiratory isolation by placing a HEPA filter on your mask and placing a mask on the patient. Any cutaneous lesions should be covered with a dry sheet to prevent further contamination. All equipment, including the transport vehicle, will need to be decontaminated appropriately before being placed back into service.



WMD/NBC Agents with Antidotes for EMS Use in the Prehospital Setting



Antidotes to three WMD/NBC agents are currently available to EMS providers in the prehospital setting. These agents are cyanide, nerve agents, and organophosphates. The course provides basic information regarding the antidotes that are most commonly available throughout the state of Ohio, but is not inclusive of all medications used as antidotes.

The treatment of cyanide, nerve agents, and organophosphates exposures should be initiated in the field as these agents rapidly cause death. Although it is important to be familiar with the antidotes for these agents, it is imperative for all EMS providers to recognize the signs and symptoms caused by these agents.

Cyanide

Cyanide blocks the use of oxygen by the cells of the body. It has the odor of bitter almonds, but half of the population is unable to smell it. Pulse oximetry is not helpful in the diagnosis as the pulse oximetry reading is often normal.

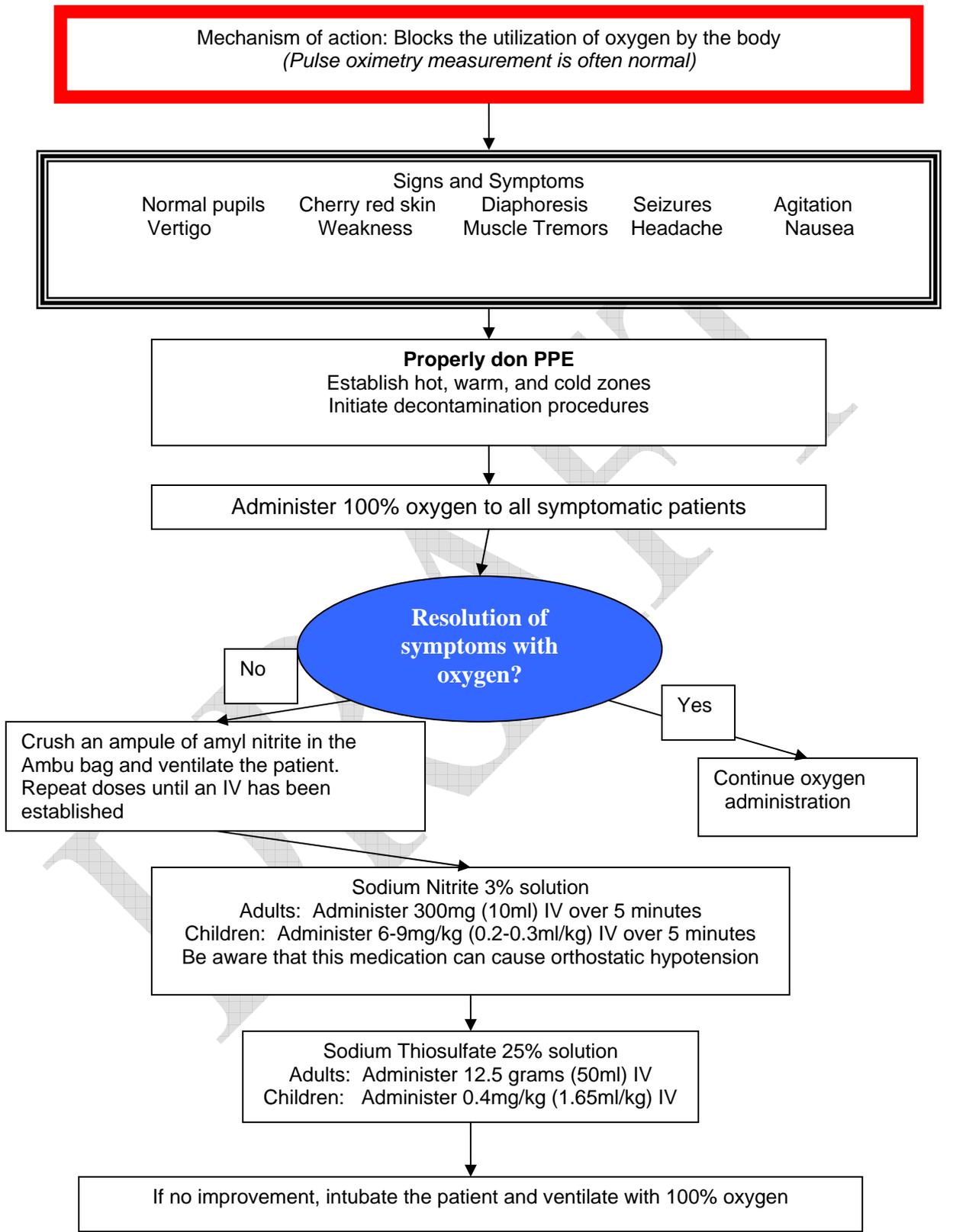
The signs and symptoms of cyanide exposure include normal pupils, cherry red skin, diaphoresis, seizures, agitation, vertigo, weakness, muscle tremors, headache, or nausea. It is important to appreciate the rapid onset of these symptoms. The patient may develop dyspnea and tachypnea followed by sudden collapse. Cyanide will cause death within 4-10 minutes if not treated quickly. The patient's pupil size may be normal until they are in the terminal stages of poisoning. Cherry red skin, diaphoresis, and the neurologic symptoms are the hallmarks of cyanide exposure.

Administer oxygen to the all patients. If the patient is unconscious or not breathing, ventilate the patient with 100% oxygen via a bag valve mask and crush an ampule of amyl nitrite into the bag. This is a temporizing measure that can be repeated until the necessary IV medications are administered. Once the IV is established, sodium nitrite should be given intravenously followed by sodium thiosulfate intravenously with dosing according to your local EMS protocol or the state of Ohio WMD protocol.



Cyanide Antidote Kit

State of Ohio Cyanide Exposure Guidelines and Procedures



Organophosphates

Both nerve agents and organophosphates act by blocking the enzyme acetylcholinesterase in the nerve endings. The signs and symptoms that they produce are similar, although the antidote doses required for treatment of an organophosphate exposure are typically higher than that for a nerve agent. Nerve agents are toxic and are not available to the general public. Organophosphates are in pesticides and are easily bought and sold to the public every day.

SLUDGEM is the mnemonic used to describe the symptoms caused by nerve agents and organophosphates. There will be excessive secretions in the form of salivation, excessive tearing, urination, diarrhea, and vomiting as well as abdominal cramping, muscle twitching, and pinpoint pupils. The onset of symptoms and progression to death will vary depending on the amount and route of exposure.

S-Salivation
L-Lacrimation (tearing)
U-Urination
D-Defecation
G-Gastrointestinal upset
E-Emesis
M-Muscle twitching/Miosis

The Mark I kits contain atropine and 2-PAM are designed for the rescue of the symptomatic first responder, but they can be administered to victims as well. The medications in these kits are contained in auto-injectors which avoids the delay of drawing it out of a bottle into a syringe and provides ease in rapid administration.

For symptomatic patients, atropine and 2-PAM should be administered intravenously or intramuscularly in doses according to your local EMS protocols or the State of Ohio WMD protocols. An exposure to a nerve agent or organophosphate does not directly affect the victim's heart rate. Therefore, administration of the contents of a Mark I kit should not be withheld during a known or suspected nerve agent or organophosphate exposure regardless of the victim's heart rate.

The EMS Board of the State of Ohio recently changed the administrative rules to allow EMS providers of all certification levels to administer nerve agent antidote auto-injectors in a declared emergency if they have received the proper training to perform the procedure.

Mark I Kits



State of Ohio Nerve Agent Exposure Guidelines and Procedures

Mechanism of action: Inhibition of acetylcholinesterase causing overstimulation of the nervous system

Signs and Symptoms

SLUDGEM

Salivation, **L**acrimation, **U**rination, **D**efecation,
Gastrointestinal upset, **E**mesis, **M**uscle twitching/**M**iosis

Properly don PPE

Establish hot, warm, and cold zones
Initiate decontamination procedures

Infant or young child

Older child or adult

Administer atropine 0.02 mg/kg IV or IM every 5 minutes until secretions diminish.
For mild to moderate exposures (SLUDGEM, agitation, respiratory distress), give 1-2 doses of atropine initially.
For severe exposures (SLUDGEM, agitation, respiratory distress, seizures), give 3 doses of atropine initially.

Administer atropine 2 mg IV or IM every 5 minutes until secretions diminish.
For mild to moderate exposures (SLUDGEM, agitation, respiratory distress), give 1-2 doses of atropine initially.
For severe exposures, (SLUDGEM, agitation, respiratory distress, seizures), give 3 doses of atropine initially.

If dyspnea develops, administer pralidoxime (2-PAM) 25-50 mg/kg IV or IM only after the patient begins to improve after atropine

If dyspnea develops, administer pralidoxime (2-PAM) 1 gm IV or 600 mg-1.2 gm IM only after the patient begins to improve after atropine

If a CHEMPACK has been opened, administer diazepam 0.2-0.5 mg/kg IV or 0.5 mg/kg rectally for seizures (maximum dose of 5 mg); otherwise follow your local protocols for treatment of seizures

If a CHEMPACK has been opened, administer diazepam 5-10 mg IV for seizures (maximum dose of 10 mg); otherwise follow your local protocol for treatment of seizures

Specialized Protocols

In the event of a declared disaster or emergency, EMS providers may be authorized by order of the governor, public health director, state or local EMS medical directors, or the federal government to administer medications under specialized protocols. The Department of Health and Human Services, the Department of Homeland Security, and the Centers for Disease Control have developed a Strategic National Stockpile (SNS) program throughout the country. The SNS has medications that will be urgently needed by patients exposed to WMD or NBC agents for treatment and prophylaxis. The goal of the SNS is to position these medications closer to the public for rapid distribution. The medications will provide the initial treatment until the patients can be transported to a health care facility or until additional supplies of medications can be delivered to the affected areas.

CHEMPACK

The CHEMPACK program provides a SNS of medications to hospitals and EMS agencies in the event of a potential nerve agent exposure. The CHEMPACK should only be used when the number of people affected by the nerve agent will overwhelm the nerve agent antidote resources of the local EMS agencies and hospitals. Designated hospitals will have hospital CHEMPACKs for hospital use and EMS CHEMPACKs for distribution to EMS providers in the field. The EMS CHEMPACK contains Mark 1 auto-injectors, atropine solution and auto-injectors, diazepam (Valium) solution and auto-injectors, 2-PAM solution, and vials of sterile water. The atropine and 2-PAM are administered to treat the SLUDGEM symptoms and the diazepam is used to treat seizures.

CHEMPACK deployment requires a suspected or confirmed nerve agent release that will affect a large number of patients and will overwhelm the local EMS and hospital supplies of nerve agent antidotes. Due to variations in resources throughout the state of Ohio, regional CHEMPACK deployment protocols have been developed to best meet the needs of the local EMS agency, local health care facilities, and the citizens served within their geographic area. The CHEMPACK fielding procedures were developed by the CDC, the Ohio Department of Health, and the Ohio Department of Public Safety, Division of EMS. The fielding procedures determine the local authorities to be contacted by EMS to initiate a CHEMPACK deployment and present guidelines to coordinate the efforts of the CDC and local health care facilities to best support EMS during the CHEMPACK deployment.

During a CHEMPACK deployment, utilization of the State of Ohio WMD nerve agent protocol is mandatory and supersedes local EMS protocols for nerve agent treatment only. The State of Ohio WMD nerve agent protocol that is to be followed during a CHEMPACK deployment is outlined in the algorithm that follows.

The dose of atropine is 0.02 mg/kg IV or IM for the pediatric patient and 2 mg IV or IM for the adult patient every five minutes until secretions diminish. If an auto-injector is administered, a dose calculation prior to administration is not necessary and additional auto-injectors can be administered until secretions diminish. Pediatric atropine auto-injectors (0.5 mg) should be administered to children who appear to weigh up to 20 kilograms. The EMS provider can administer two pediatric atropine auto-injectors (0.5 mg) simultaneously to an adult if adult atropine auto-injectors (1.0 mg) are unavailable.

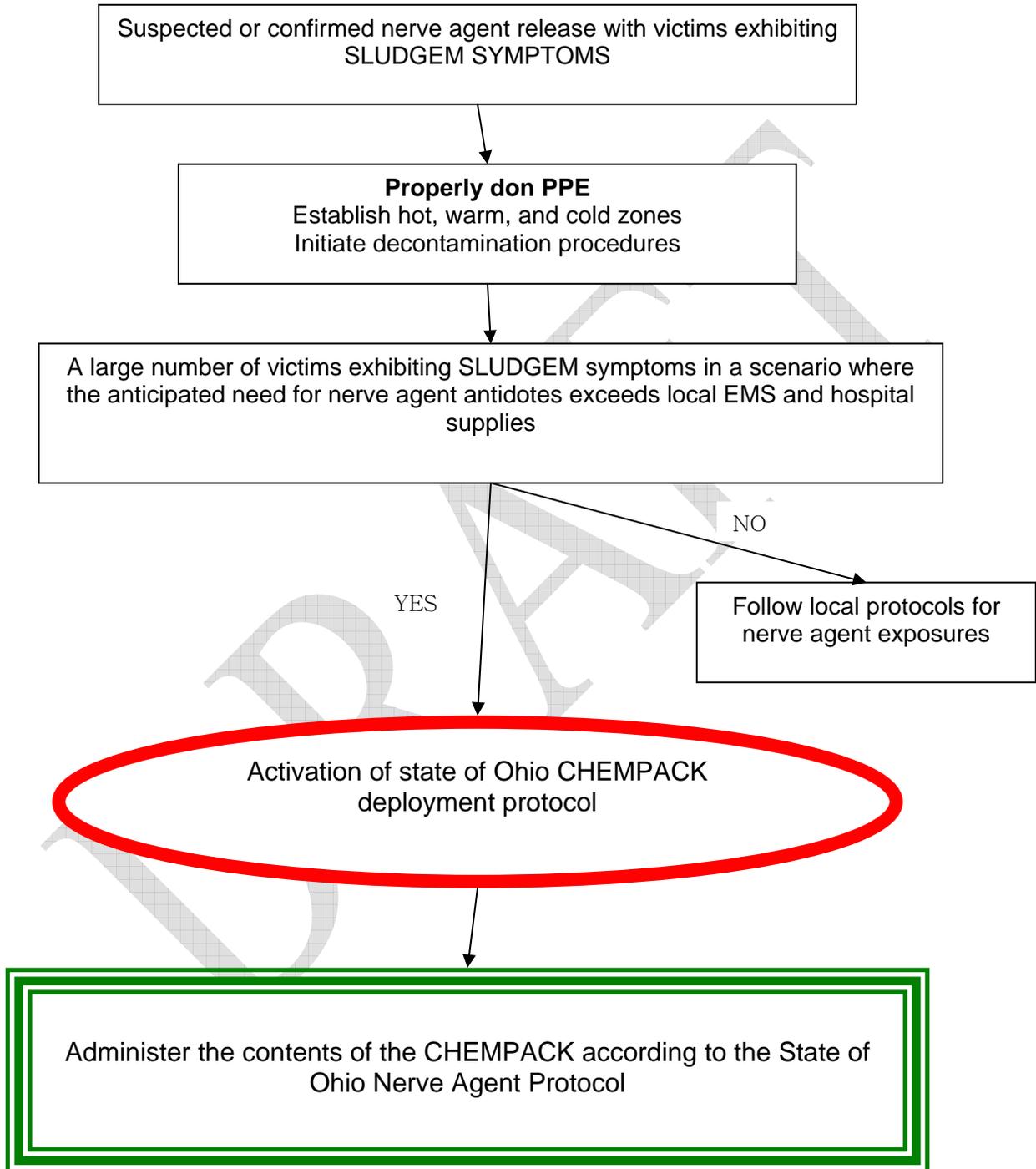
The dose of 2-PAM is 25-50 mg/kg for the pediatric patient and 1 gm IV or 600 mg-1.2 gm IM for the adult patient. The dose of diazepam for the pediatric patient is 0.2 mg/kg IV or 0.5 mg/kg rectally with a maximum total dose of 5 mg. The dose of diazepam for the adult patient is 5-10 mg IV with a maximum total dose of 10mg.

Patients with mild to moderate nerve agent exposure will have SLUDGEM symptoms, agitation and possibly respiratory distress. These patients should receive 1-2 doses of atropine initially. If respiratory distress persists after the patient has begun to improve following atropine administration, then a dose of 2-PAM should be administered to the patient. Patients with a severe nerve agent exposure will have SLUDGEM symptoms, agitation, respiratory distress, and seizures. Patients with a symptoms of a severe nerve agent exposure should receive 3 doses of atropine initially, a dose of 2-PAM after improvement following atropine administration, and also diazepam every 2-5 minutes for the seizures.

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Specialized Protocols

CHEMPACK



CHEMPACK Deployment Fielding Guidelines

The incident commander or EMS provider should activate a CHEMPACK deployment if the following criteria have been met:

1. Known or suspected nerve agent release
2. A large number (greater than 50) victims exhibit SLUDGEM symptoms
3. The anticipated need for nerve agent antidotes will exceed the supply of antidotes available from the responding EMS units and mutual aid.

If the criteria for CHEMPACK deployment have not been met, the EMS provider should treat any victims presenting with SLUDGEM symptoms with nerve agent antidotes from local EMS, HazMat, and mutual aid resources according to their local nerve agent and mass casualty incident (MCI) protocols.

If the criteria for CHEMPACK deployment have been met, EMS providers should immediately don PPE, declare a disaster, and establish incident command. The CHEMPACK deployment is initiated by contacting the state of Ohio CHEMPACK activation agency, the Law Enforcement Response Plan (LERP) by calling **(866) 599-LERP (5377)**. The state of Ohio CHEMPACK activation agency will contact the appropriate point of contact (POC) at a CHEMPACK hospital. From the report provided by the EMS provider, medical control, the incident commander, and the EMS staff will determine the criteria for CHEMPACK deployment have been met. Ideally the report should include a description of patient symptoms, the anticipated number of victims, and the estimated geographical area potentially involved by the known or suspected nerve agent release.

When the CHEMPACK deployment has been activated, the state of Ohio CHEMPACK transportation protocol will be initiated by LERP to transport the CHEMPACK assets to the staging area of the scene of the incident. The transportation personnel must identify themselves and sign a CHEMPACK Controlled Substance Transfer Form to receive the assets. The transport vehicle must have lights and siren, and the transportation personnel must possess a DEA registration or exemption. A security escort for the transportation vehicle and personnel is strongly recommended.

When the CHEMPACK assets have arrived at the staging area of the scene of the incident, the incident commander or the incident commander's designee provides identification and signs a CHEMPACK Controlled Substance Transfer Form to accept custody of the CHEMPACK assets. The staging area personnel transports and distributes the CHEMPACK assets to the EMS providers on scene. When the CHEMPACK is opened, all EMS providers shall follow the nerve agent protocol in the State of Ohio WMD Guidelines and Procedures for administration of CHEMPACK assets to patients.

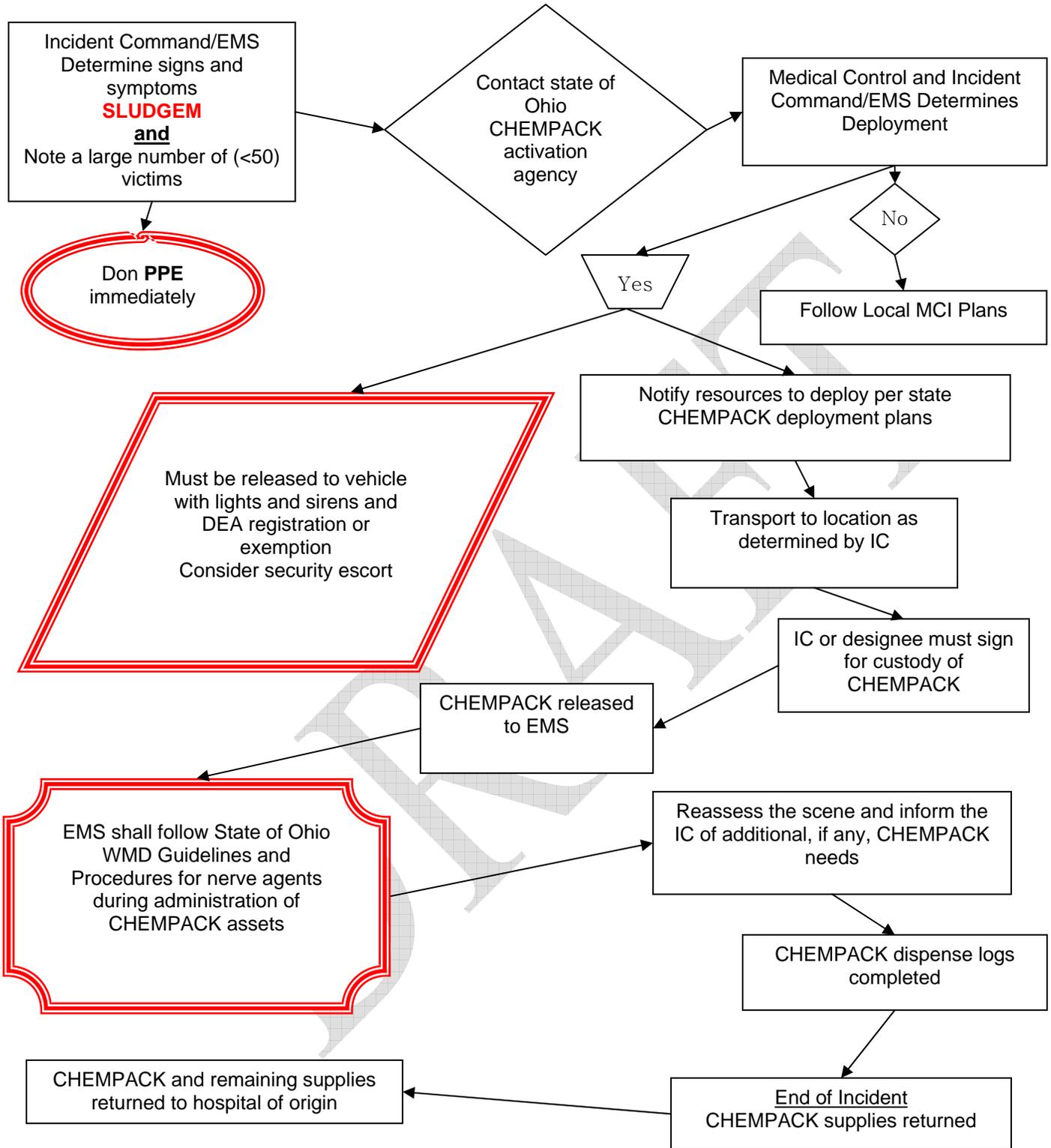
The EMS providers should reassess the scene and notify the incident commander of anticipated additional, if any, nerve agent antidote needs. The incident commander will contact the state of Ohio CHEMPACK activation agency, LERP to request additional CHEMPACK assets. Once the incident has ended, the EMS providers should complete the CHEMPACK dispensing logs and return all CHEMPACK assets, supplies, and documentation directly to the originating CHEMPACK storage sites.

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State of Ohio CHEMPACK Deployment Fielding Guidelines

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NOTE: EMTs of all levels of certification may administer nerve agent antidote auto-injectors in a declared emergency if they have completed proper training.

Cities Readiness Initiative

The Cities Readiness Initiative provides the distribution of the initial doses of antibiotics for the prophylaxis against potential biologic agent exposures. Rather than going to health care facilities, citizens in the affected areas will be directed to shelter in their homes and the antibiotics are delivered to their mailboxes by trained laypersons (i.e. United States Postal Service employees). Upon order of the governor, local or state public health agencies, or federal government, EMS providers may be directed to administer these antibiotics to citizens. The EMS Board of the State of Ohio recently changed the administrative rules to allow EMS providers to administer immunizations and medications in the event of a declared emergency at the direction of the authorities mentioned. The State of Ohio EMS WMD protocol has guidelines for antibiotics administration for biologic agents that can be used as an informational resource when addressing questions or concerns raised by the citizens if they are unable to contact the local public health agency. The antibiotics administration guidelines include special considerations for the pediatric population as well as pregnant or lactating women where indicated.

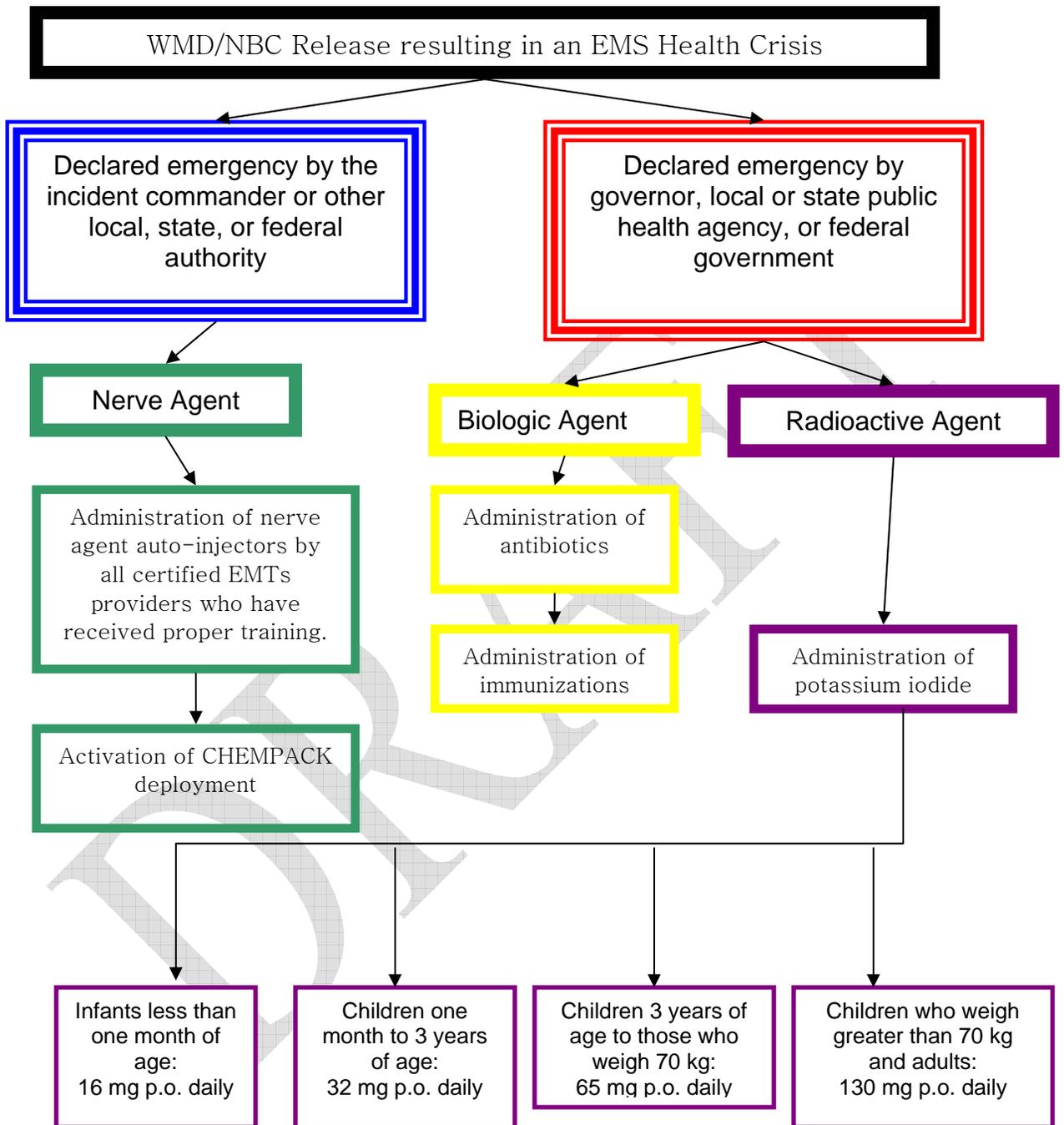
Immunizations

Routine administration of immunizations by EMS is not within the scope of practice. However, in an emergency situation, EMS can administer immunizations if authorized and ordered by the governor, local or state public health agencies, or the federal government. Effective vaccines have been developed for the prophylaxis of anthrax and smallpox.

Potassium Iodide

Release of radioactivity may occur as a result of an accidental release or an intentional release (i.e. a “dirty bomb”). Potassium iodide blocks the uptake of radioactivity by the thyroid gland. Administration of potassium iodide by EMS requires an order from the governor, local or state public health agencies, or the federal government. Potassium iodide is administered daily via the oral route to protect the thyroid gland and EMS may be asked to distribute or administer the initial doses. The daily dose for an adult is 130 mg. For the pediatric population, the dose for infants less than one month of age is 16 mg daily. The dose for children between the ages of 1 month and 3 years is 32 mg daily and the dose for children over 3 years of age and those up to a weight of 70 kg is 65 mg daily.

Specialized Protocols



Informational Resources

Disaster Management:

<http://www.fema.gov/nims>

<http://www.bt.cdc.gov/masstrauma/>

START and Jump START Triage:

<http://www.start-triage.com>

<http://www.jumpstarttriage.com>

Personal Protective Equipment:

<http://www.osha.gov/Publications/osha3151.pdf>

<http://www.emedicine.com/emerg/topic894.htm>

Cyanide:

<http://www.vnh.org/CHEMCASU/03/Cyanide.html>

<http://www.bt.cdc.gov/agent/cyanide/>

Nerve Agents and Organophosphates:

<http://www.vnh.org/FieldManChemCasu/nerveagents.htm>

<http://www.bt.cdc.gov/stockpile/index.asp>

Immunizations:

<http://www.bt.cdc.gov/agent/agentlist.asp>

Potassium Iodide:

<http://www.bt.cdc.gov/radiation/ki.asp>