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Headquarters, 7<sup>th</sup> Infantry Division (Integrated)  
Fort Carson, Colorado 80913-5000  
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Medical Services  
TROOP MEDICAL CARE

**Summary.** This regulation describes the responsibilities and procedures for the conduct of troop medical care at unit aid stations (UAS) and troop medical clinics (TMC).

**Applicability.** This regulation applies to all Active, Reserve, and National Guard Component organizations conducting medical care at Fort Carson or Pinon Canyon.

**Change statement.** Changes to this regulation are not official unless they are authenticated by the Chief of Staff, 7<sup>th</sup> Infantry Division (Integrated) and Fort Carson.

**Suggested improvements.** The proponent agency for this regulation is the Chief, G3, Plans and Exercises, 7<sup>th</sup> Infantry Division (Integrated) and Fort Carson. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, 7<sup>th</sup> Infantry Division (Integrated) and Fort Carson, ATTN: AFZC-DT-PL (PLEX), Fort Carson, CO 80913-5000.

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(Integrated) and Fort Carson, ATTN: Chief of Staff, Fort Carson, CO 80913-5000.

FOR THE COMMANDER:

OFFICIAL: MARK S. LANDRITH  
COL, GS  
Chief of Staff

KAREN K. MOODY  
Director of  
Information Management

**DISTRIBUTION** of this regulation is intended for all Fort Carson, 7<sup>th</sup> Infantry Division (Integrated), and visiting training units down to company level.

**Copies furnished:** HQ III Corps, HQ 4<sup>th</sup> Infantry Division, and AMEDD, Fort Sam Houston.

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\*This regulation supersedes FC and 4ID Reg 40-4, dated 29 December 1986



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**1. References**

See Appendix A.

**2. Purpose**

This regulation informs all units and agencies performing medical care at Fort Carson and/or Pinon Canyon Maneuver Site of the requirements that will be met in order to provide quality medical care to personnel at Unit Aid Stations and Troop Medical Clinics.

**3. Intent**

To provide quality health support to all active duty members which addresses the three pillars of Force Health Protection; a healthy and fit force, casualty prevention, and casualty care and management. This level of medical support will be achieved through strict adherence to this regulation and through detailed planning and coordination conducted by individual units.

**4. Policy**

Failure to comply with this regulation will result in unit aid stations being closed. Continued failure to comply with this regulation may result in administrative or Uniform Code of Military Justice action against the training unit's chain of command and leadership.

**5. General**

- a. Algorithm Directed Troop Medical Care

(ADTMC). This is a set of procedures outlined in HSC PAM 40-7-21, which is mandatory in the garrison medical care system. It is a structured, easily supervised, and audited approach to management of sick call. It reliably triages patients into groups based on the level of care required. It maximizes the use of enlisted medics in the treatment for minor injuries and illnesses while ensuring more ill patients receive prompt attention from more skilled providers. The system is based on triage algorithms applied by the enlisted medic. The outcome of each triage is a decision to:

- (1) Treat according to a protocol followed by the ADTMC trained and certified medics (Level IV) or,
- (2) Refer to a PA on a routine basis (Level III) or,
- (3) Refer to a PA on an immediate basis (Level II), or
- (4) Refer to a physician on an immediate basis (Level I).

b. Echelons of Treatment. Troop medical care is organized into echelons. In order to provide the quickest return of the soldier to duty and maximize utilization of medical personnel, treatment must be delivered at the lowest echelon at which the medical capability exists.

(1) First Echelon Treatment. A unit's organic medical personnel normally provide this echelon. In garrison a medical platoon or section at battalion/squadron provides this at their aid stations. The medic trained as an ADTMC screener performs the primary assessment. Units without organic medical assets may receive treatment at a:

- (a) Troop Medical Clinic, which normally provides second echelon care.
- (b) Nearby unit's aid station (i.e. area medical support).
- (c) Unit Aid Station provided to the unit in its area by another unit having organic medical personnel.

(2) Second Echelon Treatment. Medical personnel assigned to units whose primary mission is medical care (e.g. a Troop Medical Clinic) normally provide this echelon. The level of treatment provided is more sophisticated in that physicians and physician assistants (PA) are the primary care providers; or some ancillary services (i.e. laboratory) are available.

(3) Third Echelon Treatment. This is a hospital-based treatment not organic to a division and provided by a MEDDAC in garrison, and a Corps Support Command (COSCOM) in the field. In certain field situations (e.g. Pinon Canyon), this echelon may be provided by nearby civilian hospitals.

**NOTE 1:** The objective of first echelon treatment is to quickly triage, sort, and evacuate those patients who require a higher echelon of care; treating and returning to duty those who require only first aid or self-care. First echelon care providers are also responsible for preventive medicine activities, individual and unit medical deployment readiness, and health record maintenance.

**NOTE 2:** The objective of second echelon treatment is to treat and return patients to duty or to stabilize for further evacuation. Second echelon treatment providers often must provide first echelon treatment on an area basis to units having no organic medical assets. They also may provide preventive medicine functions and health record maintenance on an area basis. Some specialized functions such as dental, optometry, and mental health support are also provided at this level.

**NOTE 3:** The objective of third echelon treatment is to provide sophisticated diagnostic and treatment modalities.

## 6. Responsibilities

a. Deputy Commanding General (DCG), 7<sup>th</sup> Infantry Division (Integrated) and Fort Carson will:

(1) Ensure command compliance with instructions published in this regulation.

(2) Approve or deny unit requests for exemption to this regulation.

b. Chief of Staff, 7<sup>th</sup> Infantry Division (Integrated) and Fort Carson will:

(1) Recommend approval or denial to DCG of unit requests for exception to this regulation.

(2) Direct revision of this regulation as required or upon annual review.

c. G-3, 7<sup>th</sup> Infantry Division (Integrated) and Fort Carson will:

(1) Establish, publish, and maintain this regulation.

(2) Schedule annual review of this regulation. Publish changes to this regulation based upon annual review, medical support lessons learned, or as directed.

d. The Director, Health Services (DHS) is the Commander, USA MEDDAC and is responsible to:

(1) Ensure that quality medical care and medical readiness services are provided in garrison and in the field environment.

(2) Establish the criteria and standards for establishing and maintaining UASs.

(3) Designate the Chief, Family Practice to serve as the DHS's representative for issues concerning troop medical care. This includes supervision, external inspections, Quality Assurance, and evaluation of garrison UASs and Troop Medical Clinics to ensure quality medical care is provided. Ensure that UASs are in compliance with the DHS' criteria for establishing and maintaining UASs. The DHS, based on recommendations of the Division Surgeon, will designate which units can establish UASs and which units will be serviced at each TMC. The DHS has the authority to suspend unit aid station garrison patient care privileges, if necessary, until appropriate corrective actions have been taken.

(4) Coordinate for Annual Training Site support.

(5) Verify credentials and approve privileges for medical officers working in a Unit Aid Station.

(6) Provide units with ADTMC instruction manuals for use in local training.

e. Surgeon, 7<sup>th</sup> Infantry Division and Fort Carson will:

(1) Provide medical planning support to field exercises.

(2) Provide oversight for garrison medical readiness services.

(3) Assist units in addressing field medical support issues.

f. MSC Commanders will:

(1) Ensure the UASs in their assigned units meet the criteria and standards for establishing and maintaining UASs as directed by the DHS.

(2) Ensure assigned medical personnel, to include Physicians, Physician Assistants (PAs),

and other medical personnel are available to appropriately staff UAS and TMCs.

(3) Ensure that all new soldiers in process at the UAS within one week of signing into the unit. Ensure that soldiers, in units without an UAS, in process their servicing TMC within one week of signing into the unit.

(4) Ensure that all soldiers out-process through their supporting UAS or TMC prior to signing out of their unit.

g. The MSC Surgeon, if assigned, is responsible for intermediate level supervision, quality medical care, internal inspections, and evaluation of the UAS operations. The results of these internal inspections will be provided to the Division Surgeon and Chief, Family Practice.

h. The UAS's OIC, medical platoon leader (NCOIC, if no OIC is assigned), is:

(1) Responsible for the manning, training, and administrative operations of the UAS in support of its daily patient care mission.

(2) Responsible for ensuring that medical personnel receive the required annual medical sustainment training and maintain current BCLS certification.

(3) Responsible to ensure appropriate medical manning is accomplished as determined by the MSC Surgeon and Chief, Family Practice. As a minimum, whenever a medical officer works at a Troop Medical Clinic at least one 91W medic will accompany the medical officer to facilitate care of the unit soldiers.

(4) Responsible to ensure ADTMC is being conducted and reviewed IAW HSC Pam 40-7-21.

## 7. Procedures.

a. Sickcall Log. A log will be maintained and, at a minimum, will record the date and time each soldier reports for treatment and departs, the complaint, and the ADTMC level to which he was triaged. Health record sign-out will also be recorded.

b. Level IV Treatment. All patients evaluated or provided any treatment whatsoever will be documented using the appropriate algorithm recorded on DA Form 5181-R. The screener will sign the form in the appropriate block. Level IV 5181-Rs will not be filed until the supervising medical officer has audited them. This audit must be completed on the same day as treatment. In any case where an assigned

medical officer is not available the OIC/NCOIC will arrange to have a medical officer at the servicing TMC audit the records.

c. Sick Call. All troop sick call in garrison will be conducted IAW HSC PAM 40-7-21.

(1) Hours of Operation. Unit aid stations will operate at all times the unit is in garrison except federal and battalion training holidays. The commander may set sick call hours for his unit aid station so long as all first echelon sick call is completed no later than 1000. Soldiers seeking care outside sick call hours will be screened IAW HSC PAM 40-7-21 at their unit aid station. Soldiers without unit aid stations will be screened at their TMC. Soldiers screened as Level IV will be treated and returned to duty. Those screened at Level I or II will be referred immediately to a medical officer at the TMC. Those screened at Level III will be instructed to return during next routine sick call. Sick slip and HSC 5181-R will be so annotated unless treatment is required for acute injury. Aid stations that have a training holiday must contact their supporting TMC five (5) days prior to the holiday to notify them that they will be closed.

(2) Manning. The unit aid station OIC/NCOIC will ensure sufficient screeners and administrative personnel are on hand during sick call hours. Manning should be commensurate with expected sick call. ADTMC screeners will accomplish all Level IV treatment at the unit aid station. Medical officers will report to their aid stations at the beginning of sick call and accomplish as much Level II and III treatment as possible before reporting to their TMC assignments. They will report to their TMC assignments NLT 1000. At least one 91W medic will accompany the medical officer to facilitate care for their unit soldiers. An ADTMC certified screener will remain on duty in each UAS until 1600 daily to manage records and provide first aid.

(3) Level II and III Treatment. The supervising PA will accomplish as much Level II and III treatment at the aid station as possible. The PA will evaluate all Level II and III patients with the screener present. This will be used as an opportunity for training.

(4) Additional Medical Functions. All personnel assigned to the unit served by an aid station will receive immunizations, periodic

physicals (except Over-40 and medical board related physicals), occupational health related medical surveillance, ear plug fitting, body fat measurement, and other medical readiness, and administratively required procedures at their aid station. By prior arrangement UAS personnel may also use space in their TMC.

(5) Physician Supervision. Physician Assistants will consult with their primary physician supervisor when available. In the absence of the primary supervisor the TMC Physician OIC will be consulted. If neither physician can be reached, the Division Surgeon, Chief, Family Practice, or the Emergency Room physician will be consulted.

(6) Deployments. In the event that the unit deploys, the Aid Station NCOIC will notify the supporting TMC NCOIC that the aid station will be closed. However, if medical personnel are still available from the unit, the Aid Station will remain open and operational for record management and medical screening.

(7) Intravenous Therapy. If during the conduct of sick call at the Aid Station an I.V. is indicated the medic administering the I.V. must have I.V. certification. Assistance in I.V. certification training can be coordinated with the MEDDAC. This will be documented in the medic's competency file.

(8) The use of medications during sick call must follow the procedures indicated in Appendix 4 – Aid Station Sick Call Medication SOP.

d. Performance Improvement/Quality Assurance.

(1) Certification. Effective 90 days after the publication of this regulation, all enlisted medical personnel involved in garrison sick call must be certified in ADTMC by the unit medical officer or Division Surgeon. The certification program may be implemented by any unit surgeon for their unit or by any Troop Medical Clinic OIC on request. Any PA or physician skilled in the management of ADTMC may conduct the certifying program in a field environment. The Chief, Family Practice, will inspect each BAS to ensure compliance with HSC PAM 40-7-21.

(a) New Screener Credentialing. New screeners must complete the following steps before applying for credentialing:

(i) Attend training in ADTMC. (note: ADTMC Instruction Manuals and sample written exams can be obtained thru the S2/3 Section, MEDDAC, Fort Carson).

(ii) Achieve a score of 80% on a written exam.

(iii) Complete 10 charts under direct supervision without logic or format error. A "no go" in any area will require repeat of the entire process before certification will be granted.

(b) Old Screener certification. Screeners with at least 60 days experience using ADTMC at the time of publication of this regulation may be "grandfathered" by completing 20 charts under direct supervision with no logic or format errors.

(c) Supervisor Verification. Screeners seeking certification under (a) or (b) above must have documentation of completion of these criteria in their competency folder at the aid station.

(d) Annual Reverification. Certified screeners must be rotated periodically through unit aid station or TMC sickcall in order to maintain competence. Annual reverification of certification will be based on a review of 10 charts completed with no logic or format errors and a recommendation from the supervising medical officer.

(e) Records Audits. The results of the audits of Level IV screener records will be summarized weekly by the supervising medical officer. The summary will include the number of records audited, the number of unsatisfactory records, and supervisory steps taken to correct the problem. (sample form provided, see appendix 3)

(2) Screener Competency Files. The OIC/NCOIC will maintain a Competency file on each certified screener in the UAS. This file will contain, at a minimum, a copy of the screener's initial certifying documents and reverification, all weekly forms 425-R records of any special training or certification (ie, field sanitation team certification, immunization team certification, BCLS certification, Emergency Medical Technician certification, completion of Medical Proficiency Training), and records of any counseling regarding clinical performance. The file will contain a control sheet where the supervising medical officer will document no

less than quarterly that a complete review of the screener's clinical performance has been conducted.

(3) Performance Improvement Meetings. Chief, Family Practice will, in coordination with the Division Surgeon, conduct ongoing PI meetings IAW AR 40-66, AR 40-48, and HSC PAM 40-7-21. These meetings are mandatory for all credentialed medical officers providing care at troop medical clinics or unit aid stations.

(4) Quality Assurance Visits. The Chief, Family Practice or their representative (but must be 0-4 or higher) will conduct periodic visits to UAS to evaluate and advise on those conditions, practices, and procedures that impact on the quality of care provided. The results of these visits will be provided in writing to the OIC, supervising medical officer, and to the Division Surgeon.

(5) UAS Without Assigned Medical Officers. The OIC of the servicing TMC will designate a physician's assistant to perform record audits and supervise screeners

e. Medical Records Management.

(1) UAS will maintain health records on all members of the unit they support IAW specifications of AR 40-66. The OIC/NCOIC will ensure that a screener is on duty until 1600 to manage medical records as well as to provide first aid and screen personnel reporting on sick call. When the unit is in the field the commander will designate a member of the rear detachment as medical records custodian responsible for the sign-in and sign-out of health records and for securing all incoming medical data and records until the UAS returns.

(2) Procedures.

(a) The UAS will be a mandatory checkpoint for Unit In and Out Processing.

(b) UAS will sign in a medical record for each soldier in the unit. When a soldier signs in without a health record the UAS will immediately call Central In and Out Processing Medical Section to determine the status of the soldier's record. No soldier may complete in-processing until his/her health record is accounted for.

(c) At the time of in-processing the PA will screen the record IAW AR 40-66 para 5-7, b.(2) and ensure the Master Problem List is complete and that follow-up of any unresolved medical problems is completed.

(d) During in-processing, DD Form 2766 will be in duplicate. One copy will be forwarded to the unit personnel section for inclusion in the soldier's Personal Readiness Folder (PRF); the other will be maintained in the medical record.

(e) A sign in/out log will be maintained to control issue and turn-in of health records. Any record not returned within 7 days will be accounted for by the aid station. The battalion commander will be apprised monthly of health records out more than 7 days.

(f) The screener on duty will file all incoming medical data in the appropriate records daily.

(3) Inspections.

(a) Health records will be inspected at least annually by the installation medical records custodian (Chief, Patient Administration Division) and at least quarterly by either the Chief, Family Practice or the Division Surgeon's Office.

(b) The three agencies above will provide assistance on request for brigade or battalion level health records inspection.

(c) Units Without UAS. The TMC where the unit's health and dental records are maintained will be a required in-processing check point. Every soldier will be required to turn in his or her health and dental record. Semiannually, the commander will designate two responsible soldiers to assist with a complete purge of all the unit's health and dental records. The purge will be coordinated with the TMC/DC NCOIC who will provide sufficient medical/dental personnel to assist in the purge and to provide unit personnel with the medical/dental data necessary to update DD Form 2766.

## **8. HEALTH MAINTENANCE AND MEDICAL READINESS.**

a. Units With UAS. The OIC/NCOIC will maintain a suspense system to ensure notification of soldiers due for periodic physical and dental exams, immunizations, audio exams, and occupational health related medical surveillance or requiring eye glasses or mask inserts, panoramic x-rays, or medical warning tags. (This list is not exhaustive and additional requirements must also be monitored as appropriate.) No less than monthly the

OIC/NCOIC will provide the battalion commander with a written list of all personnel requiring medical/dental updates. Commanders, through command channels, will ensure that all medical/dental procedures are completed. DD Form 2766 will be maintained in the soldier's Personal Readiness Folder (PRF) and a duplicate maintained in the medical record. DD Form 2766 will be updated quarterly. The provider will use this form as a tool to document ongoing medical problems, update immunizations, document health counseling, and apply to the tenants of Putting Prevention Into Practice.

b. Units Without UAS. The DD Form 2766, completed at Central In and Out Processing and forwarded with the inprocessing packet will be maintained in the soldier's PRF. At the same time as the unit's semi-annual health records purge, those personnel designated by the commander to assist with the purge will collect the unit's DD Form 2766 and, after prior coordination with the TMC NCOIC and Dental Clinic NCOIC, will update the DD Form 2766. The TMC/DC personnel will extract the required information. The unit's personnel will update the DD Form 2766 and prepare a list for the commander of all those requiring medical-dental procedures. The commander, through command channels, will ensure that all personnel are referred to the appropriate medical facility for completion of the procedures and that scheduling of an immunization team or the audio van is accomplished.

c. Immunizations. Immunizations will be administered according to the latest guidance from the Division Surgeon. The UAS will train immunization team personnel and conduct immunizations according to the following standards:

(1) As a minimum an Influenza/SRP Immunization Team will consist of:

(a) At least one senior medic knowledgeable in the recognition of anaphylaxis and certified by the Division Surgeon or unit surgeon to supervise immunizations on site at all times.

(b) A medical officer will be on site for 400 or more personnel and on call within three minutes for less than that number.

(c) At least one 71C or other medical MOS to screen health records, determine the required immunizations, and enter

immunizations given on PHS 731, DD Form 2766, and update MOBLAS.

(d) Sufficient 91W's to prepare and administer immunizations.

(e) An NCOIC to coordinate with the MEDDAC SRP Site NCOIC to ensure necessary personnel, equipment, and supplies are on hand; to ensure that all medical personnel are trained in their duties, especially the management of anaphylaxis, proper administration of intradermal, subcutaneous, and intramuscular injections, site preparation, and safe needle disposal; to ensure that all health records are on hand and that all personnel have their PHS 731.

(f) A unit representative to provide personnel control and accountability.

(2) Appendix 1 and 2 describe Immunization Guidance and minimal equipment requirements. Contact the Chief, Preventive Medicine USA MEDDAC or the Division Surgeon for the most current recommendations.

(3) Vaccine Management. The OIC/NCOIC will maintain strict accountability of vaccine material to ensure that wastage is less than 5 percent of doses issued. Close attention will be paid to refrigeration requirements and expiration dates. When vaccine materials are kept on hand they will be inventoried monthly. Opened vials will be dated when opened. Any unopened vaccine will be returned to the point of issue no less than one month prior to the date of expiration. Open vials that cannot be fully used in the UAS before expiration will be turned in to the medical section at the SRP Site.

(4) Important. All immunizations must be recorded in both the SF 601 and the PHS 731.

**9. FIELD MEDICAL CARE.** The organic UAS provides medical care in the field the same as in garrison, providing routine sick call, emergency treatment, and evacuation to the next higher level of care. It is the responsibility of the unit surgeon and the OIC/NCOIC of the UAS to plan and coordinate field medical care and to provide the commander with the medical support plan.

a. Medical Records. Health records will not normally be taken to the field except under the custodianship of the support battalion medical company. The UAS will take a copy of DD Form 2766 for each soldier deploying on off-post deployments. All medical care rendered in

the field will be recorded on either HSC 5181-R or on a SF 600, or SF 1380 (Field Medical Card). These records will be filed in the soldier's health record immediately upon redeployment to Ft Carson.

b. Additional Medical Support. Any additional medical support required will be coordinated with the MSU or Division Surgeon as appropriate and requested through G3 Tasking if necessary. PROFIS requests will follow established procedures IAW AR 601-142. Support will also follow the guidelines established in FC Regulation 350-1-1, Medical Support Plan: Fort Carson and Pinon Canyon Training Requirements.

**10. MEDICAL TRAINING.** An ongoing medical training program will be conducted by the OIC/NCOIC with the technical assistance of the unit surgeon. Records of training will be maintained by the UAS. Documentation of individual training of ADTMC screeners will be maintained in their Competency Folders.

**11. CENTRAL IN AND OUT PROCESSING MEDICAL SECTION (CIOP).**

a. In-processing. At in-processing the medical section will secure every soldier's health record, create a new record for those soldiers who have none, screen the record IAW AR 40-66, complete an audiologic and optometric exam, order required glasses, warning tags, and inserts, administer immunizations, conduct a weigh-in, and prepare/update DD Form 2766. The section will maintain a sign in/out log on all health records. Medical Readiness information will also be inputted into MOBILAS.

b. Out-processing. The section will screen the soldier's health record, check for HIV testing if required, conduct a weigh-in, and have the soldier sign for his record before clearing.

**12. OCCUPATIONAL HEALTH PROGRAM AND MEDICAL SURVEILLANCE.** The UAS OIC/NCOIC will accompany industrial hygiene personnel (MEDDAC Preventive Medicine Service) during Local Occupational Health Hazard Inventories (LOHHI). He will become familiar with the occupational health hazards specific to his unit and will monitor compliance with counter-measures for the unit commander and

Division Surgeon. He will advise the commander on medical surveillance measures required and coordinate compliance. In units without a UAS the commander will designate a responsible officer or NCO to accomplish these duties. Individual medical surveillance requirements will be recorded on DD Form 2766 and monitored for periodic surveillance.

**13. INFECTION CONTROL.**

a. Each OIC/NCOIC will ensure the compliance of his staff with the MEDDAC Infection Control Program (MEDDAC Reg 40-5).

b. Each UAS OIC/NCOIC will develop, implement, monitor, and maintain an Infection Control SOP. The MEDDAC Infection Control Manual will be followed.

c. The MEDDAC Infection Control Nurse will serve as a consultant.

**14. DEPLOYMENT MEDICINE PROGRAM.**

a. Upon notification that a member or members of the unit are deploying (including in a TDY status) to an OCONUS area, the OIC/NCOIC will screen the medical records and schedule the soldier for immunizations, medical tests, and administration of chemoprophylaxis as required for the deployment. He will conduct a deployment medicine briefing to include the environmental medical threats and countermeasures, proper use of chemoprophylaxis, and any indications for medical screening on return.

b. For deployments OCONUS for greater than 30 days a "Predeployment Health Questionnaire", DD Form 2795, must be completed. Coordination for this requirement will be with the Medical SRP site or the Chief, Preventive Medicine, USA MEDDAC.

c. During deployment, the unit surgeon will monitor sick call for unusually high levels of febrile illness, gastrointestinal illness, sexually transmitted diseases, environmental illness, injuries, and skin disorders. With the assistance of the field sanitation officer he will ensure personnel and unit hygiene and sanitation, water discipline, and safety of food and water. DNBI Surveillance will be in compliance with Department of Defense Instruction (DODI) 6490.3, 7 August 1997, "Implementation and

Application of Joint Medical Surveillance for Deployments”.

d. Upon redeployment, the unit surgeon, or OIC/NCOIC will schedule any medical screening required for disease surveillance. DD Form 2796, “Post Deployment Health Assessment” will be completed if required. Units must contact the Medical SRP Site NCOIC or Division Surgeon to check on post deployment requirements.

e. In the conduct of the unit deployment medicine program, the unit surgeon will assist the OIC/NCOIC. Consultants include the Division Surgeon, the Commander of the 223rd Medical Detachment (Preventive Medicine), and the Chief of the Preventive Medicine Service, MEDDAC.

f. Units without UAS may request assistance from the Division Surgeon (7<sup>th</sup> ID Units) or the Commander, 223rd Med Det (43rd Support Group units), or the Chief, Preventive Medicine Careline, MEDDAC (all others).

#### 15. FACILITIES.

- a. As a minimum, every UAS must have:
  - (1) A telephone for use in emergencies.
  - (2) A hand washing facility with running water, adequate drainage, full and functional soap dispenser, paper towels, and a waste disposal receptacle for infection control.
  - (3) A locking file cabinet for storage of health records.
  - (4) A refrigerator if vaccines or other supplies requiring refrigeration are to be used.
  - (5) A locking cabinet for the storage of pilferable items and pharmaceuticals.
  - (6) Sufficient walls or screens to provide patient privacy.
  - (7) Sufficient space to separate screening areas from waiting and administrative areas.
- b. Medical equipment will be that authorized by with supplementation, if needed, through the Installation Medical Supply Activity.
- c. Aid stations cannot be located in high traffic areas. Areas or receptacles where medical supplies, equipment, and records are stored cannot be shared with other activities.
- d. Units without organic UAS may be supported for daily sick call by a temporary aid station provided expressly for this purpose. Where permanent space cannot be set aside, a temporary aid station using litters and stands

may be set up and taken down each morning. Records must be permanently stored, however, and provision made for issue, turn-in, and records management throughout the duty day.

**16. REPORTS.** The UAS will submit Medical Summary Reports IAW AR 40-400.

**17. STAFF ASSISTANCE.** The UAS receives staff assistance from the Division Surgeon's Office, the Primary Careline MEDDAC, S2/3 Section MEDDAC, and the IMSA.

#### 18. REFERENCES.

- a. AR 40-5, Preventive Medicine.
- b. AR 40-48, Nonphysician Health Care Providers.
- c. AR 40-66, Medical Record and Quality Assurance Administration.
- d. AR 40-400, Patient Administration.
- e. AR 40-501, Medical Services Standards of Medical Fitness.
- f. AR 40-562, Immunization Requirements and Procedures.
- g. AR 340-18, The Army Functional Files System.
- h. HSC PAM 40-7-21, Algorithm-Directed Troop Medical Care.
- i. DODD 6490.2, 30 August 1997, “Joint Medical Surveillance”.
- j. DODI 6490.3, 7 August 1997, Implementation and Application of Joint Medical Surveillance for Deployments”.
- k. ASD-HA memorandum, 6 October 1998, “Policy for Pre-and Post-Deployment Health Assessments and Blood Samples”.
- l. FC and 7<sup>th</sup> ID Regulation 350-1-1, Medical Support Plan, Fort Carson and Pinon Canyon Training Requirements, 31 July 2000.
- m. MEDDAC Regulation 40-5, Infection Control, Fort Carson, CO, 1 March 01.

## Appendix 1

**General Immunization Requirements for Active Duty Soldiers**

Immunizations for active duty soldiers are dependent upon the type of unit assigned and location of deployment. The following table delineates the requirements extracted from existing regulations for soldiers (not recruits). Although not an immunization, PPD testing should be performed prior to OCONUS deployments greater than 30 days and repeated at 90 days upon return

<b>Soldier Category</b>	<b>Immunizations Required / Frequency</b>
<b>All active duty soldiers (basic shot series that all AD must have)</b>	Influenza / annually  Tetanus-diphtheria / booster every 10 years  Hepatitis A / primary series, 2 doses 6 months apart
<b>Add to the above basic shot series the following if they apply:</b>	
<b>a. Assigned to a unit on alert status (designated to be in a state of readiness for immediate deployment within 30 days or less of notification)</b>	Typhoid (injectable) / every 2 years * <b>OR</b> Typhoid (oral) / every 5 years  Yellow Fever / every 10 years
<b>b. Prior to deployment involving travel to high risk areas</b>	Anthrax Vaccine**: primary series of 6 given at 0, 2, 4 weeks then 6, 12, 18 months, booster every year.  Japanese Encephalitis Vaccine: primary series of 3, booster every 3 years  Meningococcal / booster every 5 years  Polio vaccine and MMR (both should have been administered in basic training already) / no additional booster required  Typhoid (injectable) / every 2 years * <b>OR</b> Typhoid (oral) / every 5 years  Yellow Fever / every 10 years  Additional vaccines may be required based on Combatant CINC requirements to include plague, anthrax, tick borne encephalitis**, rift valley fever**
<b>c. Medical personnel or soldiers PCSing to Korea</b>	Hepatitis B vaccine series ( 3 dose series given at 0, 1 and 6 months)
<b>d. Special Forces personnel</b>	Operate under USASOC supplement to AR 40-562
<b>e. Occupational Risk</b>	Rabies series for those at risk (i.e., veterinarians and animal handlers, SOF personnel) Hepatitis B series, plague vaccine series, varicella
<b>f. III Corps Immunizations</b>	Presently they are requiring influenza, tetanus-diphtheria, typhoid, hepatitis A, yellow fever, polio, MMR, and MGC be current.

\* Note: Typhoid produced by Wyeth requires an initial 2 dose series 4 weeks apart then a booster every 3 years, Wyeth is no longer in the inventory. Typhoid vaccine produced by Pasteur Merieux Connaught (Typhim Vi) has only a single injection for the primary series and then a booster every 2 years. Typhim Vi is the vaccine of choice. MUST state the company name when administering this vaccine.

\*\* Note: Under investigational protocol.

## General Immunization Information

## 1. General Immunization Table

Vaccine	Dose Route	Timing	Given in Pregnancy?
Anthrax	0.5 ml SQ *	0, 2, 4 weeks then 6, 12, 18 months, booster each year	Category C **
Hepatitis A	1ml IM ***	Two dose series 6 months apart	Category C
Hepatitis B (Recombivax HB or Engerix-B)	1ml IM	Three dose series at 0, 1, and 6 months. Two brands may be interchanged	Yes
Influenza	0.5 ml IM	Annual requirement	Yes
Japanese Encephalitis	1 ml SQ	Primary series is 3 doses at 0, 7, and 30 days, booster dose at 3 years	Category C
Measles, Mumps, Rubella (MMR)	0.5 ml SQ	If born after 1957 one dose as an adult	Contraindicated
Meningococcus (MGC)	0.5 ml SQ	Booster every 5 years	Category C
Plague	Primary series, first dose 1 ml, second and third dose 0.2 ml, booster 0.2 ml, all IM	Primary: 3 dose series at 0,1,5 months Booster every 6 months while at risk	Category C
Polio Oral (OPV) Inactivated (IPV)	OPV: prepack dose IPV: 0.5 ml SQ	Primary series as a child, single booster as an adult	Only IPV presently given
Rabies (Pre-exposure protection) Human Diploid Cell Vaccine (HDCV) or Rabies Vaccine Absorbed (RVA) or Purified Chick Embryo Cell Culture (PCEC)	1 ml IM regardless of type used	3 dose series given at 0, 7, and 21 or 28 days	May be given if required
Tetanus-diphtheria	0.5 ml IM	Primary series as child, booster every 10 years	Yes
Typhoid Oral or Typhim Vi	Oral contains 4 capsules, given every other day for 4 doses (must keep refrigerated) Typhim Vi: 0.5 ml IM	Oral: Booster of 4 capsule package every 5 years  Typhim Vi: Every 2 years	Category C
Yellow Fever	0.5 ml SQ	booster every 10 years	Relative Contraindication

\* SQ = subcutaneous route \*\* Category C = Data not available to support safe use in pregnancy. Risk versus benefit must be determined on a case by case basis.

\*\*\* IM = intramuscular, generally in deltoid region for adults

**General Immunization Administration Guidance Continued**

2. Multiple Dose Vaccine Series. There is no requirement to restart a vaccination series due to a delay in the sequence. For example, if a person received hepatitis B vaccination at 0 and 1 month but did not receive the third dose until 1 year later it would still be considered complete. If vaccination occurs prior

to the recommended time then that dose will be considered invalid. For example, if an individual received hepatitis B vaccination at 0 and 1 month and the third dose at 4 months the third dose is invalid and another dose would be given at the appropriate time to complete the series. **At no time will a series be restarted or additional doses given because the vaccine is not given at the time sequence specified.** The time sequence provides minimum spacing requirements for effectiveness. Questions should be addressed with a preventive medicine officer or the command surgeon.

3. Pregnancy. Prior to any immunization of a vaccine that is category C or contraindicated the female soldier must be asked if they are pregnant and this documented in the medical records. If there is any uncertainty then a pregnancy test must be performed prior to immunization. If given the MMR, the female individual should be counseled against pregnancy for up to 3 months after receipt of the vaccine.

4. Oral Typhoid vaccine. The oral typhoid vaccine cannot be given within 24 hours of any dose of chloroquine, mefloquine, or any antibiotic. The interval for this vaccine may not be lengthened. The capsule must be taken with cool drink about one hour before a meal and swallowed not chewed.

5. HIV. All personnel, military or civilian, will have a documented negative HIV screening within the last 24 months prior to the administration of any live virus vaccines. Live virus vaccines include measles, mumps, rubella, yellow fever, oral polio, and oral typhoid.

6. Adverse events. All adverse events following immunization will be described in detail in the health record on forms SF600 or SF 558. Vaccine reactions resulting in hospitalization or more than 24 hours away from duty or which are included in the Federal Vaccine Injury Table must be reported to the Vaccine Adverse Event Reporting System (VAERS) of the U.S. Department of Health and Human Services. These reactions will also be reported to the Chief, Preventive Medicine. Vaccine reactions resulting in low grade or self-limited fever of less than 24 hours duration, or local soreness, redness or swelling at the site of immunization are not reported to the VAERS unless lot contamination is suspected. Form VAERS-1 will be used for reports to the VAERS. Form VAERS-1 is distributed as follows: original sent to VAERS, PO Box 1100, Rockville, MD 20849-1100, one copy retained in medical file, one copy to U.S. Army Medical Command, Preventive Medicine Division, ATTN: MCHO-CL-W, Fort Sam Houston, TX 78234-6000, one copy sent to Chief, Preventive Medicine, USAMEDDAC, Fort Carson. See Figure 1 for copy of the VAERS form.

7. The National Childhood Vaccine Injury Act and other regulations impose special requirements for the administration of diphtheria, measles, mumps, pertussis, polio, and rubella vaccines. These requirements pertain to all active duty, reserve, National Guard, and civilian personnel. Every administration of any of the above seven vaccines will be recorded in the health record on SF 600 in addition to SF 601 and PH form 731. The date of administration, manufacturer and lot number of the vaccine, and the name, address, and title of the person administering the vaccine are the minimum data to be recorded. Informed consent is not required from active duty personnel but **is** required from all others. All personnel should be provided vaccine information for the seven vaccines listed.

8. It is imperative that package inserts are read and storage/handling procedures are strictly followed for all vaccines. Vaccines must also be administered in the proper manner. See figure 1 and 2 for description of injection technique.

9. As a general rule there are no contraindications to simultaneous administration of any vaccines (except cholera and yellow fever). Live vaccines that are not administered simultaneously should be separated by at least 4 weeks. This rule does not apply to OPV and MMR vaccines. Either vaccine may be administered at any time before or after the other.

10. There are only two permanent contraindications to vaccination: severe allergy to a vaccine component or following a prior dose of a vaccine, and encephalopathy without a known cause occurring within 7 days of a dose of pertussis vaccine. Persons may be allergic to the vaccine antigen, animal protein, antibiotics, preservatives, or stabilizers. The most common animal protein allergen is egg protein found in yellow fever, measles, mumps, and influenza vaccine.

11. There is no evidence that a concurrent acute illness reduces vaccine efficacy or increases vaccine adverse events. The concern is that an adverse event (particularly fever) following vaccination could complicate the management of a severely ill person. If a person has a moderate or severe acute illness vaccination should be delayed until the illness has improved. **Mild, common illnesses (such as otitis media, upper respiratory infections, colds, and diarrhea) are NOT contraindications to vaccination.**

12. Figure 2 and 3 provide visual assistance in the proper procedure for intramuscular and subcutaneous injections respectively.

13. Exemptions and waivers. (AR 40-562, Immunizations and Chemoprophylaxis)

a. Exemptions:

- (1) May be granted for medical reasons.
- (2) May be temporary or permanent. Temporary waivers are often granted for pregnancy and febrile illness. Permanent waivers are most often granted due to allergy to a vaccine or vaccine component, e.g. egg protein.
- (3) Granted by the unit surgeon or the commander of the local MTF.
- (4) May involve assignment limitation. For example a permanent exemption for yellow fever vaccination would preclude assignment of a soldier to a yellow fever endemic region of the world.

b. Waivers:

- (1) Granted for administrative reasons.
- (2) Permanent waivers are ordinarily granted only in the case of legitimate religious objections to immunization. Only the Surgeon General can grant a permanent waiver.
- (3) Temporary waivers may be granted for brief periods under conditions that make disease exposure unlikely. The Surgeon General has delegated this authority to the MACOM Command Surgeons.
- (4) Waivers may be revoked if necessary to ensure the accomplishment of the military mission.

## Appendix 2

## Immunization Procedural Requirements

1. Review these guidelines frequently, take all necessary precautions, and use appropriate techniques.
2. Before administering an immunization, a trained medic or Physician Assistant (PA) must interview the patient and/or screen his/her record for any of the following conditions. If there are any questions, refer to a medical officer:
  - a. Any immunosuppressive disease (Leukemia, Lymphoma, HIV (AIDS, ARC) syndrome, generalized malignancy, etc.)
  - b. Receiving immunosuppressive drugs (corticosteroids, alkylating drugs, antimetabolics, radiation therapy, etc.)
  - c. Previous hypersensitivity to an immunization or constituents (mercurials, phenols, albumin, glycine, etc.)
  - d. Allergic to eggs or egg products.
  - e. Previous anaphylactic shock after an immunization.
  - f. Moderate or severe febrile illness.
  - g. Pregnancy (may receive all immunizations except live viruses, e.g. yellow fever, polio, measles & MMR). Pregnancy testing (urine) will be done for actual deployments and in the patients being immunized with live virus vaccines.
  - h. Functional or anatomic asplenia.
3. Screen patients through review of their medical record, e.g. their Master Problem List and by interview. When large groups are receiving immunizations, e.g. influenza immunizations with a jet injection gun, as a minimum conduct an informational briefing.
4. During the screening process check the five "R's" before giving any immunization:
  - a. Right patient (verify name and SSN against records).
  - b. Right vaccine (Double check potency, date, and vaccine just before administration).
  - c. Right dose.
  - d. Right route.
  - e. Right interval.
5. A BLS-certified EMT NCO will be present and directly supervise all immunizations. A PA or Physician will be notified prior to the administration of the immunization, must approve its administration and must be immediately available, able to be on site for an emergency within 5 minutes.
6. All personnel who administer immunizations will be certified by the MEDDAC or by the supervising Medical Officer of that medical section and will have a current BLS card.
7. A current list of all personnel certified in administering immunizations will be posted at the site of immunizations.
8. A log of all shots administered will be maintained at the site where immunizations are given. The log will include as a minimum the date, time, rank, full name, SSN, unit/company, and type of immunization given.
9. Vaccine which is less stable in solution, e.g. Dried Typhoid Vaccine or Yellow Fever, must be mixed with a diluent before administration. Read and follow the instructions in the package circular on how to

mix the diluent and vaccine. As a minimum a log of the date, time and lot numbers of the vaccine and diluent will be maintained at the site of immunization. All open vials will likewise be marked.

10. Whenever possible, soldiers should receive their immunizations 30-60 days before their deployment to allow them adequate time to develop an antibody response.

11. IAW AR 40-562, paragraph 7-2, immunizations must be recorded at the time of immunization, in both the individual's yellow shot record (PHS 731) and on the SF 601, Health Record Immunization Record.

12. A 12 month log of all immunizations will be maintained at each site immunizations are administered. Ensure each immunization is logged on a separate line.

13. A second log of all serum lot numbers, diluent lot numbers along with the date and time they were reconstituted will be maintained at the site of immunization for a minimum of 12 months.

14. It is extremely important that care is taken in documenting all immunizations. Extra immunizations, administered due to a lack of documentation, can cause hypersensitivity to a vaccine or its components and cause the soldier an unnecessary inconvenience. If there are any questions on the necessity of an immunization or the proper procedure in documenting its administration, ask your PA, Physician, Garrison Surgeons Office, or call the Chief, Preventive Medicine for clarification.

### **Emergency Treatment Supplies**

1. An emergency treatment kit (replaces the SPARKS KIT) is available from the MEDDAC In-patient Pharmacy. As a minimum the following equipment and supplies will be maintained at the site of immunizations.

a. Epinephrine, 1:1,000 with Tubex Injector	3 ea
b. Beta-agonist Inhaler (e.g. Albuterol)	1 ea
c. Benadryl, 50mg for Injection	1 ea
d. Oral-Pharyngeal Airway (Lg, Med, Sm)	1 ea
e. Oxygen with Non Rebreather Mask	1 ea
f. Bag Valve Mask (BVM)	1 ea
g. Intravenous Solution (Lactated Ringers) (1 liter bag) along with Admin Set	3 ea
h. IV Catheter (no smaller than 18 ga)	3 ea
i. Venous Constriction Band	1 ea
j. Stethoscope	1 ea
k. Blood Pressure Cuff	1 ea
l. Tongue Depressors	6 ea
m. Penlight	2 ea
n. Tourniquets	2 ea
o. Ammonia Inhalants	1 pk

2. A list of qualified personnel will be posted along with the emergency equipment maintained on site. Ensure all personnel working at the site know where the emergency equipment is located and who is authorized to use it.

## **Treatment of Anaphylactic Shock**

### **IDENTIFICATION OF THE SIGNS AND SYMPTOMS OF ANAPHYLACTIC SHOCK**

1. The casualty may have difficulty breathing. He/she may wheeze, cough, or feel like he/she is suffocating. Respirations are usually noisy and he/she may struggle to breathe.
2. Weak, rapid, or imperceptible pulse may be present. The agent causing the allergic reaction may also cause a severe drop in blood pressure, leading to shock.
3. Cyanosis (blueness) around the lips due to lack of oxygen may be present. Individuals with dark skin may appear gray. Check the mucosa inside the lips for signs of cyanosis.
4. Flushing, burning, or an itching sensation may be present. Hives may develop. Redness of the skin is caused by congestion of capillaries in the skin brought about by a vasodilatation in response to the poisonous affect of the drug, insect bite, or sting.
5. Dizziness or syncope due to lack of oxygen may be present.

**TREATMENT OF ANAPHYLACTIC SHOCK** Begin treatment as soon as anaphylaxis is suspected, do not wait for symptoms to develop.

1. Call the EACH ER to dispatch EMS and to communicate with a physician.
2. Place the patient in the supine position.
3. Maintain the airway and administer Oxygen by nasal cannula or mask at the rate of 5-10L/min. Assist with ventilation using the bag-valve-mask system or perform rescue breathing as needed.
4. Start an IV using Ringer's Lactate solution and run at the rate of 0.51L per hour.
5. Administer epinephrine under the supervision (or radio supervision) of a physician or physician assistant by IM or SQ injection, (1:1000 solution)
  - a. 0.3cc to 0.5cc
  - b. Four or five additional injections of epinephrine may be necessary if signs and symptoms of shock worsen or recur. Give injections of 0.2cc increments every 15 minutes up to 1.0cc total dosage.
6. Monitor the blood pressure and pulse every 5 to 15 minutes until the pressure is normal, stable, and the casualty is free of respiratory distress, that is, breathing without assistance.
7. Administer diphenhydramine (Benadryl) 50mg IV or IM as early as possible.

### **TRANSPORT TO AN EMERGENCY ROOM**

Once the patient is stabilized, transport him/her to ER for future evaluation and treatment.

### **Requesting Storage and Disposal of Vaccines**

1. Requisition of Vaccines.
  - a. Request vaccine and medical supplies only after screening medical records and shot records to establish the quantities required.

b. Prepare your DA 3161 with one copy and attach a copy of your screening list. (Use a TACCS printout, a Unit immunization readiness report from MRP, or a list of personnel needing immunizations.) Fill in the quantities requested on the Blank 3161.

c. Submit vaccine and supply requests 30 working days prior to your SRP date to the medical supply that supports you, 3 ACR RMSO, 3BDE Medical Supply, MEDDAC, or 10th CSH Supply.

## 2. Storage of Vaccines:

a. Keep a thermometer in the refrigerator/freezer, and maintain a temperature log.

b. Store immunizations IAW the package circular and AR 40-562, Chapter 2.

c. Date and initial all vials after opening. (a time is also required for Yellow Fever.)

d. Do not keep Yellow Fever vaccine for more than an hour after it is reconstituted or thawed.

Typhoid can be stored for 30 days after reconstitution. All other vaccines can be stored for up to 90 days after opening.

e. Do not draw vaccines in advance or store in plastic syringes for more than 1 hour.

Components of some vaccines, e.g. phenol can react with the plastic.

f. Turn in all vaccines which are improperly stored, expired, or no longer needed to your medical supply as soon as possible.

## 3. Disposal of vaccine and supplies:

a. All used needles and empty vaccine vials should be placed in a plastic disposal container available through medical supply.

b. Do not recap or clip the needles. Drop them into the medical waste container immediately after use.

c. Turn in all waste materials to the Hazardous Waste Office at Evans Army Community Hospital immediately following your SRP.



## Appendix 4

### Aid Station Sick Call Medication SOP

#### AID STATION SICK CALL MEDICATION SOP

1. General. Aid Stations at Fort Carson provide garrison sick call support for their units. For the purposes of this SOP, there are three different types of aid stations.
  - a. Aid stations that have a Medical Officer (Physician or Physician Assistant)
  - b. Aid stations that have no Medical Officer but have medics that are ADTMC trained and certified screeners.
  - c. Aid stations that have no Medical Officer and do not have medics that are ADTMC trained or certified.

In the past, aid stations have been dispensing sick call medications from their Medical Equipment Sets (MES). This is their “Go to War” stocks. The “Aid Station Sick Call Medication SOP” describes the procedures and responsibilities that will allow aid stations to receive daily sick call medications from the MEDDAC.

2. Purpose. To delineate the administrative and clinical roles, responsibilities, and requirements that must be followed by aid stations to receive and dispense medications provided by the MEDDAC.
3. Scope. The “Aid Station Sick Call Medication SOP” applies to all aid stations on Fort Carson and the MEDDAC.
4. Responsibilities.
  - a. CDR, MEDDAC will
    - (1) Provide pre-packed medications (Appendix A) for aid stations that have been approved to dispense medications at Fort Carson’s garrison aid stations.
    - (2) Be the approving authority for garrison aid stations that can dispense the pre-packed medications. The DHS has the authority to suspend a garrison aid station’s medication dispensing privileges, if they are not compliant with this SOP.
    - (3) Designate pharmacy or logistic personnel to conduct staff assistance visits to aid stations dispensing pre-packed medications on a quarterly basis to ensure that there is an appropriate quality control program.
    - (4) Designate the Chief, Family Practice as the action officer to:
      - (a) Update the list of all aid stations at Fort Carson (Appendix C).
      - (b) Provide recommendations, to the DHS, concerning approval of garrison aid stations to receive prepackaged medications IAW this SOP.
      - (c) Monitor aid stations to ensure that all parties comply with this SOP. Report non-compliance to the DHS. A standardized inspection checklist to record findings will be used as part of the monitoring process. A copy of the findings will be given to aid station’s OIC/NCOIC, Brigade/Regimental Surgeon, and 7<sup>th</sup> Infantry Division Surgeon (Appendix B). If the standardized inspection form changes, the aid station’s OIC/NCOIC, the Unit Surgeon, and Division Surgeon will be provided a copy of the new checklist.
  - b. Garrison Aid Station’ Medical Officers, Medical Platoon Leaders, and Medical Platoon Sergeants will:
    - (1) Ensure that dispensing, quality control, and ordering medications are IAW this SOP.

(2) Ensure that medications provided for garrison sick call are used solely for this purpose. These medications are not authorized for use in the aid stations Medical Equipment Sets. If an aid station places these medications in their MESSs, the service providing medications from the MEDDAC may be suspended and the unit commander will be notified.

(3) Only pre-packed medications provided by the MEDDAC's pharmacy may be dispensed at the aid station. Use of medication in the MESSs is not authorized for garrison sick call.

(4) Ensure that a list of approved personnel authorized to dispense medications is posted on the medication cabinet. Medication cabinets must be locked at all times when approved personnel are not in the immediate area.

(a) Only trained ADTMC screeners, on the medication access roster, are authorized to screen patients and dispense approved ADTMC screener medications (Appendix A). All medications dispensed by the ADTMC screeners will have a prescription. These prescriptions will be maintained IAW Appendix D.

(b) Only medical officers (physician or physician assistants), on the access roster will be authorized to dispense non-ADTMC screener medication (Appendix A). Medics that are on the access roster may take the medication from the cabinet and give them to the medical officer who will dispense the medication. All medications dispensed by a medical officer will have a prescription. These prescriptions will be maintained IAW Appendix D.

5. Obtaining DHS' approval to dispense medications, in garrison, and receive pre-packed medications for garrison sick call.

a. Aid stations that have a Medical Officer (Physician or Physician Assistant) and comply with this SOP. Medics at these aid stations can dispense approved ADTMC medications only if they are trained ADTMC screeners. Medics that are not trained ADTMC screeners may not dispense or prescribe medications (to include approved ADTMC medications). NOTE: All medical records for patients that are screened as self care (Category IV) must be reviewed by a medical officer within 24 hours after the patient is released from the aid station. These aid stations will be recommended for approval to receive pre-packaged medications for garrison sick call. Failure to comply with this SOP, maintain certified ADTMC screeners, or to have the medical records (of Category IV patients) reviewed by a medical officer may have this service suspended.

b. Aid stations that have no Medical Officer but have medics that are ADTMC trained and certified screeners and comply with this SOP. Medics at these aid stations can dispense approved ADTMC medications only if they are trained ADTMC screeners. Medics that are not trained ADTMC screeners may not dispense or prescribe medications (to include approved ADTMC medications). NOTE: All medical records for patients that are screened as self care (Category IV) must be reviewed by a medical officer within 24 hours after the patient is released from the aid station. These aid stations will be recommended for approval to receive pre-packed medications for garrison sick call. Failure to comply with this SOP, maintain competent, trained, and certified ADTMC screeners, or to have the medical records (of Category IV patients) reviewed by a medical officer may have this service suspended.

c. Aid stations that have no Medical Officer and do not have medics that are certified ADTMC. These aid stations will NOT be recommended for approval to receive approved ADTMC medications. These aid stations can perform records management and refer all patients to their servicing TMC. They are not authorized to medically screen and are not authorized to dispense any medication.

**APPENDIX A** (Medications authorized at garrison aid stations).**APPROVED ADTMC MEDICATIONS:**

4:00	ANTI-HISTAMINE DRUGS	Actifed Tablets
12:12	SYMPATHOMIMETIC AGENTS	Sudafed 30 mg Tablets
28:08.04	NONSTEROIDAL ANTI-INFLAMMATORY	Aspirin 325 mg Tablets
28:08.92	ANALGESICS AND ANTIPYRETICS	Tylenol 325 mg Tablets
48:16	EXPECTORANTS	Robitussin DM
52:08	ANTI-INFLAMMATORY AGENTS	Hydrocortisone Cream 1.0% Topical
52:28	MOUTHWASHES AND GARGLES	Cepacol Lozenges
542:32	EENT VASOCONSTRICTORS	Afrin Nasal Spray Visine Eye Drops
56:04	ANTACIDS AND ADSORBENTS	Maalox Extra Strength Suspension
56:08	ANTIDIARRHEA AGENTS	Kaopectate
56:12	CATHARTIC AND LAXATIVES	Colace 100 mg Capsules
84:04.04	ANTIBIOTICS	Bacitracin Topical Ointment
84:04.08	SKIN AND MUCOUS MEMBRANE FUNGICIDE	Clotrimazole Cream Clotrimazole Solution
84:04.16	MISCELLANEOUS LOCAL ANTI-INFECTIVES	Betadine Scrub Hydrogen Peroxide
84:06	ANTIPRURITICS AND LOCAL AGENTS	Nupercainal Ointment
84:12	ASTRINGENTS	Domeboro Tablets Hemorrhoidal Suppositories
84:20	DETERGENTS	Sebutone Shampoo
84:24.04	SKIN BASIC LOTIONS & LINIMENTS	Calamine Lotion
84:24.08	BASIC OIL AND OTHER SOLVENT	Analgesic Balm
84:80	SUNSCREENING AGENTS	Zinc Oxide Ointment

**APPROVED MEDICATIONS FOR AID STATIONS WITH MEDICAL OFFICERS:**

All approved ADTMC screener medications (Appendix A, para. 1) plus medications approved for Physician Assistants. The exception, at this time, would be no injectable medication or narcotics. If a patient requires injectable medication they should be referred to their servicing TMC or to the Emergency Room. Approval for stocking injectable medications at aid stations will require approval of the P&T Committee. Not all medications authorized for the physician assistant will be stocked at the Aid Station. It will be based on a need/usage survey. These pre-packed medications for medical officers will initially consist of the medication listed below. Changes in this list will be based on requests and usage by the Aid Station's Medical Officer. Approval for adding medications to the Medical Officer's aid station pharmacy will be through the Chief, Family Practice and Chief, Pharmacy, MEDDAC. The list will be standardized for all Aid Stations with Medical Officers.

Duravent

Deconamine

CTM

Antibiotics

Penicillin VK 250 mg

Amoxicillin 250 mg

Erythromycin 250 mg

Keflex 250 mg

Septra DS

Dicloxacillin 250 mg

Anti-Inflammatory

Motrin 800 mg

Naprosyn 375 mg

Indomethacin 25 mg

Cortisporin Otic gtts

Flexaryl 10 mg

Robaxin 500 mg

Humabid DM

Imodium 2 mg

Proventil Inhaler

Phenergan Tablets 25 mg

Anusol HC rectal suppository

Sulfacetamide Ophthalmic

Bacitracin Ophthalmic

**APPENDIX B (Standardized Drug Storage Area Inspection Form)  
DRUG STORAGE AREA INSPECTIONS**

DATE: \_\_\_\_\_

Aid Station : \_\_\_\_\_

- |  |        |
|--|--------|
| 1. Does the aid station contain controlled substances?   | YES/NO |
| 2. Are TOE medications stored with MEDDAC's pre-packed medications?  | YES/NO |
| 3. Is the aid station prescribing and dispensing TOE medications for garrison use?                           | YES/NO |
| 4. Does the aid station have injectable medications?   | YES/NO |
| (If YES: IMMEDIATELY NOTIFY Chief, Pharmacy and Chief, Family Practice)                                      |        |
| 5. Are drugs requiring special storage conditions for stability stored properly?                             | YES/NO |
| 6. Is the area free of unauthorized medication?  | YES/NO |
| 7. Is the drug stockage level reasonable for the type/number of patients being treated?                      | YES/NO |
| 8. Is the area free of outdated drugs or discontinued drugs?   | YES/NO |
| 9. Is there a thermometer in the refrigerator?   | YES/NO |
| 10. Is the temperature between 35 and 48 degree Fahrenheit?  | YES/NO |
| TEMPERATURE: _____   |        |
| 11. Is the drug storage area in the refrigerator free of food and other unauthorized items?                  | YES/NO |
| 12. Is the Poison Control Number posted?   | YES/NO |
| 13. Are the following references present?  | YES/NO |
| A. Hospital Formulary with Metric apothecary conversion table?   | YES/NO |
| B. PDR, AHFS Drug Information, or Facts and Comparisons?   | YES/NO |
| 14. Is the list of approved ADTMC screeners posted IAW this SOP?   | YES/NO |
| 15. Are prescriptions being properly completed for all dispensed medications (to include ADTMC medications)? | YES/NO |
| 16. Does the aid station have a copy of the Aid Station Sick Call Medication SOP?                            | YES/NO |

Elaborate on any NO answers: \_\_\_\_\_

Aid Station OIC/NCOIC: \_\_\_\_\_ CHECKED BY: \_\_\_\_\_

Copy of Inspection sent to: Chief, Pharmacy  
Chief, Family Practice  
Brigade/Regimental Surgeon  
Aid Station OIC/NCOIC  
7<sup>th</sup> Infantry Division Surgeon

**APPENDIX C (List of established Fort Carson Aid Stations)**

1. The following is a list of current Aid Stations at Fort Carson, their units, and their servicing Troop Medical Clinic. All listed aid stations have preliminary approval pending initial evaluation by Family Practice. After the initial evaluation, the unit aid stations will receive certificate of approval by the DHS.

**3D BCT**

<b>AID STATION</b>	<b>SERVICING TMC</b>	<b>PA</b>
1/68 Armor Battalion	Robinson TMC	Yes
1/12 Infantry Battalion	Robinson TMC	Yes
1/8 Infantry Battalion	Robinson TMC	Yes
3/29 Field Artillery	Robinson TMC	Yes
4 <sup>th</sup> Engineer Battalion	Robinson TMC	NO
64 <sup>th</sup> Forward Support Battalion	Robinson TMC	Yes

**3D ACR**

<b>AID STATION</b>	<b>SERVICING TMC</b>	<b>PA</b>
1/3 ACR	Robinson TMC	Yes
2/3 ACR	Robinson TMC	Yes
3/3 ACR	Robinson TMC	Yes
4/3 ACR	Robinson TMC	Yes
Support Squadron	Robinson TMC	Yes

**43D ASG**

<b>AID STATION</b>	<b>SERVICING TMC</b>	<b>PA</b>
52 <sup>nd</sup> Engineer Battalion	TMC # 9	Yes
759 <sup>th</sup> MP Battalion	TMC # 9	No

**APPENDIX D (Prescriptions and Ordering Medications)**

1. Prescriptions and dispensing ADTMC approved medications.
  - a. ADTMC approved medications can be dispensed only by medics that are trained ADTMC screeners. Appropriate patient education and warnings, for these medications, should be given to the patient. No other medication maintained at the garrison aid station may be dispensed by medics.
  - b. An approved access roster will be posted on the medication cabinet.
  - c. Prescriptions for approved ADTMC medication that is dispensed will be completed by the certified ADTMC screener. The signature on the prescription will be that of the ADTMC screener. The screener must print, or stamp, their name and MOS below their signature.
2. Prescriptions and dispensing approved non-ADTMC medications.
  - a. Only medical officers can dispense approved non-ADTMC medications. Medics that have approved access to the medication storage area can remove the prescribed medication and give it to the medical officer. Only the medical officer can dispense these medications and give the appropriate patient education and warnings.
  - b. Dispensing these medications by personnel not authorized may result in suspension of this service.
3. NO medication from the TOE equipment sets may be dispensed at the garrison aid station. Only the prepackaged medication provided by the MEDDAC's pharmacy can be dispensed.
4. To order medications for garrison aid stations, the aid station must:
  - a. Be approved by the Fort Carson's DHS and comply with this SOP.
  - b. Designate an NCO (91B/C) that will serve as the aid station's POC concerning garrison aid station medications and the required Quality Control. This NCO will ensure that a quality control plan that is approved by the MEDDAC's Chief, Pharmacy is followed.
  - c. Maintain these medications in a locked storage cabinet. An approved access roster will consist only of the medical officer and medics that are trained and certified ADTMC screeners.
  - d. Have personnel on a signature card, signed by their commander, authorizing them to order and pick up medications that are ordered. These personnel must be on the medication access roster.
  - e. Determine an initial one week stockage level for medications. This stockage level will be adjusted according to the usage level at the aid station.
  - f. Once a week the aid station will submit a request for approved medications using a bulk drug order pharmacy request form. This form will be submitted through the aid station's supporting TMC.
  - g. Only medical personnel with a signature card may pick-up resupply medication at the TMC.
5. The supporting TMC will:
  - a. Maintain all prescriptions from the aid station. These prescriptions will be maintained separately from other aid stations and the TMC.
  - b. Submit all supported aid station resupply requests to the inpatient pharmacy. Only approved aid stations will be allowed to request these medications.
  - c. After receiving resupply medications from the pharmacy, only aid station personnel with a signed signature card will be authorized to pick up these medications.
6. The pharmacy will prepare the aid station's medication resupply and package it separately according to the requesting aid station. This medication will be delivered to the TMC. The TMC will contact the aid station to pick up the medication by a soldier that is on a signature card.