

## Post-Disaster Child Care Center Sanitation Assessment Form

Date & Time of Inspection:			County:			
Name of Facility:			Current Facility ID:			
Operator/Director (Name/Title):						
Street Address:						
City:			Zip Code:			
Email:			Phone Number:			
<b>Purpose of Assessment</b>						
Reason for Assessment (ex. hurricane, power outage):						
Name of event, if applicable (ex. Hurricane Florence):						
Is the center currently operating?		<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Did the center close at any time?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>If yes, duration closed:</i>		
If unable to complete the assessment, explain:						
<b>***IF IT IS NOT SAFE to complete the assessment, DO NOT proceed!***</b>						
<b>Department of Child Development &amp; Early Education (DCDEE) Communication</b>						
Name of Licensing Consultant:			Phone Number:			
Email:						
<b>Other Agency Communication</b>						
Has the operator communicated with the following agencies?						
	Yes	No				
DCDEE/Licensing Consultant	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, date:</i>			
Fire Marshall	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, date:</i>			
Building Inspection Dept.	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, date:</i>			
Public Water Supply	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, date:</i>			
Other (please describe):		Date:				
<b>Communicable Disease</b>						
Is this visit associated with a communicable disease or outbreak?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Has the operator communicated with the Communicable Disease Authorities?			<input type="checkbox"/> Yes (date):	<input type="checkbox"/> No		
<i>If yes, who did the operator speak with?</i>						
Comments:						
<b>Temporary Center Changes</b>						
Have any center operations been relocated off site?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<i>If yes, location address:</i>						
Have children been relocated within the center (ex. temporary room changes)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Has access to any areas within the center been restricted (ex. classroom, kitchen)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<i>If yes to any of the above questions, who approved these changes?</i>						
Comments:						
<b>Environmental Hazards</b>						
Are any of the following environmental hazards observed?				Location / Other Comments:		
	Yes	No	Unknown			
Flooding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Structural damage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

<i>(continued)</i>		Yes	No	Unknown	Location / Other Comments:
Damaged foundation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Damaged or burst pipes		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mold growth		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Water damage		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exposed wastewater		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fire damage		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Outdoor/landscaping debris		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Broken windows/glass		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gas line leaks		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Odors from potential leaks		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exposed electrical		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chemical spills		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (please describe):					
Is there an identified history of the following?					
		Yes	No	Unknown	
Lead paint		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asbestos		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Power &amp; Electricity</b>					
		Yes	No	Unknown	Location / Other Comments:
Was power lost?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>If yes,</i>	duration of outage (days/hours):				
	date & time power restored:				
Was a generator used?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>If yes,</i>	did it run consistently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	run duration (days/hours):				
	is it still in use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	equipment connected to generator:				
	location of fuel storage:				
Are any of the following concerns observed?					
		Yes	No	Unknown	
Damaged electrical system		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Downed power lines		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<i>If yes: Are they in water?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insufficient lighting		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (please describe):					
<b>Food Storage &amp; Services</b>					
Under normal operations:		Yes	No	Location / Other Comments:	
Is food prepared on site?		<input type="checkbox"/>	<input type="checkbox"/>		
Is food brought from home?		<input type="checkbox"/>	<input type="checkbox"/>		
Is food provided by a permitted establishment or other center?		<input type="checkbox"/>	<input type="checkbox"/>		
<i>If yes,</i>	name of establishment or center:				

Under post-disaster operations:	Yes	No	Location / Other Comments	
Is food prepared on site?	<input type="checkbox"/>	<input type="checkbox"/>		
Is food brought from home?	<input type="checkbox"/>	<input type="checkbox"/>		
Is food provided by a permitted establishment or other center?	<input type="checkbox"/>	<input type="checkbox"/>		
<i>If yes,</i>	name of establishment or center:			
Were any of the following contaminated or impacted?			If discarded, describe method:	
	Yes	No	Unknown	
Perishable foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frozen foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Formula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Human milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Packaged foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Canned foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Refrigerator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Freezer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stove	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dishwasher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ice machine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Utensils (multi-use)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tableware (multi-service)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Single service articles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Paper products (ex. towels, napkins)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (please describe):				

**Food Temperature Observations**

Item/Location	Temp (°F)	Item/Location	Temp (°F)	Item/Location	Temp (°F)

**Refrigerator & Freezer Equipment Observations**

Equipment in kitchen/food prep areas	Location/Room	Temp (°F)	Did food thaw? (Y/N)	What was the condition of the food inside? (ex. unaffected, refrozen, discarded)

<b>Water Supply</b>						
Water supply: <input type="checkbox"/> Community* <input type="checkbox"/> Non-Transient Non-Community* <input type="checkbox"/> Transient Non-Community* <input type="checkbox"/> Non-Public						
Has the water supply been contaminated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A						
*If yes, for community, non-transient non-community, or transient non-community, EHS should contact public water supply.						
			Yes	No	Unknown	Location / Other Comments:
Are there any active water notices or advisories?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, please list:						
Is water provided from a well?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Has any of the on-site water supply been impacted by flood waters?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, has the well been chlorinated?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Were water samples collected?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, date collected:						
Does EHS need to contact local On-Site Water Supply Program?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, date contacted:						
Do any of the following items present concerns or been otherwise impacted?						
			Yes	No	Unknown	
Well			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Power supply (ex. well pump)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Water pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Backflow (pressure loss)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sinks			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drinking fountains			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (please describe):						
<b>Water Temperature Observations</b>						
Fixture/Location	Temp (°F)	Fixture/Location	Temp (°F)	Fixture/Location	Temp (°F)	
<i>Water temp requirements: kitchen sink 120°F or above; tempered water 80°F-110°F; can wash 80°F or above</i>						
<b>Wastewater</b>						
Wastewater system: <input type="checkbox"/> Community <input type="checkbox"/> On-site						
Has the wastewater system been impacted or present any concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A						
If yes, are any of the following malfunctions observed?			Location / Other Comments:			
			Yes	No	Unknown	
Standing wastewater/effluent			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Interior overflows or back up			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Power supply (ex. control panel)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (please describe):						

	Yes	No	Unknown			
Does EHS need to contact local On-Site Wastewater Program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<i>If yes,</i>	date contacted:					
<b>Water Intrusion or Damage</b>						
Is there visible water intrusion from <b>rainwater</b> (ex. ceiling, wall, floor, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A			
Is there visible water intrusion from <b>surface flooding</b> (ex. creeks, rivers, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A			
Do any materials have visible water damage/contamination (ex. furniture, toys, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Do any materials have visible mold/mildew (ex. walls/baseboard, ceiling, toys, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
<i>If yes to any of the above questions, complete the table below to provide details:</i>						
Item	Location	Damage	Item	Location	Damage	
<b>HVAC</b>						
Per the operator, does the HVAC system function like it did prior to the disaster?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A		
<i>If no,</i> has the operator contacted a licensed HVAC contractor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>If yes, date:</i>			
Are all room temperatures within 65°F – 85°F?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
<i>If any rooms are out of temperature range or feel humid, complete this table to detail which room(s):</i>						
Room/Location	Temp (°F)	Humid (Y/N)	Room/Location	Temp (°F)	Humid (Y/N)	
Other Comments:						
<b>Pest Control &amp; Outdoor Learning Environment</b>						
Are any of the following concerns observed?			Location / Other Comments:			
	Yes	No	N/A			
Debris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Damaged play structure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Damaged fence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Standing water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Insects (fire ants, mosquitos, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Rodents (rats, mice, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Other pests (snakes, possums, etc.):						
Are there sites nearby that may contaminate or otherwise affect the child care facility?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<i>If yes,</i>	Source of contamination:		Potential hazard:			
	Location of hazard with respect to child care center (ex. distance, downhill/uphill):					

