Adams SAFETY TRAINING

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EMSA Childcare Prevention of Illness & Injury

(EMSA Approval # 03-0919-DC)

Student Workbook & Forms

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Understanding the Spread of Disease

Infants and young children in child care have an increased rate of certain infectious disease and an increased risk of getting antibiotic-resistant organisms. Prevention of infectious disease in the child care setting will help families and child care providers improve their quality of life and save time, health care costs, and lost work.

What Is a Communicable Disease?
Illnesses caused by infection (invasion of the body) with specific germs such as viruses, bacteria, funguses, and parasites are called *infectious diseases. Communicable diseases* are those illnesses that can be spread from one person to another either directly or indirectly. Infectious diseases that commonly occur among children are often communicable and may spread very easily from person to person.
Most illnesses are contagious before their signs and symptoms appear. Some people may pass the germs without having the symptoms or continue passing them even after recovering from the illness.

Why Do Children in the Child Care Setting Have More Illnesses?
Anyone at any age can be infected with communicable illnesses, but young children are at greater risk because:
They have not yet been exposed to many of the most common germs; therefore, they have not yet built up resistance or immunity to them.
They have many habits that promote the spread of germs. For example, they often put their fingers, toys and other objects in their mouths. In this way, germs enter and leave the body and can then infect the child or are passed on to others.
Close contact between a number of children in the child care setting increases exposure.
How Are Illnesses Spread?
Communicable diseases are spread from the source of infection to the exposed, vulnerable person (host). For this transmission to happen, three things are necessary.

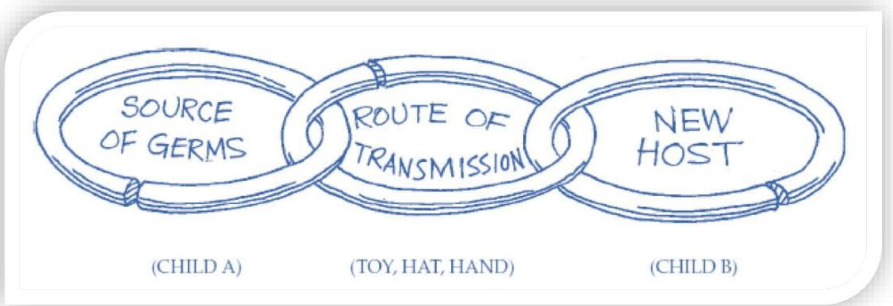
A **source** of germs must be present.
The **route or ways** of transmission along which germs can be carried must be present.
A host or vulnerable person who is not immune to the germ must be present and come in contact with the germs.

What Can You Do to Keep the Children and Yourself Healthy?

Break the chain of transmission by severing at least one of the three links; although it is best to organize more than one method of control in order to reduce the transmission of infectious disease.
You can control the spread of communicable disease in three ways:

Attack the source of infection or the "first link" by identification, treatment, and, if necessary, isolation of the sick person. In the child care setting this is accomplished by doing a morning health check/observation, and, if necessary, excluding ill children, referring them for medical care, and notifying health authorities when required.

Attack the route of transmission or the "second link" by personal and general hygiene, healthy practices, proper disinfection and environmental improvement. This means disinfecting toys and



surfaces, using proper diapering techniques, hand washing, ventilation, etc.
Protect the vulnerable person or the "third link" through immunization, balanced nutrition, and healthy practices such as proper hand washing, etc.

Major Ways for the Spread of Illnesses or "Routes of Transmission" to Occur

Direct contact with the infected person's skin.
Skin infections such as impetigo, ringworm, herpes simplex, scabies, and head lice are examples of illnesses and infestations that may be spread by direct contact with infected skin areas and fluid from infected sores or infested articles. Superficial bacteria, viral infections, or parasites cause these illnesses. They are common and not usually serious. Because young children are constantly touching their surroundings and the people around them, these infections are easily spread among children and their caregivers in the child care setting.

Air or "respiratory transmission" (passing from the lungs, throat or nose of one person to another person through the air).

Respiratory illnesses such as the common cold, measles, whooping cough, chickenpox, flu, meningitis, strep throat, etc., are all spread through microscopic, contagious droplets of fluids from the nose, eyes or throat. When an infected person talks, coughs, sneezes or blows his or her nose, infectious droplets get into the air where they can be breathed in by another person. Droplets can also land on hands or objects such as toys or food, and can be touched, mouthed or eaten by other persons. When the germs in these infected droplets come in contact with the nose, eyes or mouth of an uninfected person, they can multiply in his or her nose and throat and cause infection.

Stool or "Fecal-Oral Transmission" (transfer of a germ from an infected person's stool into another person's mouth to infect him or her).

Contagious diarrheal diseases (such as giardia, shigella, salmonella, and campylobacter), hepatitis A, and polio are examples of illnesses that are usually spread through exposure to germs in the stool or by what is known as "Fecal-Oral Transmission." This means that germs leave the body of the infected person in their stool (bowel movement) and enter the body of another person through his or her mouth.

In most situations this happens when hands or objects such as toys which have become contaminated with undetectable amounts of stool are placed in the mouth. Transmission can also occur if food or water is contaminated with undetectable amounts of human or animal stool and then is eaten or drunk. Improperly prepared foods made from animals (for example, meat, milk and eggs) are often the source of infection with campylobacter, *E. coli* and salmonella. Some infections, such as salmonella and campylobacter, may be spread through direct exposure to infected animals.

4. Contact with blood and body fluids.

Blood infections are spread when blood (and sometimes other body fluids such as urine and saliva) from a person with an infection gets into the bloodstream of an uninfected person.
Hepatitis B and C, CMV, and HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome) are serious viral infections spread by contact with infected blood. These viruses can be spread when blood containing the virus enters the blood stream of another person. Spread can also occur when infected blood or body fluids comes in contact with skin that has open sores, is damaged by conditions such as eczema, or with a broken surface of the mucous membranes (such as the inside lining of the mouth, eyes, nose, rectum or genitals). An infected mother can also transmit these infections to her newborn infant. Once these viruses enter a person's body, they may stay for months or years. This person may appear to be healthy but can still spread the viruses.

How to Reduce the Spread of Illnesses through Direct or Indirect Contact

To reduce the spread of superficial skin infections, follow these hand washing and cleanliness guidelines: Make sure staff and children wash their hands after contact with any body fluids. Wear disposable gloves when possible.

Use free-flowing water for hand washing, if possible. Do not use basins or stopper sinks, which can become contaminated with the germs.
Use liquid soap dispensers whenever possible.
Always use disposable tissues or towels for wiping and washing.
Never use the same tissue or towel for more than one child.
Dispose of used tissues and paper towels in a lined, covered step can which is kept away from food and child care materials.

Wash and disinfect toys at least daily. Wash or vacuum frequently used surfaces (tables, counters,

furniture and floors) in the program daily.
Make sure that each child has his or her own crib or mat and does not switch.

Do not allow children to share personal items such as combs, brushes, blankets, pillows, hats, and clothing.

Store each child's dirty clothing separately in plastic bags and send it home for laundering.

Wash and cover sores, cuts or scrapes promptly and wipe away eye discharge.
Report rashes, sores, running eyes and severe itching to the parents so they can contact their health care provider(s).

How to Reduce the Spread of Respiratory Illnesses
Hand washing and cleanliness in the program are essential. Caregivers should do the following:
Ensure that staff and children wash their hands after wiping or blowing their noses; after contact with any fluids from noses, throats, or eyes; and before preparing or eating food.

Prevent food or eating utensils from being shared.
Wash and disinfect any mouthed toys and frequently used surfaces (such as tables) at least once daily.
Wash eating utensils carefully in hot, soapy water, then disinfect and air dry them. Use a dishwasher whenever possible.

Use disposable cups whenever possible. When reusable cups must be used, wash them in hot, soapy water after each use.

Air out the facility daily (even in winter) and encourage outdoor play.
Teach children and staff to cough or sneeze into their elbows. If they sneeze or cough into a hand or tissue, they must properly dispose of the tissue and wash their hands.
Wipe runny noses and eyes promptly, and wash hands afterwards.

Use disposable towels and tissues.
Dispose of towels and tissues contaminated with fluids from noses, throats or eyes in a covered container with a plastic liner. Keep them away from food and materials used in child care.
Refrain from kissing children on the lips. Instead, give big hugs or kisses on the forehead.

Examples of How Some Childhood Infectious Diseases Are Spread

Air or Respiratory Transmission:

How the disease is spread	Behaviors that spread	Examples of diseases	Possible symptoms
Breathing germs in the air Contact with infected saliva and mucus	•Coughing or sneezing into the air Kissing on the mouth Sharing mouthed toys Wiping noses without thorough hand washing Poor ventilation	Cold Flu Measles Pinkeye Chickenpox Tuberculosis (TB)	Coughing Fever Rash Runny nose Sore throat Earache

Stool or Fecal-Oral Transmission:

How the disease is spread	Behaviors that spread	Examples of diseases	Possible symptoms
• Mouth contact with items and hands contaminated by infected stool.	•Diapering and toileting or food preparation without thorough hand washing Sharing mouthed toys Unsafe food preparation Not disinfecting diapering areas	Salmonella Shigella Giardia Pinworms Hand-foot-and-mouth disease Hepatitis A Polio E. coli	Stomach ache Nausea Vomiting Diarrhea

Direct Contact:

How the disease is spread	Behaviors that spread	Examples of diseases	Possible symptoms
• Contact with infected hair, skin and objects.	•Touching skin or hair that is infected Sharing clothing, hats and brushes that are infected	Herpes Ringworm Scabies Head lice Impetigo Chickenpox	Rash Oozing sores Itching Visible nits or eggs

Contact with Blood and Bodily Fluids

How the disease is spread	Behaviors that spread	Examples of diseases	Possible symptoms
• Contact with infected blood and sometimes other body fluids.	•Sexual contact Changing bloody diapers without gloves Providing first aid without gloves Getting infected blood or body fluids into broken skin, eyes or mouth	HIV/AIDS Hepatitis B & C Cytomegalovirus (CMV) Herpes	Fatigue Weight loss Yellow skin Weakened immune system

Exposure to Communicable Disease

As a child care provider, you join hands with parents in your efforts to create a healthy environment for children in your care. You and the parents will benefit from the communication of your health and safety policies, health and safety messages, and new knowledge gained on health and safety issues. You are also required to inform parents when children in your care are exposed to a communicable disease.

This will help you to prepare a written notice to parents about their children's exposure to a communicable disease. The notice will alert them to watch for signs of that illness and seek medical advice when necessary.

You can use the "Notice of Exposure to Communicable Disease" form and any relevant information on disease or illness to prepare the exposure notice.

Please keep in mind that the confidentiality of the child should be maintained. You should not report the name of the child, other family member, or staff member who is ill to other parents.

As you are required* to report some communicable diseases to both Community Care Licensing and your public health department, a list of "Communicable Diseases Reportable in California" is enclosed.
When you report to licensing and your local health department, the parents of the child must be informed that you are required to report the disease. Also, let them know that you will be sending exposure notices to other parents but will not mention any names. The child's health care provider is also required to report the communicable disease to the health department.
We encourage you to work closely with the local health department to reassure and inform parents and staff.
Call your local Health Department if you would like to discuss your situation with them or obtain information on a specific illness or disease.

* At the moment the requirement to report communicable diseases to the local health department only applies to child care centers. However, we also encourage family child care providers to report communicable diseases and work closely with their local health department.

Forms

Notice of Exposure to Contagious Disease

Name of Child Care Program:_____

Address of Child Care Program_____

Telephone Number of Child Care Program_____

Date: / /

Dear Parent or Legal Guardian:

A child in our program has or is suspected of having:_____

Information about this disease:

The disease is spread by:_____

The symptoms are: _____

_____

_____

The disease can be prevented by:_____

_____

What the program is doing to reduce the spread:_____

_____

What you can do at home to reduce the spread:_____

_____

If your child has any symptoms of this disease, call your health care provider to find out what you can do and be sure to tell them about this notice. If you do not have a regular health care provider for your child, contact your local health department for instructions on how to find one, or ask staff here for a referral. If you have any questions, please contact:

_____ at (___)_____

(Caregiver's name) (Telephone number)

Communicable Diseases Reportable in California

Child care providers working in child care centers are required to report outbreaks of any disease, including diseases not on the list.

Acquired Immune Deficiency Syndrome (AIDS)
Amebiasis◑✉
Anisakiasis ◑✉
Anthrax ☎
Babesiosis ◑✉
Botulism (infant, food borne or wound)
Brucellosis
Campylobacteriosis ◑✉
Chancroid
Chlamydial Infections
Cholera☎
Ciguatera Fish Poisoning☎
Coccidioidomycasis
Colorado Tick Fever ◑✉
Conjunctivitis, acute infectious of the newborn (specify etiology) ◑✉
Cryptosporidiosis◑✉
Cysticercosis
Dengue Fever☎
Diarrhea of the newborn (outbreaks)☎
Diphtheria ☎
Domoic Acid Poisoning (Amnestic Shellfish Poisoning)☎
Echinococosis (Hydatid Disease)
Ehrlichiosis
Encephalitis—viral, bacterial, fungal or parasitic (specify etiology) ◑✉
Escherichia coli 0157:H7 infection☎
Food borne illness (food poisoning) ✞◑✉
Giardiasis
Gonococcal infections
Haemophilus influenzas (invasive disease) ◑✉
Hantavirus infections ☎
Hemolytic Uremic Syndrome☎
Hepatitis A
Hepatitis B (specify acute case or chronic) Hepatitis C (specify acute case or chronic) Hepatitis D (Delta)
Hepatitis, other, acute
Kawasaki Syndrome
Legionellosis
Leprosy (Hansen's disease) Leptospirosis
Listeriosis ◑✉
Lyme disease
Lymphocytic Choriomeningitis
Malaria ◑✉
Measles (Rubeola) ◑✉
Meningitis—viral, bacterial, fungal or parasitic (specify etiology) ◑✉
Meningococcal infections☎
Mumps
Non-Gonococcal Infections (Excluding laboratory confirmed Chlamydial Infections)
Occurrence of any unusual disease
Outbreaks of any disease (including diseases not listed here)☎
Paralytic shellfish poisoning☎
Pelvic Inflammatory Disease (PID)
Pertussis (whooping cough) ◑✉
Plague☎
Poliomyelitis, paralytic ◑✉
Psittacosist ◑✉
Q Fever ◑✉
Rabies (human or animal)☎
Relapsing Fever ◑✉
Reye's Syndrome
Rheumatic Fever, acute
Rocky Mountain Spotted Fever
Rubella (German measles)
Rubella Syndrome, congenital
Salmonellosis (Other than Typhoid Fever) ◑✉
Scombroid fish poisoning☎
Shigellosis ◑✉
Streptococcal infections (outbreaks and cases in food handlers & dairy workers only) ◑✉
Swimmer's Itch (Schistosomal Dermatitis) ◑✉
Syphilis◑✉
Tetanus
Toxic Shock Syndrome Toxoplasmosis
Trichinosis◑✉
Tuberculosis◑✉
Tularemia
Typhoid Fever (specify whether case/carrier) ◑✉
Typhus Fever
Vibrio infections ◑✉
Viral Hemorrhagic Fever (e,g, Crimean-Congo, Ebola, Lassa and Marburg Viruses)☎ Water-associated disease ◑✉
Yellow Fever☎
Yersiniosis ◑✉

Urgency Reporting Requirements
=Report immediately by telephone (designated by a ◆ in regulations).
=Report immediately by telephone when two (2) or more cases or suspected cases of food borne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations).
◑✉= Report by fax, telephone, or mail within one (1) working day of identification (designated by a + in regulations).
All other diseases/conditions should be reported by fax, telephone, or mail within seven (7) calendar days of identification.
(There are no standard reporting forms for child care providers to use. Please call your local health department immediately to report any outbreak or suspected outbreak of a communicable disease at a child care center.)

The Daily Morning Health Check

Perform a quick health assessment of each child **every** day upon arrival and before the parent leaves. This allows you to make a judgment about what is normal or not for each child rather than to diagnose an illness. It also identifies problems early.

You should do your quick check not in a formal exam routine, but as a casual observation of the child in your initial contact as you welcome the child. You are checking for easily observable and simple signs of well-being. A health check is not a medical examination. It is not the way to enforce your policies with a parent. It is not a way to find reasons to exclude children. Exclusion of a child may result from a quick check observation and your follow-up, but your goal is to know your children better and to provide good care.

In a child care setting where many people are coming at the same time, it is hard to take a moment with each child. However, this welcoming routine can establish many things and is a good child development policy. This contact will help you better understand each child, help the children feel comfortable and good about themselves, reduce the spread of illness by excluding children with obvious signs of illness, and foster better communication with parents.

Signs to Observe

When conducting a morning health check, you should watch for the following:

- General mood and changes in behavior (happy, sad, cranky, sluggish, sleepy, unusual behavior)
- Fever or elevated body temperature (if there is a change in child's behavior or appearance)
- Skin rashes, itchy skin, or itchy scalp, unusual spots, swelling or bruises
- Complaints of pain and not feeling well
- Other signs and symptoms of disease (such as severe coughing, sneezing, breathing difficulties, discharge from nose, ears or eyes, diarrhea, vomiting and so on)
- Reported illness in child or family members since last date of attendance

Use All Your Senses to Check for Signs of Illness

Listen to what the child and parents tell you about how the child is feeling. Is the child's voice hoarse, is he having trouble breathing, or is he coughing?
Look at the child from her level. Observe for signs of crankiness, pain, discomfort or being tired. Does the child look pale; have a rash or sores; a runny nose or eyes?
Feel the child's cheek and neck for warmth, clamminess or bumps as a casual way of greeting.
Smell the child for unusual odor in her breath, diaper or stool.

Using Findings to Make Decisions

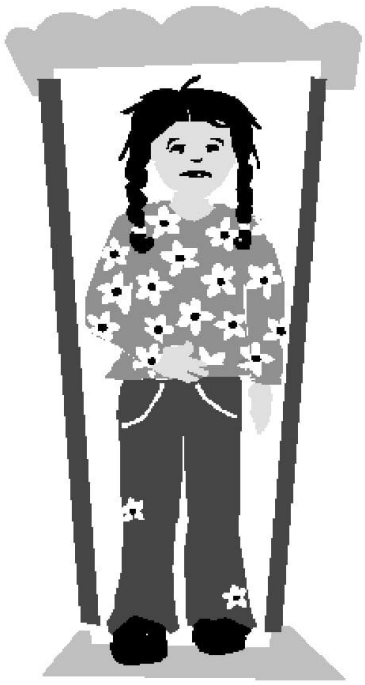
If you have concerns about how a particular child looks or feels, discuss them with the parent right then. Perhaps the parent needs to take the child home. If you decide that the child will remain, be sure to discuss how you will care for the child and at what point you will call the parent. It is your decision, not the parent's, whether the program will accept responsibility for the ill child. If the child stays all day, make sure you inform the parent about changes in the child's health status. Simple information about activity level, appetite, food intake, bowel movements and nap-time can be invaluable to the family.

Contrary to popular belief and practice, only a few illnesses require exclusion of sick children to ensure protection of other children and staff. When your child care setting agrees to allows mildly ill children to attend, take these steps to better meet their needs and be sure to follow

California regulations:

- Maintain a small room or area where they can spend quiet time while being supervised.
- Assign one staff person to remain with these children when others go outside.

MORNING HEALTH CHECK



Signs to Observe:

- General mood and changes in behavior
- Fever or elevated body temperature
- Skin rashes, unusual spots, swelling or bruises
- Complaints of pain and not feeling well
- Signs/symptoms of disease (severe coughing, sneezing, breathing difficulties, discharge from nose, ears or eyes, diarrhea, vomiting etc.)
- Reported illness in child or family members

Use all of your senses . . .

- **LOOK** - for signs
- **LISTEN** - for complaints
- **FEEL** - for fever
- **SMELL** - for unusual odor

STANDARD PRECAUTIONS:

Universal Precautions

GUIDELINES FOR LICENSED COMMUNITY CARE FACILITIES

Following are guidelines or sometimes called standard precautions or universal precautions these simply procedures to help lessen the spread of germs that can cause disease. These simply precautions of hand washing, wear gloves, cleaning and disinfecting, and proper disposal of garbage - standard precautions are easy and will help keep children and childcare providers health and lessen the likelihood of illness in childcare.

GENERAL GUIDELINES

Assume that *anyone* may be infected with a virus.

Standard precautions combine universal precautions (which apply to blood and other body fluids) and body substance isolation (which apply to moist body substances).

Standard precautions apply to: 1) blood; 2) all body fluids, secretions and excretions (except sweat) whether or not they contain visible blood; 3) non-intact skin (including cuts, scratches, and badly chapped skin); and 4) mucous membranes. This includes: urine; feces; wound drainage; gastric drainage; nasal, mouth, and eye secretions; and open lesions or wounds on the skin.

HANDWASHING

Hand washing is the single most effective infection-control measure known to reduce the potential for spreading germs in any facility.

Wash hands with soap and warm running water following possible contact with blood, body fluids, secretions or excretions while caring for a client—or following contact with surfaces or equipment that may be soiled with blood or other body fluids—whether or not gloves are worn.

Wash hands routinely with a plain, non-medicated soap (non-antimicrobial). Use disposable paper towels to dry hands.

Alcohol-based hand rub products should be used only when there is no running water available. Otherwise these alcohol based waterless lotions should not be widely used. Also, children with skin conditions, such as eczema, should not use these products as it could cause exacerbation of painful conditions

Hand sanitizers using an alcohol-based active ingredient must contain 60% to 95% alcohol to be effective in killing most germs including multi-drug resistant pathogens. Child care programs should follow the manufactures instructions for use, check instructions to determine how much product and how long the hand sanitizer needs to remain on the skin surface to be effective.

While alcohol-based hand sanitizers are helpful in reducing the spread of disease when used correctly, there are some common diarrhea-causing germs that are not killed (e.g. norovirus,

spore-forming organisms) (1). These germs are common in child care settings, and children less than 2 years are at the greatest risk of spreading diarrheal disease due to frequent diaper changing. Even though alcohol-based hand sanitizers are not prohibited for children under the age of 2 years, hand washing with soap and water is always the preferred method for hand hygiene
(As per AAP test Caring for our Children 3rd edition)

In a facility, examples of specific times when hands should be washed include:

- Whenever hands are visibly soiled
- After removing gloves
- Before preparing or eating food
- After using the toilet
- After changing a diaper.
- Before and after treating or bandaging a cut
- Before and after providing direct care to a client
- After wiping down surfaces, cleaning spills, or performing other housekeeping tasks

Hand Washing

Most Important Concepts about Hand Washing

The most important concepts to remember about hand washing-are:

1. You must use running water which drains out—not a stopper sink or container. A container of water spreads germs!

2. You must use soap, preferably liquid.

3. Antibacterial soap is not required or necessary because:

    - Both bacteria and viruses are common causes of illnesses, and antibacterial soaps are designed to kill bacteria—not viruses or fungus.
    - They are not usually applied in a way that allows them to work properly, since they are not left on the skin long enough before being rinsed off.
    - Studies have shown that there is little or no evidence that the antibacterial products offering any additional protection against bacteria. On the contrary, antibacterial products may add to the existing problem of antibiotic-resistant bacteria.

4. You must rub your hands together for at least 10 seconds. This helps remove the germs. Rinse hands well under running water until all the soil and soap are gone.

5. You must turn off the faucet with a paper towel. The faucet is considered "dirty" at all times. If you touch it with clean hands, you will be recontaminated. Ideally, then throw the paper towel into a lined, covered trash container with a foot pedal.

6. Frequent hand washing can worsen sores and cuts on the hands or cause cracked dry skin. These areas are hard to clean and can contain germs. Cuts should be washed well with soap and water and kept covered with a dry, clean bandage. Having hand lotion at the sink for staff that must frequently wash their hands is a good way to prevent skin dryness and cracking.

7. When assisting a child in hand washing, either hold the child (if an infant) or have the child stand on a

safety step at a height at which the child's hands can hang freely under the running water. Assist the child in performing all the steps for proper hand washing and then wash your own hands.

8. Hot water is not necessary, but warm water can be used for comfort and will help increase duration of hand washing.

Children love water play. If you make hand washing a pleasant time (sing songs such as "Wash, wash, wash your hands," etc.), they will be more willing to wash regularly.

Ideally, sinks should be located near all toileting and food areas. Locate your diapering area next to a sink whenever possible. If you are renovating or building new space, consider installing a sink with a knee or elbow faucet handle to avoid the concerns of recontaminating hands.

Teach the children in your care good hand washing practices. Be sure that their hands are washed when they arrive at the child care setting, before they eat or drink, after they use the toilet or have their diapers changed, and after they've touched children who may be sick.

HAND WASHING SONG

Ask children to sing this song to the tune of "Row, Row, Row Your Boat" while washing their hands. If children wash their hands with soap under running water during the time it takes to sing this song, they will have thoroughly cleaned them.

Wash, wash, wash your hands
Play our handy game.
Rub and scrub, and scrub and rub.
Germs go down the drain. HEY!

Wash, wash, wash your hands
Play our handy game.
Rub and scrub, and scrub and rub.
Dirt goes down the drain. HEY!

RESPIRATORY HYGIENE/COUGH ETIQUETTE

Respiratory hygiene/cough etiquette should be used when first interacting with a potentially infected client to help prevent the spread of respiratory tract infections.

Consider posting signs requesting clients and visitors to inform facility staff if they have symptoms of a respiratory infection. Also consider posting signs that emphasize handwashing and covering coughs/sneezes, such as the federal Centers for Disease Control and Prevention's (CDC) Cover Your Cough sign. For links to signs and brochures, please see http://www.cdc.gov/flu/protect/covercough.htm.

Make handwashing supplies available where sinks are located, and provide dispensers of alcohol-based hand rubs in other locations.

Provide tissues to clients or visitors who are coughing or sneezing so that they can cover their nose and mouth.

If tolerated, offer facemasks to clients or visitors who are coughing during flu season, or at any other time when there are increased respiratory infections in the community. Some facilities find it easier to do this year-round. Facemasks include procedure masks (have ear loops) and surgical masks (have ties).

Provide wastebaskets or no-touch receptacles (e.g., a wastebasket with a foot-pedal operated lid) for disposal of tissues or materials soiled with nasal or respiratory secretions.

Provide space for and encourage coughing persons to sit at least three feet away from others in common areas, if tolerated. *(But a client with an acute respiratory infection should be encouraged to stay six feet away from others.)*

GLOVES

Use gloves only one time, for one incident or for one client. Gloves are not washable or reusable. Clean, non-sterile latex, vinyl or synthetic gloves are adequate. If gloves are used often, Nitrile gloves should be used as children and staff exposed to latex often can acquire a latex allergy. Using nitrite gloves is the best practice in childcare to avoid causing a latex allergy.

Wear gloves for contact with all blood, body fluids, secretions, excretions, and contaminated items or surfaces. Examples of when to wear gloves in a facility include:

- When facility staff have cuts or scratches on their hands
- When assisting with incontinent care or when cleaning up urine, stool or vomit
- When administering first aid for a cut, a bleeding wound or a bloody nose

Put gloves on just before touching mucous membranes or contacting blood, body fluids, secretions or excretions.

Wash hands before putting on gloves if hands are visibly soiled, or if assisting a client with a health-related procedure.

Remove gloves when a specific task is completed, and wash hands. Dispose of used gloves immediately after use.

For standard housekeeping/equipment-cleaning activities only, general-purpose utility gloves, such as household rubber gloves, may be washed, disinfected and reused. Discard these gloves if they are peeling, cracked, punctured, torn, discolored, or otherwise showing signs of deterioration.

Disposable Gloves

The Centers for Disease Control (CDC) and Occupational Safety and Health Administration (OSHA) recommend that you wear gloves in the following situations:

- When contact with blood or blood-containing fluids from a child is likely particularly when the caregiver's hands have open cuts or sores (e.g., when using first aid for a child's cut, or changing a diaper with bloody diarrhea)
- When cleaning surfaces or handling clothes and supplies that have been contaminated with blood or gross contamination with body fluids, such as large amounts of vomit, urine or stool
- When caring for oozing skin rashes or lesions
- When you provide mouth or eye care and special medical procedures such as finger prick for blood glucose test, etc.

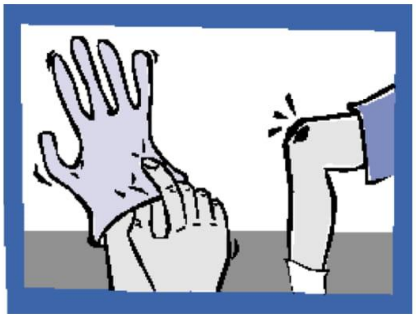
Once the gloves are dirty, remove them correctly and discard them properly. Be careful that you don't contaminate your hands, other objects or people with the dirty gloves. Wash hands and change gloves between diaper changes. Do not reuse the gloves. This can spread germs from one child to another.

Although gloves are not necessary for diaper changing, they may reduce contamination of providers' hands and reduce the presence of infectious disease as they provide a protective barrier. However, they offer little protection beyond that achieved by a good hand washing. Some child care policies recommend that caregivers use gloves for all diaper changes or for all diaper changes with stool. Make sure to follow your policies. Using gloves at the proper times requires being prepared in advance. You may want to make gloves available on the playground, in the first aid kit, at the diaper-changing table, in the car on field trips, with cleaning materials, and in your pockets.

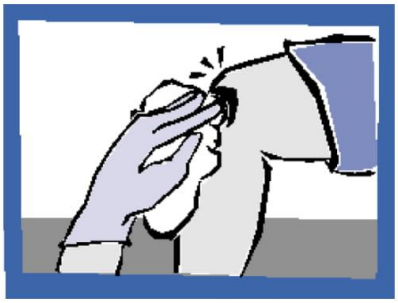
Gloves provide added protection from communicable disease only if used correctly. If you use gloves incorrectly, you actually risk spreading more germs than if you don't use gloves at all. Pay attention to your gloving technique so that you do not develop a false sense of security (and carelessness) when wearing gloves.

It is important to know that certain products like barrier creams, no-soap hand cleansers or "invisible gloves" also provide a false sense of security and cannot be alternatives for protective gloves in child care settings.

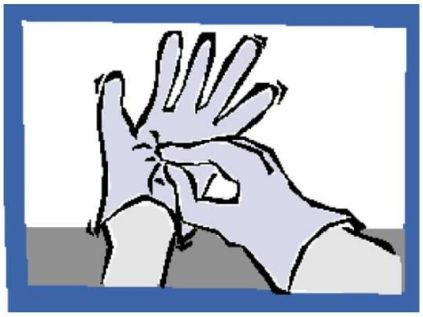
Gloves should never be used as a substitute for hand washing.



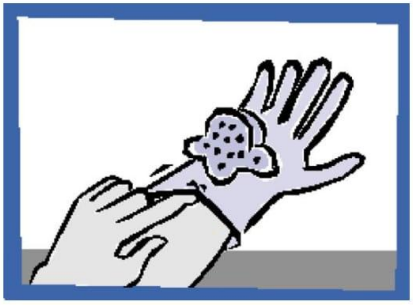
1. Put on a clean pair of gloves.



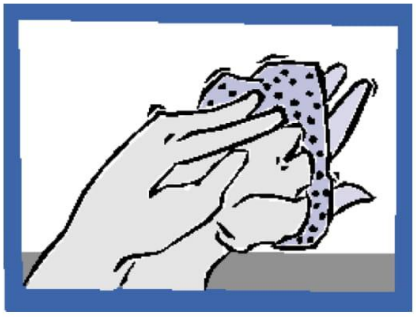
2. Provide appropriate care.



3. Remove each glove carefully. Grab the first glove at the palm and strip the glove off. Touch dirty surfaces only to dirty surfaces.



4. Ball up the dirty glove in the palm of the other gloved hand.



5. With the clean hand, strip the glove off from underneath at the wrist, turning the glove inside out. Touch clean surfaces only to clean surfaces.

6. Discard the dirty gloves immediately in a step can. Wash your hands.

GOWNS
Although not commonly worn in facilities, sometimes it may be advisable for facility staff to consider wearing a gown, such as when soiling of clothes with a client's respiratory secretions is anticipated.
Wear a gown (a clean, non-sterile gown is adequate) to protect skin and to prevent soiling of clothing during activities that may result in contact with blood, body fluids, secretions or excretions. If a cloth gown becomes soiled, remove it immediately to prevent fluids from soaking through onto clothing, and wash hands thoroughly.

Change gowns after each client encounter and wash hands.

LINEN AND LAUNDRY
Soiled linen and laundry, especially linen soiled by incontinent clients, is grossly contaminated with a variety of germs. The risk of disease transmission is considerably reduced if soiled linen and laundry are handled properly.
Treat all soiled linen as potentially infectious.

Wash hands after having contact with all soiled linen.

Keep soiled linen away from clothing, and wear gloves when handling soiled linen contaminated with blood or body substances.

Do not shake soiled linen, which may aerosolize infectious particles.

Place soiled linen in a container or plastic bag that prevents seepage of liquid blood and body fluids to the outside of the container.

Place all soiled linen directly into a linen container or bag. Avoid putting wet, soiled linen on bedside tables, chairs or countertops. Special color-coded bags or bags labeled "infectious" or "contaminated" are not necessary.

Wash linen and laundry properly. Linen and laundry may be washed in a standard washing machine with warm water and detergent. Bleach may be added but is not necessary.

Cleaning, Sanitizing, Disinfecting

Cleaning and Disinfecting in Childcare Video

https://www.youtube.com/watch?v=c1nar0haDK8

It is inevitable that germs will spread to surfaces and objects after being soiled with blood or bodily fluids such as stool, urine, vomit, mucus, saliva, human milk, etc. To prevent the spread of germs and create a sanitary and hygienic environment for children, you need to regularly clean and disinfect those surfaces and objects.

Are Cleaning, Sanitizing, and Disinfecting the Same?

You need to do all three to keep germs from spreading.

Cleaning gets rid of the dirt you can see. Routine cleaning with soap and water is the most useful method for removing germs from surfaces in the child care setting. Good cleaning (scrubbing with soap and water) physically reduces the number of germs from the surface, just as hand washing reduces the number of germs from the hands.

Sanitizing, to reduce germs on inanimate surfaces to levels considered safe by public health codes or regulations.

Disinfect, to destroy or inactivate most germs on and inanimate object, but not bacterial spores

Cleaning removed the surface dirt

Cleaning with a bleach solution (or other approved disinfectant) to kill and get rid of most of the germs you cannot see but which remain on surfaces after cleaning.

The disinfection process uses chemicals that are stronger than soap and water, and will destroy and reduce the number of germs. It usually requires soaking or wetting the item for several minutes to give the chemical time to kill the remaining germs.

Items that can be washed in a *dishwasher* or *hot cycle of a washing machine* do not have to be disinfected because these machines use water that is hot enough for a long enough period of time to kill most germs.

Surfaces considered must likely to be contaminated are those with which children are most likely to have close contact. These include toys that children put in their mouths, crib rails, food preparation areas, and surfaces likely to become *very* contaminated with germs, such as diaper-changing areas. Sinks and sponges are the worst.

What Disinfectants Should Be Used?

A disinfectant is a chemical used to destroy harmful germs. One of the most commonly used chemicals for disinfection in child care settings is a *homemade solution of household bleach and water.* Bleach is cheap and easy to get. The solution of bleach and water is easy to mix, nontoxic, safe if handled properly, and kills most germs.

Other commercial products that meet the Environmental Protection Agency's (EPA's) standards for hospitals may be used for the purpose of disinfection.

“Cleaning, sanitizing, and disinfecting products should not be used in close proximity to children, and adequate ventilation should be maintained during any cleaning, sanitizing, or disinfecting procedure to prevent children and caregivers/teachers from inhaling potentially toxic fumes.” Furthermore, sanitizing or disinfecting with bleach should not be done in the presence of children or staff with asthma. Bleach is a trigger for asthma attacks. Also, bleach fumes linger for a while after its use, so make sure to keep children away from the fumes until the area is well-ventilated and there are no fumes lingering. This information is taken from the text” Caring for Our Children’s, third Edition, by American Academy of Pediatrics.

Common Disinfectants Used at Home

Chemical Name	Examples of Trade Products Using These Chemicals	Uses*/Advantages/Disadvantages
Orthophenyl phenolics Phenyl phenol Benzyl-p-chlorophenol	Lysol Pheno-Cen Ves-Phene Staphene	• May be used on floors and walls, but do not use in kitchens, on toys, or on objects that people put into their mouths. • May be used with detergents. • Inadequately diluted solutions are associated with hyperbilirubinemia in infants. • Can be irritating to skin and other body tissues.
Chlorine bleach Sodium hypochlorite	Clorox Purex Household bleach	• May be used on all surfaces, providing that the correct dilution is used. • Are corrosive to metal and damaging to plastics and rubber. • Bleach solutions should be made fresh daily. • Work best when surface dirt or other extraneous material has been removed. • Less effective when mixed with soap, detergents, or alkaline chemicals. • Do not mix with ammonia, vinegar, or rust removers. • Leaves no residue. • Are the least expensive.
Quaternary ammonias Benzalkonium chloride Dimethylbenzyl ammonium chloride	San-O-Six Clean-N-San D/S/O Tri-Quat Mytar Sage	• Are made less effective when a residue of soap is present on a surface. • May be used on kitchen floors. • Are relatively nontoxic. • Are not as effective at destroying some types of bacteria as bleach, phenols, or alcohol.
Alcohol (70% - 90%)	Ethyl Alcohol Isopropyl Alcohol	• Leaves no residue. • May be used on skin as well as hard surfaces. • Dries skin. • Over the long term may harden rubber and plastic. • Requires 10 to 15 minutes of exposure.
Pine oil cleaners	Pine-Sol Murphy's Oil Soap	• Pleasant odor may mask housekeeping problems. • Are ineffective against staph infections. • Are less effective at killing some bacteria than phenols, chlorine bleach, and alcohols.

* Follow the manufacturer's guidelines to determine the correct application techniques and dilution. (From *Child Care Infection Control Guide*, Seattle-Kings County Department of Public Health, Child Care Health Program, 1994)

Schedule for Cleaning and Disinfecting			
Area	**Clean**	**Disinfect**	**Frequency**
Classrooms/Child Care/Food Areas			
Countertops/tabletops	X	X	Daily and when soiled.
Food preparation and service surfaces	X	X	Before and after with food activity; between preparation of raw and cooked foods.
Floors	X	X	Daily and when soiled.
Door and cabinet handles	X	X	Daily and when soiled.
Carpets and large area rugs (clean with a carpet cleaning)	X		Vacuum daily when children are not present. Method approved by local health authority. Clean carpets only when children are not present until the carpet is dry. Clean carpets at least monthly in infant areas, at least every 3 months in other areas, and when soiled.
Small rugs	X		Shake outdoors or vacuum daily. Launder weekly.
Utensils, surfaces, and toys that go into the mouth or have been in contact with saliva or other body fluids.	X	X	After each child's use, or use disposable (the one-use) utensils or toys.
Toys that are not contaminated with body fluids.	X		Weekly.
Dresses and clothes not worn on the head.	X		Weekly.
Sheets and pillowcases, individual cloth towels (if used), combs and hairbrushes, washcloths, and machine-washable cloth toys (none of these should be shared among children).	X		Weekly and when visibly soiled.
Blankets, sleeping bags	X		Monthly and when soiled.
Hats	X		After each child's use.
Cubbies	X		Weekly.
Cribs	X		Weekly.
Toilet Areas:			
Hand-washing sinks, faucets, surrounding counters	X	X	Daily and when soiled.
Soap dispensers	X	X	When being refilled and when soiled.
Toilet seats, toilet handles, door knobs or cubicle handles, floors	X	X	Daily or immediately if visibly soiled.
Toilet bowls	X	X	Daily.
Door knobs	X	X	Daily.
Changing tables	X	X	After each child's use.
Potty chairs (Use of potty chairs in child care is discouraged due to high risk of contamination).	X	X	After each child's use.
Any surface contaminated with body fluids:	X	X	Immediately.

saliva, mucus, vomit, urine, stool, or blood.

Cleaning and Disinfecting

Preparing Bleach Solution

We can no longer give a standard recommendation for bleach/water mixture because bleach comes in different concentrations and what is now sold is a higher concentration than sold in the past. You most look at the label and follow the instructions on the label. If the bleach is 8.25% bleach then 2 TSP of bleach to one-gallon water, *use this solution for routine, everyday cleaning and disinfecting items and surfaces, i.e. table top, toys, eating utensils and plates.*

For certain types of heavily contaminated or very high-risk body fluids, *a strong bleach solution of one-part bleach to ten parts water is necessary (e.g., one cup bleach in ten cups of water).* Use this stronger solution, which might gradually eat away some surfaces or cause excessive wear if used routinely, in the following situations:

- To clean and disinfect all *blood spills* or blood-contaminated items.
- To clean and disinfect *gross contamination with body fluids,* such as large amounts of vomit or feces. (This is not necessary for removing traces of feces or urine from a changing table or small amounts of "spit-up" from a high-chair tray.)

You must use your judgment to decide which strength is needed. The use of rubber gloves is recommended whenever you must clean areas contaminated with body fluids.

You should purchase fragrance-free bleach that is EPA-registered 8.25% sodium hypochlorite.

Do not use professional-grade bleach which is generally 12% sodium hypochlorite, which is too strong for use in the child care setting.

Do not need to buy commercially sold disinfectants, since either of these recommended bleach solutions can be made easily at very little cost. *However, you must make any bleach solution each* day because bleach loses its strength (and thus its effectiveness) as it is exposed to air. It is best to store it in a carefully labeled spray bottle.

Recipe for Bleach Disinfecting Solution (for use in bathrooms, diapering areas, etc.)

Read the label and follow recommendations indicated on the label. Use only an EPA–registered product. If the bleach concentration is 8.25% then ½ cup of bleach 1 gallon of cool water

Add the household bleach (8.25 % sodium hypochlorite) to the water.

Recipe for Weaker Bleach Disinfecting Solution (for use on toys, eating utensils, etc.)

2 TSP (1/3 oz) of bleach 1 gallon of cool water

Add the bleach to the water.

The National Health and Safety Performance Standards: Guidelines for Out-of-Home Care Programs **recommends using *household bleach with water. It is effective, economical, convenient and readily available. However, it should be used with* caution on metal and metallic surfaces. I f you use a commercial (brand-name) disinfectant, read the label and always follow the manufacturer's instructions exactly.**

There are alternatives to chlorine bleach

A product that is not chlorine bleach can be used in child care settings IF:

1. It is registered with the EPA;
2. It is also described as a sanitizer or a disinfectant;
3. IT is used according to the manufacturer's instructions.

Check the label to see how long you need to leave the sanitizer or disinfectant in contact with the surface you are treating, whether you need to rinse if off before contact by children, for any precautions when handling, and whether it can be used on a surface that may come in contact with child's mouth.

Some child care settings are using products with hydrogen peroxide as the active ingredient instead of chlorine bleach. Check to see if the product has a EPA registration number and follow the manufacturer's instructions for use and safe handling.

In addition, some manufacturers of sanitizer and disinfectant products have developed "green cleaning products" that have EPA registration. As new environmentally-friendly cleaning products appear in the market, check to see if they are EPA-registered.

When Preparing Bleach Solution

All staff of a child care home or center should be provided with hazard information regarding cleaners, including access to and review of the Material Safety Data Sheets (MSDS) as required by the Occupational Safety and Health Administration (OSHA), about the presence of toxics such as cleaners, sanitizing and disinfecting supplies in use in the facility or home. The MSDS explain the risk of exposure to products so that appropriated precautions may be taken.

When Preparing Bleach Solution:

- Use personal protective equipment (PPE) which are gloves, safety goggles, and aprons. **DO NOT USE FACE MASKS,** as these can trap the bleach fumes and cause illness.
- Avoid purchasing bleach with no concentration specified on the label.
- Use quart-size (32 oz) opaque spray bottle to dilute bleach
- Use a calibrated dispensing pump or a tablespoon and a teaspoon.
- Keep a safe distance from the bleach when diluting
- Maximize ventilation by opening windows or doors in the area
- Ensure the children are in another area when diluting, sanitizing, or disinfecting
- Apply bleach solution onto surfaces while spraying away from the breathing zone
- Ensure that surfaces are completely dry before children are allowed back into the area after sanitizing or disinfecting
- Use a digital timer to ensure proper (2 minutes) contact time for the bleach solution
- Do not mix different products or chemicals
- Do not recycle or reuse bleach solution spray bottles for any other use
- Label the spray bottle used for cleaning solutions. Rinse the surface with water after disinfecting
- Keep bleach and other cleaning products out of reach of children
- Avoid using spray bottles for diluted bleach that are similar-looking to the ones used for play
- Utilize an emergency eyewash station, in case of accidental exposure while preparing the bleaching solution
- Avoid using aerosol and deodorizing sprays, as these both irritate the respiratory system and may cause or exacerbate asthma.
-

Required information and Training if you use Bleach or Pest controls around your property.

See information for the law and the training below:

The law, SB 1405, in legislative text:
http://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201320140SB1405

Healthy Schools Act Expanded -- Further Protects Children When children returned from winter break, there was greater emphasis on safer pest management methods at the places where they learn and play. As of January 1, 2015, new changes to the Healthy Schools Act (HSA) expand the scope of pesticide information provided to parents and educate childcare providers about less hazardous ways to control pests. Child care centers applying pesticides are required to establish an integrated pest management plan (IPM) and report pesticide use annually to the Department of Pesticide Regulation (DPR). Previously, the law only required pest management companies that apply pesticides at child care centers to report use to DPR. Now, under the amended law, anyone who applies pesticides, including child care center staff, will need to report that pesticides were used, the time of application, the location, and the amount of the product. Child care centers that use pesticides must now have an IPM plan. This will allow parents to view pest management strategies. These plans will be posted online or sent out to parents or guardians and staff with the annual pesticide notice. DPR has posted an IPM plan template on their Web site for child care centers to use.

In addition to changes beginning in January, a new training requirement begins July 1, 2016. Anyone who applies any pesticide— including disinfectants like bleach—at a child care center will need to take a DPR-approved IPM training course. This includes both licensed child care center staff and hired pesticide applicators applying pesticides at child care centers. DPR is developing free online training courses that will fulfill this requirement. For licensed applicators, the training will be offered as continuing education courses. For more information about changes to the Healthy Schools Act, templates, or articles, you can visit the DPR website at: www.cdpr.ca.gov/schoolipm/childcare

The law also puts new training requirements on pest control companies that service schools and child care centers. Beginning July 2016, anyone who applies pesticide at a school or child care center will need to complete a training approved by the California Department of Pesticide Regulation (DPR). This includes school and child care staff, as well as hired pest control companies.

In a 2010 study, CERCH found that 90 percent of California child care centers reported at least one pest problem and about half reported using pesticide sprays, with one in five applying pesticide sprays monthly, an approach that is not consistent with least toxic pest control methods. In response, they worked with the UCSF Child Care Health Program to develop an award-winning IPM Toolkit for child care providers.

"We realized that pest control companies are also important partners in pest management," says **Asa Bradman**, associate director for exposure assessment at CERCH. "So, we teamed up with Dr. Andrew Sutherland at UC IPM and Pestec, a pest control company using IPM, to develop a continuing education course for licensed pest management professionals."

The free online course, Providing Integrated Pest Management Services in California Schools and Child Care, is reviewed and approved by DPR and the Pest Control Operators of California. A directory of licensee's who have completed the course will be kept on the CERCH website as

a resource for schools and child care centers. This project was funded by the California Department of Pesticide Regulation Pest Management Alliance Program.

More about the online training here:
http://www.cdpr.ca.gov/docs/dept/insights/ipm_training.htm

http://sph.berkeley.edu/new-training-course-pesticide-use-in-schools

Cleaning and Disinfecting

GENERAL RECOMMENDATIONS FOR CLEANING AND DISINFECTING

1. Items which get daily use should be washed and disinfected daily. Heavily soiled areas need longer contact time with the disinfecting solution.

2. After cleaning and disinfecting, air dry all items before returning them to the setting.

3. Paper towels are the cleaning tools with the least risk for spreading infections, but only use them once. Sponges and handy wipes give germs the two things they need most to grow: moisture and food sources.

4. Include children whenever possible in hand washing and the cleaning of table tops and chairs.

5. Pour or dump all liquids or solutions used for cleaning and disinfecting into a closed disposal system, i.e. flush them down the toilet.

6. Wash and disinfect mops and other cleaning materials daily.

All surfaces, furnishings and equipment that are not in good repair or require cleaning and disinfecting need to be taken out of service until they can be cleaned and disinfected effectively.

Washing and Disinfecting Diaper Changing Areas

Diaper changing areas should:

- Only be used for changing diapers
- Should be smooth and nonporous, such as Formica (NOT wood) or a plastic-covered pad.
- Have a raised edge or low "fence" around the area to prevent a child from falling off.
- Be next to a sink with running water
- Be easily accessible to providers and be out of reach of children
- Not be used to prepare food, mix formula, or rinse pacifiers

Diaper changing areas should be cleaned and disinfected after each diaper change as follows:

1. Clean the surface with soap and water, and rinse with clear water to reduce the number of germs on the surface.
2. Dry the surface with a paper towel.
3. Thoroughly wet the surface with the recommended bleach solution.
4. Air dry. Do not wipe. This will give the chemicals time to kill the remaining germs.

Washing and Disinfecting Toilets, Seats, Hand-washing Sinks, Faucets, and Doorknobs

Bathroom surfaces, such as faucet handles and toilet seats, should be washed and disinfected several times a day if possible, but at least once a day or when soiled.

The bleach and water solution, chlorine-containing scouring powders or other commercial, bathroom surface cleaners /disinfectants can be used in these areas. Surfaces that infants and young toddlers are likely to touch or mouth, such as crib rails, should be washed with soap and water and disinfected with a nontoxic disinfectant, such as bleach solution, at least once every day and more often if visibly soiled.

After the surface has been drenched or soaked with the disinfectant for at least 10 minutes, surfaces likely to be mouthed should be thoroughly wiped with a fresh towel moistened with tap water. Be sure not to use a toxic cleaner on surfaces likely to be mouthed. Floors, low shelves, door knobs and other surfaces often touched by children wearing diapers should be washed and disinfected at least once a day and whenever soiled.

Washing and Disinfecting Toys

- Whenever possible, infants and toddlers should not share toys. Toys that children (particularly infants and toddlers) put in their mouths should be washed and disinfected between uses by individual children.
  Toys for infants and toddlers should be chosen with this in mind. If you can't wash a toy, it probably is not appropriate for an infant or toddler.
- When an infant or toddler finishes playing with a toy, you should retrieve it from the play area and put it in a bin reserved for dirty toys. This bin should be out of reach of the children. Toys can be washed at a later, more convenient time, and then transferred to a bin for clean toys and safely reused by other children.

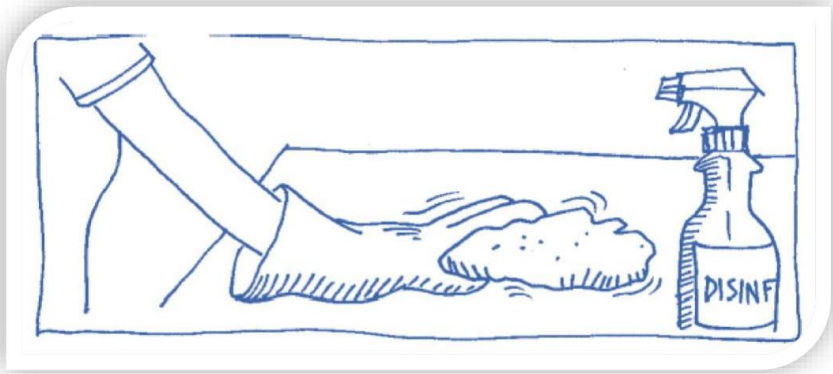
To wash and disinfect a hard-plastic toy:

- Scrub the toy in warm, soapy water. Use a brush to reach into the crevices.
- Rinse the toy in clean water.
- Put the toy in bleach solution (see above) and allow it to soak in the solution for 10-20 minutes.
- Remove the toy from the bleach solution and rinse well in cool water.
- Air dry.

- Hard plastic toys that are washed in a dishwasher, or cloth toys washed in the hot water cycle of a washing machine, do not need to be additionally disinfected.
- Children in diapers should only have washable toys. Each group of children should have its own toys. Toys should not be shared with other groups.
- Stuffed toys used only by a single child should be cleaned in a washing machine every week or more frequently if heavily soiled.
- Toys and equipment used by older children and not put into their mouths should be cleaned at least weekly and when obviously soiled. A soap and water wash followed by clear water rinsing and air drying should be adequate. No disinfection is required. (These types of toys and equipment include blocks, dolls, tricycles, trucks and other similar toys.)
- Clean and disinfect brushes used to clean toys.
- Do not use wading pools, especially for children in diapers.

Cleaning Up Body Fluid Spills

Spills of body fluids, including blood, feces, nasal and eye discharges, saliva, urine, and vomit should be cleaned up immediately.

- Wear gloves unless the fluid can be easily contained by the material, e.g., paper tissue or cloth, being used to clean it up. Be careful not to get any of the fluid you are cleaning up in your eyes, nose, mouth or any open sores you may have.
- Clean and disinfect any surfaces, such as countertops and floors, on which body fluids have been spilled
- Discard fluid-contaminated material in a plastic bag that has been securely sealed.
- Mops used to clean up body fluids should be:
  (1) Cleaned
  (2) rinsed with a disinfecting solution
  (3) wrung as dry as possible
  (4) hung to dry completely
- 

Be sure to wash your hands after cleaning up any spill even if you wore gloves.

Disposal of Garbage

Proper storage and disposal of garbage not only prevents the spread of disease, it also helps to prevent unpleasant odors and other problems with insects and rodents. Soiled items that are disposable (e.g. disposable diapers, gloves, paper towels, tissues) should be thrown away immediately in an appropriate trash container.

- Store garbage in water and rodent-proof containers with tight lids.
- Use containers operated with a foot pedal (e.g. step can). This is especially recommended for diaper disposal.
- Use a plastic bag to line covered containers.
- Put the containers within reach of the diaper changing area, hand washing sink, and food preparation area.
- Remove, clean, and sanitize containers from children's area daily.
- Make sure that infants and toddlers cannot knock over or reach into the containers.

Diapering / Toileting

Diapering and the use of potty chairs carry distinct risks to the child care environment. Since the changing area is one of the places where germs which cause disease are most likely to live and spread, these activities must be handled with extreme care and attention to sanitation.

The Diapering Area

The health and safety of the children in your child care setting demand that diapering be carried out in an environment that has been carefully planned. These are some important rules about the diapering area that should be remembered:

- Use the area only for diapering.
- Set up the diapering area as far away as possible from any food handling area.
- Provide running water so hands can be washed immediately after a diaper is changed. Ideally, a diaper changing area should be within arm's reach of a sink.
- Construct a flat and safe diapering surface high enough so that you do not put extra stress on your back.
- Be sure this surface is clean, waterproof and free of cracks or crevices. A good pad on the surface with a waterproof cover is more comfortable for the child.
- Cover the surface with a disposable cover. Use cheap materials such as paper bags, used computer paper (on the "wrong" side), rolls of paper, etc. or buy disposable squares from discount medical supply companies.
- Keep all creams, lotions and cleaning items out of the reach of children, but within your reach. Never give a child any of these to play with while being diapered, since he or she could be poisoned.
- Childcare Providers should not use talc powder for diapering.
- Add a guard rail at least three inches high or a recessed area as a good, extra safety measure.
- Always keep a hand on the child.
- Never leave the child unattended, even for a second.

You should never wash or rinse diapers or clothes soiled with stool in the child care setting. Because of the risk of splashing and gross contamination of hands, sinks, and bathroom surfaces, rinsing diapers increases the risk that you, other providers and the children would be exposed to germs that cause infection. All soiled clothing should be put in a plastic bag, securely closed, and sent home with the child without rinsing. (You may dump solid stool into a toilet.) You need to tell parents about this procedure and why it is important. They often request that diapers and training pants be rinsed out to avoid staining.

Recommended Procedure for Diapering a Child

Changing Diapers in Childcare

https://www.youtube.com/watch?v=GwN3DXeXmWg

(1) *Organize needed supplies within reach, before you bring the child to the diaper-changing area*

- Wash your hands and gather what you need; such as disposable covering, fresh diaper, clean clothes (if you need them), wipes for cleaning the child's bottom, a plastic bag for any soiled clothes, disposable gloves (if they will be used), and a dab of any diaper cream (if the child uses it).
- Place a disposable covering (such as roll paper) on the portion of the diapering table where you will place the child's bottom.

(2) *Avoid contact with soiled items.*

- If using gloves, put them on immediately.
- Using only your hands, pick up the child. Do not cradle the child in your arms and risk soiling your clothing. Provide steps for older children.
- Lay the child on the paper or towel.

(3) *Remove the soiled diaper.*

- Remove soiled diaper (and soiled clothes) without contaminating any surface not already in contact with stool or urine.
- Fold the soiled surface inward,
- Put disposable diapers in a covered, plastic-lined trash can.
- Put soiled, reusable diaper and/or soiled clothes without rinsing in a plastic bag securely closed to give to parents. Remove rubber pants and diapers as a single unit.

(4) *Clean the child's diaper area*

- Use disposable wipes to clean and dry the skin on the child's bottom. Place the soiled wipes into the soiled diaper or directly into a covered plastic-lined trash can.
- If the child needs a more thorough washing, use soap, running water, and paper towels.
- Remove the disposable covering from beneath the child. Discard it into a covered plastic-lined trash can.
- If you are wearing gloves, remove and dispose of them immediately into a covered plastic-lined trash can.

(5) *Put on a clean diaper and dress the child*

- Use a facial or toilet tissue to apply any necessary creams or ointments.
- Note and plan to report any skin problems such as redness.
- Slide a fresh diaper under the child, then adjust and fasten it. If pins are used, place your hand between the child and the diaper when inserting the pin.

(6) *Wash the child's hands and return the child to a supervised area.*

(7) *Clean and sanitize the diaper changing surface.*

- Clean and disinfect the diapering area, all equipment or supplies that were touched, and soiled crib or cot, if needed.

(8) *Wash your own hands thoroughly.*

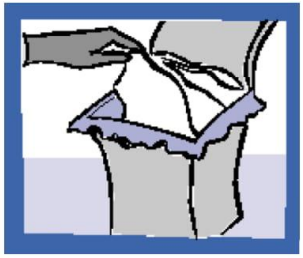
Diapering Procedures

1. Organize needed supplies within reach.

- Wash your hands and gather what you need.
- Place a disposable cover on the diapering surface.

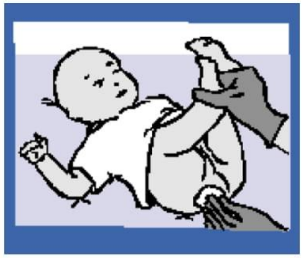
2. Avoiding contact with soiled items.

- If using gloves, put them on immediately.
- Using only your hands, pick up the child.
- Provide steps for older children.
- Lay the child on the disposable cover.
- Never leave the child unattended.



3. Remove the soiled diaper.

- Remove soiled diaper and soiled clothes.
- Fold the soiled surface inward.
- Put disposable diapers in a covered, plastic-lined trash can.
- Put soiled, reusable diaper and/or soiled clothes (without rinsing) in a plastic bag for parents.

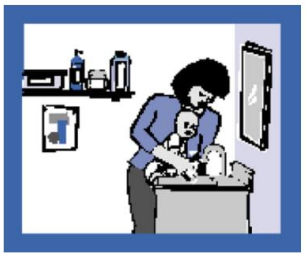


4. Clean the child's diaper area.

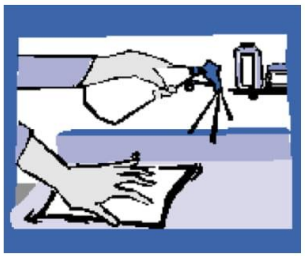
- Use disposable wipes to clean and dry the child's bottom.
- If the child needs a more thorough washing, use soap, running water, and paper towels.
- Remove the disposable covering from beneath the child and discard it into a covered plastic-lined trash can.
- If you are wearing gloves, remove and dispose of them immediately into a covered, plastic-lined trash can.

5. Put on a clean diaper and dress the child.

- Use a facial or toilet tissue to apply any necessary creams or ointments.
- Childcare Providers should not use Talc Powder for diapering.
- Note and plan to report and skin problems such as redness.
- Slide a fresh diaper under the child, then adjust and fasten it. If pins are used, place your hand between the child and the diaper when inserting the pin.



6. Wash the child's hands and return the child to a supervised area.



7. Clean and sanitize the diaper changing surface.

- Clean and disinfect the diapering area, all equipment or supplies that were touched, and soiled crib or cot, if needed.

8. Wash your own hands thoroughly.

Important Rules About Diapering

- Use the area only for diapering
- Set up the diapering area as far as possible from any food handling area.
- Provide running water so hands can be washed immediately after a diaper is changed.
- Construct a diapering surface which is flat, safe and preferably at least three feet above the floor.
- Be sure this surface is clean, waterproof, and free of cracks and crevices. Cover it with a disposable cover. Use cheap materials such as paper bags, used computer paper (on the "wrong" side), rolls of paper, etc., or buy disposable squares from discount medical supply companies.
- Keep all creams, lotions, and cleaning items out of reach of children. Never give a child any of these to play with while being diapered, since he or she could be poisoned.
- Use a guardrail or recessed area as an extra safety measure. Always keep a hand on the child.

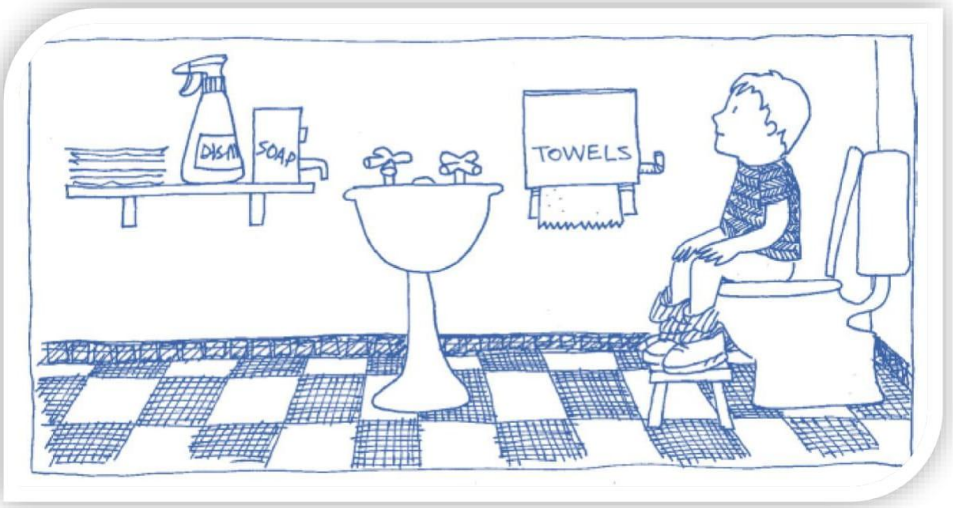
NEVER LEAVE THE CHILD, EVEN FOR A SECOND.

Using Toilet-Training Equipment

The use of potty chairs in the child care setting should be discouraged. Potty chairs are difficult to keep clean and are in the reach of children. Small, flushable toilets or modified toilet seats and step aids are preferable.

If potty chairs are used for toilet training, you should use them only in a bathroom area and out of reach of other potty chairs. After each use of a potty chair, you should:

- Immediately empty the contents into a toilet, being careful not to splash or touch the water in the toilet
- Rinse the potty chair with water and empty into toilet.
- Wash the chair with soap and water. Consider using paper towels or a disposable mop. Empty some water into toilet.
- Rinse again. Empty into toilet and flush.
- Spray with bleach solution.
- Air dry.
- Wash and disinfect sink.
- Wash hands.
- Assist children in washing their hands.



Child Care Nutrition

Good nutrition and physical activity are an important part of a healthy childhood. For optimal health, children need a variety of safe and nutritious foods, accompanied by daily physical activity. Balanced nutrition and physical activity have positive effects not only on physical health, but also on children's growth, mood, quality and quantity of sleep, and ability to learn. Good nourishing and attractive food is the cornerstone for health, growth, and development as well as developmentally appropriate learning experiences. In child care programs, young children develop preferences and habits regarding food and activity and these early habits are likely to continue throughout their lives. Children look to adults as role models for the foods they prefer and childcare staff has an opportunity to influence children's food preferences and experiences in ways that will promote health by offering foods that are safe, nutritious and appealing.

Child care centers and family child care homes serve an important role in helping young children develop good eating and physical activity habits. Children in care settings may receive half or more of their daily nutritional needs while in care. Since these meals and snacks supply such a major portion of a child's total intake, the food and the environment in which the foods are offered impact children's health, not only today, but in the future as well. Child care providers have a major responsibility to provide healthy foods in a supportive environment. Mealtimes can be a time for learning about nutrition, hand washing, table manners, conversations and motor skills, as well as an opportunity to try new foods.

For more information on general information about children nutrition go to www.emsa.ca.gov/childcare_nutrition

California's Healthy Beverages in Child Care Law (AB 2084, 2010)

http://www.healthybeveragesinchildcare.org/

This law was creating because 20% children ages 2 to 5 are overweight the standards effective January 1, 2012 are as follows:

Children should only drink:

- Clean and safe drinking water must be readily available throughout the day, including at all meal, snack, and play times.
- Serve only fat-free or low-fat (1%) unsweetened, plain milk for children two years of age or older.
    - A maximum of one serving (4 to 6 ounces for 1---6-year-old*) of 100% juice is allowed per day.
    - Beverages with added sweeteners, either natural or artificial are prohibited (not including infant formula or complete balanced nutritional products designed for children.

Beverages are the liquids we drink. Today, there is a wide variety of fluid choices. If not selected carefully, beverages can add significant calories to children's diets without adding nutrients. Water is the best beverage choice for children between meals, including at snack time. Water satisfies thirst without adding calories that could lead to weight gain. It also helps prevent dental caries by decreasing the amount of acid in the mouth. Studies show that children who drink soft drinks are more likely to be overweight. Meals should include 1% or skim milk for children over age 2, with water or 100% juice served at snacks. Provide no more than one serving (4 to 6 ounces) per day of 100 % juice.

Dietary Guidelines for Americans, scientific recommendations from the National Academy of Medicine for (CACFP) Centers and Day Care Homes must comply with the updated meal patterns by October 1, 2017. Greater Variety of Vegetables and Fruits

The combined fruit and vegetable component is now a separate vegetable component and a separate fruit component; and Juice is limited to once per day.

More Whole Grains
At least one serving of grains per day must be whole grain-rich; Grain-based desserts no longer count towards the grain component; and ounce equivalents (oz) are used to determine the amount of creditable grains (starting October 1, 2019).

More Protein Options
Meat and meat alternates may be served in place of the entire grains component at breakfast a maximum of three times per week; and Tofu counts as a meat alternate.

Age Appropriate Meals
A new age group to address the needs of older children 13 through 18 years old.
Less Added Sugar
Yogurt must contain no more than 23 grams of sugar per 6 ounces; and Breakfast cereals must contain no more than 6 grams of sugar per dry ounce.

Dietary Guidelines for Americans

The Dietary Guidelines are the cornerstone of the Federal Nutrition policy and are used for guidance and education of American on nutrition. These Dietary Guidelines issued and updated every 5 years jointly by the Department of Agriculture (USDA) and the Department of Health and Human Services (HHS). These are science-based nutrition guidance to help in the proper education and development of health and happy children. These dietary guidelines can help family and childcare providers to maximize the nutritional content of their meals. The intent of the guidelines is to help in the choice of healthy, nutritional adequate diets.
Recommendations in the Dietary Guidelines are targeted to the general public over 2 years of age. The science-based guidelines are the backbone of all federal policies concerning nutrition and are the primary source of dietary health information for policymakers, nutritionists, nutrition educators and health care providers. Information in the guidelines is useful for the development of educational materials and will help the public in reducing their risk of obesity and chronic disease.

Food groups to encourage. Increased intake of fruits, vegetables, whole grains, and fat-free or low-fat milk and milk products can have important health benefits for most Americans.
• Consume a sufficient amount of fruits and vegetables while staying within energy needs.
• Choose a variety of fruits and vegetables each day. In particular, select from all five vegetable subgroups (dark green, orange, legumes, starchy vegetables, and other vegetables) several times a week.

We should cut back on foods with added sugar.

- Minimize or exclude trans fats, sugars used as sweeteners, and refined starches.
- Read food labels to see how many sugar grams are in each.
- Stay away from products with added sugar, honey, or any ingredient ending in the letters "ose." That means they contain sugar.
- If sugars are in the ingredients, make sure they are not one of the first three ingredients on the ingredient list. If they are, that means that sugar makes up most of the product.

Serving Foods that are Low in Fat

- Limit use of butter, margarine, gravy, and regular cheeses on vegetables, grains, and other foods.
- Limit serving fried foods.
- Use of herbs and no-salt spices to flavor vegetables and other foods.

Serving Foods that are Low in Salt:

- Choose low-sodium soy sauce and catsup
- Avoid using flavor packets that come with processed foods. Use lemon juice, lemon or orange zest, fresh or dried herbs, and 100% fruit juice to add flavor to foods, without adding salt.
- Drain and rinse canned and pre-cooked beans and vegetables.
- Avoid packaged or canned foods as these products almost always contain added salt.
- Limit adding salt when cooking and at the table.
- Purchase foods labeled "low salt," "no salt added," "reduced sodium," or "no sodium."
- Do not serve processed foods, as they contain added salt.

Meal planning tips for children

Two- to 3-year-old children need the same numbers of servings as 4- to 6-year-old children.

FRUIT GROUP CHOICES

CITRUS, MELONS, BERRIES	OTHER FRUITS
blueberries or raspberries	apple, banana, peach, or
cantaloupe	nectarine

100% citrus juice (orange) grapefruit honeydew kiwifruit orange strawberries tangerine watermelon pieces	apricots cherries dried fruit applesauce canned pineapple slices grapes mango papaya pear cut-up fresh, canned, or cooked fruit

- Introduce children to different fruits that are seasonal this gets children to try different fruits such as cherries in the spring, watermelons in the summer.
- Serve fresh or frozen fruit (no sugar added).
- Serve canned fruit (without added sugar, in water, or 100% fruit juice).
- Serve unsweetened dried fruit with care for choking concerns. This kind of fruit may be needed to be chopped finely.
- Serve fruit by itself and as part of other foods, such as in soups and salads.

Fruit-type Snacks

• choose small, whole fruits in season to reduce cost and waste
• cut in slices or halves for variety, and serve plain or with cottage cheese, ricotta cheese, or yogurt (dairy or soy)
• raisins and other dried fruits

• Apple ring sandwiches (creamy peanut butter on apple rings)
• Frozen fruit cups (freeze pureed or crushed fruit and allow to soften slightly in the fridge before serving)
•Canned fruit packed in light syrup or water is also acceptable.

•Homemade Popsicles: freeze any 100% fresh fruit juice (except pineapple juice which does not freeze well) and pour it into small paper cups or ice cube trays. Insert Popsicle sticks and freeze until solid. Then remove Popsicle

VEGETABLE GROUP CHOICES

DARK-GREEN LEAFY	DEEP-YELLOW	STARCHY
cooked collard greens leafy raw vegetables—romaine lettuce, spinach, or mixed green salad cooked broccoli spears cooked turnip greens, kale, or mustard greens	whole carrots, cooked raw carrot sticks (3" long) winter squash	medium ear of corn French fries, regular size baked potato, medium potato salad green peas lima beans plantain

DRY BEANS & PEAS cooked black, kidney, pinto, or garbanzo beans, or black-eyed peas cooked lentils bean soup cooked split peas	**OTHER** cucumber raw snow or sugar pea pods cooked green beans brussels sprouts raw summer squash coleslaw cooked cabbage celery sticks (3" long) tomato or spaghetti sauce vegetable juice vegetable soup tomato cherry tomatoes	

(Frozen or canned vegetables without added sodium are also acceptable)
- soft-cooked vegetables—carrots, asparagus, green beans, pea pods, sweet potato strips, broccoli or cauliflower served with a cottage cheese, hummus, or yogurt (dairy or soy) dip
- green pepper slices, tomato wedges or zucchini strips served with creamy peanut butter, cream cheese or cottage cheese
- grilled cheese and tomato sandwiches, or cheese and veggie quesadillas.

** Avoid "chunky" peanut butter, raw celery and carrots because they are a choking hazard.*

- Serve seasonal vegetables such as broccoli in the winter and corn in the summer.
- Serve fresh, frozen, or canned low sodium vegetables.
- Serve dark green and orange vegetables.
- Serve vegetables without added salts, oils, and sauces. Do not use added salts, oils, or sauces excessively when serving vegetables.

MEAT GROUP CHOICES

Cooked lean meat, poultry, or fish equal one serving from this group.

cooked lean meat
cooked poultry or fish
1 egg (yolk and white)
peanut butter
drained canned salmon or tuna
cooked kidney, pinto, or white beans
tofu
soy burger patty

- Serve poultry: chicken and turkey.

- Serve lean meats: beef, pork, lamb.
- Serve fish—fresh, frozen, or canned.
- Serve shellfish with care for allergy concerns.
- Serve legumes, such as lentils, beans and peas--cooked, canned, or frozen (includes tofu, legume-based vegetable patties, and hummus).
- Serve nuts, seeds, and nut butters with care to allergies and choking concerns.
- Serve meats grilled, roasted, poached, or boiled, rather than fried.
- Trim away visible fat on meats.
- Serve eggs-hard boiled, devilled, or scrambled (cook eggs thoroughly to avoid salmonella). Limit serving processed meats (like hot dogs, [hot dogs are choking hazards, and must be prepared with guidance], chicken nuggets and fish sticks).

Meat-type Snacks

• Hard cooked eggs (wedges or slices)
• Kabobs made with any combination of cheese, fruit, vegetables and sliced or cubed cooked meat or tofu *(remove the toothpicks before serving!)*
• Pita pocket filled with lean, sliced meat; tuna; hummus, tofu, cheese (dairy or soy), lettuce and/or tomato
• English muffins or pita bread topped with tomato sauce, grated cheese (soy or dairy) and lean cuts of meats or tofu, baked, and cut into quarters
• Pita bread, flour or corn tortillas with beans or canned chili, sprinkled with grated cheese (soy or dairy), and topped with plain yogurt or sour cream if desired

GRAIN GROUP CHOICES

Offer whole or mixed grain products.

WHOLE GRAIN	**ENRICHED**	**Grain Products with More Fat and Sugars**
cooked brown rice	cooked rice or pasta	biscuit or muffin
graham cracker squares	cooked spaghetti	cornbread
whole grain crackers	English muffin or bagel	doughnut
cooked oatmeal	slice white, wheat, French or Italian bread	animal crackers
cooked bulgur	hamburger or hot dog bun	small cookies
popped popcorn	small roll	
rice or popcorn cakes	crackers (saltine size)	
ready-to-eat whole grain cereal	pita bread	
pumpernickel, rye, or whole wheat bread	pancake	
taco shells	cooked grits	
corn tortilla	cooked farina or other cereal	
	ring pretzels	
	ready-to-eat, non-sugar coated, cereal	
	flour tortilla	

- All of a child's grains should be whole grains.
- Serve whole-grain wheat flour products.
- Serve whole-grain brown rice, wild rice, and quinoa.
- Serve whole-grain oatmeal—old-fashioned rolled oats or steel-cut oats without added sugar.
- Serve whole-grain barley.
- Serve whole-grain cornmeal.
- Serve whole-grain cereal.
- Serve 100% whole-grain bread (stay away from white bread or wheat bread that isn't 100% whole wheat.).
- Serve whole-grain wheat pasta or wholegrain noodles.
- Serve whole-grain tortillas and whole-corn tortillas (stay away from flour tortillas).
- Serve whole-grain crackers.

Bread-type Snacks
• Mini flavored rice or corn cakes
• Pumpkin, zucchini, banana, or cranberry bread
• Bran, corn, apple, banana, or blueberry muffins
• Homemade soft pretzels or bread sticks
• Non-sugared cereals
• whole grain crackers, breads or bagels with various soft cream cheese spreads, creamy peanut butter, jelly, cottage cheese or hummus

Serve healthy beverages

- Children must have easy access to water throughout the day, including at meals and snacks, indoors and outside.
- It is a good practice to serve water at the table with meals and snacks, even if another beverage is served.
- Serve one-percent or non-fat cow's milk (non-flavored) to children age 2 and older with attention to allergies and lactose intolerance.
- Serve whole milk to one-year-olds.
- Health Beverage
  1) All milk should contain vitamins A and D (at levels specified by the Food and Drug Administration).
  2) Milks and juices must be pasteurized.
  3) Juices are not needed or recommended. Avoid serving juices because whole fruit is more beneficial than juice and provides dietary fiber and other nutrients. If you choose to serve fruit juice, make sure to serve an age-appropriate portion of 100% juice not more than once daily.

Do not serve sweetened beverages (with added sugar or artificial sweeteners

MILK GROUP CHOICES

One serving of the milk group is based on the amount of calcium in 1 cup of milk. This group is where partial servings are eaten most often.

BELOW ARE EXAMPLES OF MILK GROUP SERVING OPTIONS:
milk
soy milk, calcium fortified
yogurt
natural cheese
process cheese
string cheese
cottage cheese
ice cream
frozen yogurt
pudding

- Store milk in the refrigerator below 40 degrees.
- A child who is lactose intolerant may still be able to enjoy milk-based foods. Discuss this issue with the child's family so they may discuss this with the child's medical professional to see how this can be done.
- For children who are lactose-intolerant or vegan, a parent may choose alternatives milk (almond, soy, coconut) that is enriched with calcium, iron, and vitamins A and D. Be sure to discuss these choices with a child's parent with regard to whether a child is allergic to such alternatives for milk.

Dairy-type Snacks

• Yogurt with applesauce or pureed fruit
• Flavored or plain yogurt (dairy or soy) or cottage cheese combined with fruit
• Pudding
• Slices of cheese or "string" cheese (dairy or soy)
• Homemade frozen "juice pops" with calcium-fortified juices (combine yogurt - dairy or soy - with 100% fruit juice, and add pureed or very soft fruit)
• Fruit shake (blend together cow's milk or soy/ rice milk with fruit and add a dash of cinnamon and nutmeg)

Planning Meals

Looking ahead and planning a menu can be an economic and efficient way of ensuring that Children receive a nutritionally balanced diet every day. A well-planned menu, will provide meals and snacks with foods from all the food groups. Consider foods that are seasonal and save some money. Try to plan of ways to use the same food in a couple of meals or snacks. It will make budgeting, ordering and shopping for food quick and easy, and help staff plan time for cooking and preparing food. When planning a menu: • aim for a balance of nutritious foods and drinks from the five food groups as recommended and when possible have the children help in the planning.

Offer two courses at main meals and a drink with all meals and snacks – tap water is a good choice • choose appropriate foods according to: - budget and accessibility of foods - cooking/food preparation skills - food preparation time and equipment available.

Offer appropriate portion sizes for the different age groups

ONE DAY'S SAMPLE MEALS AND SNACKS

GRAIN -VEGGIE -FRUIT -MILK -MEAT

Breakfast -SAMPLE
1 small cup of 100% fruit juice, 1 slice of toast, and 1 bowl of fortified cereal with milk.

Mid-Morning Snack -Sample
2 squares of graham crackers, and a small cup of milk

Lunch - Sample
1 serving of meat (beef or, poultry, or fish) a small bowl of macaroni, 1 serving of vegetable, and 1 cup of milk

Mid-Afternoon Snack –Sample
A few whole grain crackers, a small amount of peanut butter, and a cup of cold water

Dinner
1 serving of meat (beef, or poultry, or fish) 1 serving of potato, 1 serving of broccoli, a piece of cornbread, and a cup of milk.

All serving should be served family style so children can serve the amount and what they would like to eat.

Feeding Infants and Toddlers in Child Care

- Promote breastfeeding in the child care setting.
    1. Welcome families and let them know that your childcare program wants to support the family to continue to breastfeed their child.
    2. Work with the parents to plan for infant feeding and try to schedule the drop off and pick up around the breastfeeding of the infant.

3. Create a safe private area where Mother's feel comfortable to come a breastfeed their child.
4. Develop feeding policies.
5. Encourage Mother's to breastfeed their babies until at least 12 months of age
6. Encourage Mother's that must return to work, to continue breastfeeding by expressing the breast-milk on the job.

Child Care Food Program (CACFP) meal patterns for infants

Dietary Guidelines for Americans, scientific recommendations from the National Academy of Medicine, and stakeholder input. CACFP centers and day care homes must comply with the updated meal patterns by October 1, 2017.

This updates the meal pattern requirements for the Child Care Food Program to better align them with the Dietary Guidelines for Americans, as required by the Healthy, Hunger-Free Kids Act of 2010.
This rule requires centers and day care homes participating in the Child Care Food Program to serve more whole grains and a greater variety of vegetables and fruit, and reduces the amount of added sugars and solid fats in meals.

Solid foods are introduced at 6 months of age with the flexibility to introduce solid foods before and after 6 months when requested by a parent or guardian. Allows cheese, cottage cheese, and yogurt.

https://www.fns.usda.gov/cacfp/meals-and-snacks

The updated CACFP meal patterns lay the foundation for a healthy eating pattern for children in care. USDA also developed optional best practices that build on the meal patterns and highlight areas where centers and day care homes may take additional steps to further improve the nutritional quality of the meals they serve. The best practices reflect recommendations from the Dietary Guidelines for Americans and the National Academy of Medicine to further help increase participants' consumption of vegetables, fruits, and whole grains, and reduce the consumption of added sugars and saturated fats**.**

Infants
Support mothers who choose to breastfeed their infants by encouraging mothers to supply breastmilk for their infants while in day care and offer a quiet, private area that is comfortable and sanitary for mothers who come to the center or day care home to breastfeed.
Vegetables and Fruit
Make at least 1 of the 2 required components of a snack a vegetable or a fruit.
Serve a variety of fruits and choose whole fruits (fresh, canned, dried, or frozen) more often than juice.

Provide at least one serving each of dark green vegetables, red and orange vegetables, beans and peas (legumes), starchy vegetables, and other vegetables once per week.

Grains
Provide at least two servings of whole grain-rich grains per day.
Meat and Meat Alternates
Serve only lean meats, nuts, and legumes.

Limit serving processed meats to no more than one serving per week.

Serve only natural cheeses and choose low-fat or reduced fat-cheeses.

Milk
Serve only unflavored milk to all participants. If flavored milk is served to children 6 years old and older, or adults, use the Nutrition Facts Label to select and serve flavored milk that contains no more than 22 grams of sugar per 8 fluid ounces, or the flavored milk with the lowest amount of sugar if flavored milk within this sugar limit is not available.

https://fns-prod.azureedge.net/sites/default/files/cacfp/CACFP_MealBP.pdf

https://fns-prod.azureedge.net/sites/default/files/cacfp/CACFP_factBP.pdf

- Phase-in solid foods, advancing texture as appropriate and in consultation with parents, not independently.
    1. When an infant is ready a plan should be developed, and discussed with the parents. Once a plan is developed and approved by the parent's soft food other than breast-milk or formula should be added to the child's diet and it is recommended that complementary foods rich in iron should be added starting at around 6 months.
    2. Infant cereal made from rice or barley.
    3. The cereal should have introduced gradually and one at a time.
    4. Each time a new food is introduced wait a few days before adding another.
    5. Monitor the baby for a reaction such as gas, diarrhea or diaper rash.
    6. After cereals have been successful introduced we can start introducing pureed vegetables and fruits, one at a time and watch for a reaction such as gas, diarrhea or diaper rash.
    7. Once an infant begins teething, chewable finger foods can be given care should be given to prepare foods so they are not choking hazards.

Safely feed human milk in the child care setting:

The following are guidelines for storing breast milk:

- Breast milk should be in a ready-to-feed bottle to avoid exposure and spills.
- Label bottles of breast milk brought to the center with the child's name and date, if your

facility is caring for more than one bottle-fed infant.
- Promptly refrigerate.
- Use breast milk on the day it is brought into the program.
- Throw away all milk not used within 24 hours.
- Never give breast milk intended for one child to another.

- Creating a place for breastfeeding moms to nurse their children in your child care home or center. The Mother and infant should a private area so the Mother is comfortable and does not feel she is in the way we want to promote mothers to breastfeed their infants.
- Infants should be breastfed or bottle feed when they show signs being hungry verses on a schedule so as to not encourage over eating.
- Breast- or bottle-fed babies can be weaned to a cup. Discuss with parents first and develop a plan, and get permission from the parents to use a cup. Have the parents supply the type of cups they want the infant use and introduce very small amounts of liquid in the cup.

Appropriate portion sizes for feeding babies (see these links for the correct portions for infants:
http://www.fns.usda.gov/sites/default/files/feeding_infants.pdf
http://www.dhcs.ca.gov/formsandpubs/publications/CaliforniaFoodGuide/9InfantFeeding0-12months.pdf

- Safe storage of breast milk and formula in refrigerator 40 degrees or lower.
- Formula preparation – the importance of adhering to instructions. The importance of not adding ingredients to a baby's formula.)
- Once a baby is over 12 months of age with the permission of the parents, babies should be offered small amounts of water several times a day and whole juices once a day.

Infant Feeding

General Guidelines

Feeding infants takes some extra care and preparation. Always wash your hands and utensils before handling breast milk, infant formulas, and foods. Be sure to follow directions on packages regarding expiration dates and preparations.

Breast Milk

Breastfeeding provides numerous health benefits to young infants, including protection against infectious diseases caused by bacteria, viruses and parasites. It is an ideal source of infant nutrition, largely uncontaminated by environmental pathogens, and reduces some of the risks that are greater for infants in group care such as diarrhea, lower respiratory disease, otitis media, and SIDS. Breast milk is the best food to meet the nutritional needs of an infant from birth until 4 to 6 months of age.

The clear advantage of breast milk over any formula requires child care providers to promote

breastfeeding for working mothers who are willing to nurse their babies and if necessary expressing and supply their breast milk to child care facilities. Like formula, it is important to store breast milk carefully so it does not spoil.

Breast milk may appear thinner, paler or even bluish in color compared to formula. This is normal. If it has been stored properly, it is completely safe and very nutritious for the infant.

Previously frozen breast milk that has been thawed in the refrigerator must be used within 24 hours or discarded. **Do not refreeze** previously frozen breast milk.

Care should be taken to wash hands and feeding tools (bottles, spoons etc., before and after handling human milk.

Care should be taken that all human milk is labeled with the child's name and date expressed so as to avoid errors.

Proper Handling and Storage of Human Milk

Safely Preparing and Storing Expressed Breast Milk

- Be sure to wash your hands before expressing or handling breast milk.
- When collecting milk, be sure to store it in clean containers, such as screw cap bottles, hard plastic cups with tight caps, or heavy-duty bags that fit directly into nursery bottles. Avoid using ordinary plastic storage bags or formula bottle bags, as these could easily leak or spill.
- If delivering breast milk to a child care provider, clearly label the container with the child's name and date.
- Clearly label the milk with the date it was expressed to facilitate using the oldest milk first.
- Do not add fresh milk to already frozen milk within a storage container. It is best not to mix the two.
- Do not save milk from a used bottle for use at another feeding.

Safely Thawing Breast Milk

- As time permits, thaw frozen breast milk by transferring it to the refrigerator for thawing or by swirling it in a bowl of warm water.
- Avoid using a microwave oven to thaw or heat bottles of breast milk
  - Microwave ovens do not heat liquids evenly. Uneven heating could easily scald a baby or damage the milk
  - Bottles may explode if left in the microwave too long.
  - Excess heat can destroy the nutrient quality of the expressed milk.
- Do not re-freeze breast milk once it has been thawed.

If expressed human milk is given to another child: Breast milk from a mother is specific to her own child and should be used only with the intended child. Risk of HIV transmission from breast milk that another child has drunk is believed to be low.

However, if one child is mistakenly fed another child's bottle, or one child fed from a bottle that another child has dropped or put down, this should be seen as an accidental exposure to a potential

HIV-contaminating body fluid. In such cases providers should:

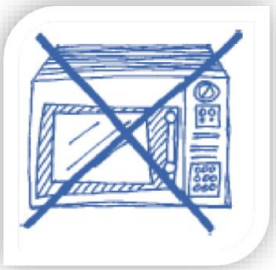
a. Inform the parents of the child who was given the wrong bottle and notify the child's health care provider of the exposure. This is so they may have baseline testing for HIV.
b. Inform the mother who supplied the breast milk and ask if she has ever had an HIV test and, if so, would she be willing to share the results with the parents of the exposed child.
c. Complete and submit an Unusual Incident Report to Community Care Licensing by using licensing form Lic 624 for child care center or 624 B for child care homes to report the accidental exposure.
d. Besides the Unusual Incident Report – the child care provider must also call the licensing agency by telephone in order to report the incident by the next work day.

Formula

It is important for the infant's health that formula be prepared correctly and stored safely. Spoiled formula can make infants very sick.

Clean the following before preparing formula

- The counter or work area
- A bottle that was not well cleaned
- Unclean water used to make the formula
- Formula stored too long
- A bottle left at room temperature



Concentrated and powdered infant formula should be sent from the child's home in its original factory-sealed container and prepared according to package directions. To prevent illness from shared bottles or giving incorrect formula, label each child's bottles and formula with the child's name and the date the formula was prepared. Refrigerate the bottles as soon as they arrive or are made. Prepared formula that has not been given to an infant may be stored in the refrigerator for 24 hours to prevent bacterial contamination and discard prepared formula within 1 hour after serving to an infant.

Do not warm infant formula or breast milk in microwave oven.

Reading Ingredient Lists to Learn about Foods before Purchase

- Watch for the word, "hydrogenated" in the ingredient list.
- Choose products made with vegetable oils that are not hydrogenated and do not contain trans fats.
- Instead of butter, lard, margarine, and shortening, cook with oils that are not hydrogenated, such as olive oil, and coconut oil
- Do this with the children, if possible, teach them what you are looking for in the labels and ask them to determine what food group the product should be in (fruit, veggie, dairy, meat or other).
- What is the main food it the product according to the label.
- Calories is the product and serving size according to the label

Here are some tips for making the most of the information on the Nutrition

Facts label:

On May 20, 2016, the FDA announced the new Nutrition Facts label for packaged foods to reflect new scientific information, including the link between diet and chronic diseases such as obesity and heart disease. The new label will make it easier for consumers to make better informed food choices. FDA published the final rules in the Federal Register on May 27, 2016.

Highlights of the Final Nutrition Facts Label

Compliance Dates

Original Vs New Label

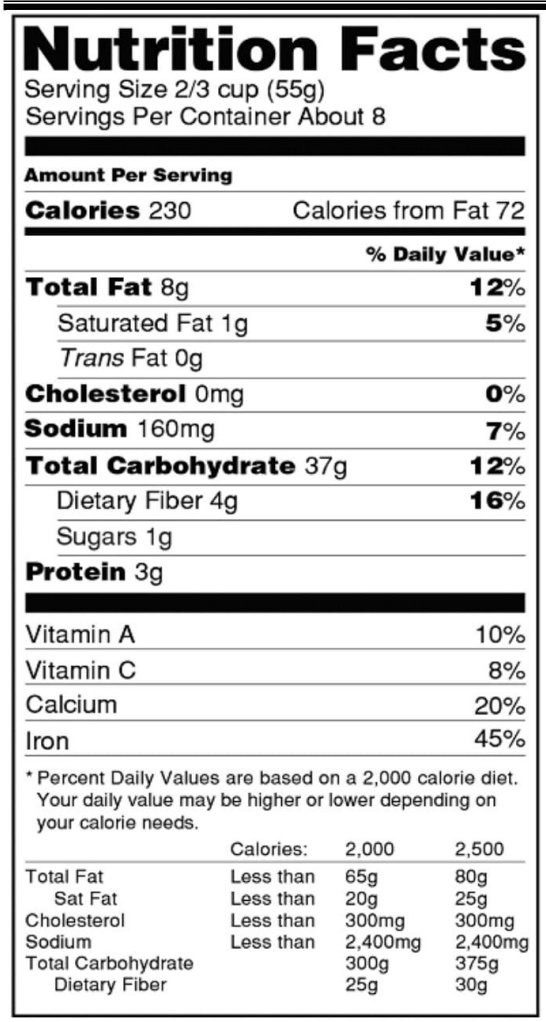
Questions & Answers

Label Format Examples

Bilingual Label

For Industry

Original vs. New Format - Infographics to Help Understand the Changes



Nutrition Facts

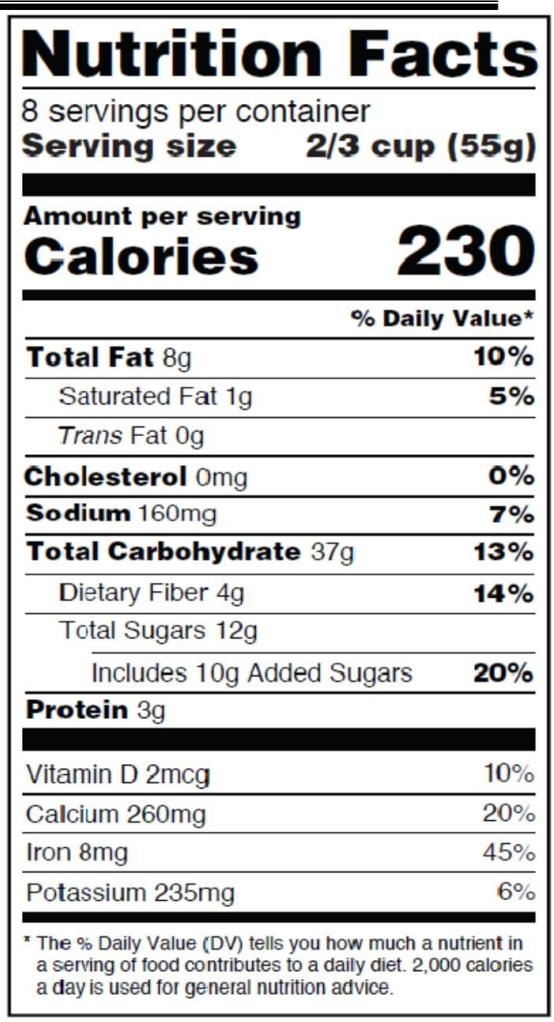
Serving Size 2/3 cup (55g)
Servings Per Container About 8

Amount Per Serving

Calories 230	Calories from Fat 72
	% Daily Value*
Total Fat 8g	**12%**
Saturated Fat 1g	**5%**
Trans Fat 0g	
Cholesterol 0mg	**0%**
Sodium 160mg	**7%**
Total Carbohydrate 37g	**12%**
Dietary Fiber 4g	**16%**
Sugars 1g	
Protein 3g	
Vitamin A	10%
Vitamin C	8%
Calcium	20%
Iron	45%

* Percent Daily Values are based on a 2,000 calorie diet. Your daily value may be higher or lower depending on your calorie needs.

	Calories:	2,000	2,500
Total Fat	Less than	65g	80g
Sat Fat	Less than	20g	25g
Cholesterol	Less than	300mg	300mg
Sodium	Less than	2,400mg	2,400mg
Total Carbohydrate		300g	375g
Dietary Fiber		25g	30g



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Trans Fat 0g	
Cholesterol 0mg	**0%**
Sodium 160mg	**7%**
Total Carbohydrate 37g	**13%**
Dietary Fiber 4g	**14%**
Total Sugars 12g	
Includes 10g Added Sugars	**20%**
Protein 3g	
Vitamin D 2mcg	10%
Calcium 260mg	20%
Iron 8mg	45%
Potassium 235mg	6%

* The % Daily Value (DV) tells you how much a nutrient in a serving of food contributes to a daily diet. 2,000 calories a day is used for general nutrition advice.

https://www.fda.gov/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/LabelingNutrition/ucm385663.htm

The Importance of teaching children about Nutrition

Teach children about nutrition in fun creative ways limit lectures, use hands-on activities reading labels and talking about what is in our foods and what each ingredient does for our bodies. Integrate the children in helping to plan meals and snacks. Do role playing activities planning meals, preparing meals, and shopping. Visit stores if not possible teach them what the childcare provider is looking for in nutrition and take the children when possible on a field trip to Farmers Markets to help teach them about different seasonal fruits and vegetables. Plan and start a garden with the children this will also help teach them about seasonal fruits and vegetables. The more the children

learn about nutrition the more likely they take ownership of their diets and eating habits. Children that understand the value of different healthy foods are more likely to try new foods and eat these foods at home.

Information about the CACFP

- The CACFP is a state government-run program that has resources to help child care providers prepare high quality meals to improve health and nutrition, promote a healthy lifestyle, and reduce diseases related to unhealthy eating. The CACFP can provide ideas for recipes, menu planning, food preparation, and nutrition education.
- State CACFP workers can provide you with ideas for feeding children in a fun way and for fun physical play activities for you to do with the children in your care.
- Consider enrolling in the CACFP. For those child care providers who enroll in the program, the CACFP can provide subsidies for the purchase of healthy food that is served in a child care program. This program will teach you about healthy eating and feeding. This can help you, your family, and the children in your care!
- Provide the web address for the California CACFP program:
  a) For information on how you can receive CACFP assistance for your child care program meals and snacks, visit the federal website at http://www.fns.usda.gov/cacfp/child-and-adult-care-food-program
  b) And you may also visit the California website for CACFP at http://www.cde.ca.gov/ls/nu/cc/
- When you contact the California CACFP, you will find out if you are eligible for the program. They will explain the program and answer your questions. They will help you to learn how to enroll in the program, and will help you with the forms that are necessary to enroll.
- The referral telephone number for the California CACFP is **916-327-6466**.

Childcare Staff should be Role Models for Healthy Eating

The child care staff can be great role models for the children in healthy eating while children are in the child care environment. Child care staff can eat healthy foods including lots fruits and vegetables to encourage children what, when, why and how much they should eat. The childcare staff can try a variety of different foods and encourage children to try them as well. The child care staff can encourage children to try new foods, with different colors, and with different textures again by eating them with the children at meal times. Child care staff can teach children by example how to read labels, and plan meats. Child care staff can show by example portion serving size and proper table manners by eating with the children and eating the same foods. Child care staff can drink healthy beverages including lots of water to encourage children what, when, why and how much they should drink. Children and their eating habits can be greatly influenced by the examples they see from the child care staff.

The division of responsibility

The division of responsibility means - which the child care provider chooses which healthy foods

to prepare and offer to children, when and where to provide the food and children choose what and how much they will eat from the foods.

- Allow children to serve themselves: they choose what they want from what you serve. They choose what portions to put on their plates, and they decide when they are "full."
- Child care providers eat with the children at a communal table.
- Offer a variety of foods from each of the food groups (fruits and vegetables, meat and meat alternatives, grains including whole grains, and dairy products.)
- Colorful foods with varying textures appeal to children's palates.
- Encourage children to taste a new food, but do not force or reward children to eat or to clean their plates. It is normal for children to dislike some foods and favor others.
- Children may need to be introduced to a new food 10 to 20 times before they accept it.
- Planning menus helps to provide a healthy variety of foods to children, and can help save money.

Family-Style Meal Service
State of Arizona video on Family Style Meals

https://www.youtube.com/watch?v=nj_s89ydnBs

Have foods served is bowls on the table and have all children sit at the table as a family. Each child helps (with supervision) serve how much and of what items on they will eat. The childcare staff also sits at the table as role models.

Family Style eating will help teach children

- This will help children to learn and practice social skills.
- Encourage children to try new foods
- Encourage children to talk about the foods a nutrition
- The benefits of family style meal service are: it helps children self-regulate the amount eaten, provides more opportunity for provider to talk about food, allows for more trying of new foods, allows for more modeling of positive eating, and provides for socialization and development of fine motor development.
- Using child-size serving utensils facilitates family style meal service.
- Children to serve themselves from communal serving dish or bowl.

Writing Policies Regarding Feeding Children in Child Care

A policy is a written course of action that is enforced. Policies are established to guide and determine present and future decisions.

The childcare providers may want to develop policies for example:

Snacks and Foods coming from home
Children with allergies
Choking hazard foods
High sugar foods
Sweetened drinks

- Written nutrition policies can help child care staff to provide healthier meals and snacks to the children in their care.

    - Use polices that make sense for your facility and talk with your staff and parents when developing the polices.

    - The policy should clearly state the policy
    - The purpose of the policy
    - How it is to be enforced
    - What will happen if the policy is not followed
    - Who is assigned special actions in the policy

- Writing policies can help child care providers understand what will be served and how it will be served in the child care program.
- Written policies should be shared with all staff that provides care to children.
- Written policies should be shared with the children's families; families need to understand what will be followed in their child's care setting, including what types of foods can be brought into the child care environment for meals, snacks, and celebrations. This is especially important to keep children with food allergies and special dietary needs safe in the child care setting. Policies can also help families learn new information.
- Written policies help new staff learn about the responsibilities in the child care setting and also what they are expected to do regarding feeding the children in their care.

Sample Childcare Center Breastfeeding Policy

Because breastfeeding has been shown to be the best form of infant nutrition, providing a multitude of health benefits to both infant and mother, and because breastfeeding employees need ongoing support from childcare providers to provide their milk for their babies.

_____subscribes to the following policy: (Insert facility name)

1. Breastfeeding mothers shall be provided a place to breastfeed or

express their milk.

Breastfeeding mothers, including employees, shall be provided a private and sanitary place to breastfeed their babies or express milk. This area will have an electrical outlet, comfortable chair, and nearby access to running water.

2. A refrigerator will be made available for storage of expressed breast milk.

Breastfeeding mothers and employees may store their expressed breast milk in the center refrigerator. Mothers should provide their own containers, clearly labeled with name and date.

3. Sensitivity will be shown to breastfeeding mothers and their babies.

The childcare center is committed to providing ongoing support to breastfeeding mothers, including providing an opportunity to breastfeed their baby in the morning and evenings, and holding off giving a bottle, if possible, when mom is due to arrive. Artificial baby milks (formula) and solid foods will not be provided unless the mother has requested. Babies will be held closely when feeding and bottles will never be propped.

4. Staff shall be trained in handling human milk.

All childcare center staff will be trained in the proper storage and handling of human milk, as well as ways to support breastfeeding mothers. The center will follow guidelines from the American Academy of Pediatrics and Centers for Disease Control in ensuring that breast milk is properly treated to avoid waste. Special precautions are *not* required in handling human milk.

Storage Guidelines for Human Milk:
http://www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.htm
http://www.healthychildren.org/English/ages-stages/baby/breastfeeding/pages/Storing-and-Preparing-Expressed-Breast-Milk.aspx

5. Breastfeeding employees shall be provided flexible breaks to accommodate breastfeeding or milk expression.

Breastfeeding employees shall be provided a flexible schedule for

breastfeeding or pumping to provide breast milk for their children. The time allowed would not exceed the normal time allowed to other employees for lunch and breaks. For time above and beyond normal lunch and breaks, sick/annual leave may be used, or the employee can come in a little earlier or leave a little late to make up the time.

Food Allergies

Some foods can trigger an allergic reaction by the immune system. Foods that are common allergens include peanuts, tree nuts (walnuts, pecans, etc.), shellfish, fish, milk, soy, wheat and eggs. If a child in your care has a nut allergy, you must have an Auto injector (EpiPen or similar device) available at all times. A care plan from the child's health provider, plus training on how to use the Auto injector from a public health nurse, the child's health provider, or the parent is also required. For more information regarding allergies, visit www.emsa.ca.gov/childcare_nutrition for more information.

Children with food allergies can pose challenges for parents and child care providers alike. Allergies of all kinds are the most frequent chronic disease found in child care. The Food Allergy Network reports that approximately 2 percent of the general population suffers from food allergies. That means 6 to 7 million Americans suffer some type of reaction to the foods they eat.

Which foods are the most common allergens?

Eight foods account for the majority of allergic reactions:

- peanuts
- fish
- shellfish
- eggs
- milk
- soy
- wheat
- Tree nuts (walnuts, pecans, etc.)

For allergic reactions refer to EMSA Licensed Childcare Pediatric CPR and First Aid training for emergency treatment and the use of an auto injector

Practicing food safety in order to provide healthy and safe meals to children in child care.

Always buy health foods in good condition and properly store the foods

- Keep all foods that can spoil in the refrigerator or freezer until you're ready to cook them.
- Return all leftovers to the refrigerator immediately after cooling.
- Keep fresh fruits and vegetables away from raw meat, poultry, or seafood while shopping, washing, preparing, or storing them.
- Cook foods to the proper temperatures.
- Don't rinse raw fish, seafood, meat, or poultry, as this can spread germs to sinks, kitchen surfaces, cooking utensils, and other foods.
- Quickly store fresh vegetables and fruits that can rot—put them in the refrigerator at 40 degrees or below. (Be aware that there are some fruits (such as bananas) and vegetables (such as tomatoes) that may rot more quickly if placed in the refrigerator.
  For more information go to www.emsa.ca.gov/childcare_nutrition

Food-Borne Illness

Food-borne illnesses are wide-spread and making headlines. Because a small dose of infectious or toxic materials can lead to serious illnesses among children, food safety is an increasingly important issue for parents and caregivers, particularly those looking after young children.

What is a food-borne illness?

A food-borne illness is a disease caused by ingesting food or drink contaminated by microbes, chemicals or toxins. Every person is at risk for food-borne illness, but young children, pregnant women, elderly people, persons with liver disease, and those with weakened immune systems are at a higher risk.

Food-Borne Disease

Contaminated food products are linked with a large number of illnesses and deaths in people of all ages. However, children and especially those with weak immune systems are particularly at risk of illness from a lot of food-borne germs. To reduce the risk of infection and disease from eating contaminated food products, the American Academy of Pediatrics' Committee on Infectious Diseases recommends the following preventive measures:

Unpasteurized milk and cheese. Children should not drink unpasteurized milk or eat unpasteurized cheese. Pasteurization is a method of preserving food by heating it to a certain point which will kill off harmful organisms but will not harm the flavor or quality of the food. This technique is mostly used with milk, fruit juices, cheeses and egg products. The American Academy of Pediatrics strongly endorses the use of pasteurized milk and recommends that parents and public health officials are fully informed of the important risks associated with consumption of unpasteurized milk.

Eggs. Children should not eat raw or undercooked eggs, unpasteurized powdered eggs, or products containing raw eggs. Ingestion of raw or improperly cooked eggs can produce severe salmonella disease.

Raw and undercooked meat. Children should not eat raw or undercooked meat or meat products, as they have been associated with disease. Knives, cutting boards, utensils, and plates used for raw meats should not be used for preparation of any food until the utensils have been cleaned properly. Do not place cooked or barbecued meat back onto the plate that held the raw meat.

Unpasteurized juices. Children should only drink pasteurized juice products unless the fruit is washed and freshly squeezed (e.g. orange juice*)* immediately before consumption. Consumption of packaged fruit and vegetable juices that have not undergone pasteurization or a comparable treatment has been associated with food-bome illness due to *E. coli* O157:H7 and salmonella species.

Alfalfa sprouts. The FDA and the Centers for Disease Control and Prevention have reaffirmed health advisories that persons who are at high risk for severe food-borne disease, including children, persons with compromised immune systems and elderly persons, should avoid eating raw alfalfa sprouts until intervention methods are implemented to improve the safety of these products.

Fresh fruits and vegetables. Many fresh fruits and vegetables have been associated with disease because of contamination. All fruits and vegetables should be cleaned before eating. Knives, cutting boards, utensils, and plates used for raw meats should not be used for preparation of fresh fruits or vegetables until the utensils have been cleaned properly.

Raw shellfish and fish. Many experts recommend that children should not eat raw shellfish, especially raw oysters. Some experts caution against children eating raw fish. Raw shellfish, including mussels, clams, oysters, scallops and other mollusks, have been associated with many germs and toxins.

Honey. Children younger than one year of age should not be given honey unless the product has been certified to be tree of *Clostridium botulinum* spores.

How does food become contaminated?

We live in a microbial world with many opportunities for food to become contaminated as it is produced, processed, stored and prepared. Bacteria may already be present on products such as raw meat, poultry, seafood, and eggs when you purchase them. Even safely cooked foods can become cross-contaminated with raw products, meat juices or other contaminated products. Common food handling practices that contribute to food-borne illnesses include improper cooling, a lapse of 12 or more hours between preparation and eating, handling of foods by infected persons, inadequate reheating, contaminated raw food or ingredients, food from unsafe sources, improper cleaning of equipment and utensils, and inadequate cooking.

What causes food-borne illnesses?

While a good number of more than 250 different recognized food-borne diseases are caused by a variety of bacteria, viruses and parasites, others are caused by harmful toxins or chemicals that have contaminated the food. Foods most often implicated in food-borne illness outbreaks include meat and poultry, eggs and egg products, milk and milk products (including pastries with cream or custard filling), and home-canned and low-acid foods such as vegetables and meats.

What are the symptoms?

It may take from hours to days to develop symptoms of illness after a person has consumed contaminated food or drinks. This period is called the incubation period. Nausea, vomiting, abdominal cramps and diarrhea are usually the first symptoms in many food-borne diseases. However, symptoms will vary according to the type and amount of microbes and may include fever, headache, severe exhaustion, and sometimes blood and pus in the stools. Symptoms usually last a day or two, but in some cases can continue for a week to 10 days. Different kinds of food-borne diseases may require different treatment depending on the symptoms they cause. Many food-borne illnesses will improve in two to three days without any medicine, and illnesses caused by viruses do not require antibiotics.

When should I seek medical help?

Seek medical help if:

- Diarrhea lasts more than three days.
- Vomiting lasts longer than 12 hours.
- There is blood in the stool.
- High fever (temperature that is over 101.5º F measured orally) is present.
- Vomiting and diarrhea are causing severe abdominal cramps.
- Signs of dehydration (such as dry mouth, decrease in urination, and feeling dizzy when standing up) are present.

How can I avoid food-borne illnesses?

Food safety involves proper food purchasing, food storage, handling and cooking. A few simple precautions can prevent food from spreading illnesses:

- ***Clean.*** Wash hands and surfaces often.
- ***Separate.*** Do not cross-contaminate.
- ***Chill.*** Refrigerate promptly.
- ***Cook.*** Cook to proper temperatures.

Food Safety

Poor food preparation, handling, or storage can quickly result in food being contaminated with germs, and may lead to illness if eaten. To prevent food from spreading illness, you can do some very simple things.

When You Purchase Food

- Don't buy food in poor condition. Make sure that refrigerated food is cold to the touch, frozen food is rock-solid, and canned goods are free of dents, cracks or bulging lids.

- Check the "use by," "sell by" or "expiration date" on foods before purchase.
- Be sure that the meats and poultry you purchase have been inspected and passed for wholesomeness by federal or state inspectors.
- Keep packages of raw meat separate from other foods, particularly foods that are eaten fresh.
- Use only pasteurized milks, milk products and fruit juices.
- Do not use home-canned foods.
- Shop for meat, fish, poultry and cold food last. Take foods straight home to the refrigerator. Never leave food in a hot car.

When You Store Food

- Store all perishable foods at temperatures that will prevent spoilage (refrigerator temperature, 40° F or lower, and freezer temperature, 0° F or lower.)
- Have a working thermometer to monitor the temperature in the refrigerator and freezer.
- Set up refrigerators so that there is enough shelf space to allow for air circulation around shelves and refrigerator walls. This will help maintain proper food temperatures.
- Always examine food when it arrives to make sure it is not spoiled, dirty or infested with insects.
- Store unrefrigerated foods in clean, rodent and insect-proof covered metal, glass or hard plastic containers. (Large shortening cans available from bakeries are ideal for storing flour and other commodities.)
- Store containers of food above the floor (at least 6") on racks or other clean slotted surfaces that permit air circulation.
- Keep storerooms dry and free from leaky plumbing or drainage problems. Repair all holes and cracks in store rooms to prevent insect and rodent infestation.
- Keep store rooms cool (about 60° F) to increase the food's shelf life.
- Store all food items separately from non-food items.
- Use an inventory system: the first food stored is the first food used. This will ensure that stored food is rotated.
- Pay close attention to expiration dates, especially on foods that spoil easily (dairy products, mayonnaise).

When You Prepare Food

Keep everything clean by following these hygiene procedures:

- Wear clean clothes, maintain a high standard of personal cleanliness, and carry out strict hygiene procedures during working hours.
- Wash hands carefully and thoroughly before preparing and serving food.
- Keep hands clean while handling food, surfaces, dishes and utensils.
- Do not prepare or serve food while ill with a communicable disease.
- If possible, do not diaper children or assist with toileting when you are handling food.
- Wash all raw fruits and vegetables before use.
- Wash tops of cans before opening.
- Keep work surfaces, utensils, towels, dish cloths and appliances clean.

Thaw frozen meat, poultry or fish in the refrigerator (or put quick-thaw foods in plastic bags under cold running water for immediate preparation).

- Do not thaw frozen foods by allowing them to stand at room temperature.
- Keep raw meat and poultry (and their juices) away from other food and preparation surfaces to avoid spreading bacteria in the kitchen.

Cook thoroughly! Use a meat thermometer to check internal temperatures to be sure food has been cooked evenly.

- Use a thermometer to check the cooked temperature of poultry, stuffing (cook in separate pan from poultry or meat) and pork and pork products (minimum of 165°F).
- Heat foods to 140° F
- Never reuse a spoon for cooking that was used for tasting.
- Cut food into pieces smaller than 1/4 inch for infants and 1/2 inch for toddlers.
- Prepare these foods as quickly as possible once removed from a refrigerator, serve them immediately, and refrigerate leftovers immediately:
  - Meat salads, poultry salads, egg salads, seafood salads and potato salads
  - Cream-filled desserts or puddings
  - Other prepared foods containing milk, meat, poultry, fish and/or eggs

When You Serve the Food

- Serve food promptly after preparation or cooking. Keep hot foods hot and cold foods cold.
- Serve food on a table that was cleaned and disinfected before use. Use clean or disposable plates, cups and utensils.
- Make sure that all children and adults wash their hands before serving and eating food.
- Do not allow children to share food or drinks.
- Do not serve food or drinks in dishes which might contain lead.

When You Handle the Leftovers

- Refrigerate leftovers immediately or discard. Prevent the growth of bacteria by keeping foods at temperatures lower than 40° F or higher than 140° F during transportation and while holding until served.
  (Bacteria multiply most rapidly between 40° F and 140° F.)
- Cover or completely wrap foods during transportation.
- Never reuse a spoon that has been used even once for tasting.
- Reserve food for second servings at safe temperatures in the kitchen.
- Leftover food from serving bowls on the table must be thrown away with these possible exceptions:
  - Raw fruits and vegetables that can be thoroughly washed
  - Packaged foods that do not spoil
- Place foods to be stored for reuse in shallow pans and refrigerate, or freeze immediately to rapidly bring temperature to 40° F or lower.
- Leftovers or prepared casseroles held in the refrigerator must be discarded after two days.
- Leftover foods should not be sent home with children or adults because of the hazards of bacterial growth during transport.
- Keep lunches brought from home in the refrigerator until lunch time.

When You Clean and Care for Equipment

Provide easy-to-clean equipment and utensils.

- Use food contact surfaces and utensils that are easy to clean, nontoxic, corrosion-resistant, and non-absorbent.
- Use disposable articles that are made of non-toxic materials. Do not reuse disposable articles.
- Install appliances so that they, and the areas around them, can be cleaned easily.
- Be sure food contact surfaces are free of cracks and crevices, pots and pans are free of pits and dents, and plates are free of chips and cracks. Cracks in any surface can hold germs.

Wash equipment frequently

- Clean range tops during food preparation as needed and on a daily basis.
- Clean ovens and overhead hoods at least weekly.
- Wash the inside and outside of refrigerators weekly with bleach solution. Defrost when ice is 1/4" thick.
- Wash tables with bleach solution before and after each meal.

Air-dry all food contact surfaces after cleansing and sanitizing. Do not use reusable wiping cloths.

Make sure that food contact surfaces and utensils are kept clean.

- Cloths used for wiping counters and tables should not be used for anything else.
- Scrape and presoak dishes, pots, pans and utensils, if necessary, to remove food particles before washing.
- Wash highchair trays, bottles and nipples in a dishwasher, if available. If the trays do not fit in the dishwasher, wash in detergent, rinse, spray with bleach solution, and air dry.
- Use the proper concentration of suitable detergent for hand and machine dishwashing, according to package directions.

When You Are Hand Washing Dishes

The best way to wash, rinse and disinfect dishes and eating utensils is to use a dishwasher. If a dishwasher is not available or cannot be installed, a three-compartment sink will be needed to wash, rinse and disinfect dishes. A two-compartment or one-compartment sink can be used by adding one or two dishpans, as needed. In addition, you will need a dish rack with a drain board to allow dishes and utensils to air dry.

It is best to use running water to rinse, because if you use a dishpan for rinsing, the water in this pan will be contaminated after the first dish is rinsed.

To *wash, rinse and disinfect dishes by hand:*

- Fill one sink compartment or dishpan with hot tap water and dishwashing detergent.
- Fill the second compartment or dishpan with hot water.
- Fill the third compartment or dishpan with hot tap water and 1 tablespoon of liquid chlorine bleach for each gallon of water.
- Scrape dishes and utensils, and dispose of excess food.
- Dip scraped dish or utensil in the first sink compartment and wash thoroughly.
- Rinse dish or utensil in the second dishpan of clear water.
- Dip dish or utensil in the third dishpan of water and bleach solution for at least one minute.
- Place the dish or utensil in the rack to air-dry.
- Pick up and touch clean spoons, knives and forks only by the handles, not by any part that will be in contact with food.
- Handle clean cups, glasses and bowls so that fingers and thumbs do not touch the inside or the lip.

Food preparation and dishwashing sinks should only be used for these activities, and should not be used for routine hand washing or diaper-changing activities.

Note: If you do not have adequate facilities for cleaning and sanitizing dishes and utensils, use only disposable items.

Kitchen Safety Basics

Here's where the hazards can occur and how to minimize the risks

For young children, the kitchen is a compelling place: Parents are bustling around, pulling colorful items from refrigerators and cupboards. Things are going on out of a toddler's sight on counters and stoves, and he wants to see and participate.

The combination of all this activity, your child's innate curiosity, and your sometimes-divided attention means that it's especially important to childproof the kitchen. Here's where the hazards can occur and how to minimize the risks:

General Safety

- **Check for sharp edges and corners** where children could bang heads or injure their eyes. Install protective guards or cushioning.
- **Secure all knobs and handles.**
- **Seal off all electrical outlets with safety plugs.**
- **Keep floor skid-proof.** Use nonskid rugs. Wipe up spills immediately.
- **Install safety latches** on all cabinets and cupboards with contents that could pose risks to children.
- **Keep spices out of children's reach.** Many are toxic.
- **Use a child-resistant garbage can** or keep your trash behind closed doors in a locked cabinet.
- **Dispose of plastic bags safely** by tying each in a knot before throwing it in the trash.
- **Keep aluminum foil, waxed paper, and plastic wrap dispensers away from children.** The serrated edges on the boxes can cut little fingers.
- **Don't leave small objects that could pose choking hazards within striking range of little fingers.** That includes toothpicks, rubber bands, and paper clips, as well as food.
- **All alcohol should be securely stored out of a child's sight and reach.** After a party, make sure to empty all glasses.

Here's how to childproof your appliances.

Stove

- **Make sure stoves, ovens, and burners are in good working order.** If fueled by gas, regularly check that there are no leaks and that the pilot lights function properly.
- **Use back burners whenever possible.** Some of the most common accidents occur when a child reaches up and grabs a pot or pan, spilling the hot contents over himself. When it's necessary to use the front burners, turn all pot handles toward the back so they are not as easy to reach.
- **Keep flammable objects** such as curtains, towels, oven mitts and debris away from the stove.
- **Make sure handles on pots and pans are secure, not loose.** Tighten them if they are wobbly, or if they can't be fixed, throw the pots and pans out.
- **Place childproof covers on stove and oven knobs or remove knobs** entirely from the stove so that burners and oven cannot be turned on easily by a child. Knobs can be stored conveniently in a drawer on a shelf, out of your child's reach.
- **For extra safety, use a stove guard** that helps prevent little hands from touching hot surfaces.
- **Check for hot surfaces.** Some units are poorly insulated and the outside may get hot enough to cause

burns. Check the outside of your oven when it's at roasting temperature to make sure it's only warm, not hot, to the touch. If it does become too hot, install a safety gate at the kitchen during cooking times.

- **Always turn the oven off when not in use,** and never use it to heat a room.
- **Be careful of opening the door of a hot oven** when a child is standing by. He may try to touch the inside of the door, or may get a face full of very hot air.
- **Bolt the stove to the wall** if you have a low oven or broiler door so that the stove will not tip over should a child open the door and stand on it.

Refrigerator and Freezers

- **Use a childproof door latch:** Velcro or buckle type, to secure the door shut.
- **Remove refrigerator magnets.** Children can choke on small items, and colorful refrigerator magnets are particularly enticing.
- **Warn children not to touch ice-cold surfaces with their tongues.** Your child's tongue will stick to the surface.
- **For added precaution keep glass bottles and jars off easily accessible shelves** and never store batteries or film or other interesting inedible objects in the refrigerator.
- **Remove doors from old appliances** you are replacing as soon as the new ones arrive. Refrigerators as well as coolers, freezers, and other larger airtight appliances can entrap a child who many crawl inside and be unable to get out. Also, as soon as your child is old enough to understand, instruct her never to hide in any appliance.

Dishwasher

- **Never leave sharp implements including knives, inside the dishwasher.** No doubt, your child will see you placing dishware into and out of the dishwasher and will want to do the same. If you do place sharp utensils in the dishwasher, make sure they are pointed downwards during the cycle, and remove them as soon as they are washed. Also, remove breakable items immediately.
- **Use a childproof appliance latch for added protection.**

Small Appliances

- **Unplug toasters, blenders, coffee makers, food processors, and other small appliances** when not in use and store them out of the reach of children.
- **Use cord ties** to take up the slack in appliance cords so that the cords are less likely to dangle.
- **Never use a knife or other metal object to unclog a toaster.** This could cause electrocution. If something becomes lodged in a toaster, unplug it and wait a few moments before trying to extract it. Shake it loose, or use a wooden spoon to dislodge it.

Whether you have an eat-in kitchen or a separate dining room, observe the following:

- **Repair or dispose of rickety chairs.**
- **Shove chairs back in place flush against the table** when not in use. Don't let them stand out from the table where they may be treated as steps for a toddler to climb.
- **Secure tables with center pedestals.** Tables that have center pedestals rather than corner legs are more likely to topple over if a child's weight bears down on the sides. Teach your child never to lean on the table's edge.
- **Make sure tabletops are securely anchored to bases.**
- **Be wary of folding or collapsible tables and chairs.** Brace them so they are secure around children or remove folding tables and chairs when not in use.
- **Check for protruding nails, splintered wood, staples, sharp bolts, and jagged edges.** Get down on all fours and take a look at the undersides of your tables and chairs.
- **Place fine china, glassware, and other breakable items safely behind closed doors.**
- **Do not keep a cloth on the dining table.** Toddlers are likely to pull it – and everything on it – down off the table and on top of themselves.

Oral Hygiene

Oral hygiene is the practice of keeping teeth and gums healthy. With good oral hygiene, the teeth will be clean and the mouth will have a clean and sweet odor. The type of hygiene and oral/dental care children receive, such as exposure to preventive agents like dental sealants and fluoride, along with diet, will mostly determine their dental health throughout their lives.

How to Promote Oral Health

Your program can help prevent dental illnesses by serving well-balanced, nutritious food and by limiting sugary and sticky foods. You will be teaching preschool children dental health, helping them to brush their teeth, and encouraging parents to get regular dental care for their children.

1. *Healthy Food for Teeth:* Low-sugar, fresh fruit and vegetables make a great snack or dessert alternative. Food with high amounts of sugar is clearly linked to tooth decay. Germs in the mouth change the sugar in food to acid, which can eat a cavity in the tooth. Avoid or limit sweet drinks, candy, jelly, jam, cake, cookies, sugared gelatin, and sweetened canned fruit.

2. *Prevention of Baby Bottle Tooth Decay:* Baby Bottle Tooth Decay (BBTD) is one form of early childhood tooth decay which can result from the overuse of a baby bottle feeding of milk, formula, juices and soda. Babies should not be put to bed with a bottle at naptime or at night.

3. *Brushing Teeth:* Although it is often difficult, brushing teeth in the child care setting helps children to develop good habits. To brush teeth properly and to prevent the spread of infections from germs found in saliva and blood on toothbrushes:

    - Always supervise children when they are brushing their teeth.
    - Make sure that each child has his or her own toothbrush clearly labeled with his or her name. Do not allow children to share or borrow toothbrushes.
    - Apply (or have child apply) a pea-sized amount of fluoride toothpaste to a dry toothbrush (about 1/4 to 1/2 the size of a pea for children under 2 years of age). Children should be supervised up to age six when placing toothpaste on their toothbrushes.
    - Instruct each child to brush his or her teeth and then spit out the toothpaste.
    - Using a paper cup, each child should rinse his or her mouth out with water.
    - Store each toothbrush so it cannot touch any other toothbrush, and allow it to air dry.
    - Never "disinfect" toothbrushes. If a child uses another child's toothbrush or if two toothbrushes come in contact, throw them away and give the children new toothbrushes.
    - If a child uses the toothbrush of another child who is known to be ill or to have a chronic bloodborne infection (such as Hepatitis B and C or HIV), parents of the child who used the ill child's brush must be notified so that the parents can provide notice to the child's professional medical provider.
    - Replace toothbrushes every three to four months or sooner if bristles have lost their tone.

Tips for Preventing Oral Disease and Infections

- ***Cleaning teeth and gums*** is the single most important way to prevent dental and gum disease.

- ***Good nutrition,*** which is good for the body, is also good for the mouth. The most harmful foods are those containing sugar.

- ***Regular dental visits*** will ensure early detection and correction of oral/dental problems. If not previously referred by a health care provider, children should get regular dental checkups by a dentist or pediatric dentist after age three.

- ***Use of fluoride*** reduces tooth decay. Research shows that fluoride reduces cavities by up to 50 percent in children. Toothpaste and drinking water may have fluoride. It is suggested that only children between 6 months and 16 years of age living in non-fluoridated areas use additional fluoride prescribed by a dentist or health care provider.

- ***Use of sealants*** (plastic coatings applied to teeth by a dental professional) will help prevent tooth decay by creating a physical barrier between the teeth and plaque and food. Since permanent molars are the most at risk for decay, the 6-year and 12-year molars need sealants.

- ***Using mouth protectors*** prevents oral/dental injuries among children involved in recreational activities such as soccer, hockey football, and even bicycling and rollerblading. "Stock" mouth protectors are available in stores, and a better-fitting variety can be custom fitted by your dentist.

- ***Avoid frequent exposure to sugary liquids*** such as milk (including breast milk) fruit juice and other sweet liquids to help prevent baby bottle tooth decay.

- ***Learn how to handle dental emergencies:*** You can help a child avoid losing a tooth.

- ***Help parents find a dentist provider in their area.***

Open Space and Air Quality

The cheapest big space available is the outdoors! Children should play outside every day of the year except in cases of extreme weather or air pollution. Outdoor play is healthy on many levels: it provides open space to decrease the spread of infections, a variety of opportunities for gross motor development, and balance in the child's play and routine. Some children who have particularly high energy levels need a lot of outdoor play. Consider the following suggestions for your use of space:

- Do not concentrate toys and equipment in small areas.
- Place cots/cribs at least three feet from each other and alternating foot to head so that air circulates freely and children are not breathing directly on each other.
- Provide a covered outdoor area if possible for shade and protection from rain and snow.
- Take children outdoors as often as possible, especially during the winter months when the indoors may be overcrowded and overheated and respiratory illnesses are at their peak.

Develop a space design which promotes the separation of infants and toddlers from preschoolers which, among many advantages, can limit the spread of infectious diseases. (Many diseases are spread from children in diapers.)

Maintaining Good Ventilation of Indoor Space

Adequate ventilation, humidity, and temperature control increase each person's resistance to illness and his ability to get well after sickness. In winter, dry, hot air takes moisture from the skin and mucous membranes. In summer, hot and humid air prevents a child's body from cooling off well and causes overheating. Therefore, pay specific attention to the air around you, and try to do the following:

- Keep air temperature between 68 - 85°F, if possible.
- Open windows in every room every day to circulate fresh air, even in winter (except in centrally air-conditioned or ventilated buildings). Windows must be screened and not open wider than four inches to prevent children from falling out.
- Offer more liquids and sponge bathing in extremely hot weather to prevent overheating and dehydration. You may want to use sprinklers outside for toddlers and preschoolers. Young children, especially infants, become dehydrated more easily than adults.
- Provide extra clothing during sudden extremes of cold weather to maintain body heat. Extra clothing or layers should not be used for infant sleep, as this is a risk factor for SIDS.
- Ask parents to leave extra clothing at the program, if possible, or develop your own supply of extras from unneeded hand-me-downs. (Just remember that shared clothing must be washed between uses by different children). Hats should never be shared among children due to the possible spread of head lice.
- Use a cool air humidifier or cool air vaporizer to add moisture to dry air. Do not use a steam vaporizer.
- If you use an air conditioner, be sure that it is cleaned and serviced regularly. Air conditioners can build up molds and dust that are harmful allergens for some children and adults.
- Avoid strong odors in the program. Some people, including children, have allergic responses to smoke, perfume, room deodorizers, etc.

Keeping Sand Boxes and Sand Play Areas Safe

Children love and learn from the freedom and creativity involved in sand play area activities. Yet, an uncovered sand box is an invitation for cats or other animals to defecate or urinate, and therefore is a source of disease transmission.

To prevent contamination and transmission of disease from animal feces in the sand box, make sure they are safe by following these guidelines:

- Sand p lay areas must be distinct from landing areas for any moving equipment such as slides, swings, etc.
- If less than 10 feet by 10 feet, keep sandboxes covered when not under adult supervision. Fasten the cover to prevent children or animals from getting under it and to prevent contamination by solids or liquids.
- Equip sandboxes with an effective drainage system that presents no safety hazards.
- Use sterilized sand or smooth-surfaced, fine pea gravel in sand boxes instead of compacting sand.
- Make sure anything used in the sandbox is free of health or safety hazards. Play materials should be free from toxic and harmful ingredients. Sand that is used as building material or collected from a site containing toxic materials maybe harmful.
- Remove sand contaminated with urine, feces or other toxic substances and replace with fresh sand.
- Sand in the boxes should be washed and free of organic materials. Treatment of sand with chemicals to attempt to sterilize it within the sandbox is not recommended.
- Sandboxes/sand play areas must be inspected for signs of contamination and safety hazards such as cat and other animal feces or insects before each use.
- Sand in sandboxes and play areas must be replaced as needed, and at least every two years.
- Sandboxes should be located away from prevailing winds. If this is not possible, provide windbreaks by using bushes, trees or fences.

Water Supply

"The National Health and Safety Performance Standards: Guidelines for Out-Of-Home Child Care Programs" recommends that every child care setting be supplied with piped running water under pressure, from a source approved by the Environmental Protection Agency (EPA) and/or the state or local health authority. The water should be sufficient in quantity and pressure to supply water for cooking, cleaning, drinking, toilets and outside uses.

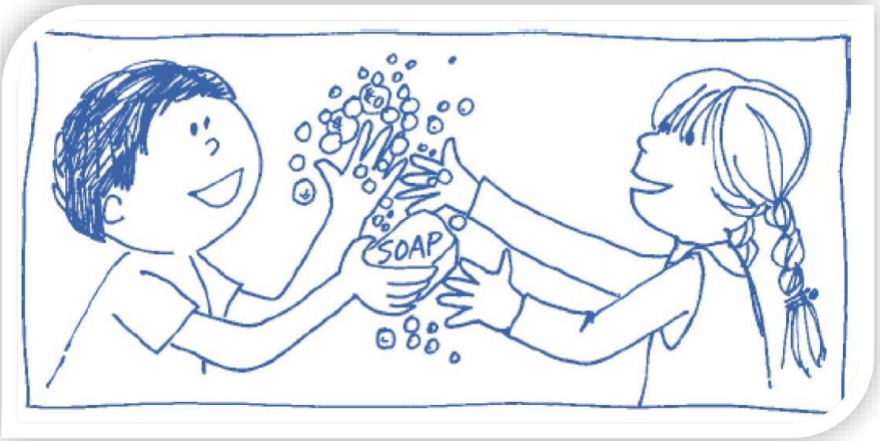
If a child care setting in California is using water from a private source, the licensing regulations require that they provide evidence of an onsite inspection of the source of the water, and a laboratory report showing the safety of the water. Testing of water must be conducted by the local health department, the State Department of Health Services or a licensed commercial laboratory.

Any facility not served by a public water supply shall keep documentation of approval of the water supply on file.

Drinking water must be safe for consumption. Exposure to toxic levels of lead can cause neural damage and developmental problems. In both private and public drinking water supplies where piping or joints contain lead or other toxic materials, water needs to be evaluated at the beginning of operation and at least every two years by the local health authority to determine safe lead levels.

Newly installed water handling and treatment equipment should meet applicable National Sanitation Foundation Standards.

The availability of running water for hand washing is important. No barrier (gloves) or chemical substitute (sanitizer solutions) is as effective as running water. Hand sanitizers do not substitute for hand washing. When plumbing is not available to produce a hand-washing sink, the child care facility should provide an approved hand-washing sink using a portable water supply that flows by gravity or pumping action during use. Children must not wash in a communal basin because those who wash in the same water share contamination.



Other Issues Related to a Healthy Environment

Pets in the Child Care Setting

Many child care providers who care for children in their homes have pets, and many centers include pets as part of their educational program. Pets can be excellent companions, and meet the emotional needs of children and others for love and affection. Caring for pets also gives children an opportunity to learn how to treat and be responsible for others. However, since animals can pass on disease to people, some guidelines for protecting the health and safety of the children should be followed.

- All pets, whether kept indoors or outside, should be in good health, show no evidence of disease, and be friendly toward children.
- Dogs or cats should be appropriately immunized (check with a veterinarian) and be kept on flea, tick, and worm control programs. Proof of immunizations should be kept in a safe place.
- Pet living quarters should be kept clean. All pet waste should be disposed of immediately. Litter boxes should never be accessible to children.
- Child care providers should always be present when children play with pets.
- Children should be taught how to behave around a pet. They should be taught not to provoke the pet or remove the pet's food. They should always keep their faces away from a pet's mouth, beak, or claws.
- If you have a pet in your child care setting, tell parents before they enroll their child. Some children have allergies that may require the parents to find other child care arrangements.
- Children and providers should wash their hands after handling pets or pet items.
- All reptiles carry salmonella. Therefore, small reptiles that might be handled by children, including turtles and iguanas, can easily transmit salmonella to them. Iguanas and turtles are not appropriate pets for child care settings.
- Some pets, particularly "exotic" pets such as some turtles, iguanas, venomous or aggressive snakes, spiders and tropical fish, may not be appropriate in the child care setting. Check with a veterinarian if you are unsure whether a particular pet is appropriate for children. Check with the local health department for regulations and advice regarding pets in the child care setting.

Keep children's play areas free of animal wastes, insects, rodents or other pest infestations. Do not let pets use play areas for shelter.

Insect and Rodent Control

As with many other environmental health issues such as lead poisoning, children are not just smaller versions of adults. They do things which put them at greater risk, like putting everything in their mouth, eating food which has been dropped on the ground, and playing on the floor and in the dirt. They are also more vulnerable to toxic substances because their immature body systems cannot respond as well, and they may store toxins in their bodies for a longer period of time. Therefore, the use of pesticides in the child care setting can be dangerous.

Providers also need to realize the difference between following one set of practices at home with their own families and another set of practices with the children they care for in the child care setting. For example, they might wipe their own child's face with a wash cloth that has been used by another family member, but they should never follow this same procedure in a child care setting. Similar issues arise around using pesticides, over-the-counter medications, feeding practices, and the well-known “spit bath.”

For controlling flying insects, use only approved pyrethrin-based insecticides or a fly swatter in the food preparation areas. Use products in accordance with directions and cautions appearing on their labels. Do not allow insecticides to come in contact with raw or cooked food, utensils, equipment used in food preparation and serving, or with any other food contact surface. Do not use insect strips that hang from the ceiling.

It is not necessary or recommended to use house or furniture sprays when head lice has been identified in your program. They have not been shown to be effective, and they needlessly expose children to toxic pesticides. Vacuuming and disposal of the vacuum bag are sufficient.

Only certified insect control personnel should apply insecticides, and they should do so in a manner approved by the Environmental Protection Agency (EPA). A staff member should monitor where the insecticides are applied to be certain that food preparation surfaces or child contact areas are not contaminated.

Be sure that all doors and windows have screens in good condition. Keep screens closed at all times. Close all openings to the outside to prevent rodents and insects from entering.

Use nontoxic extermination methods, and use only when children are not present.
Use only a certified or licensed exterminator.

No Smoking or the Use of Alcohol or Illegal Drugs

Scientific evidence has linked respiratory health risks to passive or secondhand smoke. You should have a written policy stating that smoking tobacco (cigars, cigarettes, or pipes) and using or having illegal drugs are prohibited in your setting at all times, and alcohol use is prohibited when children are in care. Discuss this law with parents and inform them of the dangers of these substances to children.

No children, especially those with respiratory problems, should be exposed to additional risk from the air they breathe. Inhaling secondhand cigarette smoke has been linked to respiratory problems in children and is especially dangerous for young infants. Children exposed to cigarette smoke are at increased risk of dying of Sudden Infant Death Syndrome and developing bronchitis, pneumonia, and ear infections when they get common respiratory infections such as colds. Children with asthma are especially in danger of having their conditions get worse when they are exposed to cigarette smoke. Smoking in rooms other than those occupied by the children is not a sufficient remedy, as smoke gets into the ventilation system and is distributed throughout the building. Therefore, ***no*** smoking should be allowed when children are present.

Regarding Electronic Cigarettes, Electronic Nicotine Delivery Systems (ENDS) and Other Vapor Products:

Children's caregivers:

- Should not allow children to play with electronic cigarettes or similar devices. They contain batteries and liquid chemicals which, if swallowed, could cause serious health complications. Nicotine is a known poison. Bottles of e-juice, used in e-cigarettes, are a poison risk for small children and pets.
- Should store e-cigarettes and their highly toxic refills out of reach of children.
- Should be aware that electronic cigarettes and similar electronic nicotine delivery devices are available in a variety of flavors, such as bubble gum, strawberry, chocolate, mint, candy, cereal, and fruit flavors *which may be attractive to children*.
- Further, recent studies have indicated that the nicotine from e-cigarettes can have significant repercussions for children's health. Information from the recently released 50th Anniversary Surgeon General report shows that nicotine in high enough doses is acutely toxic, and that exhaled e-cigarette vapor contains formaldehyde and acetaldehyde as well as traces of other carcinogens. There is also suggestive evidence that nicotine exposure during adolescence, when cognitive development is at a critical stage, may have lasting adverse consequences for brain development.

AAP Statement on E-Cigarette Poisoning Data

by: James M. Perrin, MD, FAAP, president, American Academy of Pediatrics

Pediatric Concerns

Because e-cigarettes are offered in many child-friendly flavors, there is a concern surrounding toxicity- the nicotine cartridges and refills pose a poison risk to children. And, more and more children being exposed to these dangerous products each month.

"New data released today from the federal government confirms pediatricians'

concerns about e-cigarettes and their liquid nicotine refills: they are poisoning children at an alarming rate. According to the Centers for Disease Control and Prevention's (CDC) new findings, calls to poison control centers related to e-cigarette exposure increased from one per month four years ago to 215 per month as of February 2014.

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"A teaspoon of that solution could potentially kill a child, there's no doubt."

Kids are the biggest worry — as little as a teaspoon of highly concentrated liquid nicotine could cause serious harm, said Lee Cantrell, director of the San Diego division of the California poison control system. Reports of poisonings in kids jumped 10-fold at his site in the past 14 months.

"I went online and found some retailers selling concentrations of 7.2 percent nicotine in 100-milliliter bottles," Cantrell said. "A teaspoon of that solution could potentially kill a child, there's no doubt."

Because of the high concentration of nicotine, the very toxic liquid can be extremely dangerous if someone touches it or accidentally swallows it. The fluid that contains nicotine can cause illness just by being absorbed into the skin.

The assistant director of California's Poison Control Centers, Dr. Cyrus Rangan, says, "Poison control centers across the country have been reporting that young children have been getting into these, and, with just a few drops of exposure, a very young child could become very toxic and require hospitalization."

Children across the country have been rushed to emergency rooms after drinking the liquid, which may smell sweet and have flavors like bubble gum and green apple. E-cigarettes are particularly appealing to children and adolescents because they are widely available in candy and fruit flavors such as cotton candy and grape, as well as flavors that mimic popular children's products, such as breakfast cereal flavors.

Bathroom Safety Basics

Standing water, scalding hot water, hard and slippery surfaces, pretty poisons in the guise of toiletries and medications, razor blades, and electrical appliances - ordinary components of practically any bathroom - are hazards that warrant childproofing attention. Here's what you can do to make it safe.

Water Hazards

- **Never let even a small amount of water stand in the tub.** Children have been known to drown in as little as two inches of water. Toilet bowls and diaper pails pose similar drowning hazards to curious, top-heavy toddlers. Choose diaper pails with locking lids, and always close the toilet lid after use. Invest in a special child-safe toilet lock that is easy for adults to maneuver, but difficult for your child to figure out.
- **Water temperature in your water-heating system should not exceed 120 degrees F.** Set the water heater to a maximum of 120°F to prevent the possibility of scalds. For added protection, install an anti-scald device. Double-check water temperature with a bath thermometer. If your house was built in the mid-1980s or later, anti-scald valves may be built into your plumbing. If not, several different types of do-it-yourself retrofit devices that stop the flow of water when the temperature reaches 115°F are available. Whole-value replacements maintain a maximum temperature of 115 – 120°F and compensate for any changes in water pressure and temperature that may occur. They are best installed by a plumber.
- **Install childproof tub and sink knobs, so a child cannot turn the water on.** Also use a faucet cover that pads the faucet and prevents burns caused by brushing up against it when it's hot. They are available in countless fun shapes, colors, and characters.
- **Hard, slippery surfaces.** A wet tub or wet tile floor can be extremely slippery. Injuries can easily occur if a young child slips as she sits, stands, or climbs in or out of a tub. Place a nonslip mat or appliqués at the bottom of the tub and a nonskid rug or bathmat on the floor next to the tub. Always wipe up water that has splashed on to the floor quickly, so it will not add to the risk of slipping. Commercial padding is available that fits snugly over the top edge of the tub, cushioning the hard surfaces and preventing serious injury should a child fall against it. Or drape a thick damp towel over the tub side during your child's bath.
- **Avoiding shock.** Cap all electrical outlets not in use with safety covers. Make sure outlets are protected by ground fault circuit interrupters (GFCI) to safeguard against electrocution. Always unplug small appliances, such as hair dryers and curling iron, when not in use, and put them safely out of the reach of children. Remember, too, that some items can retain enough electricity to cause shock after they have been turned off. Don't use appliances near a bathtub or sink full of water and keep the toilet lid closed when small appliances are in use. As an added precaution against electrocution, do not use space heaters or extension cords in the bathroom.

Chemical Hazards

- **Lock away all bathroom cleaning products and supplies.** Most are toxic when ingested and harmful if they come into contact with skin or eyes, and some are so potent that just inhaling the fumes can cause serious damage. Medications – over-the-counter preparations from aspirin to vitamins and those prescribed by a doctor -are best safety locked away in a special chest, drawer, closet, or medicine cabinet.
- **Use easy-to-install medicine chest locks.** Choose locks that are simple for an adult, but not a child, to operate. (Note that many medications are best stored in a room other than the bathroom, since the heat and humidity may cause them to deteriorate).
- **Make sure medication comes in childproof containers.** Toiletries – from shampoo and deodorants to perfume and cosmetics – should not be accessible to very young children. Place them high and well out of sight and reach, or lock them up. Be sure to check the area around your tub and shower, removing shampoos, conditioners, and razors.

Other Hazards

- **Secure hampers or laundry shoots** so a child cannot become trapped or fall in.
- **Put safety locks on any windows.**
- **Lock away the garbage can** inside a cabinet or under the sink so that it, too, is out of a toddler's reach.
- **Keep cat litter boxes contained.** If you keep a cat litter box in the bathroom, choose an enclosed model with a small opening or place it behind a childproof gate. (Cats easily learn to jump over.)

Childproofing Around the Building

Children's curiosity will propel them to grow intellectually and emotionally, but it will also lead them into harm's way. Many of the accidents that could befall them are avoidable. In addition to your room-by-room childproofing, be sure to:

1. **Have smoke detectors and carbon monoxide detectors.** Install them on each level of the house and replace batteries twice a year.
2. **Routinely check your water supply.** If you have a well, check it once a year for contaminants, including lead. Also, be sure that the well has a secure cap and cover. Periodically check water from a public source, as well. Keep bottled water on hand in the event of a health alert from your water supplier. Boil water for use by newborns.
3. **Check your home for unseen contaminants.** Have your home checked for radon. If your home was built before 1980, check the paint on the walls for lead. Old painted furniture and imported painted dishware should also be checked for lead. Check the soil, too, for pesticide residue and lead. Hire a qualified professional if you need to do any renovations that might release asbestos into the air.
4. **Conduct regular household safety checks.** As your child's abilities grow, so do her chances of getting into trouble. Don't wait until your child is walking to childproof areas of your home that are seemingly impossible for your child to reach. Remember, you need to literally stay one step ahead of your baby, always anticipating the next surge in development.
5. **Conduct seasonal household safety checks.** Before winter, have your chimney and heating system professionally checked. Clean and if necessary replace air-conditioning filters in the spring, rather than waiting for the first heat spell.
6. **Protect your child from falls.** Falls are the number-one cause of injury to young children. Take a survey of all falling hazards in your home and minimize the danger. Remove scatter rugs, which can trip a new walker. Cushion sharp-edged furniture covers. Install safety gates at the tops and bottoms of stairs. Always use the safety harness on the high chair and changing table, don't leave your baby – even for a few seconds – alone on a bed or other high surface, and be sure that windows have protective bars. Don't use walkers, which allow your child to zip around a room without the benefit of being able to see her feet and the ground.
7. **Beware of glass.** Young children don't have the experience to know that what they can see beyond glass isn't within their grasp. So, place decals or other visual aids on sliding glass doors and on windows to alert your child to the presence of a barrier.
8. **Avoid burns.** Adjust the thermostat on your water heater so that water never exceeds 120°F. Always use the back burners of the stove and always turn pot handles inward so your curious

toddler will not be tempted to reach for a visible pot handle. Never cook your child's food in the microwave, which results in super-hot spots in the food or formula and can lead to scalding. Never leave a hot iron where your child can reach it or its cord, and avoid ironing when your child is nearby. Also avoid electrical burns from outlets by putting in outlet covers.

9. **Watch out for water hazards.** Children can drown in just an inch of water. Never leave cleaning buckets filled with water where your child has access to them. Never leave your child unsupervised – even a few seconds – in the bath, and install safety latches on toilet seats. If you have a pool, be sure that it is surrounded by a locked fence through which your child cannot enter.
10. **Safely store all potentially harmful items.** Cleaning products, medicines, buttons, coins – any items that your child could ingest – need to be kept out of reach and locked in a secure place.
11. **Restrict especially hazardous areas.** From the time your child is crawling, make sure that dangerous areas of your home are off-limits with doors that cannot be opened by your toddler. These areas include the laundry room, the bathroom, the garage, and any terrace or loft area.
12. **Be vigilant.** The most important safety rule is to keep your child under constant supervision.

Childproofing for Ages 4 and Up

Don't relax just yet – bigger kids may just mean bigger accidents. Here are top dangers to guard against.

Merely warning your child about risks is insufficient. Regardless of your rules, it's hard for curious kids to control their impulses. That's why you must supervise them more carefully than you may realize – and take the following precautions against nine common hazards:

Make Tub Time Safe

Care Providers know not to leave babies and toddlers alone in the tub, but many children bathe on their own once they're 4. Experts stress that you need to remain near them. "Parents should stay in the bathroom till kids are about 8," says Angela Mickalide, Ph.D., Program Director of the National Safe Kids Campaign. Adjust your water heater to a maximum of 120°F.

Stay Window-Wise

Although they're no longer clumsy toddlers, kids age 4 and up can still tumble out of windows. If a bed is near a window, children can push each other when jumping on the mattress and fall through the screen. Curiosity may also tempt a child out onto an overhang. The American Academy of Pediatrics (AAP) recommends safety guards or childproof locks that allow windows to be raised no more than four inches.

Exercise Caution

Kids can get their fingers caught in exercise bikes or treadmills, and free weights can drop on their feet. Warn your child about these hazards to discourage him from playing with home exercise equipment. The best policy: keep the equipment in a room that's off-limits and, ideally, locked.

Protect Your Pet

“Children often can't tell when they're playing too roughly, and even the most docile pet can bite if provoked,” says Kim Blindauer, D.V.M., a dog-bite specialist at the Centers for Disease Control and Prevention, in Atlanta. Supervision is recommended, indoors and out. Still, it's almost inevitable that your child will be alone with a dog or cat for short periods when you're elsewhere in the house. Carefully observe how the two interact, and give your child plenty of safety instructions, including: never disturb a pet while it's eating, sleeping, ill, or nursing.

Defeat the Street

"Children under 10 do not have the cognitive ability to judge the speed and distance of oncoming traffic," Dr. Mickalide says. Moreover, they still lack self-control. If the ice-cream truck is across the street, your child might run to it without remembering to look both ways. So, watch at all times when she's playing near a street, and tell her never to go out of the yard to retrieve a toy. Most pedestrian injuries to 4- to 9-year-old kids occur when they dart into traffic mid-block. If your child insists that she's old enough to cross the street, explain that you make the safety decisions, and reinforce them frequently. A 6-year-old may assume the rules no longer apply because she's now a whole month older.

Watch Little Chefs

The AAP recommends that parents supervise children under 12 at all times in the kitchen. Make it a house rule that kids never light the stove, turn on the oven, or use the microwave without Mom or Dad in the room. “Unplug toasters, coffeemakers, and other small appliances when not in use, and coil the cords out of sight,” says Miriam Bachar Settle, Ph.D., coauthor of *The Complete Idiot's Guide to Child Safety* (Alpha Books, 2000) and Deputy Director of the University of North Carolina's Center for Health Promotion and Disease Prevention, in Chapel Hill. Use outlet covers throughout the home. Though a determined 4-year-old could still pull one out, they create one more obstacle for your child to overcome before making mischief. "These devices are child-resistant, not childproof," Dr. Mickalide warns. "They are no substitute for supervision."

Banish Burns

Young kids can strike matches before you'd expect they'd be able to. Teach fire safety, but don't count on your child to keep his promise not to play with matches and lighters. Make sure they're locked up or kept out of reach, and regularly test smoke detectors.

Stow It Safely

Continue to store cleaning solutions, batteries, medicines, and other hazardous substances out of children's reach. Older kids may think they're helping you by taking their medicine by themselves, but they don't understand doses or the fact that commonly used medications can be dangerous. "I had one young patient who decided to have a tea party with a friend," Dr. Elbirt recalls, "and the 'tea' was the tasty purple cold medicine she had found on the kitchen counter earlier that day."

Get Grounded

Older kids love to test their physical limits, whether they're leaning back on two legs of a chair or scaling a bookcase to reach something on a high shelf. Secure high dressers and bookcases to the wall, and teach children never to climb on furniture.

Make Safety Lessons Stick

- Offer explanations. Spell out why an activity is dangerous. As you help your child cross the street, don't simply say, "Look both ways" – tell him what to look for. Teach the subtleties of safety, such as confirming that traffic has stopped even if the light is red.
- Work warnings into your routine. If you're putting away medicine, remind your child that she can get hurt if she takes too much or the wrong kind, and that only adults may give it. When you're lighting the grill, say that matches can start fires that hurt people.
- Practice "safe independence." Because your child won't adopt safe habits overnight, let him become independent gradually. For instance, though he can't yet cross the street alone, he may be ready to cross without holding your hand or with you just watching.

Backyard Safety Basics

Your backyard offers your child a world of fun. To keep the fun safe:

1. **Barbecue with extreme care.** Choose sturdy and reliable outdoor cooking equipment and store it in a locked shed when not in use. Use barbecue grills only in well-ventilated outdoor areas, and never in a garage or other indoor space, even with the door open, since carbon monoxide may enter your home. Always follow the manufacturer's guidelines in the use of the grill and fuel. Store fuels and cooking utensils safely out of your child's reach. If possible, fence in a barbecue area to restrict your child's access to it.
2. **Check decks and porches for safety.** As with staircases, remove any protruding posts; check that deck slats are vertical and no more than 3-1⁄2 inches apart; and be sure that the railing around a porch is sturdy, high enough to prevent a child from toppling over it, and that no climbable furniture is nearby. Enclose the back of an open-backed outdoor staircase to prevent the risk of entrapment.
3. **Beware of glass hazards.** If you have a sliding glass door, place decals at your child's eye level to alert him to the presence of glass. Use only non-breakable, plastic tableware for outdoor eating.
4. **Limit water hazards.** If you have an outdoor pool, be sure to take all necessary safety precautions.
5. **Have child wear shoes.** Any time your child is outdoors, even on a well-manicured lawn, have her wear shoes. Any discarded material, a built-in sprinkler, or even natural debris such as acorn pods, can hurt tender feet.
6. **Be careful around backyard play equipment.** Choose sturdy, age-appropriate playsets, not swings and climbers that your child will grow into. Be sure to position the equipment safely in the yard, far enough away from walls, fences, trees, and high-traffic areas (such as next to your outdoor dining area) to avoid collisions. Periodically check the equipment for wear and repair or replace any jagged, splintering, cracked or otherwise damaged pieces. Be sure that the ground area around the play yard allows for safe landings. There should be a soft surface, loose sand or mulch about 12 inches deep, or special foam or rubber mats designed for playgrounds.
7. **Be watchful in garages and driveways.** Never let child play around automatic garage doors or use the remote to open and close the doors. If possible, separate the driveway from the outdoor play area with a sturdy fence. If your child is not in the car with you, make sure that another adult is supervising her as you pull out of the driveway. Get in the habit of walking around your car before getting in to make sure that play equipment – or even your child – is not behind the car. Honk or call out to any child you think might be in the area before pulling out. Also, always lock cars when not in use because children can climb into and engage the car.
8. **Use caution when gardening.** Follow the manufacturer's directions when using any chemicals on your lawn. Keep your child away from the lawn for twice the time suggested by the manufacturer. Store all gardening chemicals in a locked place out of your child's reach. Don not use these chemicals while your child is gardening with you.
9. **Store equipment and supplies wisely.** Lay ladders on their sides rather than storing them upright, which could entice your child to climb. Lay rakes with tines down. Store pesticides, fertilizer, and other hazardous materials in a locked, ventilated area.
10. **Never use motor-driven machines near kids.** Keep your children indoors when you use motor-powered equipment. Nearly 8,000 kids are injured each year in the United States in lawnmower-related accidents. Children should never ride on mowers nor should they be in the yard while you're using any power mowers or power tools such as hedge cutters or power saws.
11. **Be aware of dangers from common items.** Store hoses properly after each use to avoid tripping hazards. String clothes lines out of your child's reach. Install a ground fault circuit interrupter to avoid electrical shock. Be sure that yard fencing material is free of rust, splinters, and other hazards and that it cannot be climbed or opened by a toddler. Keep the garbage can inaccessible.
12. **Keep a wireless phone with you in the yard.** In case of an accident you want to be able to get help immediately and not have to leave your injured child to go inside for a phone.

Preventive Health Policies

Health policies are important because they provide specific guidelines to promote health and safety in child care programs. Policies should include specific guidelines required by licensing or regulations; best practices and information specific to your setting. All policies need to be discussed with parents when they enroll their child and with staff as part of their orientation.

Which Written Policies Are Recommended?
The Centers for Disease Control and Prevention (CDC) recommend that you establish written policies about the following topics. Some of these policies will be described later in this section

1. Health History and Immunizations for Children in Child Care
2. Health History and Immunizations for Providers of Child Care
3. Exclusion for Illness
4. Reporting Requirements
5. Emergency Illness or Injury Procedures
6. Children with Special Needs
7. Medication Administration
8. Nutrition/Foods Brought from Home
9. No Smoking or Use of Alcohol or Illegal Drugs

Other Topics to Include in Your Policies

- Injury Prevention
- Managing Injuries and First Aid
- Emergency Preparedness
- Child Abuse/Neglect
- Transportation
- Sleep Position
- Dental Health

In developing policies, you should make sure that you:

- Have the equipment, supplies and staff necessary to make the policies work.
- Organize the child care program to support the policies.
- Use proper procedures to support the policies.
- Keep lines of communication open with everyone involved: staff members, parents and children. Assure that all staff, parents and others are educated regarding the policies.
- Have a list of resources to assist families and staff in meeting your policies.

In develop in your policies consider:

- What should be done?
- Why should it be done?
- Who is responsible?
- When will it be done?
- How will it be done?
- How will it be communicated, enforced and monitored?

To prevent the spread of contagious diseases, recommended policies and procedures need to be followed at all times because:

- People can spread an infection to others before showing any symptoms of illness.
- People can carry and spread germs without ever getting sick themselves.
- In a child care setting where people from different families spend many hours together in close physical contact, germs are spread more easily.

Clearly Define the Roles of Caregivers:

The qualifications and requirements for each of these roles are defined by the child care license. Centers which receive subsidies from the Department of Education may have different requirements and centers, infant programs, school age, large and small family child care programs each have different requirements for each role.

1. ***The Director or Administrator.*** In large child care facilities, the administrator is responsible for overseeing all health services, policies, and procedures in the program.

2. ***Teaching Staff and Licensed Child Care Provider***

3. ***Other Staff and Family Members***. These include food handlers, janitorial staff, maintenance workers, etc.

4. ***The Child Care Health Consultant***. Whenever possible, each child care setting should have access to a child care health consultant. Ask your health consultant to assist in developing health policies, approve them, and link you with community health resources.

5. ***Parents***

Model Childcare Health Policies

I. **Admissions**
   - A. Admissions Policy
   - B. Enrollment
   - C. Daily Record Keeping/Daily Health Checks

II. **Supervision**
   - A. Principle
   - B. Child /Staff Ratios
   - C. Supervision of Active (Large Muscle) Play
   - D. Family/Staff Communication
   - E. Infant / Safe sleeping

III. **Discipline**
   - A. Philosophy of Discipline
   - B. Permissible Methods of Discipline
   - C. Prohibited Practices (Child Abuse)
   - D. Suspected Child Abuse

IV. **Care of Acutely Ill Children**
   - A. Admission and Exclusion
   - B. Admission and Permitted Attendance
   - C. Procedure for Management of Short-Term Illness
   - D. Reporting Requirements
   - E. Obtaining Immediate Medical Help

V. **Health Plan**
   - A. Child Health Services
   - B. Health Consultation
   - C. Health Education

VI. **Medication Policy**
   - A. Principle
   - B. Procedure

VII. **Emergency Plan**
   - A. First Aid Kits
   - B. Emergency Phone Numbers
   - C. Lost or Missing Children
   - D. Child Abuse (See Discipline)
   - E. Injuries or Illnesses Requiring Medical or Dental Care
   - F. Serious Illness, Hospitalization, and Death
   - G. Media Inquiries

VIII. **Evacuation Plan, Drills and Closings**
   - A. Evacuation Procedure
   - B. Fire or Risk of Explosion
   - C. Power Failures
   - D. Closing Due to Snow/Storm
   - E. Floods, Tornadoes, Hurricanes, Earthquakes, Blizzards or Other Catastrophes

IX. **Authorized Caregivers**
   - A. Documentation of Authorized Caregivers
   - B. Sign-in/ Sign-out Procedure
   - C. Policy for Handling an Unauthorized Person Seeking Custody
   - D. Policy for Handling an Intoxicated Person or Person Who Poses a Safety Risk

X. **Safety Surveillance**
   A. Hazard Identification and Correction
   B. Review of Injury Reports

XI. **Transportation and Field Trips**
   A. Daily Transportation to and From the Program
   B. Facility Vehicular Requirements
   C. Driver Requirements
   D. Seat Restraint Requirements
   E. Route Planning and Trip Safety

XII. **Sanitation and Hygiene**
   A. Hand washing
   B. Diapering
   C. Toileting
   D. Facility Cleaning Routines
   E. Pets
   F. Plants
   G. Toys
   H. Exposure to Blood and Other Potentially Infectious Materials

XIII. **Food Handling and Feeding Policy**
   A. Drinking Water
   B. Food Safety/Dishes, Utensils and Surfaces
   C. Food Brought from Home
   D. Food Prepared at or for the Facility
   E. Infant /Toddler Feeding
   F. Preschool/School-age Feeding
   G. Feeding of Children with Nutritional Special Needs

XIV. **Sleeping**
   A. Area for Sleeping /Napping
   B. Handling of Sleeping Equipment
   C. Bed Linen
   D. Infant Safe Sleep/SIDS Risk Reduction

XV. **Smoking, Prohibited Substances, and Guns**

XVI. **Staff Policies**
   A. Pre-employment Requirements
   B. Benefits
   C. Breaks
   D. Ongoing Health Requirements
   E. Training
   F. Performance Evaluation

XVII. **Design and Maintenance of the Physical Building and its Contents**

XVIII. **Review and Revision of Policies, Plans, and Procedures**

Sample Illness Policy

Policy: Children who are mildly ill but do not qualify for exclusion will be accepted for care in the regular program. Children who become ill with excludable symptoms while at the child care program will be cared for away from the group until the child is picked up by an authorized adult. Specialized care plans will be followed.

Purpose: To insure every child a healthy, safe and supportive experience.
To protect the health of everyone in the group.
To assist program staff in meeting all children's needs.
To protect the rights of the family and child.

Procedure:

1. *Understand the reason for excluding a child.*

   a. The illness prevents the child from comfortably participating in daily activities.
   b. The illness requires more care than the child care staff is able to provide without compromising the health and safety of the other children.
   c. The symptoms or illnesses are any of those specified on the Inclusion/Exclusion Guidelines.

2. *Conditions for which you would not automatically exclude a child.*

   a. Certain conditions, in the absence of symptoms listed on Inclusion/Exclusion Guidelines do not require exclusion unless recommended by the child's health care provider or if symptoms appear.
   b. CMV or HIV infection or hepatitis B and C virus carrier state.
   c. Pink eye without yellow/green drainage.
   d. Rash without temperature or behavior changes.
   e. Non-contagious conditions such as chronic medical conditions or disabilities.
   f. Runny nose if the child is feeling well.

The final decision to exclude a child from care is made by the staff of the child care program.

Health History and Immunization Policy for Children

You need to know the health history and medical emergency information for every child in your care. When a child enrolls in your child care setting, you should find out:

- Where parents can be reached: full names, addresses, and work and home phone numbers.
- At least two people to contact if parents can't be reached: phone numbers and addresses.
- The child's regular health care providers: names, addresses and phone numbers.
- The hospital the child's family uses: name, address and phone number.
- The date of the child's last physical examination. Any child who has not had a well-baby or well-child examination recently (within the past six months for children under two years of age, and within one year for two to six-year- old) should be examined within 30 days of entering your child care setting.
- Any special health problems or medical conditions that a child may have and procedures to follow to deal with these conditions. Examples of conditions needing procedures are allergies, asthma, diabetes, epilepsy and sickle cell anemia. These conditions can cause sudden attacks that may require immediate action. You should know: 1) what happens to the child during a crisis related to the condition; 2) how to prevent a crisis; 3) how to deal with a crisis; and 4) whether you need training in a particular emergency procedure.
- The child's immunization status.
- Whether the child has been evaluated with a TB skin test -- only high-risk children in the centers need a skin test.

California regulations require that each child accepted for care in centers has a written medical assessment before or within 30 calendar days. The medical assessment can inform the child care provider about any necessary health related services the child may need. If special care is needed and the provider is willing and able, make sure to get permission from the parent to talk directly with the health care provider.

Immunization Requirements for Child Care

The law requires you to have written proof of each child's up-to-date immunizations. Children attending child care especially need all of the recommended immunizations to protect themselves, the other children, the child care provider and their families. Several diseases that can cause serious problems for children and adults can be prevented by immunization. These diseases are chickenpox, diphtheria, Haemophilus influenzae, meningitis, hepatitis B, measles, mumps, polio, German measles (rubella), tetanus and whooping cough (pertussis).

Parents must present their child's Immunization Record prior to enrollment. Copy the full date (month/day/year) of each shot onto the blue California School Immunization Record card and then determine if the child is up-to-date. Blue cards are available free from the Immunization Coordinator at your local health department. As the child care provider, it is your responsibility to follow up regularly until all shots have been given and recorded.

Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES, 2018

- Consult relevant ACIP statements for detailed recommendations (www.cdc.gov/vaccines/hcp/acip-recs/index.html).
- When a vaccine is not administered at the recommended age, administer at a subsequent visit.
- Use combination vaccines instead of separate injections when appropriate.
- Report clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) online (www.vaers.hhs.gov) or by telephone (800-822-7967).
- Report suspected cases of reportable vaccine-preventable diseases to your state or local health department.
- For information about precautions and contraindications, see www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

Approved by the

Advisory Committee on Immunization Practices
(www.cdc.gov/vaccines/acip)

American Academy of Pediatrics
(www.aap.org)

American Academy of Family Physicians
(www.aafp.org)

American College of Obstetricians and Gynecologists
(www.acog.org)

This schedule includes recommendations in effect as of January 1, 2018.

The table below shows vaccine acronyms, and brand names for vaccines routinely recommended for children and adolescents. The use of trade names in this immunization schedule is for identification purposes only and does not imply endorsement by the ACIP or CDC.

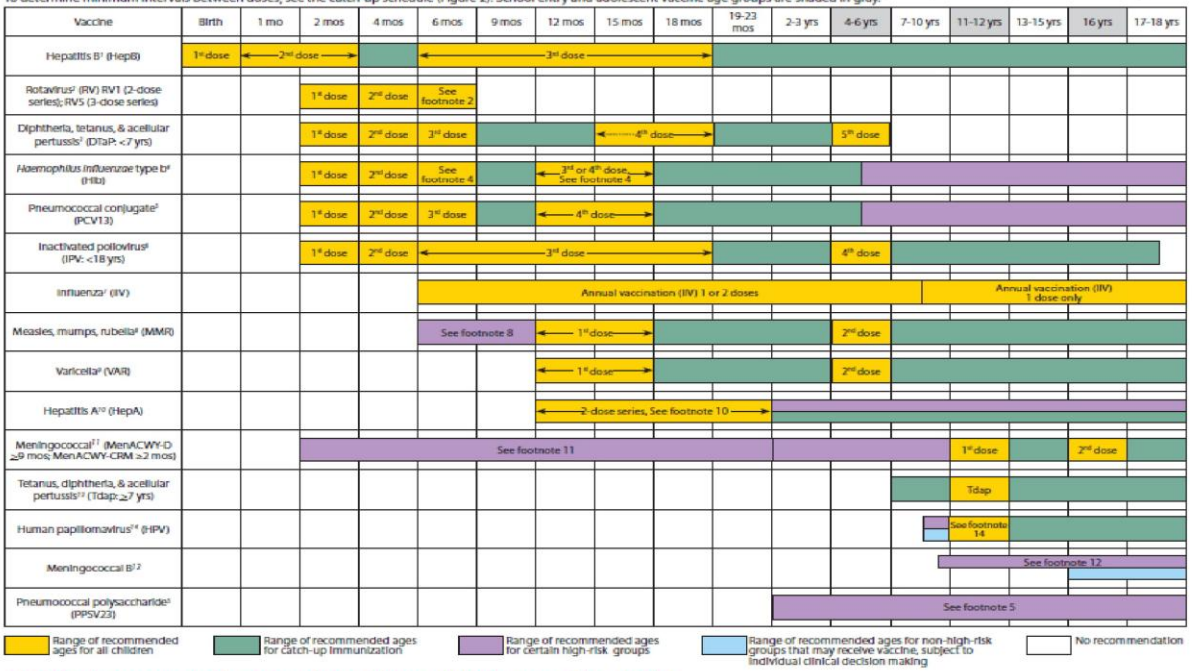
Vaccine type	Abbreviation	Brand(s)
Diphtheria, tetanus, and acellular pertussis vaccine	DTaP	Daptacel Infanrix
Diphtheria, tetanus vaccine	DT	No Trade Name
Haemophilus influenzae type B vaccine	Hib (PRP-T) Hib (PRP-OMP)	ActHIB Hiberix PedvaxHIB
Hepatitis A vaccine	HepA	Havrix Vaqta
Hepatitis B vaccine	HepB	Engerix-B Recombivax HB
Human papillomavirus vaccine	HPV	Gardasil 9
Influenza vaccine (inactivated)	IIV	Multiple
Measles, mumps, and rubella vaccine	MMR	M-M-R II
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D MenACWY-CRM	Menactra Menveo
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero Trumenba
Pneumococcal 13-valent conjugate vaccine	PCV13	Prevnar 13
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax
Poliovirus vaccine (inactivated)	IPV	IPOL
Rotavirus vaccines	RV1 RV5	Rotarix RotaTeq
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel Boostrix
Tetanus and diphtheria vaccine	Td	Tenivac No Trade Name
Varicella vaccine	VAR	Varivax
Combination Vaccines		
DTaP, hepatitis B and inactivated poliovirus vaccine	DTaP-HepB-IPV	Pediarix
DTaP, inactivated poliovirus and *Haemophilus influenzae* type B vaccine	DTaP-IPV/Hib	Pentacel
DTaP and inactivated poliovirus vaccine	DTaP-IPV	Kinrix Quadracel
Measles, mumps, rubella, and varicella vaccines	MMRV	ProQuad

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Figure 1. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2018.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded in gray.



NOTE: The above recommendations must be read along with the footnotes of this schedule.

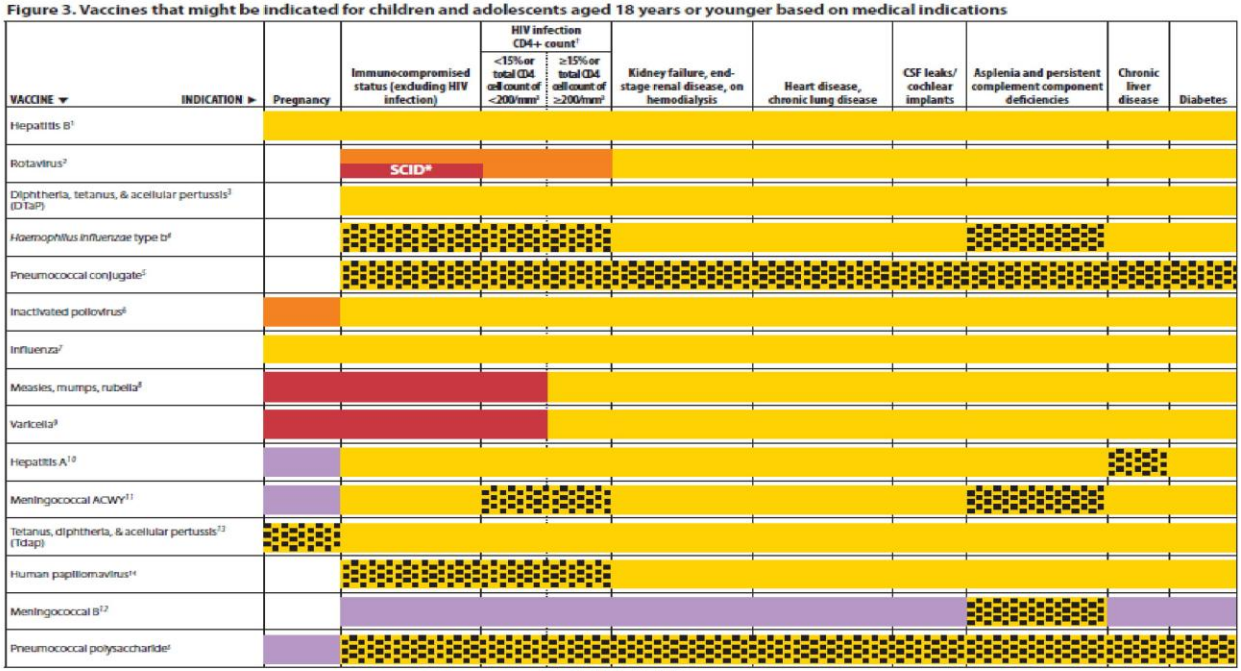
FIGURE 2. Catch-up immunization schedule for persons aged 4 months–18 years who start late or who are more than 1 month behind—United States, 2018.

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B[1]	Birth	4 weeks	8 weeks ***and*** at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.		
Rotavirus[2]	6 weeks Maximum age for first dose is 14 weeks, 6 days	4 weeks	4 weeks[2] Maximum age for final dose is 8 months, 0 days.		
Diphtheria, tetanus, and acellular pertussis[3]	6 weeks	4 weeks	4 weeks	6 months	6 months[3]
Haemophilus influenzae type b[4]	6 weeks	4 weeks if first dose was administered before the 1st birthday. 8 weeks (as final dose) if first dose was administered at age 12 through 14 months. No further doses needed if first dose was administered at age 15 months or older.	4 weeks[4] if current age is younger than 12 months **and** first dose was administered at younger than age 7 months, **and** at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix) or unknown. 8 weeks ***and*** age 12 through 59 months (as final dose)[4] • if current age is younger than 12 months **and** first dose was administered at age 7 through 11 months; OR • if current age is 12 through 59 months **and** first dose was administered before the 1st birthday, **and** second dose administered at younger than 15 months; OR • if both doses were PRP-OMP (PedvaxHIB; Comvax) **and** were administered before the 1st birthday. No further doses needed if previous dose was administered at age 15 months or older.	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate[5]	6 weeks	4 weeks if first dose administered before the 1st birthday. 8 weeks (as final dose for healthy children) if first dose was administered at the 1st birthday or after. No further doses needed for healthy children if first dose was administered at age 24 months or older.	4 weeks if current age is younger than 12 months and previous dose given at <7 months old. 8 weeks (as final dose for healthy children) if previous dose given between 7-11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was given before age 12 months. No further doses needed for healthy children if previous dose administered at age 24 months or older.	8 weeks (as final dose) This dose only necessary for children aged 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus[6]	6 weeks	4 weeks[6]	4 weeks[6] if current age is < 4 years 6 months (as final dose) if current age is 4 years or older	6 months[6] (minimum age 4 years for final dose).	
Measles, mumps, rubella[8]	12 months	4 weeks			
Varicella[9]	12 months	3 months			
Hepatitis A[10]	12 months	6 months			
Meningococcal[11] (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)	6 weeks	8 weeks[11]	See footnote 11	See footnote 11	
Children and adolescents age 7 through 18 years					
Meningococcal[11] (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)	Not Applicable (N/A)	8 weeks[11]			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis[13]	7 years[13]	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1st birthday. 6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday.	6 months if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus[16]	9 years	Routine dosing intervals are recommended.[14]			
Hepatitis A[10]	N/A	6 months			
Hepatitis B[1]	N/A	4 weeks	8 weeks **and** at least 16 weeks after first dose.		
Inactivated poliovirus[6]	N/A	4 weeks	6 months[6] A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella[8]	N/A	4 weeks			
Varicella[9]	N/A	3 months if younger than age 13 years. 4 weeks if age 13 years or older.			

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Figure 3. Vaccines that might be indicated for children and adolescents aged 18 years or younger based on medical indications



*Severe Combined Immunodeficiency

†For additional information regarding HIV laboratory parameters and use of live vaccines; see the General Best Practice Guidelines for Immunization "Altered Immunocompetence" at: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html; and Table 4-1 (footnote D) at: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Footnotes — Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES, 2018

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.
For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.

Additional information

- For information on contraindications and precautions for the use of a vaccine, consult the *General Best Practice Guidelines for Immunization* and relevant ACIP statements, at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum interval or minimum age should not be counted as valid and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see Table 3-1, *Recommended and minimum ages and intervals between vaccine doses,* in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccine requirements and recommendations is available at wwwnc.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, *Vaccination of persons with primary and secondary immunodeficiencies,* in *General Best Practice Guidelines for Immunization,* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html; and Immunization in Special Clinical Circumstances. (In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2015 report of the Committee on Infectious Diseases. 30th ed.* Elk Grove Village, IL: American Academy of Pediatrics, 2015:68-107).
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information; see www.hrsa.gov/vaccinecompensation/index.html.

1. Hepatitis B (HepB) vaccine. (minimum age: birth)

Birth Dose (Monovalent HepB vaccine only):

- **Mother is HBsAg-Negative:** 1 dose within 24 hours of birth for medically stable infants ≥2,000 grams. Infants <2,000 grams administer 1 dose at chronological age 1 month or hospital discharge.
- **Mother is HBsAg-Positive:**
  - Give **HepB vaccine** and **0.5 mL of HBIG** (at separate anatomic sites) within 12 hours of birth, regardless of birth weight.
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.
- **Mother's HBsAg status is unknown:**
  - Give **HepB vaccine** within 12 hours of birth, regardless of birth weight.
  - For infants <2,000 grams, give **0.5 mL of HBIG** in addition to HepB vaccine within 12 hours of birth.
  - Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, give **0.5 mL of HBIG** to infants ≥2,000 grams as soon as possible, but no later than 7 days of age.

Routine Series:

- A complete series is 3 doses at 0, 1–2, and 6–18 months. (Monovalent HepB vaccine should be used for doses given before age 6 weeks.)
- Infants who did not receive a birth dose should begin the series as soon as feasible (see Figure 2).
- Administration of **4 doses** is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum age** for the final (3rd or 4th) dose: 24 weeks.
- **Minimum Intervals:** Dose 1 to Dose 2: 4 weeks / Dose 2 to Dose 3: 8 weeks / Dose 1 to Dose 3: 16 weeks. (When 4 doses are given, substitute "Dose 4" for "Dose 3" in these calculations.)

Catch-up vaccination:

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, and 6 months.
- Adolescents 11–15 years of age may use an alternative 2-dose schedule, with at least 4 months between doses (adult formulation **Recombivax HB** only).
- For other catch-up guidance, see Figure 2.

2. Rotavirus vaccines. (minimum age: 6 weeks)

Routine vaccination:

Rotarix: 2-dose series at 2 and 4 months.

RotaTeq: 3-dose series at 2, 4, and 6 months.

If any dose in the series is either RotaTeq or unknown, default to 3-dose series.

Catch-up vaccination:

- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Figure 2.

3. Diphtheria, tetanus, and acellular pertussis (DTaP) vaccine. (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination:

- 5-dose series at 2, 4, 6, and 15–18 months, and 4–6 years.
  - **Prospectively:** A 4th dose may be given as early as age 12 months if at least 6 months have elapsed since the 3rd dose.
  - **Retrospectively:** A 4th dose that was inadvertently given as early as 12 months may be counted if at least 4 months have elapsed since the 3rd dose.

Catch-up vaccination:

- The 5th dose is not necessary if the 4th dose was administered at 4 years or older.
- For other catch-up guidance, see Figure 2.

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

4. ***Haemophilus influenzae* type b (Hib) vaccine. (minimum age: 6 weeks)**

Routine vaccination:
- **ActHIB, Hiberix, or Pentacel:** 4-dose series at 2, 4, 6, and 12–15 months.
- **PedvaxHIB:** 3-dose series at 2, 4, and 12–15 months.

Catch-up vaccination:
- **1st dose at 7–11 months:** Give 2nd dose at least 4 weeks later and 3rd (final) dose at 12–15 months or 8 weeks after 2nd dose (whichever is later).
- **1st dose at 12–14 months:** Give 2nd (final) dose at least 8 weeks after 1st dose.
- **1st dose before 12 months and 2nd dose before 15 months:** Give 3rd (final) dose 8 weeks after 2nd dose.
- **2 doses of PedvaxHIB before 12 months:** Give 3rd (final) dose at 12–59 months and at least 8 weeks after 2nd dose.
- **Unvaccinated at 15–59 months:** 1 dose.
- For other catch-up guidance, see Figure 2.

Special Situations:
- **Chemotherapy or radiation treatment**

  12–59 months
  - Unvaccinated or only 1 dose before 12 months: Give 2 doses, 8 weeks apart
  - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

  Doses given within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
- **Hematopoietic stem cell transplant (HSCT)**
- 3-dose series with doses 4 weeks apart starting 6 to 12 months after successful transplant (regardless of Hib vaccination history).
- **Anatomic or functional asplenia (including sickle cell disease)**

  12–59 months
  - Unvaccinated or only 1 dose before 12 months: Give 2 doses, 8 weeks apart.
  - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

  Unimmunized persons 5 years or older*
  - Give 1 dose
- **Elective splenectomy**

  Unimmunized* persons 15 months or older
  - Give 1 dose (preferably at least 14 days before procedure).
- **HIV infection**

  12–59 months
  - Unvaccinated or only 1 dose before 12 months: Give 2 doses 8 weeks apart.
  - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

  Unimmunized persons 5–18 years*
  - Give 1 dose
- **Immunoglobulin deficiency, early component complement deficiency**

  12–59 months
  - Unvaccinated or only 1 dose before 12 months: Give 2 doses, 8 weeks apart.
  - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

**Unimmunized* = Less than routine series (through 14 months) OR no doses (14 months or older)*

5. **Pneumococcal vaccines. (minimum age: 6 weeks [PCV13], 2 years [PPSV23])**

Routine vaccination with PCV13:
- 4-dose series at 2, 4, 6, and 12–15 months.

Catch-up vaccination with PCV13:
- 1 dose for healthy children aged 24–59 months with any incomplete* PCV13 schedule
- For other catch-up guidance, see Figure 2.

Special situations: High-risk conditions: Administer PCV13 doses before PPSV23 if possible.

Chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma treated with high-dose, oral, corticosteroids); diabetes mellitus:

Age 2–5 years:
- Any incomplete* schedules with:
  - 3 PCV13 doses: 1 dose of PCV13 (at least 8 weeks after any prior PCV13 dose).
  - <3 PCV13 doses: 2 doses of PCV13, 8 weeks after the most recent dose and given 8 weeks apart.
- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).

Age 6–18 years:
- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).

Cerebrospinal fluid leak; cochlear implant:

Age 2–5 years:
- Any incomplete* schedules with:
  - 3 PCV13 doses: 1 dose of PCV13 (at least 8 weeks after any prior PCV13 dose).
  - <3 PCV13 doses: 2 doses of PCV13, 8 weeks after the most recent dose and given 8 weeks apart.
- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).

Age 6–18 years:
- No history of either PCV13 or PPSV23: 1 dose of PCV13, 1 dose of PPSV23 at least 8 weeks later.
- Any PCV13 but no PPSV23: 1 dose of PPSV23 at least 8 weeks after the most recent dose of PCV13
- PPSV23 but no PCV13: 1 dose of PCV13 at least 8 weeks after the most recent dose of PPSV23.

Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and other diseases associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:

Age 2–5 years:
- Any incomplete* schedules with:
  - 3 PCV13 doses: 1 dose of PCV13 (at least 8 weeks after any prior PCV13 dose).
  - <3 PCV13 doses: 2 doses of PCV13, 8 weeks after the most recent dose and given 8 weeks apart.
- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose) and a 2nd dose of PPSV23 5 years later.

Age 6–18 years:
- No history of either PCV13 or PPSV23: 1 dose of PCV13, 2 doses of PPSV23 (1st dose of PPSV23 administered 8 weeks after PCV13 and 2nd dose of PPSV23 administered at least 5 years after the 1st dose of PPSV23).
- Any PCV13 but no PPSV23: 2 doses of PPSV23 (1st dose of PPSV23 to be given 8 weeks after the most recent dose of PCV13 and 2nd dose of PPSV23 administered at least 5 years after the 1st dose of PPSV23).

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

- PPSV23 but no PCV13: 1 dose of PCV13 at least 8 weeks after the most recent PPSV23 dose and a 2nd dose of PPSV23 to be given 5 years after the 1st dose of PPSV23 and at least 8 weeks after a dose of PCV13.

Chronic liver disease, alcoholism:

Age 6–18 years:

- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).

*Incomplete schedules are any schedules where PCV13 doses have not been completed according to ACIP recommended catch-up schedules. The total number and timing of doses for complete PCV13 series are dictated by the age at first vaccination. See Tables 8 and 9 in the ACIP pneumococcal vaccine recommendations (www.cdc.gov/mmwr/pdf/rr/rr5911.pdf) for complete schedule details.

6. Inactivated poliovirus vaccine (IPV). (minimum age: 6 weeks)

Routine vaccination:

- 4-dose series at ages 2, 4, 6–18 months, and 4–6 years. Administer the final dose on or after the 4th birthday and at least 6 months after the previous dose.

Catch-up vaccination:

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- If 4 or more doses were given before the 4th birthday, give 1 more dose at age 4–6 years and at least 6 months after the previous dose.
- A 4th dose is not necessary if the 3rd dose was given on or after the 4th birthday and at least 6 months after the previous dose.
- IPV is not routinely recommended for U.S. residents 18 years and older.

Series Containing Oral Polio Vaccine (OPV), *either mixed OPV-IPV or OPV-only series*:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements. For guidance to assess doses documented as "OPV" see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Figure 2.

7. Influenza vaccines. (minimum age: 6 months)

Routine vaccination:

- Administer an age-appropriate formulation and dose of influenza vaccine annually.
  - **Children 6 months–8 years** who did not receive at least 2 doses of influenza vaccine before July 1, 2017 should receive 2 doses separated by at least 4 weeks.
  - **Persons 9 years and older** 1 dose
- Live attenuated influenza vaccine (LAIV) not recommended for the 2017–18 season.
- For additional guidance, see the 2017–18 ACIP influenza vaccine recommendations (*MMWR* August 25, 2017;66(2):1-20: www.cdc.gov/mmwr/volumes/66/rr/pdfs/rr6602.pdf).

(For the 2018–19 season, see the 2018–19 ACIP influenza vaccine recommendations.)

8. Measles, mumps, and rubella (MMR) vaccine. (minimum age: 12 months for routine vaccination)

Routine vaccination:

- 2-dose series at 12–15 months and 4–6 years.
- The 2nd dose may be given as early as 4 weeks after the 1st dose.

Catch-up vaccination:

- Unvaccinated children and adolescents: 2 doses at least 4 weeks apart.

International travel:

- **Infants 6–11 months:** 1 dose before departure. Revaccinate with 2 doses at 12–15 months (12 months for children in high-risk areas) and 2nd dose as early as 4 weeks later.
- **Unvaccinated children 12 months and older:** 2 doses at least 4 weeks apart before departure.

Mumps outbreak:

- Persons ≥12 months who previously received ≤2 doses of mumps-containing vaccine and are identified by public health authorities to be at increased risk during a mumps outbreak should receive a dose of mumps-virus containing vaccine.

9. Varicella (VAR) vaccine. (minimum age: 12 months)

Routine vaccination:

- 2-dose series: 12–15 months and 4–6 years.
- The 2nd dose may be given as early as 3 months after the 1st dose (a dose given after a 4-week interval may be counted).

Catch-up vaccination:

- Ensure persons 7–18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4], at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2 doses of varicella vaccine:
  - **Ages 7–12:** routine interval 3 months (minimum interval: 4 weeks).
  - **Ages 13 and older:** minimum interval 4 weeks.

10. Hepatitis A (HepA) vaccine. (minimum age: 12 months)

Routine vaccination:

- 2 doses, separated by 6-18 months, between the 1st and 2nd birthdays. (A series begun before the 2nd birthday should be completed even if the child turns 2 before the second dose is given.)

Catch-up vaccination:

- Anyone 2 years of age or older may receive HepA vaccine if desired. Minimum interval between doses is 6 months.

Special populations:

Previously unvaccinated persons who should be vaccinated:

- Persons traveling to or working in countries with high or intermediate endemicity
- Men who have sex with men
- Users of injection and non-injection drugs
- Persons who work with hepatitis A virus in a research laboratory or with non-human primates
- Persons with clotting-factor disorders
- Persons with chronic liver disease
- Persons who anticipate close, personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity (administer the 1st dose as soon as the adoption is planned—ideally at least 2 weeks before the adoptee's arrival).

11. Serogroup A, C, W, Y meningococcal vaccines. (Minimum age: 2 months [Menveo], 9 months [Menactra].

Routine:

- 2-dose series: 11-12 years and 16 years.

Catch-Up:

- Age 13-15 years: 1 dose now and booster at age 16-18 years. Minimum interval 8 weeks.
- Age 16-18 years: 1 dose.

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

Special populations and situations:
Anatomic or functional asplenia, sickle cell disease, HIV infection, persistent complement component deficiency (including eculizumab use):

- **Menveo**
  - 1st dose at 8 weeks: 4-dose series at 2, 4, 6, and 12 months.
  - 1st dose at 7–23 months: 2 doses (2nd dose at least 12 weeks after the 1st dose and after the 1st birthday).
  - 1st dose at 24 months or older: 2 doses at least 8 weeks apart.
- **Menactra**
  - Persistent complement component deficiency:
    - 9–23 months: 2 doses at least 12 weeks apart
    - 24 months or older: 2 doses at least 8 weeks apart
  - Anatomic or functional asplenia, sickle cell disease, or HIV infection:
    - 24 months or older: 2 doses at least 8 weeks apart.
    - **Menactra** must be administered at least 4 weeks after completion of PCV13 series.

Children who travel to or live in countries where meningococcal disease is hyperendemic or epidemic, including countries in the African meningitis belt or during the Hajj, or exposure to an outbreak attributable to a vaccine serogroup:

- Children <24 months of age:
  - **Menveo (2-23 months):**
    - 1st dose at 8 weeks: 4-dose series at 2, 4, 6, and 12 months.
    - 1st dose at 7-23 months: 2 doses (2nd dose at least 12 weeks after the 1st dose and after the 1st birthday).
  - **Menactra (9-23 months):**
    - 2 doses (2nd dose at least 12 weeks after the 1st dose. 2nd dose may be administered as early as 8 weeks after the 1st dose in travelers).
- Children 2 years or older: 1 dose of **Menveo** or **Menactra**.

Note: Menactra should be given either before or at the same time as DTaP. For MenACWY booster dose recommendations for groups listed under "Special populations and situations" above, and additional meningococcal vaccination information, see meningococcal *MMWR* publications at: www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

12. Serogroup B meningococcal vaccines (minimum age: 10 years [Bexsero, Trumenba].

Clinical discretion: Adolescents not at increased risk for meningococcal B infection who want MenB vaccine.

MenB vaccines may be given at clinical discretion to adolescents 16–23 years (preferred age 16–18 years) who are not at increased risk.

- **Bexsero:** 2 doses at least 1 month apart.
- **Trumenba:** 2 doses at least 6 months apart. If the 2nd dose is given earlier than 6 months, give a 3rd dose at least 4 months after the 2nd.

Special populations and situations:
Anatomic or functional asplenia, sickle cell disease, persistent complement component deficiency (including eculizumab use), serogroup B meningococcal disease outbreak

- **Bexsero:** 2-dose series at least 1 month apart.
- **Trumenba:** 3-dose series at 0, 1-2, and 6 months.

Note: Bexsero and **Trumenba** are not interchangeable.
For additional meningococcal vaccination information, see meningococcal *MMWR* publications at: www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

13. Tetanus, diphtheria, and acellular pertussis (Tdap) vaccine. (minimum age: 11 years for routine vaccinations, 7 years for catch-up vaccination)

Routine vaccination:

- **Adolescents 11–12 years of age:** 1 dose.
- **Pregnant adolescents:** 1 dose during each pregnancy (preferably during the early part of gestational weeks 27–36).
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination:

- **Adolescents 13–18 who have not received Tdap:** 1 dose, followed by a Td booster every 10 years.
- **Persons aged 7–18 years not fully immunized with DTaP:** 1 dose of Tdap as part of the catch-up series (preferably the first dose). If additional doses are needed, use Td.
- **Children 7–10 years** who receive Tdap inadvertently or as part of the catch-up series may receive the routine Tdap dose at 11–12 years.
- **DTaP inadvertently given after the 7th birthday:**
  - **Child 7–10:** DTaP may count as part of catch-up series. Routine Tdap dose at 11-12 may be given.
  - **Adolescent 11–18:** Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Figure 2.

14. Human papillomavirus (HPV) vaccine (minimum age: 9 years)

Routine and catch-up vaccination:

- Routine vaccination for all adolescents at 11–12 years (can start at age 9) and through age 18 if not previously adequately vaccinated. Number of doses dependent on age at initial vaccination:
  - **Age 9–14 years at initiation:** 2-dose series at 0 and 6–12 months. Minimum interval: 5 months (repeat a dose given too soon at least 12 weeks after the invalid dose and at least 5 months after the 1st dose).
  - **Age 15 years or older at initiation:** 3-dose series at 0, 1–2 months, and 6 months. Minimum intervals: 4 weeks between 1st and 2nd dose; 12 weeks between 2nd and 3rd dose; 5 months between 1st and 3rd dose (repeat dose(s) given too soon at or after the minimum interval since the most recent dose).
- Persons who have completed a valid series with any HPV vaccine do not need any additional doses.

Special situations:

- **History of sexual abuse or assault**: Begin series at age 9 years.
- **Immunocompromised* (including HIV)** aged 9–26 years: 3-dose series at 0, 1–2 months, and 6 months.
- **Pregnancy:** Vaccination not recommended, but there is no evidence the vaccine is harmful. No intervention is needed for women who inadvertently received a dose of HPV vaccine while pregnant. Delay remaining doses until after pregnancy. Pregnancy testing not needed before vaccination.

*See MMWR, December 16, 2016;65(49):1405–1408, at www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6549a5.pdf.

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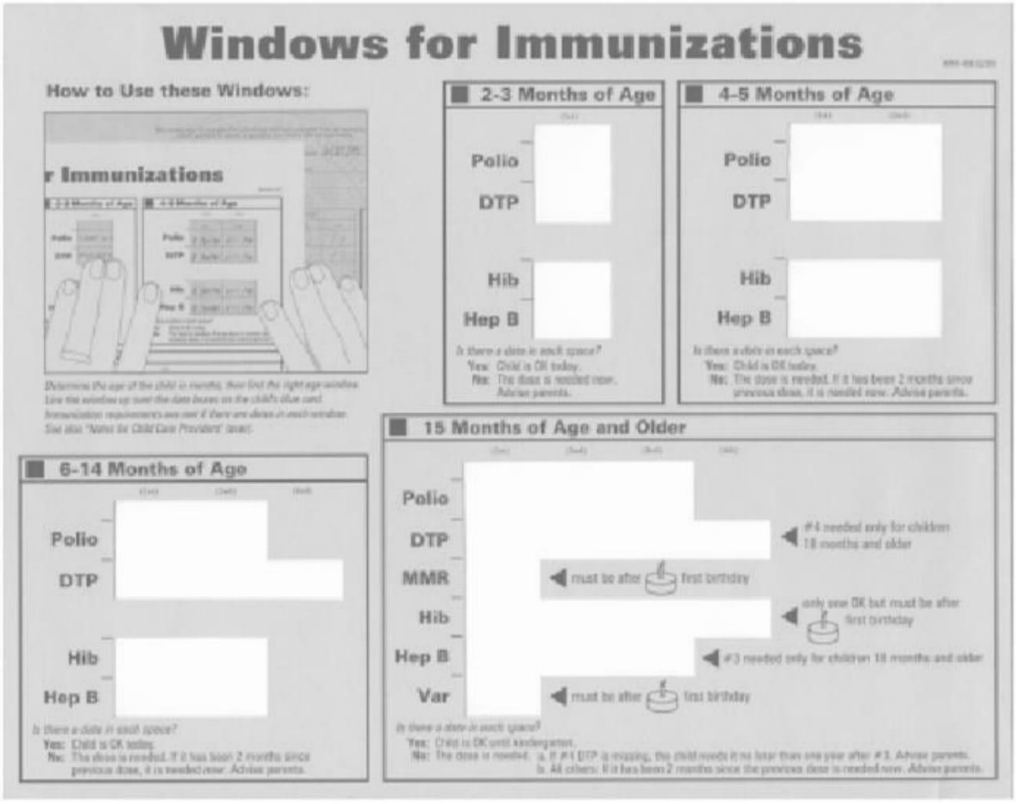
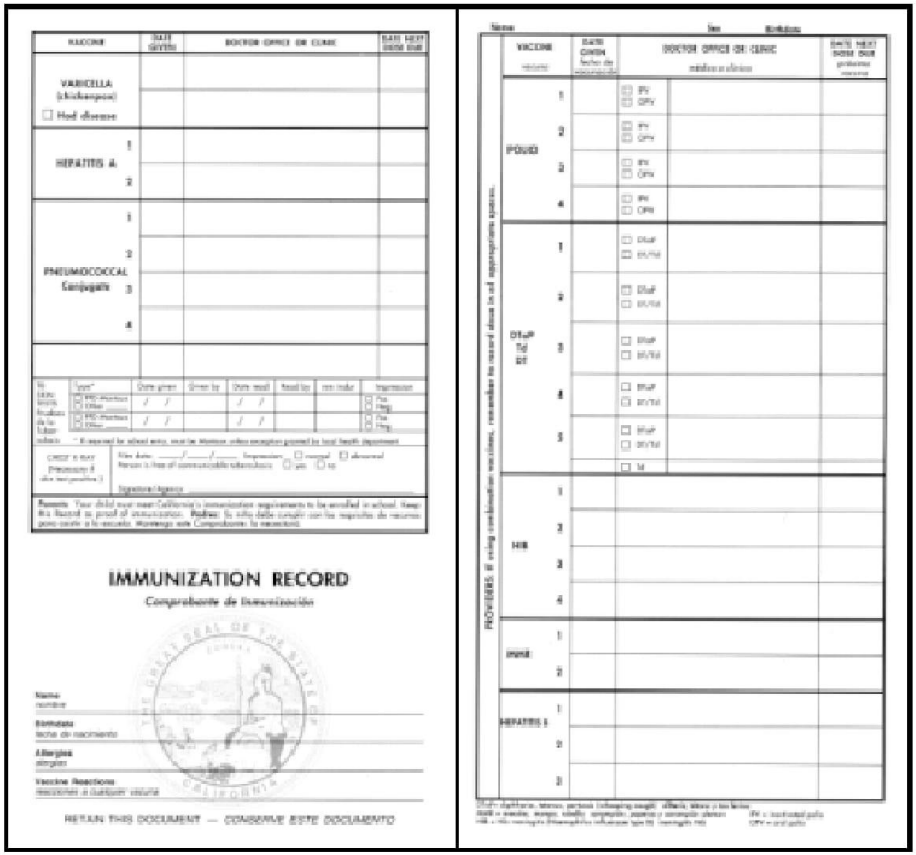
Windows for Immunizations





IMMUNIZATION RECORD

Comprobante de Inmunización

RETAIN THIS DOCUMENT — CONSERVE ESTE DOCUMENTO

Note: Not shown at actual size.
The California Immunization Record (yellow card)
can be folded into three parts and stored in a plastic holder.

Health History and Immunization Policy for Providers

As a child care provider, you will be exposed to infectious diseases more frequently than will someone who has less contact with children. To protect yourself and the children in your care, you need to know which immunizations you received as a child and whether you had certain childhood diseases. If you are not sure, your health care provider can test your blood to determine if you are immune to some of these diseases and can vaccinate you against those to which you are not immune. If you are pregnant or may become pregnant, it is important to have protection since some of the vaccine-preventable diseases can harm you and your unborn baby.

Tuberculosis (TB) Testing

Persons who are beginning work as child care providers are required to have a TB skin test to check for infection with the TB germ. Anyone who has a positive result from the skin test should be evaluated promptly by a physician, who will check for active TB.

Recommended Immunizations for Child Care Providers

SB 792 – http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0751-0800/sb_792_bill_20150227_introduced.pdf

This bill requires all childcare providers to have a measles and whooping cough vaccination by Sept 1, 2016 and a Flu shoot annually – these can be waived if the childcare provider provides a letter that they do not want the Flu vaccine. They should strongly consider and discuss with their Healthcare Provider before waiving to not get the vaccines. All other vaccines can only be waived with a letter from the Childcare Provider's Healthcare Provider indicating the Childcare Provider has an underlining health reason why they should not or cannot get the vaccines.

Child care providers should have received all immunizations routinely recommended for adults.

Influenza (Flu): All child care providers, especially those who have chronic health conditions or are over 65 years of age, should be annually vaccinated against influenza.

Measles, Mumps, Rubella (MMR): Providers born before 1957 can be considered immune to measles and mumps. Others can be considered immune if they have a history of measles or mumps disease, or have received at least one dose of rubella vaccine on or after their first birthday.

Tetanus, Diphtheria (Td): Child care providers should have a record of receiving a series of three doses (usually given in childhood) and a booster dose given within the past 10 years.

Polio: Child care providers, especially those working with children who are not toilet-trained, should have a record of a primary series of three doses (usually given in childhood) and a supplementary dose given at least six months after the third dose in the primary series.

Hepatitis A: Hepatitis A vaccine is not routinely recommended for child care providers but may be indicated if the local health department determines that the risk of hepatitis A in the community is high.

Chickenpox: Child care providers who know they have had chickenpox can assume they are immune. All other providers should consider getting vaccinated because of the high risk of exposure to chickenpox.

Hepatitis B: Child care providers who may have contact with blood or blood-contaminated body fluids (such

as bloody noses or cuts), or who work with developmentally disabled or aggressive children, should be vaccinated against hepatitis B with one series of three doses of vaccine.

Preventive Health Needs of Staff

An important part of setting health policies is to include those persons who keep the child care service going: yourself and your staff or family. Healthy staff are the key ingredient to quality child care. For this reason, providers must address the health issues and problems that affect staff in order to ensure a quality program.

Ways to Promote Good Adult Health

Unfortunately, many child care providers neglect their personal needs in order to focus on those of the children. It is important to recognize that they can best care for children only when they keep themselves healthy. California requires verified health screening including testing for tuberculosis. The following guidelines were designed for center staff, but are also recommended for family child care providers.

Your staff health policy should specify the following for each type of examination:

- Content of the exam and who can perform the exam
- How often it must occur
- Special examinations for specific positions, if any, such as vision testing for drivers
- Who receives the findings
- Where the examinations can be performed, and who pays for the exam

In order for examinations to be effective, the health professional conducting the exam must know the nature and demands of the adult's job. For instance, a woman planning to get pregnant will need to talk to her doctor about infectious diseases, or a chronic lower back problem may not interfere with the job performance of a social worker, but would surely affect the teacher of a toddler group.

Pre-Employment Screenings

Ideally, the results of a health screening should be received before a job offer is made final and before contact with the children begins. In practice, this is difficult to do – but doing it is still very important. It is hard to address health concerns after an individual has begun to develop relationships in your setting. An exam that follows actual employment may reveal health problems to which other staff and the children have already been exposed.

It is recommended that a pre-employment health screening include:

- Assessment of emotional and physical fitness, including vision and hearing
- Assessment for the presence of contagious disease, including a Mantoux tuberculosis test (also required for volunteers)
- Review of immunization status and history of childhood illness
- Assessment and recommendations for specific medical conditions
- Additional assessment for the risk of exposure to chickenpox, cytomegalovirus (CMV), measles, mumps, hepatitis B, herpes, fifth disease and HIV (all of which may cause fetal damage), should be considered if the woman is of child bearing age or planning a pregnancy.

Infectious Disease in Child Care Employees

Infectious diseases are common in child care programs. Most are not serious and would probably spread at a similar rate

from children to adults in a large family setting. However, since child care staff care for a number of young children, many of whom cannot control their secretions and have not yet learned principles of hygiene, there is the potential for the spread of infections to the employee. Employees may infect other employees, children, family members, and in the case of a pregnant employee, the fetus. Therefore, it is important that employees be familiar with the infections that are common in the child care setting, and the measures they can take to prevent them. For details on these infections and ways to reduce their spread, see "Information on Specific Diseases" (Appendix C).

The two important barriers which help prevent the spread of infection are *Immunization* and *universal precautions.*

Health Risks for Pregnant Child Care Providers

Knowing your health history is especially important if you are pregnant or could become pregnant and are providing child care. Several childhood diseases can harm the unborn child, or fetus, of a pregnant woman exposed to these diseases for the first time. These diseases are:

1. **Chickenpox (Varicella Virus):** First-time exposure to this virus during pregnancy may cause miscarriage, multiple birth defects or severe disease in newborns. Chickenpox can be a serious illness in adults. Most people (90 to 95 percent of adults) were exposed to chickenpox as children and are immune. For women who do not know if they had chickenpox as a child, a blood test can verify their immune status.

2. **Cytomegalovirus (CMV):** First-time exposure to CMV during pregnancy may cause hearing loss, seizures, mental retardation, deafness and/or blindness in the newborn. In the United States, CMV is a common infection passed from mother to child at birth. Providers who care for children under two years of age are at increased risk of exposure to CMV. Most people (and 40 to 70 percent of women of childbearing age) have been exposed to CMV and are immune. It is important to practice standard precautions and washing hands prevent infections among children and staff. It is a good suggestion that pregnant staff be reassigned to work (if possible) with older children (over age 3) or temporarily in an administrative role throughout the pregnancy to reduce her risk of infection with cytomegalovirus.

3. **Fifth Disease (Slapped Cheek):** First-time exposure to fifth disease during pregnancy may increase the risk of fetal damage or death. Most people (and 30 to 60 percent of women of childbearing age) have been exposed to the virus and are immune.

4. **Rubella (German or Three-Day Measles):** First-time exposure to rubella during the first three months of pregnancy may cause fetal deafness, cataracts, heart damage, mental retardation, miscarriage or stillbirth. Rubella can also be a severe illness in adults.

   Child care providers can be considered immune only if (a) they have had a blood test for rubella antibodies and the laboratory report shows antibodies, or (b) they have been vaccinated against rubella on or after their first birthday. Providers who are not immune should be vaccinated. After vaccination, a woman should avoid getting pregnant for three months.

Keeping Health Records

It is required that child care centers obtain a medical record and a detailed developmental health history for each child in the program. Maintain the file for each child in one central location within the setting. It is recommended that family child care providers also do this, but it is not required in California.

All child care providers should become familiar with this information. In addition to obtaining health data for individual children, child care staff must learn how to deal with their specific needs. For instance, asthma is very common in early childhood. If you have a child with asthma in your program, review the history of treatment and current medications. It is important that each provider and staff member know the child's physical history, including allergies. Obtain permission (both oral and written) before any medication is given to a child.

In California, a new law (AB 221 Blood Glucose Monitoring – Finger Stick) authorizes blood glucose testing for the purpose of monitoring a child with diabetes. Required documents include written instructions from the child's medical provider on how to conduct the test, how to determine if results are in the acceptable range, any restrictions in activities or diet, and how to recognize the signs of low/high glucose level and any actions to be taken.

The medical record on file for each child should include a medical report completed and signed by the child's health care provider, preferably prior to enrollment or no later than six weeks after admission. The medical report shall include the following medical and developmental information:

(1) Records of the child's immunizations
(2) A description of any disability, sensory impairment, developmental variation, seizure disorder, or emotional or behavioral disturbance that may affect adaptation to child care
(3) An assessment of the child's growth
(4) A description of health problems or findings from an examination or screening that need follow-up
(5) Results of screenings – vision, hearing, dental, nutrition, developmental, tuberculosis, hemoglobin, urine, lead, etc.
(6) Dates of significant communicable diseases (e.g., chickenpox)
(7) Prescribed medication(s), including information on recognizing, documenting and reporting potential side effects
(8) A description of current acute or chronic health problems under or needing treatment
(9) A description of past serious injuries that required medical attention or hospitalization
(10) Special instructions for the caregiver

In California a new TB Skin Policy has been introduced. Effective August 22, 1997 the skin test for tuberculosis (Mantoux) is not required for children in family child care programs unless the child's medical provider concludes that she or he is at risk for TB.

Communication About Illness in Child Care

Parents are the primary teachers and role models for young children. When parents are asked what is the most important thing they look for when seeking child care, a healthy and safe environment is at the top of the list. With this in mind, child care providers must include parents in their efforts to create healthy environments and teach healthy habits to the children in their child care program.

The child care providers enrolled in the health and safety class may be new providers, or experienced providers who are taking the course for the first time or repeating the class to refresh their knowledge and assure they are up-to-date. Whatever their knowledge level, they should communicate all health and safety messages in the curriculum to parents.

There are several important times and methods for communicating with parents, so please be sure these are discussed throughout the module:

- Communicate without judgment: do not criticize anyone's parenting skills.
- Review all health and safety policies prior to enrolling a child. The health and safety of their children is a top priority for parents, so this review will reassure them that the provider will be working to promote the well-being of the children in their care.
- Communicate any changes in health and safety policies at parent meetings, by written notice in the primary language of the parent (when possible), and informally as you greet the parents at the beginning and end of the day.
- Communicate new knowledge gained on health and safety issues in newsletters, notes, handouts, posted information—any method you can think of that will reach a particular parent group.

All of the steps above will demonstrate to the parents that the child care provider is working in the best interest of the children in their care.

Communication with the Health Care Provider

Most child care programs communicate with the health care provider through the parent. If a child appears sick, you can ask the parent to take the child to a health care provider. To communicate your concerns, send along a "Form for Communication with the Health Care Provider" (see page 103 & 114), develop your own form or just write a simple note. The purpose of your communication is to share your specific observations about a child (and perhaps some information about your program) and to get an opinion about the child's condition, as well as recommendations on when a child can return to care.

Usually confidentiality limits your talking directly to a child's doctor or clinic So if you want specific information about a child's acute or chronic condition, you must get written authorization to do so (see "Sample Authorization Form for Release of Medical Information," see page 103).

Before you call, summarize your concerns and jot down the questions you want answered. While you may have opinions about what is wrong or what should be done, it is often useful to first describe what you have observed and listen to the health care provider's opinion. It can be helpful to repeat back your understanding of any recommendations and, if there is disagreement, ask for clarification.

Parent-Provider Communication

Just as child care providers have an obligation to report when children in care are exposed to a contagious disease, parents have the same obligation to report diseases to the child care program within 24 hours of a diagnosis, even if they keep their child at home. That way, the child care provider can alert other parents to watch for signs of that illness in their children and seek medical advice when necessary. You can use the "Notice of Exposure to Contagious Disease" see page 106), or a notice developed by your health consultant. Use "Information on Specific Diseases" (see page 12) to prepare the exposure notice. The confidentiality of the child should be maintained. You should not report the name of the child or other family member who is ill. When you report to your local health department, the parents of the child must be informed that you are required to report the disease and so is the health care provider. Also let them know you will be sending home exposure notices to parents but will not mention any names.

I understand that information regarding my child is generally confidential and may not be given to employees of other schools, public agencies or individual professionals in private practice without my consent or other legal requirement.

Consent for Release of Information

I,_____ hereby consent to the release of the following information
FULL NAME OF PARENT/GUARDIAN

Regarding my child_____ held by
FULL NAME OF CHILD
_____to _____ . FULL NAME
OF INDIVIDUAL OR AGENCY/ADDRESS FULL NAME OF CHILD CARE HEALTH CONSULTANT

Initial_____ Educational/Developmental Records

Initial_____ Diagnostic Assessments/Evaluations (OCCUPATIONAL/PHYSICAL THERAPY, SPEECH AND LANGUAGE PATHOLOGY, PSYCHOLOGICAL, SOCIAL-EMOTIONAL) Initial_____ Developmental/Health Screening(s)

Initial_____ Medical Initial_____ Dental Initial_____ Immunization Records

Initial_____ Other: _____ PLEASE SPECIFY:

Consent for Referral

I also authorize communication and exchange of information between: _____
NAME OF INDIVIDUAL/AGENCY HOLDING RECORDS

and/or:_____ and _____ .
NAME OF CHILD CARE HEALTH CONSULTANT NAME OF CHILD CARE PROGRAM

Further,_____(NAME OF CHILD CARE HEALTH CONSULTANT)

is authorized to share the information gained with his/her supervisor(s) and/or child care health consulting staff working directly with her/him. Consent for release of information and authorization of communication shall be for the limited purpose of understanding and addressing my child's needs.
This consent is voluntary and I understand that I can withdraw my consent for my child at any time. Unless I withdraw this consent, this authorization will be effective for the period my child is continuously enrolled in the_____ .
NAME OF CHILD CARE PROGRAM

By signing below, I am confirming that I have read, understood and agree to the above.

Name:_____ Signature: _____ Date: _____ PRINT FULL
PARENT/GUARDIAN NAME PARENT/GUARDIAN SIGNATURE:

NOTE: IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) AND APPLICABLE CALIFORNIA LAWS, ALL PERSONAL AND HEALTH INFORMATION IS PRIVATE AND MUST BE PROTECTED

Information about a child's medical history or disability is Confidential

When communication information about a medical history of disability this information is confidential and should not be shared with others unless you have consent from the parents of the child. If you have a respectful relationship with the parents, you may be able to have a conversation with them about how they would like to see you handle inquires about their child's disability from the parents and the children. Some parents will prefer that information about their child's disability continue to be kept confidential while others may welcome the opportunity to share with other families the nature of their child's disability. If a family chooses to share information about their child and his or her disability, it con provide valuable learning opportunities for all the children in the program.

http://childcarelaw.org/resource/americans-with-disabilities-act/?sf_action=get_data&sf_data=results&_sft_resource_type=laws-and-regulations&_sft_topics=children-with-disabilities&_sft_resource_region=california&_sft_resource_language=english

Once again, one of the best ways to respond to other families is outside of the context of a particular child by providing general information about what quality care is all about. High quality programs will provide opportunities for parent education, which should include discussions of the benefits to all children of inclusive child care

Reporting Requirements

When you know that a child has a contagious illness, you may need to take special measures so that the sickness does not spread to others. Some diseases or conditions must be reported to the local health department, child care licensing and others. Parents need to be informed that their child was exposed.

Suspected child abuse or neglect must also be reported. In California, report to Child Protective Services. Check with the local authorities in your area to identify the appropriate reporting agency. You also should inform parents of this reporting requirement.

Exclusion for Illness in the Child Care Setting

Keeping children healthy is a partnership between parents, child care providers, the children themselves and the medical provider. Only a few illnesses require exclusion of sick children to ensure protection of other children and staff.

Reasons to Exclude a Child

1. The illness prevents the child from participating comfortably in routine activities.
2. The illness requires more care than the child care staff is able to provide without compromising the health and safety of the other children.
3. The illness is any of the specifically diagnosed conditions listed below.

Symptoms that Require Exclusion of a Child

1. *Fever along with behavior change or other signs of illness* such as sore throat, rash, vomiting, diarrhea, earache, etc. Fever is defined as having a temperature of l00°F or higher taken under the arm, oral temperature of 101°F or greater, and rectal temperature of 102°F or greater. Oral

temperatures should not be taken on children younger than four years of age. Rectal temperatures are no longer recommended in the child care setting (have an accurate, easy to use thermometer in your First Aid kit).

2. *Symptom and signs of possible severe illness* until medical evaluation allows inclusion. May include unusual tiredness, uncontrolled coughing or wheezing, continuous crying or anger, or difficulty breathing.
3. *Diarrhea* – runny, watery or bloody stools.
4. *Vomiting* more than once in the period of 24 hours.
5. *Body rash with fever or behavior change.*
6. *Sore throat with fever and swollen glands or mouth sores with drooling,*
7. *Eye discharge* – thick mucus or pus draining from eye, or pink eye (viral conjunctivitis usually has a clear, watery discharge and may not require medication or exclusion).
8. *Severe coughing* in which the child gets red or blue in the face or makes a high-pitched whooping sound after coughing.
9. *Impetigo,* until 24 hours after treatment has been initiated.
10. *Tuberculosis,* until a health care provider states that the child can attend child care.
11. *Hepatitis A, chickenpox, mumps, measles, rubella or shingles.*
12. *Child is irritable, continuously crying,* or requires more attention than you can provide without compromising the health and safety of other children in your care.

AAP Child Care Flu Exclusion Recommendation

Any child with respiratory symptoms *(cough, runny nose, or sore throat)* and fever should be excluded from their child care program. The child can return after the fever has resolved *(without the use of fever-reducing medicine),* the child is able to participate in normal activities, and staff can care for the child without compromising their ability to care for the other children in the group.

Whenever children are together, there is a chance of spreading infections. This is especially true among infants and toddlers who are likely to use their hands to wipe their noses or rub their eyes and then handle toys or touch other children. These children then touch their noses and rub their eyes so the virus goes from the nose or eyes of one child by way of hands or toys to the next child who then rubs his own eyes or nose.

To reduce the risk of becoming sick with the flu, child care providers and all the children being cared for should receive all recommended immunizations, including the flu vaccine. The single best way to protect against the flu is to get vaccinated each year. This critically important approach puts the health and safety of everyone in the child care setting first. The flu vaccine is recommended for everyone 6 months of age and older, including child care staff. **Note:** Children 6 months through 8 years of age may need two doses spaced one month apart to get the full benefit. These children should receive their first dose as soon as the vaccine is on hand in their community.

https://www.healthychildren.org/English/health-issues/conditions/prevention/Pages/Prevention-In-Child-Care-or-School.aspx

http://www.healthychildcare.org/PDF/InfDiseases/AR_PanFlup.pdf

Head Lice

It is now no longer considered necessary to excluding children with head lice. The child should never be made to feel less than, or embarrassed because they are discovered to have head lice

*Children should not be excluded **immediately** or sent home early from early care and education due to the presence of head lice (1). If head lice are present, children should avoid any head-to-head contact with other children and should avoid the sharing of any headgear while finishing out the day. Parents/guardians of affected children should be notified and informed that their child must be treated **before returning to the child care facility**. Parents/guardians should be encouraged to follow Integrated Pest Management (IPM) best practices, which entails using the least hazardous means to control pests, including head lice."*

Since having head lice doesn't put a child at risk for any serious health problems, immediate exclusion is not necessary. However, treatment should be initiated prior to the child's return. Notification alone may be insufficient. **Some families will need support--educational, financial or both**. That is why the American Academy of Pediatrics (AAP) has materials such as *Head Lice: What Parents Need to Know* at

https://www.healthychildren.org/English/health-issues/conditions/from-insects-animals/Pages/Signs-of-Lice.aspx

And the National Association of School Nurses (NASN) has *Lice Lessons*
https://www.nasn.org/nasn/programs/educational-initiatives/lice-lessons.
Children with constantly reoccurring cases of head lice may need special, family-centered interventions by the program.
https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/aap-updates-treatments-for-head-lice.aspx
http://nrckids.org/CFOC/Database/7.5.8.1

Exclusion/Readmission Due to Illness

Disease	If a Child in Your Care Has Been Diagnosed with This Disease You Should	When to Allow Child to Return

Bacterial Meningitis	• Exclude the child from child care. In most cases, the child will be hospitalized.
	• Immediately contact your Health Department to report the case of meningitis.
	  • Ask whether you need to contact the parents of the other children in your facility. If so, in cooperation with the Health Department, contact the parents of the children in your facility.
	  • Follow any preventative measures the Health Department recommends.
		When the Health Department tells you it is safe.

Chickenpox	• Temporarily exclude the sick child from the child care setting. • Notify parents.	Six days after the rash begins or when blisters have scabbed over.

Diarrheal Disease	• Temporarily exclude the sick child from the child care setting.
	• Carefully follow group separation, hand washing and cleaning procedure.
	• If you know the diarrhea is caused by bacteria or a parasite such as shigella, campylobacter, *E. coli*, Cryptosporidium, salmonella or giardia, ask the Health Department
	  • Whether ill and well children and adults should be tested.
	  • When to allow the sick child to return to child care.
		When the child no longer has diarrhea. However, some of these diseases require negative stool cultures; allow the child to return when the Health Department tells you it is safe.

Diphtheria	• Temporarily exclude the sick child from the child care setting.
	• Immediately contact the Health Department to ask what additional preventive measures should be taken.
	• Observe all children and adults for sore throats for seven days.
	• Anyone developing a sore throat should see a physician.
	• Advise parents that their child should see a physician if:
	  • The child develops a sore throat.
	  • The child is incompletely immunized against diphtheria.
	• Carefully follow good hygiene procedures.
		When the Health Department tells you it is safe.

Epiglottitis	• A child diagnosed with this disease probably will be hospitalized. • Contact your Health Department and ask what preventive measures to take. • Carefully follow good hygiene procedures. • IMPORTANT: H-flu is not the same germ as "flu" or influenza. H-flu can cause SERIOUS ILLNESS in young children. If a case of H-flu occurs in your facility, TAKE ALL ACTIONS ABOVE.	Not do to H-flu: When treating physician tells you when it is safe. Due to H-flu: When the Health Department tells you it is safe.
Hand-Foot-and-Mouth Disease	• Exclude if child has open, draining lesion on hand or has lesions in the mouth AND is drooling.	When lesions heal or drooling ceases.

Disease	If a Child in Your Care Has Been Diagnosed with This Disease You Should	When to Allow Child to Return
Hepatitis A	• Temporarily exclude the sick child from the child care setting. • Immediately notify your Health Department. They may recommend immune globulin shots, and possibly vaccination for children and adults and additional preventive measures. Ask for specific recommendations on notifying parents and on exclusion policies. • Carefully follow good hygiene procedures.	One week after illness begins (onset of jaundice or yellow appearance).

Influenza	As per the American Academy of Pediatrics: Flu is more dangerous than the common cold for children and can lead to serious health condition like pneumonia or bacterial infections. Any child with a cough, runny nose, or sore throat AND fever should be excluded	May return after the fever resolved without the use of fever reducing medicines.
Measles	• Temporarily exclude the sick child from the child care setting. • Immediately notify your Health Department. • Identify unimmunized children and adults. Make sure they get vaccinated and/or exclude them from the child care setting until two weeks after rash appears in the last child who had measles in the child care setting.	Five days after rash appears and Health Department says it is safe.
Mumps	• Temporarily exclude the sick child from the child care setting. • Carefully follow good hygiene procedures. • Notify Health Department.	Nine days after swelling begins.
Pertussis (Whooping Cough)	• Temporarily remove the sick child from the child care setting. • Immediately notify your Health Department. • Exclude, until diagnosed by a physician, any other child who develops a cough within two weeks of the initial case. • Carefully follow good hygiene procedures.	Five days after antibiotics are begun and Health Department says it is safe.
Pinworms	• Temporarily exclude the child from the child care setting. • Notify parents.	24 hours after treatment and bathing.
Pneumonia	• A child diagnosed with this disease will probably be hospitalized. • Contact your Health Department and ask what preventive measures to take. • Carefully follow good hygiene procedures. • IMPORTANT: H-flu is not the same germ as "flu" or influenza. H-flu can cause SERIOUS ILLNESS in young children. If a case of H-flu occurs in your facility, TAKE ALL ACTIONS ABOVE.	Not do to H-flu: When treating physician tells you when it is safe. Due to H-flu: When the Health Department tells you, it is safe.
Ringworm	• Temporarily exclude the child if the lesion cannot be covered.	If unable to cover lesion, after treatment begins and the lesion starts to shrink.
Rubella (German or Three-day Measles)	• Temporarily exclude the child from the child care setting. • Immediately notify your Health Department. • Advise any pregnant women in the facility who are not known to be immune to see their physicians. • Carefully follow good hygiene procedures.	Six days after rash appears and Health Department says it is safe.
Scabies	• Temporarily exclude the child from the child care setting. • You may contact your Health Department about identifying and treating exposed children and adults.	24 hours after treatment has begun.
Streptococcal sore throat (Strep Throat)	• Temporarily exclude the child from the child care setting • Contact your Health Department if two or more children are diagnosed with strep throat.	24 hours after antibiotics are begun.
Active Tuberculosis (TB) Infection	• Immediately notify your Health Department. • Children with TB may usually remain in child care after treatment as long as they are receiving appropriate treatment.	When Health Department says it is safe.

Suspected Illness or Communicable Disease Exclusion Form

Name of Child _____ **Facility** _____

Date of Birth _____ **Date** _____

Dear Parent or Guardian:

Today at the child care facility your child was observed to have one or more of the following signs or symptoms:

- ❑ Diarrhea (more than one abnormally loose stool
- ❑ Difficult or rapid breathing
- ❑ Earache
- ❑ Fever (101°F or above orally)
- ❑ Gray or white stool
- ❑ Headache and stiff neck
- ❑ Infected skin patches
- ❑ Crusty, bright yellow, dry or gummy areas of skin
- ❑ Loss of appetite
- ❑ Pink eye
- ❑ Tears, redness of eyelid lining
- ❑ Irritation
- ❑ Swelling and/or discharge of pus
- ❑ Severe coughing
- ❑ Child gets red or blue in the face
- ❑ Child makes a high-pitched croupy or whooping sound after he or she coughs
- ❑ Sever itching of body/scalp
- ❑ Sore throat or trouble swallowing
- ❑ Unusual behavior
- ❑ Child cries more than usual
- ❑ Child feels general discomfort
- ❑ Cranky or less active
- ❑ Just seems unwell
- ❑ Unusual spots or rashes
- ❑ Unusually dark, tea-colored urine
- ❑ Vomiting
- ❑ Yellow skin or eyes
- ❑ Head lice or nits

Contact your physician if there is:

- Persistent fever (over 100°) without other symptoms
- Breathing so hard he cannot play, talk, cry or drink
- Severe coughing
- Earache
- Sore throat with fever
- Thick nasal drainage
- Rash accompanied by fever
- Persistent diarrhea
- Severe headache and stiff neck accompanied by fever
- Yellow skin and/or eyes
- Unusual confusion
- Rash, hives, or welts that appear quickly
- Sever stomach ache that causes the child to double up and scream
- No urination over an 8-hour period; the mouth and tongue look dry
- Black stool or blood mixed with the stool
- Any child who looks or acts very ill or seems to be getting worse quickly

We are excluding your child from attendance at our program until (possible options):

- ❑ The signs or symptoms are gone
- ❑ The child can comfortably participate in the program
- ❑ We can provide the care your child needs
- ❑ Other: _____

Community Resources Information for Children Health and Prevention of Diseases

Contra Costa County
Contra Costa County – Public Health
597 Center Avenue
Martinez, CA
925-313-6750

Alameda County

Health Care Services
1000 San Leandro Blvd
San Leandro, CA 94577
510-618-3452

Children's and Youth Services

Big Brothers/Big Sisters of San Francisco and the Peninsula, 65 /battery Street 2nd floor, San Francisco 94111 415-503-4050, (TDD) 693-7777, fax 693-7799, email info@sf-bbbs.org. To provide positive, long-term mentoring to youths who face the challenges of growing up in low income, single-parent homes.

California Children's Services Program (CCS), 720 Empey Way San Jose 408-793-6200 Program Director. CCS provides medical care and rehabilitation for Californians under age 21. Services include diagnostic evaluation, treatment, medical case management, physical and occupational therapy and orthopedic and pediatric clinic services.

Catholic Charities of the Archdiocese of San Francisco, 990 Eddy Street , San Francisco 94109, 415-972-1200, website http://www.ccasf.org; Catholic Charities administers a wide variety of children and family services, aging services, HIV housing and services, housing and programs for homeless and at-risk families.

Children's Council of San Francisco, 445 Church St , San Francisco 94102, 415-276-2900, Services include child care resource and referral, subsidized child care, child care provider technical assistance, start-up and training, child development and mental health consultation. All services available in English and Spanish.

Chinatown Child Development Center (Community Mental Health Service),1525 Grant Ave, San Francisco 94108,415-984-1450. Mental health services for children 0-14 years old. Focus on family. Cantonese, Mandarin, Vietnamese and Cambodian language capacities.

American Academy of Pediatrics
Resource in English and Spanish on a variety of pediatric health topics for families and health care professionals.
www.aap.org

California Center for Childhood Injury Prevention
Resource center on child and adolescent injury prevention strategies; data; technical assistance with injury prevention programs and links with agencies, researchers, advocates and injury professionals, a variety of

education materials. One of the four national sites of the Children's Safety Network.
http://www.cccip.org/main.htm

California Department of Health Services
All the latest health information on medical insurance, infectious disease, family planning, and children's medical services, as well as local and county health department contacts and many valuable health links.
http://www.dhs.cahwnet.gov/

Center for Nutrition Policy
Dietary guidance materials; resources include recipes and tips for healthy, thrifty meals and the Food Guide Pyramid.
www.usda.gov/cnpp

Centers for Disease Control and Prevention
Information regarding allergies; cigarette and tobacco issues; drug addiction; disease and disease prevention; immunization; and general, dental and mental health. Information available in Spanish at
www.cdc.gov/spanish
www.cdc.gov

Centers for Disease Control and Prevention
Also from CDC, The ABCs of Safe and Healthy Child Care, assists child care providers with information on reducing sickness, injury and other problems in child care homes or centers.
http://www.cdc.gov/ncidod/hip/abc.htm

Child Care Environment Safety Checklist
This Web Guide reviews statistics about child care services and offers suggestions on maintaining a safe environment for children in your care.
www.ianr.unl.edu/pubs/safety/g1213.htm

Child Care Food Program
Part of the Nutrition Services Division of the CA Department of Education, this state and federally funded program gives aid to licensed child care centers and homes.

www.cde.ca.gov/ls/nu/cc/

California Children and Families Commission
Provides, on a community-by-community basis, all California children prenatal to five years of age with a comprehensive, integrated system of early childhood development services. Through the integration of health care, quality child care, parent education and effective intervention programs for families at risk, children and their parents and caregivers will be provided with the tools necessary to foster secure, healthy and loving attachments. These attachments will lay the emotional, physical and intellectual foundation for every child to enter school ready to learn and develop the potential to become productive, well-adjusted members of society.
www.ChildsWorld.ca.gov

Children and Family Services Division, CA Department of Social Services
Responsible for designing and overseeing an array of program and services for California's at-risk families and children, providing a statewide system for out-of-home care providers and appropriate services to children in

out-of-home care, and facilitation of adoptions for children who need permanent homes.
www.ccfa.ca.gov

Consumer Product Safety Commission
Consumer and business information, including a library, recall information, public calendar, and keyword search engine. www.cpsc.gov

Family Doctor
User-friendly site with health information for the whole family from the American Academy of Family Physicians. Information in Spanish available at Doctor para la Familia:
http://familydoctor.org/online/famdoces/home.html www.familydoctor.org

The Future of Children
Provides policymakers, service providers, and the media with timely, objective information based on the best available research. *The Future of Children* web site now includes special resources and interactive tools. *The Future of Children* journal, published twice per year, offers comprehensive, cross-disciplinary articles focusing on issues related to children.
http://www.futureofchildren.org

Healthy Child Care
This bimonthly magazine offers information on safety, health, nutrition and infectious disease prevention – for classrooms and child care setting.
www.healthychild.net

Injury Prevention Web
Hosts the websites of several agencies and organizations working to prevent injuries. This site contains a weekly literature update of recent journal articles and agency reports, injury data for every U.S. state, more than 1400 links to government and non-profit injury prevention sites worldwide.
http://injurypreventionweb.org

KidsHealth
Doctor-approved health information about children from before birth through adolescence; provides families with accurate, up-to-date, and jargon-free health information, with separate areas for kids, teens, and parents.
www.kidshealth.org

National Health Information Center
A health information referral service including publications, an extensive health information resource database, national health observances, and toll-free numbers and web links.
www.health.gov/nhic

Occupational Safety and Health Administration (OSHA)
Establishes protective standards, enforces those standards, and reaches out to employers and employees through technical assistance and consultation programs.
www.osha.gov

CONSENT FOR HEALTH CONSULTATION SERVICES FOR THE CHILD

I, _____, give permission for my child,

_____ to receive the services **checked and initialed** below. The purpose of these services is to understand and address my child's needs within the context of their child care program. These services will be provided or administered by

_____.

❏ Observation of my child in his/her child care setting.
❏ Consultation with program staff regarding my child's health, safety and/or behavior.
❏ Consultation with family regarding my child's health, safety and/or behavior.
❏ Developmental and/or health screening (including, but not limited to, speech, vision and hearing)
❏ Health and/or Child Care Records review (please specify):
_____

❏ Health assessment
❏ Developmental assessment
❏ Behavioral assessment
❏ Other (please specify):
_____

I understand that information regarding my child is generally confidential and may *not* be given to employees of other schools, public agencies or individual professionals in private practice without my consent or other legal requirement. My signature on this form provides permission for results of the above-checked service(s) to be shared with staff at

_____.

Further, _____
is authorized to share the information gained with his/her supervisor(s) and/or child care health consulting staff working directly with her/him. Consent for release of information and authorization of communication shall be for the purpose of understanding and addressing my child's needs. This consent is voluntary and I understand that I can withdraw my consent for my child at any time. Unless I withdraw this consent, this authorization will be effective for the period my child is continuously enrolled in the
_____.

By signing below, I am confirming that I have read, understood and agree to the above conditions and services.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

Staff Illness and Exclusion Policy

Like children, adults are also capable of transmitting communicable diseases. A child care provider should be temporarily excluded from providing care to children if she or he has one or more of the following conditions:

Condition	Exclude from Child Care Setting
Chickenpox	Until six days after the start of rash or when sores have dried/crusted.
Influenza (Flu)	Respiratory symptoms (cough, runny nose, or sore throat) AND fever should be excluded from child care, until the fever resolves without the use of fever reducing medications.
Shingles	Only if sores cannot be covered by clothing or a dressing; if not, exclude until sores have crusted and are dry. A person with active shingles should not care for immune-suppressed children, or work with immune-suppressed staff or parents.
Rash with fever or joint pain	Until diagnosed not to be measles or rubella.
Measles and rubella	Until six days after rash starts.
Vomiting	If two or more episodes of vomiting during the previous 24 hours, or if accompanied by a fever, until vomiting resolves or is determined to be due to such noninfectious conditions as pregnancy or a digestive disorder.
Pertussis (Whooping Cough)	Until after five days of prescribed antibiotic therapy.
Mumps	Until nine days after glands begin to swell.
Diarrheal illness	If three or more episodes of loose stools during the previous 24 hours, or if diarrhea is accompanied by fever, until diarrhea resolves.
Hepatitis A	For one week after jaundice appears or as directed by health department, especially when no symptoms are present.
Impetigo (a skin infection)	Until 24 hours after prescribed antibiotic treatment begins and lesions are not draining.
Active Tuberculosis (TB) (not a positive skin test only)	Until the local health department approves return to the setting.
Strep throat (or other streptococcal infection)	Until 24 hours after initial antibiotic treatment, and fever has ended.
Scabies/head lice/etc.	Until after the first treatment; scabies until treatment has been completed.
Purulent Conjunctivitis	Until 24 hours after prescribed treatment has begun.
Haemophilus Influenza Type b (Hib)	Until the prescribed antibiotic treatment has begun.
Meningococcal Infection	As specified in specific disease section of this manual.

Respiratory Illness	If the illness limits the staff member's ability to provide an acceptable level of child care and compromises the health and safety of children or other staff.
Herpes cold sores	Should cover and not touch their lesions, carefully observe hand washing policies and must not kiss or nuzzle infants and children, especially those with dermatitis.
Other conditions mandated by state public health law	As required by law (consult your local health department).

Health Limitations of Child Care Staff

It is recommended that child care providers and volunteers have a health care provider's release to return to work in the following situations:

a. When they have experienced conditions that may affect their ability to do their job (such as pregnancy,
specific injuries or infectious disease).

b. After serious or prolonged illness.

c. Before return from a job-related injury.

During the course of an identified outbreak of any communicable illness in the child care setting, if the health department or health consultant determines that he or she is contributing to the transmission of the illness at the setting.

Caring for Children with Mild Illness

Young children enrolled in child care have a high incidence of illness such as upper respiratory tract infections, including otitis media and other temporary conditions such as eczema, diarrhea and exacerbation of asthma that may not allow them to participate in the usual activities. Most child care settings will need to provide at least temporary care for ill children. If a child becomes ill during the day, providers can help manage the illness and keep the child comfortable until a designated adult arrives.

Basic Issues for Decision-Making

A. Set Policies and Know When to Be flexible

Many health policies concerning the care of ill children have been based upon common misunderstandings about contagion, risks to ill children, and risks to other children and staff. Current child care research clearly shows that certain ill children *do not* pose a health threat. Also, the research shows that keeping certain *other* mildly ill children at home or isolated at the child care setting *will not* prevent other children from becoming ill.

Appropriate reasons to exclude mildly ill children are:

- The child's disease is highly communicable.
- The child does not feel well enough to participate.
- The staff is not able to care for sick children in the child care setting.

Severity Level:

Decisions should be made on a case-by-case basis. Child care facilities should specify in their policies what severity levels of illness they can handle and their plan of care with their local county health department, the child's health care provider, and / or related health care professionals.

- *Severity Level 1*: Child feels well enough and shows high interest in participating in activities because of an absence of symptoms of illness such as recovery from pink eye, rash or chicken pox. Appropriate activities for this level include most of the normal activities for the child's age and developmental level, including both indoor and outdoor play. For full recovery, children at this level need no special care other than medication administration (according to the policy) and observation.

- *Severity Level 2:* Child's demonstrates a medium activity level because of symptoms such as low-grade fever. Child may also be at the beginning or recovery period of an illness. Appropriate activities include crafts, puzzles, table games, fantasy play, and the opportunity to move about the room freely.

- *Seventy Level 3:* Child's activity level is low because of symptoms that prevent much involvement. Appropriate activities are sleep and rest; light meals and liquids, passive activities such as stories and music; and for children who need physical comforting, being held and rocked (especially children under three years of age).

Ways to manage ill or infected children:

The major options for management of ill or infected children in child care and for controlling spread of infection include the following:

(1) Antibiotic treatment prophylaxis or immunization when appropriate.
(2) Exclusion of ill or infected children from the facility.
(3) Provision of alternative care at a separate site (such as care in the child's own home, care in a small family-child-care home, care in the child's own center with special provisions designed for the care of ill children, or care in a separate center that serves only children with illness and temporary disabilities).
(4) Limiting admission of newly enrolled children.
(5) Closing facility (a rarely exercised option).

B. Issues for Providers to Consider

When you need to decide whether to keep a mildly ill child at your child care setting, ask these questions:

- **Are there sufficient staff** (including volunteers) to change the program for a child who needs some modifications such as quiet activities, staying inside or extra liquids?
- **Are staff willing and able to care for a sick child** (wiping a runny nose, checking a fever, providing extra loving care) without neglecting the care of other children in the group?
- **Is there a small space where the mildly ill child can rest if needed?** Is there a Space that might be used as a "Get Well Room" which meets California standards so that several children could be cared for at once? Is the child familiar with the caregiver?
- **Are parents able or willing to pay extra for sick care** if other resources are not available, so that you can hire extra staff as needed?
- **Have parents made arrangements prior to illness** for pick-up and cane of ill children if they are not available?

C. Issues for Parents to Consider

When parents need to decide whether or not to send a child to child care, they must weigh many facts such as how the child feels (physically and emotionally), the child care program's ability to serve the needs of the mildly ill child, and income /work lost by staying home.

When to Call For Help

At any time you believe the child's life may be at risk or you believe there is a risk of permanent injury, seek immediate medical treatment. Do not delay or hesitate, when in doubt, call 911.

Document what happened and what actions were taken; share verbally and in writing with the parents.

Be prepared to call for Emergency Medical Services immediately (EMS) 911 if:

- You believe the child's life is at risk or there is a risk of permanent injury.
- The child is acting strangely, much less alert, or much more withdrawn than usual.
- The child has difficulty breathing, is having an asthma exacerbation, or is unable to speak.
- The child's skin or lip look blue, purple, or gray.
- The child has rhythmic jerking of arms and legs and a loss of consciousness (seizure).
- The child is unconscious.
- The child is less and less responsive.
- The child has any of the following after a head: decease in level of alertness, confusion, headache, vomiting, irritability, or difficulty walking.
- The child has increasing or severe pain anywhere.
- The child has a cut or burn that is large, deep, and/or won't stop bleeding.
- The child is vomiting blood.
- The child has a severe stiff neck, headache, and fever.
- The child is significantly dehydrated: sunken eyes, lethargic, not making tears, not urinating.
- Multiple children affected by injury or serious illness at the same time.
- When in doubt, call 911 (EMS).
- After you have called 911, remember to contact the child's legal guardian.

Some children may have urgent situations that do not necessarily require ambulance transport but still need medical attention. The parents should be called if you see any of the below condition. If the parents cannot be reached or cannot reach a doctor within one hour - the child should be transported to the hospital.

- Fever in any age child who looks more than mildly ill. (Fever is defined as a temperature above 101 F (38.3 C) orally, above 102 F (38.9 C), or 100 F (37.8 C) or higher taken axillary (armpit) or measured by an equivalent method.)
- Fever in a child less than two month (eight weeks) of age.
- A quickly spreading purple or red rash.
- A large volume of blood in the stools.
- A cut that may require stitches.
- Any medical condition specifically outlined in a child's care plan requiring parental notification.

The Best Way to Take a Temperature

For more information see the following handout fact sheet prepared by California Childcare Health Program http://www.ucsfchildcarehealth.org/pdfs/factsheets/feverEN_0512.pdf

Digital thermometers should be used with infants and young children when there is a concern for fever, Tympanic (ear) thermometers may be used with children four months and older. However, while a tympanic thermometer gives quick results, it needs to be placed correctly in the child's ear to be accurate.

Glass or mercury thermometers should not be used. Mercury containing thermometers and any waste creates from the cleanup of a broken thermometer should be disposed of at a household hazardous waste collection facility.

Oral (under the tongue) temperatures can be used for children over age four. Individual plastic covers should be used on oral thermometers with each use or thermometers should be cleaned and sanitized after each use according to the manufacturer' instruction.

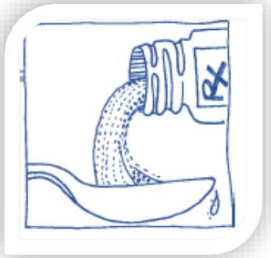
Auxiliary (under the arm) temperatures are less accurate but is a good option.

Rectal Temperatures

Taking a rectal temperature is not acceptable per California Licensing regulations and should never be done in childcare.

The site where a child's temperature is taken (oral, auxiliary, or tympanic) should be documented along with the temperature reading and the time the temperature was taken, because different sites give different results and affect interpretation of temperature.

Medications Administration Policy



Medication administration video -
https://www.youtube.com/watch?v=WsOBLpbVUgE

Some children in your child care setting may need to take medications during the hours you provide care for them. The administration of medicines at the child care facility should be limited to prescribed or nonprescription medication prescribed/recommended by a health care provider for a specific child. Before agreeing to give any medication, whether prescription or over-the-counter (OTC), you should obtain written permission from the parent. Also, check with your local child care licensing agency regarding local regulations on administering medications. If you need to administer medications, they must be given to the right child, in the correct amount (dose), in the right way, and at the right time and write it down record the administration of medication in a log.

Have a Written Policy

Child care facilities should have a written policy for the use of prescription and nonprescription medication. Your medication policy should cover use of any commonly used nonprescription medication. Your health consultant could be helpful in preparing such a policy as it relates to acetaminophen, sunscreen, syrup of ipecac, etc.

Child care providers need to be aware of what medication the child is receiving, who prescribed the medicine and when, and what the known reactions or side effect may be if a child has negative reaction to the medicine.

In the child care setting it is justified to give medications if:

- Dosage cannot be adjusted so that it can be taken before and after child care.
- A child has chronic health conditions *(e.g.* asthma, diabetes) which may require urgent administration of medicine.
- Refusal to administer the medication would pose a significant hardship, such as requiring the child's absence from child care to recover from an illness when the child is well enough to attend child care (e.g. ear infection after the first day or so).

Medications Which Can Be Given Safely

The administration of medications at the child care program shall be limited to:

1. Prescribed medications ordered by a health care provider for a specific child and a specific illness
2. Nonprescription medications recommended by a health care provider for a specific child, with written permission of the parent or legal guardian, referencing a written or telephone instruction received by the child care program from the health care provider
3. Medications which responsible staff have been trained to administer including oral, topical, nasal, ear and eye.
4. Medications which bear their original prescription label or a manufacturer's label and which are provided in safety lock containers, transported safely with regard to temperature, light and other physical storage requirements. It would be preferred that medication be transported by the parent to the child care center in a lock box but this is not requirement.
5. Child care center are to store refrigerated medication in a lock box
6. Medications for which all the criteria on the program's approval form have been met.
7. Medication given should be documented at the time it is given on the child's medication log.

Medication Which You Can Accept to Administer

Make sure that any prescribed medication parents may give you meets the following criteria:

Parents to provide medication

- The first and last name of the child are on the container.
- The medication has been prescribed by a licensed health professional. Check to see that the name and phone number of the health professional who ordered the medication are on the container.
- The medication is in the original package or container.
- The container shows the date the prescription was filled.
- The container has an expiration date.
- The container has specific instructions for administering, storing and disposing of the medication.
- The container is childproof.
- The medication is for the current episode of illness.
- Parents are not required to provide medication in a lock box

***Child care homes and center staff to confirm the above information and mediation provided by the parents is correct*.**

All medications, refrigerated or unrefrigerated, shall:

- Have child-protective caps.
- Be kept in an orderly fashion.
- Be stored away from food.
- Be stored at the proper temperature.
- Be inaccessible to children.
- Not be used beyond the date of expiration.
- Be given only for the purpose identified on the label/prescription.
- Be clearly labeled with the child's name.
- Child care homes and center should store mediations that need to be refrigerated in a **lock box** in the refrigerator.

Who Should Be the Person Responsible for Administering Medication?

Someone who:

- Has designated time for administering medications
- Has been trained to administer the type of medication as required by protocol of the local health consultant
- Will assure safe storage and disposal of medication
- Has access to locations where medication is stored and administration records are kept
- Knows the children to whom the medication is to be given
- Knows about the potential reactions to the medications to be administered, and how to respond to such reactions
- Knows when and how to contact parents, pharmacists or health providers to clarify the need and instructions for administration of medication in child care

Which Records Should Be Maintained?

A medication record maintained on an ongoing basis by designated staff shall include the following:

1. Specific, signed parental consent for the caregiver to administer the specific medication
2. Prescription by a health care provider, if required
3. Administration log listing names, dates, time, dose and medication names
4. Checklist of information on medication brought to the setting by the parents

Each child must have his or her own *individualized*, written plan for providing Incidental Medical Services. The child care provider, the family, and the physician must work together to decide whether (and how) the provider can give medication to that *individual* child. The *individual* plan should be kept in the child's file, but does not have to be submitted to the Community Care Licensing Division. Community Care Licensing is not involved in making the plan, and cannot prohibit a child care provider from giving a child medication.

Child care programs also must keep complete records of the necessary documents to support giving IMS to a particular child in that child's record (see below

1. Written **consent from the child's parent or authorized representative** that the child may receive specified IMS at the facility, and the names of all child care staff who will be trained to give the medication;
2. Written **medical orders from the child's physician**, which includes:

(a) a statement that a non-medical person may provide the IMS;

(b) if medication is prescribed, the name of the medication, method, amount, and time schedule for administering the medication; and

(c) a description of the required training for all staff who will be giving the medication.

3. Written verification that the **designated licensee or staff** has completed the training required by the physician's medical orders, and that at least one of the designated and trained staff persons will be at the facility at all times that the child needing services is in care.

Child care providers or programs then submit a Plan of Operation to Provide Incidental Medical Services to Community Care Licensing. The provider must revise the Plan whenever there are changes to the services provided.
The Plan describes the facility's IMS policies and procedures to ensure the proper safeguards are in place. ***Some*** of the topics to be covered in the Plan are:

- Types of Incidental Medical Services to be provided;
- Records to be obtained and maintained, such as permission from the parental/authorized representative to provide the IMS; written instructions from the child's physician; verification of staff training; how you will keep records of the medication or service provided;
- Plan for safe storage of medications and equipment/supplies;
- Training requirements, including how to administer medication/service, who will provide the training and what to do in emergencies;
- How you will ensure adequate staffing to provide IMS to all children who need it;
- Plan for ensuring proper safety and hygiene procedures;
- Plan for transporting medication, equipment, and supplies with child(ren) to ensure IMS are not interrupted during field trips or when there is a disaster; and
- Plan for reporting any serious incidents to the parent/guardian and appropriate authorities.
- In addition to *individualized* plans for children who require IMS, a child care program that cares for children who need IMS shall identify those services in its general Plan of Operation that it submits to the Community Care Licensing Division.

- A facility applying for a license should include the IMS information in their Plan submitted at the time of application. Currently licensed facilities must submit a revised Plan of Operation for approval at the time that they begin to provide IMS to children in their care.

Remember these five ''rights" when you give medicines:

The right CHILD

The right MEDICINE

The right DOSE

The right ROUTE (by mouth, or on skin, etc.)

The right TIME

Rational use of antibiotics

Write it down on the record the administration of medication in a log

Antibiotics are powerful drugs that kill bacteria that cause disease. If a child in your care has a bacterial infection, his or her health care provider may prescribe a specific type of antibiotic for a specific period of time. Antibiotic resistance is a growing concern and a major public health problem. More than 126 million doses of antibiotics are prescribed annually in the US of which 20 to 50 percent are unnecessarily prescribed. The rise in antibiotic resistance prolongs illness, increases illness rates and results in higher and unnecessary health care costs. Approximately three-fourths of all outpatient antibiotic prescriptions for children are given for five upper respiratory tract conditions—ear infection, sinusitis, cough illness/bronchitis, sore throat, and nonspecific upper respiratory tract infection or the common cold. Health care providers report that many parents, often asked by child care providers, try to pressure them into dispensing unnecessary antibiotics. Children treated with an antibiotic are at increased risk of becoming earners of resistant bacteria. Carriers of a resistant strain who develop illness from that strain are more likely to fail antibiotic therapy. In some conditions, therefore, such as ear infection with fluid, observation without antibiotic therapy is the preferable option, while in other conditions such as the common cold or cough, antibiotic therapy is not indicated. Child care providers can play a very important role in changing parents' awareness and understanding regarding the responsible use of antibiotics by having exclusion policies that do not exclude children unnecessarily or until a prescription is obtained.

Medication Administration Form

The (name of facility/center) _____ will administer medication to children for whom a plan has been made and approved by the Director. Because medication poses an extra burden on staff and having medication in the facility is a safety hazard, parents/guardians should check with the child's health care provider to see if a dose schedule can be arranged that does not involve the hours the child is in care by this facility/center. Parents/guardians may come to administer medication to their own child during the day.

If a liquid oral medication is to be administered at the facility/center, the parent/guardian must provide the administration device with clearly marked measurements (medicine sip-vial, medicine cup, dropper, or syringe).

Medication in Child Care:

Requires parent/guardian to complete and sign this *Medication Administration Form*; form shall be kept in the child's record with all supportive documentation.

1. Medication must be in original, child-proof container and labeled with child's name.
2. All medication containers and dispensers will be stored out of the reach of children and in a locked cabinet, or refrigerator if necessary, and will be returned to parent/guardian when completed.
3. Requires a written plan to record the administration of all medications and to inform the child's parent/guardian daily when such medications have been given.
4. When no longer needed by the child, or when the child withdraws from the program, all medications should be returned to the child's parent/guardian or disposed of after an attempt to reach parent/guardian.

Prescription Medications:

- Medication is administered in accordance with the pharmacy label directions as prescribed by the child's healthcare provider
- The instructions from the child's parent/guardian shall not conflict with the label directions as prescribed by the child's healthcare provider.

Non-Prescription (Over-the-Counter) Medications:

- May be administered without approval or instructions from the child's healthcare provider.
- Shall be administered in accordance with the product label directions on the container.
- The instructions from the child's parent/guardian shall not conflict with the product label directions on the container.

AUTHORIZATION FOR MEDICATION ADMINISTRATION

I hear by authorize designated agents of (name of facility/center): _____

to administer the following medication to my child _____. I further agree to indemnify and hold harmless this facility/center, their agents, and servants against all claims as a result of any and all acts performed under this authority.

Parent/Guardian Name_____ Telephone _____

My child's healthcare provider is _____ My child's condition is_____

Purpose of Medication is _____

Time of Administration _____ Name of Medication_____

Duration of Administration _____ Method of Administration_____

Possible side effects _____

In case of emergency contact _____ Telephone _____

Parent/Guardian Signature _____ Date _____

Monthly Medication Record

Child Name_____

Monthly Medication Record

Dates to administer	Dosage amount	Time of administration	Staff signature and time given	Staff signature and second time given (if required)	Parent initial to acknowledge administration
Monday Date:					
Tuesday Date:					
Wednesday Date:					
Thursday Date:					
Friday Date:					
Monday Date:					
Tuesday Date:					
Wednesday Date:					
Thursday Date:					
Friday Date:					
Monday Date:					
Tuesday Date:					
Wednesday Date:					
Thursday Date:					
Friday Date:					
Monday Date:					
Tuesday Date:					
Wednesday Date:					
Thursday Date:					
Friday Date:					

Insect Repellent Permission Form

Parent/Guardian Permission to Apply Insect Repellant to Child

Name of Child: _____

As a parent, I recognize that insect bites to my child pose a risk of allergic reactions and disease. Therefore, I give permission for the staff of _____ to apply an insect repellant approved for use on children containing (no more than) 10%-15% DEET (name of product) _____ to my child under the following conditions:

1. When mosquitoes are present.
2. During field trips that may expose a child to ticks or mosquitoes.
3. Always used according to directions on the label.
4. Applied only to exposed skin and clothes.
5. Not applied to babies under 2 months.
6. Not applied near eyes or mouth or on hands.

Use of the product may occasionally cause a skin reaction. If that happens, we will discontinue use of the product, wash affected skin and notify you so you can seek advice from your health care provider. It is best if you use this or a similar product on your child once or twice at home first to monitor for reactions.

I have checked and initialed below all applicable information regarding the child care program's choice in brand/type and use of insect repellant for my child:

❑ ___ Staff may use the program's insect repellant indicated above according to the directions on the product label.

❑ ___ I do not know of any allergies my child has to children's insect repellant.

❑ ___ My child is allergic to some insect repellants. Please use only the following brand(s)/type(s) of repellant: _____, according to the directions on the label.

❑ ___ I have provided the following brand/type of insect repellant for use on my child:

_____

❑ ___ For medical or personal reasons, please DO NOT apply insect repellent to the following areas of my child's body:

_____

❑ ___ **Please do not apply insect repellant to my child.**

Parent/Guardian's Name: _____ Date: _____

Parent/Guardian's Signature: _____

Health Provider's Signature (optional): _____

Get Children to take Medicine

1. In general, medicine isn't absorbed as quickly when it's paired with solid food or milk, explains Tom McGinnis, a pharmacist and deputy associate commissioner for health affairs at the FDA. "But if this is the only way you can get your child to take the medicine, it's fine," says McGinnis. Some exceptions: penicillin G and erythromycin lose their potency when mixed with acidic foods like applesauce, orange juice, or soda.

2. Check with your pharmacist to make sure it's okay to crush a tablet. Some medications may irritate the stomach if you destroy the protective coating, or they may fail to do the job they're meant to do.

3. Make sure your child swallows – and doesn't chew – a tablet after it has been crushed. Chewing can interfere with a time-release feature; a non-chewable medicine may be especially bitter; and some of the medication could stick to your child's teeth, preventing him from getting the full dosage.

4. Don't overdo it. If you mix the medicine with too much of a particular food or beverage, your child might have trouble getting it all down and therefore won't receive the full dosage.

5. Don't freeze the medicine or warm it up to make it more palatable. Temperature changes may alter the efficacy of the medication.

6. Don't call the medicine candy. Emphasize to your child that you are giving him medicine, not a treat. And store all medications out of sight and reach.

7. If you can't convince your little one to cooperate, let your doctor know he isn't getting the prescribed medication.

Sunscreen Permission Form

PARENT/GUARDIAN'S PERMISSION TO APPLY SUNSCREEN TO HIS/HER CHILD

Name of Child: _____
(last, first)

As the parent/guardian of the above child, I recognize that too much exposure to UV rays may increase my child's risk of getting skin cancer someday. Therefore, I give permission for the staff at: _____
(name of child care program)

to apply a sunscreen product that is broad spectrum with SPF 15 or higher to my child, as specified below, when he or she will be playing outside, especially during the months of March through October and between the daily time of 10 a.m. and 4 p.m. I understand that sunscreen may be applied to exposed skin, including but not limited to the face (except eyelids), tops of ears, nose, bare shoulders, arms and legs.

I have *checked* and *initialed* below **all** applicable information regarding the child care program's choice in brand/type and use of sunscreen for my child:

❑ ___ I do not know of any allergies my child has to sunscreen.
❑ ___ My child is allergic to some sunscreens. Please use ONLY the following brand(s)/type(s) of sunscreen: _____
❑ ___ Staff may use the sunscreen of the program's choice following the directions and recommendations printed on the product container.
❑ ___ I have provided the following brand/type of sunscreen for use for my child:

_____
❑ ___ For medical or other reasons, please do NOT apply sunscreen to the following areas of my child's body: _____

Parent/Guardian's Name: _____**Date:** _____

Parent/Guardian's Signature: _____

Health Care Provider's Signature (*optional*): _____

NOTE: DO NOT RELY ON SUNSCREEN ALONE TO PROTECT CHILDREN FROM SKIN CANCER!

SUN-SMART POLICY FOR CHILD CARE PROGRAMS

Our Sun-Smart policy has been developed to ensure that all children and staff participating in this program are protected from skin damage caused by the harmful UVB and UVA rays of the sun. This policy will be implemented throughout the year, but with particular emphasis from March through October.

🎧 **Sun-Smart strategies**:

1. Encourage staff and children to wear hats with wide brims that protect their face, neck and ears whenever they are outside.
2. Encourage staff and children to wear sun-protective clothing (i.e., tightly woven, loose-fitting, full length, light-colored and light-weight) when temperatures are reasonable.
3. Encourage staff to wear sunglasses that block 100 percent of UVA and UVB rays (broad spectrum) whenever they are outside.
4. Provide sufficient areas of shelter and/or trees providing shade on the play yard.
5. Encourage children to seek and use available areas of shade for outdoor play activities.
6. Schedule excursions and all outdoor activities *before* 10 a.m. and *after* 4 p.m. (10 a.m. to 3 p.m. during the winter months) whenever possible. The availability of shade will be considered when planning excursions and outdoor activities during these times.
7. Children will be hydrated and encouraged to drink water before and during prolonged physical outdoor activities in warm weather.
8. Staff and parents/guardians will model sun safety behaviors by:
    - ❑ Wearing appropriate hats and clothing when outdoors.
    - ❑ Using broad spectrum SPF 15 or higher sunscreen for protection
    - ❑ Seeking shade whenever possible.
9. Provide broad spectrum SPF 15 or higher (and *paba* and *alcohol* free, if possible) sunscreen for staff and children to use on exposed skin, except eyelids, 30 minutes before exposure to the sun and every two hours while in the sun, unless parent/guardian provides their own sunscreen for their child.
10. Parents/guardians will complete and sign the *Parent/Guardian's Permission to Apply Sunscreen to His/Her Child* (see reverse) and it shall remain on file at the program.
11. Include learning about the skin and ways to protect the skin from the UV rays of the sun into the program's curriculum and daily routines.
12. The *Sun-Smart Policy* will be reinforced in positive ways through parent newsletters, staff memos, bulletin boards and meetings. Signage shall be posted that reminds staff, parents and children to practice sun safety.
13. Staff and parents will be provided with educational materials and resources on sun safety and protection.

🎧 **When enrolling their child, parents/guardians will be**:

1. Informed of the program's *Sun-Smart Policy*.
2. Asked to provide a suitable hat for their child's use when outdoors in the care setting.
3. Required to provide permission for staff to apply sunscreen (and *optional*: health care provider's signature included on consent form).
4. Asked to provide a broad-spectrum SPF 15 or higher sunscreen if their child is allergic to the program's offered brand/type.
5. Encouraged to practice *Sun-Smart* behaviors themselves.

RECOMMENDED STANDARD/OPTIONAL: Every child should have on file a standing order from their health care provider for the use of sunscreen.

Children with Special Needs

Children with developmental disabilities, chronic illness or weak immune systems warrant special consideration either because they are unusually susceptible to infection or because they may infect other children.

The ADA allows states to provide greater protection for people with disabilities. In California, additional state laws protect people with disabilities. These laws include the Unruh Civil Rights Act, which guarantees full and equal privileges and services in all business establishments of every kind whatsoever. They also include the California Disabled Persons Act, which states that people with disabilities or medical conditions have the same right as the general public to the full and free use of public places. A child care provider that violates the ADA also violates the Unruh Civil Rights Act and California Disabled Persons Act.

The ADA provides a list of specific places that are considered public accommodations including "a nursery, elementary, secondary, undergraduate, or postgraduate private school, or other place of education" and "day care center(s)." These private entities are considered places of public accommodation because they hold themselves out to the public as a business. A child care provider, whether operating out of a center or a family child care home, is a place of public accommodation.

In practical terms, what is reasonable will vary. The accommodations must be based on individualized assessments of the child's needs and the program's ability to make the necessary modifications. Generally, the three most important variables are (1) the needs of a person with a disability, (2) the accommodations requested, and (3) the resources available to the program. A family child care home that has fewer resources and a smaller staff may not be required to make the same accommodation required of a larger center.

- In cases of changes in policies, practices or procedures, the accommodation would **fundamentally alter the nature of the program or services offered**;
- In the case of auxiliary aids and services, the accommodation **would fundamentally alter the nature of the program or pose an undue burden** (i.e., pose a significant difficulty or expense);[
- In the case of the removal of physical or structural communication barriers, the accommodation is **not readily achievable**. If removal of such a barrier is not readily achievable, the ADA requires providers to make services available through alternative methods if such methods are readily achievable.

Child care providers should begin the process of identifying reasonable modifications by talking with the parent(s) or legal guardian about the child's needs and the accommodations sought. If the child has an individualized family services plan (IFSP) or an individualized education plan (IEP) to meet his or her educational needs as required under the Individuals with Disabilities Education Act, the provider can look to the IEP for information about what services and accommodations a school is providing to help the child attain his or her educational goals. An IFSP or IEP is only one tool for determining accommodations, and not the definitive answer as to what is reasonable

1. Children with Developmental Disabilities

In general, children with developmental disabilities are not particularly vulnerable to infection and require no special precautions or procedures. A few categories of disabilities are associated with higher rates of infection, however, such as children with spina bifida, cerebral palsy or Down Syndrome.

The Americans with Disabilities Act (ADA) protects individuals with disabilities and requires that every effort be made to reasonably accommodate disabilities. Child care providers are expected to modify their basic policies, practices and procedures to make reasonable accommodation to include children with disabilities in their programs. In most cases, such accommodation is compatible with a safe and healthy environment from which all the children in the child care setting can benefit.

Child care providers must offer services in the most natural setting appropriate to the needs of the individual. In addition to making physical changes such as installing ramps, wide doors and restrooms that can accommodate children in wheel chairs, you may need to provide for a child's special physical, emotional or psychological needs. Other special needs may include assistance in feeding, following special dietary requirements, giving medicines and/or performing medical procedures, and ensuring that special equipment is functional or is used properly. There is help available through many different programs to assist providers in properly caring for children with special needs.

Before you admit a child with developmental disabilities, make sure that you can comfortably answer the following questions:

1. Does the child's disability require more care than you are reasonably able to provide?
2. Do you have the skills and abilities needed to perform medical or other duties required for the child's care, or can you readily acquire those skills?
3. Is your child care program equipped to meet the health and safety needs of this child?
4. Is the extra time you will need to devote to taking care of this child more than you can handle without putting the other children in your care at increased risk for illness or injury, or without causing you to neglect their needs?

The *Americans with Disabilities Act* requires that as a provider responsible for all the children in your care, you should ensure that the extra demands on your time to care for a child with special needs are supported with additional resources, including help from experts. You should work with the child's parents and health care professionals to make sure that you have the support you need.

Many child care providers are concerned that certain infections acquired before or around the time of birth *(e.g.,* rubella, CMV, herpes simplex, hepatitis, and AIDS) may persist and be spread to other children or staff members. In some cases, these congenital infections pose a very small risk to others, and with proper precautions, affected children may safely participate in most child care or educational programs. In other cases, special precautions are warranted.

2. Children with Chronic Illness

Children with chronic illnesses, weakness or malnutrition are particularly vulnerable to infection. For example, infants who were premature, children who have chronic lung disease and children with cystic fibrosis, frequently have a higher than average incidence of respiratory infections. Similarly, children with congenital heart disease may have unusual difficulty with some respiratory viruses. Children with diseases or structural abnormalities of the urinary tract are highly vulnerable to infections of the bladder and kidneys. Although it is not always possible to prevent these diseases, providers should be alert to the symptoms of infection and notify the child's parents and/or health care provider if they occur. Once treatment is initiated, these children should be able to participate in regular group care activities.

3. Children with Weak Immune Systems

Certain diseases or treatments can lower the body's natural defenses against infection. AIDS, cancer of the blood and some other diseases of the immune system significantly change the body's ability to fight infection, allowing even common organisms to quickly become life threatening. In children with previously normal immune systems, some drugs that are used to treat chronic conditions (e.g. steroids) suppress the body's ability to fight infection. Drugs used to prevent rejection of organ transplants or to temper the body's attack on its own organs can also interfere with the normal immune response. In a child with cancer, both the disease itself and the drugs used to treat it inhibit the body's defense mechanisms.

Children with diseases or treatments that affect the immune system may need to be isolated from other children during periods of particular sensitivity. Their health care providers may prescribe special precautions regarding limited exposure to infection, particularly to chickenpox, since this disease can kill individuals with suppressed immunity. Keep in mind that vaccines with live viruses such as measles, rubella, chickenpox and polio (OPV) are not recommended for people with known weak immune systems.

Despite the risks of spreading or getting infections, children in these special population groups need to have opportunities for socialization that are as normal as possible. With care and planning, the majority of these children can be safely integrated into child care and school settings. Administrators, teachers and child care providers should work closely with parents and health care providers to establish a safe environment for these children, their peers and staff members who care for them.

Special Health Care Plan

The special health care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on appropriately accommodating the special health concerns and needs of this child while in child care.

Name of Child: _____

Date:

Facility Name: _____

Description of condition(s): (include description of difficulties associated with each condition)

Team Member Names and Titles (parents of the child are to be included)

Care Coordinator (responsible for developing and administering the Special Health Care Plan):

ⓘIf training is necessary, then all team members will be trained.
❑Individualized Family Service Plan **(IFSP)** attached ❑Individualized Education Plan **(IEP)** attached

Outside Professionals Involved Telephone Numbers:

Health Care Provider (MD, NP, etc.):
Speech & Language Therapist:
Occupational Therapist:
Physical Therapist:
Psychologist/Mental Health Consultant:
Social Worker:
Family-Child Advocate:
Other:

Communication
How the team will communicate (notes, communication log, phone calls, meetings, etc.):
How often will team communication occur: ❑ **Daily** ❑ **Weekly** ❑ **Monthly** ❑ **Bi-monthly** ❑ **Other**
Date and time specifics:

Emergency Illness and Procedures

When parents enroll their child, they should provide you with the contact information and consent that you will need if there is an emergency involving that child.

All parents of children in your care should know your emergency procedures. Let parents know that you are trained in first aid and CPR as taught by a California approved training facility. Tell parents how often you take refresher courses. Tell them that in the event of an emergency, you will:

1. Quickly assess the child's health.
2. Call 9-1-1 or another appropriate emergency help as needed.
3. Give first aid and CPR, if necessary.
4. Contact parents or the person they have listed to call in an emergency.
5. Call Poison Control if their child is exposed to toxic substances.

At All Times, You Should

- Have emergency numbers posted by the phone: police and ambulance (9-1-1), and the poison control center (1-800-376-4766 in California).
- Keep parents' consent forms for emergency treatment and numbers for emergency contacts on file, and take a copy with you whenever you leave the facility.
- Maintain a current CPR and first aid certificate.
- Post first aid procedures where they can be easily seen.
- Write up an emergency procedure and evacuation route. Make sure you are familiar with it.
- Keep a fully stocked first aid kit in easy reach of all providers, but out of reach of children. Check the first aid kit regularly and restock it as necessary.
- In addition to the supplies listed for your first aid kit, you should also keep ice cubes or ice bags in the freezer to use to reduce swelling of some injuries.
- Place a stocked first aid kit in every vehicle used to transport the children. In addition to the items in your child care program's first aid kit, your vehicle kit should also include a bottle of water (refreshed on a regular basis), soap, coins for a pay telephone and a first aid guide.
- Don't use first aid sprays and ointments. They may cause allergic reactions or skin damage. Use alcohol or antiseptic wipes.
- Wear gloves if you might come in contact with blood.
- Have first aid supplies handy on the playground by keeping a zip-lock plastic bag stocked with disposable gloves, sterile wipes, gauze wrap and bandage strips in your pocket.

If an Injury Occurs

1. Stay calm.
2. Check for life-threatening situations (choking, severe bleeding, or shock). Do not move a seriously injured child.
3. Call 9-1-1 or your local emergency number, if the child is seriously hurt. Make sure other children are safe.
4. Give CPR or first aid, if necessary.
5. Contact the parent/emergency contact.
6. Record all injuries on a standard form developed for that purpose.

Understanding Injuries in the Child Care Setting

Injuries occur as a result of unsafe conditions in the environment, participation in activities which are not developmentally appropriate, and/or a lack of adult supervision. Age and sex of children, size of the facility, adult-to-child ratio, specific program offerings (e.g., swimming, field trips), playground equipment, supervision, and enforcement of policies and regulations are some of the factors that may influence the risk of injury in child care settings.

Successful strategies for preventing child care injuries require a better understanding of injuries—what injuries happen, to whom, where, how and when.

What types of injuries are common?
Children attending child care are most likely to face the following types of injuries:

- Minor injuries such as cuts, scrapes and bruises
- Severe injuries such as head injuries, broken bones, internal injuries, dislocations or dental injuries
- Poisoning
- Drowning
- Burns
- Choking and suffocation

Who gets injured? Studies show that:

- Injury rates are low for infants and increase with the age of the child. Injuries are most frequent among two- to five-year-old.
- The difference for boys and girls in preschool is small. At age five, the number of injuries increases among boys as they are more often involved in more active physical play.

How are children injured?
The following factors contribute to injuries and may be divided between child-related factors and environment-related factors:

- Falls are the leading cause of serious injuries. The playground is the major site of injury in the child care setting and accounts for 50 to 60 percent of all child care injuries. Sometimes furniture, stairs or windows are also involved.
- Another child is involved (fighting, pushing, colliding, throwing, biting, etc.).
- The child collides with objects such as moving playground equipment, furniture, part of the building, plants, toys, a fence or gate, etc.
- The child is cut by a sharp edge, burned by a hot surface, hot tap water or heater, or poisoned by toxic materials.
- Injuries occur related to transportation and cars.

When do injuries happen?

- In the summer and spring, probably due to outdoor play and particularly the
  use of playground equipment
- Late in the morning and late in the afternoon, when children are hungry or tired, and when providers are busy or less available to supervise

Why are children injured?

Children may be injured due to:

- Lack of safety knowledge
- Lack of ability or imitation of others more physically advanced
- Hazards in the environment and access to toxic materials
- Lack of safety precautions, safety devices or supervision

Contra Costa County

Contra Costa County – Public Health
597 Center Avenue
Martinez, CA 925-313-6250
Child's Health & Disability Prevention Program
595 Center Avenue Suite 310
Martinez, CA 925-313-6250
Communicable Disease Prevention General Information
597 Center Avenue
Martinez, CA 925-313-6740

Alameda County

Health Care Services
1000 San Leandro Blvd #300
San Leandro, Ca 94577 510-618-3452

Risk of Injury and Stages of Development

Children are at risk for injuries because developmental factors limit their physical, mental and emotional abilities. They grow quickly and want to test and master their environment. Their curiosity, fearlessness and lack of safety knowledge put them at risk of attempting actions for which they may lack the skills and physical capabilities. The type of injuries children may incur is related to their development. For example, an infant's neck is too weak to support the weight of his head, so he will be at risk of serious injury and even death if shaken. Infants and toddlers explore their surroundings by putting objects in their mouths, and therefore are at risk of choking. Toddlers like to walk fast, climb and reach for objects, and therefore are at risk of falling or poisoning. Motor vehicle accidents are the leading cause of injury in all age groups.

As child care providers, we want to assure that children are challenged by their environment and can explore safely. Knowing the children in your care and being careful to remove hazards and set up the environment with their abilities in mind can prevent injuries. Because each child develops at her own rate and not according to any exact age, the examples below are only a framework. One child may crawl at six months, another at one year.

Examples of Stages of Growth, Risk of Injury and Prevention Tips

Age	Characteristics	Risk of Injury	Prevention Tips
Birth to 3 months	Eats, sleeps, cries Has strong sucking reflex Begins grasping and rolling over unexpectedly Needs support of head and neck	Falls from couches, tables, changing tables and bed Burns from hot liquids Choking and suffocation SIDS (Sudden Infant Death Syndrome)	Never leave infants alone on beds, changing tables, sofas, chairs, or any other high surface Always check water temperature before bathing infant. Set hot tap water temperature below 120°F. Install smoke alarms and check the batteries twice a year Keep small objects and toys away from the baby All infants should be placed on their backs for sleeping Do not use soft bedding in a baby's sleeping area Approved child safety seats must be properly installed in the back seat facing the back of the car, and used.

Age	Characteristics	Risk of Injury	Prevention Tips
4 to 6 months	• Sits with minimum support • Plays with open hands • Reaches for objects • Begins to put things in mouth • Is increasingly curious about surroundings • Wants to test, touch	• Vehicle occupant injury • Falls • Burns from hot liquids • Choking and suffocation • SIDS (Sudden Infant Death Syndrome) • Shaken Baby Syndrome	• Approved safety seats must be properly installed in the back seat facing the back of the car, and used. • Never leave infants alone on beds, changing tables, sofas, chairs, or any other high surfaces. • Always check water temperature before bathing infant. Set hot tap water temperature below 120°F. • Keep small objects and toys away from the baby. • All infants should be placed on their backs for sleeping. • Do not use soft bedding in a baby's sleeping area • Never shake a baby, even playfully.
7 to 12 months	• Sits alone • Very curious about everything • Crawls • Starts to walk • Explore surroundings • Pulls things • Likes to go outside • Imitates movements of adults and others • Begins eating solid food	• Vehicle occupant injury • Falls • Burns from hot liquids and surfaces • Choking and suffocation • Sudden Infant Death Syndrome • Shaken Baby Syndrome	• Approved child safety seats must be properly installed and used. • Do not use walkers and another walker-type equipment. • Always check water temperature before bathing infant. Set hot top water temperature below 120°F. • Keep hot foods and liquids out of the reach of children. • Put guard around radiators, hot pipes and other hot surfaces. • All infants should be placed on their back for sleeping. • Always carefully supervise; never leave a child alone in or near any water (including tubs, toilets, buckets, swimming pool or any other containers of water) even for a few seconds. • Never shake a baby, even playfully.

Age	Characteristics	Risk of Injury	Prevention Tips
• 1 and 2 years	• Likes to go fast • Is unsteady • Tries to reach objects • Runs • Walks up and down stairs • Likes to climb • Pushes and pulls objects • Can open doors, drawers, gates and windows • Throws balls and other objects • Begins talking, but cannot express needs	• Motor vehicle injuries • Falls • Burns • Poisoning • Choking • Drowning • Child abuse	• Put toddler gates on stairways and keep any doors to cellars and porches locked. • Show child how to climb up and down stairs. • Remove sharp-edged furniture from frequently used areas. • Turn handles to back of stove while cooking. • Teach child the meaning of "hot." • Keep electric cords out of child's reach. • Use shock stops or furniture to cover used and unused outlets. • Store household products such as cleaners, chemicals, medicines and cosmetics in high places and locked cabinets. • Avoid giving child peanuts, popcorn, raw vegetables and any other food that could cause choking. • Toys should not have small parts. • Always carefully supervise; never leave a child alone in or near any bodies of water even for a few seconds. • Check floors and reachable areas carefully for small objects, such as pins, buttons, coins, etc.

Age	Characteristics	Risk of Injury	Prevention Tips
• 3 and 4 years	• Begins making choices • Has lots of energy • Seeks approval and attention •	• Traffic injuries • Burns • Play area • Poisons • Tools and equipment • Choking	• Check and maintain playground equipment ad environment. • Child should play on age and weight-appropriate equipment. • The surface under and around play equipment should be soft and shock absorbent. Use specifically approved surface materials. Do not use crumb rubber – the EPA is currently researching the effects of crumb rubber because of concerns from parents and sports coaches. • Check that child is dressed appropriately to avoid strangulation (e.g. no drawstrings on shirt, jackets, etc.). • Store household products, medicines and cosmetics out of child's sight and reach. • Teach child about the difference between food and nonfood, and what is not good to eat. • Watch child carefully during arts-and-crafts projects for mouthing of paints, brushes, paste, and other materials. Use nontoxic supplies. • Store garden equipment, scissors,

Age	Characteristics	Risk of Injury	Prevention Tips
• 5 years and up	• Is stronger • Likes to explore the neighborhood • Will ask for information • Will seek out playmates • Becomes involved in sports • Plans and carries out ideas	• Traffic injuries • Burns • Play area • Guns •	• Teach pedestrian and traffic safety rules. • Older children must wear safety belts. Be a positive role model: cross streets correctly and wear a safety belt at all times when traveling in a car. • Always use helmets even on bicycles with training wheels or tricycles. • Teach children how to drop and roll if their clothing catches fire. • Practice fire drills so child becomes familiar with the escape route and the sound of the smoke alarm. • Keep matches and lighters away from children. Stress bringing found matches to adults. • Check and maintain playground equipment and environment. • Child should play on developmental and weight-appropriate equipment. • The surface under and around play equipment should be soft and shock absorbent. Use specifically approved surface materials. • Teach safe play rules and encourage child to put toys away after playing. • Do not keep guns or any other weapons in the child care setting.

Be a positive role model: keep in mind that your own attitudes and behaviors are as important as the physical environment of your facility. Role modeling should reflect the behaviors the child care provider wishes to pass on to the children. Education and supervision also help providers maintain a safe child care environment.

To prevent injuries in the child care setting, a safety policy and plan should be implemented.

Examples of Safe Practices that Can Be Used for Safety Policies

- Explaining safety actions to the children
- Practicing safe activities in the child care and community environment
- Using safety devices such as smoke alarms and electrical outlet plugs
- Being sensitive to unsafe conditions

- Having daily routines for safety checks
- Removing hazards to ensure a safe physical environment
- Educating oneself on safety issues and practices
- Communicating with parents about safety measures
- Teaching what to do in an emergency and clarifying the provider's safety behavior during practice drills and role-play
- Using special care plans for children with disabilities, behavior issues, and/or special health care needs.

Active Outdoor Play

State of Arizona Physical Activity in Childcare

https://www.youtube.com/watch?v=F-mcKvLKNtk

Winter brings many wonderful opportunities for children to delight in seasonal changes while playing outdoors. But all too often cold or rainy days mean that many young children spend their day indoors engaged in quiet activities. Keep the following in mind:

- Playing outdoors in cold weather doesn't cause colds—germs do. Playing outdoors will reduce the amount of time children and adults are exposed to germs while cooped up inside.
- Dress in layers and keep extra dry clothing for children who get wet or muddy.
- Open a window and let in the fresh air periodically. Overheated rooms with stale, dry air can be a health hazard.
- Change your furnace and air filters regularly and watch for mold.
- Use sunscreen to prevent sunburn and decrease the risk of developing skin cancer at a later age whenever your child is playing outdoors. Unless it's actually raining, sun damage can occur whether it's sunny or cloudy.
- The American Academy of Pediatrics recommends that all trampolines be avoided due to the high number of injuries at all ages.
- Prevent slips and falls by wiping down wet outdoor equipment. Check for adequate cushioning under climbing equipment, as sand and bark may compact when wet.
- Never let toddlers play around water without constant supervision. It takes very little time and only a few inches of water for a puddle to become a drowning hazard.

During the Spring, Summer and Fall where it is common to have high temperatures always check all outdoor toys and equipment to make sure they are not too hot to use and or cause burns.

And remember—have fun outdoors with your children. Even when the weather is less than perfect, it's good for you too!

Studies show that regular physical activity helps children be fit and healthy, improves self-esteem and decreases the risk of serious illnesses such as heart disease and stroke later in life. Active outdoor play enhances children's senses of smell, touch and taste, and the sense of motion through space, which are powerful ways of learning. Children's perceptual abilities may suffer when they experience the world mainly through television, computers and books. Their social abilities to cooperate, help, share and solve problems with other children are fostered when playing together outdoors. And when they have access to the outdoors, they gain the ability to navigate their immediate environment safely, and lay the foundation for the courage that will enable them eventually to lead their own lives.

Ideas for active play

Infants count on you to set up a safe space away from more mobile children where they can explore with their senses, practice using their muscles and move freely. A large blanket on the floor with some colorful toys or objects of different sizes, shapes and textures will keep them active and interested. Try to take infants outdoors each day, even for a short walk in the yard.

Toddlers explore and learn about the world through unstructured play time. Running, climbing and playing in a sandbox are all fun and offer opportunities to develop and practice new skills. You can lead movement activities such as jumping with two feet, skipping and running. Explore the crunchy leaves, bare tree limbs and what can float in puddles.

Preschool-age children can enjoy simple games, such as Simon Says. They can roll large balls, play catch and ride wheel toys, dance, sing or move to music. Unstructured time allows them to learn important skills, use their imaginations, and offers time to wind down. Gardening or simple science activities can encourage their enjoyment of the outdoors while using all their senses.

School-age children are ready for new learning experiences and both team and individual sports. Children who prefer not

to participate in organized teams need regular exercise, such as running, walking, skating, bicycling, dance and nonviolent martial arts.

Children with chronic health conditions and disabilities should be included in outdoor play activities; they receive the same positive benefits from exercise and exploration. Some activities may need to be modified or adapted.

Model Safety Policy

Supervision of Active (Large Muscle) Play

Observation of active (large muscle) play in indoor and outdoor spaces will be as follows:

- High-risk play areas (i.e., climbers, slides, swings and water play) will receive the most staff attention.
- All children using playground or indoor play equipment will be supervised. No children will be permitted to go beyond a caregiver's range of direct supervision. Child-to-staff ratios will be at least as high as those for other child care activities.
- Children will be specifically assigned to a caregiver and regularly counted to confirm their whereabouts at all times.
- A written schedule will be prepared by _____ (staff title/name) and used to assign staff to supervise high-risk areas.
- When swimming, wading or performing other gross-motor play activities in water are part of the program, there will be one-to-one supervision of infants by adults, at least two-to-one supervision for toddlers, four-to-one supervision of preschool age children and six-to-one supervision for school-age children. Pools are not recommended for children in diapers.
- Pushing and dunking of a child or running shall be prohibited.
- Children shall not be allowed to bring non-water toys and flotation devices into the water-play area.

Staff Assignment for Active (Large Muscle) Play

Week of:	Climbers	Swings	Slides	Riding Toys	Other
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

Child Care Environment Safety Checklist

General Indoor Areas

Yes	No	
❑	❑	Guns are not allowed or kept in the child care setting.
❑	❑	Areas are kept clean and unobstructed (to prevent physical injuries and fire hazards).
❑	❑	Stairways are carpeted and have a child-height railing on the right side for descending.
❑	❑	Check that carbon monoxide alarms and working
❑	❑	Smoke alarms are working.
❑	❑	No peeling paint is visible; no lead-based paint is used.
❑	❑	Electrical sockets are high and out of reach, or securely covered.
❑	❑	No dangling or covered electrical extension cords are present.
❑	❑	Medications and cleaning solutions are never kept in the classroom or playroom.
❑	❑	All hardware on cribs, tables and bookcases is checked monthly (screws and bolts are tight).
❑	❑	Chairs or tables are not used as ladders to hang items.
❑	❑	No sharp corners are exposed on tables or other furniture.
❑	❑	Toys are safe, with no sharp areas, pinch points or small parts.
❑	❑	Fire exit from the room requires only one turn or pull-down action to open the door or gate.
❑	❑	Accessible above-ground-level windows are protected with adequate grills or screens.
❑	❑	Children cannot reach hot surfaces, hot pipes, heaters or vents.
❑	❑	Freestanding space heaters are not used.
❑	❑	Temperature of tap water for handwashing is maintained at 120°F or less.
❑	❑	Lighting is adequate in all rooms.
❑	❑	Walkways are clear between sleeping cots for children and staff.
❑	❑	Children are never left alone in high chairs, chairs, or on changing tables.
❑	❑	Infant walkers are never used.
❑	❑	Pacifiers with strings longer than six inches are not allowed.
❑	❑	Emergency phone is accessible.
❑	❑	Trash cans are covered and secured.
❑	❑	No smoking is allowed.

Yes	No	
❑	❑	Floors are smooth, clean and not slippery.

Kitchen

Yes	No	
❑	❑	Only authorized personnel are allowed in the kitchen.
❑	❑	Sharp utensils are kept out of reach.
❑	❑	All containers are clearly marked and have secure lids.
❑	❑	Fire extinguishers are easily accessible.
❑	❑	Items on shelving units, such as cans of food, are neatly organized, secured, and not piled high.
❑	❑	Separate sinks are used for handwashing and food preparation.
❑	❑	Refrigerated medicines are out of reach of children.

Bathrooms

Yes	No	
❑	❑	Cleaning supplies and medicines are not accessible.
❑	❑	Toilets and sinks are appropriate for use by children; step stools are provided.
❑	❑	Water temperature for handwashing is maintained at 120° or less.
❑	❑	Floors are non-skid.

Outdoor Playground

Yes	No	
❑	❑	Equipment is checked weekly for sharp protrusions.
❑	❑	Bolts are covered; swings have soft seats.
❑	❑	Ground is covered with loose-fill surface material.
❑	❑	Play area is fenced; gate has safety locks.
❑	❑	Equipment is developmentally appropriate.
❑	❑	Slides are enclosed or have handrails.
❑	❑	Only one child at a time uses equipment
❑	❑	There are no spaces where child's head, leg or arm could be trapped. (3-1/2 – 9 inches)
❑	❑	Constant supervision is provided.
❑	❑	No poisonous plants, trash or sharp objects are in the area surrounding the playground.
❑	❑	Sandboxes are kept covered when not in use.

Toxic Chemicals

Yes	No	
❑	❑	Kitchen and cleaning supplies should have their own locked unit.
❑	❑	Cleaning solutions for use in classrooms and playrooms are stored in a locked cabinet.

Computers, Televisions and Electrical Equipment

Yes	No	
❑	❑	Ensure that the equipment is flush against the wall so that electrical outlets are not exposed.
❑	❑	Only authorized people provide service for equipment.
❑	❑	Liquids are not allowed near equipment.
❑	❑	Children are supervised while equipment is in use.

Vans and Other Vehicles

Yes	No	
❑	❑	First aid kit is available
❑	❑	Child restraint devices are appropriate for the child's size, weight, and development.
❑	❑	Seat belts are used and maintained.
❑	❑	Radio sound level is kept at a minimum, and the program content is appropriate for children.
❑	❑	Vehicle tires, oil and brakes are maintained regularly.
❑	❑	Driver has a current driver's license and is properly trained.
❑	❑	Children are not allowed in the front seat.
❑	❑	Vehicle is checked for sharp or rusty metal.
❑	❑	An adult trained in CPR and first aid is available when traveling.
❑	❑	Bike helmets are available when needed.

Training

Yes	No	
❑	❑	A person certified in pediatric first aid, rescue breathing and first aid for choking is on site at all times.
❑	❑	Children are taught safety and emergency procedures.
❑	❑	Staff is fully trained in emergency procedures for all children, including those with special health and/or developmental needs.

Art Supplies

Yes	No	
❑	❑	Nontoxic and natural materials such as dyes and water-based products are used.
❑	❑	Use of scissors is supervised.
❑	❑	Aerosol sprays and solvent-based glues are avoided.

Field Trips

Yes	No	
❑	❑	Adequate supervision is provided.
❑	❑	Each child wears identification.
❑	❑	Young children hold hands in pairs or hold onto a rope when walking in a group.
❑	❑	Emergency medications are taken along.

Equipment

Yes	No	
❑	❑	First aid kit is appropriately stocked.
❑	❑	Sports equipment is safe and soft.

Emergency and Severe Weather Drills

Yes	No	
❑	❑	All children are safely evacuated to a safe area within three minutes.
❑	❑	Monthly fire drills are held.
❑	❑	Smoke detectors and the alarm system are in place and working.

❑ ❑ Earthquake kits are well stocked and available.
❑ ❑ Each child has an emergency kit in his or her cubby.

Motor Vehicle, Transportation and Pedestrian Safety

What a child care provider needs to know
Motor vehicle crashes are the leading cause of death and disability in the United States. Motor vehicle injuries to children occur when they are riding in a car that stops suddenly or crashes; when they are pedestrians and hit by a car; or when they are riding bicycles. Children of all ages can be the unfortunate victims of car crashes, but those between the ages of two and six pose a special challenge because their levels of curiosity, activity and need for constant reinforcement are at a peak. As a child care provider, you can make a difference by practicing preventive measures for car travel, field trips and by teaching children about traffic safety.

Safety seats and boosters
The California child restraint law is based on safety concerns regarding the improper use of vehicle seat belts and addresses the minimum safety standards. Misuse of child restraints is widespread. The misuse rate varies by location, but it is estimated that about 85 to 95 percent of children who are placed in child safety seats and booster seats are improperly restrained. If used properly, child safety seats and safety belts are very effective in preventing death and severe injuries in a crash.

California Law

- Children under the age of 8 must be secured in a car seat or booster seat in the back seat.
- Children who are 8 years of age **OR** have reached 4' 9" in height must be secured by a safety belt in the back seat.

- Passengers who are 16 years of age and over are subject to California's Mandatory Seat Belt law.
- **Effective January 1, 2017** - Children under 2 years of age shall ride in a rear-facing car seat unless the child weighs 40 or more pounds **OR** is 40 or more inches tall. The child

shall be secured in a manner that complies with the height and weight limits specified by the manufacturer of the car seat.

The impact of air bags may cause serious or fatal injuries to infants and children. Even a child correctly buckled up could be injured by an air bag. Never put a rear-facing infant in front of an airbag and keep other children in the back seat away from the airbag.

Child restraints are available for children with special needs who cannot ride safely in other child passenger restraints. The American Academy of Pediatrics (www.aap.org) has a resource entitled, "Car Seat Shopping Guide for Children with Special Needs," that can help with selecting the correct child restraint.

Safety around cars

Young children walking to child care are also at risk of traffic injuries. Many children are also killed when adults back over them with a car. In addition, there have been cases of deaths to young children who were left unattended by an adult in a car. Some of these children were under the care of a child care provider at the time of death. When transporting children, make sure a child is not left behind.

CHILD RESTRAINT SYSTEM AND SAFETY SEATS

Any child under the age of least 8 years old or until they are at least 4 feet 9 inches in height must be secured in a federally approved child passenger restraint system and ride in the back seat of a vehicle.

Proper car seat installation can be checked by contacting local law enforcement or the fire department which may provide this service or refer you to a Child Passenger Safety (CPS) Technician in your area. As your child grows, check with these agencies to confirm that the car seat is the correct size for your child.

Children ages least 8 years old or until they are at least 4 feet 9 inches in height, must be properly secured in an appropriate child passenger restraint system or safety belt which meets federal safety standards.

RIDING SAFELY WITH AIR BAGS

Most people can take steps to eliminate or reduce risk without turning off air bags. The biggest risk is being too close to the air bag. An air bag needs about 10 inches of space to inflate. Ride at least 10 inches (measured from the center of the steering wheel to your breastbone) from the air bag cover if you can do this while maintaining full control of the vehicle. If you cannot safely sit 10 inches away from the air bag, contact your vehicle dealer or manufacturer for advice about additional ways of moving back from your air bag.

Passengers should also sit at least 10 inches away from the passenger side air bag.

SIDE-IMPACT AIR BAGS

Side-impact air bags can provide extra safety benefits to adults in side-impact crashes. However, children who are seated next to a side air bag may be at risk of serious or fatal injury. Since there are differences in the design and performance of side air bags, you should consider the benefits and risks associated with the use of side air bags if you transport children. Studies have shown that children who are leaning against a side air bag when it inflates are at risk of serious injury. These studies also show that children who are traveling in an age and weight appropriate,

and correctly installed child restraint system, are not at risk of serious injury. These children are usually not in the path of a side air bag when it inflates.

UNATTENDED CHILDREN IN MOTOR VEHICLES

It is illegal to leave a child six year of age or younger unattended in a motor vehicle when:

- There are conditions that present a significant risk to the child's health or safety. Example: Leaving a child in a closed car on a very hot day.
- The vehicle's engine is running, the keys are in the ignition, or both. Children can start or move the car causing injuries and/or deaths to themselves or others.
- The court may fine violators and require the person to attend a community education program. Also, the penalties for leaving an unattended child in a vehicle are more severe if the child is injured, requires emergency medical services, or dies.

Suggestions for Child Care Providers

1. Always use a child restraint every time you transport a child in your care.
2. Make sure your vehicle is in good working order and seat belts are all working.
3. ALWAYS buckle up children in the back seat if possible. Never place a rear-facing infant in the front seat with a passenger air bag.
4. Develop and consistently use a Safe Transportation Policy. Let your parents, helpers or staff know about the policy.
5. Include car seat safety education in your curricula and circle times.
6. Encourage your kids to become Buckle Up Buddies in child care and at home, too.
7. Post the Car Seat Law in your family child care or child care center (required for centers).
8. Receive training in the proper use of child safety seats.

Child and Car Prevention of Hyperthermia

1. Children overlooked by child care drivers transporting children.
   Child care providers should implement a procedure for accounting for children who are being transported to and from child care or to activities. They should also implement procedures for check vehicles after each transport. If a child care provider drives the center or child care home children to an event she/he should take roll call to assure everyone is safely off the vehicle, and then check the entire vehicle thoroughly before leaving the vehicle
2. Busy parent changes his/her routine and forgets to drop the child off at the child care home or center and leaves the child all day in a locked car at the place of work.
   Child care providers should implement a system in which they make telephone calls to a child's parents to check on the whereabouts of the child when the child is not brought into their child care home or center at their regular drop-off time or is absent from the child center home or center without an excuse (much like a school makes calls to parents for unexcused school absences). The child care provider can also share prevention methods with the parents, such as placing a purse, or briefcase, or other necessary item in the back seat, so the parent will have to open the back door to retrieve the item, and then see the child in the car seat.
   another idea for reminding a parent about a child in the back seat as a stuffed animal in the front seat as a reminder that their child is with them during the transport.

3. Parent leaves one child in car while delivering another child to child care or school.
   Child care providers and center directors should implement a policy in their child care center and homes that children will not be left alone in cars on the child care home or center premises, and that they will not be left in cars during drop-times siblings or other children at the child care home or center. Child care providers can educate parents that children should not be left alone in cars for any reason.
4. Children playing in unlocked cars.
   Make sure all cars that are on the child care home or center premises are locked when parked on the premises. Teach children not to play in or near vehicles. Supervise children during play.

5. Children are left in cars as punishment.

This is never an acceptable option for child care. Child care providers should use age-appropriate and safe methods to discipline (teach) children.

6. Parent or child care provider leaves child in car as substitute for child care.

This is never an acceptable option for child care. For parents experiencing difficulty in obtaining child care, or for a parent with few child care options, they may find assistance by calling a social services agency, such as a child abuse prevention council, for assistance with respite or emergency care, or a resource and referral agency that can advocate for safe care for their child.

Common Problems When Using Car Seats

Safety seat checkups held in counties throughout the state reveal levels of misuse at 95 percent. These are some common mistakes found at car seat checkups:

- A child not riding in a safety seat or sitting in the seat without using the harness adjusted securely.
- An infant facing the front of the car. Babies should face the rear until they are at least 24 months of age, 40 inches tall or 40 pounds.
- An infant riding in the front seat with a passenger air bag. Move the infant to the back seat facing the rear.
- Children riding in the front seat when a back seat is available. Children under age 13 should ride in the back seat.
- Too many people in the car. Each person must have his/her own safety belt.
- The car seat not secured tightly to the car. Tighten the seat so that it does not move more than one inch to the side or the front of the car.

Safety Belt Songs

Singing Buckle-Up Songs

Introduce either or both of these songs. "Buckle, Buckle, Buckle Up" reminds children always to wear their safety belts and to ride in the back seat. "Where's Your Safety Belt?" is a reminder of the correct way to wear safety belts.

Older children can be divided into two groups so some can sing the questions and others can sing back the answers. Then repeat the song, with children trading parts.

"Buckle, Buckle, Buckle Up"

Sung to the tune of "Row, Row, Row Your Boat"

Buckle, buckle, buckle up
Riding in the car.
Always put your safety belt on
Going near or far.

I am very special, and
I take care of me.
Riding safely in the back's The
safest place to be.

Suggested motions:

1. Hold two ends of safety belt and buckle up.
2. Hug self.
3. Thumb over shoulder, point to back seat.

"Always Buckle Up"

Sung to the tune of "The Farmer in the Dell"

I always buckle up
I always buckle up
Whenever riding in the car
I always buckle up
My ( )* buckles up
My ( )* buckles up
Whenever riding in the car
My ( )* buckles up

* Add Daddy, Mommy, puppy, etc.

"Where's Your Safety Belt?" *Sung to the tune of "Where is Thumbkin?"*

Where's your safety belt?
Where's your safely belt?
Here is mine! Here is mine!
Buckled 'round my hips
Buckled 'round my hips
Where is yours?
Where is yours?

Suggested motions:

1. Hand against forehead searching.
2. Pat front of belt.
3. Pat hips.
4. Palms up, questioning.

"Wear Your Safety Belt" *Sung to the tune of "Allouette"*

Wear your safety belt
Always wear your safety belt
Wear your safety belt
Riding in the car
When I'm riding in the car,
If I'm going near or far,
I buckle up
I buckle up
I buckle up
I buckle up
Oh - uh - uh - oh
(Repeat above)

Bus Safety

1. **No child who is too small to use a shoulder- lap belt restraint and air bag system should ride in the front seat.**

2. **If the vehicle is a school bus, before every trip in the bus, a staff member will instruct children and all adults using the bus about the 10-foot danger zone around the vehicle where the driver cannot see.**

3. **Caregivers will interact with children who are awake while traveling by telling stories, singing songs, playing games, or talking about what the children see.**

4. **A staff member will explain rules of the road and provide a positive example by obeying these rules; children will be asked to point out and identify traffic warning signs.**

5. **No child should be transported for more than an hour, one way, on a daily basis.**

6. **A designated staff member should be responsible for assuring all children are accounted for before the vehicle leaves the facility, when the children disembark at the destination, and when the children re-enter the vehicle upon return to the facility. Staff will conduct a "sweep" of the vehicle each time the vehicle is parked to be sure that no child is left in the vehicle.**

7. **The same child/staff ratios required at the facility are to be maintained during transportation. The driver will not be counted as staff in the ratio for children less than six years of age.**

8. **Each child must be assigned to an adult for every part of the trip.**

9. **Children must never be left alone in a vehicle or unsupervised by an adult.**

10. **The facility will provide a plan based on a functional assessment of any special needs of children during transportation. This plan will be based on information provided in writing by the child's physician and will address special equipment, staffing requirements and care in the vehicle during transport.**

Field Trip Safety in Child Care

Field trips can offer fun and educational opportunities for children as long as they are well-planned. Be sure to review your field trip/transportation policies before traveling with children. Discuss the specific points with parents and staff before the field trip to ensure that everything is clear. Listed below are recommendations and practical ideas for safe travel.

Vehicle requirements (car, van, truck or bus)

1. Meets state vehicle licensing laws.
2. Heater and air conditioner works.
3. Regular servicing and safety checks.
4. Have a back-up vehicle available in case of an emergency or last-minute change.

During the trip, keep in the vehicle:

- Proof of vehicle insurance and registration.
- Emergency medication should be taken along on the field trip
- First-aid kit

During the field trip the first aid kit should be removed from the car and taken with the child care providers along with any other emergency medications that maybe temperature –sensitive.

- Binder or clip board with: safety checks, vehicle service records, emergency procedures, injury report forms (the same ones child care usually uses), and trip records (when, where and who traveled),
- Keep vehicle doors locked and windows opened only slightly (if needed).
- Remove or keep sharp or heavy objects in the trunk,
- NO smoking, NO loud music or cell phone use.

Driver requirements

- 18 years or older; current driver's license.
- Select drivers based on experience, driving record and safe driving habits.
- NO drinking alcohol in the previous 12 hours before the trip; NO use of any drugs that cause drowsiness or impair judgment.

Planning ahead

Trip Leader:

- Develops a checklist with vehicles, drivers and children assigned to each. Be sure there is adequate insurance coverage for the trip.
- Ensures that an adult with first aid and pediatric CPR training rides in each vehicle.
- Provides name tag including the name and phone of the child care program for each child (some programs provide each child with a brightly colored tee shirt containing the program name and phone).
- Ensures that staff/child ratios as mandated by child care licensing are maintained. More adults allow for smaller groups, easier supervision of children and more fun.
- Counts children before leaving, when arriving and periodically during the trip to ensure that no child is left behind. Ensures that children are supervised at all times.
- Selects someone with child passenger safety training to check for proper child restraint use before leaving.
- Checks that all children under age 13 ride in the back seat in their own useable child passenger restraint.

Give each driver:

- A map with the field trip route, the closest hospital and the pick-up and drop-off points
  clearly marked (give to all parents, too).
- A clipboard with the names and copies of the emergency cards of all children riding in the vehicle.
- A cell phone (for emergency use).

AB 1207 Child Abuse Mandated Reporter Training Signed by Governor

It is now law that all childcare providers take the State Child Abuse Mandated Reporter Training;

This bill would, beginning January 1, 2018, require the department to develop and disseminate information to providers, administrators, and employees of licensed child day care facilities regarding detecting and reporting child abuse, and to provide training including statewide guidance on the responsibilities of those persons as mandated reporters, as provided. Beginning January 1, 2018, the bill would require those persons, as a condition of licensure, to complete that training provided by the department, as specified.

After the law goes into effect on January 1, 2018, you must take the training if you are a licensee, administrator, or employee of a licensed child care facility, including child care centers and family child care homes.

If the Community Care Licensing Division ("Licensing") finds that you did not take the training during inspection or upon request, then it will issue you a "notice of deficiency." You'll then have 45 days to take the training to correct the deficiency. If you fail to take the training within 45 days, Licensing *may* revoke your child care license.

http://mandatedreporterca.com

- Current licensees, administrators, or employees of licensed child care facilities → You must take the training by March 30, 2018.
- Child care licensee applicants → If you apply to obtain your child care license on or after January 1, 2018, then you must complete the training before getting your license.
- Child care administrators and employees hired on or after January 1, 2018 → If you become an administrator (without a child care license) or an employee of a licensed child care on or after January 1, 2018, then you must take the training within 90 days from the start of your employment.
- The training must be taken every two years after the initial training
- The training is Free and online
- The training takes between 2 and 4 hours
- The training is provided in most languages
-

You are required by law to report child abuse to your local Child Protective Services agency if you have good reason to suspect that it is occurring.

Remember that you do not have to be sure that abuse or neglect has occurred, but you must have a reasonable suspicion. You cannot be punished for reporting child abuse, but if you do not report, you can be punished. Providers can call their Child Protection Services agency anonymously to discuss their concerns.

County Child Protective Services Emergency Hotlines

Alameda	510-259-1800	No Description Available
Alpine	530-694-2235 800-694-2235	Days After 5PM and on weekends
Amador	209-223-6550 209-223-1075	Monday - Thur 8-5 After Hours
Butte	530-538-7882 800-400-0902	 24 Hours
Calaveras	209-754-6452 209-754-6500	Days After Hours
Colusa	530-458-0280	No Description Available
Contra Costa	877-881-1116	Central West East
Del Norte	707-464-3191	No Description Available
El Dorado	530-642-7100 530-573-3201	Placerville (24 hours) South Lake Tahoe (24 hours)
Fresno	559-255-8320	Hotline 24/7
Glenn	530-934-6520	After Hours Number for County
Humboldt	707-445-6180	No Description Available
Imperial	760-337-7750	24 Hours
Inyo	760-872-1727	No Description Available
Kern	661-631-6011	24 hours
Kings	559-582-8776	No Description Available
Lake	707-262-0235 800-386-4090	24 hours / 7 days a week
Lassen	530-251-8277 530-257-6121	Days Nights & Weekends
Los Angeles	800-540-4000 213-639-4500	In State Out of State
Madera	559-675-7829	No Description Available

	800-801-3999	
Marin	415-473-7153 415-479-1601	TDD
Mariposa	209-966-3030 M-F 8AM-5PM	After Hours, Call Mariposa County Sheriffs Dpt @ 209-966-3615
Mendocino	866-236-0368	24-Hr Countywide ER Hotline
Merced	209-385-3104	209-722-9915 After 4:45 PM , Weekends, and Holidays
Modoc	530-233-6602 530-233-4424 866-233-4424	M-F, 8:30AM-5:00PM After business hours Out of area 24 hr toll free
Mono	760-932-7755 800-340-5411	No Description Available
Monterey	Office Hours M-F 8-5 831-755-4661 800-606-6618 After Hours - Standby 831-755-5100	
Napa	707-253-4261	This is the Emergency Response phone number manned 24 hours a day 7 days a week.
Nevada	530-273-4291	24 hour number
Orange	714-940-1000 800-207-4464	Registry (Toll Free)
Placer	(916) 872-6549 (866) 293-1940 Toll Free	Hotline-24/7
Plumas	530-283-6300 800-242-3338	Evenings and Weekends
Riverside	800-442-4918 877-922-4453	Public Mandated Reporters
Sacramento	916-875-5437	No Description Available
San Benito	831-636-4190 831-636-4190	Days Nights
San Bernardino	800-827-8724 909-384-9233	Nights
San Diego	858-560-2191 800-344-6000	Child Abuse Hotline
San Francisco	415-558-2650 800-856-5553	No Description Available
San Joaquin	209-468-1333	No Description Available
San Luis Obispo	805-781-5437 800-834-5437	No Description Available
San Mateo	650-595-7922 800-632-4615	No Description Available
Santa Barbara	800-367-0166 805-737-7078 805-683-2724	Days Lompoc Nights
Santa Clara	408-299-2071	San Jose

	650-493-1186 408-683-0601	North South
Santa Cruz	831-454-2273 831-454-4222	Days Nights
Shasta	530-225-5144	No Description Available
Sierra	530-289-3720 530-993-6720	No Description Available
Siskiyou	530-841-4200 530-842-7009	Days Nights
Solano	800-544-8696	No Description Available
Sonoma	707-565-4304	No Description Available
Stanislaus	800-558-3665	
Sutter	(530)822-7227	No Description Available
Tehama	800-323-7711 530-527-9416	Hotline number CPS Main Phone
Trinity	916-623-1314	No Description Available
Tulare	(559)730-2677	No Description Available
Tuolumne	209-533-5717 209-533-4357 866-388-7502	Days Nights Emergency, after hours toll free
Ventura	805-654-3200	24/7 Response Hotline
Yolo	530-669-2345 530-669-2346 530-666-8920 888-400-0022	Days Days Nights
Yuba	530-749-6288	No Description Available

SUSPECTED CHILD ABUSE REPORT

To Be Completed by Reporting Party
Pursuant to Penal Code Section 11166

A. CASE IDENTIFICATION — *TO BE COMPLETED BY INVESTIGATING CPA*
VICTIM NAME: _____
REPORT NO./CASE NAME: _____
DATE OF REPORT: _____

B. REPORTING PARTY

NAME/TITLE

ADDRESS

PHONE ( )	DATE OF REPORT	SIGNATURE

C. REPORT SENT TO

☐ POLICE DEPARTMENT ☐ SHERIFF'S OFFICE ☐ COUNTY WELFARE ☐ COUNTY PROBATION

AGENCY	ADDRESS	
OFFICIAL CONTACTED	PHONE ( )	DATE/TIME

D. INVOLVED PARTIES

VICTIM

NAME (LAST, FIRST, MIDDLE)	ADDRESS	BIRTHDATE	SEX	RACE

PRESENT LOCATION OF CHILD — PHONE ( )

SIBLINGS

NAME	BIRTHDATE	SEX	RACE	NAME	BIRTHDATE	SEX	RACE
1.				4.			
2.				5.			
3.				6.			

PARENTS

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE	SEX	RACE	NAME (LAST, FIRST, MIDDLE)	BIRTHDATE	SEX	RACE

ADDRESS	ADDRESS

HOME PHONE ( )	BUSINESS PHONE ( )	HOME PHONE ( )	BUSINESS PHONE ( )

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET OR OTHER FORM AND CHECK THIS BOX. ☐

1. DATE/TIME OF INCIDENT	PLACE OF INCIDENT	*(CHECK ONE)* ☐ OCCURRED ☐ OBSERVED

IF CHILD WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE:
☐ FAMILY DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME ☐ SMALL FAMILY HOME ☐ GROUP HOME OR INSTITUTION

2. TYPE OF ABUSE: *(CHECK ONE OR MORE)* ☐ PHYSICAL ☐ MENTAL ☐ SEXUAL ASSAULT ☐ NEGLECT ☐ OTHER

3. NARRATIVE DESCRIPTION:

4. SUMMARIZE WHAT THE ABUSED CHILD OR PERSON ACCOMPANYING THE CHILD SAID HAPPENED:

5. EXPLAIN KNOWN HISTORY OF SIMILAR INCIDENT(S) FOR THIS CHILD:

SS 8572 (Rev. 1/93)

INSTRUCTIONS AND DISTRIBUTION ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). A CPA is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS-8583 if (1) an active investigation has been conducted and (2) the incident is not unfounded.

Police or Sheriff-WHITE Copy; County Welfare or Probation-BLUE Copy; District Attorney-GREEN Copy; Reporting Party-YELLOW Copy

Sudden Infant Death Syndrome (SIDS)
or SUID Sudden Unexpected Infant Death Syndrome

What a child care provider needs to know

Sudden Infancy Death Syndrome (SIDS) is the sudden, unexpected and unexplained death of an apparently healthy infant that remains unexplained after a thorough post mortem investigation, including an autopsy, examination of the death scene and review of the case history. SIDS can happen even if all safe sleep guidelines have been followed. There are still babies who die of SIDS from no known cause

After case investigation, SUIDS (Sudden Unexpect Infant Death Syndrome) can be attributed to suffocation, asphyxia, entrapment, infection, ingestions, metabolic diseases, arrthythmia-associated cardiac channelopathies, and other SUIDs particularly those that occur during and observed or unobserved sleep period (sleep-related infant deaths).

SIDS is the leading cause of death for children one month to one year of age. Many more children die of SIDS in a year than die of cancer, heart disease, pneumonia, child abuse, AIDS, cystic fibrosis and muscular dystrophy combined. SIDS causes nearly 3,000 infant deaths each year in the United States. Because more infants are in out-of-home care, many of these deaths occur in the child care setting. Ninety-five percent occur before age six months, with most cases occurring between two and four months of age. The majority of deaths occur during the winter months (October to April).

The cause of SIDS is unknown. While researchers do not know what causes SIDS, they have identified several major factors associated with increased risk of SIDS:

1. Placing a baby on the stomach (prone position) to sleep.
2. Being exposed to tobacco smoke during pregnancy and after birth.
3. Using soft surfaces and objects that trap air or gasses, such as pillows and water beds, in a baby's sleeping area.
4. Over bundling/overheating of a baby, such as too many clothes, blankets and allowing the sleep area to get too hot.
5. Not breastfeeding a baby.

Other risk factors (environmental and behavioral influences that can provoke ill health) are related to the mother's health and behavior during pregnancy, such as young maternal age, poor prenatal care, low weight gain, anemia, use of illegal drugs, and etc.

What a child care provider can do to reduce SIDS

Develop and follow a policy regarding sleep position in your child care setting. Including the following recommendations in your sleep position policy will *reduce* the risk of SIDS:

- **Place babies only on their backs to sleep**. This recommendation from the American Academy of Pediatrics and the National Back to Sleep Campaign applies the research shows it is important for child care providers to place babies on their backs for sleep.

- **Use firm, flat mattresses in safety-approved cribs for babies' sleep.** Don't use soft sleeping surfaces. The U.S. Consumer Product Safety Commission has issued advisories for parents on the hazards to infants of sleeping on beanbag cushions, sheepskins, foam pads, foam sofa cushions, waterbeds, synthetic-filled adult pillows and foam pads covered with comforters. Bumper should not be used in cribs.

- **Don't smoke.** Provide a smoke-free environment for babies in your care; encourage parents who smoke to quit. Recent research indicates that the risk of SIDS doubles among babies exposed only after birth to cigarette smoke and triples for those exposed both during pregnancy and after birth.

- **Encourage mothers who breastfeed to provide you with bottled breast milk**. Studies show that babies who died of SIDS were less likely to have been breastfed. Breastfeeding prevents digestive and respiratory illnesses and infections.

- **Avoid overheating**. Overheating (too much clothing, bedding that is too heavy and a room that is too warm) may increase the risk of SIDS.

- **Offer infants a pacifier if the infant uses a pacifier at home** and will not be attached by a string to the infants clothing

- **Sleeping infants should be visually checked and supervised at all times**. The infant will be observed to verify that the infant's skin color is normal, and the infant's chest is rising and falling as she breathes.

- **Infants will never be put to sleep on a couch, chair, cushion, or an adult bed even a twin**

bed – only in a crib.

- **Infants will not share a crib**.
- **Awake infants will have supervised "Tummy Time"**
- **Stress the importance of regular checkups and immunizations**
- **If a child in your care is not breathing and is unresponsive and if you are the lone rescuer, provide CPR for two minutes and then call 9-1-1. Continue CPR until an emergency medical professional arrives to take over care of the child. If there are two rescuers one can call 9-1-1,** while the other provides CPR. Once you are able to, call the parent.

Tummy Time for Infants

In June, 1994, a national "Back to Sleep Campaign" was initiated in the United States to reduce the risk of Sudden Infant Death Syndrome (SIDS). Since that time the number of infants dying of SIDS has dropped by more than half. Putting infants to sleep on their backs is a simple and effective practice for reducing the risk of SIDS. But the other part of the "Back to Sleep Campaign" message is "Tummy to Play." Many infants are not getting enough "tummy time."

Why is "Tummy Time" important?
Infants now miss out on the 12 hours of tummy time that they used to get when sleeping on their tummies. Many infants also spend long hours in swings, car and infant seats when awake. Because of these practices, some infants are developing motor delays.

Tummy time is important because it helps infants:
• stretch and strengthen the head, neck, shoulder and back muscles they will need to learn important motor skills (for instance, how to push up, roll over, sit up, crawl, and pull to a stand).
• develop their sensory-perceptual, social emotional, problem solving, balance, visual, and hearing abilities.
• develop normally-shaped heads (infants who spend most of their time on their backs when asleep and in infant seats when awake are at risk for developing flat spots on the backs of their heads).

How can we make sure infants get enough "Tummy Time" when they are awake?

The way to prevent these problems is to make sure infants spend plenty of time on their tummies, in the "prone" position, starting when they are newborns. Some infants get fussy when they are put on their tummies because they are not used to it, and it is hard work for an infant to hold his head up. Unless babies are put on their tummies (prone) to play from the first days and week of life, they may not easily accept "tummy time."

Tips for making tummy time more interesting:

• Lay the infant over your leg while you are sitting on the floor

• Buy an exercise ball* that is 60 centimeters in diameter. Lay the infant over the ball on his tummy and move him gently back and forth and from side to side by rolling the ball carefully, and move him up and down by pushing down gently on his back.

Put the infant on her tummy on a blanket on the floor. Make the floor interesting by choosing a blanket with an interesting pattern or texture, or a special tummy time mat. Lie down on the floor with the infant. She will enjoy exploring you as well as the toys on the floor.

• Lie down with the infant on your chest tummy-side down.

Carry the infant around on his tummy instead of upright.

• Make a bolster by rolling up a towel. Place the bolster under the infant's chest and armpits with her arms over the bolster. You can move the infant gently back and forth on the bolster.

• Older infants can be placed lengthwise on the bolster (with an arm and a leg on either side of the bolster) and rolled gently from side to side.

Remember, a happy infant develops best. If an infant starts to fuss, try to make tummy time more interesting through gentle movement or a change of toys. Rhythm and movement together work wonders for infants' development, so turn on some music for tummy time. At first, you may have to try tummy time for several short periods during the day until the infant gets used to being on his tummy.

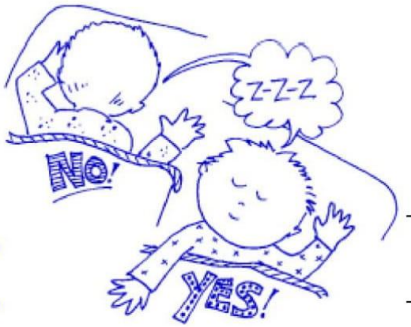
When to seek help

Infants should be holding up their heads and pushing up on their arms by the end of three months. Infants who are getting enough tummy time and are still delayed in reaching these milestones should be evaluated by their health care provider.

Facts about SIDS

SIDS IS NOT

- Caused by vomiting or choking
- Caused by minor illnesses or infections
- Caused by vaccines or immunizations
- Contagious
- Child abuse
- The cause of every unexpected infant death



TO REDUCE THE RISK OF SIDS

1. Place babies only on their backs to sleep.
2. Use firm, flat mattresses in safety-approved cribs.
3. Do not smoke. Provide a smoke-free environment.
4. Encourage mothers who breastfeed to provide you with bottled breast milk.
5. Avoid overheating.
6. Visually supervise asleep infants at all times for normal skin color and normal breathing chest movements

Crib Safety

Infant should sleep in a crib only!

Your baby crib should be a haven of safety and comfort. He will certainly spend many hours here, both at play and at sleep. A good crib, you will find, is a place where you can keep your baby safe while sleeping.

To help ensure the safety of your youngest children, follow Home Safety Council's guidelines to select and maintain a crib for your new baby:

- Find out if cribs, especially older models, have been recalled. Visit the U.S. Consumer Product Safety Commission's (CPSC) website at www.cpsc.gov for recent updates.
- Make sure crib hardware is strong and secure.
- Remove soft bedding, pillows, toys and stuffed animals from the crib.
- Use sleepers instead of blankets.
- Follow the product guidelines for crib toys and discontinue use at the recommended age. If toys attach to crib railings, hang these on the wall side of the crib.
- Make sure the crib sheet and mattress fit tightly to avoid entrapment and suffocation.

- Remove bumper pads to deter children from climbing out easily.

- Keep cribs away from windows and window blind cords.

- For metal or wooden cribs, make sure slats are 2 3/8 inches apart or less. Corner posts should not be over 1/16 inch high. Avoid headboards and footboards with cutouts large enough that a baby's head can become trapped.

- For mesh-sided cribs or playpens look for mesh less than 1/4 inch in size, securely attached to the top rail and floor plate. If staples are used, make sure none are missing or exposed.

Buying a Safe Crib

All new cribs on the market today meet the safety standards of the Consumer Product Safety Commission (CPSC) and the Juvenile Products Manufacturers Association (JPMA).

Before getting a used crib, check to see if it has been recalled at www.recalls.gov. Also, look for the following suffocation and strangulation hazards:

- Sharp or jagged edges
- Missing, broken or loose parts
- Loose hardware
- Cut out designs in the headboard or footboard
- Crib slats more than 2 3/8 inches apart (width of a soda can)
- Corner post extension over 1/16 of an inch high
- Gaps larger than 2 fingers width between the sides of the crib and the mattress
- Drop side latches that could be easily released by your baby

When using any crib:

- Follow the directions for assembly.
- Don't try to fix any part of it with tape, wire, a rope, or by putting a broken side up against the wall.

Burns and Fire

What a child care provider needs to know

Children are very vulnerable to fires and burns because of their curiosity and ignorance of the danger of fire. Hundreds of children in the United States die and countless others are disfigured every year as a result of burn injuries. Children ages five or younger are especially vulnerable to burns and have one of the highest fire death rates.

Hot liquids – not fire – are the most common cause of burns to young children. Hot liquids burn like fire and can cause serious and painful burns. However, fires caused by playing with matches and lighters are the number one cause of fire-related deaths among young children.

In the child care environment, four types of hazards may contribute to the risk of fire and burns: scalding, contact, electrical and chemical.

Planning ahead and practicing fire prevention skills can reduce the chances of a fire occurring, protect children and adults, and reduce property damage.

What a child care provider can do to reduce burn injuries

As a child care provider, you can take the following steps to reduce the risk of fires and burns in your facility:

1. Provide safety education. Help the children learn about hazards that can cause fires and burns. They should be taught that some objects are off-limits for play.
2. Check for environmental hazards and limit access to burn-producing objects.
3. Safety devices such as smoke alarms and fire extinguishers should be present and in working condition.
4. Plan the escape routes in advance. Children should also have regular practice drills for fire evacuation and should know how to crawl low under smoke, and how to stop, drop to the ground and roll if their clothes catch fire.
5. Model preventive behaviors that will reinforce fire and burn accident prevention.
6. Communicate your prevention activities to parents so they can support your efforts and prevent burns and fires at home.
7. Invite a community service representative from the local fire department to your program for a safety workshop.

Causes of Fire and Burns in the Child Care Environment

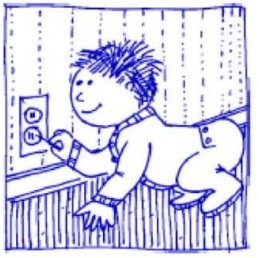
1. Scalding:

- Boiling liquids or food
- Steam
- Hot coffee, tea or cocoa
- Hot tap water

2. Contact

- Hot pan on stove
- Touching fire in fireplace
- Matches, lighters
- Candles or candle wax
- Cigarettes, cigars, pipes
- Flammable clothing, sleeping materials
- Hot playground equipment
- Clothes iron
- Heaters
- Curling irons and hair appliances

3. Electrical



- Sticking a foreign object into an electrical outlet
- Touching a live wire
- Water contact with an electrical appliance

4. Chemical

- Strong household chemicals
- Automobile chemicals
- Lawn and garden chemicals

Burn and Fire Prevention in the Child Care Environment

- Install and regularly check smoke detectors. Check batteries frequently.
- Keep a fire extinguisher on hand, know how to use it and refill it immediately after each use.
- Do not allow children in cooking areas without supervision. Teach them that there are areas of the facilities that are "off-limits" for play and exploration.
- Do not drink or carry anything hot near a child.
- Keep hot foods and drinks away from the edge of tables and counters. Do not leave them on a tablecloth that a child can grab.
- Use the rear burners for cooking. Turn the handles of pots towards the rear or center of the stove.
- Test hot food before giving it to a child. This includes food from a microwave oven.
- Never warm bottles in a microwave oven.
- Put barriers around fireplaces, radiators and hot pipes.
- Teach children to stay away from hot things and not to play with matches, lighters, chemicals and electric equipment.
- Plan a fire escape route and practice it. Train children how to properly respond to a fire (they should know the sound of a smoke alarm; two ways out of every room; how to stop, drop and roll, etc.)
- Never use portable open flame or space heaters.
- Use safety devices to cover electrical outlets. Avoid overloading electrical wiring.
- Lower the temperature of your hot water heater to 120° F or lower. Always check the water temperature before placing your child in the tub. Supervise children in the tub.
- Store matches, lighters, chemicals and other hazardous items out of the reach of children. Check for fire and burn dangers, and make the necessary changes.

Fire Safety

Fire Safety and Fire Drills

https://www.youtube.com/watch?v=2GNHSYA6HS8

Create an escape plan for your Childcare – plus how to give age-specific instructions.

Each year, more than 39,000 kids under the age of 14 are injured by fires. Children are more vulnerable than adults because their bodies are less able to tolerate smoke, fumes, and burns. Kids are also naturally curious. Playing with matches is the leading cause of fire deaths for kids 5 and under. You can prevent most fires in your childcare by taking a few precautions. Our guide will also help prepare you and your childcare in the event that a fire does break out.

Planning a Fire Drill

There's no time for mistakes when a fire strikes. In fact, it can take less than two minutes for smoke fumes to overcome a child or an adult. To prepare a safe escape:

Make a plan. On a large piece of paper or poster board, draw a floor plan of your childcare, indicating at least two exits from each room, if possible. Mark the regular exit in black and emergency exits in red. Post your map in an easy-to-see place, and review it regularly with everyone in your childcare.

Give age-specific instructions. Set off a smoke detector so childcare know what it sounds like. **Children over 5** can be trusted to leave the house by themselves, so walk through the escape routes with them to a designated meeting spot outside your building. **For children 5 and under,** teach them how to get out of the house in case of a fire, but explain that if their way is blocked by smoke -- or if they become frightened and can't remember what to do – they should stand next to a window you chose beforehand and wait for a staff member or a firefighter to come for them. Decide which staff member will be assigned to each small child.

Practice. Make sure the children know how to:

- Stop, drop, and roll if their clothes catch fire.
- Crawl under smoke. The cleanest air will be one or two feet above the floor. (Don't let them wiggle on their bellies; poisonous gasses settle on the floor.)
- Cover their noses and mouths with a shirt or a rag to prevent smoke inhalation.

Stage a fire drill. Practice occasionally at different times of the day. Send the children to different rooms and have them practice feeling their door before opening it to see if it's hot and quiz them on other exits they should take if it is. As you move around your building, pretend some exits are blocked by smoke by holding sheet three feet above the floor.

Try the emergency exits. Have each person open the windows in the building – they shouldn't be painted or nailed shut, and window guards should have quick-release mechanisms that kids 6 and up can operate. Make sure there is a way to get down from each window: a balcony, a tree, a porch roof, or an escape ladder that's stored near the window. (Ladders should be sturdy and strong enough to hold the heaviest member of your family.) Don't let children actually practice

climbing out of the window, as they could injure themselves.

Select a meeting spot. Pick a safe place well away from your childcare, such as a mailbox or a neighbor's house. Mark this spot on your map. Teach the children that if they leave the house alone, they should wait there for help to arrive and that they should never reenter a burning building to retrieve anyone or anything.

Apartment Rules

- Check with your landlord to make sure your building has working sprinklers, fire doors in the hallways, and smoke detectors in each unit.
- Teach children to never to use the elevator during a fire, and show them where the nearest fire escape is.
- If there is a fire in another part of your building, try to get downstairs as quickly as possible, checking each door for heat before you open it. If it is hot or you encounter a smoke-filled hallway, look for an alternative exit. If every exit is blocked, return to your apartment. Once inside, call the fire department to say exactly where you are. Then stand by the window and wave a brightly colored cloth to signal for help.

Mechanical Airways Obstruction (Choking)

What a child care provider needs to know

Young children in their first three years of life are at greater risk of choking and suffocation. They may choke during meals or during playtime because they use their mouths to explore and experiment with unfamiliar objects. Some situations that are likely to lead to choking on food include eating while rushed, running and laughing.

In the United States, death by choking, strangulation, suffocation or entrapment results in about 700 deaths each year to children and adolescents. Half of these deaths occur in the first year of life and three-quarters occur in children younger than five years.

Food and coins are the most common causes of choking. Children have been strangled by clothing or string around their neck that becomes caught on furniture, playground equipment or some other object. Some consumer products that have strangled children include window-blind cords and the lids of toy chests. Entrapment and asphyxiation can occur in unsafe cribs as well as other household items such as refrigerators, ice chests and clothes dryers. Suffocation can occur if children have access to plastic bags.

Choking and suffocation are frightening because they occur suddenly. Only six minutes without oxygen can cause brain damage in children. The signs of choking and suffocation in children are difficulty speaking or breathing, the inability to cough, wheezing sounds, clutching of throat or gesturing, a bluish face, confusion and unexplained loss of consciousness (this is a very late sign).

What a child care provider can do to reduce this type of injury

You can take the following steps to reduce the risk of mechanical airway obstruction:

- Learn the proper response and techniques for helping choking or suffocating infants and children.
- Foods that are round, hard, small, thick, sticky, smooth or slippery should not be offered to children younger than four years of age. For infants, foods should be cut in small pieces no longer than ¼" cubes; for toddlers, pieces no longer than ½" cubes. Children should not be allowed to eat while walking, running, playing, lying down or riding in a vehicle.
- Objects smaller than 1¼" in diameter should not be accessible to children who put things in their mouths.

Possible Choking and Suffocation Hazards

Foods

- Big chunks of meat
- Whole grapes and raisins
- Gum
- Hard candy and cough drops
- Hot dogs and sausages cut in rounds
- Lollipops
- Whole olives
- Peanuts, nuts
- Popcorn
- Raw vegetables (carrots, etc.)
- Watermelon seeds
- Spoonful of peanut butter
- Dried fruit

Toys

- Balloons
- Game pieces
- Game tokens
- Jacks
- Marbles
- Plastic bags
- Play jewelry
- Small objects
- Small toys (less than 1½")
- Toy chests with no air holes

Objects

- Pins and nails
- Toothpicks
- Pencils and pens
- Crayons
- Staples
- Coins
- Jewelry
- Small Batteries in greeting cards, small appliances, jewelry, and faux candles. These can be quite treacherous and may cause a whole host of serious injuries and even death if swallowed.

Can you think of anymore?

Falls & Prevention

What a child care provider needs to know

Falls are the single greatest cause of injury in the child care environment and the most common injury requiring medical care. Thus, the prevention of falls will pose one of the greatest challenges to a safe environment.

Although many injuries resulting from falls are minor (cuts and scrapes), many others such as heavy bleeding, broken bones, and head and eye injuries will be more severe and could be potentially life-threatening.

The most common type of fall leading to hospitalization is a fall from one level to another, such as from playground equipment, beds, tables, chairs and stairs. Falls resulting in severe or fatal injuries are usually due to falls from second story (or higher) windows.

Children are capable of falling or hurting themselves at any age. A tiny baby can wiggle, move and push. An older baby can roll over, crawl and creep. Toddlers can climb to get to places that were formerly inaccessible to them.

Indoor furniture and playground equipment are frequently related to injuries from falls. Changing tables vary greatly and can be the cause of an infant's fall if the infant is left unattended. Although baby walkers are tested, they are the cause of more injuries than any other infant equipment. Injuries occur when young children in walkers fall down stairs or off porches. (Walkers are outlawed in child care.)

What a child care provider can do to reduce falls

You know well, as a child care provider, that there is not much you can do to block the activity levels of children in your care. However, you can reduce the risk of injuries through control of the children's environment, by teaching appropriate behaviors (both indoors and outdoors) and by careful supervision.

Any large and heavy furniture should be secured to the wall so that children cannot climb on and tip the furniture over on themselves and be crushed. This will help prepare the furniture in case of an earthquake as well.

Fall Prevention

Modification of equipment and environment

- Use child and playground equipment that is safe and well maintained.
- Use durable, balanced furniture that will not tip over easily.
- Get rid of baby walkers.
- Place safety gates at the top and bottom of stairs.
- Keep windows screened and install window guards on upstairs windows.
- Pick up toys and other objects from the floor and clean up spills quickly.
- Secure or remove loose mats and rugs.
- Use skid-proof mats or stickers in the bath.
- Keep the area well lit.
- Use safe playgrounds. The surface under and around play equipment where children can fall should be shock-absorbent and soft.

Bring about a change of behavior through education and supervision

- Do not allow children to climb on furniture, stools or ladders.
- Never leave toddlers and infants unattended on beds, on changing tables or in play areas.
- Discourage indoor running.
- Teach children how to play safely, involve them in making rules for playground behavior, and enforce these rules consistently.
- Remove a misbehaving child from play, and explain how her or his actions could hurt someone.

Poisoning

What a child care provider needs to know

The most common emergency involving children is poisoning. In the United States, about 2 million cases of exposure to poisons are reported each year. Children under five years of age are the most likely to get poisoned. They are curious and will eat and drink almost anything – even if it does not taste good.

Although most poisoning occurs in the child's home, it can also occur in the child care setting. Poisons can be found in any room of the house or center, and poisonings can happen anywhere. However, most poisonings occur in the kitchen, bathroom or bedroom and in the presence of mothers or providers, when products are not in their usual storage area and are in direct reach of young children.

Poisonings occur from many common items found in a household or in the child care environment. Items that can be poisonous to a child include medicines (both prescription and non-prescription such as aspirin, cough and cold preparations, vitamins and iron); household cleaning products (such as furniture polishes, detergents and drain cleaners); substances stored in the garage (such as car and gardening products); mushrooms; plants (such as castor beans, foxglove and oleander); cosmetics; batteries; arts and crafts materials; and lead-containing paint, dust and pottery. Poisoning can occur by ingestion (eating or drinking), absorption (contact with skin, getting in the eyes), inhalation (breathing the fumes), injection (puncture wounds), and animal and insect bites.

What a child care provider can do to reduce poisoning

About 95 percent of all unintentional poisonings can be prevented. Methods of prevention include modification of the environment, and education and supervision for change of behaviors.

Modification of environment

Providers should make a room-by-room inspection and evaluate the outdoor play area for potential poisons in the environment. Removing all hazards for exposure to poisons provides a protected environment. Poisons should be kept out of sight and reach of children, and in a locked cabinet. Remember what good climbers' children can be! Parents and teachers should always put their purses, diaper bags, backpacks, etc. out of reach of the children. Create a special place for parents to place their items when they are just there for a short period.

Supervision

Remember that no area is 100 percent safe. Good safety practices and supervision help prevent accidents involving poisoning. Adult supervision is the number one method of preventing poisonings among small children. Discourage children from mouthing paint brushes, crayons or other objects and materials. Never call medicine "candy."

Education

Teach poison prevention to children and staff. Teach children never to put anything other than clean food into their mouths.

Be prepared

Children act fast, and so do poisons. Even when people are very careful, poisoning exposures can occur. It is important to be prepared before something happens:

1. Attach the phone number of the Poison Center to the telephone (call 800-222-1222 to request telephone stickers). Call the emergency number 800-222-1222 if a poisoning exposure occurs.

2. Have a first-aid kit at your facility. There are poisons and situations where it is dangerous to induce vomiting.

3. If a poisoning occurs, do not panic. Do not follow the first-aid procedures recommended on the product as they may be incorrect. If the child is in obvious distress, call 9-1-1 for help. Otherwise, call the Poison Center for advice and document the incident and your actions. Call the parent.

4. **Ways in Which Poisoning Can Occur**

5. **Ingestion** occurs by eating or drinking. Children are attracted to bright colorful packages, pills and odd shapes. They often mistake pills and vitamins for candy. Approximately 85 percent of poisonings occur through ingestion.

6. **Absorption** occurs when poisonous substances such as pesticides or plants come in contact with a person's skin or eyes. In this type of indirect poisoning, the poison is absorbed through the skin or mucous membrane into the blood stream.

7. **Inhalation** occurs when children breathe fumes from carbon monoxide, pesticides, and

certain types of art materials or dust that may contain lead. The air is exchanged in the lungs and comes in direct contact with the blood stream.

8. **Animal and insect bites** can cause an allergic reaction, but they can also be very toxic and can lead to death. These include ticks which cause Lyme disease or Rocky Mountain spotted fever, and reptiles such as rattlesnakes. (For Information on infectious diseases caused by pets and pests please see *Prevention of Infectious Disease: A Curriculum for the Training of Child Care Providers).*

9. **Injection** occurs when there is a puncture wound. The danger may come from the substance that was injected or from the threat of tetanus. Today there is an extra threat of children finding needles that have been used to inject drugs. An incident like this can cause the child to be exposed to HIV, hepatitis B or other infections.

Preventing Poisonings

Poison Children in Home Find

https://www.youtube.com/watch?v=q60NZ4rkLqA

- Always supervise children in your care. They act fast, and so do poisons.
- Inspect your child care facility from a child's-eye view.
- Remove poisons or lock them up, out of sight and reach of children.
- Select products with child-resistant covers.
- Return products to safe storage immediately after use.
- Read and follow label directions on all products before using.
- Never tell children that vitamins or medicine are candy.
- Keep all purses, diaper bags and backpacks out of reach of children.
- Get rid of old medicines. Properly discard outdated medicines.
- Store hazardous household products and food in separate areas.
- Keep products in original containers. Never put them into food containers.
- Do not turn your back on a child when a hazardous product is in use.
- Discourage children from mouthing paintbrushes, fingers, crayons or other objects and materials.
- Label indoor and outdoor plants for quick and easy identification.
- Keep all toxic plants up high and out of reach of children.
- Teach children not to put any plant parts in their mouths.
- Keep the phone number of the Poison Center attached to the telephone.
- Teach poison prevention to children and their parents.
- Act immediately when prevention fails.

New California Poison Control Number 1-800-222-1222

Common Hazardous Household Substances

Check for these poisonous products ... then lock them up or throw them away

Kitchen

- ammonia
- carpet and upholstery cleaners
- cleaning fluid
- cleansers and scouring powders
- drain cleaner
- furniture polish
- metal cleaners
- oven cleaners
- powder and liquid detergents
- rust remover
- vitamins

Bedroom

- cologne/ perfume
- cosmetics
- medications

Garage, Basement, Workshop

- antifreeze
- arts and crafts supplies
- adhesives/ glues
- fertilizer
- gasoline and oil
- kerosene
- lighter fluid
- lime, cement, mortar
- paint, remover and thinner
- pesticides/garden sprays
- turpentine
- windshield cleaner

Bathroom

- aftershave
- bath oil
- deodorant
- hair dyes
- hair remover
- nail polish and remover
- permanent wave solution
- room deodorizer
- rubbing alcohol
- shampoo
- shaving lotion
- toilet bowl cleaner

General

- alcoholic beverages
- batteries
- flaking paint

Closets, Attic, Storage Places

- moth balls and sprays
- rat, mouse and ant poisons

Purse

- cigarettes
    1. e-cigarettes, cartridges, and other vaping paraphernalia away from children, as these can be deadly. Much vaping packaging is developed to look and smell like candy, and is very attractive to children. Nicotine, one of the main ingredients in e-cigarettes, can be deadly just by being absorbed through the skin.
- cigarette lighters
- medicines
- perfume

Laundry

- bleach
- bluing, dyes
- disinfectants
- powder and liquid detergents
- stain remover

Disposal of Household Products

☠ = Considered Hazardous Waste. Your County Health Department should be able to advise you on proper disposal.

🛢 = Product can be put in the garbage can.

💧 = Product can be flushed down the toilet or poured down the drain, diluted with lots of water.

Courtesy of the California Poison Control System

Oral/Dental Injuries

What a child care provider needs to know

Most oral/dental injuries occur in children and adolescents. One out of three children may have signs of dental injury and about 80 percent of all fractured teeth occur in children. Injury rates increase with age (with the most incidents at 2 to 4 and 8 to 10 years of age) due to children's involvement in more active physical play, and it appears that boys have more injuries than girls.

Indoor and playground falls, involvement with another child, colliding with objects, and injuries related to transportation are the most common causes of oral injuries, with the upper front teeth being most often involved. The most common oral injuries and dental emergencies a child care provider might have to deal with include a broken tooth, a knocked-out permanent tooth, a cut or bitten tongue, lip or cheek, a broken jaw, bleeding after a baby tooth falls out, toothache and objects caught between teeth. To apply proper dental first aid, child care providers can add the following items to their general first-aid-kits:

- Dental floss, or toothpicks for removing objects from between teeth
- Dental wax for stopping irritation to the cheeks or gums from a chipped tooth
- Salt Solution (or a commercial preparation designed to preserve teeth) and whole cold milk for temporarily storing a knocked-out tooth.

What a child care provider can do to reduce oral/dental injuries

Child care providers can help promote children's dental health and prevent most oral injuries. Children and their parents should be educated early about the importance of the prevention of oral and facial injuries. By learning and practicing these safety rules, children will be in a better position to decrease the incidence of oral and facial injuries during play and recreational activities:

- Never hit or push another playmate.
- Do not hit a can or bottle while another playmate is drinking from it.
- Do not push down another playmate's head while he or she is drinking from a water fountain.
- Follow playground safety rules.
- When walking or running, watch out for trees, stumps and other objects in your path.

Shaken Baby Syndrome "Abusive Head Trauma"

What a child care provider needs to know

The term "Shaken Baby Syndrome" (SBS) or "Abusive Head Trauma" describes the consequences which occur when a young child's head is whiplashed back and forth during shaking. Babies and young children have very weak neck muscles that only gradually develop the strength to control their heavy heads. If shaken, their heads wobble rapidly back and forth, which can result in the brain being bruised from banging against the skull wall.

Infants and young children up to age five are vulnerable to head trauma, and different parts of their bodies can be affected. Shaking can cause brain damage, partial or total blindness, deafness, learning problems, retardation, cerebral palsy, seizures, speech difficulties and death.

Generally, shaking happens when someone gets frustrated with a baby or small child. Usually the shaker is fed up with constant crying. Some babies cry a lot when they are hungry, wet, tired or just want company. Some infants cry at certain times. Feeding and changing them may help, but sometimes even that does not work.

Many adults enjoy tossing children in the air, mistaking the child's excitement and anxious response for pleasure. Tossing children, even gently, may be harmful and can cause major health problems later on in life.

Damage from shaking may not be noticeable for years. It could show up when the child goes to school and is not able to keep up with his classmates.

What a child care provider can do to reduce Shaken Baby Syndrome You can do many things to prevent Shaken Baby Syndrome:

- Never shake a baby—not in anger, play, or for any reason. Remember, no matter how angry or impatient you feel, never shake a baby.
- Avoid tossing small children into the air.
- If a young child in your care cries a lot, try the following:
  - Feed the baby slowly and burp the baby often.
  - Offer the baby a pacifier, if supplied by parents.
  - Hold the baby against your chest and walk or rock him/her.
  - Take the baby for a ride in a stroller or car, or put her in a baby swing.
  - Be patient. If you find you cannot calmly care for the baby or have trouble controlling your anger, take a break. Ask someone else to take care of the baby or put him in a safe place and let him cry it out.

Preventing Shaken Baby Syndrome

Never shake a baby –
not in anger, play or for any reason.

Shaken Baby Syndrome Resources and Information for Early Care and Education (Child Care) Providers

http://www.cdc.gov/Concussion/pdf/Preventing_SBS_508-a.pdf
http://purplecrying.info/

The following information is from the CDC website provided above:

Example Messages for Child Care Providers:
1) Crying is normal for babies.
a) Crying is one-way babies communicate.
b) Excessive crying is a normal phase in infant development.
■ Babies cry most between 2 and 4 months.
■Prolonged, inconsolable crying generally lessens when babies are around 5 months old.
■Most babies who cry a great deal are healthy and stop crying spontaneously.
c) Child care Providers are not bad providers if the baby continues to cry after they have done all they can to calm him or her.
d) Remember, this will get better.

2) When a baby cries, there are steps the child care provider can take to try to comfort him or her.
a) Check for signs of illness or discomfort like a dirty diaper, diaper rash, teething, fever, or tight clothing.
b) Assess whether s/he is hungry or needs to be burped.
c) Rub his/her back, gently rocking him/her; offer a pacifier; sing or talk; take a walk using a stroller or a drive in a properly-secured car seat.
d) Call the doctor if you think the child is ill.
e) Remember you are not a bad Child care provider if the baby continues to cry after you have done all they have try can to calm him or her.

3) When child care provider feels frustrated, angry, or stressed while caring for the baby, take a break.

a) Put the baby in a crib on his or her back, make sure the baby is safe, and then walk

away for a bit, checking on him or her often.
b) Remember, this will get better.
4)Be aware of signs of frustration and anger in child care providers and others staff caring for the baby:

No matter how impatient or angry you feel, never shake a baby.

Shaken Baby Syndrome "Abusive Head Trauma" in the licensed child care setting:

a. If a child care provider realizes that a baby's crying is a trigger for the provider's negative stress reactions, that provider should consider not providing care for infants.
b. Child care providers frustration over crying babies is connected to the risk for shaking children and causing injuries and death.
c. The ***Period of PURPLE Crying*** and is a phase of alarming crying and is considered a normal developmental phase in the young baby—all babies cry and although it may be difficult for child care providers to hear, there are things that can help a child care provider react and act safely when faced with an alarmingly and steadily crying baby.
d. Upon enrollment of a new baby, the child care provider should discuss with parents/guardians about their baby's crying pattern at home, so that the provider may know what to expect in relation to a particular baby. Having that information ahead of time can help the provider to prepare for dealing safely with crying bouts.
e. The mitigations for the child care setting to reduce shaken baby syndrome that are acceptable *per the Department of Social Services Community Care Licensing Division are:*
    - Child care providers should discuss with all staff shaken baby syndrome and the procedures to protect against shaking a baby that will be implemented in a child care home or center.
    - A child care provider who works in a center may ask another child care provider coworker to provide care to a crying baby while the child care provider takes a safety break.
    - The child care provider in a home setting should designate a **qualified substitute provider** who can provide help to a child care provider who is stressed due to a baby's crying. A qualified substitute provider is someone who goes through the licensing process for background checks, and is registered as a substitute provider with Licensing for that specific facility.
    - The parent/guardian may also designate an **emergency contact**, in addition to herself/himself, that can be called if a baby's crying is alarming. The emergency contact person's information would have to be provided in writing by the parent. This person would have to be designated as a person who can pick up and take the baby away from the child care facility in an emergency.

Drowning

What a child care provider needs to know

Drowning is a major cause of death among children under five years of age in California. Water safety presents a particular challenge to California child care providers. Most drowning in this age group occur in home swimming pools. Water-filled bathtubs, wading pools, toilets, buckets or other containers are also places where young children can drown.

Children between the ages of one and four years are at greatest risk from drowning. These children are just learning to walk and explore. They excel at getting out from under the watchful eye of the provider.

Small children are top-heavy; they tend to fall forward and head first when they lose their balance. They do not have enough muscle development in their upper body to pull themselves up out of a bucket, toilet or bathtub, or for that matter, any body of water. Even a bucket containing only a few inches of water can be dangerous for a small child.

Wading in bodies of fresh water may carry the additional risk of injury from cuts, puncture wounds and infections. Standing bodies of water such as swimming pools, wading pools, and hot tubs also have the potential for spreading disease, so they are not recommended for use with young children. Instead, the use of sprinklers is recommended.

What a child care provider can do to reduce the risk of drowning

Reduce water hazards and prevent access to water.
Safety precautions must be taken to keep any water in the child care environment as risk-free as possible. Since any body of water poses a threat and young children can drown in as little as one inch of water, the outdoor environment should be thoroughly screened to detect hazards that may lead to the risk of drowning.

Promote safe behaviors.
Children themselves pose a threat when a body of water is present in the outdoor environment. They move fast, are curious and do not understand their physical abilities. The majority of drowning occur within a surprisingly short period of time. Never, ever, leave a child alone, even for a moment, when there is a body of water in the outdoor environment. When outdoors and near the water, always reinforce safety for the children. If the children are allowed to play in water, plan this activity for the time when they are the least tired and the most alert. Teach children safe practices for swimming and playing in the water to further protect them. Have a telephone within easy reach at all times. Never leave the area when children are present for a moment, even to answer the phone.

Learn the proper response if there is a water emergency. Act immediately.

- Pull the child from the water and place the child on his/her back.
- Check for breathing, and clear the mouth and nose of any obstructions.
- Get another adult to call for emergency help.
- Begin rescue breathing or CPR as needed until the child is revived or help arrive.

Preventing Drowning

- Never leave a child alone in or near any body of water (tub, wading pools, shower, pool or even a bucket).
- Latch toilet-seat covers down when not in use.
- Always provide careful, direct and constant supervision of young children if there is a body of water present in the outdoor environment.
- Never expect swimming instruction to eliminate the risk of drowning in children.
- Supervise children in the water even if they are wearing flotation devices. These devices are not substitutes for constant supervision.
- Any hazard should be enclosed with a fence that is at least five feet tall and difficult to climb. A door or sliding-glass door is not a safe substitute for a fence.
- Gates should have locks that are at least 55" high and self-closing. Keep gate keys in a safe place away from children.
- Never leave pool covers partially in place because children can become trapped beneath them. Pool covers are not a substitute for fencing.
- Keep chairs, tables and climbing equipment away from pool fences to prevent children from climbing over the fence into the pool.
- Learn CPR and keep rescue equipment at poolside, including a life preserver, shepherd's crook and cordless telephone.
- If a portable wading pool is used in child care (although it is not recommended), it should be filled with water, used immediately and drained and put away as soon as children leave the pool.
- Never leave infants or children unattended around five-gallon buckets containing even a small amount of liquid. Empty all buckets when not in use.
- Children with seizure disorders are particularly vulnerable to drowning. Know your children's medical history.
- Teach your children water safety behaviors (e.g., not to run, push or play around swimming areas; not to bring glass or bottles near swimming or wading areas; not to swim with anything in their mouths; not to swim in very cold water because it increases the risk of drowning; to be on the lookout for other children who might be in danger; not to go near a pool unless supervised; not to scream for help unless they mean it; not to roughhouse or fool around in water, etc.).
- Keep in mind that young children who have had swimming lessons are more at risk

because of over-confidence.

Surprising Home Drowning Hazards

Did you know that a small child can drown in as little as one to two inches of water – which is just enough to submerge her mouth and nose? Be sure to childproof these danger zones in your home and yard.

Bathtubs. Never leave a child under four alone in the tub or near a running bath. A school-age child can bathe by himself – but a parent should stay within earshot.
Baby bath seats or rings. Never leave your child unattended in a bath seat – he could slip down into the water and get trapped underneath, or the ring could tip over.
Buckets and containers. A curious toddler can fall headfirst into a water-filled bucket and be unable to get out. Even a cooler filled with melting ice can be a drowning hazard. Always make sure to empty after use.
Toilet bowls. Keep toilet cover down and bathroom door closed at all times. Install a toilet-cover safety latch.
Diaper pails. Make sure the top of your diaper pail fits securely and can't be lifted off by small fingers.
Wading pools. Empty child-size pools after use and store on their sides.

Electric Shock

A must-know plan to protect and save your child

Electricity-related accidents sent more than 6,000 children to hospital ERs in 1997. Kids under 5 who either chewed on electrical cords or played with wall sockets accounted for 70 percent of these injuries. If your toddler touches a household current, he'll likely pull his hand away in time to prevent serious harm. But if he grabs an electrical appliance while standing in water or bites through an electrical cord, the 110-volt current that runs through most households can pass through his blood and nerves, knock him unconscious, and even stop his heart. Here's lifesaving advice you must know.

If Your Child Is Electrocuted . . .

All electrical injuries must be examined by a doctor. If your toddler pokes a fork into a wall socket, call your pediatrician, even if your child looks fine. If she bites through an electrical cord, however, take her to the ER right away. The initial burn may not be apparent, but she may have sustained serious internal injuries, symptoms of which can develop over the next eight hours.

If an electric shock knocks your child unconscious, follow these steps:

Turn off the power source. If an electrical cord and plug are involved, carefully pull the plug being careful not to touch any exposed wires, or switch off the electricity at the fuse box or circuit breaker. In the rare case that this isn't possible, separate your child from the current with a dry, nonconductive object, such as a wooden or plastic broomstick.

Have someone call 911 (or your local emergency number). If you're alone, perform the following lifesaving measures for one minute before calling for help.

Check your child's breathing If your child isn't breathing, start CPR until breathing is restored or medical help arrives.

Check for burns once your child resumes breathing. Apply cool, wet cloths to first- or second-degree burns (look for blisters, redness, and swelling) and elevate the affected areas as you wait for medical help. Do not touch more serious burns (leathery skin that may look gray or black and charred).

Even if your child is only slightly injured, monitor his condition until you can get to a doctor. After the body suffers a trauma, it may go into shock, preventing the vital organs from

receiving enough blood. Watch for restlessness, anxiety, nausea, vomiting, and skin that is pale, cold, or clammy. Elevate your injured child's feet 8 to 10 inches and cover him with a blanket to stop the progression of or treat shock.

Electricity Do's and Don'ts

By Lynda Liu

Reduce your family's risk of electric shock by following this advice

DO

- Crawl around your house for a child's-eye view of potential hazards.
- Place safety covers on all unused outlets.
- Replace – never tape – cracked or frayed cords.
- Install ground-fault circuit interrupters – designed to switch off power if they detect changes in electrical current – on any outlet that could be exposed to water, such as in the bathroom or kitchen.
- Place furniture in front of outlets to keep them out of your child's sight.
- Use cord covers to tuck loose electrical cords against a baseboard so children can't pull, chew, or trip on them.
- Know where your home's fuse boxes and circuit breakers are and how to turn them off in an emergency.

DON'T

- Use extension cords as permanent substitutes for too few outlets.
- Overload an extension cord with more appliances than it is designed to accommodate.
- Keep appliances close to the sink or tub, where they could accidentally fall into the water.
- Run electrical cords under rugs. Walking over cords could fray or damage them.
- Allow electrical cords to hang off countertops, where a child might pull them.

Firearm Injuries

What a child care provider needs to know

Firearm injuries in the United States have become a leading cause of death during childhood and adolescence. Firearms are responsible for over 38,500 deaths each year. Injuries resulting from firearms are estimated to be five times higher than deaths from firearms (California is losing hundreds of children to guns every year (nearly two children die every day in California from guns).

A study by the Centers for Disease Control and Prevention (CDC) indicated that American children are 12 times more likely to die from a firearm injury than children in other industrialized countries. The majority of deaths are from handguns rather than rifles or automatic weapons.

Firearm-related deaths begin in infancy, increase throughout childhood, and peak during the teenage and young adult years. Children explore everything and can unintentionally injure themselves or others with a firearm. Because of the way guns are represented on television and in movies, and because they are sold as toys, your children may not know that guns are dangerous. The availability of guns dramatically increases the chance of deaths and injuries. Guns are much more likely to hurt and kill children than protect them.

Violence is related to many issues, including poverty, unemployment, drugs, alcohol, child abuse and failure in school. Nevertheless, the presence of guns increases the likelihood that violence will result in a fatal injury.

What a child care provider can do to reduce the risk of firearm injuries

Gun violence is now considered a public health problem as well as a criminal justice problem. Firearm injuries should be addressed and dealt with in the same way that other types of injuries are being addressed. As with motor vehicle injuries, we must use education, product modification, environmental modification, legislation and regulation to reduce firearm injuries and deaths.

As a child care provider, you play a major role in preventing injuries from weapons and reducing gun violence. You may start to reduce the risks by taking the following steps:

Do not keep guns and any other weapons in the child care setting.
Use alternate means of protection. Inform parents that a gun in the home increases the risk of suicide, domestic homicide and accidents. If they must keep a gun at home, it should be kept out of reach of children, unloaded and locked. Guns and bullets should always be stored and locked separately.

Make sure that your children know the dangers of guns and not to touch or handle guns.
Teach children that guns are dangerous and can harm them. Tell them that

guns are for adults, not children. If they see a gun they should stop what they are doing, not touch the gun. Leave the area immediately and tell a trusted adult. Read and discuss developmentally appropriate books about guns with children.

Do not allow the use of toy guns, swords, knives and other toy weaponry in the child care setting.

Promote healthy ways to express anger and disagreement. Support children in using positive means of resolving conflict such as talking about feelings, making choices to avoid fights, and getting help from a trusted adult. Talk to children about guns and violence. Talk to children about the differences between media violence and violence in real life. Explain that in reality, guns can kill or cause long-term disabilities. Even small children can understand this, and healthy responses learned at this age can last a lifetime. Help parents understand the importance of these lessons.

Emergencies

- All staff should be aware of any special needs, allergies, etc., of all children in their care, with special care plans accessible for children with special health needs.

In the event of an emergency in your child care environment, remember these three important things:

1. Keep calm. If you panic, the children are likely to panic, too.
2. Follow your emergency procedures.
3. Act quickly.

Assess the injury event

Whenever you are faced with an emergency situation, follow these steps:

1. ***Survey the scene***. Prevent injuries to the rescuer or messenger.
2. ***F i n d out what happened***. Who is hurt? How? What caused this?
3. ***Check for life- threatening problems.***
4. ***Call the Emergency Medical Services (EMS) system (9-1-1) for help if needed.***
5. ***Comfort and reassure the victim.***
6. ***Check for injury***. Do a secondary survey for specific injuries. Look, listen and feel, but do not move the victim.

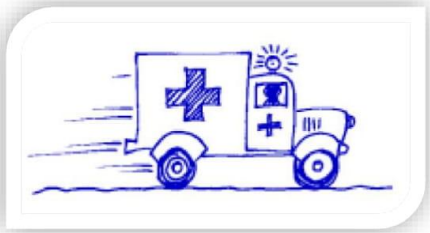
Outline of Emergency Procedures

1. Remain calm. Reassure the victim and others at the scene.

2. Stay at the scene and give help until the person assigned to handle emergencies arrives.

3. Send word to the person who handles emergencies for your program. This person will take charge of the emergency, assess the situation, and give any further first aid as needed.

4. Do not move a severely injured or ill person except to save his or her life.



5. If appropriate, phone for help. Give all the important information slowly and clearly. To make sure that you have given all the necessary information, wait for the other party to, hang up first. Arrange for transportation of the injured person by ambulance or other such vehicle, if necessary. Do not drive unless accompanied by another adult. Bring the Emergency Transportation Permission Form with you.

6. If the child is having a medical emergency (such as asthma or anaphylaxis) that requires medication administration, then administer the child's medication if you have been given all necessary parental and health care provider permissions and training to use the medication. For poisonings, do not administer anything by mouth, and call Poison Control Center as well as 9-1-1- (for poisoning) or physician (for other illness).

7. Notify parent(s) of the emergency and agree on a course of action with the parent(s).

8. If a parent cannot be reached, notify parent's emergency contact person and call the physician shown on the child's Emergency Transportation Permission Form.

9. Be sure that a responsible individual from the program stays with the child until the parent(s) take charge.

10. Fill out the accident report within 24 hours. File it in the child's folder. Give the parent(s) a copy, preferably that day. Note injury information in a central injury log.

Contents of First-Aid Kit

Item	Date Checked (Restock after each use and inventory monthly)				
Disposable nonporous gloves (to protect hands from contact with blood or body fluids)					
Sealed packages of antiseptic (for cleaning)					
Scissors (to cut tape or dressing)					
Tweezers					
Thermometer (for taking temperature)					
Bandage tape (to hold gauze pads or splint in place)					
Sterile gauze pads (to clean Injured areas and cover cuts and scrapes)					
Flexible roller gauze (to hold gauze pad, eye pad or splint in place)					
Triangular bandage (to support Injured arm or hold a splint in place)					
Safely pins (to pin triangular bandage)					
Eye dressings (to cover both eyes if a foreign body is present and cannot be removed)					
Pen/pencil and note pad (to write down Information and Instructions)					
Cold pack (for bumps and bruises when away from					
Current American Academy of Pediatrics or Infant/Child first aid resource or equivalent guide (Instructions)					
Coins (for use in pay phone)					
Poison control telephone number					
Water (bottled or a water source for cleaning injured areas and handwashing)					
Small plastic metal splint (to Immobilize an Injured					
Soap (to wash hands or injured area)					
Initials of person who checked					

KEEP OUT OF THE REACH OF CHILDREN

Child Care Emergency Contact information

Child's Name: _____ . Birth date: _____

Legal Guardian #1 Name: _____

Telephone Numbers: Home: _____ ....Work: _____

Legal Guardian #2 Name: _____

Telephone Numbers: Home: _____ Work: _____

Emergency Contacts (to whom child may be released if legal guardian is unavailable)

Name#1: _____

Telephone Numbers: Home: _____Work: _____

Name #2: _____

Telephone Numbers: Home: _____Work: _____

Child's Usual Source of Medical Care

Name: _____Address: _____

Telephone Number: _____

Child's Health Insurance Name of Insurance Plan: _____ ID#: _____

Subscriber's Name (on insurance card): _____

Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations

_____

Transport Arrangement in an Emergency Situation

Child will be taken to: Parents/guardians preference Hospital _____
EMS will decide the proper hospital to provide the proper care for the child's condition
(Parents/guardians are responsible for all emergency transportation charges)

Parent/Legal Guardian Consent and Agreement for Emergencies

As parent/legal guardian, I give consent to have my child receive first aid by facility staff, and, if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above to act on my behalf until I am available, I agree to review and update this information whenever a change occurs and at least every 6 months.

Date: _____ Parent/Legal Guardian's Signature #1: _____

Date: _____ Parent/Legal Guardian's Signature #2: _____

Injury Report Form

Fill in the blanks and boxes carefully.

Name of Program: _____ Phone: _____

Address of Facility: _____

Child's Name: _____ Sex: M F Birth date: __/__/__Incident Date: __ /__ /__

Time of Incident: _____: _____am/pm Witnesses: _____

Name of Legal Guardian/Parent Notified: _____Notified by: _____ Time Notified: ____: ____am/pm

EMS (911) or other medical professional ❑ Not notified ❑ Notified Time Notified: ____: _____am/pm

Location where incident occurred: ❑ playground ❑ classroom ❑ bathroom ❑ hall ❑ kitchen ❑ doorway ❑ large muscle room or gym ❑ office ❑ dining room ❑unknown ❑other (specify)_____

Equipment/product involved: ❑ climber ❑ slide ❑ swing ❑ playground surface ❑sandbox ❑trike/bike ❑hand toy (specify): _____

❑other equipment (specify): _____

Cause of injury: (describe)_____

❑ fall to surface; estimated height of fall _____ feet; type of surface: _____
❑ fall from running or tripping ❑ bitten by child ❑motor vehicle ❑ hit or pushed by child ❑ injured by object
❑ eating or choking ❑ insect sting/bite ❑ animal bite ❑ injury from exposure to cold ❑ other (specify): _____

Parts of body injured: ❑ eye ear ❑ nose ❑ mouth ❑ tooth ❑other part of face ❑ other part of head ❑ neck ❑arm/wristband ❑leg/ankle/foot ❑trunk other (specify): _____

Type of injury: ❑ cut ❑ bruise or swelling ❑ puncture ❑ scrape ❑ broken bone or dislocation ❑ sprain ❑crushing injury ❑ burn ❑ loss of consciousness ❑ unknown ❑ other (specify): _____

First aide given at the facility: (e.g., comfort, pressure, elevation, cold pack, washing, bandage): _____

Treatment provided by: _____

❑ no doctor's or dentist's treatment required
❑ treated as an outpatient (e.g., office or emergency room)
❑ hospitalized (overnight) # of days:_____

Number of days of limited activity from this incident: _____ Follow-up plan for care of the child: _____

Corrective action needed to prevent reoccurrence: _____

Name of official/agency notified: _____ Date: _____

Signature of staff member: _____ Date: _____

Signature of Legal Guardian/Parent: _____Date: _____

This form must be filed with the Department of Social Services Community Care Licensing Division, LLC 634 for child care centers, and LIC 624 B for child care homes.

These below forms are required by the Child Care Licensing Agency (Analyst) and should be completed and submitted within 24 hours

These forms can be found with the attached links

The child care home or center, official reporting forms for "unusual incidents" in licensed child care that are required by the Licensing agency, in cases of serious injuries or illnesses.

The below link is the LIC624A Death Report form, Licensing should be call within 24 hours of any death and the Death Form must be completed and submitted within 7 days to licensing.
http://www.cdss.ca.gov/cdssweb/entres/forms/English/LIC624A.PDF

The second page of this link is a step by step general instructions for completion of the form.

The below link is the LIC624 unusual incident/Injury Report – Child Care Center. In the event of an incident, death, any injury that requires medical treatment, any missing child, any suspected child abuse of any child in care, and fire or explosions, any communicable disease outbreak, any poisoning, or other incident that threatens the physical or emotional health of a child.

The child care provider should call the parent the day of the incident, within the next day (within 24 hours) notify Licensing, within 7 calendar days submit this written report and keeps copies of all report submitted to Licensing
http://www.cdss.ca.gov/cdssweb/entres/forms/English/LIC624.PDF

The below link is the LIC624B unusual incident/Injury Report – Family Child Care Home. In the event of an incident, death, any injury that requires medical treatment, any missing child, any suspected child abuse of any child in care, and fire or explosions, any communicable disease outbreak, any poisoning, or other incident that threatens the physical or emotional health of a child.

The child care provider should call the parent the day of the incident, within the next day (within 24 hours) notify Licensing, within 7 calendar days submit this written report and keeps copies of all report submitted to Licensing.
http://www.cdss.ca.gov/cdssweb/entres/forms/English/LIC624B.PDF

The second page of this link is a step by step general instruction for completion of the form.

Evacuation Drill Log

Select a location in the building for the site of a "pretend" fire which could change the usual evacuation route. Plan and conduct an evacuation drill using alternate exits.

Date	Time	"Pretend" Fire Location	Length of Time to Evacuate	Number of Children	Name/Signature of Person Observing Drill											

Earthquake and Disaster Preparedness

Earthquake Drills

https://www.youtube.com/watch?v=SYMfNUalrIw

What you can do before an earthquake

1. Prepare your facility and its contents (e.g., move heavy objects to lower shelves fasten bookcases/tall cabinets to the wall, move beds/cribs away from windows
2. Have frequent drills – at least quarterly.
3. Talk to parents about emergency plans and encourage them to practice at home to reinforce.
4. Prepare an emergency kit for your program and small kits in each child's cubby.

What you can do during an earthquake

1. Duck, cover and close your eyes. If you are under a heavy piece of furniture, hold onto the legs. Do not move until the shaking stops and keep the children as close as possible.
2. If you are outside, stay away from overhead power lines, trees and overpasses. Duck and cover.
3. If you are in a car, pull over to the side. Stay away from overhead power lines, trees and overpasses. Stay in the car until the shaking stops.

What you can do after an earthquake

1. Be prepared to duck and cover if there are aftershocks.
2. Attend to the first-aid needs of injured children and staff.
3. Account for children; locate missing children and staff.
4. Extinguish small fires. Check for damage to utility systems and appliances; if necessary, shut off the main power, gas and water. Shut off the gas only if you can smell it or hear it leaking.
5. Calm and reassure frightened children.

6. If you think that the building and/or its contents are too damaged, leave the building. If you must leave the area, place a note for the parents.

Preparing for a Disaster

Childcare Emergency Disaster Plan

https://www.youtube.com/watch?v=c9RL5NhfXrE

Our guide will help keep your family safe in any kind of emergency.

In our increasingly insecure world, it's more important than ever to be ready for a large-scale emergency or catastrophe, whether it's a natural disaster or a biological attack. The best way to protect your family is to stay prepared. Here's how.

Emergency Supply Kit

Store and protect essentials in a waterproof box so they're on hand if you need them.

- Buy gallon jugs of water, or store tap water in sturdy plastic containers that have tight screw lids, such as two-liter soda bottles. Keep at least three gallons on hand for each family member.
- Flashlights
- Radio or television (battery-operated)
- Duct tape
- Batteries
- First-aid kit (include gauze pads, scissors, tweezers, thermometer, acetaminophen)
- A week's supply of any prescription taken by any member of the family
- Toilet paper, personal-hygiene items, and garbage bags
- Cash or travelers' checks and a credit card
- One change of clothing per person
- Blankets and a sleeping bag for each person
- Games, books, or toys to occupy the kids
- Matches in a waterproof container
- A tool kit
- A whistle and a set of car keys

Plan Ahead

Follow these steps when making an emergency plan for your family.

1. Pick two meeting spots: one right outside your home in case of a sudden emergency, such as a fire; and another outside your neighborhood – in the event you are evacuated from your home. Children should know the address and phone number of the remote location.
2. Select someone out of state as your emergency contact. It's often easier to make long-distance calls than local ones in times of high call volume. Consider purchasing a cell phone if you don't own one.
3. Discuss and frequently review evacuation procedures. Keep instructions simple. The more you get kids involved in planning, the more prepared and less afraid they'll be during an emergency.

Important Papers

Keep these documents in a waterproof, portable container.

- Wills, insurance policies, contract deeds, stocks, and bonds
- Passports or ID cards, Social Security cards, immunization records
- Bank and credit-card account numbers
- Family records, such as birth, marriage, and death certificates

Safeguarding Your Home

- Make sure you have adequate homeowners' or renters' insurance. Consider special coverage if you live in areas subject to natural disasters such as floods or earthquakes.
- Install smoke alarms on each floor of your home, and change the batteries twice a year.
- Make sure items that could fall during an earthquake, like mirrors and shelves, are anchored to the wall.
- If a hurricane is forecast for your area, move expensive electronics upstairs and away from windows; bring in outdoor objects that might fly around, such as lawn furniture and trash cans; and cover windows with plywood or shutters.

Car 911

Be prepared for any kind of emergency on the road by stocking your car with the following:

- First-aid kit
- Jumper cables
- Flashlight (and batteries)
- Road flares or reflectors
- Gloves
- Paper towels
- Fire extinguisher
- Pocketknife
- Lighter or matches
- Candle
- Blanket
- Small tool kit
- Water and snacks
- Emergency fuel additive

Keep Your Baby Safe

Pregnant women and new moms should stockpile basics for an emergency birth or for infant care, including:

- Soap and water
- Sanitary gloves
- Trash bags

- String, scissors, knife
- Blankets, pillows, towels, sheets
- Formula and bottles
- Medications
- Diapers for at least three days
- Bulb syringe to clean Baby's nose

Young Children and Disasters

Disasters and Trauma

After experiencing a disaster – whether it is a flood, earthquake, fire, hurricane or bombing – children may react in ways that are difficult to understand. Even if you or your child were not physically injured, the emotional response can be strong. They may act clingy, irritable or distant, and although they are very young and do not seem to understand what is going on, they are affected as much as adults. Adult fears and anxieties are communicated to children in many ways. The experience is more difficult for them, as they do not understand the connection between the disaster and all the upheaval that follows. They need reassurance that everything is all right.

There is a wide range of "normal" reactions for children following a disaster, most of which can be handled with extra support at home, child care and school. In some cases, professional intervention may be needed, despite everyone's best efforts. Early intervention can help a child avoid more severe problems.

Message to Parents

Some ways to provide reassurance after a disaster are:

- Try to remain calm.
- Remember the effect and anxiety produced by watching television coverage or listening to the radio. Keep TV/radio/adult conversations about the disaster at a minimum around young children.
- Spend extra time being close to your children).
- Answer all questions as honestly and simply as possible. Be prepared to answer the same questions over and over. Children need reassurance to master their fears.
- Spend extra time with your child at bedtime—soothing and relaxing time—talking, reading or singing quietly.
- Spend extra time with your child when bringing them to child care—they may be afraid you will not come back.
- Try to return to a normal routine as soon as possible to restore a sense of normalcy and

security.

- Don't promise there won't be another disaster. Instead, encourage children to talk about their fears and what they can do to help in case of disaster. Tell them you will do everything you can to keep them safe.

Be patient and understanding if your child is having difficulties.

- Never use threats. Saying, "If you don't behave an earthquake will swallow you up," will only add to the fear and not help your child behave more acceptably.
- Consider how you and your child can help. Children are better able to regain their sense of security if they can help in some way.
- Share your concerns with your child's teacher or child care provider. Consider assistance from professionals trained to work with disaster victims.

Message to Child Care Providers

You can be a support and resource to parents by helping them understand behavioral and emotional responses. Be sensitive to how parents feel when they are separated from their children in a disaster. It may be very helpful for parents, children and you to take some extra time when dropping off children in the morning. A group meeting to reassure parents, discuss your response to their children's reactions, and review your emergency plan will help everyone feel more secure.

To help children "Listen, Protect and Connect" really listen to what they are saying hear the words and their feelings, help them feel protected talk about being afraid, and practice what you will do the next time a disaster strikes. Because young children think the world revolves around them, children may need reassurance that they did not cause the disaster. Connect with the child provide a sense of support for them and their family.

Consider referring a family for professional help if any of the behaviors on the following page persists two to four weeks after the disaster. Children who have lost family members or friends, or who were physically injured or felt they were in life-threatening danger, are at special risk for emotional disturbance. Children who have been in previous disasters or who are involved in a family crisis may also have more difficulty coping.

For more information

National Children's Disaster Mental Health CONOPS project supported by HHS:
http://www.cdms.uci.edu/conops_final_120511.pdf

This is an update of the Listen, Protect and Connect" family of Psychological First Aid strategies for community resilience with special focus on children.

US Dept of Homeland Security's link for parent/child version at
http://www.ready.gov/sites/default/files/documents/files/pfa_parents.pdf

LPC Neighbor to Neighbor, family to family:
http://www.cdms.uci.edu/protect.pdf

Typical Reactions of Children Ages 1 to 5 Following a Disaster

Regressive Reactions	Physiological Reactions	Emotional/Behavioral Reactions
• Resumption of bedwetting • Thumb sucking • Fear of darkness • Fear of animals • Fear of "monsters" • Fear of strangers	• Loss of appetite • Overeating • Indigestion • Vomiting • Bowel or bladder problems (e.g. diarrhea, constipation, loss of sphincter control. • Sleep disorders and nightmares. •	• Nervousness • Irritability • Disobedience • Hyperactivity • Tics • Speech difficulties • Anxiety about separation from parents • Shorter attention span • Aggressive behavior • Exaggeration or distortion of disaster experience • Repetitive talking about experiences • Exaggeration of behavioral problems

Typical Reactions of Children Ages 5 to 11

Following a Disaster

Regressive Reactions	Physiological Reactions	Emotional/Behavioral Reactions
• Increased competition with younger siblings • Excessive clinging • Crying or whimpering • Wanted to be fed or dressed • Engaging in habits they had previously given up	• Headaches • Complaints of visual or hearing problems • Persistent itching and scratching • Nausea • Sleep disturbance, nightmares, night terrors.	• School phobia • Withdrawal from play group and friends • Irritability • Disobedience • Fear of wind, rain, etc. • Inability to concentrate and drop in level of school achievement • Aggressive behavior • Repetitive talking about their experiences • Sadness over losses

Toy safety

What a child care provider needs to know

Toys and games help children develop coordination and learn about sizes, shapes, colors, numbers and letters. Child care providers offer toys and other play materials for fun and to help children learn. Toys and playing spark creativity and give children an opportunity to experiment, develop new skills, experience a sense of accomplishment and be active.

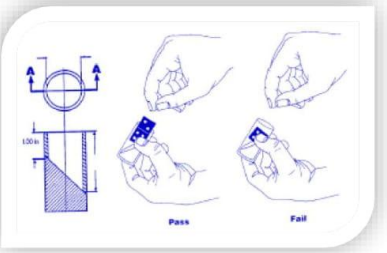
Some toys can harm children. Toys that are poorly designed, not developmentally appropriate, used incorrectly, made with glass or breakable plastic, have small parts, or are broken or worn out are not safe and may cause injuries, or even death.

Reported cases of deaths from toys include those associated with choking on toys and riding on toys. Injuries from toys are those associated with tripping over a toy, bumping into a toy or being hit by a thrown toy, rather than directly related to the design of the toy.

What a child care provider can do to reduce the risk

Toys should be examined for hazards and must be as safe and as risk-free as possible. Child care providers can use tools such as the choking hazard checklist and the toy safety checklist to eliminate those toys that may present risk. Toys and toy parts should be large enough that they cannot be swallowed.

Toys intended for use by children younger than three years should not have accessible, small parts that fit into a standard cylinder with an inside diameter of 1 ¼" and depth varying from 1 to 2½". This standard cylinder (available at some juvenile products stores and through catalogs) can be used to test toy parts.



Knowledge of developmentally appropriate toys will help child care providers select toys that are safe for the child care environment. If the group is of mixed ages and developmental levels, supervision and safety practices should be used to protect the youngest children from the risk of playing with toys that may present a hazard to them.

Developmentally Appropriate Toys

Children whose development differs from the typical may need toys that are interesting, stimulating and safe for their individual needs.

Age Group	Suggested Toys
Up to 1 year	• large blocks of wood or plastic • pots and pans • soft washable animals and dolls or balls • toys that make noises, busy boards, squeeze toys • bright movable objects that are out of a baby's reach
1 to 2 years	• cloth or plastic books with large pictures • stacking toys, balls, large blocks • push or pull toys without long strings • toy telephone without long cord • tapes with simple stories or music
3 to 6 years	• books (short stories or action stories) • building blocks • crayons • nontoxic paints • hammer and bench • housekeeping toys • outdoor toys (e.g. sandbox with lid, slide, swing, playhouse) • transportation toys (e.g. tricycles, cars or wagons) • tape or record player • puzzles with large pieces, chalkboards • balls • simple board games • dramatic play toys

Toy Safety Checklist

Yes	No	
❑	❑	Toys and play equipment have no sharp edges or points, small parts, pinch points, chipped paint, splinters, or loose nuts or bolts.
❑	❑	All toys are painted with lead-free paint.
❑	❑	Toys are put away when not in use.
❑	❑	Children are not permitted to play with any type of plastic bag or balloon.
❑	❑	Toys are too large to fit completely into a child's mouth and have no small, detachable parts to cause choking. No coins, safety pins or marbles for children under four years of age.
❑	❑	Infants, toddlers and those with swallowing difficulties are not permitted to eat small objects and foods that may easily cause choking, such as hot dogs, hard candy, seeds, popcorn, and uncut round foods such as whole grapes and olives.
❑	❑	Toy chests have air holes and a lid support or have no lid. A lid that slams shut can cause head injuries or suffocation.
❑	❑	Shooting or projectile toys are not present.
❑	❑	Commercial art materials are stored in their original containers out of children's reach. The word nontoxic appears on the manufacturer's label.
❑	❑	Rugs, curtains, pillows, blankets and cloth toys are flame resistant.
❑	❑	Toys are not hung across the cribs of infants who can sit up. Rattles, pacifiers or other objects are never hung around an infant's neck.
❑	❑	Infant walkers are not used (prohibited by California licensing).

Back Injuries Among Providers

What a child care provider needs to know

Back injury is the most common cause of occupational injury for child care providers, and can cause a great deal of pain, medical expenses, lost work time and inconvenience. Providers need to exercise and practice good body mechanics to stay healthy.

Dr. Rene Giatz and her colleagues studied the health risk factors associated with the child care work site and put together the following list of the top eight health risk problems:

1. Incorrect lifting of children, toys, equipment, etc.
2. Inadequate work heights (e.g., child-sized tables and chairs)
3. Lowering and lifting in and out of cribs
4. Frequent sitting on the floor with back unsupported
5. Excessive reaching above shoulder height to obtain stored supplies
6. Frequent lifting of children on and off the diaper changing tables
7. Awkward positions and forceful motions needed to open windows
8. Carrying garbage diaper bags to dumpster

What a child care provider can do to reduce back injury

You can prevent back injury in the following ways:

1. Learn proper lifting and carrying techniques, such as keeping the child as close as possible to you and avoiding any twisting motion as you lift the child. Encourage independence in children—for example, walk upstairs with toddlers, rather than carrying them.
2. Use adult furniture, not child-sized chairs, tables or desks. Use sit/kneel chairs.
3. Always lower the crib side before lifting a child out, and use proper body mechanics when lifting.
4. Sit up against a wall or furniture for back support when possible. Perform stretching exercises.
5. Redesign the kitchen area so that the heaviest items are at waist height. Reorganize snacks and supplies to simplify procedures for preparation of snacks. Use step stools when retrieving items above cupboard height.
6. Use adult-height changing tables. Use a ramp or small, stable stepladders or stairs to allow children, with constant supervision, to climb up to changing tables or other places to which they would be lifted.
7. Use step stools for better leverage. Have maintenance staff improve the quality of window slides.
8. Use a cart to transport trash, and relocate the garbage cart closer to the work area. Reduce the size and weight of loads.

Resources

Community Resources for Further Training and Consultation

American Academy of Pediatrics
www.aap.org

American Academy of Pediatric Dentistry
www.aapd.org
www.apha.org

California Child Care Resource and Referral Network
1182 Market St #300, San Francisco, Ca 94102
415-882-0234

California State Automobile Association (AAA)
Traffic Safety Department
(415) 565-2350 Northern California
(714) 885-2305 Southern California

Child Care Law Center
445 Church Street
San Francisco, CA 94103
(415) 558-8005
www.childcarelaw.org

California Department of Health Services
Office of Dental Health Services
P.O. Box 997377
Sacramento, CA 95899-7377
1-916-558-1784

California Poison Control System
1-800-222-1222.
www.calpoison.org

(407) 444-7912 National
www.csaa.ccom

Centers for Disease Control and Prevention (CDC)
www.cdc.go
v

Department of Social Services/ Community Care Licensing
744 P Street, M.S. 19-50
Sacramento, CA 95814
(916) 323-3952
(916) 323-8352 Fax
http://ccld.ca.gov

California Childcare Health Program website address: http://cchp.ucsf.edu

California Childcare Health Program Staff:

UCSF School of Nursing
2 Koret Way Box 0606
San Francisco, CA 94143-0606

Abbey Alkon, RN PNP PHD
415-476-4695 (office)
415-753-2161 FAX
abbey.alkon@ucsf.edu

Bobbie Rose RN PHN
415-502-2825 (office)
bobbie.rose@ucsf.edu

Motor Vehicle Safety Resources

Air Bag & Seat Belt Safety Campaign
National Safety Council
E-mail: airbag@nsc.org
www.nsc.org/airbag.htm

California Office of Traffic Safety
Occupant Safety
Sacramento, CA 95823
(916) 509-3030
www.ots.ca.gov

California Highway Patrol
Office of Public Affairs
415-557-1094
www.chp.ca.gov

National SAFE KIDS Campaign
www.safeklds.org

Safety Belt Safe U.S.A.
www.carseat.org

Sudden Infant Death Syndrome (SIDS) Resources www.sidscenter.org

Sudden Infant Death –Mayo Clinic

www.mayoclinic,org

California Sudden Infant Death Syndrome Program
CASIDSProgram@cce.csus.edu

- Their toll-free information line is: 800-369-SIDS (7437)

Deborah L. Hunt, Ph.D.
California State University, Sacramento | College of Continuing Education
3000 State University Drive, Sacramento, CA 95819-6103
T 916.278.4826 | C 916.473.3320 | F 916.278.4500

Other Resource Organizations

National Fire Protection Association
www.nfpa.org

National Association for the Education of Young Children
1509 16th Street, NW
Washington, D.C. 20036
(202)232-8777
www.naeyc.org

National Child Care Information Center
www.icf.com

National Resource Center for Health and Safety in Child Care
www.nrkids.org

U.S. Consumer Product Safety Commission
4330 East-West Highway
Bethesda, MD 20814-4408
(800) 638-2772 (Consumer Hotline)
301-595-7054
(301) 504-0990
www.cpsc.gov

U.S. Maternal and Child Health Bureau, U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 619-0257
(877) 696-6775
hhsmail@osdhhs.gov
www.mchb.hrsa.gov

CA Department of Health Services www.dhs.cahwnet.gov
Seeks to protect and improve the health of all Californians. Offers a list of Frequently Called Phone Numbers on topics including medical insurance, infectious disease, family planning, and children's medical services.

CA Dept. of Social Services, Children and Family Services Division www.dhcs.ca.gov
Responsible for designing and overseeing an array of programs and services for California's at-risk families and children, providing a statewide system for out-of-home care providers and appropriate services to children in out-of-home care, and facilitation of adoptions for children who need permanent homes.

Emergency Medical Services Authority (EMSA) www.emsa.ca.gov
Approves training curricula (first aid, CPR and preventive health practices) for child care providers; ensures quality patient care by administering an effective, statewide system of coordinated emergency medical care, injury prevention, and disaster medical response, and more.

Early Care & Education

CA Association for Family Child Care www.cafcc.org
Provides educational opportunities at the local and state level toward meeting the child care and development needs of children, parents, child care providers and the community; resources include Professional Development, Early Learning, Health Notes, Referral Services, Child Care Provider Web Pages, Calendar of Events, Child Care Associations, Health Notes, Legislative Updates, and Licensing Updates.

California Association for the Education of Young Children www.caeyc.org
Children with primary focus on the provision of educational services and resources to adults who work with and for children birth through age eight.

CA Child Care Resource & Referral Network http://www.rrnetwork.org/rrnet/index.htm
Coordinates services that assist local child care resource and referral (R&R) agencies in providing child care information and services to parents, child care providers, policy makers, and business and community leaders in every county in the State.

Community Care Licensing/Dept. of Social Services www.ccld.ca.gov
Child care licensing forms, updates, links; CA SIDS program, Child Care Advocate Program (CCAP); technical support program; TrustLine, and LiveScan Fingerprint services.

Contra Costa Child Care Council www.cocokids.org
Promotes quality child care by empowering parents and strengthening families; developing and supporting quality and affordable child care and early education which values cultural diversity and respects the role of parents as the child's primary caregiver and building a broad base of community support for children, families and child care.

National Association for the Education of Young Children www.naeyc.org
Early childhood educators and others dedicated to improving the quality of programs for children from birth through third grade; regional Affiliate Groups work to improve professional practice and working conditions in early childhood education and to build public support for high quality early childhood programs.

National Child Care Information Center www.nccic.org
A national resource that links information and people to complement, enhance and promote the child care delivery system, working to ensure that all children and families have access to high-quality comprehensive services.

National Network for Child Care www.nncc.org
Child care publications and resources. KIDCARE - an e-mail list service; support and assistance from experts in child care and child development. CONNECTIONS newsletters for family child care, center-based care, and school-age child care.

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Child Development

California Head Start Association www.ca-headstart.org
Has plans to provide informational pages designed to benefit Head Start administrators, staff, parents, other Early Childhood Educators and all the friends of Head Start.

Frank Porter Graham Child Development Center www.fpg.unc.edu
University of North Carolina, Chapel Hill
Multidisciplinary centers for the study of young children and their families. Research and education activities focus on child development and health, especially factors that may put children at risk for developmental problems.

Parents' Action for Children www.parentsaction.org
Formerly Rob Reiner's I Am Your Child Foundation, this organization is building a national constituency of parents to change our nation's policies for children and families. Links parents together to share their stories and learn from each other.

Zero to Three www.zerotothree.org
For parents and professionals, to promote the healthy development of babies and toddlers.

Children with Special Needs

Family Resource Centers Networks of California (FRCN)

www.frcnca.org
Actively collaborate with local regional centers and education agencies and help many parents, families and children access information about early intervention services. Families of infants and toddlers, birth to 36 months at risk of or with developmental delays and disabilities, can receive parent-to-parent support from Early Start FRC/Ns.

Regional Centers http://www.dds.ca.gov/RC/RCList.cfm
Non-profit private corporations that have offices throughout California to provide a local resource to help find and access the many services available to individuals with developmental disabilities and their families.

Diversity

Cross-Cultural Health Care Program www.xculture.org
Addressing broad cultural issues that impact the health of individuals and families in ethnic minority communities in Seattle and nationwide.

Health and Safety

American Academy of Dermatology: Kids' Connection www.aad.org/Kids/index.html
Provides children, ages eight through adolescence, with information about skin conditions, common questions and links to other Web sites.

American Academy of Pediatrics www.aap.org
Resources in Spanish and English on a variety of pediatric health topics for families and health care professionals.

American Heart Association www.americanheart.org
Current information about heart disease, including addresses of local AHA offices, heart and stroke guides, and news for health care professionals; information on obtaining CPR training.

Center for Nutrition Policy www.usda.gov/cnpp
Publishes dietary guidance materials for the general public and nutrition and health educators; publishes "Dietary Guidelines for Americans;" also maintains and updates the Thrifty Food Plan (the nutritional basis for determination of Food Stamp Program benefits); resources include recipes and tips for healthy, thrifty meals and the Food Guide Pyramid.

Centers for Disease Control and Prevention www.cdc.gov
Information regarding allergies, cigarette and tobacco issues, drug addiction, disease and disease prevention, immunization, and general, dental, and mental health.

Consumer Product Safety Commission www.cpsc.gov
Consumer and business information, including a library, recall information, public calendar, and keyword search engine.

Healthy Child Care www.healthychild.net
Bimonthly magazine with information on health issues affecting classrooms or child care settings, health and safety resource guide, and Web links.

Immunization Action Coalition www.immunize.org
A source of childhood, adolescent and adult immunization information and hepatitis B educational materials. All materials on this site are camera ready and copyright free.

Kids Health www.kidshealth.org
Provides doctor-approved health information about children from before birth through adolescence; separate areas for kids, teens, and parents - each with its own design, age-appropriate content, and tone.

National Health Information Center www.health.gov/nhic
Publications, health information resource database, national health observances, toll-free numbers; links to US Dept. of Health and Human Services.

Occupational Safety and Health Administration (OSHA) www.osha.gov
Provides inspectors, complaint discrimination investigators, engineers, physicians, educators, standards writers, and other technical and support personnel throughout the country; establishes protective standards, enforces those standards, and reaches out to employers and employees through technical assistance and consultation programs.

Health Insurance and Child Welfare Services

Covering Kids www.coveringkids.org
Health access initiative for low-income uninsured children.

Dept. of Social Services www.dss.cahwnet.gov
CalWORKs, Child Support, Cal-Learn, Food Stamps, Emergency Food Assistance Program, Child Protective Services

Children Now www.childrennow.org
Publications, Action Alerts and Guides, Web links, newsletters.

Children's Defense Fund www.childrensdefense.org
Works to "Leave No Child Behind." Community resources, publications, Web links.

Appendix 1: Information on Specific Diseases

Amebiasis
Campylobacter
Chickenpox
Common Cold (Upper Respiratory Infections)
Conjunctivitis (Pink Eye)
Cytomegalovirus (CMV)
Ear Infections (Otitis Media)
Fifth Disease (Slapped Cheek Disease)
German Measles (Rubella)
Giardiasis (Giardia)
H1N1 swine flu
Haemophilus Influenzae Infections
Hand-Foot-and-Mouth Disease (Coxsackie Virus A16)
Head Lice (Pediculosis)
Hepatitis A
Hepatitis B
Hepatitis C
Herpes ("Cold Sores" or "Fever Blisters")
HIV/AIDS
Impetigo
Kawasaki Disease
Measles xlviii
Meningitis
Monilia (Candida) or Yeast Infections (Thrush)
Pinworms
Ringworm (Tinea)
Roseola (Sixth Disease)
Rotavirus Infections
Salmonella
Scabies
Shigellosis
Strep Throat and Scarlet Fever
Tuberculosis (TB)
Whooping Cough (Pertussis)

AMEBIASIS

What is it?
Amebiasis is an intestinal illness caused by a microscopic parasite called *Entamoeba histolytica*.

What are the symptoms?

On average, about 10 percent of people who are infected with *E. histolytica* become sick from the infection. The symptoms could be intestinal or outside the intestine. Intestinal symptoms are often quite mild and can include loose stools, stomach pain and stomach cramping. Amebic dysentery is a severe form of amebiasis associated with stomach pain, bloody stools and fever. Rarely, *E. histolytica* invades the liver and forms an abscess. Even less commonly, it spreads to other parts of the body, such as the lungs or brain. Examination of stools under a microscope is the most common way for a health care provider to diagnose amebiasis. Sometimes, several stool samples must be obtained.

Who gets it and how?
Although anyone can have this disease, it is most common in people who live in developing countries that have poor sanitary conditions. In the United States, amebiasis is most often found in immigrants from developing countries. It also is found in people who have traveled to developing countries and in people who live in institutions with poor sanitary conditions. The illness is more severe in the very young, the elderly, and pregnant women.

Amebiasis is contracted by swallowing the cyst stage of the parasite in contaminated food or water. It can also be spread by person-to-person contact. Some people with amebiasis may carry the parasite for weeks to years, often without symptoms. Infection is transmitted by:

- Putting anything into your mouth that has touched the stool of a person infected with *E. histolytica*
- Swallowing something, such as water or food, contaminated with *E. histolytica*
- Touching and bringing to your mouth cysts picked up from surfaces that are contaminated with *E. histolytica*

When should people with this illness be excluded?
A child in whom acute diarrhea develops while in child care should be moved to a separate area away from contact with other children until the child can be removed by a parent. Exclusion for acute diarrhea should continue until the diarrhea ceases. A child with bloody stools needs to be examined by a health care provider and should receive antimicrobial therapy before readmission. Children without symptoms who pass cysts do not require exclusion from child care program. This illustrates the need for frequent hand washing and environmental cleaning in out-of-home child care facilities.

Where should I report it?
Amebiasis is a reportable condition in California.

How can I limit the spread of amebiasis?

- Follow universal precautions and proper procedures for diapering, toilet use and toilet training.
- Proper hand washing procedure is the single most important measure for preventing infection.
- Follow guidelines for sanitary handling of food.
- Use safe drinking water.

CAMPYLOBACTER

What is it?
Campylobacter is a bacterial infection and one of the major causes of diarrhea in children and adults.

What are the symptoms?
The bowel infection caused by campylobacter is similar to those caused by some other germs. Campylobacter infection occurs two to ten days after the bacteria are swallowed. It can cause diarrhea with fever, stomach cramps and vomiting in adults and children. The diarrhea may be severe and bloody. Mild infections last one to two days and most patients recover in less than one week, but 20 percent have relapse, prolonged or severe illness. Usually symptoms disappear without treatment in less than a week, but there may still be bacteria in the stools for several weeks if treatment is not received.

Who gets it and how?

Although outbreaks of campylobacter diarrhea have been reported from child care facilities, these are rare. Child care providers are more likely to encounter this as a separate case. Persons often become infected when they eat or drink foods or liquids contaminated with feces of infected animals, especially poorly cooked poultry products, unpasteurized milk and contaminated water. Similar exposure to human feces, especially from diapered children, may happen in the child care setting. When puppies and kittens have this germ in their stools, they may also infect people.

When should people with this illness be excluded?
Exclude children with diarrhea, especially those in diapers, from child care until one of the following has occurred:

- It has been documented that the child has received a minimum of 48 hours of antibiotic treatment, or
- The diarrhea has subsided and can be contained by the diaper or clothing.

Children in the child care setting who were exposed to campylobacter need not be checked for infection unless they develop symptoms. Although campylobacter may be present in the feces for a few weeks after diarrhea has stopped, transmission is believed less likely than during episodes of diarrhea.

Where should I report it?
You must report cases of campylobacter to parents and staff. Also notify your state or local health department if you become aware that a child or adult in your facility has developed campylobacter.
Family and household members in contact with a person with campylobacter diarrhea should be made aware of their possible exposure to the bacteria, especially if they are involved in food handling or preparation. If they develop diarrhea, they should immediately see their health care provider and get a stool culture.

How can I limit the spread?

- Make sure that all meats, especially poultry, are cooked completely before serving. Take care to avoid contaminating foods that will not be cooked with juice from raw meats and poultry.
- Practice good hygiene, especially careful hand washing, after handling pets and cleaning their ages or pens.
- Isolate animals with diarrhea from children and take them to a veterinarian for diagnosis and treatment. However, these bacteria may also be present in the feces of apparently healthy pets.

CHICKENPOX

What is it?
Chickenpox is a very contagious disease caused by a varicella zoster virus. Most children in the United States experience chickenpox before they are school-aged. A vaccine against chickenpox is now available. Although chickenpox is not a serious disease for most children, those whose immune systems are impaired (e.g., newborns and persons who are on chemotherapy for cancer, have AIDS, or take steroids like cortisone) may experience severe disease, or even death. Chickenpox can also cause more severe health problems in pregnant women, causing stillbirths or birth defects, and can be spread to their babies during childbirth.

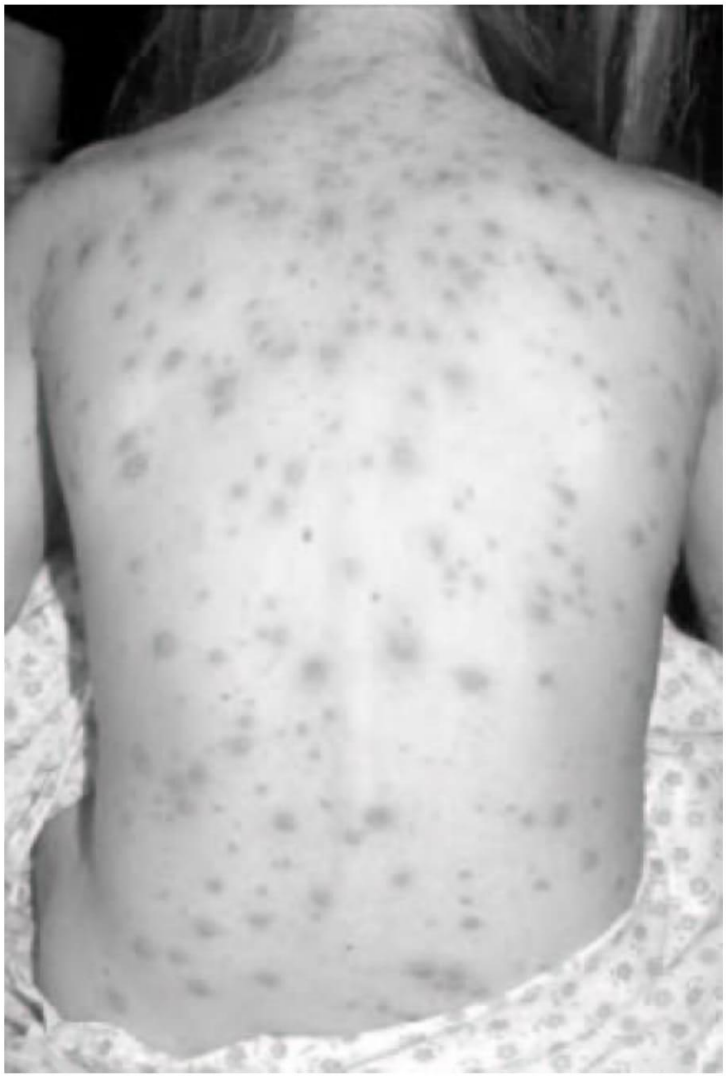
What are the symptoms?
Chickenpox usually begins with a mild fever and an itchy rash. The rash appears with small red bumps on the stomach or back and spreads to the face and limbs. These bumps rapidly become blistered and oozy, and then crust over. People may have only a few bumps or may be totally covered. Once a person has been infected with the virus and gets chickenpox, the virus remains (without symptoms) in the body's nerve cells. In some people, the virus becomes active again at a later time and is called "shingles" or "zoster." With shingles a red, painful, itchy, blistery rash appears, usually in a line along one side of the body. There is no fever. The virus shed in the blisters of the rash can cause chickenpox in a person who has not had it, if that person has direct contact with the infected shingles blisters.

Who gets it and how?
Anyone who is exposed to the varicella zoster virus and has not had chickenpox before will almost certainly get it. If you had chickenpox once, it is extremely rare to get it again. Chickenpox is most common in young children, whereas shingles are most common in adults. The disease is spread by close contact (sharing breathing space or direct touching contact) with infected discharge from the nose, throat or rash. It takes about 10 to 21 days from the time of exposure until a person develops the symptoms of chickenpox. Persons with chickenpox are contagious from two days before the rash appears until the last blister has developed crusts (about five days).

When should people with this illness be excluded?
Children/staff with chickenpox should be excluded for six days after the rash first appears or until all blisters are crusted over and dry. Persons who receive the chickenpox vaccine can come down with a mild case of the disease, and are also contagious. Follow these exclusion guidelines:

- Children with shingles shed the virus that causes chickenpox and could cause an outbreak of chickenpox in the facility. Therefore, unless the shingles rash can be completely covered, it is advisable that persons with shingles stay home until the rash is crusted over and dries. The person with shingles must be very careful about personal hygiene.
- Be sure to inform parents of children with impaired immune systems when another child has received chickenpox vaccine.

Adolescent female with chickenpox lesions in various stages.
Source: AAP



CHICKENPOX (continued)

Where do I report it?
Notify parents and staff about occurrences of chickenpox, especially pregnant staff and parents who may be vulnerable. Also notify your health consultant. You do not need to report cases of shingles or chickenpox to the local health department.

How do I limit the spread of chickenpox?

- Assure that all children and vulnerable staff are immunized.
- Don't expose newborns, pregnant women or people with immune problems.
- Temporarily exclude the sick child or adult.
- Wipe noses with clean tissues, dispose of them properly and wash your hands.
- Don't share food, bottles or toothbrushes.
- Don't kiss children on the mouth.
- Open windows and maximize outdoor play.
- Develop a system for immediate notification if someone develops chickenpox or shingles.
- Keep a person with chickenpox (or shingles with a rash that cannot be completely covered) at home until the rash is completely dry and crusted.
- Watch closely for early symptoms in others for three weeks following the most recent case. If a child or staff member develops a suspicious rash, he/she should call his/her health care provider so the rash can be diagnosed.

COMMON COLD (UPPER RESPIRATORY INFECTIONS)

What is it?

The common cold is a mild infection of the upper respiratory tract (the nose, throat, ears and eyes) which is caused by over 100 different types of viruses. The most common of these is a rhinovirus (nose virus).

What are the symptoms?

Cold symptoms include stuffy or runny nose, sore throat, coughing or sneezing, watery eyes, chills and fever. "Flu" is also caused by viruses (influenza A or B) and has symptoms of high fever, chills, congestion, coughing and muscle aches. Most people who get the flu feel too ill to attend child care.

A runny nose generally accompanies a cold but can also accompany allergies. In the case of a cold, the mucus from the nose generally progresses from being very thin and watery in the beginning (when it is most contagious) to thick and cloudy as the cold progresses. At this time, it can also become yellow or green. The green discharge is not as contagious, but becomes a problem for the child if it lasts more than 10 to 14 days. If accompanied by a fever or headache, it may indicate a sinus infection which will need medical treatment. A cough accompanied by wheezing or difficulty breathing requires medical attention.

Who gets colds and how?

Young children usually catch many colds each year, and will catch even more if they have young siblings or attend a child care facility. Colds and flu are very contagious. They spread when people touch discharges from the nose or mouth, cough and sneeze, kiss on the mouth, share food or eating utensils, and are together in crowded, poorly ventilated and overheated rooms. The virus concentration is usually highest and most contagious two to three days before a person develops symptoms of illness. Viruses continue to be present in respiratory discharges for three to five days after symptoms begin. As a result, infected children and staff have already spread viruses before they begin to feel ill. In fact, children and adults often have mild colds which may go undetected but still cause these persons to be contagious.

When should people with this illness be excluded?

There is no need to exclude these children and staff if they feel well enough to attend and do not require more care and attention than the program can provide.

How can I limit the spread of colds?

- Make sure that all children and staff use good hand washing practices.
- Wipe noses with clean tissues, dispose of them properly and wash your hands.
- Don't share food, bottles or toothbrushes.
- Don't kiss children on the mouth.
- Open windows and maximize outdoor play.

- Teach children to cough into their elbow and away from people.
- Keep the environment clean.
- Limit physical contact between young infants and infected children.

CONJUNCTIVITIS (PINK EYE)

What is it?
Conjunctivitis or pink eye is a common, mild eye infection or irritation. It can be caused by germs (infectious conjunctivitis) and often occurs with a cold or ear infection. Allergies, chemicals or irritants (e.g., smoke, dust, etc.) can also cause it.

What are the symptoms?
It involves one or both eyes and usually lasts three to five days. With this infection, the white parts of the eyes become pink and the eyes produce lots of tears and discharge. Eyes can be itchy and painful, sensitive to light, and in the morning the discharge may make the eyelids stick together. There is no treatment for viral conjunctivitis; it will go away by itself, but may last a week or more. Bacteria usually cause thick yellow or green pus.

Who gets it and how?
Preschoolers and school-aged children have conjunctivitis most often. If caused by germs (infectious conjunctivitis), they can spread it to people taking care of them or to other children when some discharge or pus gets into an uninfected person's eyes. It can also be caused by mucus from the nose and throat during a respiratory infection. Children often pass the infection by rubbing their eyes, getting discharge on their hands, and touching:

- Another child's eyes
- The hands of another child who then touches his eyes
- An object which another child touches before putting her hands to her eyes

Conjunctivitis can also be spread when providers wash, dry or wipe a child's face and then use the same washcloth/towel/paper towel/tissue on another child's face. Providers could also get eye discharge on their hands when wiping a child's eyes and then pass it along as outlined above.

When should people with this illness be excluded?
Children with purulent discharge should be excluded until examined by the child's physician and cleared for readmission to the program with or without treatment as determined by the health provider. Children with conjunctivitis observed in child care do not need to be sent home in the middle of the day. Let parents know that the symptoms were noticed. The parents should notify the facility if the health care provider decides not to prescribe a medicine. Children with conjunctivitis caused by allergies need not be excluded.

Where should I report it?
Notify parents and staff.

How do I limit the spread?

- Make sure that all children and staff use good hand washing practices.
- Encourage the child not to rub his or her eyes.
- Keep children's eyes wiped free of discharge and always wash your hands after wiping a child's eyes.
- Use disposable tissues and towels.
- Teach children to wash their hands after wiping their eyes.
- Be sure that articles which may touch children's eyes (binoculars, toy cameras, etc.) are washed well with soap and water at least once daily.
- Use the same precautions practiced to stop the spread of respiratory diseases.

CYTOMEGALOVIRUS (CMV)

What is it?
CMV is a very common infection caused by a virus and with which most people eventually become infected. CMV can be dangerous for people with immune problems and pregnant women who can spread the illness to their unborn babies. It occurs commonly among children in child care.

What are the symptoms?
Children usually have no symptoms when they become infected with CMV. Occasionally, older children in child care will develop an illness with a fever, sore throat, swollen glands (lymph nodes) in the neck, enlarged liver, rash, and tiredness. However, these symptoms are very rare, especially in young children in child care.

Who gets it and how?
CMV is spread from person to person by direct contact with bodily fluids such as blood, urine or saliva. Thus, it may be spread through close contact such as in diaper changing, kissing, feeding, bathing and other activities where a healthy person comes in contact with the urine or saliva of an infected person. CMV can also be passed from a mother to the child before birth. Children and staff in the child care setting are especially likely to be infected. Some people infected with CMV are contagious for a very short time; others can spread the virus for months to years.

When should people with this illness be excluded?
There is no reason to exclude the child from child care, because the program probably has other children who have CMV.

Is it a problem for pregnant woman?
If infected for the first time during pregnancy, women are at a small risk of delivering an infant with CMV disease which can cause hearing loss, mental retardation and other birth defects. Female child care providers who are not preventing pregnancy should be tested for immunity against CMV. If the test shows no evidence of previous CMV infection:

- Reduce contact with infected children by working, at least temporarily, with children age 2 years or older, among whom there is far less virus circulation.
- Carefully wash hands with warm water and soap after each diaper change and after contact with children's saliva.
- Avoid contact with children's saliva by not kissing children on the lips and by not placing children's hands, fingers, toys and other saliva-contaminated (soiled) objects in their own mouths.

Remember! Contact with children that does not involve exposure to saliva or urine poses no risk to a mother or child care provider and should not be avoided out of fear of potential infection with CMV.

How can I limit the spread of CMV?

- Make sure that all children and staff use good hand washing practices.
- Follow universal precautions in the child care setting.
- Clean and disinfect all mouthed toys and frequently used surfaces on a daily basis.
- Don't kiss children on the mouth.
- Do not share food, pacifiers, bottles, toothbrushes, eating utensils or drinking cups.

Because of the risk of CMV infection in child care staff members and the potential consequences of infection for female staff members, those who are pregnant or not preventing pregnancy should discuss the issue with their health care provider.

EAR INFECTIONS (OTITIS MEDIA)

What are they?
Infection of the middle ear, or otitis media, is an infection of the part of the ear behind the eardrum. It is usually a complication of an upper respiratory infection, such as a cold. It can be acute (new), chronic (persistent), or serious (associated with fluid that does not contain germs). Otitis media is more common in young children because the tube that connects the middle ear to the nasal passages is very short and straight, making it easy for bacteria in the mouth and nasal passages to reach the inner ear. Most ear infections are caused by bacteria.

What are the symptoms?
Symptoms result from swelling of the middle ear. The child may cry persistently, tug at the ear, have a fever, be cranky and unable to hear well. When infection occurs, pus develops, pushes on the eardrum, and causes pain and often fever. Sometimes the pressure is so great that the eardrum bursts and the pus drains out into the ear canal. Although this can frighten parents, the child feels better and the hole in the eardrum will heal over. Today, the biggest problem from otitis media is the potential for hearing loss. Fluid may remain in an ear as long as six months after an infection is gone.

Who gets it and how?
Middle ear infections are common in children between the ages of one month and six years, and most common under age three. Some children develop ear infections a few days after some cold starts. Some children have one infection after another, whereas others never have any. Conditions that increase a child's risk of ear infections are frequent colds, allergic runny noses, bottle propping, exposure to smoke and attendance in child care.

When should people with this illness be excluded?
Since ear infections themselves are not contagious, there is no reason to exclude a child with one from your facility unless they have a high fever or cannot participate in activities because of pain.

How can I limit the spread?
Prevent the spread of colds and other upper respiratory infections which may lead to otitis media.

Special care notes for children who have frequent ear infections:

- Never use cotton swabs and never put anything smaller than your finger into a child's ear. Do not allow the child to do so, either.
- Do not feed or bottle-feed infants lying on their backs.
- Be especially alert for any sign of hearing or speech problems that may develop. Refer the child to the family's health care provider or other community resources.
- Be sure that antibiotics are taken for the full amount of time prescribed to avoid resistant infections.

Special care notes for children who have ear tubes:

- An ear tube creates a hole in the eardrum so fluid and pus may drain out. It usually stays in for three to six months.
- Since pus can drain out, water from the outside world (which has germs in it) can also run into the middle ear easily. Therefore, you must be very careful that children with tubes do not get water in their ears. This usually means no swimming unless there are special earplugs and permission from the health care provider.
- Watch for any sign of hearing or speech problems.

FIFTH DISEASE (SLAPPED CHEEK DISEASE)

What is it?
Fifth disease is a mild rash, also called slapped cheek. It is caused by a virus called parvovirus B19. Outbreaks most often occur in winter and spring, but a person may become ill with fifth disease at any time of the year.

What are the symptoms?
Symptoms begin with a mild fever and complaints of tiredness. After a few days, the cheeks take on a flushed appearance that looks like the face has been slapped. There may also be a soft, light rash on the chest, arms and legs. Not all infected persons develop a rash. As the rash appears, the child usually begins to feel better, and the fever resolves. The rash may last for over a week and may recur in response to sunlight or a warm bath. Most persons who get fifth disease are not very ill and recover without any serious consequences. However, children with sickle cell anemia, chronic anemia or a weak immune system may become seriously ill when infected with parvovirus B19 and require medical care.

Who gets it and how?
Children and adults can get the illness. The virus of fifth disease lives in the nose and throat and can be spread from person to person through coughing, sneezing, kissing on the lips, and sharing food, eating utensils and mouthed toys. Women who develop fifth disease during pregnancy may pass the infection to their unborn fetuses. Fifth disease is contagious one to two weeks before the rash appears. Once the rash appears, a person is no longer contagious.

When should people with this illness be excluded?
A child who has been diagnosed with fifth disease need not be excluded from child care.

Is fifth disease a problem for a pregnant woman?
If a pregnant woman becomes infected with fifth disease for the first time, there is a small risk (less than 10 percent) that the fetus may suffer damage, including the possibility of miscarriage or stillbirth. The woman herself may have no symptoms or a mild illness with rash or joint pains. If pregnant women are exposed to fifth disease, they should consult their health providers.

How can I limit the spread of fifth disease?
- Make sure that all children and staff use good hand washing practices, especially after wiping or blowing noses; after contact with any nose, throat or eye secretions; and before preparing or eating food.
- Do not share food, pacifiers, bottles, toothbrushes, eating utensils or drinking cups.
- Clean and disinfect all mouthed toys and frequently used surfaces on a daily basis.
- Don't kiss children on the mouth.
- Play outdoors as much as possible.
- Avoid exposing pregnant women and people with blood disorders and immune problems.
- Make sure that the child care facility is well ventilated, either by opening windows or doors or using a ventilation system.
- Make sure that children are not crowded together, especially during naps on floor mats or cots.
- Teach children to cough and sneeze into their elbow and away from people.

If an outbreak of fifth disease occurs in the child care setting:
- Notify all parents and staff members. Pregnant women and parents of children who have a damaged immune system, sickle cell anemia or other blood disorders may want to consult their health care providers.
- Make sure that all children and adults use good hand washing techniques. See the Health and Safety Note, *The Hygiene Health Connection: Personal Hygiene Habits Which Reduce the Spread of Disease.*
- If you are pregnant, consult your health care provider.

GERMAN MEASLES (RUBELLA)

What is it?
Rubella, also called German measles or three-day measles, is a childhood disease caused by the rubella virus.

What are the symptoms?
The symptoms of rubella include fever, swollen lymph nodes (glands), and a red rash that covers the body from the face to the trunk and then to the upper limbs. Some children present no symptoms.

Who gets it and how?
Rubella is a common viral illness of childhood. It is rare today because most children are immunized against it. People who have had rubella before or who were immunized usually cannot catch it again. Although it is a mild disease in children, it can be very serious if a pregnant woman catches rubella during the first three months of pregnancy. It can lead to miscarriage, stillbirth or to severe birth defects.
Rubella is generally diagnosed by the characteristics of the rash and confirmed by a blood test. There is no specific treatment. Pregnant women who are exposed or who get the disease should contact their health provider immediately.

It is spread by saliva and respiratory discharges from the nose and mouth, through the air, or on hands and surfaces. A person can spread the disease from as many as five days before the rash appears to five to seven days afterwards.

When should people with this illness be excluded?
Exclusion is generally for six days after the rash appears. It is contagious several days before the rash appears and for five days after. It takes two to three weeks for the illness to appear after exposure.

Where should I report it?
All parents should be notified, with a special warning to pregnant women. The local health department should also be notified.

How can I limit the spread of rubella?
- Make sure that all children and staff use good hand washing practices.
- All children in care should be fully immunized against rubella following the recommended schedule.
- All female staff in their childbearing years should have a blood test for sensitivity to rubella.
- Keep all pregnant women, infants and unimmunized individuals away from a person ill with rubella.
- Follow universal precautions.
- Carefully observe other children, staff, or family members for symptoms.
- Notify parents that the illness is present in the child care program.

GIARDIASIS (GIARDIA)

What is it?
Giardiasis is a chronic diarrhea illness caused by a parasite, *Giardia lamblia.*

What are the symptoms?
Many children infected with giardia have no symptoms. Other children may have foul-smelling, greasy diarrhea, gas, stomach aches, fatigue and weight loss. Although many persons who have giardia do not experience these symptoms, they are still passing *Giardia lamblia* cysts in their stools and are infectious if untreated. Health care providers will diagnose giardiasis by examination of stool under a microscope. Because *Giardia lamblia* is present in stools only some of the time, several examinations must be made. Most health providers agree that persons with giardia who are ill and/or have diarrhea should receive medication.

Who gets it and how?
Giardia is very common — between three and 20 percent of all people have it at any one time. It spreads quickly at child care facilities, especially when infants and children in diapers are present. Giardia is spread from person to person when a person touches the stool or an object which has been contaminated by the stool of an infected person, and then ingests the germs. Infection is often spread by not properly washing hands after bowel movements, after changing diapers or before preparing foods. Giardia may also be transmitted through contaminated water, such as in water play tables. Outbreaks have also been linked to portable wading pools and contaminated water supplies. After exposure, it usually takes one to two weeks to develop the illness.

When should people with this illness be excluded?
Exclude if there is diarrhea with illness, fever or vomiting. After diarrhea resolves the patient may return to child care.

Where should I report it?
Notify parents and staff if a child or staff member is diagnosed with giardiasis. Also notify your health consultant and your local health department.

How can I limit the spread?
- Exclude any child or adult with acute diarrhea.
- Make sure that all children and adults practice good hand washing techniques.
- In a large child care facility, the person preparing food should not change diapers.
- In a small child care facility, the child care provider should carefully wash hands after changing diapers and before handling foods.
- If possible, keep diapered children apart from toilet-trained children.
- Wash and disinfect toys that can be put in a child's mouth after each child's use.
- Use diapers that can contain liquid stool or urine.
- Make sure that diapers have waterproof outer covers or use plastic pants.
- Children should wear clothes over diapers.
- Wash children's hands before they use water play tables.

H1N1 Swine Influenza

Swine Influenza A (H1N1) Information for Child Care Providers

The CDC has identified cases of swine influenza A (H1N1) virus infection in people in California, Texas and Kansas with possible cases in New York. CDC is working with local and state health agencies to investigate these cases. It has been determined that this virus is spreading from human to human.

Mexico has reported increased levels of respiratory disease including reports of severe pneumonia cases and deaths. The swine influenza viruses identified by CDC from cases in Mexico are similar to swine influenza viruses from patients in the United States; however, the limited number of patients identified thus far in the US has not been severe, with only one hospitalized person. Nevertheless, the CDC is concerned about these cases in the United States and the World Health Organization (WHO) is concerned about continued spread of this new virus. Right now, there is no vaccine for this new virus and the current seasonal influenza is thought to be unlikely to provide protection against this new strain.
For child care providers, it would be prudent to
First and most importantly, remind parents and enforce policies for ill children staying at home during their illness. In addition, remind and inform workers not to come to work while ill.
A child may be infectious for up to 10 days after illness onset with influenza while adults are generally infectious for 5-7 days.
Review plans for responding to a pandemic and make sure they are up to date.

Know local/state plans for child care in the event of a mild or severe pandemic. This information may be available from state or local health authorities, child care licensing agencies or resource and referral agencies.
Develop and implement a system to track illness and absence due to illness among children and staff if one is not already in place. The system should be simple and easy to maintain but should record the number of persons with various illnesses (e.g. respiratory, diarrhea, rash) by day or at least by week. (see Caring for Our Children Standards 3.001 and 3.002 for information on how to do this http://nrckids.org/CFOC/PDFVersion/Chapter%203.pdf

Review and implement CDC Guidelines and Recommendations for Preventing the Spread of Influenza (the Flu) in Child Care Settings: Guidance for Administrators, Care Providers, and Other Staff, http://www.cdc.gov/flu/professionals/infectioncontrol/childcaresettings.htm

Make sure staff are familiar with the above guidelines and that they are being followed in your program. Remind child care staff to clean/disinfect frequently touched surfaces within the facility.
Provide information to parents on steps that they could take to prevent flu. (See attached fact sheet that could be distributed to each parent or posted on a door to the facilities with providers calling attention to the posted fact sheet).
Monitor the postings on the CDC web site about this virus to see if child care facilities should begin preparing for possible closure or changes in operation (www.cdc.gov/swineflu).
Contact your local public health department if you have questions or suspected cases.
Review your facilities emergency preparedness plans and consult with state and/or local health department's pandemic plans, particularly if the number of cases escalates dramatically.
Child care and preschool programs can help protect the health of their staff and the children and families they serve by calling attention to the everyday preventive actions parents can initiate to protect their children. (Please consider posting or distributing the attached message in your child care facility).

More information on preventing the spread of influenza can be found at: http://www.pandemicflu.gov/plan/school/preschool.html. For generic information on disaster preparedness, see NACCRRA's web site http://www.naccrra.org/for_parents/coping/disaster.php

Additional generic planning information for schools, including examples of state and local plans, can be found on the Department of Education's website at: http://www.ed.gov/admins/lead/safety/emergencyplan/pandemic/index.html.

Preventing the Flu: Good Health Habits Can Help Stop Germs

Fact Sheet

1. Avoid close contact

Avoid close contact with people who are sick. When you are sick, keep your distance from others to protect them for getting sick too.

2. Stay home when you are sick.

Stay home from work, school, and errands when you are sick. Keep sick children at home. You will help prevent others from catching the illness.

3. Cover your mouth and nose.

Cover your mouth and nose with a tissue when your cough or sneeze. Throw the tissue in the trash after you use it.

4. Wash your hands often.

Washing your hands and the hands of your children often will help protect you from germs.

5. Avoid touching your eyes, nose or mouth.

Germs are often spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.

6. Practice other good health habits.

Get plenty of sleep, be physically active, manage your stress, drink plenty of fluids, and eat nutritious food.

There is no vaccine available at this time for the current outbreak of the Swine Flu virus, so it is important for people living in the affected areas to take steps to prevent spreading the virus to others. If people are ill, they should stay at home and limit contact with others, except to seek medical care. Healthy residents living in these areas should take the everyday preventive actions listed above.

People who live in these areas who develop an illness with fever and respiratory symptoms, such as cough and runny nose, and possibly other symptoms, such as body aches, nausea, vomiting and/or diarrhea, should contact their health care provider. Their health care provider will determine whether influenza testing is needed.

HAEMOPHILUS INFLUENZAE INFECTIONS

What is it?
Haemophilus influenza (not related to the viral disease called "flu") is a group of bacteria. There are six different types of *H. influenza* bacteria. *Haemophilus influenza* type b or Hib causes the most severe disease. Hib is a major cause of meningitis and permanent brain damage. The bacteria can infect the ears, eyes, sinuses, skin, lungs, blood, joints, throat and covering of the heart.

What are the symptoms?
Haemophilus influenza causes ear infection, sinus infection, infection of the epiglottis, arthritis, meningitis and pneumonia.

Who gets it and how?
The source of the organism is the upper respiratory tract (throat, ears and nose). People spread the bacteria by direct contact or by spreading the germs into the air that other people breathe. Many (60 to 90 percent) children carry *Haemophilus influenza* bacteria in their throats without being sick. Up to 5 percent of well children have Hib in their throats. Children between the ages of three months and three years are most likely to get Hib disease. At young ages, children are less able to kill bacteria which have a protective capsule such as Hib does.

When should people with this illness be excluded?
Exclude children and staff ill with the disease until the local health department recommends they return. Exclude all children and staff exposed until preventive treatment (Rifampin) has been given, if indicated and prescribed.

How can I limit the spread of Haemophilus influenza?

- To prevent disease, make sure that children in your care (beginning from two months up to five years of age) are vaccinated. The vaccine is not required for school-age children.
- It is important to carefully observe those who are exposed, but who have not been vaccinated or completely immunized. Exposed children who develop an illness with fever need to be examined by a health care provider should receive antibiotics if indicated and prescribed.
- All contacts should receive prophylaxis (preventive treatment), including those who have received the Hib vaccine.
- Preventive treatment must be given to everyone at the same time for four days. Anyone not treated at the time preventive treatment (Rifampin) is administered to everyone else must be excluded until he or she has had Rifampin.

HAND-FOOT-AND-MOUTH DISEASE (COXSACKIE VIRUS A16)

What is it?

Hand-foot-and-mouth disease is a common and mild childhood illness caused by a virus called coxsackie virus A16.

What are the symptoms?

In many people, infection with the virus causes mild or no symptoms. Symptoms include sores in the mouth followed by a rash of tiny painful blisters on the hands and feet. Symptoms may also include mild fever, sore throat and stomach ache. The fluid in the blisters contains the virus, and symptoms may last for seven to ten days. The infection usually goes away without any serious complications.

Who gets it and how?

This viral illness easily spreads among children through direct contact with saliva, from blisters in the mouth, the fluid from blisters on the hands and feet, or through the infected person's stool (bowel movement). Outbreaks in child care facilities usually happen with an increased number of cases in the community, and are most common in the summer and fall.

When should people with this illness be excluded?

Children with hand-foot-and-mouth disease do not need to stay home as long as they are feeling well enough to participate. Exclusion may not prevent additional cases. Since the virus may be present in the stool for weeks after the symptoms have disappeared, children will have been exposed before the symptoms appeared, and many children will have no symptoms. Children with hand-foot-and-mouth disease usually do not need treatment and will get better on their own within a week.

How can I limit the spread of hand-food-and-mouth disease?

- Follow strict hand washing and personal hygiene procedures. See the Health and Safety Note on
- *Personal Hygiene: Habits Which Reduce the Spread of Disease.*
- Always wash hands, especially after using the bathroom, diapering or assisting the child in the bathroom, and before eating or handling food.
- Wash and disinfect all articles contaminated with stool or mucus.

If an outbreak of hand-foot-and-mouth disease occurs in the child care setting:

- Notify parents and staff members.
- Make sure that all children and adults use good hand-washing techniques.

Where should I report it?

Parents should be notified so they can be aware of hand-foot-and-mouth symptoms.

HEAD LICE (PEDICULOSIS)

What are they?
Head lice are tiny insects that live primarily on the head and scalp. They should not be confused with body lice, which may be found in clothing and bedding as well as on the body, or crab lice, which infest the pubic area. Head lice are found only on humans and should not be confused with fleas, which may be found on dogs, cats and other pets. They hatch from small eggs, called nits (appearing as tiny white or dark ovals), which are firmly attached to the individual hairs near the scalp and cannot be easily moved up or down the hair (as could specks of dandruff.) Nits may be found throughout the hair but are most often located at the back of the scalp, behind the ears, and on the top of the head. The eggs hatch in about 10 days, with new lice reaching adulthood in about two weeks. The female louse is about the size of a sesame seed, can live for 20 to 30 days, and can lay about six eggs a day. The lice, generally found on top of the head, live by biting and sucking blood from the scalp. Lice can survive up to eight hours between feedings and can do so off the body.

What are the symptoms?
The major symptom of head lice is itching caused by the bite of the louse. Persistent scratching of the head and back of the neck should be viewed with suspicion. Often, red bite marks and scratch marks can be seen on the scalp and neck, and a secondary bacterial infection can occur causing oozing or crusting. Swollen neck glands can also result. Diagnosis is usually made by finding nits, which are tiny, pearl gray and oval-shaped specks attached to the hair near the scalp. Use a magnifying glass and natural light when you search for them on the hair at the back of the neck, behind the ears and on the top of the head.
Most children with head lice will be treated with a medicated shampoo, rinse or lotion developed specifically for head lice. These treatments are very powerful insecticides and may be toxic if not used as recommended. Do not treat if you do not find nits. ***However, the single most effective treatment is removal of all nits and environmental cleaning.***

Who gets them and how?
Head lice are not a sign of unclean people or homes. They can occur at any age and to either sex. Anyone who has close contact with an infested person or shares personal items can become infested. Lice are spread only by crawling from person to person directly or onto shared personal items such as combs, brushes, head coverings,

clothing, bedding, towels, etc. Once treatment has been started, refer persons with a suspicious rash to their health care providers for appropriate diagnosis and treatment.

When should people with this illness be excluded?

Children should not be excluded or sent home early from childcare or school because of head lice. Parents of affected children should be notified and informed that their child must be properly treated before returning to school the next day. Other close contacts should be checked to determine if there are other cases. If your facility is having a problem with head lice, you should conduct morning "head checks" before the children socialize together. After proper application of an appropriate treatment, re-infestation of children from an untreated infested contact is more common than treatment failure. "No-nit" policies requiring that children be free of nits before they return to child care or school have not been effective in controlling head lice transmission and are not recommended. Regardless of the policy, to ensure successful treatment the children need to be checked for new nits for ten days after therapy.

Head lice and nits in hair (left) and close-up on hair shaft (above).

How can I limit the spread?

To prevent the spread of head lice when a case occurs in the child care setting:

- Caregivers and parents should learn to recognize nits and regularly check children's hair when there is a known case of head lice in the facility. Because almost all facilities will have outbreaks of head lice periodically, and because the "hysteria" produced by head lice is far greater than their threat to health, this is a prime area for preventive, anticipatory, parent information.
- A well-organized and prompt response to the first few cases can prevent a widespread problem.
- Nits can be removed using a fine-toothed comb. (A pet flea comb may work best.) Commercial preparations to remove nits should be used according to the manufacturer's recommendations to assure that the residual activity of the insecticide is not affected.
- On the same day, screen all children in the classroom or group and any siblings in other classrooms for adult lice or nits. Children found to be infested should also be excluded and treated. Simultaneous treatment of all infested children is necessary to prevent spread back to previously treated children.
- Educate parents regarding the importance of following through with the same recommendations at home and notifying the facility if head lice have been found on any member of the household.
- Although head lice are not able to survive off of humans for more than a few days, many persons recommend washing clothes (including hats and scarves) and bedding in very hot water, and vacuuming carpets and upholstered furniture in rooms used by person infested with these insects.
- Combs and hair brushes may be soaked in hot (65º C) water for at least one hour. Flea bombs and other environmental insecticides are not effective against head lice.

For additional information see the Health and Safety Note on head lice called *So You Have Head Lice in Your Program Again!*

HEPATITIS A

What is it?
Hepatitis A is an infection of the liver caused by the hepatitis A virus. It can last from one week to several months.

What are the symptoms?
Young children often have no symptoms or very mild symptoms of disease. Adults and older children are more likely to have typical symptoms, which include fever, loss of appetite, nausea, diarrhea and general ill feeling (malaise). The skin and whites of the eyes take on a yellow color (jaundice). A person who has no symptoms is still infectious to others.

Who gets it and how?
Anyone can get this infection, which spreads quickly in groups of small children who are not yet toilet-trained and who cannot wash their own hands well. Hepatitis A is spread through stool (by the fecal-oral route). This means the disease is spread by putting something in the mouth that has been contaminated with the stool of an infected person. It can also be spread when a person eats food or drinks beverages which have been handled by a person infected with hepatitis A and not subsequently cooked. Outbreaks of hepatitis A among children attending child care facilities and persons employed at these facilities have been recognized since the 1970s. Because infection among children is usually mild or without symptoms
and people are infectious before they develop symptoms, outbreaks are often only recognized when adult contacts (usually parents) become ill. Poor hygienic practices among staff who change diapers and also prepare food contribute to the spread of hepatitis A. Children in diapers are likely to spread the disease because of contact with contaminated feces. Outbreaks rarely occur in child care settings serving only toilet-trained children. There is no treatment that cures hepatitis A. However, because the incubation period is so long, in cases of outbreaks the illness can be prevented by giving persons in the facility and households a protective shot of immune globulin within two weeks of their exposure to the virus.

When should people with this illness be excluded?
If a child or adult in your child care facility is diagnosed with hepatitis A:

- Exclude the child or adult from child care until one week after the onset of symptoms.
- Immediately notify your local health department and request advice. Gamma globulin, if administered within the first two weeks after exposure, can prevent the infection from spreading to other children and families.

How can I limit the spread of hepatitis A?

- Strictly enforce hand washing and universal precautions.
- Make sure all parents and staff notify the facility if any person in their household is diagnosed with hepatitis A.
- A new vaccine is available to prevent hepatitis A, but is not currently licensed for children less than two years of age. Although outbreaks of hepatitis A sometimes occur in child care settings, they do not happen often enough to make it necessary for child care providers or children attending child care to be routinely vaccinated against hepatitis A. When outbreaks occur in child care settings, gamma globulin may be administered to children, providers and families of child care attendees to limit transmission of hepatitis A.

HEPATITIS B

What is it?
Hepatitis B is a viral infection of the liver. This virus is completely different from hepatitis A.

What are the symptoms?
Only about 10 percent of children who become infected with hepatitis B virus show any symptoms. When children do have symptoms, they may be similar to those of hepatitis A: fatigue, loss of appetite, jaundice (yellowing of the skin and whites of eyes), dark urine, light stools, nausea, vomiting and abdominal pain. However, hepatitis B is a much more serious infection. As with hepatitis A infection, young children are less likely to be jaundiced or show symptoms of illness. Unlike hepatitis A infection, hepatitis B can cause chronic infection in up to 10 percent of those infected, with persistent "shedding" of the virus into body discharges and blood. Persons with such chronic infections are called virus carriers. These persons can develop chronic liver disease, cirrhosis with liver failure, and liver cancer years after infection. An infected mother can transmit the infection to her newborn infant. Although these infants often show no obvious symptoms of hepatitis B, they have a high likelihood of becoming carriers.

Who gets it and how?
Hepatitis B infections are more difficult to transmit than hepatitis A infections (which are spread via infected stool). Hepatitis B infections occur most frequently in persons who have contact with other people's blood (such as laboratory technicians or health care providers who may accidentally puncture their skin with blood-contaminated needles or intravenous drug users who may share needles). It is most commonly spread by infected mothers to newborn infants through blood exposure at birth, sharing contaminated needles during intravenous drug abuse, sexual intercourse, and exposure of cuts or mucous membranes to contaminated blood. This infection can also be transmitted if infected blood or bodily fluids come in contact with the broken skin of a healthy person, such as by biting. However, this is rare. Although hepatitis B viruses have been found in almost all bodily fluids, only blood, genital fluids and saliva have been found infectious (or able to spread the disease). Transmission in child care facilities is unusual. If an infected person at a facility has behavioral or medical problems such as biting behavior or oozing skin sores, the risk may be higher.

When should people with this illness be excluded?
A staff person ill with hepatitis B should stay home until she/he feels well, and fever and jaundice are gone. A child or staff person with chronic hepatitis B infection who has open sores that cannot be covered should not attend child care until the sores are healed. Hepatitis B is usually contagious from about one month before until one month after the start of jaundice. You do not have to exclude a child who is a carrier of the hepatitis B virus as long as she/he does not have uncontrolled biting or oozing skin lesions that cannot be covered.

How can I limit the spread of hepatitis B?
Hepatitis B is vaccine-preventable. All infants should be vaccinated with three doses of hepatitis B vaccine during the first 18 months of life. Children not previously vaccinated should receive three doses of vaccine by the age of 11 or 12 years. Child care providers should discuss with their doctor whether it is appropriate for them to receive hepatitis B vaccine. To reduce the spread of hepatitis B:

- Assure that all children and staff in your facility are immunized.
- Follow the universal precautions and make sure that all children and adults use proper hand washing practices.
- Clean up blood spills immediately.
- Wear gloves when cleaning up blood spills unless the spill is so small it can be contained in the cloth or towel being used to clean it up. Wash your hands well afterwards.
- Wear gloves when changing a diaper soiled with bloody stools and wash your hands well afterwards.
- Disinfect any surfaces on which blood has been spilled, using freshly prepared bleach solution.
- If a child care provider has open sores, cuts or other abrasions on the hands, the provider should wear gloves when changing diapers or cleaning up blood spills.
- Do not allow sharing of personal items which may become contaminated with infectious blood or body fluids, such as toothbrushes, food or any object that may be mouthed.
- Place disposable items contaminated with blood or bodily fluids in sealed plastic bags in covered containers.
- Store clothing or other personal items stained with blood and/or discharges separately in a sealed plastic bag to be sent home with the child for appropriate cleaning. Ask parents to wash and then bleach these

articles.
- Discourage aggressive behavior (biting, scratching) at the facility.

If a person at your facility receives a specific infectious exposure (such as a bite that causes bleeding) to a person with known hepatitis B, contact your local health department and the exposed person's health care provider for advice. The exposed person will need to receive a preventive immune globulin injection and the vaccine series.

Where should I report it?
Notify parents and staff about acute hepatitis B infections and report these cases to your health consultant and local health department. If your facility has one or more known carriers of hepatitis B, inform all staff of this fact and carefully train them about measures to prevent its spread. Inform them of the availability of the vaccine.

HEPATITIS C

What is hepatitis C?
Hepatitis C is a viral infection of the liver caused by the hepatitis C virus (HCV).

What are the symptoms?
Children usually don't show any signs or symptoms. Adults often suffer from tiredness, loss of appetite, nausea, abdominal pain, fever and jaundice (yellowing of the skin and whites of the eyes) as well as dark brown urine and pale-colored stools.

Who gets it and how?
The viruses that cause hepatitis C are spread through blood (exposure to blood and blood products from HCV infected persons) or other body fluids. It is also spread by infected mothers to newborn infants through blood exposure at birth. Like hepatitis B, the spread of hepatitis C is unusual in the child care setting.

When should people with this illness be excluded?
Exclude carriers of hepatitis C virus only if they have uncontrolled biting or oozing skin lesions that cannot be covered.

Where should I report it?
Notify parents and staff. Notify your local health department and request advice. Parents and staff must also notify you if anyone in their household is diagnosed with hepatitis C.

How can I limit the spread?
- Follow universal precautions and make sure that proper hand washing and diaper changing practices are followed.
- Clean up blood spills immediately. Wear gloves when cleaning up blood spills or providing first aid for bleeding wounds. Wash your hands afterwards.
- Wear gloves when changing a diaper soiled with bloody stools. Wash your hands afterwards. If you have open sores or rash, cuts or other abrasions on the hands, wear gloves for changing diapers.
- Disinfect diaper-changing areas and surfaces on which blood has been spilled. Use freshly-prepared bleach solution.
- Do not allow sharing of personal items which may become contaminated with infectious blood or bodily fluids, such as toothbrushes, food or any object that may be mouthed.
- Place disposable items contaminated with blood or bodily fluids in sealed plastic bags in covered trash containers. Put other items contaminated with blood or body fluid in sealed plastic bags.
- Discourage aggressive behavior such as biting and scratching.

HERPES ("COLD SORES" or "FEVER BLISTERS")

What are they?
They are common infections in children and adults caused by viruses. There are two types of herpes virus—HSV type 1 (usually found in the mouth) and HSV type 2 (usually found on the genitals).

What are the symptoms?
Children often become infected with this virus in early childhood and many have no symptoms. When symptoms do occur, they may include fever, runny nose and painful lesions (fever blisters or cold sores) on the lips or in the mouth. The blisters or cold sores usually form scabs and heal within a few days.
Herpes infections in children are generally caused by HSV type 1 and, while uncomfortable, are rarely serious. People who have severe eczema or immune system problems may have more severe infections with herpes. Once a person is infected, these viruses remain in nerve cells, and herpes tends to recur at the same places on the body again and again.

Who gets it and how?
Cold sores are spread by direct contact with the lesions or saliva of an infected person. Spreading the virus within families is common. HSV type 1 is most common in young children, whereas HSV type 2 (due to its sexual transmission) is more common in adults. Diagnosis is usually made based on the distinctive appearance of the blisters or sores.

When should people with this illness be excluded?
- Only exclude a child with open blisters or mouth sores if the child is a bitter, drools uncontrollably, or mouths toys that other children may in turn put in their mouths.
- Exclude staff with open, oozing sores that cannot be covered. Do not exclude children or staff with genital herpes or skin blisters (in locations other than the mouth or finger) that can be covered.

Allow returns as follows:
- Children with oozing mouth blisters can return when blisters are crusted over.
- Children or staff with skin blisters that cannot be covered can return when the blisters are crusted over.

How can I limit the spread of herpes?
- Make sure all children and adults in the facility use good hand washing practices.
- Do not allow children to share toys that can be put in their mouths, as the virus may be present even though sores are absent or not noticeable.
- After a child has mouthed a toy, remove it from the play area and put it in a bin for toys to be disinfected at day's end.
- Do not kiss the child or allow the child to kiss others where direct contact with the sore may occur.
- Use gloves if applying medicated ointment to the sore.

HIV/AIDS (HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNODEFICIENCY SYNDROME)

What is it?
AIDS is an infection caused by a virus called HIV (human immunodeficiency virus). Over time, it damages the body's immune system and other organs, and can lead to severe life-threatening illness.

What are the symptoms?
When a person is first infected with the human immunodeficiency virus (HIV), he or she may have no symptoms or may become ill with a fever, night sweats, sore throat, general tiredness, swollen lymph glands and a skin rash lasting for a few days to a few weeks. These early symptoms then go away by themselves. However, the virus stays in the body (becomes a chronic infection) and causes increasing loss of immune function. This results in the body

becoming unable to fight off infections to which we are all normally exposed. The late stage of this infection is called acquired immunodeficiency syndrome (AIDS). A person who is infected becomes potentially infectious to others for life. Early symptoms of HIV infection in children include failure to grow and gain weight, chronic diarrhea without a specific cause, enlarged liver and spleen, swollen lymph glands, chronic thrush (yeast infections) and candida (yeast) skin infections, pneumonia, and other bacterial, viral, fungal and parasitic infections that healthy children do not usually get. However, many children are infected with HIV for many years before developing any symptoms.

Who gets it and how?
HIV is not easily transmitted. For HIV to spread, the virus, present in blood and other body fluids, must enter the uninfected person's blood stream through a break in the skin or through the mucous membranes. In a child care setting, this can only happen through blood-to-blood exchange. It cannot be transmitted through urine, stool, vomit, saliva, mucus or sweat. There is no evidence of casual transmission by sitting near, living in the same household with, or playing with an individual with clinical AIDS or evidence of infection with HIV virus.
HIV is most commonly spread:

- By sharing contaminated needles for intravenous drug abuse, tattoos and body piercing
- Through sexual intercourse
- By infected pregnant women to the fetus
- By exposure to infected blood through a blood transfusion

Less commonly, HIV may be spread:

- By infected mothers who breastfeed their infants
- Occupationally to health care workers, primarily after being stuck with a needle containing HIV in infected blood
- By exposure of open skin or mucous membranes to HIV-contaminated body fluids. Although it is very rare, a few cases have been reported in which HIV was spread by contact with blood or other body fluids from an infected person.

Reports available at this time definitely indicate that biting does not transmit HIV infection. Three factors would have to be present, and it is highly unlikely that these events would occur simultaneously.

(2) The bite would have to be so severe that the skin would be punctured enough for blood to flow (this rarely happens).
(3) The biter would have to have an open, bloody sore or injury in the mouth.
(4) One of the two would have to be infected with the HIV virus.

Recommendations for child care providers who care for children with AIDS/HIV:

- Provide in service education for appropriate personnel to insure accurate information about AIDS and the practice of universal precautions.
- Protect all children and staff at the facility by strictly following special procedures for cleaning and handling blood and body fluids containing blood.
- Protect vulnerable HIV-infected people from infections by communicable diseases (e.g., chickenpox or measles) by excluding them with the advice of their health provider if there is an outbreak.
- Immediately notify parents of all children, including HIV-infected children, if the child has been exposed to chicken pox, tuberculosis, fifth disease, diarrheal disease, or measles through other children in the facility.
- Immediately refer children with HIV to their health care providers to receive appropriate preventive measure (immune globulin) and decision about readmission to the child care facility if they are exposed to measles or chicken pox.
- Protect the right to privacy of these children by maintaining confidential records and by giving medical information only to persons with an absolute need to know it, and with consent of the parent or guardian.
- Help children with clinical AIDS or evidence of infection with the HIV virus to lead as normal a life as possible.

How can I limit the spread of HIV/AIDS?
No vaccine against HIV is available. However, HIV is not likely to be spread from one child to another in a child care

setting, and no such case has ever been reported. The family home provider or center director should be informed by the child's parents or guardians when an HIV-positive child is admitted to child care, but this is the parent's decision. Because of concern over stigmatization, the persons aware of a child's HIV infection should be limited to those who need such knowledge to care for the children in the child care setting. In situations where there is concern about the possibility of exposure of others to infected blood or other body fluids, a child who is infected with HIV should be evaluated by a team that includes the child's parents or guardians, the child's physician, public health personnel, and the proposed child care provider to determine the most appropriate child care setting. This evaluation should consider the behavior, neurologic development and physical condition of the child, and the expected type of interaction with others in the child care setting. In each case, risks and benefits to both the infected child and to others in the child care setting should be weighed.

Children with HIV infection need to be closely monitored by their physicians because they are more vulnerable to severe presentations of infectious illnesses than are other children. Children with HIV infection should receive childhood vaccinations (diphtheria-pertussis-tetanus vaccine, measles-mumps-rubella vaccine, inactivated polio vaccine, *Haemophilus influenzae* type b conjugate vaccine, influenza vaccine and pneumococcal vaccine) following the immunization schedule. Parents of children with weakened immune systems, whether due to HIV infection or other causes, should be advised when certain infectious diseases, such as cryptosporidiosis and fifth disease, have occurred in the child care setting. Such children may need to be removed from the child care setting until the outbreak has subsided in order to protect them from infections that could have severe complications for them. If a child care provider has a weakened immune system, he or she should discuss with his or her health care provider the precautions to be taken to avoid becoming infected with the many infections that young children are likely to transmit.

To reduce the risk of spreading HIV in the child care setting, all child care providers should routinely follow precautions necessary to prevent the spread of any bloodborne infection (including hepatitis B):

- Make sure all children and adults use good hand washing practices.
- Make sure all adults use good diapering practices.
- Wear gloves when changing a diaper soiled with bloody stools.
- Wash skin on which breast milk has spilled with soap and water immediately.
- Do not allow children to share toothbrushes.
- Clean up blood spills immediately.
- Wear gloves when cleaning up blood and bodily fluid spills unless the spill is so small it can be contained in the cloth or towel being used to clean it up.
- Disinfect any surfaces on which blood or bodily fluids have been spilled with freshly prepared bleach solution.
- If a child care provider has open sores, cuts or other abrasions on the hands, wear gloves when changing diapers or cleaning up blood spills.
- Cover open wounds on children and adults.
- Develop policies and procedures to follow in the event of an exposure to blood.
- Screening children for the presence of the HIV antibody prior to program entry is not justified or recommended.
- Parents of children attending group programs do not have the "right" to know the HIV status of other children in the program. Caregivers and teachers need to know when a child has an immunodeficiency, regardless of cause, so that precautions can be taken to protect the child from other infections. However, this does not require knowledge of HIV status.
- Programs offering services specifically for children with HIV infections may provide appropriate alternative placements for individual children, but separate programs are not necessary for infection control and should not be used to segregate children.

IMPETIGO

What is it?
Impetigo is a very common and mild skin infection caused by streptococcal or staphylococcal bacteria.

What are the symptoms?
Impetigo appears as a blistery rash. When the blisters open, they produce a thick, golden-yellow discharge that dries, crusts and sticks to the skin. It may start as oozing at an injured spot on the skin (such as an insect bite, cut, or burn) and can easily be spread by the person's hands to other areas of the skin. Children often have impetigo on their faces. Impetigo is most commonly seen in the warm summer months.

Who gets it and how?
Impetigo is spread from person to person through direct contact with the discharge from the lesions. Most children have impetigo at least a few times. Impetigo bacteria are found all over infected skin, on the crusts and in the discharge, they can be spread to another person who directly touches the skin or a surface contaminated by the discharge or crusts. This infection can rapidly spread among persons in close contact, such as children in a child care facility. Usually the skin protects the body from bacteria. When the skin is broken (cut, scraped, bitten or scratched), bacteria can get under the surface, multiply and cause an infection. Children often have multiple cuts and scrapes on their bodies which make them more vulnerable to impetigo than adults. In most cases, impetigo is treated with some combination of special soap and an antibiotic ointment. An oral antibiotic is given with more extensive impetigo.

When should people with this illness be excluded?
Exclude the child from the center until 24 hours after treatment has begun and the child no longer has a discharge. Children and staff do not need to be sent home in the middle of the day if a suspected impetigo rash is noticed. Wash a child's rash area with soap and water and cover it. Wash your hands and the child's afterwards. Notify the parents when they come to pick up the child and tell them that the child should be seen by a health care provider.

How can I limit the spread of impetigo?
If a child in your facility has impetigo:

- Make sure that all children and adults practice good hand washing technique.
- Exclude the child from the center until 24 hours after treatment has begun and the child no longer has a discharge.
- Infected areas should be washed with mild soap and running water.
- Wash the infected child's clothes, linens and towels at least once a day and never share them with other children.
- Wear gloves while applying any antibiotic ointment that a physician may recommend and wash your hands afterwards. Antibiotics taken by mouth may also be prescribed.
- Make sure to follow policies on cleaning and disinfecting toys.

KAWASAKI DISEASE

Child with Kawasaki disease.

What is it?
Kawasaki disease is an acute childhood illness. It was first described in Japan in 1967. It is now the leading cause of heart disease in children in the United States, and occurs most frequently in children under five years of age. The cause of Kawasaki disease is unknown, and does not appear to be hereditary. Scientists who have studied the disease think it is caused by an infectious agent such as a virus.

What are the symptoms?
A fever that lasts five days or more, redness of the eye, redness of the mouth, lips, tongue and throat, swollen glands in the neck, and extreme irritability are the classic signs of Kawasaki disease.
In as many as 20 percent of the children with Kawasaki disease, the heart is affected. The coronary arteries or the heart muscle itself can be damaged.

Who gets it and how?
The cause is unknown. Peak age of occurrence in the United States is between 18 and 24 months. Fifty percent of patients are younger than 2 years of age, and 80 percent are younger than 5 years of age; children older than 8 years of age rarely develop the disease. Epidemics generally occur during the winter and spring at 2- to 3-year intervals.

When should people with this illness be excluded?
There is no need to exclude a child with Kawasaki disease, unless he or she feels too ill to participate in child care activities.

How can I limit the spread of Kawasaki disease?
Universal precautions are recommended.

MEASLES

What is it?
Measles is a serious disease caused by a virus. Although rare today because of immunization, there are occasional outbreaks when children have not been fully immunized.

What are the symptoms?

Symptoms begin with fever, red and watery eyes, runny nose, cough and tiredness followed by a reddish-brown blotchy rash. The rash usually starts on the face, spreads down the body, and lasts three or more days. Most children with measles become quite ill, but recover with no ill effects. Occasionally, however, measles can lead to pneumonia or swelling of the brain and permanent disability or death. Adults and very young children tend to have more severe illness. People with immune disorders can become seriously ill. Measles can cause miscarriage or premature delivery in pregnant women who have never had the disease and become infected.

Who gets it and how?
Measles is very contagious. It is spread by contact with respiratory discharges from the nose or mouth and from saliva. It is transmitted by coughing, sneezing, sharing eating utensils and mouthed toys. It is transmitted by hands and other surfaces contaminated by the virus. It is contagious from five days before until four days after the start of the rash. Illness begins about one to two weeks after exposure.

When should people with this illness be excluded?
A person with measles should stay home until six days after the rash appears and until feeling well enough to participate in regular daily activities again.

Where should I report it?
Report to all other parents and to the health department.

How can I limit the spread of measles?
Measles is vaccine preventable. Measles vaccine is usually administered as part of the MMR vaccine (measles, mumps, and rubella). Immunization of all children at 12 to 15 months, with a booster at ages four to six years or 10 to 12 years, is critical.

- Staff who have never had measles or been immunized for it should consult their health care provider.
- Adults born after 1957 may need a measles booster.
- Keep the ill child away from the child care program and away from pregnant women, infants and from people with immune problems.
- Always use the same precautions to prevent the spread of respiratory disease, including hand washing, cleaning and disinfecting the environment, and not sharing mouthed toys and eating utensils. There should be no kissing on the lips with the infected person.

MENINGITIS

What is it?
It is a relatively rare infection of the covering of the brain and spinal cord. It can be caused by a virus, bacteria, parasite or fungus. Meningitis caused by a bacterial infection (sometimes called spinal meningitis) is one of the most serious types, occasionally leading to permanent brain damage or even death.

What are the symptoms?
Meningitis usually starts suddenly and includes symptoms such as fever, headache, neck pain or stiffness, vomiting (often without abdominal complaints), and irritability. These symptoms may quickly progress to decreased consciousness (difficulty in being aroused), convulsions and death. For this reason, if any child displays symptoms of possible meningitis, he or she should receive immediate medical care. Young children with meningitis show symptoms of unusual irritability, poor feeding, vomiting, fever and excessive, loud crying. Older children and adults may experience severe headache, neck pain and stiffness. If a case of meningitis occurs in your child care program, it is most important to find out what kind it is so you can alert the other parents, if necessary. You will need the cooperation of the health care provider, your health consultant and perhaps the health department.

Who gets it and how?
Although older children and adults can get meningitis, it occurs most frequently in children under five years of age

(and especially in babies one to 12 months of age). Usually germs causing meningitis are carried in the upper back part of the throat (called the nasopharynx) of an infected person. They are spread either through the air, when the person coughs or sneezes organisms into the air, or by direct contact with discharges from the nasopharynx of the infected person. However, transmission usually occurs only after very close contact with the infected person. Some meningitis can be spread through infected feces on hands or surfaces and then ingested. The period of communicability depends upon the type of germ, and can vary from one to two weeks before symptoms begin to long after. Bacterial meningitis is generally not contagious after 24 to 48 hours of antibiotic treatment. Meningitis and the type of germ causing it are diagnosed by health care providers performing a spinal tap and lab test. Once a diagnosis is made, it should be communicated to you by the health care provider as soon as possible, along with appropriate instructions about what to tell other parents.

When should people with this illness be excluded?
People with meningitis generally feel too ill to attend child care. They can return when they feel better with no fever, or when the health care provider determines the disease is no longer contagious.

How can I limit the spread of meningitis?
Meningitis caused by *Hemophilus influenza* serotype b (Hib) can be prevented with Hib vaccine, which is part of routine childhood immunizations. Some cases of meningococcal meningitis can also be prevented by vaccine. However, this vaccine is not used routinely, and usually only during outbreaks or in high-risk children. The best ways to prevent the spread of meningitis are to:

- Always practice good hand washing and environmental sanitation.
- Assure that all children (and staff) are appropriately immunized, especially with the Hib vaccine.
- Communicate with the health department to determine how the specific disease should be managed as well as share information with the child's parent, other parents, the child's health care provider and your own health consultant.

MONILIA (CANDIDA) OR YEAST INFECTIONS (THRUSH)

What is it?
Monilia, candida or yeast infections are caused by various species of candida, especially *Candida albicans*, and are very common in babies and young children in diapers.

What are the symptoms?
Thrush is seen in the mouths of infected children as white patches which look like milk curds but cannot be wiped off. Diaper rash caused by monilia looks different and starts as very red, raised, round spots. Often there will be a larger spot with surrounding smaller ones. Sometimes the spots all run together, and what you see are large areas of beefy red, raised skin which are very sore and may even bleed. Occasionally a bacterium will invade this raw skin and create a secondary infection with ooze.

Who gets it and how?
These infections are particularly common in diapered children, but adults can get thrush in their mouths or a monilial rash in their groin or other moist areas. They are very mild infections in healthy people and almost everyone gets exposed. Yeast organisms which cause monilial infections are everywhere. Although they can be spread from one person to another, people usually catch it from themselves. Usually the organisms are already on the body waiting for the right conditions. When skin is wet and a little raw (such as in diaper and groin areas), the yeast can invade the skin and start spreading. Yeast infections can also occur after treatment with antibiotics for other conditions. Many infants get candida infections from their mothers during birth. Many of those who escape this infection soon acquire candida from close contacts with other family members, relatives and friends. These early exposures may result in an oral infection (thrush). In most persons, these infections run their course and then heal. However, in newborns or persons with weak immune systems, this yeast can cause more serious or chronic infections.

When should people with this illness be excluded?
Since most persons are already infected with candida, children with thrush and candida diaper rash need not be excluded from child care as long they are able to participate comfortably. If children have diaper rashes which last more than one to two days, ask the parents to see their health care provider for diagnosis and treatment. The child's health care provider will prescribe medication (drops for mouth, cream for the diaper area). High absorbency disposable diapers may help keep the skin dry. Plastic pants that do not allow air to circulate over the diaper area should not be used, although the diapering system should be able to hold urine or liquid feces.

How can I limit the spread of these infections?
Child care providers should follow good hygiene. This includes careful hand washing and disposal of nasal and oral discharges of children with thrush in order to avoid spread of infection to children who are not already infected.

PINWORMS

What are they?
Pinworms are tiny worms that commonly infect children and live in the lower intestine. The female worms (resembling short, white threads less than half an inch long) come out through the anus at night and lay their microscopic eggs around the opening.

What are the symptoms?
In some people this causes intense itching; in others, nothing. Symptoms include anal itching, sleeplessness, irritability and anal irritation due to scratching. Pinworms are common in school-aged children. Pinworms do not cause teeth grinding or bedwetting and are not dangerous, just irritating.

Who gets them and how?
It is estimated that five to 15 percent of people in the United States have pinworms at any one time (the rate is higher in other countries). Preschool and school-aged children frequently have pinworms, and members of an infected child's household can become infected and re-infect a treated child. Pinworms are spread when an uninfected person touches the anal area of an infected person (e.g., during diaper changing), or sheets or other articles contaminated with pinworm eggs, then touches the mouth, transferring the eggs, and swallows the eggs. An infected person can spread pinworms by scratching the anal area, then contaminating food or other objects which are then eaten or touched by uninfected persons. Pinworms can be spread as long as either worms or eggs are present. Eggs can survive up to two weeks away from a human host. People can also keep re-infecting themselves by swallowing eggs that are on their own hands. A health care provider can make the diagnosis by asking the parent to apply the sticky side of transparent tape around the anal area so any eggs on the skin will stick to it. This is best done first thing in the morning before bathing. The tape is then placed sticky side down on a slide and examined under a microscope to see if there are any eggs. Several medicines are available for treatment of this infection. Often the health care provider will treat the whole family if one person in the home is infected, and will repeat treatment two weeks later.

When should people with this illness be excluded?
Children and adults should be excluded ONLY until treatment has begun (initial dose).

Where should I report it?
Notify parents and staff so that they may watch for symptoms in themselves and their children.

How can I limit the spread of pinworms?
- In addition to following hand washing and cleanliness procedures, child care facilities should be sure each child uses only bedding and clothing that has that child's name on it.
- Each child's clothing should be stored separately in plastic bags and sent home for laundering.

- Clean and disinfect bathroom surfaces.

RINGWORM (TINEA)

What is it?
Ringworm (or tinea) is a mild and common fungal infection of the skin, scalp, feet or nails.

What are the symptoms?
On the skin, ringworm appears as a flat, growing, ring-shaped rash. The edges of the circle are usually reddish and may be raised, scaly and itchy. Another type of ringworm fungus can cause the skin to become lighter in flat patches, especially on the trunk and face. On the scalp, infection begins as a small bump and spreads outward, leaving scaly patches of temporary hair loss. On the feet, the skin between the toes scales and cracks, and blisters may be seen. On the nails, a chronic infection can cause thickening, discoloration and fragility.

Who gets it and how?
Ringworm is spread by direct contact with a person or animal infected with the fungus. It can also be spread indirectly through contact with articles (such as combs or clothing), or with surfaces which have been contaminated with the fungus. A child with ringworm is infectious as long as the fungus remains present in the skin lesion. The fungus is no longer present when the lesion starts to shrink.
These infections can often be diagnosed by their typical appearance. Occasionally, scrapings of suspicious skin may be examined under the microscope or cultured to see if a ringworm fungus is present. An antifungal ointment is usually applied to the skin for several weeks. Occasionally, antifungal medicine is taken by mouth, particularly if the diagnosis is ringworm of the scalp.

When should people with this illness be excluded?
There is no need to exclude children/staff with these common, mild infections once treatment has been started. Refer persons with a suspicious rash to their health care providers for appropriate diagnosis and treatment and allow them to return as soon as treatment has begun.

Where should I report it?
Notify parents and staff if more than one person at the facility develops ringworm.

How can I limit the spread of ringworm?
- Keep lesions covered, if possible.
- Observe good hand washing technique among all children and adults.
- Keep the child care environment as clean, dry and cool as possible, since ringworm fungi grow easily on moist, warm surfaces.
- Keep feet clean and dry.
- Pets with skin rashes should be evaluated by a veterinarian. If the pet's rash is caused by fungus, children should not be allowed to come in contact with the pet until the rash has been treated and heals and the pet has been bathed.
- Don't share combs, brushes, towels or bedding.
- Dry skin thoroughly after washing.
- Clean and disinfect bathroom surfaces and toys daily.

ROSEOLA (SIXTH DISEASE)

What is it?
Roseola is a common rash in infants caused by a virus.

What are the symptoms?
Symptoms include a high fever that lasts for three to five days, runny nose, irritability, eyelid swelling and tiredness. The high fever can occasionally cause febrile seizures in certain infants. When the fever breaks, a pink,

patchy rash appears over the neck, chest and body and lasts several days.

Who gets it and how?
It is most common in young children under the age of two. Roseola is spread from person to person, but it is not known how. Roseola is not very contagious; usually, it goes away without any treatment.

When should people with this illness be excluded?
A child with fever and rash should be excluded from child care until seen by a health care provider. A child with rash and no fever may return to child care.

ROTAVIRUS INFECTIONS (Viral Gastroenteritis of Infants and Children)

What is it?
Rotavirus is a common cause of seasonal diarrhea in infants and young children. Almost all children have had rotavirus infection by the time they are four or five years old. In the U.S., rotavirus causes outbreaks of diarrhea during the winter months, and it is a special problem in the child care setting and children's hospitals.

What are the symptoms?
In children ages three months to two years, rotavirus is one of the most common causes of gastroenteritis causing diarrhea. Children with a rotavirus infection have fever, nausea and vomiting, and watery diarrhea. After two days, the fever and vomiting usually stop, but the diarrhea can continue for five to seven days. As with all viruses, some rotavirus infections cause few or no symptoms, especially in adults.
Children with rotavirus infection can become dehydrated if they lose too much body water due to vomiting and watery diarrhea. Check for signs of dehydration including dry lips and tongue, dry skin, sunken eyes, fewer than six wet diapers a day, or (in an older child) too few trips to the bathroom to urinate. Ask the parent to call the health care provider immediately if you see any of these signs. Infants can dehydrate quickly.

Who gets it and how?
Rotavirus is present in the stool of the infected person before the onset of diarrhea and can persist for 10 to 12 days after the onset of symptoms. Transmission is by the fecal-oral route. Rotavirus can be found on toys and hard surfaces in child care centers, indicating that they may serve as a mechanism of transmission. Respiratory transmission also may have a role in disease spread, and transmission within families and institutions is common. It is an important cause of acute gastroenteritis in children attending child care, and outbreaks have been reported. The rate of hospitalization from rotaviral diarrhea in infected children can be as high as 2.5 percent.

When should people with this illness be excluded?
Children with rotavirus infection whose stool cannot be contained by diapers or toilet use should be excluded from the child care facility until diarrhea ceases.

Where should I report it?
Report cases of rotaviral diarrhea to parents and staff. Report outbreaks to local health authorities. Individual cases are not reported.

How can I limit the spread of rotavirus infections?
- Follow universal precautions and proper procedures for diapering, toilet use and toilet training.
- Proper hand washing procedure is the single most important measure for preventing infection.
- Children with rotaviral diarrhea in whom stool cannot be contained by diapers or toilet use should be excluded from child care centers until diarrhea ceases.
- Clean and disinfect surfaces.
- The Centers for Disease Control and Prevention (CDC) has recently recommended that health care providers stop administering the rotavirus vaccine while risks associated with it are being evaluated. The vaccine has been linked to bowel obstruction.

SALMONELLA

What is it?
The salmonella group of bacteria are a common cause of diarrheal illness among persons in the United States. These bacteria are often found in the digestive tract of a variety of animals as well as humans.

What are the symptoms?
Persons with salmonella infections often experience fever, stomach cramps, nausea and vomiting in addition to diarrhea. Symptoms may remain for two weeks or more but are usually gone within a week. These symptoms usually develop a day or two after bacteria are accidentally swallowed and may disappear untreated in two to five days. Bacteria may be present in the stool for several weeks after the diarrhea is over. Very rarely, salmonella causes a blood stream infection or infects a part of the body (such as a joint). People who do not have diarrhea but are passing salmonella bacteria in their stools are called carriers.

Who gets it and how?
Salmonella is present in the feces of ill and recently recovered persons, and infections may be spread from person to person. However, outbreaks in child care settings are rare and most persons are believed to have acquired their infections from contaminated food. Some foods, such as chicken, come from naturally infected sources while others, such as tomatoes and some vegetables, are contaminated during processing. Food handlers may also contaminate food if they are infected or do not practice good hygiene in preparing food. An ordinarily safe food, such as baked goods, may become contaminated from juices of uncooked foods such as poultry. Although it has been known that salmonella may be present in cracked eggs for some time, only recently salmonella has been found in uncooked whole eggs. In addition to food-borne illnesses, pets, especially animals such as turtles, lizards and birds, often carry salmonella in their digestive tracts.

When should people with this illness be excluded?
Each case of salmonella must be considered separately. A health care provider should be consulted. The decision will be based on whether the carrier is a child or staff member, on the type of strain of salmonella, and on the age of the child and risk of communicability. The decision to do a laboratory check for the carrier status of healthy child care attendees depends on the strain of salmonella being carried. It is common policy to have three negative (normal) stool cultures before you can say that someone is clear of the infection and is no longer a carrier.

Where should I report it?
Notify parents and staff if a child or staff member is diagnosed with salmonella. Notify your health consultant and your local health department. Make family and household members in contact with a person with salmonella diarrhea aware of their possible exposure to this bacterium, especially if they are involved in food handling or preparation. If they develop diarrhea, they should immediately see their health care provider and get a stool culture.

How can I limit the spread of salmonella?
While child care providers are most likely to encounter this condition as a result of infection outside their facility, they need to be aware of good hygiene and food handling practices to prevent food borne illness from occurring within their facility. Additionally, providers may reduce the likelihood of salmonella infection by:

- Making sure that children wash their hands after handling animals and cleaning their cages or pens.
- Because of the risk of salmonella infection, turtles, lizards and other reptiles should not be kept as pets in child care centers.
- Limiting the serving of snacks and treats prepared outside the facility and served for special occasions to those from commercial sources. Home-prepared snacks may not only be prepared under less than optimal circumstances, but may be transported and stored under conditions that will allow bacteria to grow. Avoid

food containing raw eggs, including homemade ice cream made with raw eggs.

- Make sure that lunches brought from home are refrigerated when necessary. These include meals containing raw vegetables as well as those with meats. Dairy products and liquid formula should also be kept refrigerated in order to limit the growth of bacteria, including salmonella.

SCABIES

What is it?
Scabies is a skin infection caused by a tiny (microscopic) bug called a mite. The mite burrows into the skin, causing a rash.

What are the symptoms?
The skin rash caused by scabies is without accompanying illness. The rash begins as an itchy, raised and usually red rash. Although it is most commonly found around fingers, wrists and belt line, the rash can occur anywhere on the body below the face. In infants and young toddlers, the rash may look different, and can also occur on the face or scalp.

Who gets it and how?
Only humans carry the mites causing scabies. It can be carried by people from all socioeconomic levels without regard to age, sex or standards of personal hygiene. Because mites can survive only briefly if not on the human body, you can only get scabies from direct contact with another person or by sharing an infected person's clothes. A person may not develop the rash until four to six weeks after exposure.
Over-the-counter insecticide lotion treatments are available for killing the mites. Young children suspected of having scabies should see a health care provider, as should persons with extensive skin disease.

When should people with this illness be excluded?
If a child is suspected of having scabies, the child should be separated from skin contact with other children for that day. Adult contacts should wash their hands. The child should not return to the group until diagnosed and treated for 24 hours prior to re-entry. Household members should be checked and treated at the same time if necessary.

Where should I report it?
Notify any other adults or the parents of children who may have had direct contact with the infected person. Other providers and children and their families may have been infected, and may need treatment.

How can I limit the spread of scabies?

- Look for the signs of scabies in the morning check, and refer suspected cases for evaluation and treatment.
- Do not share hats and jackets.
- Keep personal clothes and bedding separate.
- Launder clothes, towels and bedding in a machine, and dry in a hot dryer or press with a hot iron.
- For non-washable items, dry clean or seal in a plastic bag for four to seven days.
- Vacuum carpets, upholstered furniture and car seats.

SHIGELLOSIS

What is it?
Shigellosis is a diarrheal illness caused by the *Shigella* group of bacteria.

What are the symptoms?
Illness generally begins one to four days after accidental swallowing of the bacteria. Depending on the infectious dose, infection with *Shigella* may be very mild or it may result in severe bloody diarrhea, fever, cramping, nausea

and vomiting. Numerous outbreaks have been reported from child care settings. Children may spread infections acquired in child care facilities to their parents and siblings, and whole families may be ill within a matter of days. Deaths have been reported from this illness: it is one of the more serious infections providers are likely to encounter in the child care setting. Although symptoms usually disappear without treatment after four to seven days, bacteria may still be passed out in the stool for several more weeks.

Who gets it and how?
Shigellosis is most common in children under five and can be a significant problem in child care facilities. Only a few bacteria are needed to cause an infection and, unlike many of the diarrheal agents in child care settings, *Shigella* may spread through groups of children who are toilet trained as well as through groups of children who are in diapers. Infection is spread by the fecal-oral route. It is spread when diarrheal stools get on hands or objects and then onto other children's hands and mouths. It can also be spread through stool-contaminated food, drink, or water. Children and adults who have *Shigella* in their stool should receive antibiotic medication which shortens both the duration of the illness and the length of time that bacteria are passed with the stools.

When should people with this illness be excluded?
The child should not attend child care and return to group until completion of five days of antibiotics or until two successive stool cultures are negative.

Where should I report it?
Notify your local health department, parents and staff.

How can I limit the spread of shigellosis?
If you suspect a case of shigellosis in your child care facility:

- Contact your state or local health department. Prompt intervention may help prevent the spread of shigellosis to others. Your health department should be in a position to give assistance and advice.
- Exclude the ill child and any children who subsequently develop diarrhea from child care until they no longer have diarrhea and have been shown to be free of the *Shigella* bacteria.
- Make sure all children and adults use careful hand washing and that staff are practicing good diapering practices.
- Make sure procedures for cleaning and disinfecting toys are being followed, and that toys are being cleaned and disinfected between uses by children who are likely to put them in their mouths, especially in groups where there have been ill children.
- Notify parents of children in the involved classroom of the illness. Ask that they have any child with diarrhea, vomiting or severe cramping evaluated by a health care provider, and that they inform you of diarrheal illness in their child and family. Explain to them the value of hand washing with soap and running water in stopping the spread of infection in the home. In the event of an outbreak, your health department may recommend a more extensive notification of parents.

STREP THROAT AND SCARLET FEVER

What are they?
A variety of infections, including strep throat, scarlet fever and impetigo are caused by Group A *Streptococci* bacteria.

What are the symptoms?

- Strep throat infections are characterized by a very red, painful throat often accompanied by fever, tender and swollen glands, headache and stomach ache. Sometimes a strep throat will be accompanied by coughing or a runny nose. Note, however, that the vast majority of sore throats in children and adults are caused by cold viruses, not strep bacteria.
- Scarlet fever is a type of streptococcal infection characterized by a skin rash. The rash usually consists of

fine, red bumps that feel sandpapery and appear on the neck, chest, groin and/or inner surface of the knees, thighs and elbows. It may last only a few hours. Other scarlet fever symptoms include flushed cheeks, paleness around the mouth and a red tongue which resembles the surface of a strawberry. Scarlet fever is no more serious than strep throat.

- Rheumatic fever (abnormalities of the heart valves and swelling of the joints) can develop five to six weeks after the occurrence of any type of strep infection which goes untreated. In rare instances, kidney disease can also follow an untreated strep infection. Therefore, it is very important that all cases of strep infections be referred to health care providers for treatment.

Who gets them and how?
Strep throats occur most frequently in children above the age of three (and in adults) during the colder months and in crowded situations. If one person in a family gets strep throat, usually other family members also get it. The Group A *Streptococci* are transmitted from one person to another through direct contact with the respiratory discharges of infected persons. The symptoms will appear two to five days from the time of exposure. Strep throat is probably contagious before symptoms appear and continues to be infectious until treated for 24 hours.

When should people with this illness be excluded?

- Persons who have a positive strep culture should stay home.
- Persons who are only mildly ill can continue to attend the facility while awaiting the results of a strep culture, IF the doctor has not begun antibiotic treatment. If the culture proves to be positive, send the person home.
- Persons with strep may return to child care after they have had at least 24 hours of antibiotic medicine. The facility will have to make sure that every dose of the antibiotic needed during child care hours is taken for the next 10 days.

How can I limit the spread?

- Make sure all children and adults use careful hand washing.
- Teach children to cough and sneeze into their elbow, wipe noses with clean tissues, throw the tissue into the wastebasket, and wash hands.
- Do not allow food to be shared.
- Do not kiss children on the mouth.
- Open windows indoors and maximize outdoor play.
- Parents who become aware that their child has strep throat or scarlet fever should inform caregivers within 24 hours.

TUBERCULOSIS (TB)

What is it?
Tuberculosis is a serious respiratory infection caused by bacteria called *Mycobacterium tuberculosis*.

What are the symptoms?
You should know the difference between the two stages of TB: (1) TB infection means having the TB germ in the body without being sick, and (2) active TB or TB disease means having the germ and also being sick from it, with the symptoms of active TB. Persons with active TB have symptoms such as a cough that won't go away, a cough that brings up blood, a fever lasting longer than two weeks, night sweats, feeling very tired, or losing a noticeable amount of weight. The TB skin test cannot show active TB: active TB must be diagnosed by a health care provider, based on a physical exam, a chest x-ray, and laboratory tests. The treatment for active TB usually involves taking at least three different drugs for at least six months, and it usually cures the TB.

Who gets it and how?
TB is transmitted by respiratory discharges when an infected person has the active disease. These germs can be spread through the air when a person with TB disease coughs, sneezes, yells or sings. Children, although they may

be infectious, are usually not as likely as adults to transmit TB to others. TB is not spread by objects such as clothes, toys, dishes, walls, floors and furniture. Active disease can cause damage to the lungs and occasionally can spread to other parts of the body such as the bones, brain and kidneys. Most often the disease is inactive. This means that the bacteria have entered a person's lungs and is contained, so that it does not cause damage and is not contagious. Young children or people with immune problems are especially vulnerable. When a child has TB infection, it means that the child was infected by an adult with active TB, often a person in the home. Most persons who have TB infection do not know it because it does not make them sick. A person with only TB infection cannot spread TB to others and does not pose an immediate danger to the public. TB infection is diagnosed only by the TB skin test. This safe, simple test is given at most local health departments. A small injection is made under the skin, usually on the forearm. In persons who are infected with the TB germ, the skin test causes a firm swelling in the skin where the test was given. After one or two days, a health care provider reads the results of the TB skin test.

When should people with this illness be excluded?
A person with active disease should stay home until a health care provider determines the disease is no longer contagious. Adults are more likely than children to be contagious. Although most people with a positive TB test never develop symptoms, they may develop active disease many years later. An active case of TB that occurs within the child care program should be reported to the health department.

How can I limit the spread of TB?

- All caregivers, including all volunteers and members of a family in a family child care setting, are required by child care regulations to be tested for TB prior to employment. It is recommended that they be tested every four years after that. They should follow the recommendations of their local health department for the frequency of tests.
- In the United States, TB is more common in some populations, for example immigrants coming from Asia, Africa and Latin America and medically underserved minority populations. However, overall, TB infection in children younger than five years old is rare. Therefore, TB skin testing of all children in child care is not useful. However, a local health department may decide to test children who have more risk for infection. Some programs (e.g., Head Start) and some states require children to have a TB skin test before they can attend.

WHOOPING COUGH (PERTUSSIS)

What is it?
Whooping cough is a serious respiratory infection caused by a bacterium that is highly contagious. It gets its name from the whooping sound the child makes when trying to draw breath after a coughing spell. It can be prevented by immunization.

What are the symptoms?
Symptoms generally include those of a cold, such as runny nose and a cough that gradually worsens. Violent coughing spells frequently end with vomiting. The coughing can lead to severe episodes or fits of coughing in which children gasp (or whoop) for breaths of air. It is a very serious disease for children under six months, as they may develop other complications that require hospitalization such as pneumonia, ear infections and swelling of the brain.

Who gets it and how?
Whooping cough is very contagious and dangerous. It is spread from person to person through the air. A person who is not immune to whooping cough becomes infected by breathing air that has been contaminated with the respiratory discharges of an infected person who has coughed. Adults and partially immunized children get milder symptoms of the disease and can transmit it to children. Before vaccines and antibiotics were developed, whooping cough was a common cause of death in young children.

Today, it is vaccine preventable. Children in the United States are now immunized with the whooping cough vaccine beginning at two months of age and again at four months, six months, 15 months, and four to six years. All children attending a child care facility should be up to date on vaccinations.

When should people with this illness be excluded?
Exclude the infected person from the facility until that person has been on antibiotics for at least five days or for four weeks after onset of intense coughing.
How can I limit the spread of whooping cough?

- Require up-to-date immunization certificates for all children in your care.
- Notify the health department and other contacts.
- Always practice precautions to reduce respiratory infections such as hand washing, coughing into elbow or sleeve or away from people, disinfecting the environment and good air quality.
- In large facilities, follow appropriate group separation.
- Carefully monitor all children and staff for coughs. Anyone developing a persistent cough should be immediately referred to his or her health care provider.

EMS Authority Inhaled Medications Training

SB 1663, Chapter 625, September 1998
California Health and Safety Code, 1596.798 (4)

The following will provide you with information on how to administer inhaled medications to children who are prescribed such medications for their respiratory needs. A parent and caregiver should communicate in order to share information regarding a child's asthma triggers (allergens, substances or activities that cause respiratory problems) and symptoms. Learn to recognize a child's earliest asthma symptoms, so the symptoms can be counteracted early.

WHAT TO DO WHEN A CHILD IS HAVING AN ASTHMA ATTACK

- Provide rescue medication immediately. It is vital that rescue medication be kept close at hand because an asthma attack can quickly escalate. If the child is out on the playground, take the rescue medication to him and administer on site. Help the child use his prescribed inhaler or nebulizer the correct way and for the prescribed dose.
- A responsible adult must always remain with a child who is having an asthma attack; never leave the child alone.
- After administering the rescue medication, bring the child to a quiet place, out of the cold or extreme heat.
- Stay calm and reassure the child.
- If a child is still having trouble breathing 5-10 minutes after taking his prescribed reliever medication, then call 9-1-1.
- After rescue medication is provided, if you notice any unusual reactions from the medication, call 9-1-1 immediately.

WHAT TO DO AFTER A CHILD'S ASTHMA ATTACK HAS BEEN TREATED AND HAS SUBSIDED

- A child who has been given rescue medication for an asthma attack should be kept quiet and his activity level should be kept to a minimum.
- A child who has been treated for an asthma attack should also be closely supervised by a responsible adult.
- Record information about the attack in the child's daily log that will be shared with parents at the end of the day. Also, note the attack in the child's asthma care plan.
- Tell the parents about the attack and what medication was provided.

WHAT TO DO IN EMERGENCY CASES

Serious asthma symptoms that require you to call 9-1-1 immediately are:

- Child's wheeze, cough or shortness of breath worsens, even after medicines have had 5-10 minutes to work
- Child's neck and chest are "sucked in" with each breath
- Child has trouble talking or walking
- Child is struggling to breathe, hunching over
- Child's lips or fingernails are grey or blue

- Child has an altered level of consciousness or confusion
- Child is experiencing asthma symptoms and has no rescue medication available at the day care home or facility

TREATMENT

1. Call 9-1-1.
2. Provide emergency first aid as appropriate for respiratory distress. This may require the administration of medication as directed by the child's physician.
3. Call the child's parents and physician to alert them that 9-1-1 has been activated, but do not leave the child alone to make the call.

If a child in your care has a lung disease such as asthma and does not have rescue medication available at the child care facility, advocate for that child and explain to his or her parents or guardian that this type of medication must be provided each day the child is in day care.

PREVENTIVE MEASURES TO IMPROVE A CHILD'S ASTHMA SYMPTOMS

- Control molds, pollen, dust, dust mites, cockroaches, smoke from cigarettes, pipes, cigars, fireplace fires, strong odors, insect allergens and animal dander.
- Other triggers are paint, sprays, outdoor fires, agricultural burning, cleaning materials, chemicals, perfumes, outdoor pollution, cold, wind, and exercise.
- Follow a child's specific diet if the child has food allergies. Food allergies may cause asthmatic symptoms. Some foods that children may be allergic to are: milk, eggs, wheat, nuts, soy, seafood and legumes.
- Be sure the child has been taking adequate fluids.

RESPIRATORY CARE PLAN

The child's physician and parent/guardian should provide the child's asthma care plan or respiratory care plan. This type of plan should identify:

1. The child's specific known asthma triggers.
2. How to recognize the child's asthma symptoms and warning signs; this may include measuring a child's peak expiratory flow (how well a child can move air out of his lungs) with a peak flow meter. A peak flow meter is an important tool in monitoring a child's lung function. See page 18, "Using a Peak Flow Meter" and "Cleaning a Peak flow Meter." A child's peak flow should be measured and logged daily to map changes in his lung function. The peak flow meter should also be used when a child is having symptoms of breathing problems, in order to ascertain and record how serious the child's breathing problems are. The peak flow daily log or chart can assist the child's physician in adjusting the child's treatment plan. A child's doctor will instruct him in how to use the peak flow meter, how often to use it each day and how to log the peak flow readings. It is generally recommended to monitor peak flow in the morning when the child awakes.
3. Which medications to use routinely and on a schedule, and which to use as needed, at the earliest sign of symptoms – along with how, when, and the dosage for using each drug.
4. Emergency information, including parent and physician phone numbers and insurance information.

Use a child's specific respiratory care plan to prevent and control asthma episodes for that child.

TYPES OF ASTHMA MEDICATIONS

The general goals of asthma therapy are to:

1. Prevent chronic asthma symptoms and asthma flare-ups during day or night
2. Maintain normal activity levels
3. Have normal or near-normal lung function
4. Have no, or minimal, side effects

Asthma medications have three categories: rescuer/relievers (for immediate relief of an asthma attack), long-term relievers (do not work immediately), and controllers. Also, some of these medications must be mixed with a saline solution specific for the lungs.

RESCUER/RELIEVERS (also known as bronchodilators) These medications reduce the swelling and relax the walls of the airway to allow increased airflow. These medications are known as the rescuers, because they quickly open the airways and ease the spasms of the airways and should help the child breathe easier within 5-10 minutes. They reduce acute episodes of coughing and wheezing. Some examples of relievers are Albuterol, Proventil®, Ventolin®, Terbutaline, Metaproterenol, and Xopenex®.

LONG-TERM RELIEVERS (long acting bronchodilators)
Some reliever medications are not to be used for immediate relief of an acute asthma attack because they do not work quickly. One of these medications is Serevent®. This medication works over a period of twelve hours to reduce the swelling and relax the walls of the airways. Atrovent® is also a long-acting reliever. Atrovent® has a delayed reaction – it has an onset peak one hour after inhalation and it works over a period of six to eight hours.

CONTROLLERS (routine, scheduled preventive medicines) Controllers are asthma medications that reduce the swelling of the airways by keeping them from reacting to asthma triggers. These medications are typically given on a daily routine, to prevent asthma attacks.

Controllers will not relieve wheezing during an asthma attack. They prevent the swelling (inflammation) of the airway on a long-term basis. These medications must be taken regularly to work well. During an asthma attack, the caregiver would deliver a rescue medication, not a controller medication (unless specified otherwise by a physician). Some examples of controllers are Intal®, Tilade®, or the inhaled steroids such as Vanceril®, Flovent®, Azmacort®, Aerobid®, Beclovent®, and Kenelog®. Advair® is a relatively new medication that is a combination of a steroid (a controller) and long-term reliever, or bronchodilator. Advair® is not an immediate reliever; during an asthma attack, the caregiver would not use Advair® to relieve an acute asthma episode. Oral controllers include Montelukast, Singulair®, Zafirlukast, and Accolate®. Singulair® and Accolate® are in tablet form.

It is very important to carefully follow the specific treatment plans for each child. Missed treatments may result in an asthma attack or increased difficulty in breathing. Only prescription medications should be administered. These medications come in different forms such as liquid, powder, or pill in order to meet the needs of different children.

If you are unsure of which type of medication to give the child during an asthma attack, call 9-1-1.

HOW TO IDENTIFY SIDE EFFECTS OF THE MEDICATIONS

Some common side effects of reliever medications (bronchodilators) are:

- Shaking
- Jittering
- Pounding heart
- Nervousness

- Restlessness

If the child develops a tremor (shaking) from the treatment, any play requiring hand-eye or foot-eye coordination may be frustrating. The tremor will wear off in 10-15 minutes.

Other side effects not listed above may occur in some children. If you notice any unusual reaction, contact the child's doctor and parents or 9-1-1.

Some precautions when using reliever medications (bronchodilators) are:

- If the child still has trouble breathing after using the medication – or the condition worsens, call 9-1-1 and child's physician immediately.
- Use medications only as directed. Do not increase the dose or how often it is given unless advised to do so by the child's physician. To do so may increase side effects.
- Keep this and all other medications out of the reach of children.

Some common side effects of controller asthma medications are:

- Dizziness
- Headache
- Nausea
- Over time, the use of controller medications can cause the voice to be hoarse.

Other side effects not listed above may occur in some children. If you notice any unusual reaction, contact the child's parents and doctor, or call 9-1-1.

Some precautions when using this type of asthma medication:

- Use only as directed.
- When taking inhaled steroids, the child must rinse his mouth with water to avoid a yeast infection in the mouth.

HOW MEDICATIONS ARE DELIVERED

A nebulizer delivers the liquid form of medication. Nebulized medications are generally safe, as the amount of medication the child is prescribed and actually receives is relatively small. This way of delivering the medication is relatively easy for all age groups. The medication can be either pre-mixed or require the user to dilute the medication with saline solution that is specifically manufactured for use in the lungs.

An inhaler will deliver the liquid or powder form of medication. With inhalers, the delivered doses vary from one puff to four puffs. A spacer, which is a tool that makes the inhaler's delivery more efficient, is strongly recommended to help deliver the medication. Spacers can be modified with a mask for delivery to an infant or small child. There are spacers available with a mask and a plastic connector that can be used together to deliver inhaled medication to young children. Spacers must be prescribed by a child's physician. Prescription inhalers are safe if used according to the physician's instructions.

PROPER STORAGE OF THE INHALED MEDICATION

Keep this and all other medications out of the reach of children.

Store the inhalers at room temperature. Heat or refrigeration may cause a change in the dosing of the medication, because the contents are delivered with a gas propellant. Liquid medications for the nebulizer should not be refrigerated, as doing so can make the medication unstable. If these types of medications will be transported away from the child care facility on field trips, care must be taken to keep the medicines temperate. Be careful not to leave inhalers or nebulizer medication in a car. Extreme temperatures can cause the medication to become

ineffective.

Liquid nebulizer doses are stored at room temperature, away from direct sunlight. Some medications must remain in foil pouches, and some must be used within a specific time once they are removed from their wrappers (for example Xopenex® and Advair®). With some liquid medications, the solution should be colorless. If the solution is not colorless, the medication should be discarded. Always read the package inserts for specific information and follow the instructions on proper storage of the medication. Contact the pharmacist for more information.

USE OF THE EQUIPMENT

For detailed information on how to use inhalers, nebulizers, spacers, peak flow meters and how to clean them, read pages 243-252.

A) NEBULIZER EQUIPMENT
Refer to pages 243 & 244, "Use and Care of a Nebulizer."
Refer to page 245, "The Nebulizer Equipment."

B) INHALERS
Refer to page 246, "Steps for Using an Inhaler."
Refer to pages 247 & 248, "Using an Inhaler with a Spacer."

C) SPACER
Refer to page 247 "Using an Inhaler with a Spacer"

D) PEAK FLOW METER
Refer to page 250, "Using a Peak Flow Meter"

Equipment Handout References:
"Use and Care of a Nebulizer"
– National Institutes of Health
The National Asthma Education and Prevention Program (NAEPP)
"Operating your Nebulizer"
– American Lung Association East Bay
"Inhalers" – NIH/NAEPP
"Using an Inhaler with a Spacer"
– NIH/NAEPP
"Steps for Using Your Inhaler"
– NIH/NAEPP

HOW TO CLEAN THE EQUIPMENT

A) NEBULIZERS
Refer to pages 248 & 249, "Cleaning a Nebulizer."

B) INHALERS
Refer to page 250, "Care of an Inhaler."

C) SPACERS
Refer to page 248, "Cleaning a Spacer."

D) PEAK FLOW METERS
Refer to page 251, "Cleaning a Peak Flow Meter."

WHEN TO NOTIFY THE CHILD'S PARENTS AND PHYSICIAN

A) THE PARENT/LEGAL GUARDIAN

Inform the parent or guardian daily regarding the medications given to a child. A log for the administration of medication should be kept each day that medication is administered. The following information should be included in this log:

- The signs and symptoms the child had prior to needing medication

- The time the medicine was administered
- The amount of medication given
- The type of medication given
- Any side effects noted
- If required, note the time the parent, physician, or 9-1-1 was notified
- Were the signs and symptoms relieved after the medication was administered?
- Who gave the medication?

Also communicate to the parent any possible side effects that you have noticed (see the list provided), and share any possible warning signs you have seen. Common asthma warning signs include:

- Coughing
- Wheezing
- Feeling the chest is "tight"
- Difficulty breathing, shortness of breath
- Sneezing
- An itchy throat or chin
- Not sleeping well
- Pale skin
- Stomachache/nausea
- Loss of appetite
- Raised shoulders
- Tiredness
- Hoarseness

B) THE CHILD'S PHYSICIAN

If the child still has trouble breathing 5-10 minutes after using the medication - or if the condition worsens - **call 9-1-1**. Call 9-1-1 right away if the child's lips or fingernails are grey or blue. Then call the parent/guardian and physician to alert them that 9-1-1 has been called because the child is having a breathing emergency.

SUGGESTIONS FOR THE CHILD CARE PROVIDER

The child care provider should demonstrate the use of the nebulizer and inhaler equipment to the parent's/guardian's satisfaction; and the child care provider should have a written plan from the child's doctor or parents regarding:

- The type of medication, dosage, and frequency;
- How to prepare the medication; and
- How to use the child's specific equipment.

USE AND CARE OF A NEBULIZER

A nebulizer is a device driven by a compressed air machine. It allows you to take asthma medicine in the form of a mist (wet aerosol). It consists of a cup, a mouthpiece attached to a T-shaped part or a mask, and thin, plastic tubing to connect to the compressed air machine. It is used mostly by three types of patients:

- Young children under age five years
- Patients who have problems using metered dose inhalers
- Patients with severe asthma.

A nebulizer helps make sure a patient gets the right amount of medicine. A routine for cleaning the nebulizer is important because an unclean nebulizer may cause an infection. A good cleaning routine keeps the nebulizer from clogging up and helps it last longer.

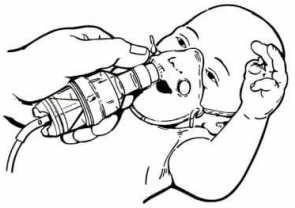
Directions for using the compressed air machine may vary (check the machine's directions), but generally the tubing has to be put into the outlet of the machine before it is turned on. It is important to keep the compressor clean and free of insects. It is also important to regularly change the compressor's filter, according to the manufacturer's instructions.

HOW TO USE A NEBULIZER

Select a comfortable area in your child care facility where the compressor can be placed and treatments can be given without interruption. A car seat or infant carrier can provide a comforting, secure place for the treatment. Wash your hands thoroughly with warm water and soap.

1. If your medication must be mixed with saline solution, measure the correct amount of normal saline solution using a clean dropper and put it into the cup. Medications for the treatment may be pre-measured in unit dose vials or in bulk solution. For bulk solution, use the eye dropper or syringe for measuring the medication. These are usually provided with the medication. Go to Step 4. If your medicine is premixed, and does not need to be mixed with normal saline, then open the unit dose vial and deposit the medication into the nebulizer cup. You may also use saline specific for use in the lungs that comes in vials or cans. Follow the instructions on their containers for measuring these. Then, go to step 5.
2. Draw up the correct amount of medicine using a clean eyedropper or syringe and put it into the cup with the saline solution. Screw the nebulizer cap shut. Gently swirl the nebulizer to mix the medication and saline solution. (It is important to have an adequate amount of rescue medication available, in case the medication is spilled.)
3. Fasten the mouthpiece to the T-shaped part and then fasten this unit to the cup OR fasten the mask to the cup. If your nebulizer includes a medication saving reservoir tubing, attach this tubing to the opposite end of the T piece. Fasten the cup to the tubing. Fasten the other end of the tubing to the compressor. Plug the compressor into a three-prong grounded outlet, or use a battery-style compressor. For a child over the age of two years, it is more efficient to use a mouthpiece unit because it will deliver more medicine than a mask. However, children up to the age of five years may prefer using a mask.
4. Position the child in a comfortable position sitting up to allow for deep breathing. Put the mouthpiece in child's mouth. Have child seal his/her lips tightly around it OR place the mask on his/her face by securing it around the child's head.
5. Turn on the air compressor machine. Look for a steady mist coming from the nebulizer cup. If the mist does not come out of the nebulizer mouthpiece or mask, check to make sure the machine's filter cap is tightly secured. Also, make sure the machine's intake area is not blocked.
6. Tell child to take slow, deep breaths in through the mouth at the beginning of the treatment. Then, the child can continue the treatment breathing normally through the mouth. If a child is using a face mask, tell the child to breathe normally. A little bit of coughing is to be expected during a nebulizer treatment. You do not have to turn off the machine if the child is mildly coughing.
7. Continue until the medicine is gone from the cup (approximately 10 minutes). As the medicine disappears, there may be some left on the bottom of the nebulizer cup. Flick the cup gently with your finger to disperse the remaining medication.
8. Store the medicine as directed after each use.
9. Nebulizers should not be shared. Keep each child's equipment separate.

NOTE: Blowing medication in front of the face without the mask or a mouth piece is **not** an efficient way to deliver the medication. Also, some children may need to be on regularly scheduled nebulizer treatments throughout the day. In these cases, it is important to have more than one nebulizer available so that clean and dry nebulizers can be used for each treatment.



After the Treatment

Turn the compressor off. Clean nebulizer equipment after each use (Refer to pages 15 & 16 Cleaning a Nebulizer).

THE NEBULIZER EQUIPMENT

- Nebulizers are used to turn liquid medication into a mist so that it can be breathed in.
- Nebulizer therapy uses a prescribed drug.
- Nebulizer equipment may vary in appearance, although most models contain the following components.

Nebulizer

T-Piece

Mouthpiece

Cup + Mouthpiece

Nebulizer + T-Piece + Mouthpiece

Mask & nebulizer ready for use

Nebulizer machine

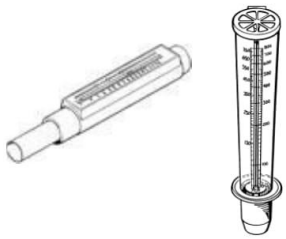
Machine tubing

Measuring Unit Dose

Medication Vial

Medication Dropper

Medication Syringe



Two Types of Peak Flow Meters

NOTE: A peak flow meter is used by people with lung disease to measure lung function. Specifically, peak flow meters measure how well a person can move air through the airways in his lungs. Peak flow meters are used both by people who use nebulizers and inhalers.

STEPS FOR USING AN INHALER

Children and parents should demonstrate their inhaler technique at every doctor's visit, so the doctor can make sure the child is using his medication correctly.

1. Remove the cap and hold inhaler upright.
2. Shake the inhaler. (If you have a spacer and the type of inhaler that can be used with a spacer, go to page 13 for instructions.)
3. Tilt your head back slightly and breathe out slowly.
4. Position the inhaler in one of the following ways- (A or B is optimal, but C is acceptable for those who have difficulty with A or B.) C is required for breath-activated inhalers.

A **B** **C** **D**

Open mouth with inhaler 1 to 2 inches away. This technique is not as efficient as use with a spacer

Use spacer/holder chamber (recommended especially for young children and for people using corticosteroids). This is the most efficient way to use this type of inhaler.

In the mouth. Do not use for corticosteroids. Using this method with corticosteroids will leave the medication on the tongue possibly causing thrush, a yeast infection of the tongue. This technique is not as efficient as when a spacer is used. However, some inhalers must be used like this because they are breath-activated and cannot be used with a spacer.

NOTE: Dry powder inhalers use a different delivery and inhalation technique. They dispense a fine dry powder, rather than a spray. To use a dry powder inhaler, it is important to close the mouth tightly around the mouthpiece of the inhaler and to inhale rapidly. You cannot use a spacer with this type of inhaler. This type of inhaler may also come in a discus, which is round, rather than a canister and inhaler.

Press down on the inhaler to release medication as child starts to breathe in slowly. With dry powder inhalers, you may have to click or slide a button or lever before sealing your mouth around the inhaler and taking a deep breath. You cannot use a spacer device with these types of inhalers.

2. Tell child to breath in slowly (3 to 5 seconds).
3. Tell child to hold his/her breath for 10 seconds to allow the medicine to reach deeply into his or her lungs. Tell the child to exhale.
4. Repeat puff as directed. If a child's doctor has prescribed two puffs, then wait between puffs for the amount of time the doctor has directed (usually 60 seconds) and take the second puff. Waiting one minute between puffs permits the second puff to penetrate the child's lungs better.
5. Spacers/holding chambers are useful for all patients. They are particularly recommended for young children and older adults and for use with inhaled corticosteroids.

Avoid common inhaler mistakes. Follow these inhaler tips:

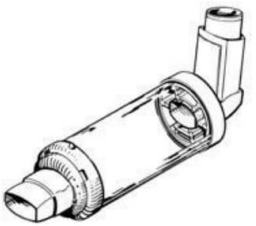
- Tell child to exhale before pressing his/her inhaler.
- Tell child to inhale slowly through his/her mouth, not his/her nose.
- Press down on a child's inhaler at the start of inhalation (or within the first second of inhalation). Tell child to keep inhaling as you press down on the inhaler.
- Press the inhaler only once while the child is inhaling (one breath for each puff).
- Make sure child inhales evenly and deeply and holds the breath for ten seconds before exhaling.

USING AN INHALER WITH A SPACER

Unless an inhaler is used correctly, much of the medicine may end up on the child's tongue, on the back of his or her throat, or in the air. Use of a spacer, or holding chamber, can help this problem.

A spacer, or holding chamber, is a device that attaches to a metered dose inhaler (spacers are not used with dry powder inhalers such as Maxair® and Advair®). It holds the medicine in its chamber long enough for a child to inhale it in one or two slow deep breaths. When a child uses a spacer, he should breathe in softly and slowly. If the spacer is being used incorrectly, it will whistle. If the spacer whistles, then the breath is too quick and hard and this means the medication is not going to be efficiently delivered. Teach the child to use the spacer without making it whistle. The spacer makes it easy to use the medicines the correct way (especially if the child is young or has a hard time using an inhaler). It helps a child not cough when using an inhaler. A spacer will also help prevent a child from getting a yeast infection (thrush) in his or her mouth when taking inhaled steroid medications (because the medication is being inhaled, rather than ending up on the tongue). However, a child should always rinse his mouth after using an inhaled steroid, even if it is used with a spacer.

There are many models of spacers or holding chambers that can be purchased through a pharmacy or medical supply company. Ask a child's doctor about the different models. A prescription is needed to purchase a spacer.



Spacer and inhaler

Child using an inhaler with a spacer

How to Use a Spacer

7. Attach the inhaler to the spacer or holding chamber as explained by your doctor or by using the directions that come with the product.
8. Shake well.
9. Place the mouthpiece of the spacer in child's mouth and tell child to inhale slowly. (A face mask may be helpful for a young child).
10. Press the button on the inhaler. This will put one puff of the medication in the holding chamber. (#3 and #4 should be done simultaneously.)
11. Tell the child to hold his/her breath for a few seconds and then exhale.
12. If child's doctor has prescribed two puffs, wait between puffs for the amount of time he or she has directed (usually 60 seconds) and repeat steps 4 and 5.

Cleaning a Spacer

After each use, rinse the spacer. To do this, remove the rubber seal in which you place the inhaler. Use warm water to rinse the inside of the spacer then rinse the rubber seal. Do not remove the mouthpiece since it is permanently attached. Allow the spacer to air dry completely before the next use. Do not use paper or lint towels to dry the inside of the spacer, because small particles that remain may be inhaled the next time the spacer is used.

Once a week, the spacer should be cleaned by using a cleaning solution made up of 1/3 part of distilled white vinegar and 2/3 parts water. Let the spacer soak in this solution for fifteen minutes and then rinse well and air dry completely before the next use.

CLEANING A NEBULIZER

Don't forget: Cleaning and disinfecting the nebulizer prevents infection. Cleaning also keeps the nebulizer from clogging up and helps it last longer.

After Each Use

1. Remove the mask or the mouthpiece and T-shaped part from the cup. Remove the tubing and set it aside. The tubing should not be washed or rinsed. Rinse the mask or mouthpiece, T-shaped part, and the eyedropper or syringe in warm running water for 30 seconds. Use distilled or sterile water for rinsing, if possible.
2. Shake off excess water. Air dry on a clean cloth or paper towel.
3. Put the mask or the mouthpiece and T-shaped part, cup, and tubing back together and connect the device to the compressed air machine. Run the machine for 10 to 20 seconds to make sure the inside of the nebulizer is dried. If the inside of the tubing has moisture in it, connect the tubing to the machine and run it until the moisture disappears.
4. Disconnect the tubing from the compressed air machine. Store the nebulizer parts and the tubing in a clean ziploc plastic bag.
5. Place a cover over the compressed air machine.

Cleaning Once Every Day

1. Remove the mask or the mouthpiece and T-shaped part from the cup. Remove the tubing and set it aside. The tubing should not be washed or rinsed.
2. Wash the mask or the mouthpiece, T-shaped part, and the eyedropper or syringe - with a mild dishwashing soap and warm water or with a cleaning solution made up of 1/3 part distilled white vinegar and 2/3 parts

water. Let the nebulizer pieces soak in this solution for fifteen minutes, then rinse well and air dry. Using this solution will not leave a residue like some dish soaps may.
Note: Do not use dishwashing soap that is strongly scented, especially lemon-scented detergent.

Doing so could cause the airways to be reactive the next time the nebulizer is used. If dishwashing soap is used, it should be one that rinses easily. Some dish soaps should not be used because they are so concentrated that they do not rinse well and can leave a residue.

3. Rinse under a strong stream of water for 30 seconds. Use distilled (or sterile) water if possible.
4. Shake off excess water. Air dry on a clean cloth or paper towel.
5. Put the mask or the mouthpiece and T-shaped part, cup, and tubing back together and connect the device to the compressed air machine. Run the machine for 10 to 20 seconds to make sure the inside of the nebulizer is dried.
6. Disconnect the tubing from the compressed air machine. Store the nebulizer parts and the tubing in a resealable plastic bag.
7. Place a cover over the compressed air machine.

Additional Cleaning

This cleaning should be done by a parent or guardian every other day. Scheduling cleaning on odd or even days may help a parent or guardian adhere to this cleaning schedule.

1. Remove the mask or the mouthpiece and T-shaped part from the cup. Remove the tubing and set it aside. The tubing should not be washed or rinsed. Wash the mask or the mouthpiece, T-shaped part, and the eyedropper or syringe - with a mild detergent dishwashing soap (a non-scented detergent is best) and warm water.
2. Rinse under a strong stream of water for 30 seconds.
3. Soak for 30 minutes in a solution that is one part distilled white vinegar and two parts distilled water. Throw out the vinegar water solution after use; do not reuse it.
4. Rinse the nebulizer parts and the eyedropper or syringe under warm running water for 1 minute. Use distilled or sterile water, if possible.
5. Shake off excess water. Air dry on a clean cloth or paper towel.
6. Put the mask or the mouthpiece and T-shaped parts, cup, and tubing back together and connect the device to the compressed air machine. Run the machine for 10 to 20 seconds to dry the inside of the nebulizer thoroughly.
7. Disconnect the tubing from the compressed air machine. Store the nebulizer parts and tubing in a Ziploc plastic bag.
8. Clean the surface of the compressed air machine with a well-wrung, soapy cloth or sponge. You could also use an alcohol or disinfectant wipe. NEVER PUT THE COMPRESSED AIR MACHINE IN WATER. Keep the compressor clean and free of insects.
9. Place a cover over the compressed air machine.
10. When the air filter in the compressor is grey in color, change to a new air filter. It is important to change the compressor filter regularly as the manufacturer instructs. Be sure the filter cap is secured after replacing the filter. If the filter cap or closure is left loose, the air cannot pass through to the tubing correctly, and the nebulizer will not work.
    NOTE: Some new nebulizer parts may be put into a dishwasher for the thorough cleaning. Ask the manufacturer of the nebulizer whether this can be done with your model, and how often it can be done. Also, most nebulizers are not made to last indefinitely. Some nebulizers are not as efficient in delivering medication after several uses. Ask the child's doctor and the nebulizer manufacturer how long a nebulizer should last under regular use.

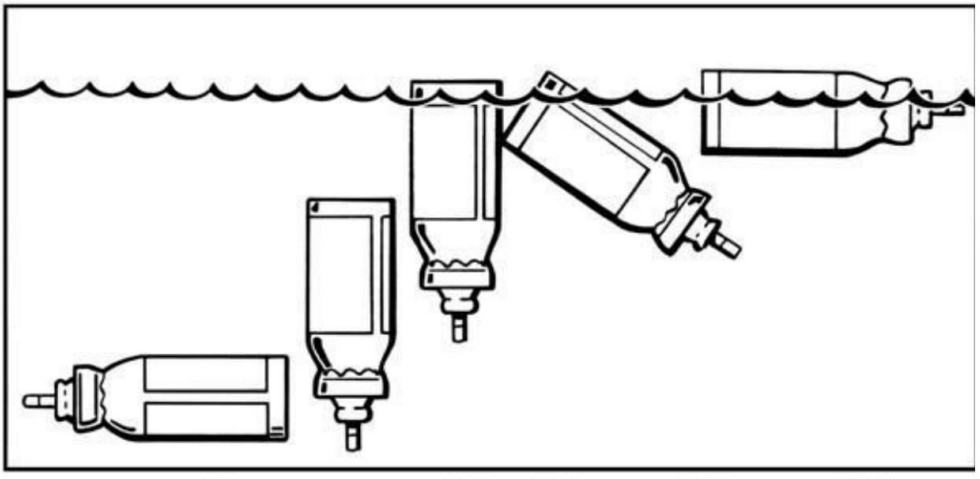
CARE OF AN INHALER

Cleaning

1. Clean the inhaler once a day. Remove the medication canister before cleaning the inhaler. Clean the plastic portion of the inhaler and plastic cap by rinsing it in warm running water. Let it air dry completely before you use it again. Have another inhaler to use while it is drying.
2. Twice a week, remove the canister and wash the plastic inhaler portion and cap with mild dishwashing soap (do not use scented detergent) and warm water. Rinse and air dry completely before putting the medication canister back inside.

Checking How Much Medicine Is Left in the Canister

1. If the canister is new, it is full.
2. An easy way to check the amount of medicine left in your metered dose inhaler is to place the canister in a container of water and observe the position it takes in the water.



Full ***¾ Full*** ***½ Full*** ***¼ Full*** ***Empty***

USING A PEAK FLOW METER

Models vary, so read the instructions that come with a specific peak flow meter. Generally, peak flow meters are used similarly. Peak flow meters usually come with child-size plastic mouthpieces that fit into the mouth area of the peak flow meter so that it will fit into a child's mouth. The indicator should be at the bottom of the scale before beginning. Hold the peak flow meter upright, being careful not to block the back of the peak flow meter. The child should stand.

Have the child inhale as deeply as possible and place his mouth firmly around the mouthpiece, making sure that his lips form a tight seal around the mouthpiece. Tell the child to blow out as hard and fast as he can. This will cause the indicator to move up the scale. The final position of the indicator is the peak flow measurement. Take three readings (to repeat the procedure, slide the indicator back to the bottom of the scale.) Record the highest of the three. Record the date and time. If a child is having trouble breathing, do not take the peak flow reading at that

time and instead assist the child with his rescue medication.

CLEANING A PEAK FLOW METER

Models vary, so read the instructions for cleaning that come with a specific peak flow meter. Generally, a peak flow meter can be washed and rinsed gently. It is not necessary to clean a child's peak flow meter after each use; once a week should be enough. Rinse the removable plastic mouth pieces (the ones provided for children) in warm water and air dry these thoroughly.

Once a week, the whole instrument may be cleaned with a mild dishwashing soap and rinsed in warm water. Shake out the water and let the instrument air dry before the next use.

Some models (check for specific instructions) may be placed in the top rack of dishwashers to be washed, but the water should be shaken out and the instrument allowed to air dry thoroughly before the next use.

These instruments should never be boiled.

Examine the peak flow meter periodically to check that it is functioning properly.

NEBULIZER CARE CONSENT/VERIFICATION
CHILD CARE FACILITIES

This form may be used to show compliance with Health and Safety Code Section 1596.798 before a child care licensee or staff person administers inhaled medication to a child in care. A copy of the completed form should be filed in the child's record and in the personnel file. ***A separate form must be filled out for each person who administers inhaled medication to the child.***

I, _____, give my consent
(Print Name of Authorized Representative)

for_____, who work(s) at
(Print Name of Licensee or Staff Person)

_____,
(Print Name and Address of Child Care Facility)

to administer inhaled medication to my child,_____, and to
(Print Name of Child)
contact my child's health care provider.

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to administer inhaled medication to my child.

I have also provided the child care facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- Specific indications (such as symptoms) for administering the inhaled medication in accordance with the physician's prescription.
- Potential side effects and expected response.
- Dose form and amount to be administered in accordance with the physician's prescription.
- Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child's physician.

_____
(SIGNATURE OF AUTHORIZED REPRESENTATIVE) DATE

_____
(ADDRESS OF REPRESENTATIVE)

_____
(HOME TELEPHONE NUMBER) (WORK TELEPHONE NUMBER)