MED-TAC INTERNATIONAL

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SCHOOL TRAUMA READINESS ASSESSMENT

A Structured Evaluation of Your Campus's Medical Response Capabilities

Version 2.0 — September 2026

Document Code: MTC-SA-002

EVIDENCE-BASED. C-TECC-ALIGNED. NFPA 3000-READY.

For school administrators, district safety directors, school resource officers, and school nurses

INSIDE

5 scored sections · 110 items · 330 points
Campus walk-test tables and response-time benchmarks
3-tier equipment audit · MARCH campus application
Gap analysis, 30/60/90 plan, and a 5-minute board summary

- SDVOSB — Service-Disabled Veteran-Owned Small Business
- Medical SME Veteran-Led
- C-TECC Educational Partner
- NFPA 3000-Aligned
- Designed & Assembled in the USA

School Safety Collection

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This document is designed for print. Complete each section as a team, tally scores in Section 7, and route the completed assessment to your district safety committee.

ASSESSMENT AT A GLANCE

5	110	330	90–120
SCORED SECTIONS	ASSESSMENT ITEMS	MAXIMUM POINTS	MINUTE TEAM SESSION

About This Edition

Version 2.0 (MTC-SA-002) supersedes the unversioned MTC-SA-001. Scoring, item wording, and the 330-point scale are unchanged except where current doctrine or a factual correction required it; the change log is printed on the back cover. Prepared by **Marco R. Torres, MD, NRP** — physician and medical educator, U.S. Navy veteran, and founder of MED-TAC International and ALKEONHealth.com.

SECTION 1

Introduction

Purpose of This Assessment

This assessment gives your campus a structured, repeatable way to evaluate its medical response capability for time-critical trauma — the injuries that can take a life in minutes rather than hours. It is built around a simple premise: a school already plans for fire, severe weather, and lockdown. Trauma response belongs in that same planning cycle, with the same rigor, the same documentation, and the same budget conversation.

The assessment is not a sales tool and it does not assume the worst about your campus. It is a diagnostic instrument. Score honestly, and the output is a prioritized, budget-aware action plan you can bring to a safety committee or a board meeting — not a list of products.

Why Trauma Readiness Matters for Schools

Uncontrolled external hemorrhage remains one of the most preventable causes of death following traumatic injury. Peer-reviewed battlefield and civilian trauma registries consistently show that a meaningful share of preventable trauma deaths involve hemorrhage that was survivable with prompt, correct intervention — direct pressure, wound packing, or a properly applied tourniquet — delivered in the first minutes, well before EMS can arrive on scene.

That timing gap is the entire rationale for public-access bleeding control. NFPA 3000®, the Standard for an Active Shooter/Hostile Event Response (ASHER) Program, was developed specifically because professional responders cannot be first on scene for every event — the people already in the building are. The American College of Surgeons' Stop the Bleed® initiative and the broader C-TECC framework for civilian tactical emergency casualty care both rest on the same finding: bystanders who are equipped and briefly trained measurably improve survivability before EMS arrival.

A school's duty of care does not end at fire drills and lockdown procedures. Where state or local mandates already require bleeding control kits on campus, this assessment gives you the structure to verify compliance. Where no mandate yet exists, it gives you a defensible, evidence-based basis to get ahead of one.

How to Use This Assessment

Who Should Complete It

This assessment is designed for a small cross-functional team, not a single person working alone. A complete team typically includes the campus or district safety director, the school resource officer or head of campus security, the school nurse or lead health services staff member, and a facilities or operations representative who knows the physical plant. Where the campus has a designated emergency management coordinator, include them as well.

Scoring Methodology

Every assessment item in this document uses the same 0–3 scale. Score the item as it currently exists on your campus — not as it is planned, budgeted, or "mostly there." An honest 1 is more useful to your action plan than an aspirational 3.

SCORE	MEANING
0 — Not Present	The capability, equipment, or practice does not currently exist on this campus.
1 — Below Standard	Present but incomplete, inconsistent, expired, or not meeting the described benchmark.
2 — Meets Standard	Present and functional, meeting the described benchmark for a campus this size.
3 — Exceeds Standard	Present, current, and exceeding the benchmark — e.g., redundant coverage, documented drills, or third-party verification.

Section 7 aggregates every section score into a single readiness percentage and assigns a color-coded readiness level — Red, Yellow, or Green — with a corresponding action-plan template. Complete Sections 2 through 6 in full before moving to the Section 7 rollup; a partial assessment will understate your true readiness gaps.

Recommended Team Approach

- Schedule a single 90–120 minute working session rather than passing the document around individually — cross-functional disagreement about a score is itself useful information.
- Walk the physical campus (Section 2) before scoring it. Do not score AED or bleeding-control station placement from memory.
- Pull actual training records and inspection logs before scoring Sections 4 and 6. Do not estimate percentages trained.
- Assign a single owner to carry the completed assessment into Section 7's action-plan template and to the board presentation summary.

The MED-TAC Preparedness Framework

Every section of this assessment maps back to a four-stage framework for campus trauma response. Understanding the framework before you begin scoring will help your team interpret what each section is actually measuring.

STAGE	WHAT IT MEANS ON CAMPUS
1. Recognize	Staff and students can identify a life-threatening bleeding emergency and know the immediate first action — call for help, apply pressure, and reach for the nearest bleeding-control station.
2. Stop the Bleeding	The right equipment — a CoTCCC-recommended tourniquet or hemostatic gauze — is within reach, and the person reaching for it has had enough hands-on practice to use it correctly under stress.
3. Stabilize	Beyond the initial bleeding-control action: airway positioning, chest seal application where trained, pressure dressings, and hypothermia prevention while the patient waits for transfer of care.
4. Transition	A clean handoff to arriving EMS — accurate information, an accessible patient, and documentation of what was done and when.

Sections 2 and 3 primarily evaluate Stage 1 and Stage 2 (the physical infrastructure and equipment that make recognition and bleeding control possible). Section 4 evaluates whether your people can execute all four stages under stress. Section 5 walks the full MARCH protocol — which spans Stages 2 through 4 — in a school-specific context.

The Compliance Landscape

This assessment is built to align with three reference points, summarized below. None of these require a specific vendor or product; they describe program elements and outcomes.

FRAMEWORK	WHAT IT COVERS	RELEVANCE TO THIS ASSESSMENT
NFPA 3000® — Standard for an Active Shooter/Hostile Event Response (ASHER) Program	Minimum program elements for organizing, managing, and sustaining a community or campus active-shooter/hostile-event response program, including planning, resource management, and incident management.	Sections 2, 3, and 6 map directly to NFPA 3000's resource-management and preparedness chapters.
C-TECC — Committee for Tactical Emergency Casualty Care	Civilian-adapted casualty care guidelines derived from military Tactical Combat Casualty Care (TCCC), specifically written for law enforcement, fire/EMS, and civilian bystander application.	Section 5's MARCH walkthrough and Section 3's equipment tiers both use C-TECC's civilian casualty-care framework as their clinical basis.
State / District Bleeding-Control Mandates	A growing number of states and districts require bleeding-control kits, AEDs, or both, in K–12 facilities, with requirements that vary by state on kit placement, quantity, and training.	Section 6 gives you the framework to check and document your specific state and district requirements — confirm current mandates with your state department of education or emergency management office, as requirements change.

This assessment references CoTCCC-recommended equipment throughout. "CoTCCC-recommended" describes a device's inclusion on the Committee on Tactical Combat Casualty Care's list of recommended devices — it is not an FDA approval or certification, and this document makes no such claim.

Assessment Team Roster

NAME	ROLE / TITLE	SECTIONS OWNED	DATE COMPLETED

NOTES / COMMENTS

SECTION 2

Campus Infrastructure Assessment

This section evaluates the physical campus itself — the layout, access points, communication systems, and existing life-safety equipment placement that either support or constrain a fast trauma response. Walk the campus with this section in hand rather than scoring from memory; placement gaps are the single most common finding in this section.

2.1 — Building Layout & Population

Record the following baseline figures before scoring. These numbers directly drive the coverage math in Sections 2.4 and 2.5 — a 40-classroom, three-building campus has fundamentally different bleeding-control station needs than a single-building campus of the same square footage.

CAMPUS METRIC	RECORDED VALUE
Number of buildings on campus	_____
Number of floors (aggregate, all buildings)	_____
Number of classrooms / instructional spaces	_____
Enrolled student population	_____
Full-time staff count (instructional + administrative + support)	_____
Approximate total square footage	_____
Public / visitor access points (doors, gates)	_____

2.2 — Access Points & Visitor Protocols

ASSESSMENT ITEM	0	1	2	3
All exterior public access points are identified, mapped, and known to security/administrative staff.	☐	☐	☐	☐
Visitor entry is controlled through a single, monitored point of entry during instructional hours.	☐	☐	☐	☐
Visitor management includes identity verification (sign-in, badge, or electronic visitor system).	☐	☐	☐	☐
Perimeter access points are documented in the campus emergency operations plan with unique identifiers (e.g., "Door 4-North") usable by both staff and responding EMS/fire/law enforcement.	☐	☐	☐	☐
Access point identifiers are posted and visible from both inside and outside the building.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

2.3 — Communication Systems

ASSESSMENT ITEM	0	1	2	3
Campus has a functioning mass-notification system (PA, text/email alert, or both) tested within the last 12 months.	☐	☐	☐	☐
Security/administrative staff carry two-way radios with campus-wide coverage, including areas with known dead zones (gymnasiums, portables, athletic fields).	☐	☐	☐	☐
A documented protocol exists for how a medical emergency is communicated from point of injury to the front office / dispatch point.	☐	☐	☐	☐
The campus has a direct, tested line of communication to local EMS dispatch (not solely relying on 911 from a cell phone with unknown campus location accuracy).	☐	☐	☐	☐
Communication protocol includes a designated method for directing arriving EMS to the exact location of the patient (staged "meet and greet" point, radio relay, or runner).	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

2.4 — AED Placement & Maintenance

Sudden cardiac arrest survival drops sharply for every minute defibrillation is delayed; national resuscitation guidelines commonly cite roughly a 7–10% reduction in survival for each minute without defibrillation in the initial minutes of arrest. AED placement and maintenance discipline directly determines whether that window is met.

ASSESSMENT ITEM	0	1	2	3
Campus has a documented AED placement plan providing coverage across all occupied buildings.	☐	☐	☐	☐
AEDs are positioned so that a 1–3 minute round-trip retrieval time is achievable from any occupied instructional space (verify by walking the actual distance, not estimating).	☐	☐	☐	☐
AED locations are marked with standard signage visible from primary hallway sightlines.	☐	☐	☐	☐
AEDs are on a documented maintenance schedule (battery/pad expiration tracked, self-test logs reviewed).	☐	☐	☐	☐
AED program is registered with local EMS per state requirement, where applicable.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

2.5 — Bleeding Control Station Placement

ASSESSMENT ITEM	0	1	2	3
Bleeding control stations exist and are placed based on a documented coverage plan, not ad hoc placement.	☐	☐	☐	☐
Stations are co-located with or near AED locations, following the same round-trip retrieval time standard as Section 2.4.	☐	☐	☐	☐
Stations are placed in areas with elevated injury risk in addition to general hallway coverage (athletic facilities, shop/vocational classrooms, science labs, cafeteria/kitchen).	☐	☐	☐	☐
Station coverage has been evaluated against known gaps (portables, athletic fields, off-campus instructional sites) and a mitigation plan exists for identified gaps.	☐	☐	☐	☐
Stations are visibly marked with consistent signage distinguishable from general first-aid signage.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

2.6 — Campus Response Time Analysis

Physically walk — do not estimate — the distance from your farthest occupied classroom or instructional space to the nearest bleeding-control station and the nearest AED. Record actual walk time at a normal adult walking pace, then again at a hurried pace.

RESPONSE-TIME METRIC	RECORDED VALUE
Farthest classroom identified	_____
Walk time to nearest bleeding-control station (normal pace)	_____
Walk time to nearest bleeding-control station (hurried pace)	_____
Walk time to nearest AED (normal pace)	_____
Walk time to nearest AED (hurried pace)	_____
Known coverage gaps identified (list locations)	_____

A round-trip retrieval time under roughly 60–90 seconds for both AEDs and bleeding-control stations is a reasonable working benchmark for a K–12 campus; treat the 3-minute AED round trip in Section 2.4 as the outer limit, not the goal. If your farthest classroom exceeds that, Section 7's action plan should treat additional station placement as a near-term priority, not a long-term goal.

SECTION SCORE SUMMARY	
Section 2: Campus Infrastructure Assessment	**_____ / 60 points**

NOTES / COMMENTS

SECTION 3

Equipment Inventory Audit

TIER 1 · INDIVIDUAL CARRY
e.g., SRO Individual Response Kit

TIER 2 · FIXED STATIONS
e.g., TRAMEDIC Bleeding Control Kit for Schools

TIER 3 · TEAM CRISIS RESPONSE
e.g., School Mass Crisis Incident Kit

Product photos from tactical-medicine.com. Examples only — no item in Sections 2–7 requires a specific vendor.

This section audits campus trauma equipment using a three-tier hierarchy: equipment carried on the body by staff with a security or medical role, equipment fixed at known locations across campus, and equipment staged for a coordinated, multi-casualty response. Most campuses have partial coverage in Tier 2 and little or nothing in Tier 1 or Tier 3 — that is a normal starting point, not a failing grade. Score what exists today.

TIER 1 — Individual Carry (On-Body for SROs & Security Staff)

Tier 1 asks whether the people most likely to be first on scene for a violent or high-acuity medical event — school resource officers and campus security staff — carry their own trauma kit, the way a law-enforcement officer on patrol would. A wall-mounted station three hallways away does an SRO no good in the first thirty seconds of a rapidly evolving incident.

ASSESSMENT ITEM	0	1	2	3
Each SRO / campus security staff member carries an individual trauma kit on their person during duty hours (not staged in an office or vehicle).	☐	☐	☐	☐
Individual kits contain a CoTCCC-recommended windlass tourniquet (C-A-T or SOF-T Wide pattern).	☐	☐	☐	☐
Individual kits contain hemostatic gauze (kaolin or chitosan agents, e.g., QuikClot, Celox) for wounds a tourniquet cannot address.	☐	☐	☐	☐
Individual kits contain at least one chest seal appropriate for penetrating chest trauma.	☐	☐	☐	☐
Individual kits contain a compression / pressure dressing.	☐	☐	☐	☐
Individual kits contain trauma shears and nitrile gloves.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

Expiration Tracking & Replacement Schedule

ASSESSMENT ITEM	0	1	2	3
A documented inventory exists listing every individually carried kit, its owner, and its contents.	☐	☐	☐	☐
Hemostatic agents and other shelf-life-limited components are tracked against manufacturer expiration dates on a recurring schedule (quarterly or better).	☐	☐	☐	☐
A defined replacement/resupply process exists for any component used or expired, with a named owner.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

TIER 2 — Fixed Stations (Wall-Mounted & Classroom)

Tier 2 is public-access bleeding control in the NFPA 3000 sense — equipment staged where anyone on campus, trained or not, can reach it and act within the first minutes. NFPA 3000's resource-management provisions call for strategic placement of casualty-care equipment based on documented risk and occupancy, mirroring how AEDs and fire extinguishers are already placed.

ASSESSMENT ITEM	0	1	2	3
A bleeding control kit is present in every general classroom.	☐	☐	☐	☐
Bleeding control kits are present in hallway zones (in addition to classroom kits), consistent with the coverage plan scored in Section 2.5.	☐	☐	☐	☐
A bleeding control kit / station is present in the gymnasium and any dedicated athletics space.	☐	☐	☐	☐
A bleeding control kit / station is present in the cafeteria.	☐	☐	☐	☐
Bleeding control kits are present at outdoor athletic fields and any off-building instructional areas (portables, field houses).	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

Placement Strategy: Public vs. Restricted Access

ASSESSMENT ITEM	0	1	2	3
Placement strategy explicitly distinguishes public-access stations (any adult can retrieve, consistent with public access bleeding control principles) from restricted-access stations (staff-only, e.g., behind a locked office).	☐	☐	☐	☐
Public-access stations are the majority of total coverage — restricted-access placement is the exception, not the default.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

Kit Contents Verification

ASSESSMENT ITEM	0	1	2	3
Fixed-station kit contents are standardized across campus (every kit contains the same core components, regardless of vendor).	☐	☐	☐	☐
Kits contain a CoTCCC-recommended tourniquet, hemostatic gauze or dressing, a compression bandage, and printed use instructions.	☐	☐	☐	☐
Kit contents have been physically verified (opened and checked) within the last 12 months, not assumed present since installation.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

Visibility & Signage

ASSESSMENT ITEM	0	1	2	3
Every fixed station has consistent, high-visibility signage distinguishable from general first-aid or fire-safety signage.	☐	☐	☐	☐
Signage location and station location are documented in the campus emergency operations plan and shared with substitute staff / new hires during onboarding.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

Maintenance & Inspection Schedule

ASSESSMENT ITEM	0	1	2	3
A written inspection schedule exists for fixed stations (recommended: quarterly at minimum).	☐	☐	☐	☐
Inspections are logged (date, inspector, findings) rather than performed informally.	☐	☐	☐	☐
A defined process exists for restocking a station after use or after a failed inspection.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

TIER 3 — Team Crisis Response (Mass Casualty & Active Threat)

Tier 3 addresses the scenario Tiers 1 and 2 are not built for: multiple simultaneous casualties. This tier is the least commonly built out on K–12 campuses, and a low score here is common — the goal of scoring it is to make the gap visible and budgetable, not to imply it should have already been solved.

ASSESSMENT ITEM	0	1	2	3
Campus has one or more coordinated mass-casualty response bags (multi-patient trauma supply, distinct from individual or single-station kits) staged at a known location.	☐	☐	☐	☐
Mass-casualty bag contents and quantities are based on a documented casualty estimate for the campus's population, not an arbitrary quantity.	☐	☐	☐	☐
A warm-zone / cold-zone staging concept exists in the emergency operations plan — i.e., a plan for where casualty care happens relative to an ongoing threat, developed with law enforcement input.	☐	☐	☐	☐
Campus has basic triage equipment or a triage tagging protocol (even a simple color-tag system) for use if patient volume exceeds available responders.	☐	☐	☐	☐
A patient movement / evacuation plan exists for moving injured students or staff from point of injury to a casualty collection point or ambulance loading zone.	☐	☐	☐	☐
The mass-casualty response plan has been reviewed with local EMS and fire department leadership, and both agencies are aware the equipment exists.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

Tier 3 equipment and planning should always be developed jointly with local EMS, fire, and law enforcement — never in isolation. A campus plan that has not been reviewed by the agencies who will actually respond is a paper plan, not an operational one.

SECTION SCORE SUMMARY	
Section 3: Equipment Inventory Audit	**_____ / 90 points**

Fixed-Station Inspection Log

Copy this page for each quarterly inspection cycle. One row per station; record the earliest expiration date found in the kit, not the kit's purchase date. Any "N" or expired item goes on the Section 7.3 priority list.

STATION ID / LOCATION	DATE	INSPECTOR	SEAL INTACT (Y/N)	TQ PRESENT (Y/N)	EARLIEST EXP.	RESTOCKED (Y/N)

NOTES / COMMENTS

SECTION 4

Staff Training & Readiness Evaluation

Equipment without trained hands is inventory, not capability. This section evaluates how much of your campus population can actually recognize and respond to a bleeding emergency, and how deep that training runs — from a general staff briefing up through licensed medical personnel.

4.1 — Bystander Training Coverage

Record actual counts from training records, not estimates.

TRAINING METRIC	RECORDED VALUE
Total staff trained in a bystander bleeding-control course (e.g., ACS Stop the Bleed® or an equivalent hands-on course) within the last 24 months	_____ of _____ staff
Percentage of staff trained in tourniquet application specifically	_____ %
Percentage of staff who have had hands-on practice (not video-only) within the last 12 months	_____ %

ASSESSMENT ITEM	0	1	2	3
A majority of instructional and administrative staff (recommended benchmark: 75% or greater) have completed a hands-on bleeding-control course within the last 24 months.	☐	☐	☐	☐
New-hire onboarding includes bleeding-control training as a standard component, not an opt-in.	☐	☐	☐	☐
Training records are centrally tracked and auditable (not self-reported without documentation).	☐	☐	☐	☐
Substitute teachers and part-time staff are included in the training program or receive an abbreviated orientation covering station locations and the tourniquet-first principle.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

4.2 — School Resource Officer & Security Staff Medical Training Level

Record the training level for each SRO or security staff member with a medical response role. Training levels commonly referenced in this space, from foundational to advanced, include a civilian tactical emergency casualty care (TECC) course, an EMR (Emergency Medical Responder) certification, EMT certification, and paramedic licensure.

SRO / SECURITY STAFF TRAINING LEVEL	COUNT ON STAFF
No formal medical training beyond bystander bleeding-control course	_____
TECC-aligned civilian tactical casualty care course completed	_____
EMR (Emergency Medical Responder) certified	_____
EMT certified	_____
Paramedic licensed	_____

ASSESSMENT ITEM	0	1	2	3
Every SRO / security staff member has, at minimum, completed a TECC-aligned civilian casualty-care course beyond general bystander training.	☐	☐	☐	☐
SRO / security staff training level is documented and refreshed on a recurring schedule (recommended: every 2 years).	☐	☐	☐	☐
SRO / security staff training includes scenario-based practice specific to a school environment (hallways, classrooms, crowd movement), not solely classroom instruction.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

4.3 — School Nurse Trauma Capability

ASSESSMENT ITEM	0	1	2	3
School nurse(s) have documented trauma-specific training beyond standard school-nurse licensure requirements (e.g., a bleeding-control instructor course or equivalent).	☐	☐	☐	☐
School nurse office maintains direct access to Tier 1/Tier 2 equipment described in Section 3, not solely a standard first-aid supply.	☐	☐	☐	☐
School nurse has a defined role in the campus mass-casualty response plan (Section 3, Tier 3), including triage responsibilities where applicable.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

4.4 — General Staff & Administrative Awareness

ASSESSMENT ITEM	0	1	2	3
All staff — including those never expected to render care — can identify the location of the nearest bleeding-control station and AED.	☐	☐	☐	☐
Staff awareness of station locations is verified periodically (e.g., a spot-check drill), not assumed from initial training.	☐	☐	☐	☐
Front-office and administrative staff know the campus's communication protocol for a medical emergency, as documented in Section 2.3.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

4.5 — Drill Frequency & Scenario Types

A drill program that only covers fire and lockdown leaves a trauma-response gap. This subsection evaluates whether medical response is exercised with the same discipline as your other emergency drills.

DRILL TYPE	CONDUCTED IN LAST 12 MONTHS?	FREQUENCY
Tabletop exercise (discussion-based, no physical response)	Y / N	_____
Functional exercise (partial physical response, single department)	Y / N	_____
Full-scale exercise (campus-wide, multi-agency)	Y / N	_____

ASSESSMENT ITEM	0	1	2	3
Campus conducts at least one medical-response-specific drill annually, separate from fire/lockdown drills.	☐	☐	☐	☐
Drills include a bleeding-control or mass-casualty scenario, not solely evacuation or shelter-in-place.	☐	☐	☐	☐
Drills involve local EMS or fire department participation at least once every two years.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

4.6 — After-Action Review Process

ASSESSMENT ITEM	0	1	2	3
A documented after-action review process exists for both real incidents and drills.	☐	☐	☐	☐
After-action reviews produce written findings and a tracked corrective-action list, not just verbal debrief.	☐	☐	☐	☐
Corrective actions from the most recent after-action review have been closed out or have an active timeline.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

SECTION SCORE SUMMARY	
Section 4: Staff Training & Readiness Evaluation	**_____ / 57 points**

Drill & After-Action Log

Use this log as the evidence behind your 4.5 and 4.6 scores and the Section 6.4 retention standard.

DATE	DRILL TYPE	SCENARIO	AGENCIES PRESENT	AAR FILED (Y/N)	OPEN ACTIONS

SECTION 5

MARCH Protocol Campus Application

MARCH is the clinical sequencing logic behind every tourniquet, chest seal, and pressure dressing referenced elsewhere in this assessment. It orders casualty care by what actually kills first: Massive Hemorrhage, Airway, Respiration, Circulation, and Head Injury/Hypothermia. This section walks each letter in a school-specific context and scores your campus's readiness at each stage.

M — Massive Hemorrhage

Uncontrolled external bleeding from an extremity is the most time-critical, and most treatable, injury in the MARCH sequence — a properly applied tourniquet can stop it in under a minute with minimal training. This is why Tier 1 and Tier 2 equipment in Section 3 are weighted so heavily toward tourniquet and hemostatic-gauze availability.

ASSESSMENT ITEM	0	1	2	3
Tourniquet availability meets the coverage standard already scored in Section 3 (Tiers 1 and 2).	☐	☐	☐	☐
Hemostatic gauze is co-located with every tourniquet, for wounds at a tourniquet-inaccessible junctional location (groin, axilla, neck).	☐	☐	☐	☐
Staff trained in Section 4 can state both correct tourniquet placements: "high and tight" on the limb when the bleeding source can't be quickly identified or the scene is unsafe, and 2–3 inches above a visible wound, on bare skin, when it can — never on or across a joint.	☐	☐	☐	☐
Bleeding-control station signage reinforces the tourniquet-first message for massive hemorrhage, consistent with current civilian casualty-care guidance.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

A — Airway

Airway compromise in a school-aged population carries additional considerations beyond adult casualty care: smaller airway diameter, higher risk of rapid obstruction from swelling or blood, and a wider range of baseline conditions (asthma, tracheostomy-dependent students, students with swallowing or aspiration risk documented in an IEP or 504 plan) that staff should already know about before an emergency, not discover during one.

ASSESSMENT ITEM	0	1	2	3
Staff trained in basic airway positioning (recovery position, jaw-thrust/chin-lift as trained level allows) as part of bystander training.	☐	☐	☐	☐
Campus has a current list of students with known airway-relevant medical conditions accessible to the school nurse and front office (maintained per applicable student privacy requirements).	☐	☐	☐	☐
Fixed-station kits (Section 3, Tier 2) include an airway adjunct for trained on-site staff only, matched to their skill level.	☐	☐	☐	☐
Staff with elevated training (Section 4.2/4.3) are briefed on special-needs airway considerations specific to their assigned building or grade level.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

R — Respiration

Penetrating chest trauma — rare on a K–12 campus but not absent from national incident data — can progress to tension pneumothorax, a life-threatening buildup of air in the chest cavity that impairs breathing and circulation. Recognition and chest-seal application are trainable skills for non-clinical staff; the harder gap is usually training coverage, not equipment.

ASSESSMENT ITEM	0	1	2	3
Chest seals are present at Tier 1 and Tier 2 locations per Section 3 coverage.	☐	☐	☐	☐
Staff trained at the TECC level (Section 4.2) or higher can recognize signs of tension pneumothorax and communicate them clearly to arriving EMS.	☐	☐	☐	☐
Chest seal application is included in hands-on training, not covered by lecture or video alone.	☐	☐	☐	☐
A protocol exists for decompression-capable personnel (where present per Section 4.2/4.3) to escalate care appropriately within their scope.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

C — Circulation

Circulation care addresses what happens after initial bleeding control: monitoring for shock, maintaining pressure dressings, and recognizing that a patient who initially looks stable can deteriorate while waiting for EMS. This is where "Stabilize" in the MED-TAC Preparedness Framework becomes most relevant.

ASSESSMENT ITEM	0	1	2	3
Pressure dressings are available and staff are trained to apply and monitor them without removing an already-placed tourniquet or hemostatic pack.	☐	☐	☐	☐
Staff are trained to recognize basic shock indicators (altered mental status, pale/cool skin, rapid breathing) appropriate to their training level.	☐	☐	☐	☐
A protocol exists for repositioning or monitoring a patient's circulation status while awaiting EMS, without moving the patient unnecessarily.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

H — Head Injury / Hypothermia

The final MARCH component covers two distinct but related concerns: head injury recognition, and body-temperature management for an injured patient. Both carry a behavioral-health dimension in a school setting that adult-focused trauma frameworks often omit — the psychological impact of a traumatic event on students who witness it, not only on the patient.

ASSESSMENT ITEM	0	1	2	3
Staff trained to recognize basic head-injury indicators (loss of consciousness, confusion, unequal pupils) appropriate to their training level.	☐	☐	☐	☐
Hypothermia-prevention supplies (emergency blankets or equivalent) are included in Tier 2 and Tier 3 kits, not solely bleeding-control components.	☐	☐	☐	☐
Campus has a documented behavioral-health response plan for students and staff who witness a traumatic medical event, coordinated with school counseling staff.	☐	☐	☐	☐
Behavioral-health response planning is integrated into the after-action review process scored in Section 4.6, not treated as a separate, disconnected workstream.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

MARCH is always five components — Massive Hemorrhage, Airway, Respiration, Circulation, Head Injury/Hypothermia. This assessment does not use extended variants; keep your campus training materials aligned to the standard five-letter sequence for consistency with C-TECC and national Stop the Bleed curricula.

SECTION SCORE SUMMARY	
Section 5: MARCH Protocol Campus Application	**_____ / 57 points**

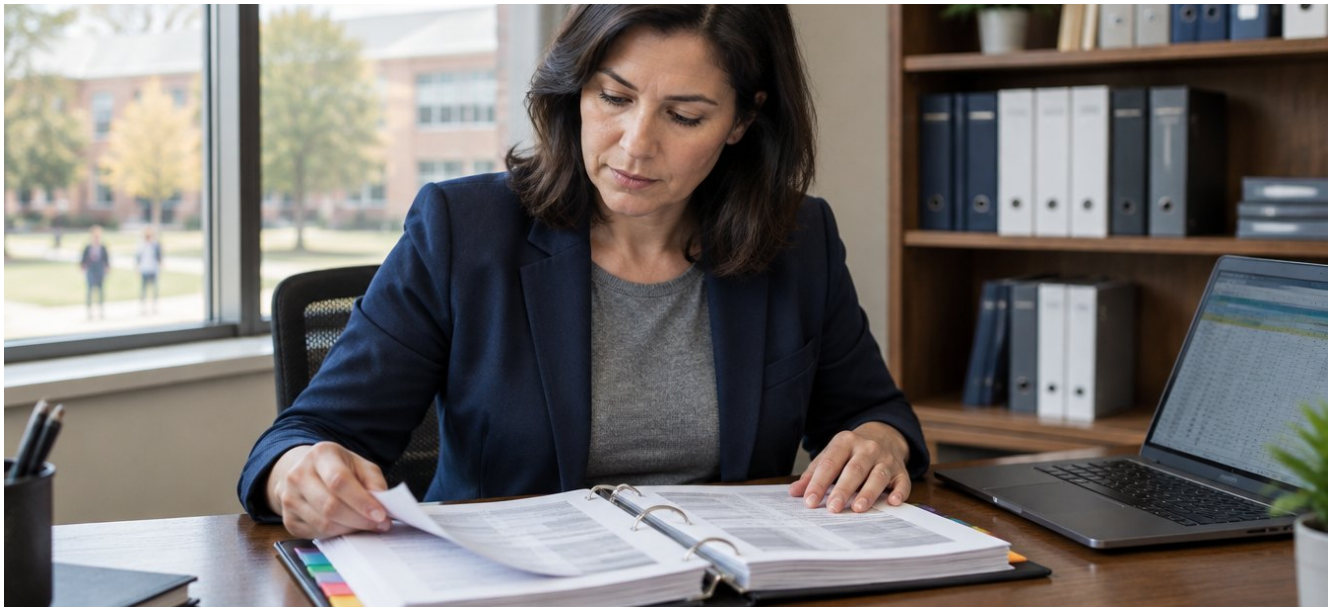
MARCH QUICK-REFERENCE CARD — CUT, LAMINATE, AND POST AT EVERY STATION

M	**MASSIVE BLEEDING** Call 911 and send someone for the bleeding-control kit and AED. Press hard on the wound. Arm or leg: tourniquet 2–3 inches above the wound on bare skin; if you can't find the source fast, or it isn't safe, go high and tight on the limb. Never on a joint. Tighten until the bleeding stops, write the time, don't loosen it. Groin, armpit, or neck: pack with hemostatic gauze and hold firm pressure per the product instructions.
A	**AIRWAY** Unresponsive but breathing: recovery position. Keep the airway open with the head-tilt/chin-lift or jaw thrust your training allows.
R	**RESPIRATION** Open chest wound: cover it with a vented chest seal. Watch for worsening breathing and tell EMS right away.
C	**CIRCULATION** Look for bleeding you missed. Keep dressings in place. Watch for shock: pale, cool skin, confusion, fast breathing. Keep the person lying down.
H	**HEAD INJURY / HYPOTHERMIA** Blanket under and over, even indoors. Watch for changing alertness. Stay with the patient and hand off to EMS: what happened, what you did, tourniquet time.

Card content is a staff memory aid consistent with this assessment's MARCH walkthrough; it does not replace hands-on training. Tourniquet placement per current MED-TAC doctrine.

SECTION 6

Compliance & Liability Review



6.1 — State & District Bleeding-Control Mandates

A growing number of states now require bleeding-control kits, training, or both, in K–12 facilities, and the requirements are not uniform — some specify kit quantity and placement, some specify staff training percentages, and some leave implementation to the district. Federal legislation has also begun to touch this space: the Improving Police CARE Act, signed into law in late 2025, opened Byrne JAG grant funding specifically for law-enforcement purchase of bleeding-control kits and directed the Department of Justice to work with stakeholder organizations on trauma-kit standards. This assessment does not attempt to enumerate every state's requirement, since they change on a rolling basis — use the checklist below to confirm your specific obligations directly with your state department of education or emergency management office.

ASSESSMENT ITEM	0	1	2	3
Campus has confirmed its state's current bleeding-control kit mandate (or confirmed no mandate currently exists) directly with the state department of education or emergency management office within the last 12 months.	☐	☐	☐	☐
Campus has confirmed any district-level policy that exceeds the state minimum, where applicable.	☐	☐	☐	☐
A named staff member owns tracking regulatory changes in this area (not left to informal awareness).	☐	☐	☐	☐
Campus documentation (Section 6.4) is structured to demonstrate compliance on request from a state or district auditor.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

6.2 — NFPA 3000 Alignment Checklist

NFPA 3000, the Standard for an Active Shooter/Hostile Event Response (ASHER) Program, is written for communities and organizations broadly, not schools specifically — but its resource-management, training, and incident-management chapters map cleanly onto a K–12 campus. The checklist below pulls the campus-relevant elements; it is not a substitute for reading the full standard if your district is pursuing formal alignment.

ASSESSMENT ITEM	0	1	2	3
Campus emergency operations plan addresses active-shooter/hostile-event response as a distinct scenario, not folded generically into "all-hazards" planning.	☐	☐	☐	☐
Casualty-care resource management (equipment placement, quantities) is documented per the standard's resource-management provisions, consistent with Sections 2 and 3 of this assessment.	☐	☐	☐	☐
Staff training scope and frequency (Section 4) is documented consistent with the standard's training chapter.	☐	☐	☐	☐
Campus has an incident-management structure (who is in charge, in what order, during a hostile event) documented and rehearsed.	☐	☐	☐	☐
After-action reporting (Section 4.6) follows a structure consistent with the standard's after-action report guidance.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

6.3 — C-TECC Alignment Verification

ASSESSMENT ITEM	0	1	2	3
Equipment selection (Section 3) is based on CoTCCC-recommended devices, consistent with C-TECC's civilian casualty-care guidance.	☐	☐	☐	☐
Training curriculum (Section 4) is based on, or crosswalked to, C-TECC's civilian tactical emergency casualty care guidelines rather than an internally developed, unreferenced curriculum.	☐	☐	☐	☐
MARCH sequencing (Section 5) is taught and practiced consistent with current C-TECC guidance, including current tourniquet-first sequencing for massive hemorrhage.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

6.4 — Documentation Requirements

In the event of an incident, documentation is what separates a campus that can demonstrate a good-faith, evidence-based safety program from one that cannot. This is true regardless of outcome.

ASSESSMENT ITEM	0	1	2	3
Training records are retained per your state's records-retention schedule and are retrievable within 24 hours of a request.	☐	☐	☐	☐
Equipment inspection logs (Section 3, Tiers 1–2) are retained and retrievable on the same standard.	☐	☐	☐	☐
AED maintenance and registration records (Section 2.4) are retained and retrievable on the same standard.	☐	☐	☐	☐
Drill and after-action review records (Section 4.5–4.6) are retained and retrievable on the same standard.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

6.5 — Liability Reduction Through Evidence-Based Equipment Selection

Liability exposure in this space is driven less by whether an incident occurs — which is largely outside a campus's control — and more by whether the campus can demonstrate it selected equipment and training based on defensible, evidence-based criteria rather than cost or convenience alone. Selecting CoTCCC-recommended devices, documenting the selection rationale, and maintaining inspection records are the three highest-leverage actions available to a district's risk management function.

ASSESSMENT ITEM	0	1	2	3
Equipment purchasing decisions document the selection rationale (CoTCCC status, vendor authentication) rather than relying on price alone.	☐	☐	☐	☐
District risk management or legal counsel has reviewed the campus's trauma-response equipment and training program at least once.	☐	☐	☐	☐
Campus has a documented process for verifying vendor authenticity, given the prevalence of counterfeit tourniquets and other safety-critical components in the broader market.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

6.6 — Grant Funding Opportunities

Several funding pathways exist specifically for school safety and bleeding-control equipment. Availability, deadlines, and award amounts change by fiscal year and by state — confirm current terms directly with each program before budgeting against them.

PROGRAM	ADMINISTERED BY	RELEVANT USE
STOP THE BLEED® Grant Program	STOP THE BLEED® Project (U.S. Department of Defense STOP THE BLEED® program)	Awards STOP THE BLEED® training kits or response-point cabinets to U.S. schools, government entities, and nonprofits that hold or have applied for a STOP THE BLEED® Educational License. Check the current cycle and eligibility before applying.
School Violence Prevention Program (SVPP)	U.S. Department of Justice / COPS Office	Federal funding for K–12 school safety measures under the STOP School Violence Act. School districts (including public charter schools), states, local governments, and law enforcement agencies apply; individual and private schools are not eligible as primary applicants. Allowable uses are set in each year's Notice of Funding Opportunity.
Nonprofit Security Grant Program (NSGP)	Federal Emergency Management Agency (FEMA)	Physical security and preparedness funding; relevant primarily to private/nonprofit K–12 schools rather than public districts in most states.
Homeland Security Grant Program (HSGP)	State/local pass-through of federal DHS funding	Public school districts typically access HSGP funds through their local or state government agency rather than applying directly — contact your state homeland security office.
Byrne JAG (bleeding-control provision)	U.S. Department of Justice	Following the Improving Police CARE Act, Byrne JAG funds may support bleeding-control kit purchases for law-enforcement partners, including SROs — confirm current program guidance.
Florida school-safety appropriations and district security funding	Florida Department of Education, Office of Safe Schools	The Safe Schools Allocation and district security grants fund district safety compliance and facility security. Some state and district programs include veteran-owned or in-state vendor preferences; verify current eligibility criteria with the administering agency. (MED-TAC is a South Florida-based SDVOSB.)

PROGRAM	ADMINISTERED BY	RELEVANT USE
State-Specific School Safety Grants	Varies by state department of education	Many states run their own competitive or formula-based school-safety grant programs with distinct application windows — check your state department of education's current cycle.

ASSESSMENT ITEM	0	1	2	3
Campus / district has identified at least one applicable grant program and tracked its current application window.	☐	☐	☐	☐
A named staff member owns grant research and application for school-safety equipment funding.	☐	☐	☐	☐
Campus has applied for, or received, external funding for trauma-response equipment or training within the last 3 years.	☐	☐	☐	☐

0 = Not Present • 1 = Below Standard • 2 = Meets Standard • 3 = Exceeds Standard

Grant program terms, funding levels, and eligibility change annually. Verify current details directly with the administering agency before including any specific figures in a budget request.

6.7 — Behavioral Health & Post-Incident Support

NOT SCORED — PLANNING CALLOUT

Trauma readiness includes the aftermath. Beyond the physical response, districts should have a documented plan for psychological first aid and post-incident support for students and staff who witness or respond to a medical emergency. Coordinate with district behavioral-health staff or contracted providers, include student support services in after-action reviews, and communicate available resources before an incident occurs — not only after one.

SECTION SCORE SUMMARY	
Section 6: Compliance & Liability Review	**_____ / 66 points**

Grant Tracker

PROGRAM	WINDOW / DEADLINE	AMOUNT REQUESTED	OWNER	STATUS

NOTES / COMMENTS

SECTION 7

Gap Analysis & Action Plan Templates

7.1 — Summary Scoring Sheet

Transfer each section's score from its Section Score Summary box into the table below, then calculate your aggregate readiness percentage.

SECTION	SCORE	MAX POINTS
Section 2 — Campus Infrastructure Assessment	_____	60
Section 3 — Equipment Inventory Audit	_____	90
Section 4 — Staff Training & Readiness Evaluation	_____	57
Section 5 — MARCH Protocol Campus Application	_____	57
Section 6 — Compliance & Liability Review	_____	66
TOTAL	_____	**330**

Readiness Percentage = (Total Score ÷ 330) × 100 = _____ %

7.2 — Color-Coded Readiness Levels

LEVEL	SCORE RANGE	INTERPRETATION
RED	**0–40%**	Critical gaps. Core trauma-response infrastructure, equipment, or training is largely absent. Immediate action required — treat Section 7.3 as urgent, not routine, budget planning.
YELLOW	**41–70%**	Moderate readiness. Foundational elements exist but coverage, training depth, or documentation has meaningful gaps. An improvement plan with a defined timeline is appropriate.
GREEN	**71–100%**	Strong readiness. Core infrastructure, equipment, and training are in place. Focus shifts to maintenance, redundancy, and closing any remaining item-level gaps identified during scoring.

A single low-scoring section can mask an otherwise strong aggregate percentage. Review section-level scores individually, not only the aggregate — a campus at 78% overall with a Section 3, Tier 3 score of zero still has a real, specific gap to close.

7.3 — Action Plan Template

Priority Ranking of Gaps

List every item scored 0 or 1 across Sections 2–6. Rank by a combination of clinical urgency (does this gap affect Massive Hemorrhage or Airway response — the most time-critical MARCH components) and feasibility (can it be closed in 30 days at low cost).

PRIORITY	GAP IDENTIFIED	SECTION REF.	CLINICAL URGENCY (H/M/L)
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____

Budget Estimation Framework

For each priority gap, estimate cost against three categories rather than a single lump figure — this makes partial funding (e.g., a grant covering equipment but not training) easier to plan around.

COST CATEGORY	PRIORITY 1	PRIORITY 2	PRIORITY 3
Equipment / hardware	_____	_____	_____
Training / instructor time	_____	_____	_____
Ongoing maintenance (annual)	_____	_____	_____

Timeline Recommendations

WINDOW	FOCUS
30 Days	Close zero-cost or low-cost gaps: signage, documentation, communication protocol updates, inspection schedule formalization.
60 Days	Execute funded equipment purchases for Priority 1–2 gaps; schedule the next staff training session.
90 Days	Complete Tier 3 / mass-casualty planning coordination with local EMS and fire; conduct a drill exercising the newly closed gaps; re-score the affected sections.

Stakeholder Assignment Template

WORKSTREAM	OWNER	TARGET DATE
Equipment procurement	_____	_____
Staff training scheduling	_____	_____
Documentation / compliance tracking	_____	_____
Grant research & application	_____	_____
EMS / fire / law enforcement coordination	_____	_____

7.4 — Board Presentation Summary Template

Use the structure below to convert this assessment into a five-minute board or safety-committee presentation. Keep it to one slide or one page per line item.

- **Current State:** Overall readiness percentage and color-coded level (Section 7.1–7.2).
- **Top 3 Gaps:** Pull directly from the Priority Ranking table (Section 7.3) — do not present more than three in the initial board conversation.
- **Cost to Close:** Sum the Priority 1–3 budget estimate from Section 7.3.
- **Funding Path:** Reference any grant program identified in Section 6.6 that offsets the cost.
- **Timeline:** The 30/60/90-day plan from Section 7.3.
- **Ask:** A single, specific request — budget approval, policy approval, or both.

SECTION SCORE SUMMARY	
Section Assessment: Aggregate Readiness (all sections)	**_____ / 330 points**

ADDITIONAL NOTES FOR BOARD PRESENTATION

SECTION 8

Resource Directory

The resources below correspond directly to the equipment tiers and frameworks referenced throughout this assessment. None of the scoring in Sections 2–7 requires a specific vendor — use this directory as a starting point for sourcing, not a mandate.

MED-TAC School & Campus Safety Collection

Classroom, hallway, and campus-wide bleeding-control kits built around the Tier 2 coverage model described in Section 3, plus components for building out Tier 1 individual-carry kits.

tactical-medicine.com/collections/school-safety

Individual First Aid Kits & IFAK Kit Builder

Pre-built individual trauma kits for the Tier 1 SRO / security-staff coverage described in Section 3, or build a custom loadout component-by-component (tourniquet, hemostatic agent, chest seal, bandage) through the IFAK Kit Builder.

tactical-medicine.com/collections/individual-first-aid-kits-ifaks

Public Access Bleeding Control Kits

Kits designed specifically for the public-access placement model referenced in Section 3, Tier 2 — equipment any trained or untrained adult on campus can retrieve and use.

tactical-medicine.com/collections/public-access-bleeding-control-kits

Training Kits & Supplies

Reusable trainer tourniquets, wound-packing trainer gauze, and task-trainer components for the hands-on staff training scored in Section 4 — kept visually distinct from operational gear to prevent accidental field use, consistent with current training best practice.

tactical-medicine.com/collections/training-kits-supplies

Custom Bleeding Control Kits for Schools

Guidance on selecting CoTCCC-recommended components over unverified low-cost alternatives, referenced in Section 6.5's liability-reduction discussion, including how to identify counterfeit tourniquets in the broader market.

tactical-medicine.com/pages/custom-bleeding-control-kits-for-schools-churches-businesses

Framework & Standards References

REFERENCE	SOURCE
NFPA 3000® — Standard for an Active Shooter/Hostile Event Response (ASHER) Program	National Fire Protection Association — nfpa.org
C-TECC — Committee for Tactical Emergency Casualty Care Guidelines	Committee for Tactical Emergency Casualty Care — c-tecc.org
Stop the Bleed®	American College of Surgeons — stopthebleed.org

Custom Campus Consultation

MED-TAC International Corp. works directly with district safety directors and school administrators on campus-specific equipment planning, coverage mapping, and training coordination.

DIRECT CONTACTS	
General inquiries	info@tactical-medicine.com
Campus consultations & B2B pricing	tactical-medicine.com/pages/institutional-procurement
Public school districts purchasing by PO	tactical-medicine.com/pages/government-procurement-solutions

Before You Buy: Authenticity Checklist

- Buy tourniquets and hemostatic gauze from the manufacturer or an authorized distributor; ask the vendor to confirm authorization in writing.
- Confirm the exact model and generation is on the current CoTCCC-recommended list — not just the brand name.
- Check packaging for lot numbers and expiration dates, and record both in your Section 3 inventory.
- Treat prices far below the market as a counterfeit warning sign, not a savings (Section 6.5).

Operational Terms

TERM	
Shipping	Free shipping on orders $200+ within the USA (CONUS).
HSA / FSA	HSA/FSA-eligible bleeding control products are available: tactical-medicine.com/pages/hsa-fsa-eligible-products

All MED-TAC kits are Designed & Assembled in the USA. Free shipping on orders $200+ within the USA (CONUS). MED-TAC International Corp. is a Service-Disabled Veteran-Owned Small Business (SDVOSB), Medical SME Veteran-Led, and a C-TECC Educational Partner. Product references to CoTCCC reflect committee recommendations and do not imply FDA approval or certification. This document is educational and is not a substitute for hands-on training, medical direction, or a formal risk assessment by qualified safety, legal, and medical personnel for your specific campus. Version 2.0 — September 2026.

READINESS IS A PLAN YOU CAN SHOW.

Walked, scored, documented, funded, and drilled.

1 **WALK IT**
Walk the campus with Section 2 in hand. Time the farthest classroom to the nearest bleeding-control station and AED.

2 **SCORE IT**
Score Sections 2–6 as a team in one 90–120 minute session, from records and logs, not memory.

3 **PLAN IT**
Roll up the 330-point total in Section 7, rank the top three gaps, and take the five-minute summary to your board.

CONTACT

General inquiries	**info@tactical-medicine.com**
Campus consultations & B2B pricing	**tactical-medicine.com/pages/institutional-procurement**
Public district & agency purchasing	**tactical-medicine.com/pages/government-procurement-solutions**
School Safety Collection	**tactical-medicine.com/collections/school-safety**

School Safety Collection

MED-TAC INTERNATIONAL CORP.

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DOCUMENT CONTROL · MTC-SA-002 · VERSION 2.0 — SEPTEMBER 2026 · SUPERSEDES MTC-SA-001

Change log — v2.0 (Sep 2026): founder credentials standardized (MD, NRP); shipping threshold corrected to $200+; partnerships email removed and consultation routing moved to institutional procurement page; Florida/state grant reference added; behavioral health callout 6.7 added; HSA/FSA resource line added; version stamp added. Also: tourniquet placement item (5, M) aligned to current MED-TAC doctrine; hemostatic item limited to gauze; STOP THE BLEED® grant administrator and SVPP eligibility corrected in 6.6; Improving Police CARE Act wording aligned to the enacted law; cross-references corrected (2.1, Section 8); section images replaced.

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