



# Stepping Stones to Caring for Our Children:

**National Health and Safety Performance  
Standards; Guidelines for Early Care  
and Education Programs,  
Third Edition**



**PROTECTING CHILDREN FROM HARM**



**American Academy  
of Pediatrics**

DEDICATED TO THE HEALTH OF ALL CHILDREN™



**American  
Public Health  
Association**



**National Resource Center  
for Health and Safety  
in Child Care and  
Early Education**

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New research and/or evolving best practices may warrant a standard to be updated or changed. Please refer to the online version of *Stepping Stones*, 3<sup>rd</sup> Edition (<http://www.nrckids.org/spinoff/steppingstones/index.htm>)

for the most current standard language. You may also look up individual standards at <http://www.cfoc.nrckids.org/>

# **Stepping Stones to**

## **Caring for Our Children:**

### **National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs,**

#### **Third Edition**

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*Stepping Stones*, Third Edition (SS3) is for reference purposes only and should not be used as a substitute for medical or legal consultation, nor be used to authorize actions beyond a person's licensing, training, or ability.

## *Availability*

The full texts of *Stepping Stones to Caring for Our Children*, Third Edition and *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*, Third Edition are available online through the National Resource Center for Health and Safety in Child Care and Early Education website (<http://nrckids.org/CFOC3/index.html>).

Print copies of the comprehensive source document *Caring for Our Children*, Third Edition are available from the American Academy of Pediatrics (<http://www.aap.org>) and the American Public Health Association (<http://www.apha.org/publications/bookstore/>).





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(Editor's Note: *Stepping Stones to Caring for Our Children*, Third Edition only includes those appendices directly mentioned in the text of the included standards. All other appendices are located in *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*, Third Edition.

<http://www.cfoc.nrckids.org/>).

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\* For a list of acronyms frequently used in this document, please refer to page [xiv](#).

## INTRODUCTION

Every day millions of children attend early care and education programs. It is critical that they have the opportunity to grow and learn in healthy and safe environments with caring and professional caregivers/teachers. Following health and safety best practices is an important way to provide quality early care and education for young children. *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*, Third Edition (CFOC3) and its companion document, *Stepping Stones*, Third Edition (SS3) were created to advance the quality and safety of child care and early education.

### ***History and Purpose***

In 1992, the American Public Health Association (APHA) and the American Academy of Pediatrics (AAP) developed and published the first edition of CFOC, which was recognized by the early childhood field as the leading set of national standards for health and safety in child care programs. Subsequently, in 1997, *Stepping Stones* was developed by AAP, APHA, and NRC to identify a subset of standards in CFOC that, when practiced, **could prevent serious harm and injury to children in child care settings** and serve as a companion piece to CFOC. (See *Advice to Users* on page [xy](#) for information on intended audiences and uses).

Since that time, second editions of CFOC and *Stepping Stones* were released in 2002 and 2003, respectively. Now a new, third edition of *Stepping Stones* based on CFOC3 (released in 2011) has been produced by AAP, APHA, and NRC, supported by Grant Number U46MCO9810 from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *Stepping Stones*, Third Edition (SS3) is the collection of selected CFOC3 standards which, when put into practice, are most likely to **prevent serious adverse outcomes in child care and early education settings**.

**Adverse outcomes** are defined as harm resulting from failure to practice the recommendations in the CFOC3 standards. These harmful results may include frequent or severe disease or injury, disability or death (morbidity and mortality). They could occur immediately or later in the child's life as a result of repeated failure to follow the recommended practices (i.e., cumulative impact leading to poor health or developmental outcomes long term).

### ***Methodology of Stepping Stones, Third Edition***

The SS3 development process was initiated in 2012 and completed in 2013 to reflect the new and revised CFOC3 standards. More than 120 national health and safety experts and child care specialists contributed their expertise in either rating the CFOC3 standards to be included in the third

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edition of *Stepping Stones* or reviewing the drafts of the book (see list of contributors beginning on page [132](#)). From the 686 standards in *CFOC3*, 138 of them were selected for inclusion in *SS3*. There are fewer standards in *SS3* than there were in *SS2*. Please see page [138](#) for a more detailed description of the *SS3* methodology and the reasoning behind the reduction in number.

### Acronyms Frequently Used in this Document

AAP	American Academy of Pediatrics
APHA	American Public Health Association
MCHB	Maternal and Child Health Bureau
NRC	National Resource Center for Health and Safety in Child Care and Early Education
CFOC	<i>Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs</i> (1992)
CFOC2	<i>Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs</i> , Second Edition (2002)
CFOC3	<i>Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs</i> , Third Edition (2011)
SS	<i>Stepping Stones to Caring for Our Children</i> (1997)
SS2	<i>Stepping Stones to Caring for Our Children</i> , Second Edition (2003)
SS3	<i>Stepping Stones to Caring for Our Children</i> , Third Edition (2013)



## ADVICE TO USERS

### *Intended Audiences and Uses*

*Stepping Stones*, Third Edition was developed to be used by multiple audiences to prevent harm and adverse outcomes in children in all early care and education environments:

- **Caregivers/Teachers/Directors** can use the standards to develop and implement sound practices, policies, and staff training to ensure that their program is healthy, safe, and age-appropriate for all children in their care.
- **Early Childhood Systems** can integrate health and safety components into their efforts to promote optimal health and development for all children.
- **Families** can use information from the standards to select quality programs and/or evaluate their child's current early care and education program. They can work in partnership with caregivers/teachers in promoting healthy and safe behavior and practice for their child and family. Families also may want to incorporate many of these healthy and safe practices at home.
- **Health Care Professionals** can assist families and can provide consultation for caregivers/teachers by using the standards as guidance on what makes a healthy, safe, and age-appropriate environment that encourages children's development of beneficial habits. Child care health consultants can use the standards to develop guidance materials to share with both caregivers/teachers and parents/guardians.
- **Licensing Professionals/Regulators** can use the evidence-based rationale to develop or improve regulations that require a healthy and safe learning environment at a critical time in a child's life and develop lifelong healthy behaviors in children.
- **Organizations that will update standards** for accreditation or guidance purposes for a special discipline can draw on the new work and rationales of the third edition just as *Caring for Our Children's* expert contributors drew upon the expertise of these organizations in developing the new standards.
- **Policy-Makers** can use the strong science and rationale to create and promote sound policy that supports children's development of lifelong healthy behaviors and lifestyles.
- **State Departments of Education (DOEs) and local school administrations** can use the standards to guide the writing of

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standards and policy for school-operated child care and preschool and Pre-K programs, and this guidance will help principals to implement good practice in early care and education programs.

- **States and localities who fund subsidized care and services for income-eligible families** can use the standards to determine the level and quality of service to be expected.
- **University/College Faculty** can instruct and model for their students the best practices for health and safety to use with young children upon entering the early childhood workplace. In addition, students will be able to demonstrate the transfer of the latest research into practice.

### ***Types of Facilities***

Several types of facilities are covered by the general definition of child care and early education. The definitions provided here are used consistently in both *CFOC3* and *SS3* to describe three types of out-of-home child care settings. When using these definitions, please be aware that they may be different than what the reader's state licensing agency uses. States vary greatly in their legal definitions for different types of child care facilities, which can cause some confusion when comparing regulations across states and within *SS3*. The general definitions used in *CFOC3* and *SS3* are:

- A **Small family child care home** provides care and education of **one to six children**, including the caregiver's/teacher's own children in the home of the caregiver/teacher. Family members or other helpers may be involved in assisting the caregiver/teacher, but often, there is only one caregiver/teacher present at any one time.
- A **Large family child care home** provides care and education of **seven to twelve** children, including the caregiver's/teacher's own children in the home of the caregiver/teacher, with one or more qualified adult assistants to meet the child:staff ratio requirements.
- A **Center** is a facility that provides care and education **to any number of children in a nonresidential setting**, or **thirteen** or more children in any setting if the facility is open on a regular basis.

**NOTE:** Unless otherwise noted beneath the standard text, the standards in *SS3* are applicable to all three types of facilities.

### ***Format and Organization***

The 686 standards in *CFOC3* are numbered according to the chapter in which they are located. The 138 standards included in *Stepping Stones*, Third Edition retain their numbers from *CFOC3* to assist users in comparing

the two documents. Chapter titles and associated numbering are shown in the following table.

<b>CFOC3 Chapter Title</b>	<b>Standard Numbers Begin with</b>
<b>Staffing</b>	<b>1</b>
<b>Program Activities for Healthy Development</b>	<b>2</b>
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*Stepping Stones*, Third Edition presents the Standard only, whereas the larger document, *CFOC3*, also includes the Rationale, Comments, Facility Type, Related Standards, and References for each standard. To review the Rationale, Comments, Related Standards, and References of a standard contained in *Stepping Stones*, Third Edition, users should consult a print version of *CFOC3* or search the online version located on the NRC's website (<http://cfoc.nrckids.org>). Also, there are standards from *CFOC3* that are referred to in *Stepping Stones*, Third Edition but were not selected for inclusion. Users should consult *CFOC3* for their wording.


The following significant content and format changes and additions were made in this new edition:

- New and updated standards include safe sleep, handling and feeding of human milk, introduction of solid foods to infants, monitoring children's development, unimmunized children, preventing expulsions, and availability of drinking water.
- Conversion charts to locate standards in SS2 and their new numbering in SS3 and vice versa.

## Interactive Online Use of Stepping Stones PDF Version

The online PDF version of this document contains links that enable you to interactively navigate within the document and locate additional information from the CFOC3 database. For example:

- To go to a standard in SS3 from the Table of Contents, click on the standard number in the Table of Contents;



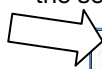
<a href="#">2.1.1.4</a> - Monitoring Children's Development/Obtaining Consent for Screening .....
<a href="#">2.1.2.1</a> - Personal Caregiver/Teacher Relationships for Infants and Toddlers .....

- To go to a section of SS3 from the Table of Contents, click on the section title in the Table of Contents;



<a href="#">Acknowledgements</a> .....
<a href="#">Introduction</a> .....
<a href="#">Advice to Users</a> .....
<a href="#">Chapter 1 – Staffing</a> .....

- To go to an appendix in SS3 from the Table of Contents, click on the section title in the Table of Contents;



<a href="#">Appendix O</a> Care Plan for Children with Special Health Needs....
<a href="#">Appendix 1</a> SS3 Methodology.....

- To go to an appendix in SS3 from within a standard, click on the appendix reference in the standard text.

In addition to Orientation Training, Standard 1.4.2.1, the orientation provided to staff in child care facilities should be based on the special health care needs of children who will be assigned to their care. All staff oriented for care of children with special health needs should be knowledgeable about the care plans created by the child's primary care provider in their medical home as well as any care plans created by other health professionals and therapists involved in the child's care. A [care plan for children with special health care needs](#) can be found in [Appendix O](#). Child care health consultants can be an excellent resource for providing health and safety orientation or referrals to resources for such training. This training may include, but is not limited to, the following topics:

- To view all the additional parts of a standard that are not included in SS3 such as the rationale, comments, etc., click on the standard title on the page where the standard text is located in this document. If you have internet access, this link will take you to the standard in the CFOC3 database. From the database you can also link to related standards and appendices.

**Standard 1.4.3.1 First Aid and CPR Training for Staff**

The director of a center or a large family child care home and the caregiver/teacher in a small family child care home should ensure all staff members involved in providing direct care have documentation of satisfactory completion of training in pediatric first aid and pediatric CPR skills. Pediatric CPR skills should be taught by demonstration, practice, and return demonstration to ensure the technique can be performed in an emergency. These skills should be current according to the requirement specified for retraining by the organization that provided the training.

**Want more?** To explore all the standards in *CFOC3* that cover any topic of interest, search the online *CFOC3* database at <http://cfoc.nrckids.org>.

***Stepping Stones, Third Edition (SS3)* is for reference purposes only and should not be used as a substitute for medical or legal consultation, nor be used to authorize actions beyond a person's licensing, training, or ability.**



## Chapter 1: Staffing

### Standard 1.1.1.1 Ratios for Small Family Child Care Homes

The small family child care home caregiver/teacher child:staff ratios should conform to the following table:

If the small family child care home caregiver/teacher has no children under two years of age in care,	then the small family child care home caregiver/teacher may have one to six children over two years of age in care
If the small family child care home caregiver/teacher has one child under two years of age in care,	then the small family child care home caregiver/teacher may have one to three children over two years of age in care
If the small family child care home caregiver/teacher has two children under two years of age in care,	then the small family child care home caregiver/teacher may have no children over two years of age in care

The small family child care home caregiver's/teacher's own children as well as any other children in the home temporarily requiring supervision should be included in the child:staff ratio. During nap time, at least one adult should be physically present in the same room as the children.

**TYPE OF FACILITY:** Small Family Child Care Homes

### Standard 1.1.1.2 Ratios for Large Family Child Care Homes and Centers

Child:staff ratios in large family child care homes and centers should be maintained as follows during all hours of operation, including in vehicles during transport.

#### **Large Family Child Care Homes**

Age	Maximum Child:Staff Ratio	Maximum Group Size
≤ 12 months	2:1	6
13-23 months	2:1	8
24-35 months	3:1	12
3-year-olds	7:1	12
4 to 5-year-olds	8:1	12
6 to 8-year-olds	10:1	12
9 to 12-year-olds	12:1	12

During nap time for children birth through thirty months of age, the child:staff ratio must be maintained at all times regardless of how many infants are sleeping. They must also be maintained even during the adult's break time so that ratios are not relaxed.

### Child Care Centers

Age	Maximum Child:Staff Ratio	Maximum Group Size
≤ 12 months	3:1	6
13-35 months	4:1	8
3-year-olds	7:1	14
4-year-olds	8:1	16
5-year-olds	8:1	16
6 to 8-year-olds	10:1	20
9 to 12-year-olds	12:1	24

During nap time for children ages thirty-one months and older, at least one adult should be physically present in the same room as the children and maximum group size must be maintained. Children over thirty-one months of age can usually be organized to nap on a schedule, but infants and toddlers as individuals are more likely to nap on different schedules. In the event even one child is not sleeping the child should be moved to another activity where appropriate supervision is provided.

If there is an emergency during nap time other adults should be on the same floor and should immediately assist the staff supervising sleeping children. The caregiver/teacher who is in the same room with the children should be able to summon these adults without leaving the children.

When there are mixed age groups in the same room, the child:staff ratio and group size should be consistent with the age of most of the children. When infants or toddlers are in the mixed age group, the child:staff ratio and group size for infants and toddlers should be maintained. In large family child care homes with two or more caregivers/teachers caring for no more than twelve children, no more than three children younger than two years of age should be in care.

Children with special health care needs or who require more attention due to certain disabilities may require additional staff on-site, depending on their special needs and the extent of their disabilities (1). See Standard 1.1.1.3.

At least one adult who has satisfactorily completed a course in pediatric first aid, including CPR skills within the past three years, should be part of the ratio at all times.

**TYPE OF FACILITY:** Center, Large Family Child Care Home

National Health and Safety Performance Standards



**Standard 1.1.1.3 Ratios for Facilities Serving Children with Special Health Care Needs and Disabilities**

Facilities enrolling children with special health care needs and disabilities should determine, by an individual assessment of each child’s needs, whether the facility requires a lower child:staff ratio.

**Standard 1.1.1.4 Ratios and Supervision During Transportation**

Child:staff ratios established for out-of-home child care should be maintained on all transportation the facility provides or arranges. Drivers should not be included in the ratio. No child of any age should be left unattended in or around a vehicle, when children are in a car, or when they are in a car seat. A face-to-name count of children should be conducted prior to leaving for a destination, when the destination is reached, before departing for return to the facility and upon return. Caregivers/teachers should also remember to take into account in this head count if any children were picked up or dropped off while being transported away from the facility.

**TYPE OF FACILITY:** Center, Large Family Child Care Home

**Standard 1.1.1.5 Ratios and Supervision for Swimming, Wading, and Water Play**

The following child:staff ratios should apply while children are swimming, wading, or engaged in water play:

Developmental Levels	Child:Staff Ratio
Infants	1:1
Toddlers	1:1
Preschoolers	4:1
School-age Children	6:1

Constant and active supervision should be maintained when any child is in or around water (4). During any swimming/wading/water play activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. The required ratio of adults to older children should be met without including the adults who are required for supervision of infants and/or toddlers. An adult should remain in direct physical contact with an infant at all times during swimming or water play (4). Whenever children thirteen months and up to five years of age are in or around water, the supervising adult should be within an arm’s length providing “touch supervision” (6). The attention of an adult who is supervising children of any age should be focused on the child, and the adult should never be engaged

in other distracting activities (4), such as talking on the telephone, socializing, or tending to chores.

A lifeguard should not be counted in the child:staff ratio.

### **Standard 1.2.0.2 Background Screening**

Directors of centers and caregivers/teachers in large and small family child care homes should conduct a complete background screening before employing any staff member (including substitutes, cooks, clerical staff, transportation staff, bus drivers, or custodians who will be on the premises or in vehicles when children are present). The background screening should include:

- a. Name and address verification;
- b. Social Security number verification;
- c. Education verification;
- d. Employment history;
- e. Alias search;
- f. Driving history through state Department of Motor Vehicles records;
- g. Background screening of:
  1. State and national criminal history records;
  2. Child abuse and neglect registries;
  3. Licensing history with any other state agencies (i.e., foster care, mental health, nursing homes, etc.);
  4. Fingerprints; and
  5. Sex offender registries;
- h. Court records;
- i. References.

All family members over age ten living in large and small family child care homes should also have background screenings.

Drug tests may also be incorporated into the background screening. Written permission to obtain the background screening (with or without a drug screen) should be obtained from the prospective employee. Consent to the background investigation should be required for employment consideration.

When checking references and when conducting employee or volunteer interviews, prospective employers should specifically ask about previous convictions and arrests, investigation findings, or court cases with child abuse/neglect or child sexual abuse. Failure of the prospective employee to disclose previous history of child abuse/neglect or child sexual abuse is grounds for immediate dismissal.

Persons should not be hired or allowed to work or volunteer in the child care facility if they acknowledge being sexually attracted to children or having

physically or sexually abused children, or are known to have committed such acts.

Background screenings should be repeated periodically taking into consideration state laws and/or requirements. Screenings should be repeated more frequently if there are additional concerns.

### **Standard 1.3.1.1 General Qualifications of Directors**

The director of a center enrolling fewer than sixty children should be at least twenty-one-years-old and should have all the following qualifications:

- a. Have a minimum of a Baccalaureate degree with at least nine credit-bearing hours of specialized college-level course work in administration, leadership, or management, and at least twenty-four credit-bearing hours of specialized college-level course work in early childhood education, child development, elementary education, or early childhood special education that addresses child development, learning from birth through kindergarten, health and safety, and collaboration with consultants OR documents meeting an appropriate combination of relevant education and work experiences (6);
- b. A valid certificate of successful completion of pediatric first aid that includes CPR;
- c. Knowledge of health and safety resources and access to education, health, and mental health consultants;
- d. Knowledge of community resources available to children with special health care needs and the ability to use these resources to make referrals or achieve interagency coordination;
- e. Administrative and management skills in facility operations;
- f. Capability in curriculum design and implementation, ensuring that an effective curriculum is in place;
- g. Oral and written communication skills;
- h. Certificate of satisfactory completion of instruction in medication administration;
- i. Demonstrated life experience skills in working with children in more than one setting;
- j. Interpersonal skills;
- k. Clean background screening.

Knowledge about parenting training/counseling and ability to communicate effectively with parents/guardians about developmental-behavioral issues, child progress, and in creating an intervention plan beginning with how the center will address challenges and how it will help if those efforts are not effective.

The director of a center enrolling more than sixty children should have the above and at least three years experience as a teacher of children in the age

group(s) enrolled in the center where the individual will act as the director, plus at least six months experience in administration.

**TYPE OF FACILITY:** Center

### **Standard 1.3.2.2 Qualifications of Lead Teachers and Teachers**

Lead teachers and teachers should be at least twenty-one years of age and should have at least the following education, experience, and skills:

- a. A Bachelor's degree in early childhood education, school-age care, child development, social work, nursing, or other child-related field, or an associate's degree in early childhood education and currently working towards a bachelor's degree;
- b. A minimum of one year on-the-job training in providing a nurturing indoor and outdoor environment and meeting the child's out-of-home needs;
- c. One or more years of experience, under qualified supervision, working as a teacher serving the ages and developmental abilities of the children in care;
- d. A valid certificate in pediatric first aid, including CPR;
- e. Thorough knowledge of normal child development and early childhood education, as well as knowledge of indicators that a child is not developing typically;
- f. The ability to respond appropriately to children's needs;
- g. The ability to recognize signs of illness and safety/injury hazards and respond with prevention interventions;
- h. Oral and written communication skills;
- i. Medication administration training (8).

Every center, regardless of setting, should have at least one licensed/certified lead teacher (or mentor teacher) who meets the above requirements working in the child care facility at all times when children are in care.

Additionally, facilities serving children with special health care needs associated with developmental delay should employ an individual who has had a minimum of eight hours of training in inclusion of children with special health care needs.

**TYPE OF FACILITY:** Center

### **Standard 1.3.3.1 General Qualifications of Family Child Care Caregivers/Teachers to Operate a Family Child Care Home**

All caregivers/teachers in large and small family child care homes should be at least twenty-one years of age, hold an official credential as granted by

the authorized state agency, meet the general requirements specified in Standard 1.3.2.4 through Standard 1.3.2.6, based on ages of the children served, and those in Section 1.3.3, and should have the following education, experience, and skills:

- a. Current accreditation by the National Association for Family Child Care (NAFCC) (including entry-level qualifications and participation in required training) and a college certificate representing a minimum of three credit hours of early childhood education leadership or master caregiver/teacher training or hold an Associate's degree in early childhood education or child development;
- b. A provider who has been in the field less than twelve months should be in the self-study phase of NAFCC accreditation;
- c. A valid certificate in pediatric first aid, including CPR;
- d. Pre-service training in health management in child care, including the ability to recognize signs of illness, knowledge of infectious disease prevention and safety injury hazards;
- e. If caring for infants, knowledge on safe sleep practices including reducing the risk of sudden infant death syndrome (SIDS) and prevention of shaken baby syndrome/abusive head trauma (including how to cope with a crying infant);
- f. Knowledge of normal child development, as well as knowledge of indicators that a child is not developing typically;
- g. The ability to respond appropriately to children's needs;
- h. Good oral and written communication skills;
- i. Willingness to receive ongoing mentoring from other teachers;
- j. Pre-service training in business practices;
- k. Knowledge of the importance of nurturing adult-child relationships on self-efficacy development;
- l. Medication administration training (6).

Additionally, large family child care home caregivers/teachers should have at least one year of experience serving the ages and developmental abilities of the children in their large family child care home.

Assistants, aides, and volunteers employed by a large family child care home should meet the qualifications specified in Standard 1.3.2.3.

### **Standard 1.4.1.1 Pre-service Training**

In addition to the credentials listed in Standard 1.3.1.1, upon employment, a director or administrator of a center or the lead caregiver/teacher in a family child care home should provide documentation of at least thirty clock-hours of pre-service training. This training should cover health, psychosocial, and safety issues for out-of-home child care facilities. Small family child care home caregivers/teachers may have up to ninety days to secure training

after opening except for training on basic health and safety procedures and regulatory requirements.

All directors or program administrators and caregivers/teachers should document receipt of pre-service training prior to working with children that includes the following content on basic program operations:

- a. Typical and atypical child development and appropriate best practice for a range of developmental and mental health needs including knowledge about the developmental stages for the ages of children enrolled in the facility;
- b. Positive ways to support language, cognitive, social, and emotional development including appropriate guidance and discipline;
- c. Developing and maintaining relationships with families of children enrolled, including the resources to obtain supportive services for children's unique developmental needs;
- d. Procedures for preventing the spread of infectious disease, including hand hygiene, cough and sneeze etiquette, cleaning and disinfection of toys and equipment, diaper changing, food handling, health department notification of reportable diseases, and health issues related to having animals in the facility;
- e. Teaching child care staff and children about infection control and injury prevention through role modeling;
- f. Safe sleep practices including reducing the risk of Sudden Infant Death Syndrome (SIDS) (infant sleep position and crib safety);
- g. Shaken baby syndrome/abusive head trauma prevention and identification, including how to cope with a crying/fussy infant;
- h. Poison prevention and poison safety;
- i. Immunization requirements for children and staff;
- j. Common childhood illnesses and their management, including child care exclusion policies and recognizing signs and symptoms of serious illness;
- k. Reduction of injury and illness through environmental design and maintenance;
- l. Knowledge of U.S. Consumer Product Safety Commission (CPSC) product recall reports;
- m. Staff occupational health and safety practices, such as proper procedures, in accordance with Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations;
- n. Emergency procedures and preparedness for disasters, emergencies, other threatening situations (including weather-related, natural disasters), and injury to infants and children in care;
- o. Promotion of health and safety in the child care setting, including staff health and pregnant workers;
- p. First aid including CPR for infants and children;

- q. Recognition and reporting of child abuse and neglect in compliance with state laws and knowledge of protective factors to prevent child maltreatment;
- r. Nutrition and age-appropriate child-feeding including food preparation, choking prevention, menu planning, and breastfeeding supportive practices;
- s. Physical activity, including age-appropriate activities and limiting sedentary behaviors;
- t. Prevention of childhood obesity and related chronic diseases;
- u. Knowledge of environmental health issues for both children and staff;
- v. Knowledge of medication administration policies and practices;
- w. Caring for children with special health care needs, mental health needs, and developmental disabilities in compliance with the Americans with Disabilities Act (ADA);
- x. Strategies for implementing care plans for children with special health care needs and inclusion of all children in activities;
- y. Positive approaches to support diversity;
- z. Positive ways to promote physical and intellectual development.

### **Standard 1.4.2.2 Orientation for Care of Children with Special Health Care Needs**

When a child care facility enrolls a child with special health care needs, the facility should ensure that all staff members have been oriented in understanding that child's special health care needs and have the skills to work with that child in a group setting.

Caregivers/teachers in small family child care homes, who care for a child with special health care needs, should meet with the parents/guardians and meet or speak with the child's primary care provider (if the parent/guardian has provided prior, informed, written consent) or a child care health consultant to ensure that the child's special health care needs will be met in child care and to learn how these needs may affect his/her developmental progression or play with other children.

In addition to Orientation Training, Standard 1.4.2.1, the orientation provided to staff in child care facilities should be based on the special health care needs of children who will be assigned to their care. All staff oriented for care of children with special health needs should be knowledgeable about the care plans created by the child's primary care provider in their medical home as well as any care plans created by other health professionals and therapists involved in the child's care. A template for a care plan for children with special health care needs can be found in [Appendix O](#). Child care health consultants can be an excellent resource for providing health and safety orientation or referrals to resources for such training. This training may include, but is not limited to, the following topics:

- a. Positioning for feeding and handling, and risks for injury for children with physical/mental disabilities;
- b. Toileting techniques;
- c. Knowledge of special treatments or therapies (e.g., PT, OT, speech, nutrition/diet therapies, emotional support and behavioral therapies, medication administration, etc.) the child may need/receive in the child care setting;
- d. Proper use and care of the individual child's adaptive equipment, including how to recognize defective equipment and to notify parents/guardians that repairs are needed;
- e. How different disabilities affect the child's ability to participate in group activities;
- f. Methods of helping the child with special health care needs or behavior problems to participate in the facility's programs, including physical activity programs;
- g. Role modeling, peer socialization, and interaction;
- h. Behavior modification techniques, positive behavioral supports for children, promotion of self-esteem, and other techniques for managing behavior;
- i. Grouping of children by skill levels, taking into account the child's age and developmental level;
- j. Health services or medical intervention for children with special health care problems;
- k. Communication methods and needs of the child;
- l. Dietary specifications for children who need to avoid specific foods or for children who have their diet modified to maintain their health, including support for continuation of breastfeeding;
- m. Medication administration (for emergencies or on an ongoing basis);
- n. Recognizing signs and symptoms of impending illness or change in health status;
- o. Recognizing signs and symptoms of injury;
- p. Understanding temperament and how individual behavioral differences affect a child's adaptive skills, motivation, and energy;
- q. Potential hazards of which staff should be aware;
- r. Collaborating with families and outside service providers to create a health, developmental, and behavioral care plan for children with special needs;
- s. Awareness of when to ask for medical advice and recommendations for non-emergent issues that arise in school (e.g., head lice, worms, diarrhea);
- t. Knowledge of professionals with skills in various conditions, e.g., total communication for children with deafness, beginning orientation and mobility training for children with blindness (including arranging the physical environment effectively for such



- children), language promotion for children with hearing-impairment and language delay/disorder, etc.;
- u. How to work with parents/guardians and other professionals when assistive devices or medications are not consistently brought to the child care program or school;
  - v. How to safely transport a child with special health care needs.

### **Standard 1.4.2.3 Orientation Topics**

During the first three months of employment, the director of a center or the caregiver/teacher in a large family home should document, for all full-time and part-time staff members, additional orientation in, and the employees' satisfactory knowledge of, the following topics:

- a. Recognition of symptoms of illness and correct documentation procedures for recording symptoms of illness. This should include the ability to perform a daily health check of children to determine whether any children are ill or injured and, if so, whether a child who is ill should be excluded from the facility;
- b. Exclusion and readmission procedures and policies;
- c. Cleaning, sanitation, and disinfection procedures and policies;
- d. Procedures for administering medication to children and for documenting medication administered to children;
- e. Procedures for notifying parents/guardians of an infectious disease occurring in children or staff within the facility;
- f. Procedures and policies for notifying public health officials about an outbreak of disease or the occurrence of a reportable disease;
- g. Emergency procedures and policies related to unintentional injury, medical emergency, and natural disasters;
- h. Procedure for accessing the child care health consultant for assistance;
- i. Injury prevention strategies and hazard identification procedures specific to the facility, equipment, etc.;
- j. Proper hand hygiene.

Before being assigned to tasks that involve identifying and responding to illness, staff members should receive orientation training on these topics. Small family child care home caregivers/teachers should not commence operation before receiving orientation on these topics in pre-service training (1).

### **Standard 1.4.3.1 First Aid and CPR Training for Staff**

The director of a center or a large family child care home and the caregiver/teacher in a small family child care home should ensure all staff members involved in providing direct care have documentation of satisfactory completion of training in pediatric first aid and pediatric CPR skills. Pediatric CPR skills should be taught by demonstration, practice, and return demonstration to ensure the technique can be performed in an

National Health and Safety Performance Standards

emergency. These skills should be current according to the requirement specified for retraining by the organization that provided the training.

At least one staff person who has successfully completed training in pediatric first aid that includes CPR should be in attendance at all times with a child whose special care plan indicates an increased risk of needing respiratory or cardiac resuscitation.

Records of successful completion of training in pediatric first aid should be maintained in the personnel files of the facility.

### **Standard 1.4.3.2 Topics Covered in First Aid Training**

First aid training should present an overview of Emergency Medical Services (EMS), accessing EMS, poison center services, accessing the poison center, safety at the scene, and isolation of body substances. First aid instruction should include, but not be limited to, recognition and first response of pediatric emergency management in a child care setting of the following situations:

- a. Management of a blocked airway and rescue breathing for infants and children with return demonstration by the learner (pediatric CPR);
- b. Abrasions and lacerations;
- c. Bleeding, including nosebleeds;
- d. Burns;
- e. Fainting;
- f. Poisoning, including swallowed, skin or eye contact, and inhaled;
- g. Puncture wounds, including splinters;
- h. Injuries, including insect, animal, and human bites;
- i. Poison control;
- j. Shock;
- k. Seizure care;
- l. Musculoskeletal injury (such as sprains, fractures);
- m. Dental and mouth injuries/trauma;
- n. Head injuries, including shaken baby syndrome/abusive head trauma;
- o. Allergic reactions, including information about when epinephrine might be required;
- p. Asthmatic reactions, including information about when rescue inhalers must be used;
- q. Eye injuries;
- r. Loss of consciousness;
- s. Electric shock;
- t. Drowning;
- u. Heat-related injuries, including heat exhaustion/heat stroke;
- v. Cold related injuries, including frostbite;
- w. Moving and positioning injured/ill persons;

- x. Illness-related emergencies (such as stiff neck, inexplicable confusion, sudden onset of blood-red or purple rash, severe pain, temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method, and looking/acting severely ill);
- y. Standard Precautions;
- z. Organizing and implementing a plan to meet an emergency for any child with a special health care need;
- aa. Addressing the needs of the other children in the group while managing emergencies in a child care setting;
- ab. Applying first aid to children with special health care needs.

### **Standard 1.4.3.3 CPR Training for Swimming and Water Play**

Facilities that have a swimming pool should require at least one staff member with current documentation of successful completion of training in infant and child (pediatric) CPR (Cardiopulmonary Resuscitation) be on duty at all times during business hours.

At least one of the caregivers/teachers, volunteers, or other adults who is counted in the child:staff ratio for swimming and water play should have documentation of successful completion of training in basic water safety, proper use of swimming pool rescue equipment, and infant and child CPR according to the criteria of the American Red Cross or the American Heart Association (AHA).

For small family child care homes, the person trained in water safety and CPR should be the caregiver/teacher. Written verification of successful completion of CPR and lifesaving training, water safety instructions, and emergency procedures should be kept on file.

### **Standard 1.4.5.1 Training of Staff Who Handle Food**

All staff members with food handling responsibilities should obtain training in food service and safety. The director of a center or a large family child care home or the designated supervisor for food service should be a certified food protection manager or equivalent as demonstrated by completing an accredited food protection manager course. Small family child care personnel should secure training in food service and safety appropriate for their setting.

### **Standard 1.4.5.2 Child Abuse and Neglect Education**

Caregivers/teachers should use child abuse and neglect prevention education to educate and establish child abuse and neglect prevention and recognition measures for the children, caregivers/teachers, and parents/guardians. The education should address physical, sexual, and National Health and Safety Performance Standards

psychological or emotional abuse and neglect. The dangers of shaking infants and toddlers and repeated exposure to domestic violence should be included in the education and prevention materials. Caregivers/teachers should also receive education on promoting protective factors to prevent child maltreatment. Caregivers/teachers should be able to identify signs of stress in families and assist families by providing support and linkages to resources when needed. Children with disabilities are at a higher risk of being abused. Special training in child abuse and neglect and children with disabilities should be provided (2).

Caregivers/teachers are mandatory reporters of child abuse or neglect. Caregivers/teachers should be trained in compliance with their state's child abuse reporting laws. Child abuse reporting requirements are known and available from the child care regulation department in each state.

### **Standard 1.5.0.1 Employment of Substitutes**

Substitutes should be employed to ensure that child:staff ratios and requirements for direct supervision are maintained at all times. Substitutes and volunteers should be at least eighteen years of age and must meet the requirements specified throughout Standards 1.3.2.1-1.3.2.6. Those without licenses/certificates should work under direct supervision and should not be alone with a group of children.

A substitute should complete the same background screening processes as the caregiver/teacher. Obtaining substitutes to provide medical care for children with special health care needs is particularly challenging. A substitute nurse should be experienced in delivering the expected medical services. Decisions should be made on whether a parent/guardian will be allowed to provide needed on-site medical services. Substitutes should be aware of the care plans (including emergency procedures) for children with special health care needs.

### **Standard 1.5.0.2 Orientation of Substitutes**

The director of any center or large family child care home and the small family child care home caregiver/teacher should provide orientation training to newly hired substitutes to include a review of ALL the program's policies and procedures (listed below is a sample). This training should include the opportunity for an evaluation and a repeat demonstration of the training lesson. In all child care settings the orientation should be documented. Substitutes should have background screenings.

All substitutes should be oriented to, and demonstrate competence in, the tasks for which they will be responsible. On the first day a substitute caregiver/teacher should be oriented on the following topics:

- a. Safe infant sleep practices if an infant is enrolled in the program;
- b. Any emergency medical procedure/medication needs of the children;

- c. Any nutrition needs of the children.

All substitute caregivers/teachers, during the first week of employment, should be oriented to, and should demonstrate competence in at least the following items:

- a. The names of the children for whom the caregiver/teacher will be responsible, and their specific developmental needs;
- b. The planned program of activities at the facility;
- c. Routines and transitions;
- d. Acceptable methods of discipline;
- e. Meal patterns and safe food handling policies of the facility (special attention should be given to life-threatening food allergies);
- f. Emergency health and safety procedures;
- g. General health policies and procedures as appropriate for the ages of the children cared for, including but not limited to the following:
  - 1. Hand hygiene techniques, including indications for hand hygiene;
  - 2. Diapering technique, if care is provided to children in diapers, including appropriate diaper disposal and diaper changing techniques, use and wearing of gloves;
  - 3. The practice of putting infants down to sleep positioned on their backs and on a firm surface along with all safe infant sleep practices to reduce the risk of Sudden Infant Death Syndrome (SIDS), as well as general nap time routines for all ages;
  - 4. Correct food preparation and storage techniques, if employee prepares food;
  - 5. Proper handling and storage of human milk when applicable and formula preparation if formula is handled;
  - 6. Bottle preparation including guidelines for human milk and formula if care is provided to children with bottles;
  - 7. Proper use of gloves in compliance with Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations;
  - 8. Injury prevention and safety including the role of mandatory child abuse reporter to report any suspected abuse/neglect.
- h. Emergency plans and practices;
- i. Access to list of authorized individuals for releasing children.

### **Standard 1.6.0.1 Child Care Health Consultants**

A facility should identify and engage/partner with a child care health consultant (CCHC) who is a licensed health professional with education and experience in child and community health and child care and preferably specialized training in child care health consultation.

CCHCs have knowledge of resources and regulations and are comfortable linking health resources with child care facilities.

The child care health consultant should be knowledgeable in the following areas:

- a. Consultation skills both as a child care health consultant as well as a member of an interdisciplinary team of consultants;
- b. National health and safety standards for out-of-home child care;
- c. Indicators of quality early care and education;
- d. Day-to-day operations of child care facilities;
- e. State child care licensing and public health requirements;
- f. State health laws, Federal and State education laws (e.g., ADA, IDEA), and state professional practice acts for licensed professionals (e.g., State Nurse Practice Acts);
- g. Infancy and early childhood development, social and emotional health, and developmentally appropriate practice;
- h. Recognition and reporting requirements for infectious diseases;
- i. American Academy of Pediatrics (AAP) and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening recommendations and immunizations schedules for children;
- j. Importance of medical home and local and state resources to facilitate access to a medical home as well as child health insurance programs including Medicaid and State Children's Health Insurance Program (SCHIP);
- k. Injury prevention for children;
- l. Oral health for children;
- m. Nutrition and age-appropriate physical activity recommendations for children including feeding of infants and children, the importance of breastfeeding and the prevention of obesity;
- n. Inclusion of children with special health care needs, and developmental disabilities in child care;
- o. Safe medication administration practices;
- p. Health education of children;
- q. Recognition and reporting requirements for child abuse and neglect/child maltreatment;
- r. Safe sleep practices and policies (including reducing the risk of SIDS);
- s. Development and implementation of health and safety policies and practices including poison awareness and poison prevention;

- t. Staff health, including adult health screening, occupational health risks, and immunizations;
- u. Disaster planning resources and collaborations within child care community;
- v. Community health and mental health resources for child, parent/guardian and staff health;
- w. Importance of serving as a healthy role model for children and staff.

The child care health consultant should be able to perform or arrange for performance of the following activities:

- a. Assessing caregivers'/teachers' knowledge of health, development, and safety and offering training as indicated;
- b. Assessing parents'/guardians' health, development, and safety knowledge, and offering training as indicated;
- c. Assessing children's knowledge about health and safety and offering training as indicated;
- d. Conducting a comprehensive indoor and outdoor health and safety assessment and on-going observations of the child care facility;
- e. Consulting collaboratively on-site and/or by telephone or electronic media;
- f. Providing community resources and referral for health, mental health and social needs, including accessing medical homes, children's health insurance programs (e.g., CHIP), and services for special health care needs;
- g. Developing or updating policies and procedures for child care facilities (see comment section below);
- h. Reviewing health records of children;
- i. Reviewing health records of caregivers/teachers;
- j. Assisting caregivers/teachers and parents/guardians in the management of children with behavioral, social and emotional problems and those with special health care needs;
- k. Consulting a child's primary care provider about the child's individualized health care plan and coordinating services in collaboration with parents/guardians, the primary care provider, and other health care professionals (the CCHC shows commitment to communicating with and helping coordinate the child's care with the child's medical home, and may assist with the coordination of skilled nursing care services at the child care facility);
- l. Consulting with a child's primary care provider about medications as needed, in collaboration with parents/guardians;
- m. Teaching staff safe medication administration practices;
- n. Monitoring safe medication administration practices;

- o. Observing children's behavior, development and health status and making recommendations if needed to staff and parents/guardians for further assessment by a child's primary care provider;
- p. Interpreting standards, regulations and accreditation requirements related to health and safety, as well as providing technical advice, separate and apart from an enforcement role of a regulation inspector or determining the status of the facility for recognition;
- q. Understanding and observing confidentiality requirements;
- r. Assisting in the development of disaster/emergency medical plans (especially for those children with special health care needs) in collaboration with community resources;
- s. Developing an obesity prevention program in consultation with a nutritionist/registered dietitian (RD) and physical education specialist;
- t. Working with other consultants such as nutritionists/RDs, kinesiologists (physical activity specialists), oral health consultants, social service workers, early childhood mental health consultants, and education consultants.

The role of the CCHC is to promote the health and development of children, families, and staff and to ensure a healthy and safe child care environment (11).

The CCHC is not acting as a primary care provider at the facility but offers critical services to the program and families by sharing health and developmental expertise, assessments of child, staff, and family health needs and community resources. The CCHC assists families in care coordination with the medical home and other health and developmental specialists. In addition, the CCHC should collaborate with an interdisciplinary team of early childhood consultants, such as, early childhood education, mental health, and nutrition consultants.

In order to provide effective consultation and support to programs, the CCHC should avoid conflict of interest related to other roles such as serving as a caregiver/teacher or regulator or a parent/guardian at the site to which child care health consultation is being provided.

The CCHC should have regular contact with the facility's administrative authority, the staff, and the parents/guardians in the facility. The administrative authority should review, and collaborate with the CCHC in implementing recommended changes in policies and practices. In the case of consulting about children with special health care needs, the CCHC should have contact with the child's medical home with permission from the child's parent/guardian.

Programs with a significant number of non-English-speaking families should seek a CCHC who is culturally sensitive and knowledgeable about community health resources for the parents'/guardians' native culture and languages.



## Chapter 2: Program Activities for Healthy Development

### Standard 2.1.1.4 Monitoring Children's Development/Obtaining Consent for Screening

Child care settings provide daily indoor and outdoor opportunities for promoting and monitoring children's development. Caregivers/teachers should monitor the children's development, share observations with parents/guardians, and provide resource information as needed for screenings, evaluations, and early intervention and treatment.

Caregivers/teachers should work in collaboration to monitor a child's development with parents/guardians and in conjunction with the child's primary care provider and health, education, mental health, and early intervention consultants. Caregivers/teachers should utilize the services of health and safety, education, mental health, and early intervention consultants to strengthen their observation skills, collaborate with families, and be knowledgeable of community resources.

Programs should have a formalized system of developmental screening with all children that can be used near the beginning of a child's placement in the program, at least yearly thereafter, and as developmental concerns become apparent to staff and/or parents/guardians. The use of authentic assessment and curricular-based assessments should be an ongoing part of the services provided to all children (5-9). The facility's formalized system should include a process for determining when a health or developmental screening or evaluation for a child is necessary. This process should include parental/guardian consent and participation.

Parents/guardians should be explicitly invited to:

- a. Discuss reasons for a health or developmental assessment;
- b. Participate in discussions of the results of their child's evaluations and the relationship of their child's needs to the caregivers'/teachers' ability to serve that child appropriately;
- c. Give alternative perspectives;
- d. Share their expectations and goals for their child and have these expectations and goals integrated with any plan for their child;
- e. Explore community resources and supports that might assist in meeting any identified needs that child care centers and family child care homes can provide;
- f. Give written permission to share health information with primary health care professionals (medical home), child care health consultants and other professionals as appropriate;

The facility should document parents'/guardians' presence at these meetings and invitations to attend.

If the parents/guardians do not attend the screening, the caregiver/teacher should inform the parents/guardians of the results, and offer an opportunity for discussion. Efforts should be made to provide notification of meetings in the primary language of the parents/guardians. Formal evaluations of a child's health or development should also be shared with the child's medical home with parent/guardian consent.

Programs are encouraged to utilize validated screening tools to monitor children's development, as well as various measures that may inform their work facilitating children's development and providing an enriching indoor and outdoor environment, such as authentic-based assessment, work sampling methods, observational assessments, and assessments intended to support curricular implementation (5,9). Programs should have clear policies for using reliable and valid methods of developmental screening with all children and for making referrals for diagnostic assessment and possible intervention for children who screen positive. All programs should use methods of ongoing developmental assessment that inform the curricular approaches used by the staff. Care must be taken in communicating the results. Screening is a way to identify a child at risk of a developmental delay or disorder. It is not a diagnosis.

If the screening or any observation of the child results in any concern about the child's development, after consultation with the parents/guardians, the child should be referred to his or her primary care provider (medical home), or to an appropriate specialist or clinic for further evaluation. In some situations, a direct referral to the Early Intervention System in the respective state may also be required.

### **Standard 2.1.2.1 Personal Caregiver/Teacher Relationships for Infants and Toddlers**

The facility should practice a relationship-based philosophy that promotes consistency and continuity of caregivers/teachers for infants and toddlers. The facility should limit the number of caregivers/teachers who interact with any one infant (1,2) to no more than five caregivers/teachers across the period that the child is an infant in child care. The caregiver/teacher should:

- a. Hold and comfort children who are upset;
- b. Engage in frequent, multiple, and rich social interchanges such as smiling, talking, touching, singing, and eating;
- c. Be play partners as well as protectors;
- d. Be attuned to children's feelings and reflect them back;
- e. Communicate consistently with parents/guardians;
- f. Interact with children and develop a relationship in the context of everyday routines (diapering, feeding, etc.)

Opportunities should be provided for each child to develop a personal and affectionate relationship with, and attachment to, that child's parents/guardians and one or a small number of caregivers/teachers whose

care for and responsiveness to the child ensure relief of distress, experiences of comfort and stimulation, and satisfaction of the need for a personal relationship.

### **Standard 2.2.0.1 Methods of Supervision of Children**

Caregivers/teachers should directly supervise infants, toddlers, and preschoolers by sight and hearing at all times, even when the children are going to sleep, napping or sleeping, are beginning to wake up, or are indoors or outdoors. School-age children should be within sight or hearing at all times. Caregivers/teachers should not be on one floor level of the building, while children are on another floor or room. Ratios should remain the same whether inside or outside.

School-age children should be permitted to participate in activities off the premises with appropriate adult supervision and with written approval by a parent/guardian and by the caregiver. If parents/guardians give written permission for the school-age child to participate in off-premises activities, the facility would no longer be responsible for the child during the off-premises activity and not need to provide staff for the off-premises activity.

Caregivers/teachers should regularly count children (name to face on a scheduled basis, at every transition, and whenever leaving one area and arriving at another), going indoors or outdoors, to confirm the safe whereabouts of every child at all times. Additionally, they must be able to state how many children are in their care at all times.

Developmentally appropriate child:staff ratios should be met during all hours of operation, including indoor and outdoor play and field trips, and safety precautions for specific areas and equipment should be followed. No center-based facility or large family child care home should operate with fewer than two staff members if more than six children are in care, even if the group otherwise meets the child:staff ratio. Although centers often downsize the number of staff for the early arrival and late departure times, another adult must be present to help in the event of an emergency. The supervision policies of centers and large family child care homes should be written policies.

### **Standard 2.2.0.4 Supervision Near Bodies of Water**

Constant and active supervision should be maintained when any child is in or around water (1). During any swimming/wading/water play activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. Children ages thirteen months to five years of age should not be permitted to play in areas where there is any body of water, including swimming pools, ponds and irrigation ditches, built-in wading pools, tubs, pails, sinks, or toilets unless the supervising adult is within an arm's length providing "touch supervision".

Caregivers/teachers should ensure that all pools meet the Virginia Graeme Baker Pool and Spa Safety Act, requiring the retrofitting of safe suction-type devices for pools and spas to prevent underwater entrapment of children in such locations with strong suction devices that have led to deaths of children of varying ages (2).

### **Standard 2.2.0.6 Discipline Measures**

Reader's Note: The word discipline means to teach and guide. Discipline is not punishment. The discipline standard therefore reflects an approach that focuses on preventing behavior problems by supporting children in learning appropriate social skills and emotional responses.

Caregivers/teachers should guide children to develop self-control and appropriate behaviors in the context of relationships with peers and adults. Caregivers/teachers should care for children without ever resorting to physical punishment or abusive language. When a child needs assistance to resolve a conflict, manage a transition, engage in a challenging situation, or express feelings, needs, and wants, the adult should help the child learn strategies for dealing with the situation. Discipline should be an ongoing process to help children learn to manage their own behavior in a socially acceptable manner, and should not just occur in response to a problem behavior. Rather, the adult's guidance helps children respond to difficult situations using socially appropriate strategies. To develop self-control, children should receive adult support that is individual to the child and adapts as the child develops internal controls. This process should include:

- a. Forming a positive relationship with the child. When children have a positive relationship with the adult, they are more likely to follow that person's directions. This positive relationship occurs when the adult spends time talking to the child, listening to the child, following the child's lead, playing with the child, and responding to the child's needs;
- b. Basing expectations on children's developmental level;
- c. Establishing simple rules children can understand (e.g., you can't hurt others, our things, or yourself) and being proactive in teaching and supporting children in learning the rules;
- d. Adapting the physical indoor and outdoor learning/play environment or family child care home to encourage positive behavior and self regulation by providing engaging materials based on children's interests and ensuring that the learning environment promotes active participation of each child. Well-designed child care environments are ones that are supportive of appropriate behavior in children, and are designed to help children learn about what to expect in that environment and to promote positive interactions and engagement with others;
- e. Modifying the learning/play environment (e.g., schedule, routine, activities, transitions) to support the child's appropriate behavior;

- f. Creating a predictable daily routine and schedule. When a routine is predictable, children are more likely to know what to do and what is expected of them. This may decrease anxiety in the child. When there is less anxiety, there may be less acting out. Reminders need to be given to the children so they can anticipate and prepare themselves for transitions within the schedule. Reminders should be individualized such that each child understands and anticipates the transition;
- g. Using encouragement and descriptive praise. When clear encouragement and descriptive praise are used to give attention to appropriate behaviors, those behaviors are likely to be repeated. Encouragement and praise should be stated positively and descriptively. Encouragement and praise should provide information that the behavior the child engaged in was appropriate. Examples: "I can tell you are ready for circle time because you are sitting on your name and looking at me." "Your friend looked so happy when you helped him clean up his toys." "You must be so proud of yourself for putting on your coat all by yourself." Encouragement and praise should label the behaviors, not the child (e.g., good listening, good eating, instead of good boy);
- h. Using clear, direct, and simple commands. When clear commands are used with children, they are more likely to follow them. The caregiver/teacher should tell the child what to do rather than what NOT to do. The caregiver/teacher should limit the number of commands. The caregiver/teacher should use if/then and when/then statements with logical and natural consequences. These practices help children understand they can make choices and that choices have consequences;
- i. Showing children positive alternatives rather than just telling children "no";
- j. Modeling desired behavior;
- k. Using planned ignoring and redirection. Certain behaviors can be ignored while at the same time the adult is able to redirect the children to another activity. If the behavior cannot be ignored, the adult should prompt the child to use a more appropriate behavior and provide positive feedback when the child engages in the behavior;
- l. Individualizing discipline based on the individual needs of children. For example, if a child has a hard time transitioning, the caregiver/teacher can identify strategies to help the child with the transition (individualized warning, job during transition, individual schedule, peer buddy to help, etc.) If a child has a difficult time during a large group activity, the child might be taught to ask for a break;

- m. Using time-out for behaviors that are persistent and unacceptable. Time-out should only be used in combination with instructional approaches that teach children what to do in place of the behavior problem. (See guidance for time-outs below.)

Expectations for children's behavior and the facility's policies regarding their response to behaviors should be written and shared with families and children of appropriate age. Further, the policies should address proactive as well as reactive strategies. Programs should work with families to support their children's appropriate behaviors before it becomes a problem.

### **Standard 2.2.0.8 Preventing Expulsions, Suspensions, and Other Limitations in Services**

Child care programs should not expel, suspend, or otherwise limit the amount of services (including denying outdoor time, withholding food, or using food as a reward/punishment) provided to a child or family on the basis of challenging behaviors or a health/safety condition or situation unless the condition or situation meets one of the two exceptions listed in this standard.

Expulsion refers to terminating the enrollment of a child or family in the regular group setting because of a challenging behavior or a health condition. Suspension and other limitations in services include all other reductions in the amount of time a child may be in attendance of the regular group setting, either by requiring the child to cease attendance for a particular period of time or reducing the number of days or amount of time that a child may attend. Requiring a child to attend the program in a special place away from the other children in the regular group setting is included in this definition.

Child care programs should have a comprehensive discipline policy that includes an explicit description of alternatives to expulsion for children exhibiting extreme levels of challenging behaviors, and should include the program's protocol for preventing challenging behaviors. These policies should be in writing and clearly articulated and communicated to parents/guardians, staff and others. These policies should also explicitly state how the program plans to use any available internal mental health and other support staff during behavioral crises to eliminate to the degree possible any need for external supports (e.g., local police departments) during crises.

Staff should have access to in-service training on both a proactive and as-needed basis on how to reduce the likelihood of problem behaviors escalating to the level of risk for expulsion and how to more effectively manage behaviors throughout the entire class/group. Staff should also have access to in-service training, resources, and child care health consultation to manage children's health conditions in collaboration with parents/guardians and the child's primary care provider. Programs should

attempt to obtain access to behavioral or mental health consultation to help establish and maintain environments that will support children's mental well-being and social-emotional health, and have access to such a consultant when more targeted child-specific interventions are needed. Mental health consultation may be obtained from a variety of sources, as described in Standard 1.6.0.3.

When children exhibit or engage in challenging behaviors that cannot be resolved easily, as above, staff should:

- a. Assess the health of the child and the adequacy of the curriculum in meeting the developmental and educational needs of the child;
- b. Immediately engage the parents/guardians/family in a spirit of collaboration regarding how the child's behaviors may be best handled, including appropriate solutions that have worked at home or in other settings;
- c. Access an early childhood mental health consultant to assist in developing an effective plan to address the child's challenging behaviors and to assist the child in developing age-appropriate, pro-social skills;
- d. Facilitate, with the family's assistance, a referral for an evaluation for either Part C (early intervention) or Part B (preschool special education), as well as any other appropriate community-based services (e.g., child mental health clinic);
- e. Facilitate with the family communication with the child's primary care provider (e.g., pediatrician, family medicine provider, etc.), so that the primary care provider can assess for any related health concerns and help facilitate appropriate referrals.

The only possible reasons for considering expelling, suspending or otherwise limiting services to a child on the basis of challenging behaviors are:

- a. Continued placement in the class and/or program clearly jeopardizes the physical safety of the child and/or his/her classmates as assessed by a qualified early childhood mental health consultant AND all possible interventions and supports recommended by a qualified early childhood mental health consultant aimed at providing a physically safe environment have been exhausted; or
- b. The family is unwilling to participate in mental health consultation that has been provided through the child care program or independently obtain and participate in child mental health assistance available in the community; or
- c. Continued placement in this class and/or program clearly fails to meet the mental health and/or social-emotional needs of the child as agreed by both the staff and the family AND a different program

that is better able to meet these needs has been identified and can immediately provide services to the child.

In either of the above three cases, a qualified early childhood mental health consultant, qualified special education staff, and/or qualified community-based mental health care provider should be consulted, referrals for special education services and other community-based services should be facilitated, and a detailed transition plan from this program to a more appropriate setting should be developed with the family and followed. This transition could include a different private or public-funded child care or early education program in the community that is better equipped to address the behavioral concerns (e.g., therapeutic preschool programs, Head Start or Early Head Start, prekindergarten programs in the public schools that have access to additional support staff, etc.), or public-funded special education services for infants and toddlers (i.e., Part C early intervention) or preschoolers (i.e., Part B preschool special education).

To the degree that safety can be maintained, the child should be transitioned directly to the receiving program. The program should assist parents/guardians in securing the more appropriate placement, perhaps using the services of a local child care resource and referral agency. With parent/guardian permission, the child's primary care provider should be consulted and a referral for a comprehensive assessment by qualified mental health provider and the appropriate special education system should be initiated. If abuse or neglect is suspected, then appropriate child protection services should be informed. Finally, no child should ever be expelled or suspended from care without first conducting an assessment of the safety of alternative arrangements (e.g., Who will care for the child? Will the child be adequately and safely supervised at all times?) (1).

### **Standard 2.2.0.9 Prohibited Caregiver/Teacher Behaviors**

The following behaviors should be prohibited in all child care settings and by all caregivers/teachers:

- a. The use of corporal punishment. Corporal punishment means punishment inflicted directly on the body including, but not limited to:
  1. Hitting, spanking (refers to striking a child with an open hand on the buttocks or extremities with the intention of modifying behavior without causing physical injury), shaking, slapping, twisting, pulling, squeezing, or biting;
  2. Demanding excessive physical exercise, excessive rest, or strenuous or bizarre postures;
  3. Compelling a child to eat or have in his/her mouth soap, food, spices, or foreign substances;
  4. Exposing a child to extremes of temperature.



- b. Isolating a child in an adjacent room, hallway, closet, darkened area, play area, or any other area where a child cannot be seen or supervised;
- c. Binding or tying to restrict movement, such as in a car seat (except when travelling) or taping the mouth;
- d. Using or withholding food as a punishment or reward;
- e. Toilet learning/training methods that punish, demean, or humiliate a child;
- f. Any form of emotional abuse, including rejecting, terrorizing, extended ignoring, isolating, or corrupting a child;
- g. Any abuse or maltreatment of a child, either as an incident of discipline or otherwise. Any child care program must not tolerate, or in any manner condone, an act of abuse or neglect of a child by an older child, employee, volunteer, or any person employed by the facility or child's family;
- h. Abusive, profane, or sarcastic language or verbal abuse, threats, or derogatory remarks about the child or child's family;
- i. Any form of public or private humiliation, including threats of physical punishment (1);
- j. Physical activity/outdoor time should not be taken away as punishment.

### **Standard 2.2.0.10 Using Physical Restraint**

Reader's Note: It should never be necessary to physically restrain a typically developing child unless his/her safety and/or that of others are at risk.

When a child with special behavioral or mental health issues is enrolled who may frequently need the cautious use of restraint in the event of behavior that endangers his or her safety or the safety of others, a behavioral care plan should be developed with input from the child's primary care provider, mental health provider, parents/guardians, center director/family child care home caregiver/teacher, child care health consultant, and possibly early childhood mental health consultant in order to address underlying issues and reduce the need for physical restraint.

That behavioral care plan should include:

- a. An indication and documentation of the use of other behavioral strategies before the use of restraint and a precise definition of when the child could be restrained;
- b. That the restraint be limited to holding the child as gently as possible to accomplish the restraint;
- c. That such child restraint techniques do not violate the state's mental health code;
- d. That the amount of time the child is physically restrained should be the minimum necessary to control the situation and be age-

appropriate; reevaluation and change of strategy should be used every few minutes;

- e. That no bonds, ties, blankets, straps, car seats, heavy weights (such as adult body sitting on child), or abusive words should be used;
- f. That a designated and trained staff person, who should be on the premises whenever this specific child is present, would be the only person to carry out the restraint.

### **Standard 2.3.3.1 Parents'/Guardians' Provision of Information on Their Child's Health and Behavior**

The facility should ask parents/guardians for information regarding the child's health, nutrition, level of physical activity, and behavioral status upon registration or when there has been an extended gap in the child's attendance at the facility. The child's health record should be updated if s/he have had any changes in their health or immunization status. Parents/guardians should be encouraged to sign a release of information/agreement so that child care workers can communicate directly with the child's medical home/primary care provider.

## Chapter 3: Health Promotion and Protection

### **Standard 3.1.2.1 Routine Health Supervision and Growth Monitoring**

The facility should require that each child has routine health supervision by the child's primary care provider, according to the standards of the American Academy of Pediatrics (AAP) (3). For all children, health supervision includes routine screening tests, immunizations, and chronic or acute illness monitoring. For children younger than twenty-four months of age, health supervision includes documentation and plotting of sex-specific charts on child growth standards from the World Health Organization (WHO), available at <http://www.who.int/childgrowth/standards/en/>, and assessing diet and activity. For children twenty-four months of age and older, sex-specific height and weight graphs should be plotted by the primary care provider in addition to body mass index (BMI), according to the Centers for Disease Control and Prevention (CDC). BMI is classified as underweight (BMI less than 5%), healthy weight (BMI 5%-84%), overweight (BMI 85%-94%), and obese (BMI equal to or greater than 95%). Follow-up visits with the child's primary care provider that include a full assessment and laboratory evaluations should be scheduled for children with weight for length greater than 95% and BMI greater than 85% (5).

School health services can meet this standard for school-age children in care if they meet the AAP's standards for school-age children and if the results of each child's examinations are shared with the caregiver/teacher as well as with the school health system. With parental/guardian consent, pertinent health information should be exchanged among the child's routine source of health care and all participants in the child's care, including any school health program involved in the care of the child.

### **Standard 3.1.3.1 Active Opportunities for Physical Activity**

The facility should promote children's active play every day. Children should have ample opportunity to do moderate to vigorous activities such as running, climbing, dancing, skipping, and jumping. All children, birth to six years, should participate daily in:

- a. Two to three occasions of active play outdoors, weather permitting (see Standard 3.1.3.2: Playing Outdoors for appropriate weather conditions);
- b. Two or more structured or caregiver/teacher/adult-led activities or games that promote movement over the course of the day—indoor or outdoor;
- c. Continuous opportunities to develop and practice age-appropriate gross motor and movement skills.

The total time allotted for outdoor play and moderate to vigorous indoor or outdoor physical activity can be adjusted for the age group and weather conditions.

- a. Outdoor play:
  1. Infants (birth to twelve months of age) should be taken outside two to three times per day, as tolerated. There is no recommended duration of infants' outdoor play;
  2. Toddlers (twelve months to three years) and preschoolers (three to six years) should be allowed sixty to ninety total minutes of outdoor play. These outdoor times can be curtailed somewhat during adverse weather conditions in which children may still play safely outdoors for shorter periods, but should increase the time of indoor activity, so the total amount of exercise should remain the same;
- b. Total time allotted for moderate to vigorous activities:
  1. Toddlers should be allowed sixty to ninety minutes per eight-hour day for moderate to vigorous physical activity, including running;
  2. Preschoolers should be allowed ninety to one hundred and twenty minutes per eight-hour day (4).

Infants should have supervised tummy time every day when they are awake. Beginning on the first day at the early care and education program, caregivers/teachers should interact with an awake infant on their tummy for short periods of time (three to five minutes), increasing the amount of time as the infant shows s/he enjoys the activity (27).

Time spent outdoors has been found to be a strong, consistent predictor of children's physical activity (1-3). Children can accumulate opportunities for activity over the course of several shorter segments of at least ten minutes each. Because structured activities have been shown to produce higher levels of physical activity in young children, it is recommended that caregivers/teachers incorporate two or more short structured activities (five to ten minutes) or games daily that promote physical activity.

Opportunities to be actively enjoying physical activity should be incorporated into part-time programs by prorating these recommendations accordingly, i.e., twenty minutes of outdoor play for every three hours in the facility.

Active play should never be withheld from children who misbehave (e.g., child is kept indoors to help another caregiver/teacher while the rest of the children go outside) (5). However, children with out-of-control behavior may need five minutes or less to calm themselves or settle down before resuming cooperative play or activities.

Infants should not be seated for more than fifteen minutes at a time, except during meals or naps. Infant equipment such as swings, stationary activity centers (ex. exersaucers), infant seats (ex. bouncers), molded seats, etc. if used should only be used for short periods of time. A least restrictive environment should be encouraged at all times (5,6,26).

Children should have adequate space for both inside and outside play.

### **Standard 3.1.3.2 Playing Outdoors**

Children should play outdoors when the conditions do not pose a safety risk, individual child health risk, or significant health risk of frostbite or of heat related illness. Caregivers/teachers must protect children from harm caused by adverse weather, ensuring that children wear appropriate clothing and/or appropriate shelter is provided for the weather conditions. Outdoor play for infants may include riding in a carriage or stroller; however, infants should be offered opportunities for gross motor play outdoors, as well.

Weather that poses a significant health risk should include wind chill factor at or below minus 15°F and heat index at or above 90°F, as identified by the National Weather Service (NWS).

#### **Sunny weather:**

- a. Children should be protected from the sun by using shade, sun-protective clothing, and sunscreen with UVB-ray and UVA-ray protection of SPF 15 or higher, with permission from parents/guardians;
- b. Children should wear sun-protective clothing, such as hats, when playing outdoors between the hours of 10 AM and 2 PM.

#### **Warm weather:**

- a. Children should be well hydrated before engaging in prolonged periods of physical activity and encouraged to drink water during periods of prolonged physical activity;
- b. Caregivers/teachers should encourage parents/guardians to have children dress in clothing that is light-colored, lightweight, and limited to one layer of absorbent material that will maximize the evaporation of sweat;
- c. On hot days, infants receiving human milk in a bottle can be given additional human milk in a bottle but should not be given water, especially in the first six months of life. Infants receiving formula and water can be given additional formula in a bottle.

#### **Cold weather:**

- a. Children should wear layers of loose-fitting, lightweight clothing. Outer garments such as coats should be tightly woven, and be at least water repellent when precipitation is present, such as rain or snow;

- b. Children should wear a hat, coat, and gloves/mittens kept snug at the wrist;
- c. Caregivers/teachers should check children's extremities for maintenance of normal color and warmth at least every fifteen minutes.

Caregivers/teachers should also be aware of environmental hazards such as contaminated water, loud noises, and lead in soil when selecting an area to play outdoors. Children should be observed closely when playing in dirt/soil, so that no soil is ingested. Play areas should be secure and away from heavy traffic areas.

### **Standard 3.1.4.1 Safe Sleep Practices and SIDS/Suffocation Risk Reduction**

Facilities should develop a written policy that describes the practices to be used to promote safe sleep when infants are napping or sleeping. The policy should explain that these practices aim to reduce the risk of sudden infant death syndrome (SIDS) or suffocation death and other infant deaths that could occur when an infant is in a crib or asleep.

All staff, parents/guardians, volunteers and others approved to enter rooms where infants are cared for should receive a copy of the Safe Sleep Policy and additional educational information and training on the importance of consistent use of safe sleep policies and practices before they are allowed to care for infants (i.e., first day of employment/volunteering/subbing). Documentation that training has occurred and that these individuals have received and reviewed the written policy should be kept on file.

All staff, parents/guardians, volunteers and others who care for infants in the child care setting should follow these required safe sleep practices as recommended by the American Academy of Pediatrics (AAP) (1):

- a. Infants up to twelve months of age should be placed for sleep in a supine position (wholly on their back) for every nap or sleep time unless the infant's primary care provider has completed a signed waiver indicating that the child requires an alternate sleep position;
- b. Infants should be placed for sleep in safe sleep environments; which includes: a firm crib mattress covered by a tight-fitting sheet in a safety-approved crib (the crib should meet the standards and guidelines reviewed/approved by the U.S. Consumer Product Safety Commission [CPSC] and ASTM International [ASTM]), no monitors or positioning devices should be used unless required by the child's primary care provider, and no other items should be in a crib occupied by an infant except for a pacifier;
- c. Infants should not nap or sleep in a car safety seat, bean bag chair, bouncy seat, infant seat, swing, jumping chair, play pen or play yard, highchair, chair, futon, or any other type of

- furniture/equipment that is not a safety-approved crib (that is in compliance with the CPSC and ASTM safety standards) (4);
- d. If an infant arrives at the facility asleep in a car safety seat, the parent/guardian or caregiver/teacher should immediately remove the sleeping infant from this seat and place them in the supine position in a safe sleep environment (i.e., the infant's assigned crib);
  - e. If an infant falls asleep in any place that is not a safe sleep environment, staff should immediately move the infant and place them in the supine position in their crib;
  - f. Only one infant should be placed in each crib (stackable cribs are not recommended);
  - g. Soft or loose bedding should be kept away from sleeping infants and out of safe sleep environments. These include, but are not limited to: bumper pads, pillows, quilts, comforters, sleep positioning devices, sheepskins, blankets, flat sheets, cloth diapers, bibs, etc. Also, blankets/items should not be hung on the sides of cribs. Swaddling infants when they are in a crib is not necessary or recommended, but rather one-piece sleepers should be used (see Standard 3.1.4.2 for more detail information on swaddling);
  - h. Toys, including mobiles and other types of play equipment that are designed to be attached to any part of the crib should be kept away from sleeping infants and out of safe sleep environments;
  - i. When caregivers/teachers place infants in their crib for sleep, they should check to ensure that the temperature in the room is comfortable for a lightly clothed adult, check the infants to ensure that they are comfortably clothed (not overheated or sweaty), and that bibs, necklaces, and garments with ties or hoods are removed (clothing sacks or other clothing designed for sleep can be used in lieu of blankets);
  - j. Infants should be directly observed by sight and sound at all times, including when they are going to sleep, are sleeping, or are in the process of waking up;
  - k. Bedding should be changed between children, and if mats are used, they should be cleaned between uses.

The lighting in the room must allow the caregiver/teacher to see each infant's face, to view the color of the infant's skin, and to check on the infant's breathing and placement of the pacifier (if used).

A caregiver/teacher trained in safe sleep practices and approved to care for infants should be present in each room at all times where there is an infant. This caregiver/teacher should remain alert and should actively supervise sleeping infants in an ongoing manner. Also, the caregiver/teacher should check to ensure that the infant's head remains uncovered and re-adjust clothing as needed.

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The construction and use of sleeping rooms for infants separate from the infant group room is not recommended due to the need for direct supervision. In situations where there are existing facilities with separate sleeping rooms, facilities should develop a plan to modify room assignments and/or practices to eliminate placing infants to sleep in separate rooms.

Facilities should be aware of the current recommendation of the AAP about pacifier use (1). If pacifiers are allowed, facilities should have a written policy that describes relevant procedures and guidelines. Pacifier use outside of a crib in rooms and programs where there are mobile infants or toddlers is not recommended.

### **Standard 3.1.5.1 Routine Oral Hygiene Activities**

Caregivers/teachers should promote the habit of regular tooth brushing. All children with teeth should brush or have their teeth brushed at least once during the hours the child is in child care. Children under two years of age should have only a smear of fluoride toothpaste (rice grain) on the brush when brushing. Those over two years of age should use a pea-sized amount of fluoride toothpaste. An ideal time to brush is after eating. The caregiver/teacher should either brush the child's teeth or supervise as the child brushes his/her own teeth. Disposable gloves should be worn by the caregiver/teacher if contact with a child's oral fluids is anticipated. The younger the child, the more the caregiver/teacher needs to be involved. The caregiver/teacher should be able to evaluate each child's motor activity and to teach the child the correct method of tooth brushing when the child is capable of doing this activity. The caregiver/teacher should monitor the tooth brushing activity and thoroughly brush the child's teeth after the child has finished brushing, preferably for a total of two minutes. Children whose teeth are brushed at home twice a day may be exempted since additional brushing has little additive benefit and may expose a child to excess fluoride toothpaste.

The cavity-causing effect of frequent exposure to food or juice should be reduced by offering the children rinsing water after snacks and meals when tooth brushing is not possible. Local dental health professionals can facilitate compliance with these activities by offering education and training for the child care staff and providing oral health presentations for the children and parents/guardians.

### **Standard 3.2.1.4 Diaper Changing Procedure**

The following diaper changing procedure should be posted in the changing area, should be followed for all diaper changes, and should be used as part of staff evaluation of caregivers/teachers who diaper. The signage should be simple and should be in multiple languages if caregivers/teachers who speak multiple languages are involved in diapering. All employees who will diaper should undergo training and periodic assessment of diapering



practices. Caregivers/teachers should never leave a child unattended on a table or countertop, even for an instant. A safety strap or harness should not be used on the diaper changing table. If an emergency arises, caregivers/teachers should bring any child on an elevated surface to the floor or take the child with them.

An EPA-registered disinfectant suitable for the surface material that is being disinfected should be used. If an EPA-registered product is not available, then household bleach diluted with water is a practical alternative. All cleaning and disinfecting solutions should be stored to be accessible to the caregiver/teacher but out of reach of any child. Please refer to [Appendix J](#), *Selecting an Appropriate Sanitizer or Disinfectant*.

**Step 1: Get organized.** Before bringing the child to the diaper changing area, perform hand hygiene, gather and bring supplies to the diaper changing area:

- a. Non-absorbent paper liner large enough to cover the changing surface from the child's shoulders to beyond the child's feet;
- b. Unused diaper, clean clothes (if you need them);
- c. Wipes, dampened cloths or wet paper towels for cleaning the child's genitalia and buttocks readily available;
- d. A plastic bag for any soiled clothes or cloth diapers;
- e. Disposable gloves, if you plan to use them (put gloves on before handling soiled clothing or diapers) and remove them before handling clean diapers and clothing;
- f. A thick application of any diaper cream (e.g., zinc oxide ointment), when appropriate, removed from the container to a piece of disposable material such as facial or toilet tissue.

**Step 2: Carry the child to the changing table, keeping soiled clothing away from you and any surfaces you cannot easily clean and sanitize after the change.**

- a. Always keep a hand on the child;
- b. If the child's feet cannot be kept out of the diaper or from contact with soiled skin during the changing process, remove the child's shoes and socks so the child does not contaminate these surfaces with stool or urine during the diaper changing.

**Step 3: Clean the child's diaper area.**

- a. Place the child on the diaper change surface and unfasten the diaper, but leave the soiled diaper under the child;
- b. If safety pins are used, close each pin immediately once it is removed and keep pins out of the child's reach (never hold pins in your mouth);
- c. Lift the child's legs as needed to use disposable wipes, or a dampened cloth or wet paper towel to clean the skin on the child's

genitalia and buttocks and prevent recontamination from a soiled diaper. Remove stool and urine from front to back and use a fresh wipe, or a dampened cloth or wet paper towel each time you swipe. Put the soiled wipes or paper towels into the soiled diaper or directly into a plastic-lined, hands-free covered can. Reusable cloths should be stored in a washable, plastic-lined, tightly covered receptacle (within arm's reach of diaper changing tables) until they can be laundered. The cover should not require touching with contaminated hands or objects.

Step 4: Remove the soiled diaper and clothing without contaminating any surface not already in contact with stool or urine.

- a. Fold the soiled surface of the diaper inward;
- b. Put soiled disposable diapers in a covered, plastic-lined, hands-free covered can. If reusable cloth diapers are used, put the soiled cloth diaper and its contents (without emptying or rinsing) in a plastic bag or into a plastic-lined, hands-free covered can to give to parents/guardians or laundry service;
- c. Put soiled clothes in a plastic-lined, hands-free plastic bag;
- d. If gloves were used, remove them using the proper technique (see [Appendix D](#)) and put them into a plastic-lined, hands-free covered can;
- e. Whether or not gloves were used, use a fresh wipe to wipe the hands of the caregiver/teacher and another fresh wipe to wipe the child's hands. Put the wipes into the plastic-lined, hands-free covered can;
- f. Check for spills under the child. If there are any, use the paper that extends under the child's feet to fold over the soiled area so a fresh, unsoiled paper surface is now under the child's buttocks.

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

- a. Slide a fresh diaper under the child;
- b. Use a facial or toilet tissue or wear clean disposable glove to apply any necessary diaper creams, discarding the tissue or glove in a covered, plastic-lined, hands-free covered can;
- c. Note and plan to report any skin problems such as redness, skin cracks, or bleeding;
- d. Fasten the diaper; if pins are used, place your hand between the child and the diaper when inserting the pin.

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

- a. Use soap and warm water, between 60°F and 120°F, at a sink to wash the child's hands, if you can.

Step 7: Clean and disinfect the diaper-changing surface.

- a. Dispose of the disposable paper liner used on the diaper changing surface in a plastic-lined, hands-free covered can;
- b. If clothing was soiled, securely tie the plastic bag used to store the clothing and send home;
- c. Remove any visible soil from the changing surface with a disposable paper towel saturated with water and detergent, rinse;
- d. Wet the entire changing surface with a disinfectant that is appropriate for the surface material you are treating. Follow the manufacturer's instructions for use;
- e. Put away the disinfectant. Some types of disinfectants may require rinsing the change table surface with fresh water afterwards.

Step 8: Perform hand hygiene according to the procedure in Standard 3.2.2.2 and record the diaper change in the child's daily log.

- a. In the daily log, record what was in the diaper and any problems (such as a loose stool, an unusual odor, blood in the stool, or any skin irritation), and report as necessary (2).

### **Standard 3.2.2.1 Situations that Require Hand Hygiene**

All staff, volunteers, and children should follow the procedure in Standard 3.2.2.2 for hand hygiene at the following times:

- a. Upon arrival for the day, after breaks, or when moving from one child care group to another;
- b. Before and after:
  1. Preparing food or beverages;
  2. Eating, handling food, or feeding a child;
  3. Giving medication or applying a medical ointment or cream in which a break in the skin (e.g., sores, cuts, or scrapes) may be encountered;
  4. Playing in water (including swimming) that is used by more than one person;
  5. Diapering;
- c. After:
  1. Using the toilet or helping a child use a toilet;
  2. Handling bodily fluid (mucus, blood, vomit), from sneezing, wiping and blowing noses, from mouths, or from sores;
  3. Handling animals or cleaning up animal waste;
  4. Playing in sand, on wooden play sets, and outdoors;
  5. Cleaning or handling the garbage.

Situations or times that children and staff should perform hand hygiene should be posted in all food preparation, hand hygiene, diapering, and toileting areas.

### **Standard 3.2.2.2 Handwashing Procedure**

Children and staff members should wash their hands using the following method:

- a. Check to be sure a clean, disposable paper (or single-use cloth) towel is available;
- b. Turn on warm water, between 60°F and 120°F, to a comfortable temperature;
- c. Moisten hands with water and apply soap (not antibacterial) to hands;
- d. Rub hands together vigorously until a soapy lather appears, hands are out of the water stream, and continue for at least twenty seconds (sing Happy Birthday silently twice) (2). Rub areas between fingers, around nail beds, under fingernails, jewelry, and back of hands. Nails should be kept short; acrylic nails should not worn (3);
- e. Rinse hands under running water, between 60°F and 120°F, until they are free of soap and dirt. Leave the water running while drying hands;
- f. Dry hands with the clean, disposable paper or single use cloth towel;
- g. If taps do not shut off automatically, turn taps off with a disposable paper or single use cloth towel;
- h. Throw the disposable paper towel into a lined trash container; or place single-use cloth towels in the laundry hamper; or hang individually labeled cloth towels to dry. Use hand lotion to prevent chapping of hands, if desired.

The use of alcohol based hand sanitizers is an alternative to traditional handwashing with soap and water by children over twenty-four months of age and adults on hands that are not visibly soiled. A single pump of an alcohol-based sanitizer should be dispensed. Hands should be rubbed together, distributing sanitizer to all hand and finger surfaces and hands should be permitted to air dry.

Situations/times that children and staff should wash their hands should be posted in all handwashing areas.

Use of antimicrobial soap is not recommended in child care settings. There are no data to support use of antibacterial soaps over other liquid soaps.

Children and staff who need to open a door to leave a bathroom or diaper changing area should open the door with a disposable towel to avoid possibly re-contaminating clean hands. If a child can not open the door or turn off the faucet, they should be assisted by an adult.

### **Standard 3.2.2.3 Assisting Children with Hand Hygiene**

Caregivers/teachers should provide assistance with handwashing at a sink for infants who can be safely cradled in one arm and for children who can stand but not wash their hands independently. A child who can stand should either use a child-height sink or stand on a safety step at a height at which the child's hands can hang freely under the running water. After assisting the child with handwashing, the staff member should wash his or her own hands. Hand hygiene with an alcohol-based sanitizer is an alternative to handwashing with soap and water by children over twenty-four months of age and adults when there is no visible soiling of hands (1).

### **Standard 3.2.3.4 Prevention of Exposure to Blood and Body Fluids**

Child care facilities should adopt the use of Standard Precautions developed for use in hospitals by The Centers for Disease Control and Prevention (CDC). Standard Precautions should be used to handle potential exposure to blood, including blood-containing body fluids and tissue discharges, and to handle other potentially infectious fluids.

In child care settings:

- a. Use of disposable gloves is optional unless blood or blood containing body fluids may contact hands. Gloves are not required for feeding human milk, cleaning up of spills of human milk, or for diapering;
- b. Gowns and masks are not required;
- c. Barriers to prevent contact with body fluids include moisture-resistant disposable diaper table paper, disposable gloves, and eye protection.

Caregivers/teachers are required to be educated regarding Standard Precautions to prevent transmission of bloodborne pathogens before beginning to work in the facility and at least annually thereafter. Training must comply with requirements of the Occupational Safety and Health Administration (OSHA).

Procedures for Standard Precautions should include:

- a. Surfaces that may come in contact with potentially infectious body fluids must be disposable or of a material that can be disinfected. Use of materials that can be sterilized is not required.
- b. The staff should use barriers and techniques that:
  1. Minimize potential contact of mucous membranes or openings in skin to blood or other potentially infectious body fluids and tissue discharges; and
  2. Reduce the spread of infectious material within the child care facility. Such techniques include avoiding touching

surfaces with potentially contaminated materials unless those surfaces are disinfected before further contact occurs with them by other objects or individuals.

- c. When spills of body fluids, urine, feces, blood, saliva, nasal discharge, eye discharge, injury or tissue discharges occur, these spills should be cleaned up immediately, and further managed as follows:
  3. For spills of vomit, urine, and feces, all floors, walls, bathrooms, tabletops, toys, furnishings and play equipment, kitchen counter tops, and diaper-changing tables in contact should be cleaned and disinfected as for the procedure for diaper changing tables in Standard 3.2.1.4, Step 7;
  4. For spills of blood or other potentially infectious body fluids, including injury and tissue discharges, the area should be cleaned and disinfected. Care should be taken and eye protection used to avoid splashing any contaminated materials onto any mucous membrane (eyes, nose, mouth);
  5. Blood-contaminated material and diapers should be disposed of in a plastic bag with a secure tie;
  6. Floors, rugs, and carpeting that have been contaminated by body fluids should be cleaned by blotting to remove the fluid as quickly as possible, then disinfected by spot-cleaning with a detergent-disinfectant. Additional cleaning by shampooing or steam cleaning the contaminated surface may be necessary. Caregivers/teachers should consult with local health departments for additional guidance on cleaning contaminated floors, rugs, and carpeting.

Prior to using a disinfectant, clean the surface with a detergent and rinse well with water. Facilities should follow the manufacturer's instruction for preparation and use of disinfectant (3,4). For guidance on disinfectants, refer to [Appendix J](#), Selecting an Appropriate Sanitizer or Disinfectant.

If blood or bodily fluids enter a mucous membrane (eyes, nose, mouth) the following procedure should occur. Flush the exposed area thoroughly with water. The goal of washing or flushing is to reduce the amount of the pathogen to which an exposed individual has contact. The optimal length of time for washing or flushing an exposed area is not known. Standard practice for managing mucous membrane(s) exposures to toxic substances is to flush the affected area for at least fifteen to twenty minutes. In the absence of data to support the effectiveness of shorter periods of flushing it seems prudent to use the same fifteen to twenty minute standard following exposure to bloodborne pathogens (5).

### **Standard 3.3.0.1 Routine Cleaning, Sanitizing, and Disinfecting**

Keeping objects and surfaces in a child care setting as clean and free of pathogens as possible requires a combination of:

- a. Frequent cleaning; and
- b. When necessary, an application of a sanitizer or disinfectant.

Facilities should follow a routine schedule of cleaning, sanitizing, and disinfecting as outlined in [Appendix K](#), Routine Schedule for Cleaning, Sanitizing, and Disinfecting.

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.

### **Standard 3.4.1.1 Use of Tobacco, Alcohol, and Illegal Drugs**

Tobacco use, alcohol, and illegal drugs should be prohibited on the premises of the program (both indoor and outdoor environments) and in any vehicles used by the program at all times. Caregivers/teachers should not use tobacco, alcohol, or illegal drugs off the premises during the child care program's paid time including break time.

### **Standard 3.4.3.1 Emergency Procedures**

When an immediate emergency medical response is required, the following emergency procedures should be utilized:

- a. First aid should be employed and an emergency medical response team should be called such as 9-1-1 and/or the poison center if a poison emergency (1-800-222-1222);
- b. The program should implement a plan for emergency transportation to a local emergency medical facility;
- c. The parent/guardian or parent/guardian's emergency contact person should be called as soon as practical;
- d. A staff member should accompany the child to the hospital and will stay with the child until the parent/guardian or emergency contact person arrives. Child to staff ratio must be maintained, so staff may need to be called in to maintain the required ratio.

Programs should develop contingency plans for emergencies or disaster situations when it may not be possible or feasible to follow standard or previously agreed upon emergency procedures (see also Standard 9.2.4.3, Disaster Planning, Training, and Communication). Children with known medical conditions that might involve emergent care require a Care Plan created by the child's primary care provider. All staff need to be trained to manage an emergency until emergency medical care becomes available.

### **Standard 3.4.3.3 Response to Fire and Burns**

Children who are developmentally able to understand, should be instructed to STOP, DROP, and ROLL when garments catch fire. Children should be instructed to crawl on the floor under the smoke if necessary when they evacuate the building. This instruction is part of ongoing health and safety education and fire drills/exercise.

Cool water should be applied to burns immediately. The injury should be covered with a loose bandage or clean, dry cloth. Medical assessment/care should be immediate.

### **Standard 3.4.4.1 Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation**

Each facility should have a written policy for reporting child abuse and neglect. Caregivers/teachers are mandated reporters of child abuse and neglect. The facility should report to the child abuse reporting hotline, department of social services, child protective services, or police as required by state and local laws, in any instance where there is reasonable cause to believe that child abuse and neglect has occurred. Every staff person should be oriented to what and how to report. Phone numbers and reporting system as required by state or local agencies should be clearly posted by every phone.

Caregivers/teachers should receive initial and ongoing training to assist them in preventing child abuse and neglect and in recognizing signs of child abuse and neglect. Programs are encouraged to partner with primary care providers, child care health consultants and/or child protection advocates to provide training and to be available for consultation.

Employees and volunteers in centers and large family child care homes should receive an instruction sheet about child abuse and neglect reporting that contains a summary of the state child abuse reporting statute and a statement that they will not be discharged/disciplined solely because they have made a child abuse and neglect report. Some states have specific forms that are required to be completed when abuse and neglect is reported. Some states have forms that are not required but assist mandated reporters in documenting accurate and thorough reports. In those states, facilities should have such forms on hand and all staff should be trained in the appropriate use of those forms.

Parents/guardians should be notified upon enrollment of the facility's child abuse and neglect reporting requirement and procedures.

### **Standard 3.4.4.3 Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma**

All child care facilities should have a policy and procedure to identify and prevent shaken baby syndrome/abusive head trauma. All



caregivers/teachers who are in direct contact with children including substitute caregivers/teachers and volunteers, should receive training on preventing shaken baby syndrome/abusive head trauma, recognition of potential signs and symptoms of shaken baby syndrome/abusive head trauma, strategies for coping with a crying, fussing or distraught child, and the development and vulnerabilities of the brain in infancy and early childhood.

**TYPE OF FACILITY:** Center

### **Standard 3.4.5.1 Sun Safety Including Sunscreen**

Caregivers/teachers should implement the following procedures to ensure sun safety for themselves and the children under their supervision:

- a. Keep infants younger than six months out of direct sunlight. Find shade under a tree, umbrella, or the stroller canopy;
- b. Wear a hat or cap with a brim that faces forward to shield the face;
- c. Limit sun exposure between 10 AM and 2 PM, when UV rays are strongest;
- d. Wear child safe shatter resistant sunglasses with at least 99% UV protection;
- e. Apply sunscreen (1).

Over-the-counter ointments and creams, such as sunscreen that are used for preventive purposes do not require a written authorization from a primary care provider with prescriptive authority. However, parent/guardian written permission is required, and all label instructions must be followed. If the skin is broken or an allergic reaction is observed, caregivers/teachers should discontinue use and notify the parent/guardian.

If parents/guardians give permission, sunscreen should be applied on all exposed areas, especially the face (avoiding the eye area), nose, ears, feet, and hands and rubbed in well especially from May through September. Sunscreen is needed on cloudy days and in the winter at high altitudes. Sun reflects off water, snow, sand, and concrete. “Broad spectrum” sunscreen will screen out both UVB and UVA rays. Use sunscreen with an SPF of 15 or higher, the higher the SPF the more UVB protection offered. UVA protection is designated by a star rating system, with four stars the highest allowed in an over-the-counter product.

Sunscreen should be applied thirty minutes before going outdoors as it needs time to absorb into the skin. If the children will be out for more than one hour, sunscreen will need to be reapplied every two hours as it can wear off. If children are playing in water, reapplication will be needed more frequently. Children should also be protected from the sun by using shade and sun protective clothing. Sun exposure should be limited between the hours of 10 AM and 2 PM when the sun’s rays are the strongest.

Sunscreen should be applied to the child at least once by the parents/guardians and the child observed for a reaction to the sunscreen prior to its use in child care.

### **Standard 3.4.6.1 Strangulation Hazards**

Strings and cords (such as those that are parts of toys and those found on window coverings) long enough to encircle a child's neck should not be accessible to children in child care. Miniblinds and venetian blinds should not have looped cords. Vertical blinds, continuous looped blinds, and drapery cords should have tension or tie-down devices to hold the cords tight. Inner cord stops should be installed. Shoulder straps on guitars and chin straps on hats should be removed (1).

Straps/handles on purses/bags used for dramatic play should be removed or shortened. Ties, scarves, necklaces, and boas used for dramatic play should not be used for children under three years. If used by children three years and over, children should be supervised.

Pacifiers attached to strings or ribbons should not be placed around infants' necks or attached to infants' clothing.

Hood and neck strings from all children's outerwear, including jackets and sweatshirts, should be removed. Drawstrings on the waist or bottom of garments should not extend more than three inches outside the garment when it is fully expanded. These strings should have no knots or toggles on the free ends. The drawstring should be sewn to the garment at its midpoint so the string cannot be pulled out through one side.

### **Standard 3.5.0.1 Care Plan for Children with Special Health Care Needs**

Reader's Note: Children with special health care needs are defined as "...those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally" (1).

Any child who meets these criteria should have a Routine and Emergent Care Plan completed by their primary care provider in their medical home. In addition to the information specified in Standard 9.4.2.4 for the Health Report, there should be:

- a. A list of the child's diagnosis/diagnoses;
- b. Contact information for the primary care provider and any relevant sub-specialists (i.e., endocrinologists, oncologists, etc.);
- c. Medications to be administered on a scheduled basis;
- d. Medications to be administered on an emergent basis with clearly stated parameters, signs, and symptoms that warrant giving the medication written in lay language;

- e. Procedures to be performed;
- f. Allergies;
- g. Dietary modifications required for the health of the child;
- h. Activity modifications;
- i. Environmental modifications;
- j. Stimulus that initiates or precipitates a reaction or series of reactions (triggers) to avoid;
- k. Symptoms for caregiver/teachers to observe;
- l. Behavioral modifications;
- m. Emergency response plans – both if the child has a medical emergency and special factors to consider in programmatic emergency, like a fire;
- n. Suggested special skills training and education for staff.

A template for a Care Plan for children with special health care needs is provided in [Appendix O](#).

The Care Plan should be updated after every hospitalization or significant change in health status of the child. The Care Plan is completed by the primary care provider in the medical home with input from parents/guardians, and it is implemented in the child care setting. The child care health consultant should be involved to assure adequate information, training, and monitoring is available for child care staff.

### **Standard 3.5.0.2 Caring for Children Who Require Medical Procedures**

A facility that enrolls children who require the following medical procedures: tube feedings, endotracheal suctioning, supplemental oxygen, postural drainage, or catheterization daily (unless the child requiring catheterization can perform this function on his/her own), checking blood sugars or any other special medical procedures performed routinely, or who might require special procedures on an urgent basis, should receive a written plan of care from the primary care provider who prescribed the special treatment (such as a urologist for catheterization). Often, the child's primary care provider may be able to provide this information. This plan of care should address any special preparation to perform routine and/or urgent procedures (other than those that might be required in an emergency for any typical child, such as cardiopulmonary resuscitation [CPR]). This plan of care should include instructions for how to receive training in performing the procedure, performing the procedure, a description of common and uncommon complications of the procedure, and what to do and who to notify if complications occur. Specific/relevant training for the child care staff should be provided by a qualified health care professional in accordance with state practice acts. Facilities should follow state laws where such laws require RN's or LPN's under RN supervision to perform certain medical procedures. Updated, written medical orders are required for nursing procedures.

### **Standard 3.6.1.1 Inclusion/Exclusion/Dismissal of Children**

(Adapted from: Aronson, S. S., T. R. Shope, eds. 2009. Managing infectious diseases in child care and schools: A quick reference guide, 39-43. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics.)

Preparing for managing illness:

Caregivers/teachers should:

- a. Encourage all families to have a backup plan for child care in the event of short or long term exclusion;
- b. Review with families the inclusion/exclusion criteria and clarify that the program staff (not the families) will make the final decision about whether children who are ill may stay based on the program's inclusion/exclusion criteria and their ability to care for the child who is ill without compromising the care of other children in the program;
- c. Develop, with a child care health consultant, protocols and procedures for handling children's illnesses, including care plans and an inclusion/exclusion policy;
- d. Request the primary care provider's note to readmit a child if the primary care provider's advice is needed to determine whether the child is a health risk to others, or if the primary care provider's guidance is needed about any special care the child requires (1);
- e. Rely on the family's description of the child's behavior to determine whether the child is well enough to return, unless the child's status is unclear from the family's report.

Daily health checks as described in Standard 3.1.1.1 should be performed upon arrival of each child each day. Staff should objectively determine if the child is ill or well. Staff should determine which children with mild illnesses can remain in care and which need to be excluded.

Staff should notify the parent/guardian when a child develops new signs or symptoms of illness. Parent/guardian notification should be immediate for emergency or urgent issues. Staff should notify parents/guardians of children who have symptoms that require exclusion and parents/guardians should remove the child from the child care setting as soon as possible. For children whose symptoms do not require exclusion, verbal or written notification of the parent/guardian at the end of the day is acceptable. Most conditions that require exclusion do not require a primary care provider visit before reentering care.

Conditions/symptoms that do not require exclusion:

- a. Common colds, runny noses (regardless of color or consistency of nasal discharge);

- b. A cough not associated with a infectious disease (such as pertussis) or a fever;
- c. Watery, yellow or white discharge or crusting eye discharge without fever, eye pain, or eyelid redness;
- d. Yellow or white eye drainage that is not associated with pink or red conjunctiva (i.e., the whites of the eyes);
- e. Pink eye (bacterial conjunctivitis) indicated by pink or red conjunctiva with white or yellow eye mucous drainage and matted eyelids after sleep. Parents/guardians should discuss care of this condition with their child's primary care provider, and follow the primary care provider's advice. Some primary care providers do not think it is necessary to examine the child if the discussion with the parents/guardians suggests that the condition is likely to be self-limited. If two unrelated children in the same program have conjunctivitis, the organism causing the conjunctivitis may have a higher risk for transmission and a child health care professional should be consulted;
- f. Fever without any signs or symptoms of illness in children who are older than six months regardless of whether acetaminophen or ibuprofen was given. Fever (temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) is an indication of the body's response to something, but is neither a disease nor a serious problem by itself. Body temperature can be elevated by overheating caused by overdressing or a hot environment, reactions to medications, and response to infection. If the child is behaving normally but has a fever of below 102°F per rectum or the equivalent, the child should be monitored, but does not need to be excluded for fever alone;
- g. Rash without fever and behavioral changes;
- h. Lice or nits (exclusion for treatment of an active lice infestation may be delayed until the end of the day);
- i. Ringworm (exclusion for treatment may be delayed until the end of the day);
- j. Molluscum contagiosum (do not require exclusion or covering of lesions);
- k. Thrush (i.e., white spots or patches in the mouth or on the cheeks or gums);
- l. Fifth disease (slapped cheek disease, parvovirus B19) once the rash has appeared;
- m. Methicillin-resistant *Staphylococcus aureus*, or MRSA, without an infection or illness that would otherwise require exclusion. Known MRSA carriers or colonized individuals should not be excluded;
- n. Cytomegalovirus infection;
- o. Chronic hepatitis B infection;
- p. Human immunodeficiency virus (HIV) infection;

- q. Asymptomatic children who have been previously evaluated and found to be shedding potentially infectious organisms in the stool. Children who are continent of stool or who are diapered with formed stools that can be contained in the diaper may return to care. For some infectious organisms, exclusion is required until certain guidelines have been met. Note: These agents are not common and caregivers/teachers will usually not know the cause of most cases of diarrhea;
- r. Children with chronic infectious conditions that can be accommodated in the program according to the legal requirement of federal law in the Americans with Disabilities Act. The act requires that child care programs make reasonable accommodations for children with disabilities and/or chronic illnesses, considering each child individually.

Key criteria for exclusion of children who are ill:

When a child becomes ill but does not require immediate medical help, a determination must be made regarding whether the child should be sent home (i.e., should be temporarily “excluded” from child care). Most illnesses do not require exclusion. The caregiver/teacher should determine if the illness:

- a. Prevents the child from participating comfortably in activities;
- b. Results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;
- c. Poses a risk of spread of harmful diseases to others.

If any of the above criteria are met, the child should be excluded, regardless of the type of illness. The child should be removed from direct contact with other children and should be monitored and supervised by a single staff member known to the child until dismissed from care to the care of a parent/guardian or a primary care provider. The area should be where the toys, equipment, and surfaces will not be used by other children or adults until after the ill child leaves and after the surfaces and toys have been cleaned and disinfected.

Temporary exclusion is recommended when the child has any of the following conditions:

- a. The illness prevents the child from participating comfortably in activities;
- b. The illness results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;
- c. An acute change in behavior      this could include lethargy/lack of responsiveness, irritability, persistent crying, difficult breathing, or having a quickly spreading rash;

- d. Fever (temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea). An unexplained temperature above 100°F (37.8°C) axillary (armpit) or 101°F (38.3°C) rectally in a child younger than six months should be medically evaluated. Any infant younger than two months of age with any fever should get urgent medical attention. See COMMENTS Below for important information about taking temperatures;
- e. Diarrhea is defined by watery stools or decreased form of stool that is not associated with changes of diet. Exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing soiled pants or clothing. In addition, diapered children with diarrhea should be excluded if the stool frequency exceeds two or more stools above normal for that child, because this may cause too much work for the caregivers/teachers. Readmission after diarrhea can occur when diapered children have their stool contained by the diaper (even if the stools remain loose) and when toilet-trained children are continent. Special circumstances that require specific exclusion criteria include the following (2):
  - 1. Toxin-producing *E. coli* or *Shigella* infection, until stools are formed and the test results of two stool cultures obtained from stools produced twenty-four hours apart do not detect these organisms;
  - 2. *Salmonella* serotype Typhi infection, until diarrhea resolves. In children younger than five years with *Salmonella* serotype Typhi, three negative stool cultures obtained with twenty-four-hour intervals are required; people five years of age or older may return after a twenty-four-hour period without a diarrheal stool. Stool cultures should be collected from other attendees and staff members, and all infected people should be excluded;
- f. Blood or mucus in the stools not explained by dietary change, medication, or hard stools;
- g. Vomiting more than two times in the previous twenty-four hours, unless the vomiting is determined to be caused by a non-infectious condition and the child remains adequately hydrated;
- h. Abdominal pain that continues for more than two hours or intermittent pain associated with fever or other signs or symptoms of illness;
- i. Mouth sores with drooling unless the child's primary care provider or local health department authority states that the child is noninfectious;

- j. Rash with fever or behavioral changes, until the primary care provider has determined that the illness is not a infectious disease;
- k. Active tuberculosis, until the child's primary care provider or local health department states child is on appropriate treatment and can return;
- l. Impetigo, until treatment has been started;
- m. Streptococcal pharyngitis (i.e., strep throat or other streptococcal infection), until twenty-four hours after treatment has been started;
- n. Head lice until after the first treatment (note: exclusion is not necessary before the end of the program day);
- o. Scabies, until after treatment has been given;
- p. Chickenpox (varicella), until all lesions have dried or crusted (usually six days after onset of rash);
- q. Rubella, until six days after the rash appears;
- r. Pertussis, until five days of appropriate antibiotic treatment;
- s. Mumps, until five days after onset of parotid gland swelling;
- t. Measles, until four days after onset of rash;
- u. Hepatitis A virus infection, until one week after onset of illness or jaundice if the child's symptoms are mild or as directed by the health department. (Note: immunization status of child care contacts should be confirmed; within a fourteen-day period of exposure, incompletely immunized or unimmunized contacts from one through forty years of age should receive the hepatitis A vaccine as post exposure prophylaxis, unless contraindicated.) Other individuals may receive immune globulin. Consult with a primary care provider for dosage and recommendations;
- v. Any child determined by the local health department to be contributing to the transmission of illness during an outbreak.

Procedures for a child who requires exclusion:

The caregiver/teacher will:

- a. Provide care for the child in a place where the child will be comfortable and supervised by someone who knows the child well and who will continue to observe the child for new or worsening symptoms. A potentially contagious child should be separated from other children by at least three feet. Each facility should have a predetermined physical location(s) where an ill child(ren) could be placed until care can be transferred to a parent/guardian or primary care provider;
- b. Ask the family to pick up the child as soon as possible;
- c. Discuss the signs and symptoms of illness with the parent/guardian who is assuming care. Review guidelines for return to child care. If necessary, provide the family with a written communication that may be given to the primary care provider. The communication should include onset time of symptoms,



observations about the child, vital signs and times (e.g., temperature 101.5°F at 10:30 AM) and any actions taken and the time actions were taken (e.g., one children's acetaminophen given at 11:00 AM). The nature and severity of symptoms and or requirements of the local or state health department will determine the necessity of medical consultation. Telephone advice, electronic transmissions of instructions are acceptable without an office visit;

- d. Follow the advice of the child's primary care provider;
- e. Contact the local health department if there is a question of a reportable (harmful) infectious disease in a child or staff member in the facility. If there are conflicting opinions from different primary care providers about the management of a child with a reportable infectious disease, the health department has the legal authority to make a final determination;
- f. Document actions in the child's file with date, time, symptoms, and actions taken (and by whom); sign and date the document;
- g. In collaboration with the local health department, notify the parents of contacts to the child or staff member with presumed or confirmed reportable infectious infection.

The caregiver/teacher should make the decision about whether a child meets or does not meet the exclusion criteria for participation and the child's need for care relative to the staff's ability to provide care. If parents/guardians and the child care staff disagree, and the reason for exclusion relates to the child's ability to participate or the caregiver's/teacher's ability to provide care for the other children, the caregiver/teacher should not be required to accept responsibility for the care of the child.

Reportable conditions:

The current list of infectious diseases designated as notifiable in the United States at the national level by the Centers for Disease Control and Prevention (CDC) are listed at [http://www.cdc.gov/osels/ph\\_surveillance/](http://www.cdc.gov/osels/ph_surveillance/).

The caregiver/teacher should contact the local health department:

- a. When a child or staff member who is in contact with others has a reportable disease;
- b. If a reportable illness occurs among the staff, children, or families involved with the program;
- c. For assistance in managing a suspected outbreak. Generally, an outbreak can be considered to be two or more unrelated (e.g., not siblings) children with the same diagnosis or symptoms in the same group within one week. Clusters of mild respiratory illness, ear infections, and certain dermatological conditions are common and generally do not need to be reported.

Caregivers/teachers should work with their child care health consultants to develop policies and procedures for alerting staff and families about their responsibility to report illnesses to the program and for the program to report diseases to the local health authorities.

### **Standard 3.6.1.2 Staff Exclusion for Illness**

Please note that if a staff member has no contact with the children, or with anything with which the children come into contact, this standard may not apply to that staff member.

A facility should not deny admission to or send home a staff member or substitute with illness unless one or more of the following conditions exists. The staff member should be excluded as follows:

- a. Chickenpox, until all lesions have dried and crusted, which usually occurs by six days;
- b. Shingles, only if the lesions cannot be covered by clothing or a dressing until the lesions have crusted;
- c. Rash with fever or joint pain, until diagnosed not to be measles or rubella;
- d. Measles, until four days after onset of the rash (if the staff member or substitute is immunocompetent);
- e. Rubella, until six days after onset of rash;
- f. Diarrheal illness, stool frequency exceeds two or more stools above normal for that individual or blood in stools, until diarrhea resolves; if *E. coli* 0157:H7 or *Shigella* is isolated, until diarrhea resolves and two stool cultures are negative, for *Salmonella* serotype *Typhi*, three stool cultures collected at twenty-four hour intervals and resolution of diarrhea is required;
- g. Vomiting illness, two or more episodes of vomiting during the previous twenty-four hours, until vomiting resolves or is determined to result from non-infectious conditions;
- h. Hepatitis A virus, until one week after symptom onset or as directed by the health department;
- i. Pertussis, until after five days of appropriate antibiotic therapy;
- j. Skin infection (such as impetigo), until treatment has been initiated; exclusion should continue if lesion is draining AND cannot be covered;
- k. Tuberculosis, until noninfectious and cleared by a health department official or a primary care provider;
- l. Strep throat or other streptococcal infection, until twenty-four hours after initial antibiotic treatment and end of fever;
- m. Head lice, from the end of the day of discovery until after the first treatment;
- n. Scabies, until after treatment has been completed;
- o. *Haemophilus influenzae* type b (Hib), prophylaxis, until antibiotic treatment has been initiated;

- p. Meningococcal infection, until appropriate therapy has been administered for twenty-four hours;
- q. 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 the children.

Caregivers/teachers who have herpes cold sores should not be excluded from the child care facility, but should:

1. Cover and not touch their lesions;
2. Carefully observe hand hygiene policies.

### **Standard 3.6.1.4 Infectious Disease Outbreak Control**

During the course of an identified outbreak of any reportable illness at the facility, a child or staff member should be excluded if the health department official or primary care provider suspects that the child or staff member is contributing to transmission of the illness at the facility, is not adequately immunized when there is an outbreak of a vaccine preventable disease, or the circulating pathogen poses an increased risk to the individual. The child or staff member should be readmitted when the health department official or primary care provider who made the initial determination decides that the risk of transmission is no longer present.

### **Standard 3.6.3.1 Medication Administration**

The administration of medicines at the facility should be limited to:

- a. Prescription or non-prescription medication (over-the-counter [OTC]) ordered by the prescribing health professional for a specific child with written permission of the parent/guardian. Written orders from the prescribing health professional should specify medical need, medication, dosage, and length of time to give medication;
- b. Labeled medications brought to the child care facility by the parent/guardian in the original container (with a label that includes the child's name, date filled, prescribing clinician's name, pharmacy name and phone number, dosage/instructions, and relevant warnings).

Facilities should not administer folk or homemade remedy medications or treatment. Facilities should not administer a medication that is prescribed for one child in the family to another child in the family.

No prescription or non-prescription medication (OTC) should be given to any child without written orders from a prescribing health professional and written permission from a parent/guardian. Exception: Non-prescription sunscreen and insect repellent always require parental consent but do not require instructions from each child's prescribing health professional.

Documentation that the medicine/agent is administered to the child as prescribed is required.

“Standing orders” guidance should include directions for facilities to be equipped, staffed, and monitored by the primary care provider capable of having the special health care plan modified as needed. Standing orders for medication should only be allowed for individual children with a documented medical need if a special care plan is provided by the child’s primary care provider in conjunction with the standing order or for OTC medications for which a primary care provider has provided specific instructions that define the children, conditions and methods for administration of the medication. Signatures from the primary care provider and one of the child’s parents/guardians must be obtained on the special care plan. Care plans should be updated as needed, but at least yearly.

### **Standard 3.6.3.2 Labeling, Storage, and Disposal of Medications**

Any prescription medication should be dated and kept in the original container. The container should be labeled by a pharmacist with:

- The child’s first and last names;
- The date the prescription was filled;
- The name of the prescribing health professional who wrote the prescription, the medication’s expiration date;
- The manufacturer’s instructions or prescription label with specific, legible instructions for administration, storage, and disposal;
- The name and strength of the medication.

Over-the-counter medications should be kept in the original container as sold by the manufacturer, labeled by the parent/guardian, with the child’s name and specific instructions given by the child’s prescribing health professional for administration.

All medications, refrigerated or unrefrigerated, should:

- Have child-resistant caps;
- Be kept in an organized fashion;
- Be stored away from food;
- Be stored at the proper temperature;
- Be completely inaccessible to children.

Medication should not be used beyond the date of expiration. Unused medications should be returned to the parent/guardian for disposal. In the event medication cannot be returned to the parent or guardian, it should be disposed of according to the recommendations of the US Food and Drug Administration (FDA) (1). Documentation should be kept with the child care facility of all disposed medications. The current guidelines are as follows:

- a. If a medication lists any specific instructions on how to dispose of it, follow those directions.
- b. If there are community drug take back programs, participate in those.
- c. Remove medications from their original containers and put them in a sealable bag. Mix medications with an undesirable substance such as used coffee grounds or kitty litter. Throw the mixture into the regular trash. Make sure children do not have access to the trash (1).

### **Standard 3.6.3.3 Training of Caregivers/Teachers to Administer Medication**

Any caregiver/teacher who administers medication should complete a standardized training course that includes skill and competency assessment in medication administration. The trainer in medication administration should be a licensed health professional. The course should be repeated according to state and/or local regulation. At a minimum, skill and competency should be monitored annually or whenever medication administration error occurs. In facilities with large numbers of children with special health care needs involving daily medication, best practice would indicate strong consideration to the hiring of a licensed health care professional. Lacking that, caregivers/teachers should be trained to:

- a. Check that the name of the child on the medication and the child receiving the medication are the same;
- b. Check that the name of the medication is the same as the name of the medication on the instructions to give the medication if the instructions are not on the medication container that is labeled with the child's name;
- c. Read and understand the label/prescription directions or the separate written instructions in relation to the measured dose, frequency, route of administration (ex. by mouth, ear canal, eye, etc.) and other special instructions relative to the medication;
- d. Observe and report any side effects from medications;
- e. Document the administration of each dose by the time and the amount given;
- f. Document the person giving the administration and any side effects noted;
- g. Handle and store all medications according to label instructions and regulations.

The trainer in medication administration should be a licensed health professional: Registered Nurse, Advanced Practice Registered Nurse (APRN), MD, Physician's Assistant, or Pharmacist.

## Chapter 4: Nutrition and Food Service

### Standard 4.2.0.3 Use of USDA CACFP Guidelines

All meals and snacks and their preparation, service, and storage should meet the requirements for meals of the child care component of the U.S. Department of Agriculture (USDA), Child and Adult Care Food Program (CACFP), and the 7 Code of Federal Regulations (CFR) Part 226.20 (1,5).

### Standard 4.2.0.6 Availability of Drinking Water

Clean, sanitary drinking water should be readily available, in indoor and outdoor areas, throughout the day. Water should not be a substitute for milk at meals or snacks where milk is a required food component unless it is recommended by the child's primary care provider.

On hot days, infants receiving human milk in a bottle can be given additional human milk in a bottle but should not be given water, especially in the first six months of life. Infants receiving formula and water can be given additional formula in a bottle. Toddlers and older children will need additional water as physical activity and/or hot temperatures cause their needs to increase. Children should learn to drink water from a cup or drinking fountain without mouthing the fixture. They should not be allowed to have water continuously in hand in a "sippy cup" or bottle. Permitting toddlers to suck continuously on a bottle or sippy cup filled with water, in order to soothe themselves, may cause nutritional or in rare instances, electrolyte imbalances. When tooth brushing is not done after a feeding, children should be offered water to drink to rinse food from their teeth.

### Standard 4.2.0.8 Feeding Plans and Dietary Modifications

Before a child enters an early care and education facility, the facility should obtain a written history that contains any special nutrition or feeding needs for the child, including use of human milk or any special feeding utensils. The staff should review this history with the child's parents/guardians, clarifying and discussing how parental/guardian home feeding routines may differ from the facility's planned routine. The child's primary care provider should provide written information about any dietary modifications or special feeding techniques that are required at the early care and education program and these plans should be shared with the child's parents/guardians upon request.

If dietary modifications are indicated, based on a child's medical or special dietary needs, the caregiver/teacher should modify or supplement the child's diet to meet the individual child's specific needs. Dietary modifications should be made in consultation with the parents/guardians and the child's primary care provider. Caregivers/teachers can consult with a nutritionist/registered dietitian.

Reasons for modification of a child's diet may be related to food sensitivity. Food sensitivity includes a range of conditions in which a child exhibits an adverse reaction to a food that, in some instances, can be life threatening. Modification of a child's diet may be related to a food allergy, inability to digest or to tolerate certain foods, need for extra calories, need for special positioning while eating, diabetes and the need to match food with insulin, food idiosyncrasies, and other identified feeding issues. Examples include celiac disease, phenylketonuria, diabetes, severe food allergy (anaphylaxis), and others. In some cases, a child may become ill if the child is unable to eat, so missing a meal could have a negative consequence, especially for diabetics.

For a child identified with special health care needs for dietary modification or special feeding techniques, written instructions from the child's parent/guardian and the child's primary care provider should be provided in the child's record and carried out accordingly. Dietary modifications should be recorded. These written instructions must identify:

- a. The child's full name and date of instructions;
- b. The child's special needs;
- c. Any dietary restrictions based on the special needs;
- d. Any special feeding or eating utensils;
- e. Any foods to be omitted from the diet and any foods to be substituted;
- f. Limitations of life activities;
- g. Any other pertinent special needs information;
- h. What, if anything, needs to be done if the child is exposed to restricted foods.

The written history of special nutrition or feeding needs should be used to develop individual feeding plans and, collectively, to develop facility menus. Disciplines related to special nutrition needs, including nutrition, nursing, speech, occupational therapy, and physical therapy, should participate when needed and/or when they are available to the facility. The nutritionist/registered dietitian should approve menus that accommodate needed dietary modifications.

The feeding plan should include steps to take when a situation arises that requires rapid response by the staff, such as a child's choking during mealtime or a child with a known history of food allergies demonstrating signs and symptoms of anaphylaxis (severe allergic reaction, e.g., difficulty breathing or severe redness and swelling of the face or mouth). The completed plan should be on file and accessible to the staff and available to parents/guardians upon request.

### **Standard 4.2.0.10 Care for Children with Food Allergies**

When children with food allergies attend the early care and education facility, the following should occur:

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- a. Each child with a food allergy should have a care plan prepared for the facility by the child's primary care provider, to include:
  1. Written instructions regarding the food(s) to which the child is allergic and steps that need to be taken to avoid that food;
  2. A detailed treatment plan to be implemented in the event of an allergic reaction, including the names, doses, and methods of administration of any medications that the child should receive in the event of a reaction. The plan should include specific symptoms that would indicate the need to administer one or more medications;
- b. Based on the child's care plan, the child's caregivers/teachers should receive training, demonstrate competence in, and implement measures for:
  1. Preventing exposure to the specific food(s) to which the child is allergic;
  2. Recognizing the symptoms of an allergic reaction;
  3. Treating allergic reactions;
- c. Parents/guardians and staff should arrange for the facility to have necessary medications, proper storage of such medications, and the equipment and training to manage the child's food allergy while the child is at the early care and education facility;
- d. Caregivers/teachers should promptly and properly administer prescribed medications in the event of an allergic reaction according to the instructions in the care plan;
- e. The facility should notify the parents/guardians immediately of any suspected allergic reactions, the ingestion of the problem food, or contact with the problem food, even if a reaction did not occur;
- f. The facility should recommend to the family that the child's primary care provider be notified if the child has required treatment by the facility for a food allergic reaction;
- g. The facility should contact the emergency medical services system immediately whenever epinephrine has been administered;
- h. Parents/guardians of all children in the child's class should be advised to avoid any known allergens in class treats or special foods brought into the early care and education setting;
- i. Individual child's food allergies should be posted prominently in the classroom where staff can view and/or wherever food is served;
- j. The written child care plan, a mobile phone, and the proper medications for appropriate treatment if the child develops an acute allergic reaction should be routinely carried on field trips or transport out of the early care and education setting.



### **Standard 4.3.1.3 Preparing, Feeding, and Storing Human Milk**

Expressed human milk should be placed in a clean and sanitary bottle with a nipple that fits tightly or into an equivalent clean and sanitary sealed container to prevent spilling during transport to home or to the facility. Only cleaned and sanitized bottles, or their equivalent, and nipples should be used in feeding. The bottle or container should be properly labeled with the infant's full name and the date and time the milk was expressed. The bottle or container should immediately be stored in the refrigerator on arrival.

The mother's own expressed milk should only be used for her own infant. Likewise, infant formula should not be used for a breastfed infant without the mother's written permission.

Bottles made of plastics containing BPA or phthalates should be avoided (labeled with #3, #6, or #7). Glass bottles or plastic bottles labeled BPA-free or with #1, #2, #4, or #5 are acceptable.

Non-frozen human milk should be transported and stored in the containers to be used to feed the infant, identified with a label which will not come off in water or handling, bearing the date of collection and child's full name. The filled, labeled containers of human milk should be kept refrigerated. Human milk containers with significant amount of contents remaining (greater than one ounce) may be returned to the mother at the end of the day as long as the child has not fed directly from the bottle.

Frozen human milk may be transported and stored in single use plastic bags and placed in a freezer (not a compartment within a refrigerator but either a freezer with a separate door or a standalone freezer). Human milk should be defrosted in the refrigerator if frozen, and then heated briefly in bottle warmers or under warm running water so that the temperature does not exceed 98.6°F. If there is insufficient time to defrost the milk in the refrigerator before warming it, then it may be defrosted in a container of running cool tap water, very gently swirling the bottle periodically to evenly distribute the temperature in the milk. Some infants will not take their mother's milk unless it is warmed to body temperature, around 98.6°F. The caregiver/teacher should check for the infant's full name and the date on the bottle so that the oldest milk is used first. After warming, bottles should be mixed gently (not shaken) and the temperature of the milk tested before feeding.

Expressed human milk that presents a threat to an infant, such as human milk that is in an unsanitary bottle, is curdled, smells rotten, and/or has not been stored following the storage guidelines of the Academy of Breastfeeding Medicine as shown later in this standard, should be returned to the mother.

Some children around six months to a year of age may be developmentally ready to feed themselves and may want to drink from a cup. The transition from bottle to cup can come at a time when a child's fine motor skills allow use of a cup. The caregiver/teacher should use a clean small cup without cracks or chips and should help the child to lift and tilt the cup to avoid spillage and leftover fluid. The caregiver/teacher and mother should work together on cup feeding of human milk to ensure the child is receiving adequate nourishment and to avoid having a large amount of human milk remaining at the end of feeding. Two to three ounces of human milk can be placed in a clean cup and additional milk can be offered as needed. Small amounts of human milk (about an ounce) can be discarded.

Human milk can be stored using the following guidelines from the Academy of Breastfeeding Medicine:

Guidelines for Storage of Human Milk			
Location	Temperature	Duration	Comments
Countertop, table	Room temperature (up to 77°F or 25°C)	6-8 hours	Containers should be covered and kept as cool as possible; covering the container with a cool towel may keep milk cooler.
Insulated cooler bag	5°F – 39°F or - 15°C – 4°C	24 hours	Keep ice packs in contact with milk containers at all times, limit opening cooler bag.
Refrigerator	39°F or 4°C	5 days	Store milk in the back of the main body of the refrigerator.
Freezer compartment of a refrigerator	5°F or -15°C	2 weeks	Store milk toward the back of the freezer, where temperature is most constant.
Freezer compartment of refrigerator with separate doors	0°F or -18°C	3-6 months	Milk stored for longer durations in the ranges listed is safe, but some of the lipids in the milk undergo degradation resulting in lower quality.
Chest or upright deep freezer	-4°F or -20°C	6-12 months	

Source: Academy of Breastfeeding Medicine Protocol Committee. 2010. Clinical protocol #8: Human milk storage information for home use for healthy full term infants, revised. Breastfeeding Med 5:127-30. [http://www.bfmed.org/Resources/Download.aspx?filename=Protocol 8English.pdf](http://www.bfmed.org/Resources/Download.aspx?filename=Protocol%208English.pdf).  
 From the Centers for Disease Control and Prevention Website: Proper handling and storage of human milk – Storage duration of fresh human milk for use with healthy full term infants. [http://www.cdc.gov/breastfeeding/recommendations/handling\\_breastmilk.htm](http://www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.htm).

### **Standard 4.3.1.5 Preparing, Feeding, and Storing Infant Formula**

Formula provided by parents/guardians or by the facility should come in a factory-sealed container. The formula should be of the same brand that is served at home and should be of ready-to-feed strength or liquid concentrate to be diluted using water from a source approved by the health department. Powdered infant formula, though it is the least expensive formula, requires special handling in mixing because it cannot be sterilized. The primary source for proper and safe handling and mixing is the manufacturer's instructions that appear on the can of powdered formula. Before opening the can, hands should be washed. The can and plastic lid should be thoroughly rinsed and dried. Caregivers/teachers should read and follow the manufacturer's directions. If instructions are not readily available, caregivers/teachers should obtain information from the World Health Organization's Safe Preparation, Storage and Handling of Powdered Infant Formula Guidelines at <http://www.who.int/foodsafety/publications/micro/pif2007/en/index.html> (8). The local WIC program can also provide instructions.

Formula mixed with cereal, fruit juice, or any other foods should not be served unless the child's primary care provider provides written documentation that the child has a medical reason for this type of feeding.

Iron-fortified formula should be refrigerated until immediately before feeding. For bottles containing formula, any contents remaining after a feeding should be discarded.

Bottles of formula prepared from powder or concentrate or ready-to-feed formula should be labeled with the child's full name and time and date of preparation. Any prepared formula must be discarded within one hour after serving to an infant. Prepared powdered formula that has not been given to an infant should be covered, labeled with date and time of preparation and child's full name, and may be stored in the refrigerator for up to twenty-four hours. An open container of ready-to-feed, concentrated formula, or formula prepared from concentrated formula, should be covered, refrigerated, labeled with date of opening and child's full name, and discarded at forty-eight hours if not used (7,9). The caregiver/teacher should always follow manufacturer's instructions for mixing and storing of any formula preparation.

Some infants will require specialized formula because of allergy, inability to digest certain formulas, or need for extra calories. The appropriate formula should always be available and should be fed as directed. For those infants getting supplemental calories, the formula may be prepared in a different way from the directions on the container. In those circumstances, either the family should provide the prepared formula or the caregiver/teacher should

receive special training, as noted in the infant's care plan, on how to prepare the formula.

### **Standard 4.3.1.9 Warming Bottles and Infant Foods**

Bottles and infant foods can be served cold from the refrigerator and do not have to be warmed. If a caregiver/teacher chooses to warm them, bottles should be warmed under running, warm tap water or by placing them in a container of water that is no warmer than 120°F. Bottles should not be left in a pot of water to warm for more than five minutes. Bottles and infant foods should never be warmed in a microwave oven.

Infant foods should be stirred carefully to distribute the heat evenly. A caregiver/teacher should not hold an infant while removing a bottle or infant food from the container of warm water or while preparing a bottle or stirring infant food that has been warmed in some other way. Only BPA-free plastic, plastic labeled #1, #2, #4 or #5, or glass bottles should be used.

If a slow-cooking device, such as a crock pot, is used for warming infant formula, human milk, or infant food, this slow-cooking device should be out of children's reach, should contain water at a temperature that does not exceed 120°F, and should be emptied, cleaned, sanitized, and refilled with fresh water daily.

### **Standard 4.3.1.11 Introduction of Age-Appropriate Solid Foods to Infants**

A plan to introduce age-appropriate solid foods (complementary foods) to infants should be made in consultation with the child's parent/guardian and primary care provider. Age-appropriate solid foods may be introduced no sooner than when the child has reached the age of four months, but preferably six months and as indicated by the individual child's nutritional and developmental needs.

For breastfed infants, gradual introduction of iron-fortified foods may occur no sooner than around four months, but preferably six months and to complement the human milk. Modification of basic food patterns should be provided in writing by the child's primary care provider.

Evidence for introducing complementary foods in a specific order or rate is not available. The current best practice is that the first solid foods should be single-ingredient foods and should be introduced one at a time at two to seven-day intervals (1).

### **Standard 4.5.0.6 Adult Supervision of Children Who Are Learning to Feed Themselves**

Children in mid-infancy who are learning to feed themselves should be supervised by an adult seated within arm's reach of them at all times while they are being fed. Children over twelve months of age who can feed

themselves should be supervised by an adult who is seated at the same table or within arm's reach of the child's highchair or feeding table. When eating, children should be within sight of an adult at all times.

### **Standard 4.5.0.9 Hot Liquids and Foods**

Adults should not consume hot liquids above 120°F in child care areas (3). Hot liquids and hot foods should be kept out of the reach of infants, toddlers, and preschoolers. Hot liquids and foods should not be placed on a surface at a child's level, at the edge of a table or counter, or on a tablecloth that could be yanked down. Appliances containing hot liquids, such as coffee pots and crock pots, should be kept out of the reach of children. Electrical cords from any appliance, including coffee pots, should not be allowed to hang within the reach of children. Food preparers should position pot handles toward the back of the stove and use only back burners when possible.

### **Standard 4.5.0.10 Foods that Are Choking Hazards**

Caregivers/teachers should not offer to children under four years of age foods that are associated with young children's choking incidents (round, hard, small, thick and sticky, smooth, compressible or dense, or slippery). Examples of these foods are hot dogs and other meat sticks (whole or sliced into rounds), raw carrot rounds, whole grapes, hard candy, nuts, seeds, raw peas, hard pretzels, chips, peanuts, popcorn, rice cakes, marshmallows, spoonfuls of peanut butter, and chunks of meat larger than can be swallowed whole. Food for infants should be cut into pieces one-quarter inch or smaller, food for toddlers should be cut into pieces one-half inch or smaller to prevent choking. In addition to the food monitoring, children should always be seated when eating to reduce choking hazards. Children should be supervised while eating, to monitor the size of food and that they are eating appropriately (for example, not stuffing their mouths full).

### **Standard 4.8.0.1 Food Preparation Area**

The food preparation area of the kitchen should be separate from eating, play, laundry, toilet, and bathroom areas and from areas where animals are permitted. The food preparation area should not be used as a passageway while food is being prepared. Food preparation areas should be separated by a door, gate, counter, or room divider from areas the children use for activities unrelated to food, except in small family child care homes when separation may limit supervision of children.

Infants and toddlers should not have access to the kitchen in child care centers. Access by older children to the kitchen of centers should be permitted only when supervised by staff members who have been certified by the nutritionist/registered dietitian or the center director as qualified to follow the facility's sanitation and safety procedures.

In all types of child care facilities, children should never be in the kitchen unless they are directly supervised by a caregiver/teacher. Children of preschool-age and older should be restricted from access to areas where hot food is being prepared. School-age children may engage in food preparation activities with adult supervision in the kitchen or the classroom. Parents/guardians and other adults should be permitted to use the kitchen only if they know and follow the food safety rules of the facility. The facility should check with local health authorities about any additional regulations that apply.

### **Standard 4.8.0.3 Maintenance of Food Service Surfaces and Equipment**

All surfaces that come into contact with food, including tables and countertops, as well as floors and shelving in the food preparation area should be in good repair, free of cracks or crevices, and should be made of smooth, nonporous material that is kept clean and sanitized. All kitchen equipment should be clean and should be maintained in operable condition according to the manufacturer's guidelines for maintenance and operation. The facility should maintain an inventory of food service equipment that includes the date of purchase, the warranty date, and a history of repairs.

### **Standard 4.9.0.2 Staff Restricted from Food Preparation and Handling**

Anyone who has signs or symptoms of illness, including vomiting, diarrhea, and infectious skin sores that cannot be covered, or who potentially or actually is infected with bacteria, viruses or parasites that can be carried in food, should be excluded from food preparation and handling. Staff members may not contact exposed, ready-to-eat food with their bare hands and should use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. No one with open or infected skin eruptions should work in the food preparation area unless the injuries are covered with nonporous (such as latex or vinyl), single use gloves.

In centers and large family child care homes, staff members who are involved in the process of preparing or handling food should not change diapers. Staff members who work with diapered children should not prepare or serve food for older groups of children. When staff members who are caring for infants and toddlers are responsible for changing diapers, they should handle food only for the infants and toddlers in their groups and only after thoroughly washing their hands. Caregivers/teachers who prepare food should wash their hands carefully before handling any food, regardless of whether they change diapers. When caregivers/teachers must handle food, staffing assignments should be made to foster completion of the food handling activities by caregivers/teachers of older children, or by caregivers/teachers of infants and toddlers before the caregiver/teacher assumes other caregiving duties for that day. Aprons worn in the food

service area must be clean and should be removed when diaper changing or when using the toilet.

### **Standard 4.9.0.3 Precautions for a Safe Food Supply**

All foods stored, prepared, or served should be safe for human consumption by observation and smell (1-2). The following precautions should be observed for a safe food supply:

- a. Home-canned food; food from dented, rusted, bulging, or leaking cans, and food from cans without labels should not be used;
- b. Foods should be inspected daily for spoilage or signs of mold, and foods that are spoiled or moldy should be promptly and appropriately discarded;
- c. Meat should be from government-inspected sources or otherwise approved by the governing health authority (3);
- d. All dairy products should be pasteurized and Grade A where applicable;
- e. Raw, unpasteurized milk, milk products; unpasteurized fruit juices; and raw or undercooked eggs should not be used. Freshly squeezed fruit or vegetable juice prepared just prior to serving in the child care facility is permissible;
- f. Unless a child's health care professional documents a different milk product, children from twelve months to two years of age should be served only human milk, formula, whole milk or 2% milk (6). Note: For children between twelve months and two years of age for whom overweight or obesity is a concern or who have a family history of obesity, dyslipidemia, or CVD, the use of reduced-fat milk is appropriate only with written documentation from the child's primary health care professional (4). Children two years of age and older should be served skim or 1% milk. If cost-saving is required to accommodate a tight budget, dry milk and milk products may be reconstituted in the facility for cooking purposes only, provided that they are prepared, refrigerated, and stored in a sanitary manner, labeled with the date of preparation, and used or discarded within twenty-four hours of preparation;
- g. Meat, fish, poultry, milk, and egg products should be refrigerated or frozen until immediately before use (5);
- h. Frozen foods should be defrosted in one of four ways: In the refrigerator; under cold running water; as part of the cooking process, or by removing food from packaging and using the defrost setting of a microwave oven (5). Note: Frozen human milk should not be defrosted in the microwave;
- i. Frozen foods should never be defrosted by leaving them at room temperature or standing in water that is not kept at refrigerator temperature (5);

- j. All fruits and vegetables should be washed thoroughly with water prior to use (5);
- k. Food should be served promptly after preparation or cooking or should be maintained at temperatures of not less than 135°F for hot foods and not more than 41°F for cold foods (12);
- l. All opened moist foods that have not been served should be covered, dated, and maintained at a temperature of 41°F or lower in the refrigerator or frozen in the freezer, verified by a working thermometer kept in the refrigerator or freezer (12);
- m. Fully cooked and ready-to-serve hot foods should be held for no longer than thirty minutes before being served, or promptly covered and refrigerated;
- n. Pasteurized eggs or egg products should be substituted for raw eggs in the preparation of foods such as Caesar salad, mayonnaise, meringue, eggnog, and ice cream. Pasteurized eggs or egg products should be substituted for recipes in which more than one egg is broken and the eggs are combined, unless the eggs are cooked for an individual child at a single meal and served immediately, such as in omelets or scrambled eggs; or the raw eggs are combined as an ingredient immediately before baking and the eggs are fully cooked to a ready-to-eat form, such as a cake, muffin or bread;
- o. Raw animal foods should be fully cooked to heat all parts of the food to a temperature and for a time of; 145°F or above for fifteen seconds for fish and meat; 160°F for fifteen seconds for chopped or ground fish, chopped or ground meat or raw eggs; or 165°F or above for fifteen seconds for poultry or stuffed fish, stuffed meat, stuffed pasta, stuffed poultry or stuffing containing fish, meat or poultry.



## Chapter 5: Facilities, Supplies, Equipment, and Environmental Health

### **Standard 5.1.1.2 Inspection of Buildings**

Newly constructed, renovated, remodeled, or altered buildings should be inspected by a public inspector to assure compliance with applicable building and fire codes before the building can be made accessible to children.

**TYPE OF FACILITY:** Center

### **Standard 5.1.1.3 Compliance with Fire Prevention Code**

Every twelve months, the child care facility should obtain written documentation to submit to the regulatory licensing authority that the facility complies with a state-approved or nationally recognized Fire Prevention Code. If available, this documentation should be obtained from a fire prevention official with jurisdiction where the facility is located. Where fire safety inspections or a Fire Prevention Code applicable to child care centers is not available from local authorities, the facility should arrange for a fire safety inspection by an inspector who is qualified to conduct such inspections using the National Fire Protection Association's NFPA 101: Life Safety Code.

**TYPE OF FACILITY:** Center

### **Standard 5.1.1.5 Environmental Audit of Site Location**

An environmental audit should be conducted before construction of a new building; renovation or occupation of an older building; or after a natural disaster, to properly evaluate and, where necessary, remediate or avoid sites where children's health could be compromised (1,3).

The environmental audit should include assessments of:

- a. Potential air, soil, and water contamination on child care facility sites and outdoor play spaces;
- b. Potential toxic or hazardous materials in building construction; and
- c. Potential safety hazards in the community surrounding the site.

A written environmental audit report that includes any remedial action taken should be kept on file.

### **Standard 5.1.3.2 Possibility of Exit from Windows**

All windows in areas used by children under five years of age should be constructed, adapted, or adjusted to limit the exit opening accessible to children to less than four inches, or be otherwise protected with guards that prevent exit by a child, but that do not block outdoor light. Where such windows are required by building or fire codes to provide for emergency

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rescue and evacuation, the windows and guards, if provided, should be equipped to enable staff to release the guard and open the window fully when evacuation or rescue is required. Opportunities should be provided for staff to practice opening these windows, and such release should not require the use of tools or keys. Children should be given information about these windows, relevant safety rules, as well as what will happen if the windows need to be opened for an evacuation.

#### **Standard 5.1.4.1 Alternate Exits and Emergency Shelter**

Each building or structure, new or old, should be provided with a minimum of two exits, at different sides of the building or home, leading to an open space at ground level. If the basement in a small family child care home is being used, one exit must lead directly to the outside. Exits should be unobstructed, allowing occupants to escape to an outside door or exit stair enclosure in case of fire or other emergency. Each floor above or below ground level used for child care should have at least two unobstructed exits that lead to an open area at ground level and thereafter to an area that meets safety requirements for a child care indoor or outdoor area. Children should remain there until their parents/guardians can pick them up, if reentry into the facility is not possible.

Entrance and exit routes should be reviewed and approved by the applicable fire inspector. Exiting should meet all the requirements of the current edition of the NFPA 101: Life Safety Code from the National Fire Protection Association (NFPA).

#### **Standard 5.1.5.4 Guards at Stairway Access Openings**

Securely installed, effective guards (such as gates) should be provided at the top and bottom of each open stairway in facilities where infants and toddlers are in care. Gates should have latching devices that adults (but not children) can open easily in an emergency. “Pressure gates” or accordion gates should not be used. Gate design should not aid in climbing. Gates at the top of stairways should be hardware mounted (e.g., to the wall) for stability. Basement stairways should be shut off from the main floor level by a full door. This door should be self-closing and should be kept locked to entry when the basement is not in use. No door should be locked to prohibit exit at any time.

#### **Standard 5.1.6.6 Guardrails and Protective Barriers**

Guardrails, a minimum of thirty-six inches in height, should be provided at open sides of stairs, ramps, and other walking surfaces (e.g., landings, balconies, porches) from which there is more than a thirty-inch vertical distance to fall. Spaces below the thirty-six inches height guardrail should be further divided with intermediate rails or balusters as detailed in the next paragraph.

For preschoolers, bottom guardrails greater than nine inches but less or equal to twenty-three inches above the floor should be provided for all porches, landings, balconies, and similar structures. For school age children, bottom guardrails should be greater than nine inches but less or equal to twenty inches above the floor, as specified above.

For infants and toddlers, protective barriers should be less than three and one-half inches above the floor, as specified above. All spaces in guardrails should be less than three and a half inches. All spaces in protective barriers should be less than three and one-half inches. If spaces do not meet the specifications as listed above, a protective material sufficient to prevent the passing of a three and one-half inch diameter sphere should be provided.

Where practical or otherwise required by applicable codes, guardrails should be a minimum of forty-two inches in height to help prevent falls over the open side by staff and other adults in the child care facility.

### **Standard 5.2.1.1 Fresh Air**

As much fresh outdoor air as possible should be provided in rooms occupied by children. Windows should be opened whenever weather and the outdoor air quality permits or when children are out of the room (1). When windows are not kept open, rooms should be ventilated, as specified in Standards 5.2.1.1-5.2.1.6. The specified rates at which outdoor air must be supplied to each room within the facility range from fifteen to sixty cubic feet per minute per person (cfm/p). The rate depends on the activities that normally occur in that room.

### **Standard 5.2.1.10 Gas, Oil, or Kerosene Heaters, Generators, Portable Gas Stoves, and Charcoal and Gas Grills**

Unvented gas or oil heaters and portable open-flame kerosene space heaters should be prohibited. Gas cooking appliances, including portable gas stoves, should not be used for heating purposes. Charcoal grills should not be used for space heating or any other indoor purposes.

Heat in units that involve flame should be vented properly to the outside and should be supplied with a source of combustion air that meets the manufacturer's installation requirements.

### **Standard 5.2.1.11 Portable Electric Space Heaters**

Portable electric space heaters should:

- a. Be attended while in use and be off when unattended;
- b. Be inaccessible to children;
- c. Have protective covering to keep hands and objects away from the electric heating element;

- d. Bear the safety certification mark of a nationally recognized testing laboratory;
- e. Be placed on the floor only and at least three feet from curtains, papers, furniture, and any flammable object;
- f. Be properly vented, as required for proper functioning;
- g. Be used in accordance with the manufacturer's instructions;
- h. Not be used with an extension cord.

The heater cord should be inaccessible to children as well.

### **Standard 5.2.4.2 Safety Covers and Shock Protection Devices for Electrical Outlets**

All electrical outlets accessible to children who are not yet developmentally at a kindergarten grade level of learning should be a type called "tamper-resistant electrical outlets." These types of outlets look like standard wall outlets but contain an internal shutter mechanism that prevents children from sticking objects like hairpins, keys, and paperclips into the receptacle (2). This spring-loaded shutter mechanism only opens when equal pressure is applied to both shutters such as when an electrical plug is inserted (2,3).

In existing child care facilities that do not have "tamper-resistant electrical outlets," outlets should have "safety covers" that are attached to the electrical outlet by a screw or other means to prevent easy removal by a child. "Safety plugs" should not be used since they can be removed from an electrical outlet by children (2,3).

All newly installed or replaced electrical outlets that are accessible to children should use "tamper-resistant electrical outlets."

In areas where electrical products might come into contact with water, a special type of outlet called Ground Fault Circuit Interrupters (GFCIs) should be installed (2). A GFCI is designed to trip before a deadly electrical shock can occur (1). To ensure that GFCIs are functioning correctly, they should be tested at least monthly (2). GFCIs are also available in a tamper-resistant design.

### **Standard 5.2.4.4 Location of Electrical Devices Near Water**

No electrical device or apparatus accessible to children should be located so it could be plugged into an electrical outlet while a person is in contact with a water source, such as a sink, tub, shower area, water table, or swimming pool.

### **Standard 5.2.5.1 Smoke Detection Systems and Smoke Alarms**

In centers with new installations, a smoke detection system (such as hard-wired system detectors with battery back-up system and control panel) or

monitored wireless battery operated detectors that automatically signal an alarm through a central control panel when the battery is low or when the detector is triggered by a hazardous condition should be installed with placement of the smoke detectors in the following areas:

- a. Each story in front of doors to the stairway;
- b. Corridors of all floors;
- c. Lounges and recreation areas;
- d. Sleeping rooms.

In large and small family child care homes, smoke alarms that receive their operating power from the building electrical system or are of the wireless signal-monitored-alarm system type should be installed. Battery-operated smoke alarms should be permitted provided that the facility demonstrates to the fire inspector that testing, maintenance, and battery replacement programs ensure reliability of power to the smoke alarms and signaling of a monitored alarm when the battery is low and that retrofitting the facility to connect the smoke alarms to the electrical system would be costly and difficult to achieve.

Facilities with smoke alarms that operate using power from the building electrical system should keep a supply of batteries and battery-operated detectors for use during power outages.

### **Standard 5.2.6.3 Testing for Lead and Copper Levels in Drinking Water**

Drinking water, including water in drinking fountains, should be tested and evaluated in accordance with the assistance of the local health authority or state drinking water program to determine whether lead and copper levels are safe.

### **Standard 5.2.7.6 Storage and Disposal of Infectious and Toxic Wastes**

Infectious and toxic wastes should be stored separately from other wastes, and should be disposed of in a manner approved by the regulatory health authority.

### **Standard 5.2.8.1 Integrated Pest Management**

Facilities should adopt an integrated pest management program (IPM) to ensure long-term, environmentally sound pest suppression through a range of practices including pest exclusion, sanitation and clutter control, and elimination of conditions that are conducive to pest infestations. IPM is a simple, common-sense approach to pest management that eliminates the root causes of pest problems, providing safe and effective control of insects, weeds, rodents, and other pests while minimizing risks to human health and the environment (2, 4).

**Pest Prevention:** Facilities should prevent pest infestations by ensuring sanitary conditions. This can be done by eliminating pest breeding areas, filling in cracks and crevices; holes in walls, floors, ceilings and water leads; repairing water damage; and removing clutter and rubbish on the premises (5).

**Pest Monitoring:** Facilities should establish a program for regular pest population monitoring and should keep records of pest sightings and sightings of indicators of the presence of pests (e.g., gnaw marks, frass, rub marks).

**Pesticide Use:** If physical intervention fails to prevent pest infestations, facility managers should ensure that targeted, rather than broadcast applications of pesticides are made, beginning with the products that pose least exposure hazard first, and always using a pesticide applicator who has the licenses or certifications required by state and local laws.

Facility managers should follow all instructions on pesticide product labels and should not apply any pesticide in a manner inconsistent with label instructions. Material Safety Data Sheets (MSDS) are available from the product manufacturer or a licensed exterminator and should be on file at the facility. Facilities should ensure that pesticides are never applied when children are present and that re-entry periods are adhered to.

Records of all pesticides applications (including type and amount of pesticide used), timing and location of treatment, and results should be maintained either on-line or in a manner that permits access by facility managers and staff, state inspectors and regulatory personnel, parents/guardians, and others who may inquire about pesticide usage at the facility.

Facilities should avoid the use of sprays and other volatilizing pesticide formulations. Pesticides should be applied in a manner that prevents skin contact and any other exposure to children or staff members and minimizes odors in occupied areas. Care should be taken to ensure that pesticide applications do not result in pesticide residues accumulating on tables, toys, and items mouthed or handled by children, or on soft surfaces such as carpets, upholstered furniture, or stuffed animals with which children may come in direct contact (3).

Following the use of pesticides, herbicides, fungicides, or other potentially toxic chemicals, the treated area should be ventilated for the period recommended on the product label.

**Notification:** Notification should be given to parents/guardians and staff before using pesticides, to determine if any child or staff member is sensitive to the product. A member of the child care staff should directly observe the application to be sure that toxic chemicals are not applied on surfaces with which children or staff may come in contact.

**Registry:** Child care facilities should provide the opportunity for interested staff and parents/guardians to register with the facility if they want to be notified about individual pesticide applications before they occur.

**Warning Signs:** Child care facilities must post warning signs at each area where pesticides will be applied. These signs must be posted forty-eight hours before and seventy-two hours after applications and should be sufficient to restrict uninformed access to treated areas.

**Record Keeping:** Child care facilities should keep records of pesticide use at the facility and make the records available to anyone who asks. Record retention requirements vary by state, but federal law requires records to be kept for two years (7). It is a good idea to retain records for a minimum of three years.

**Pesticide Storage:** Pesticides should be stored in their original containers and in a locked room or cabinet accessible only to authorized staff. No restricted-use pesticides should be stored or used on the premises except by properly licensed persons. Banned, illegal, and unregistered pesticides should not be used.

### **Standard 5.2.9.1 Use and Storage of Toxic Substances**

The following items should be used as recommended by the manufacturer and should be stored in the original labeled containers:

- a. Cleaning materials;
- b. Detergents;
- c. Automatic dishwasher detergents;
- d. Aerosol cans;
- e. Pesticides;
- f. Health and beauty aids;
- g. Medications;
- h. Lawn care chemicals;
- i. Other toxic materials.

Material Safety Data Sheets (MSDS) must be available onsite for each hazardous chemical that is on the premises.

These substances should be used only in a manner that will not contaminate play surfaces, food, or food preparation areas, and that will not constitute a hazard to the children or staff. When not in active use, all chemicals used inside or outside should be stored in a safe and secure manner in a locked room or cabinet, fitted with a child-resistive opening device, inaccessible to children, and separate from stored medications and food.

Chemicals used in lawn care treatments should be limited to those listed for use in areas that can be occupied by children.

Medications can be toxic if taken by the wrong person or in the wrong dose. Medications should be stored safely (see Standard 3.6.3.1) and disposed of properly (see Standard 3.6.3.2).

The telephone number for the poison center should be posted in a location where it is readily available in emergency situations (e.g., next to the telephone). Poison centers are open twenty-four hours a day, seven days a week, and can be reached at 1-800-222-1222.

### **Standard 5.2.9.2 Use of a Poison Center**

The poison center should be called for advice about any exposure to toxic substances, or any potential poisoning emergency. The national help line for the poison center is 1-800-222-1222, and specialists will link the caregiver/teacher with their local poison center. The advice should be followed and documented in the facility's files. The caregiver/teacher should be prepared for the call by having the following information for the poison center specialist:

- a. The child's age and sex;
- b. The substance involved;
- c. The estimated amount;
- d. The child's condition;
- e. The time elapsed since ingestion or exposure.

The caregiver/teacher should not induce vomiting unless instructed by the poison center.

### **Standard 5.2.9.3 Informing Staff Regarding Presence of Toxic Substances**

Employers should provide staff with hazard information, 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 toxic substances such as formaldehyde, cleaning and sanitizing supplies, insecticides, herbicides, and other hazardous chemicals in use in the facility. Staff should always read the label prior to use to determine safety in use. For example, toxic products regulated by the Environmental Protection Agency (EPA) will have an EPA signal word of CAUTION, WARNING, or DANGER. Where nontoxic substitutes are available, these nontoxic substitutes should be used instead of toxic chemicals. If a nontoxic product is not available, caregivers/teachers should use the least toxic product for the job. A CAUTION label is safer than a WARNING label, which is safer than a DANGER label.

**TYPE OF FACILITY:** Center, Large Family Child Care Home



### **Standard 5.2.9.4 Radon Concentrations**

Radon concentrations inside a home or building used for child care must be less than four picocuries per liter of air. All facilities must be tested for the presence of radon, according to U.S. Environmental Protection Agency (EPA) testing protocols for long-term testing (i.e., greater than ninety days in duration using alpha-track or electret test devices).

### **Standard 5.2.9.5 Carbon Monoxide Detectors**

Carbon monoxide detector(s) should be installed in child care settings if one of the following guidelines is met:

- a. The child care program uses any sources of coal, wood, charcoal, oil, kerosene, propane, natural gas, or any other product that can produce carbon monoxide indoors or in an attached garage;
- b. If detectors are required by state/local law or state licensing agency.

Facilities must meet state or local laws regarding carbon monoxide detectors. Detectors should be tested monthly. Batteries should be changed at least yearly. Detectors should be replaced at least every five years.

### **Standard 5.2.9.13 Testing for Lead**

In all centers, both exterior and interior surfaces covered by paint with lead levels of 0.06% and above, or equal to or greater than 1.0 milligram per square centimeter and accessible to children, should be removed by a safe chemical or physical means or made inaccessible to children, regardless of the condition of the surface.

In large and small family child care homes, flaking or deteriorating lead-based paint on any surface accessible to children should be removed or abated according to health department regulations. Where lead paint is removed, the surface should be refinished with lead-free paint or nontoxic material. Sanding, scraping, or burning of lead-based paint surfaces should be prohibited. Children and pregnant women should not be present during lead renovation or lead abatement activities.

Any surface and the grounds around and under surfaces that children use at a child care facility, including dirt and grassy areas should be tested for excessive lead in a location designated by the health department. Caregivers/teachers should check the U.S. Consumer Product Safety Commission's Website, <http://www.cpsc.gov>, for warnings of potential lead exposure to children and recalls of play equipment, toys, jewelry used for play, imported vinyl mini-blinds and food contact products. If they are found to have toxic levels, corrective action should be taken to prevent exposure to lead at the facility. Only nontoxic paints should be used.

### **Standard 5.3.1.1 Safety of Equipment, Materials, and Furnishings**

Equipment, materials, furnishings, and play areas should be sturdy, safe, and in good repair and should meet the recommendations of the U.S. Consumer Product Safety Commission (CPSC) for control of the following safety hazards:

- a. Openings that could entrap a child's head or limbs;
- b. Elevated surfaces that are inadequately guarded;
- c. Lack of specified surfacing and fall zones under and around climbable equipment;
- d. Mismatched size and design of equipment for the intended users;
- e. Insufficient spacing between equipment;
- f. Tripping hazards;
- g. Components that can pinch, shear, or crush body tissues;
- h. Equipment that is known to be of a hazardous type;
- i. Sharp points or corners;
- j. Splinters;
- k. Protruding nails, bolts, or other components that could entangle clothing or snag skin;
- l. Loose, rusty parts;
- m. Hazardous small parts that may become detached during normal use or reasonably foreseeable abuse of the equipment and that present a choking, aspiration, or ingestion hazard to a child;
- n. Strangulation hazards (e.g., straps, strings, etc.);
- o. Flaking paint;
- p. Paint that contains lead or other hazardous materials;
- q. Tip-over hazards, such as chests, bookshelves, and televisions.

### **Standard 5.3.1.12 Availability and Use of a Telephone or Wireless Communication Device**

The facility should provide at all times at least one working non-pay telephone or wireless communication device for general and emergency use:

- a. On the premises of the child care facility;
- b. In each vehicle used when transporting children;
- c. On field trips.

Drivers, while transporting children should not operate a motor vehicle while using a mobile telephone or wireless communications device when the vehicle is in motion or a part of traffic, with the exception of use of a navigational system or global positioning system device.

### **Standard 5.4.5.2 Cribs**

Facilities should check each crib before its purchase and use to ensure that it is in compliance with the current U.S. Consumer Product Safety Commission (CPSC) and ASTM safety standards.

Recalled or “second-hand” cribs should not be used or stored in the facility. When it is determined that a crib is no longer safe for use in the facility, it should be dismantled and disposed of appropriately.

Staff should only use cribs for sleep purposes and should ensure that each crib is a safe sleep environment. No child of any age should be placed in a crib for a time-out or for disciplinary reasons. When an infant becomes large enough or mobile enough to reach crib latches or potentially climb out of a crib, they should be transitioned to a different sleeping environment (such as a cot or sleeping mat).

Each crib should be identified by brand, type, and/or product number and relevant product information should be kept on file (with the same identification information) as long as the crib is used or stored in the facility.

Staff should inspect each crib before each use to ensure that hardware is tightened and that there are not any safety hazards. If a screw or bolt cannot be tightened securely, or there are missing or broken screws, bolts, or mattress support hangers, the crib should not be used.

Safety standards document that cribs used in facilities should be made of wood, metal, or plastic. Crib slats should be spaced no more than two and three-eighths inches apart, with a firm mattress that is fitted so that no more than two fingers can fit between the mattress and the crib side in the lowest position. The minimum height from the top of the mattress to the top of the crib rail should be twenty inches in the highest position. Cribs with drop sides should not be used. The crib should not have corner post extensions (over one-sixteenth inch). The crib should have no cutout openings in the head board or footboard structure in which a child’s head could become entrapped. The mattress support system should not be easily dislodged from any point of the crib by an upward force from underneath the crib. All cribs should meet the ASTM F1169-10a Standard Consumer Safety Specification for Full-Size Baby Cribs, F406-10b Standard Consumer Safety Specification for Non-Full-Size Baby Cribs/Play Yards, or the CPSC 16 CFR 1219, 1220, and 1500 – Safety Standards for Full-Size Baby Cribs and Non-Full-Size Baby Cribs; Final Rule.

Cribs should be placed away from window blinds or draperies.

As soon as a child can stand up, the mattress should be adjusted to its lowest position. Once a child can climb out of his/her crib, the child should be moved to a bed. Children should never be kept in their crib by placing, tying, or wedging various fabric, mesh, or other strong coverings over the top of the crib.

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Cribs intended for evacuation purpose should be of a design and have wheels that are suitable for carrying up to five non-ambulatory children less than two years of age to a designated evacuation area. This crib should be used for evacuation in the event of fire or other emergency. The crib should be easily moveable and should be able to fit through the designated fire exit.

### **Standard 5.5.0.6 Inaccessibility to Matches, Candles, and Lighters**

Matches, candles, and lighters should not be accessible to children.

### **Standard 5.5.0.7 Storage of Plastic Bags**

Plastic bags, whether intended for storage, trash, diaper disposal, or any other purpose, should be stored out of reach of children.

### **Standard 5.5.0.8 Firearms**

Centers should not have any firearms, pellet or BB guns (loaded or unloaded), darts, bows and arrows, cap pistols, stun guns, paint ball guns, or objects manufactured for play as toy guns within the premises at any time. If present in a small or large family child care home, these items must be unloaded, equipped with child protective devices, and kept under lock and key with the ammunition locked separately in areas inaccessible to the children. Parents/guardians should be informed about this policy.

### **Standard 5.6.0.1 First Aid and Emergency Supplies**

The facility should maintain first aid and emergency supplies in each location where children are cared for. The first aid kit or supplies should be kept in a closed container, cabinet, or drawer that is labeled and stored in a location known to all staff, accessible to staff at all times, but locked or otherwise inaccessible to children. When children leave the facility for a walk or to be transported, a designated staff member should bring a transportable first aid kit. In addition, a transportable first aid kit should be in each vehicle that is used to transport children to and from a child care facility.

First aid kits or supplies should be restocked after use. An inventory of first aid supplies should be conducted at least monthly. A log should be kept that lists the date that each inventory was conducted, verification that expiration dates of supplies were checked, location of supplies (i.e., in the facility supply, transportable first aid kit(s), etc.), and the legal name/signature of the staff member who completed the inventory.

The first aid kit should contain at least the following items:

- a. Disposable nonporous, latex-free or non-powdered latex gloves (latex-free recommended);
- b. Scissors;

- c. Tweezers;
- d. Non-glass, non-mercury thermometer to measure a child's temperature;
- e. Bandage tape;
- f. Sterile gauze pads;
- g. Flexible roller gauze;
- h. Triangular bandages;
- i. Safety pins;
- j. Eye patch or dressing;
- k. Pen/pencil and note pad;
- l. Cold pack;
- m. Current American Academy of Pediatrics (AAP) standard first aid chart or equivalent first aid guide such as the AAP Pediatric First Aid For Caregivers and Teachers (PedFACTS) Manual;
- n. Coins for use in a pay phone and cell phone;
- o. Water (two liters of sterile water for cleaning wounds or eyes);
- p. Liquid soap to wash injury and hand sanitizer, used with supervision, if hands are not visibly soiled or if no water is present;
- q. Tissues;
- r. Wipes;
- s. Individually wrapped sanitary pads to contain bleeding of injuries;
- t. Adhesive strip bandages, plastic bags for cloths, gauze, and other materials used in handling blood;
- u. Flashlight;
- v. Whistle;
- w. Battery-powered radio (1).

When children walk or are transported to another location, the transportable first aid kit should include ALL items listed above AND the following emergency information/items:

- a. List of children in attendance (organized by caregiver/teacher they are assigned to) and their emergency contact information (i.e., parents/guardian/emergency contact home, work, and cell phone numbers);
- b. Special care plans for children who have them;
- c. Emergency medications or supplies as specified in the special care plans;
- d. List of emergency contacts (i.e., location information and phone numbers for the Poison Center, nearby hospitals or other emergency care clinics, and other community resource agencies);
- e. Maps;
- f. Written transportation policy and contingency plans.

**Standard 5.7.0.4 Inaccessibility of Hazardous Equipment**

Any hazardous equipment should be made inaccessible to children by barriers, or removed until rendered safe or replaced. The barriers should not pose any hazard.

## Chapter 6: Play Areas/Playgrounds and Transportation

### **Standard 6.1.0.6 Location of Play Areas Near Bodies of Water**

Outside play areas should be free from the following bodies of water:

- a. Unfenced swimming and wading pools;
- b. Ditches;
- c. Quarries;
- d. Canals;
- e. Excavations;
- f. Fish ponds;
- g. Water retention or detention basins;
- h. Other bodies of water.

### **Standard 6.1.0.8 Enclosures for Outdoor Play Areas**

The outdoor play area should be enclosed with a fence or natural barriers. Fences and barriers should not prevent the observation of children by caregivers/teachers. If a fence is used, it should conform to applicable local building codes in height and construction. Fence posts should be outside the fence where allowed by local building codes. These areas should have at least two exits, with at least one being remote from the buildings.

Gates should be equipped with self-closing and positive self-latching closure mechanisms. The latch or securing device should be high enough or of a type such that children cannot open it. The openings in the fence and gates should be no larger than three and one-half inches. The fence and gates should be constructed to discourage climbing. Play areas should be secured against inappropriate use when the facility is closed.

Wooden fences and playground structures created out of wood should be tested for chromated copper arsenate (CCA). Wooden fences and playground structures created out of wood that is found to contain CCA should be sealed with an oil-based outdoor sealant annually.

### **Standard 6.2.1.9 Entrapment Hazards of Play Equipment**

All openings in pieces of play equipment should be designed too large for a child's head to get stuck in or too small for a child's body to fit into, in order to prevent entrapment and strangulation. Openings in exercise rings (overhead hanging rings such as those used in a ring trek or ring ladder) should be smaller than three and one-half inches or larger than nine inches in diameter. Rings on long chains are prohibited. A play structure should have no openings with a dimension between three and one-half inches and nine inches. In particular, side railings, stairs, and other locations where a

child might slip or try to climb through should be checked for appropriate dimensions.

Protrusions such as pipes, wood ends, or long bolts that may catch a child's clothing are prohibited. Distances between two vertical objects that are positioned near each other should be less than three and one-half inches to prevent entrapment of a child's head. No opening should have a vertical angle of less than fifty-five degrees. To prevent entrapment of fingers, openings should not be larger than three-eighths inch or smaller than one inch. A Certified Playground Safety Inspector (CPSI) is specially trained to find and measure various play equipment hazards.

### **Standard 6.2.3.1 Prohibited Surfaces for Placing Climbing Equipment**

Equipment used for climbing should not be placed over, or immediately next to, hard surfaces such as asphalt, concrete, dirt, grass, or flooring covered by carpet or gym mats not intended for use as surfacing for climbing equipment.

All pieces of playground equipment should be placed over and surrounded by a shock-absorbing surface. This material may be either the unitary or the loose-fill type, as defined by the U.S. Consumer Product Safety Commission (CPSC) guidelines and ASTM International (ASTM) standards, extending at least six feet beyond the perimeter of the stationary equipment (1,2). These shock-absorbing surfaces must conform to the standard stating that the impact of falling from the height of the structure will be less than or equal to peak deceleration of 200G and a Head Injury Criterion (HIC) of 1000 and should be maintained at all times (3). Organic materials that support colonization of molds and bacteria should not be used. All loose fill materials must be raked to retain their proper distribution, shock-absorbing properties and to remove foreign material. This standard applies whether the equipment is installed outdoors or indoors.

### **Standard 6.2.4.4 Trampolines**

Trampolines, both full and mini-size, should be prohibited from being used as part of the child care program activities both on-site and during field trips.

### **Standard 6.2.5.1 Inspection of Indoor and Outdoor Play Areas and Equipment**

The indoor and outdoor play areas and equipment should be inspected daily for the following:

- a. Missing or broken parts;
- b. Protrusion of nuts and bolts;
- c. Rust and chipping or peeling paint;
- d. Sharp edges, splinters, and rough surfaces;

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- e. Stability of handholds;
- f. Visible cracks;
- g. Stability of non-anchored large play equipment (e.g., playhouses);
- h. Wear and deterioration.

Observations should be documented and filed, and the problems corrected.

Facilities should conduct a monthly inspection as outlined in [Appendix EE](#), America's Playgrounds Safety Report Card.

### **Standard 6.3.1.1 Enclosure of Bodies of Water**

All water hazards, such as pools, swimming pools, stationary wading pools, ditches, fish ponds, and water retention or detention basins should be enclosed with a fence that is four to six feet high or higher and comes within three and one-half inches of the ground. Openings in the fence should be no greater than three and one-half inches. The fence should be constructed to discourage climbing and kept in good repair.

If the fence is made of horizontal and vertical members (like a typical wooden fence) and the distance between the tops of the horizontal parts of the fence is less than forty-five inches, the horizontal parts should be on the swimming pool side of the fence. The spacing of the vertical members should not exceed one and three-quarters inches.

For a chain link fence, the mesh size should not exceed one and one-quarter square inches.

Exit and entrance points should have self-closing, positive latching gates with locking devices a minimum of fifty-five inches from the ground.

A wall of the child care facility should not constitute one side of the fence unless the wall has no openings capable of providing direct access to the pool (such as doors, windows, or other openings).

If the facility has a water play area, the following requirements should be met:

- a. Water play areas should conform to all state and local health regulations;
- b. Water play areas should not include hidden or enclosed spaces;
- c. Spray areas and water-collecting areas should have a non-slip surface, such as asphalt;
- d. Water play areas, particularly those that have standing water, should not have sudden changes in depth of water;
- e. Drains, streams, water spouts, and hydrants should not create strong suction effects or water-jet forces;
- f. All toys and other equipment used in and around the water play area should be made of sturdy plastic or metal (no glass should be permitted);

- g. Water play areas in which standing water is maintained for more than twenty-four hours should be treated according to Standard 6.3.4.1, and inspected for glass, trash, animal excrement, and other foreign material.

### **Standard 6.3.1.4 Safety Covers for Swimming Pools**

When not in use, in-ground and above-ground swimming pools should be covered with a safety cover that meets or exceeds the ASTM International (ASTM) standard “F1346-03: Standard performance specification for safety covers and labeling requirements for all covers for swimming pools, spas, and hot tubs” (2).

### **Standard 6.3.1.6 Pool Drain Covers**

All covers for the main drain and other suction ports of swimming and wading pools should be listed by a nationally recognized testing laboratory in accordance with ASME/ANSI standard “A112.19.8: Standard for Suction Fittings for Use in Swimming Pools, Wading Pools, Spas and Hot Tubs,” and should be used under conditions that do not exceed the approved maximum flow rate, be securely anchored using manufacturer-supplied parts installed per manufacturer’s specifications, be in good repair, and be replaced at intervals specified by manufacturer. Facilities with one outlet per pump, or multiple outlets per pump with less than thirty-six inches center-to-center distance for two outlets, must be equipped with a Safety Vacuum Release System (SVRS) meeting the ASME/ANSI standard “A112.19.17: Manufactured Safety Vacuum Release Systems for Residential and Commercial Swimming Pool, Spas, Hot Tub and Wading Pool Suction Systems” or ASTM International (ASTM) standard “F2387-04: Standard Specification for Manufactured SVRS for Swimming Pools, Spas, and Hot Tubs” standards, as required by the Virginia Graeme Baker Pool and Spa Safety Act, Section 1404(c)(1)(A)(i) (1,2).

### **Standard 6.3.2.1 Lifesaving Equipment**

Each swimming pool more than six feet in width, length, or diameter should be provided with a ring buoy and rope, a rescue tube, or a throwing line and a shepherd’s hook that will not conduct electricity. This equipment should be long enough to reach the center of the pool from the edge of the pool, should be kept in good repair, and should be stored safely and conveniently for immediate access. Caregivers/teachers should be trained on the proper use of this equipment so that in emergencies, caregivers/teachers will use equipment appropriately. Children should be familiarized with the use of the equipment based on their developmental level.

### **Standard 6.3.5.1 Hot Tubs, Spas, and Saunas**

Children should not be permitted in hot tubs, spas, or saunas in child care. Areas should be secured to prevent any access by children.

### **Standard 6.3.5.2 Water in Containers**

Bathtubs, buckets, diaper pails, and other open containers of water should be emptied immediately after use.

### **Standard 6.4.1.2 Inaccessibility of Toys or Objects to Children Under Three Years of Age**

Small objects, toys, and toy parts available to children under the age of three years should meet the federal small parts standards for toys. The following toys or objects should not be accessible to children under three years of age:

- a. Toys or objects with removable parts with a diameter less than one and one-quarter inches and a length between one inch and two and one-quarter inches;
- b. Balls and toys with spherical, ovoid (egg shaped), or elliptical parts that are smaller than one and three-quarters inches in diameter;
- c. Toys with sharp points and edges;
- d. Plastic bags;
- e. Styrofoam objects;
- f. Coins;
- g. Rubber or latex balloons;
- h. Safety pins;
- i. Marbles;
- j. Magnets;
- k. Foam blocks, books, or objects;
- l. Other small objects;
- m. Latex gloves;
- n. Bulletin board tacks;
- o. Glitter.

### **Standard 6.4.1.5 Balloons**

Infants, toddlers, and preschool children should not be permitted to inflate balloons, suck on or put balloons in their mouths nor have access to uninflated or underinflated balloons. Children under eight should not have access to latex balloons or inflated latex objects that are treated as balloons and these objects should not be permitted in the child care facility.

### **Standard 6.4.2.2 Helmets**

All children one year of age and over should wear properly fitted and approved helmets while riding toys with wheels (tricycles, bicycles, etc.) or using any wheeled equipment (rollerblades, skateboards, etc.). Helmets should be removed as soon as children stop riding the wheeled toys or using wheeled equipment. Approved helmets should meet the standards of the U.S. Consumer Product Safety Commission (CPSC) (5). The standards sticker should be located on the bike helmet. Bike helmets should be

replaced if they have been involved in a crash, the helmet is cracked, when straps are broken, the helmet can no longer be worn properly, or according to recommendations by the manufacturer (usually after three years).

### **Standard 6.5.1.1 Competence and Training of Transportation Staff**

At least one adult who accompanies or drives children for field trips and out-of-facility activities should receive training by a professional knowledgeable about child development and procedures, to ensure the safety of all children. The caregiver should hold a valid pediatric first aid certificate, including rescue breathing and management of blocked airways, as specified in First Aid and CPR Standards 1.4.3.1-1.4.3.3. Any emergency medications that a child might require, such as self-injecting epinephrine for life-threatening allergy, should also be available at all times as well as a mobile phone to call for medical assistance. Child:staff ratios should be maintained on field trips and during transport, as specified in Standards 1.1.1.1-1.1.1.5; the driver should not be included in these ratios. No child should ever be left alone in the vehicle.

All drivers, passenger monitors, chaperones, and assistants should receive instructions in safety precautions. Transportation procedures should include:

- a. Use of developmentally appropriate safety restraints;
- b. Proper placement of the child in the motor vehicle in accordance with state and federal child restraint laws and regulations and recognized best practice;
- c. Training in handling of emergency medical situations. If a child has a chronic medical condition or special health care needs that could result in an emergency (such as asthma, diabetes, or seizures), the driver or chaperone should have written instructions including parent/guardian emergency contacts, child summary health information, special needs and treatment plans, and should:
- d. Recognize the signs of a medical emergency;
- e. Know emergency procedures to follow (3);
- f. Have on hand any emergency supplies or medications necessary, properly stored out of reach of children;
- g. Know specific medication administration (ex. a child who requires EpiPen or diazepam);
- h. Know about water safety when field trip is to a location with a body of water.
- i. Knowledge of appropriate routes to emergency facility;
- j. Defensive driving;
- k. Child supervision during transport, including never leaving a child unattended in or around a vehicle;
- l. Issues that may arise in transporting children with behavioral issues (e.g., temper tantrums or oppositional behavior).

The receipt of such instructions should be documented in a personnel record for any paid staff or volunteer who participates in field trips or transportation activities.

Vehicles should be equipped with a first aid kit, fire extinguisher, seat belt cutter, and maps. At least one adult should have a functioning cell phone at hand. Information, names of the children and parent/guardian contact information should be carried in the vehicle along with identifying information (name, address, and telephone number) about the child care center.

### **Standard 6.5.1.2 Qualifications for Drivers**

Any driver who transports children for a child care program should be at least twenty-one years of age and should have:

- a. A valid commercial driver's license that authorizes the driver to operate the vehicle being driven;
- b. Evidence of a safe driving record for more than five years, with no crashes where a citation was issued;
- c. No alcohol, prescription or over-the-counter medications, or other drugs associated with impaired ability to drive, within twelve hours prior to transporting children. Drivers should ensure that any prescription or over-the-counter drugs taken will not impair their ability to drive;
- d. No tobacco, alcohol, or drug use while driving;
- e. No criminal record of crimes against or involving children, child neglect or abuse, substance abuse, or any crime of violence;
- f. No medical condition that would compromise driving, supervision, or evacuation capability including fatigue and sleep deprivation;
- g. Valid pediatric CPR and first aid certificate if transporting children alone.

The driver's license number and date of expiration, vehicle insurance information, and verification of current state vehicle inspection should be on file in the facility.

The child care program should require drug testing when noncompliance with the restriction on the use of alcohol or other drugs is suspected.

### **Standard 6.5.2.2 Child Passenger Safety**

When children are driven in a motor vehicle other than a bus, school bus, or a bus operated by a common carrier, the following should apply:

- a. A child should be transported only if the child is restrained in developmentally appropriate car safety seat, booster seat, seat belt, or harness that is suited to the child's weight, age, and/or psychological development in accordance with state and federal laws and regulations and the child is securely fastened, according

to the manufacturer's instructions, in a developmentally appropriate child restraint system.

- b. Age and size-appropriate vehicle child restraint systems should be used for children under eighty pounds and under four-foot-nine-inches tall and for all children considered too small, in accordance with state and federal laws and regulations, to fit properly in a vehicle safety belt. The child passenger restraint system must meet the federal motor vehicle safety standards contained in the Code of Federal Regulations, Title 49, Section 571.213 (especially Federal Motor Vehicle Safety Standard 213), and carry notice of such compliance.
- c. For children who are obese or overweight, it is important to find a car safety seat that fits the child properly. Caregivers/teachers should not use a car safety seat if the child weighs more than the seat's weight limit or is taller than the height limit. Caregivers/teachers should check the labels on the seat or manufacturer's instructions if they are unsure of the limits. Manufacturer's instructions that include these specifications can also be found on the manufacturer's Website.
- d. Child passenger restraint systems should be installed and used in accordance with the manufacturer's instructions and should be secured in back seats only.
- e. All children under the age of thirteen should be transported in the back seat of a car and each child not riding in an appropriate child restraint system (i.e., a child seat, vest, or booster seat), should have an individual lap-and-shoulder seat belt (2).
- f. For maximum safety, infants and toddlers should ride in a rear-facing orientation (i.e., facing the back of the car) until they are two years of age or until they have reached the upper limits for weight or height for the rear-facing seat, according to the manufacturer's instructions (1). Once their seat is adjusted to face forward, the child passenger must ride in a forward-facing child safety seat (either a convertible seat or a combination seat) until reaching the upper height or weight limit of the seat, in accordance with the manufacturer's instructions (10). Plans should include limiting transportation times for young infants to minimize the time that infants are sedentary in one place.
- g. A booster seat should be used when, according to the manufacturer's instructions, the child has outgrown a forward-facing child safety seat, but is still too small to safely use the vehicle seat belts (for most children this will be between four feet nine inches tall and between eight and twelve years of age) (1).
- h. Car safety seats, whether provided by the child's parents/guardians or the child care program, should be labeled with the child passenger's name and emergency contact information.

- i. Car safety seats should be replaced if they have been recalled, are past the manufacturer's "date of use" expiration date, or have been involved in a crash that meets the U.S. Department of Transportation crash severity criteria or the manufacturer's criteria for replacement of seats after a crash (3,11).
- j. The temperature of all metal parts of vehicle child restraint systems should be checked before use to prevent burns to child passengers.

If the child care program uses a vehicle that meets the definition of a school bus and the school bus has safety restraints, the following should apply:

- a. The school bus should accommodate the placement of wheelchairs with four tie-downs affixed according to the manufactures' instructions in a forward-facing direction;
- b. The wheelchair occupant should be secured by a three-point tie restraint during transport;
- c. At all times, school buses should be ready to transport children who must ride in wheelchairs;
- d. Manufacturers' specifications should be followed to assure that safety requirements are met.

### **Standard 6.5.2.4 Interior Temperature of Vehicles**

The interior of vehicles used to transport children should be maintained at a temperature comfortable to children. When the vehicle's interior temperature exceeds 82°F and providing fresh air through open windows cannot reduce the temperature, the vehicle should be air-conditioned. When the interior temperature drops below 65°F and when children are feeling uncomfortably cold, the interior should be heated. To prevent hyperthermia, all vehicles should be locked when not in use, head counts of children should be taken after transporting to prevent a child from being left unintentionally in a vehicle, and children should never be intentionally left in a vehicle unattended.

### **Standard 6.5.3.1 Passenger Vans**

Child care facilities that provide transportation to children, parents/guardians, staff, and others should avoid the use of fifteen-passenger vans whenever possible. Other vehicles, such as vehicles meeting the definition of a "school bus," should be used to fulfill transportation of child passengers in particular. Conventional twelve

to fifteen-passenger vans cannot be certified as school buses by the National Highway Traffic Safety Administration (NHTSA) standards (2,4), and thus cannot be sold or leased, as new vehicles, to carry students on a regular basis. Caregivers/teachers should be knowledgeable about the laws of the state(s) in which their vehicles, including passenger vans, will be registered and used.

## Chapter 7: Infectious Diseases

### **Standard 7.2.0.2 Unimmunized Children**

If immunizations have not been or are not to be administered because of a medical condition (contraindication), a statement from the child's primary care provider documenting the reason why the child is temporarily or permanently medically exempt from the immunization requirements should be on file. If immunizations are not to be administered because of the parents/guardians' religious or philosophical beliefs, a legal exemption with notarization, waiver or other state-specific required documentation signed by the parent/guardian should be on file (1,2).

The parent/guardian of a child who has not received the age-appropriate immunizations prior to enrollment and who does not have documented medical, religious, or philosophical exemptions from routine childhood immunizations should provide documentation of a scheduled appointment or arrangement to receive immunizations. This could be a scheduled appointment with the primary care provider or an upcoming immunization clinic sponsored by a local health department or health care organization. An immunization plan and catch-up immunizations should be initiated upon enrollment and completed as soon as possible according to the "Recommended Immunization Schedules for Persons Aged 0 Through 18 Years – United States, 2011" from the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). Parents/guardians of children who attend an unlicensed child care facility should be encouraged to comply with the "Recommended Immunization Schedules" (6).

If a vaccine-preventable disease to which children are susceptible occurs in the facility and potentially exposes the unimmunized children who are susceptible to that disease, the health department should be consulted to determine whether these children should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.

### **Standard 7.2.0.3 Immunization of Caregivers/Teachers**

Caregivers/teachers should be current with all immunizations routinely recommended for adults by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) as shown in the "Recommended Adult Immunization Schedule" at <http://www.cdc.gov/vaccines/recs/schedules/default.htm#adult/>. This schedule is updated annually at the beginning of the calendar year and can be found in [Appendix H](#).

Caregivers/teachers should have received the recommended vaccines in the following categories: (1,2)



- a. Vaccines recommended for all adults who meet the age requirements and who lack evidence of immunity (i.e., lack documentation of vaccination or have no evidence of prior infection):
  - 1. Tdap/Td;
  - 2. Varicella-zoster;
  - 3. MMR (measles, mumps, and rubella);
  - 4. Seasonal influenza;
  - 5. Human papillomaviruses (HPV) (eleven through twenty-six years of age);
  - 6. Others as determined by the ACIP and state and local public health authorities.
- b. Recommended if a specific risk factor is present:
  - 1. Pneumococcal;
  - 2. Hepatitis A;
  - 3. Hepatitis B;
  - 4. Meningococcal;
  - 5. Others as determined by the ACIP and state and local public health authorities.
- c. If a staff member is not appropriately immunized for medical, religious or philosophical reasons, the child care facility should require written documentation of the reason.
- d. If a vaccine-preventable disease to which adults are susceptible occurs in the facility and potentially exposes the unimmunized adults who are susceptible to that disease, the health department should be consulted to determine whether these adults should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.

### **Standard 7.3.3.1 Influenza Immunizations for Children and Caregivers/Teachers**

The parent/guardian of each child six months of age and older should provide written documentation of current annual vaccination against influenza unless there is a medical contraindication or philosophical or religious objection. Children who are too young to receive influenza vaccine before the start of influenza season should be immunized annually beginning when they reach six months of age.

Staff caring for all children should receive annual vaccination against influenza. Ideally people should be vaccinated before the start of the influenza season (as early as August or September) and immunization should continue through March or April.

### **Standard 7.3.3.2 Influenza Control**

When influenza is circulating in the community, facilities should encourage parents/guardians to keep children with symptoms of acute respiratory tract illness with fever at home until their fever has subsided for at least twenty-four hours without use of fever reducing medication.

Caregivers/teachers with symptoms of acute respiratory tract illness with fever also should remain at home until their fever subsides for at least twenty-four hours.

### **Standard 7.3.5.1 Recommended Control Measures for Invasive Meningococcal Infection in Child Care**

Identification of an individual with invasive meningococcal infection in the child care setting should result in the following:

4. Immediate notification of the local or state health department;
5. Notification of parents/guardians about child care contacts to the person with invasive meningococcal infection;
6. Assistance with provision of antibiotic prophylaxis and vaccine receipt, as advised by the local or state health department, to child care contacts;
7. Frequent updates and communication with parents/guardians, health care professionals, and local health authorities.

### **Standard 7.4.0.1 Control of Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections**

Facilities should employ the following procedures, in addition to those stated in Child and Staff Inclusion/Exclusion/Dismissal, Standards 3.6.1.1-3.6.1.4, to prevent and control infections of the gastrointestinal tract (including diarrhea) or hepatitis A (1-3):

- a. Toilet trained children who cannot use a toilet for all bowel movements while attending the facility and who develop diarrhea, as defined in Standard 3.6.1.1, should be removed from the facility by their parent/guardian. Exclude diapered children if stool is not contained in the diaper, stool frequency exceeds two or more stools above normal for that child, blood or mucus in the stool, abnormal color of stool, no urine output in eight hours, jaundice, fever with behavior change, or looks or acts ill. Pending arrival of the parent/guardian, the child should not be permitted to have contact with other children or be placed in areas used by adults who have contact with children in the facility. This should be accomplished by removing the child who is ill to a separate area of

the child care program or, if not possible, to a separate area of the child's room. The area should be one where the child is supervised by an adult known to the child, and where the toys, equipment, and surfaces will not be used by other children or adults until after the child who is ill leaves and after the surfaces and toys have been disinfected. When moving a child to a separate area of the facility creates problems with supervision of the other children, as occurs in small family child care homes, the child who is ill should be kept as comfortable as possible, with minimal contact between children who are ill and well children, until the parent/guardian arrives. Caregivers/teachers with diarrhea as defined in Standard 3.6.1.2 should be excluded. Separation and exclusion of children or caregivers/teachers should not be deferred pending health assessment or laboratory testing to identify an enteric pathogen.

- b. A child who develops jaundice (when skin and white parts of the eye are yellow) while attending child care should be separated from other children and the child's parent/guardian should be contacted to remove the child. The child should remain separated from other children as described above until the parent/guardian arrives and removes the child from the facility.
- c. Exclusion for diarrhea should continue until either the diarrhea stops or the continued loose stools are deemed not to be infectious by a licensed health care professional. Exclusion for hepatitis A virus (HAV) should continue for one week after onset of jaundice.
- d. Alternate care for children with diarrhea or hepatitis A in special facilities for children who are ill should be provided in facilities that can provide separate care for children with infections of the gastrointestinal tract (including diarrhea) or hepatitis A.
- e. Children and caregivers/teachers who excrete intestinal pathogens but no longer have diarrhea generally may be allowed to return to child care once the diarrhea resolves, except for the case of infections with *Shigella*, Shiga toxin-producing *E. coli* (STEC), or *Salmonella enterica* serotype Typhi. For *Shigella* and STEC, resolution of symptoms and two negative stool cultures are required for readmission, unless state requirements differ. For *Salmonella* serotype Typhi, resolution of symptoms and three negative stool cultures are required for return to child care. For *Salmonella* species other than serotype Typhi, documentation of negative stool cultures are not required from asymptomatic people for readmission to child care.
- f. The local health department should be informed immediately of the occurrence of HAV infection or an increased frequency of diarrheal illness in children or staff in a child care facility.
- g. Recommended post-exposure prophylaxis for hepatitis A includes administration of hepatitis A vaccine or immune globulin to all

previously unimmunized staff members and attendees of a child care facility in which a person with hepatitis A is identified.

- h. If there has been an exposure to a person with hepatitis A or diarrhea in the child care facility, caregivers/teachers should inform parents/guardians, in cooperation with the health department, that their children may have been exposed to children with HAV infection or to another person with a diarrheal illness.

### **Standard 7.5.10.1 *Staphylococcus Aureus* Skin Infections Including MRSA**

The following should be implemented when children or staff with lesions suspicious for *Staphylococcus aureus* infections are identified:

- a. Lesions should be covered with a dressing;
- b. Report the lesions to the parent/guardian with a recommendation for evaluation by a primary care provider;
- c. Exclusion is not warranted unless the individual meets any of the following criteria:
  8. Care for other children would be compromised by care required for the person with the *S. aureus* infection;
  9. The individual with the *S. aureus* infection has fever or a change in behavior;
  10. The lesion(s) cannot be adequately covered by a bandage or the bandage needs frequent changing;
  11. A health care professional or health department official recommends exclusion of the person with *S. aureus* infection.

Meticulous hand hygiene following contact with lesions should be practiced. Careful hand hygiene and sanitization of surfaces and objects potentially exposed to infectious material are the best ways to prevent spread. Children and staff in close contact with an infected person should be observed for symptoms of *S. aureus* infection and referred for evaluation, if indicated.

A child may return to group child care when staff members are able to care for the child without compromising their ability to care for others, the child is able to participate in activities, appropriate therapy is being given, and the lesions can be covered.

*S. aureus* skin infections initially may appear as red raised areas that may become pus-filled abscesses or “boils,” surrounded by areas of redness and tenderness. Fever and other symptoms including decreased activity, bone and joint pain, and difficulty breathing may occur when the infection occurs in other body systems. If any of these signs or symptoms occur, the child should be evaluated by his/her primary care provider.

## Chapter 8: Children with Special Health Care Needs and Disabilities

No standards from Chapter 8 were selected to be included in *Stepping Stones*, Third Edition. However content specifically for children with special health care needs is included in the following standards:

Standard 1.1.1.2	Ratios for Large Family Child Care Homes and Centers
Standard 1.1.1.3	Ratios for Facilities Serving Children with Special Health Care Needs and Disabilities
Standard 1.3.2.2	Qualifications of Lead Teachers and Teachers
Standard 1.4.1.1	Pre-service Training
Standard 1.4.2.2	Orientation for Care of Children with Special Health Care Needs
Standard 1.4.3.2	Topics Covered in First Aid Training
Standard 3.5.0.1	Care Plan for Children with Special Health Care Needs
Standard 3.6.3.3	Training of Caregivers/Teachers to Administer Medication
Standard 4.2.0.8	Feeding Plans and Dietary Modifications
Standard 6.5.1.1	Competence and Training of Transportation Staff
Standard 9.2.3.2	Content and Development of the Plan for Care of Children and Staff Who Are Ill

## Chapter 9: Policies

### **Standard 9.2.3.2 Content and Development of the Plan for Care of Children and Staff Who Are Ill**

All child care facilities should have written policies for the management and care of children and staff who are ill. The facility's plan for the care of children and staff who are ill should be developed in consultation with the facility's child care health consultant and other health care professionals to address current understanding of the technical issues of contagion and other health risks. This plan should include:

- a. Policies and procedures for urgent and emergency care;
- b. Admission and inclusion/exclusion policies;
- c. A description of illnesses common to children in child care, their management, and precautions to address the needs and behavior of the child who is ill, as well as to protect the health of other children and staff;
- d. A procedure to obtain and maintain updated individual care plans for children and staff with special health care needs;
- e. A procedure for documenting the name of person affected, date and time of illness, a description of symptoms, the response of the caregiver/teacher or other staff to these symptoms, who was notified (such as a parent/guardian, primary care provider, nurse, physician, or health department), and the response;
- f. Medication policy;
- g. Seasonal and pandemic influenza policy;
- h. Staff illness-guidelines for exclusion and re-entry.

In group care, the facility should address the well-being of all those affected by illness: the child, the staff, parents/guardians of the child, other children in the facility and their parents/guardians, and the community. The priority of the policy should be to meet the needs of the child who is ill and the other children in the facility. The policy should address the circumstances under which separation of the affected individual (child or staff person) from the group is required; the circumstances under which the staff, parents/guardians, or other designated persons need to be informed; and the procedures to be followed in these cases. The policy should take into consideration:

- a. The physical facility;
- b. The number and the qualifications of the facility's personnel;
- c. The fact that children do become ill frequently and at unpredictable times;
- d. The fact that adults may be on staff with known health problems or may develop health problems while at work;

- e. The fact that working parents/guardians often are not given leave for their children's illnesses;
- f. The amount of care the child who is ill requires if the child remains in the program, can staff devote the time for caring of a child who is ill in the classroom without leaving other children unattended, and can the child participate in any of the classroom activities (1).

### **Standard 9.2.3.12 Infant Feeding Policy**

A policy about infant feeding should be developed with the input and approval from the nutritionist/registered dietitian and should include the following:

- a. Storage and handling of expressed human milk;
- b. Determination of the kind and amount of commercially prepared formula to be prepared for infants as appropriate;
- c. Preparation, storage, and handling of infant formula;
- d. Proper handwashing of the caregiver/teacher and the children;
- e. Use and proper sanitizing of feeding chairs and of mechanical food preparation and feeding devices, including blenders, feeding bottles, and food warmers;
- f. Whether expressed human milk, formula, or infant food should be provided from home, and if so, how much food preparation and use of feeding devices, including blenders, feeding bottles, and food warmers, should be the responsibility of the caregiver/teacher;
- g. Holding infants during bottle-feeding or feeding them sitting up;
- h. Prohibiting bottle propping during feeding or prolonging feeding;
- i. Responding to infants' need for food in a flexible fashion to allow cue feedings in a manner that is consistent with the developmental abilities of the child (policy acknowledges that feeding infants on cue rather than on a schedule may help prevent obesity) (1,2);
- j. Introduction and feeding of age-appropriate solid foods (complementary foods);
- k. Specification of the number of children who can be fed by one adult at one time;
- l. Handling of food intolerance or allergies (e.g., cow's milk, peanuts, orange juice, eggs, wheat).

Individual written infant feeding plans regarding feeding needs and feeding schedule should be developed for each infant in consultation with the infant's primary care provider and parents/guardians.

### **Standard 9.2.4.1 Written Plan and Training for Handling Urgent Medical Care or Threatening Incidents**

The facility should have a written plan for reporting and managing what they assess to be an incident or unusual occurrence that is threatening to the

health, safety, or welfare of the children, staff, or volunteers. The facility should also include procedures of staff training on this plan.

The management, documentation, and reporting of the following types of incidents, at a minimum, that occur at the child care facility should be addressed in the plan:

- a. Lost or missing child;
- b. Suspected maltreatment of a child (also see state's mandates for reporting);
- c. Suspected sexual, physical, or emotional abuse of staff, volunteers, or family members occurring while they are on the premises of the child care facility;
- d. Injuries to children requiring medical or dental care;
- e. Illness or injuries requiring hospitalization or emergency treatment;
- f. Mental health emergencies;
- g. Health and safety emergencies involving parents/guardians and visitors to the program;
- h. Death of a child or staff member, including a death that was the result of serious illness or injury that occurred on the premises of the child care facility, even if the death occurred outside of child care hours;
- i. The presence of a threatening individual who attempts or succeeds in gaining entrance to the facility.

The following procedures, at a minimum, should be addressed in the plan for urgent care:

- a. Provision for a caregiver/teacher to accompany a child to a source of urgent care and remain with the child until the parent/guardian assumes responsibility for the child;
- b. Provision for the caregiver/teacher to provide the medical care personnel with an authorization form signed by the parent/guardian for emergency medical care and a written informed consent form signed by the parent/guardian allowing the facility to share the child's health records with other service providers;
- c. Provision for a backup caregiver/teacher or substitute for large and small family child care homes to make the arrangement for urgent care feasible (child:staff ratios must be maintained at the facility during the emergency);
- d. Notification of parent/guardian(s);
- e. Pre-planning for the source of urgent medical and dental care (such as a hospital emergency room, medical or dental clinic, or other constantly staffed facility known to caregivers/teachers and acceptable to parents/guardians);
- f. Completion of a written incident/injury report and the program's response;



- g. Assurance that the first aid kits are resupplied following each first aid incident, and that required contents are maintained in a serviceable condition, by a monthly review of the contents;
- h. Policy for scheduled reviews of staff members' ability to perform first aid for averting the need for emergency medical services;
- i. Policy for staff supervision following an incident when a child is lost, missing, or seriously injured.

### **Standard 9.2.4.3 Disaster Planning, Training, and Communication**

Facilities should consider how to prepare for and respond to emergency or natural disaster situations and develop written plans accordingly. All programs should have procedures in place to address natural disasters that are relevant to their location (such as earthquakes, tornados, tsunamis or flash floods, storms, and volcanoes) and all hazards/disasters that could occur in any location including acts of violence, bioterrorism/terrorism, exposure to hazardous agents, facility damage, fire, missing child, power outage, and other situations that may require evacuation, lock-down, or shelter-in-place.

#### **Written Emergency/Disaster Plan:**

Facilities should develop and implement a written plan that describes the practices and procedures they use to prepare for and respond to emergency or disaster situations. This Emergency/Disaster Plan should include:

- a. Information on disasters likely to occur in or near the facility, county, state, or region that require advance preparation and/or contingency planning;
- b. Plans (and a schedule) to conduct regularly scheduled practice drills within the facility and in collaboration with community or other exercises;
- c. Mechanisms for notifying and communicating with parents/guardians in various situations (e.g., Website postings; email notification; central telephone number, answering machine, or answering service messaging; telephone calls, use of telephone tree, or cellular phone texts; and/or posting of flyers at the facility and other community locations);
- d. Mechanisms for notifying and communicating with emergency management public officials;
- e. Information on crisis management (decision-making and practices) related to sheltering in place, relocating to another facility, evacuation procedures including how non-mobile children and adults will be evacuated, safe transportation of children including children with special health care needs, transporting necessary

medical equipment obtaining emergency medical care, responding to an intruder, etc.;

- f. Identification of primary and secondary meeting places and plans for reunification of parents/guardians with their children;
- g. Details on collaborative planning with other groups and representatives (such as emergency management agencies, other child care facilities, schools, emergency personnel and first responders, pediatricians/health professionals, public health agencies, clinics, hospitals, and volunteer agencies including Red Cross and other known groups likely to provide shelter and related services);
- h. Continuity of operations planning, including backing up or retrieving health and other key records/files and managing financial issues such as paying employees and bills during the aftermath of the disaster;
- i. Contingency plans for various situations that address:
  - 1. Emergency contact information and procedures;
  - 2. How the facility will care for children and account for them, until the parent/guardian has accepted responsibility for their care;
  - 3. Acquiring, stockpiling, storing, and cycling to keep updated emergency food/water and supplies that might be needed to care for children and staff for up to one week if shelter-in-place is required and when removal to an alternate location is required;
  - 4. Administering medicine and implementing other instructions as described in individual special care plans;
  - 5. Procedures that might be implemented in the event of an outbreak, epidemic, or other infectious disease emergency (e.g., reviewing relevant immunization records, keeping symptom records, implementing tracking procedures and corrective actions, modifying exclusion and isolation guidelines, coordinating with schools, reporting or responding to notices about public health emergencies);
  - 6. Procedures for staff to follow in the event that they are on a field trip or are in the midst of transporting children when an emergency or disaster situation arises;
  - 7. Staff responsibilities and assignment of tasks (facilities should recognize that staff can and should be utilized to assist in facility preparedness and response efforts, however, they should not be hindered in addressing their own personal or family preparedness efforts, including evacuation).

Details in the Emergency/Disaster Plan should be reviewed and updated bi-annually and immediately after any relevant event to incorporate any best practices or lessons learned into the document.

Facilities should identify in advance which agency or agencies would be the primary contact for them regarding child care regulations, evacuation instructions, and other directives that might be communicated in various emergency or disaster situations.

#### Training:

Staff should receive training on emergency/disaster planning and response. Training should be provided by emergency management agencies, educators, child care health consultants, health professionals, or emergency personnel qualified and experienced in disaster preparedness and response. The training should address:

- a. Why it is important for child care facilities to prepare for disasters and to have an Emergency/Disaster Plan;
- b. Different types of emergency and disaster situations and when and how they may occur;
  8. Natural Disasters;
  9. Terrorism (i.e., biological, chemical, radiological, nuclear);
  10. Outbreaks, epidemics, or other infectious disease emergencies;
- c. The special and unique needs of children, appropriate response to children's physical and emotional needs during and after the disaster, including information on consulting with pediatric disaster experts;
- d. Providing first aid, medications, and accessing emergency health care in situations where there are not enough available resources;
- e. Contingency planning including the ability to be flexible, to improvise, and to adapt to ever-changing situations;
- f. Developing personal and family preparedness plans;
- g. Supporting and communicating with families;
- h. Floor plan safety and layout;
- i. Location of emergency documents, supplies, medications, and equipment needed by children and staff with special health care needs;
- j. Typical community, county, and state emergency procedures (including information on state disaster and pandemic influenza plans, emergency operation centers, and incident command structure);
- k. Community resources for post-event support such as mental health consultants, safety consultants;

- l. Which individuals or agency representatives have the authority to close child care programs and schools and when and why this might occur;
- m. Insurance and liability issues;
- n. New advances in technology, communication efforts, and disaster preparedness strategies customized to meet children's needs.

Communicating with Parents/Guardians:

Facilities should share detailed information about facility disaster planning and preparedness with parents/guardians when they enroll their children in the program, including:

- a. Portions of the Emergency/Disaster Plan relevant to parents/guardians or the public;
- b. Procedures and instructions for what parents/guardians can expect if something happens at the facility;
- c. Description of how parents/guardians will receive information and updates during or after a potential emergency or disaster situation;
- d. Situations that might require parents/guardians to have a contingency plan regarding how their children will be cared for in the unlikely event of a facility closure.

Facilities should conduct an annual drill, test, or "practice use" of the communication options/mechanisms that are selected.

### **Standard 9.2.4.5 Emergency and Evacuation Drills/Exercises Policy**

The facility should have a policy documenting that emergency drills/exercises should be regularly practiced for geographically appropriate natural disasters and human generated events such as:

- a. Fire, monthly;
- b. Tornadoes, on a monthly basis in tornado season;
- c. Floods, before the flood season;
- d. Earthquakes, every six months;
- e. Hurricanes, annually;
- f. Threatening person outside or inside the facility;
- g. Rabid animal;
- h. Toxic chemical spill;
- i. Nuclear event.

All drills/exercises should be recorded. Please see Standard 9.4.1.16: Evacuation and Shelter-in-Place Drill Record for more information.

A fire evacuation procedure should be approved and certified in writing by a fire inspector for centers, and by a local fire department representative for large and small family child care homes, during an annual on-site visit when an evacuation drill is observed and the facility is inspected for fire safety hazards.

Depending on the type of disaster, the emergency drill may be within the existing facility such as in the case of earthquakes or tornadoes where the drill might be moving to a certain location within the building (basements, away from windows, etc.) Evacuation drills/exercises should be practiced at various times of the day, including nap time, during varied activities and from all exits. Children should be accounted for during the practice.

The facility should time evacuation procedures. They should aim to evacuate all persons in the specific number of minutes recommended by the local fire department for the fire evacuation, or recommended by emergency response personnel.

Cribs designed to be used as evacuation cribs, can be used to evacuate infants, if rolling is possible on the evacuation route(s).

### **Standard 9.2.4.7 Sign-In/Sign-Out System**

The facility should have a sign-in/sign-out system to track who enters and exits the facility. The system should include name, contact number, relationship to facility (e.g., parent/guardian, vendor, guest, etc.) and recorded time in and out.

**TYPE OF FACILITY:** Center, Large Family Child Care Home

### **Standard 9.2.4.8 Authorized Persons to Pick Up Child**

Names, addresses, and telephone numbers of persons authorized to take a child under care out of the facility should be maintained during the enrollment process along with clarification/documentation of any custody issues/court orders. The legal guardian(s) of the child should be established and documented at this time.

If there is an extenuating circumstance (e.g., the parent/guardian or other authorized person is not able to pick up the child), another individual may pick up a child from child care if they are authorized to do so by the parent/guardian in authenticated communication such as a witnessed phone conversation in which the caller provides pre-specified identifying information or writing with pre-specified identifying information. The telephone authorization should be confirmed by a return call to the parents/guardians. The facility should establish a mechanism for identifying a person for whom the parents/guardians have given the facility prior written authorization to pick up their child, such as requiring photo ID or including a photo of each authorized person in the child's file.

If a previously unauthorized individual drops off the child, he or she will not be authorized to pick up the child without first being added to the authorization record. Policies should address how the facility will handle the situation if a parent/guardian arrives who is intoxicated or otherwise incapable of bringing the child home safely, or if a non-custodial parent attempts to claim the child without the consent of the custodial parent.

Should an unauthorized individual arrive without the facility receiving prior communication with the parent/guardian, the parent/guardian should be contacted immediately, preferably privately. If the information provided by the parent/guardian does not match the information and identification of the unauthorized individual, the child will not be permitted to leave the child care facility. If it is determined that the parent/guardian is unaware of the individual's attempt to pick-up the child, or if the parent/guardian has not or will not authorize the individual to take the child from the child care facility, information regarding the individual should be documented and the individual should be asked to leave. If the individual does not leave and his or her behavior is concerning to the child care staff or if the child is abducted by force, then the police should be contacted immediately with a detailed description of the individual and any other obtainable information such as a license plate number.

#### **Standard 9.4.1.10 Documentation of Parent/Guardian Notification of Injury, Illness, or Death in Program**

The facility should document that a child's parent/guardian was notified immediately in the event of a death of their child, of an injury or illness of their child that required professional medical attention, or if their child was lost/missing.

Documentation should also occur noting when law enforcement was notified (immediately) in the event of a death of a child or a lost/missing child.

The facility should document in accordance with state regulations, its response to any of the following events:

- a. Death;
- b. Serious injury or illness that required medical attention;
- c. Reportable infectious disease;
- d. Any other significant event relating to the health and safety of a child (such as a lost child, a fire or other structural damage, work stoppage, or closure of the facility).

The caregiver/teacher should call 9-1-1 to insure immediate emergency medical support for a death or serious injury or illness. They should follow state regulations with regard to when they should notify state agencies such as the licensing agency and the local or state health department about any of the above events.

#### **Standard 9.4.1.12 Record of Valid License, Certificate, or Registration of Facility**

Every facility should hold a valid license or certificate, or documentation of, registration prior to operation as required by the local and/or state statute.

### **Standard 9.4.2.6 Contents of Medication Record**

The file for each child should include a medication record maintained on an ongoing basis by designated staff for all prescription and non-prescription (over-the-counter [OTC]) medications. State requirements should be checked and followed. The medication record for prescription and non-prescription medications should include the following:

- a. A separate consent signed by the parent/guardian for each medication the caregiver/teacher has permission to administer to the child; each consent should include the child's name, medication, time, dose, how to give the medication, and start and end dates when it should be given;
- b. Authorization from the prescribing health professional for each prescription and non-prescription medication; this authorization should also include potential side effects and other warnings about the medication (exception: non-prescription sunscreen and insect repellent always require parental/guardian consent but do not require instructions from each child's individual medical provider);
- c. Administration log which includes the child's name, the medication that was given, the dose, the route of administration, the time and date, and the signature or initials of the person administering the medication. For medications given "as needed," record the reason the medication was given. Space should be available for notations of any side-effects noted after the medication was given or if the dose was not retained because of the child vomiting or spitting out the medication. Documentation should also be made of attempts to give medications that were refused by the child;
- d. Information about prescription medication brought to the facility by the parents/guardians in the original, labeled container with a label that includes the child's name, date filled, prescribing clinician's name, pharmacy name and phone number, dosage/instructions, and relevant warnings. Potential side effects and other warnings about the medication should be listed on the authorization form;
- e. Non prescription medications should be brought to the facility in the original container, labeled with the child's complete name and administered according to the authorization completed by the person with prescriptive authority;
- f. For medications that are to be given or available to be given for the entire year, a Care Plan should also be in place (for instance, inhalers for asthma or epinephrine for possible allergy);
- g. Side effects.

## Chapter 10: Licensing and Community Action

### **Standard 10.4.2.1 Frequency of Inspections for Child Care Centers, Large Family Child Care Homes, and Small Family Child Care Homes**

The licensing inspector should make an onsite inspection to measure compliance with licensing rules prior to issuing an initial license and at least two inspections each year to each center and large and small family child care home thereafter. At least one of the inspections should be unannounced and more if needed for the facility to achieve satisfactory compliance or is closed at any time (1). Sufficient numbers of licensing inspectors should be hired to provide adequate time visiting and inspecting facilities to insure compliance with regulations

The number of inspections should not include those inspections conducted for the purpose of investigating complaints. Complaints should be investigated promptly, based on severity of the complaint. States are encouraged to post the results of licensing inspections, including complaints, on the Internet for parent and public review. Parents/guardians should be provided easy access to the licensing rules and made aware of how to report complaints to the licensing agency.



### Gloving

Wash hands prior to using gloves if hands are visibly soiled.



Put on a clean pair of gloves.



Provide the appropriate care.



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



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



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



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

Note that sensitivity to latex is a growing problem. If caregivers/teachers or children who are sensitive to latex are present in the facility, non-latex gloves should be used.

Adapted with permission from: California Department of Education. 1995. *Keeping kids healthy: Preventing and managing communicable disease in child care*. Sacramento, CA: California Department of Education.

This schedule was current at time of Caring for Our Children printing in 2011.  
To check for latest edition, go to <http://www.cdc.gov/vaccines/recs/schedules/default.htm>

## Recommended Adult Immunization Schedule

### UNITED STATES • 2011

Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

**Figure 1. Recommended adult immunization schedule, by vaccine and age group**

VACCINE ▼	AGE GROUP ▶	19–26 years	27–49 years	50–59 years	60–64 years	>65 years
Influenza <sup>1,*</sup>				1 dose annually		
Tetanus, diphtheria, pertussis (Td/Tdap) <sup>2,*</sup>						Td booster every 10 yrs
Varicella <sup>3,*</sup>				2 doses		
Human papillomavirus (HPV) <sup>4,*</sup>		3 doses (females)				
Zoster <sup>5</sup>					1 dose	
Measles, mumps, rubella (MMR) <sup>6,*</sup>			1 or 2 doses		1 dose	
Pneumococcal (polysaccharide) <sup>7,8</sup>				1 or 2 doses		1 dose
Meningococcal <sup>9,*</sup>				1 or more doses		
Hepatitis A <sup>10,*</sup>				2 doses		
Hepatitis B <sup>11,*</sup>				3 doses		

\*Covered by the Vaccine Injury Compensation Program.

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of previous infection)

Recommended if none other risk factor is present (e.g., based on medical, occupational, lifestyle, or other indications)

No recommendation

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at <http://www.vaers.hhs.gov> or by telephone, 800-822-7867.  
Information on how to file a Vaccine Injury Compensation Program claim is available at <http://www.hrsa.gov/vaccinecompensation> or by telephone, 800-538-2392. Information about filing a claim for vaccine injury is available through the U.S. Court of Federal Claims, 717 Madison Plaza, N.W., Washington, D.C. 20005; telephone, 202-557-9400.  
Additional information about the vaccine in this schedule, extent of available data, and contraindications for vaccination also is available at <http://www.cdc.gov/vaccines> or from the CDC-NPD Contact Center at 800-CDC-INFO (800-232-6389) in English and Spanish, 24 hours a day, 7 days a week.

## Appendix H

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This schedule was current at time of Caring for Our Children printing in 2011.  
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**Figure 2. Vaccines that might be indicated for adults based on medical and other indications**

VACCINE ▼	INDICATION ►	Immunosuppressing conditions (excluding human immunodeficiency virus) (HIV) 3,4,5,13	HIV infection 4,13,15 CD4+ T lymphocyte count <200 cells/mm <sup>3</sup> >200 cells/mm <sup>3</sup>	Diabetes, heart disease, lung disease, chronic renal disease, chronic alcoholism	Asplenia 12 (including splenectomy and splenic dysfunction) complement component deficiencies	Chronic liver disease	Kidney failure, end-stage renal disease, receipt of hemodialysis	Healthcare personnel
Influenza 1,*								1 dose TIV or LAIV annually
Tetanus, diphtheria, pertussis (Td/Tdap) 2,*								Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs
Varicella 3,*								Contraindicated
Human papillomavirus (HPV) 4,*								2 doses
Zoster 5								3 doses through age 26 yrs
Measles, mumps, rubella (MMR) 6,*								1 dose
Pneumococcal (polysaccharide) 7,8								1 or 2 doses
Meningococcal 9,*								1 or 2 doses
Hepatitis A 10,*								1 or more doses
Hepatitis B 11,*								2 doses
								3 doses

\*Covered by the Vaccine Injury Compensation Program.

For all persons in this category who need the age-appropriate vaccine, the following information is required (to be documented at vaccination or later):

1. No contraindications to vaccination or injury

2. No evidence of previous infection

Recommended if same other risk factor is present (if not, no recommendation)

Final, lifestyle, or other indications

No recommendation

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly indicated for adults ages 19 years and older as of February 4, 2011. For all vaccines being recommended on the adult immunization schedule, a vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/pubs/acip.htm>).

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Physicians (ACP).



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



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## Footnotes

### Recommended Adult Immunization Schedule—UNITED STATES • 2011

For complete statements by the Advisory Committee on Immunization Practices (ACIP), visit [www.cdc.gov/vaccines/pubs/acip-list.htm](http://www.cdc.gov/vaccines/pubs/acip-list.htm).

#### 1. Influenza vaccination

Annual vaccination against influenza is recommended for all persons aged 6 months and older, including all adults. Healthy, nonpregnant adults aged less than 50 years without high-risk medical conditions can receive either intranasally administered live, attenuated influenza vaccine (FluMist), or inactivated vaccine. Other persons should receive the inactivated vaccine. Adults aged 65 years and older can receive the standard influenza vaccine or the high-dose (Fluzone) influenza vaccine. Additional information about influenza vaccination is available at <http://www.cdc.gov/vaccines/vpd-vpd/default.htm>.

#### 2. Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination

Administer a one-time dose of Tdap to adults aged less than 65 years who have not received Tdap previously or for whom vaccine status is unknown to replace one of the 10-year Td boosters, and as soon as feasible to all 1) postpartum women, 2) close contacts of infants younger than age 12 months (e.g., grandparents and child-care providers), and 3) healthcare personnel with direct patient contact. Adults aged 65 years and older who have not previously received Tdap and who have close contact with an infant aged less than 12 months also should be vaccinated. Other adults aged 65 years and older may receive Tdap. Tdap can be administered regardless of interval since the most recent tetanus or diphtheria-containing vaccine.

Adults with uncertain or incomplete history of completing a 3-dose primary vaccination series with Td-containing vaccines should begin or complete a primary vaccination series. For unvaccinated adults, administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second. If incompletely vaccinated (i.e., less than 3 doses), administer remaining doses. Substitute a one-time dose of Tdap for one of the doses of Td, either in the primary series or for the routine booster, whichever comes first.

If a woman is pregnant and received the most recent Td vaccination 10 or more years previously, administer Td during the second or third trimester. If the woman received the most recent Td vaccination less than 10 years previously, administer Tdap during the immediate postpartum period. At the clinician's discretion, Td may be deferred during pregnancy and Tdap substituted in the immediate postpartum period, or Tdap may be administered instead of Td to a pregnant woman after an informed discussion with the woman.

The ACIP statement for recommendations for administering Td as prophylaxis in wound management is available at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>.

#### 3. Varicella vaccination

All adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine if not previously vaccinated or a second dose if they have received only 1 dose, unless they have a medical contraindication. Special consideration should be given to those who 1) have close contact with persons at high risk for severe disease (e.g., healthcare personnel and family contacts of persons with immunocompromising conditions) or 2) are at high risk for exposure or transmission (e.g., teachers; child-care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).

Evidence of immunity to varicella in adults includes any of the following: 1) documentation of 2 doses of varicella vaccine at least 4 weeks apart; 2) U.S.-born before 1980 (although for healthcare personnel and pregnant women, birth before 1980 should not be considered evidence of immunity); 3) history of varicella based on diagnosis or verification of varicella case or to a laboratory-confirmed case or evidence of laboratory confirmation, if it was performed at the time of acute disease; 4) history of herpes zoster based on diagnosis or verification of herpes zoster by a healthcare provider; or 5) laboratory evidence of immunity or laboratory confirmation of disease.

Pregnant women should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion of pregnancy and before discharge from the healthcare facility. The second dose should be administered 4–8 weeks after the first dose.

#### 4. Human papillomavirus (HPV) vaccination

HPV vaccination with either quadrivalent (HPV4) vaccine or bivalent vaccine (HPV2) is recommended for females at age 11 or 12 years and catch-up vaccination for females aged 13 through 26 years.

Ideally, vaccine should be administered before potential exposure to HPV through sexual activity; however, females who are sexually active should still be vaccinated consistent with age-based recommendations. Sexually active females who have not been infected with any of the four HPV vaccine types (types 6, 11, 16, and 18, all of which HPV4 prevents) or any of the two HPV vaccine types (types 16 and 18, both of which HPV2 prevents) receive the full benefit of the vaccination. Vaccination is less beneficial for females who have already been infected with one or more of the HPV vaccine types. HPV4 or HPV2 can be administered to persons with a history of genital warts, abnormal Papanicolaou test, or positive HPV DNA test. Because test conditions are not evidence of previous infection with all vaccine HPV types, HPV4 or HPV2 should be administered to males aged 9 through 26 years to receive their likelihood of genital warts. HPV4 would be most effective when administered before exposure to HPV through sexual activity.

A complete series for either HPV4 or HPV2 consists of 3 doses. The second dose should be administered 1–2 months after the first dose; the third dose should be administered 6 months after the first dose.

Although HPV vaccination is not specifically recommended for persons with the medical indications described in Figure 2, "Vaccines that might be indicated for adults based on medical and other indications," it may be administered to these persons because the HPV vaccine is not a live-vaccine. However, the immune response and vaccine efficacy might be less for persons with the medical indications described in Figure 2 than in persons who do not have the medical indications described or who are immunocompetent.

## Appendix H

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## 5. Herpes zoster vaccination

A single dose of zoster vaccine is recommended for adults aged 60 years and older regardless of whether they report a previous episode of herpes zoster. Persons with chronic medical conditions may be vaccinated unless their condition constitutes a contraindication.

## 6. Measles, mumps, rubella (MMR) vaccination

Adults born before 1957 generally are considered immune to measles and mumps. All adults born in 1957 or later should have documentation of 1 or more doses of MMR vaccine unless they have a medical contraindication to the vaccine, laboratory evidence of immunity to each of the three diseases, or documentation of provider-diagnosed measles or mumps disease. For rubella, documentation of provider-diagnosed disease is not considered acceptable evidence of immunity.

**Measles component:** A second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who 1) have been recently exposed to measles (within 12 weeks of exposure), 2) are students in postsecondary educational institutions, 3) work in a healthcare facility, or 4) plan to travel internationally. Persons who received inactivated (killed) measles vaccine in childhood should be vaccinated with 2 doses of MMR vaccine.

**Mumps component:** A second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who 1) live in a community experiencing a mumps outbreak and are in an affected age group; 2) are students in postsecondary educational institutions; 3) work in a healthcare facility; or 4) plan to travel internationally. Persons vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type who are at high risk for mumps infection (e.g., persons who are working in a healthcare facility) should be revaccinated with 2 doses of MMR vaccine.

**Rubella component:** For women of childbearing age, regardless of birth year, rubella immunity should be determined. If there is no evidence of immunity, women who are not pregnant should be vaccinated. Pregnant women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the healthcare facility.

Healthcare personnel born before 1957: For unvaccinated healthcare personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, healthcare facilities should 1) consider routinely vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval (for measles and mumps) and 1 dose of MMR vaccine (for rubella), and 2) recommend 2 doses of MMR vaccine at the appropriate interval during an outbreak of measles or mumps, and 1 dose during an outbreak of rubella. Complete information about evidence of immunity is available at <http://www.cdc.gov/vaccines/recs/provisional/default.htm>.

## 7. Pneumococcal polysaccharide (PPSV) vaccination

Vaccinate all persons with the following indications:

**Medical:** Chronic lung disease (including asthma); chronic cardiovascular disease; diabetes mellitus; chronic liver disease; cirrhosis; chronic alcoholism; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy [if alcoholic splenectomy is planned, vaccinate at least 2 weeks before surgery]); immunocompromising conditions (including chronic renal failure or nephrotic syndrome); and cochlear implants and cerebrospinal fluid leaks. Vaccinate as close to HIV diagnosis as possible.

**Other:** Residents of nursing homes or long-term care facilities and persons who smoke cigarettes. Routine use of PPSV is not recommended for American Indians/Alaska Natives or persons aged less than 65 years unless they have underlying medical conditions that are PPSV indications. However, public health authorities may consider recommending PPSV for American Indians/Alaska Natives and persons aged 50 through 64 years who are living in areas where the risk for invasive pneumococcal disease is increased.

## 8. Revaccination with PPSV

One-time revaccination after 5 years is recommended for persons aged 19 through 64 years with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); and for persons with immunocompromising conditions. For persons aged 65 years and older, one-time revaccination is recommended if they were vaccinated 5 or more years previously and were aged less than 65 years at the time of primary vaccination.

## 9. Meningococcal vaccination

Meningococcal vaccine should be administered to persons with the following indications:

**Medical:** A 2-dose series of meningococcal conjugate vaccine is recommended for adults with anatomic or functional asplenia, or persistent complement component deficiencies. Adults with HIV infection who are vaccinated should also receive a routine 2-dose series. The 2-dose schedule should be administered at 0 and 2 months.

**Other:** A single dose of meningococcal vaccine is recommended for unvaccinated first-year college students living in dormitories; microbiologists routinely exposed to isolates of *Neisseria meningitidis*; military recruits; and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic (e.g., the "meningitis belt" of sub-Saharan Africa during the dry season [December through June]), particularly if their contact with local populations will be prolonged. Vaccination is required by the government of Saudi Arabia for all travelers to Mecca during the annual Hajj.

Meningococcal conjugate vaccine, quadrivalent (MCV4) is preferred for adults with any of the preceding indications who are aged 55 years and younger; meningococcal polysaccharide vaccine (PPSV4) is preferred for adults aged 56 years and older. Revaccination with MCV4 every 5 years is recommended for adults previously vaccinated with MCV4 or PPSV4 who remain at increased risk for infection (e.g., adults with anatomic or functional asplenia, or persistent complement component deficiencies).



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#### 10. Hepatitis A vaccination

Vaccinate persons with any of the following indications and any person seeking protection from hepatitis A virus (HAV) infection:  
*Behavioral:* Men who have sex with men and persons who use injection drugs.

*Occupational:* Persons working with HAV-infected primates or with HAV in a research laboratory setting.

*Medical:* Persons with chronic liver disease and persons who receive clotting factor concentrates.

*Other:* Persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A (a list of countries is available at <http://www.cdc.gov/travel/content/diseases.aspx>).

Unvaccinated 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 should be vaccinated. The first dose of the 2-dose hepatitis A vaccine series should be administered as soon as adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.

Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6–12 months (Havrix), or 0 and 6–18 months (Vaqta). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule may be used, administered on days 0, 7, and 21–30, followed by a booster dose at month 12.

#### 11. Hepatitis B vaccination

Vaccinate persons with any of the following indications and any person seeking protection from hepatitis B virus (HBV) infection:

*Behavioral:* Sexually active persons who are not in a long-term, mutually monogamous relationship (e.g., persons with more than one sex partner during the previous 6 months); persons seeking evaluation or treatment for a sexually transmitted disease (STD); current or recent injection-drug users; and men who have sex with men.

*Occupational:* Healthcare personnel and public-safety workers who are exposed to blood or other potentially infectious body fluids.

*Medical:* Persons with end-stage renal disease, including patients receiving hemodialysis; persons with HIV infection; and persons with chronic liver disease.

*Other:* Household contacts and sex partners of persons with chronic HBV infection; clients and staff members of institutions for persons with developmental disabilities; and international travelers to countries with high or intermediate prevalence of chronic HBV infection (a list of countries is available at <http://www.cdc.gov/travel/content/diseases.aspx>).

Hepatitis B vaccination is recommended for all adults in the following settings: STD treatment facilities; HIV testing and treatment facilities; facilities providing drug-abuse treatment and prevention services; healthcare settings targeting services to injection-drug users or men who have sex with men; correctional facilities; end-stage renal disease programs and facilities for chronic hemodialysis patients; and institutions and nontesidential day-care facilities for persons with developmental disabilities.

Administer missing doses to complete a 3-dose series of hepatitis B vaccine to those persons not vaccinated or not completely vaccinated. The second dose should be administered 1 month after the first dose, the third dose should be given at least 2 months after the second dose (and at least 4 months after the first dose). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose 1wmx schedule, administered on days 0, 7, and 21 to 30, followed by a booster dose at month 12 may be used.

Adult patients receiving hemodialysis or with other immunocompromising conditions should receive 1 dose of 40 µg/mL (Recombivax HB) administered on a 3-dose schedule or 2 doses of 20 µg/mL (Engerix-B) administered simultaneously on a 4-dose schedule at 0, 1, 2, and 6 months.

#### 12. Selected conditions for which *Haemophilus influenzae* type b (Hib) vaccine may be used

1 dose of Hib vaccine should be considered for persons who have sickle cell disease, leukemia, or HIV infection, or who have had a splenectomy, if they have not previously received Hib vaccine.

#### 13. Immunocompromising conditions

Inactivated vaccines generally are acceptable (e.g., pneumococcal, meningococcal, influenza [inactivated influenza vaccine]) and live vaccines generally are avoided in persons with immune deficiencies or immunocompromising conditions. Information on specific conditions is available at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>.

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## Appendix J

**SELECTING AN APPROPRIATE SANITIZER OR DISINFECTANT**

One of the most important steps in reducing the spread of infectious diseases in child care settings is cleaning, sanitizing or disinfecting surfaces that could possibly pose a risk to children or staff. Routine cleaning with detergent and water is the most common method for removing some germs from surfaces in the child care setting. However, most items and surfaces in a child care setting require sanitizing or disinfecting after cleaning to further reduce the number of germs on a surface to a level that is unlikely to transmit disease.

**What is the difference between sanitizing and disinfecting?**

Sometimes these terms are used as if they mean the same thing, but they are not the same.

**Sanitizer** is a product that reduces but does not eliminate germs on inanimate surfaces to levels considered safe by public health codes or regulations. A sanitizer may be appropriate to use on food contact surfaces (dishes, utensils, cutting boards, high chair trays), toys that children may place in their mouths, and pacifiers. See Appendix K, Routine Schedule for Cleaning, Sanitizing and Disinfecting for guidance on use of sanitizer vs. disinfectant.

**Disinfectant** is a product that destroys or inactivates germs (but not spores) on an inanimate object. A disinfectant may be appropriate to use on hard, non-porous surfaces such as diaper change tables, counter tops, door & cabinet handles, and toilets and other bathroom surfaces. See Appendix K, Routine Schedule for Cleaning, Sanitizing and Disinfecting for guidance on use of sanitizer vs. disinfectant.

The U.S. Environmental Protection Agency (EPA) recommends that only EPA-registered products be used. Only a sanitizer or disinfectant product with an EPA registration number on the label can make public health claims that they are effective in reducing or inactivating germs. Many bleach and hydrogen peroxide products are EPA-registered and can be used to sanitize or disinfect. Please see the "How to Find EPA Registration Information" section below to learn more specific information on the products.

Always follow the manufactures' instructions when using EPA-registered products described as sanitizers or disinfectants. This includes pre-cleaning, how long the product needs to remain wet on the surface or item, whether or not the product should be diluted or used as is, and if rinsing is needed. Also check to see if that product can be used on a food contact surface or is safe for use on items that may go into a child's mouth. Please note that the label instructions on most sanitizers and disinfectants indicate that the surface must be pre-cleaned before applying the sanitizer or disinfectant.

**Are there alternatives to chlorine bleach?**

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

- it is registered with the EPA;
- it is also described as a sanitizer or as a disinfectant;
- 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 it 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.

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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 an EPA registration number and follow the manufacturer's instructions for use and safe handling. (Please see the "How to Find EPA Registration Information" section below for more information.) Remember that EPA-registered products will also have available a Material Safety Data Sheet (MSDS) that will provide instructions for the safe use of the product and guidance for first aid response to an accidental exposure to the chemical.

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.

**Household Bleach & Water**

Many household bleach products are now EPA-registered. When purchasing EPA-registered chlorine bleach, make sure that the bleach concentration is for household use, and not for industrial applications. Household chlorine bleach is typically sold in retail stores as an 8.25% sodium hypochlorite solution.

EPA-registered bleach products are described as sanitizers and disinfectants. Check the label to see if the product has an EPA registration number and follow the manufacturer's safety and use instructions. (Please see the "How to Find EPA Registration Information" section below for more information.) Pay particular attention to the mixing "recipe" and the required contact time (i.e., the time the solution must remain on a surface to be effective) for each use. Remember, the recipe and contact time are most likely different for sanitizing and disinfecting.

If you are not using an EPA-registered product for sanitizing and disinfecting, please be sure you are following state or local recommendations and/or manufacturer's instructions for creating safe dilutions necessary to sanitize and/or disinfect surfaces in your early care and education environment. Using too little (a weak concentration) bleach may make the mixture ineffective; however, using too much (a strong concentration) bleach may create a potential health hazard.

**To safely prepare bleach solutions:**

- Dilute bleach with cool water and do not use more than the recommended amount of bleach.
- Select a bottle made of opaque material.
- Make a fresh bleach dilution daily; label the bottle with contents and the date mixed.
- Wear gloves and eye protection when diluting bleach.
- Use a funnel.
- Add bleach to the water rather than the water to bleach to reduce fumes.
- Make sure the room is well ventilated.
- Never mix or store ammonia with bleach or products that contain bleach.



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## Appendix J

**To safely use bleach solutions:**

- Apply the bleach dilution after cleaning the surface with soap or detergent and rinsing with water if visible soil is present.
- If using a spray bottle, adjust the setting to produce a heavy spray instead of a fine mist.
- Allow for the contact time specified on the label of the bleach product.
- Apply when children are not present in the area.
- Ventilate the area by allowing fresh air to circulate and allow the surfaces to completely air dry or wipe dry after the required contact time before allowing children back into the area.
- Store all chemicals securely, out of reach of children and in a way that they will not tip and spill.

**Adapted** from: California Childcare Health Program. 2013. Safe and Effective Cleaning sanitizing and Disinfecting. *Health and Safety Notes* (March).

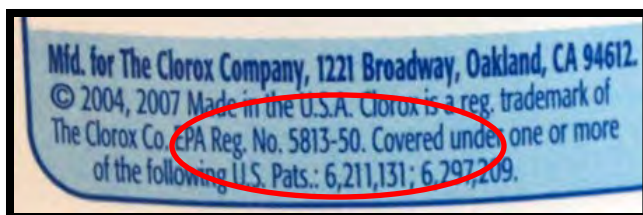
**To Review:**

- Determine if the surface requires sanitizing or disinfecting;
- Check the labels of all products to see if they are EPA-registered; there are alternatives to chlorine bleach;
- Many chlorine bleach products (8.25% sodium, hypochlorite) are now EPA-registered
  - If EPA-registered, you must follow the label instructions for “recipes” and contact times;
- If using non-EPA-registered products, follow state or local recommendations for “recipes” and contact times;
- Prepare and use the solutions safely;
- Use products that are safe for oral contact when used on food contact surfaces or on items that may mouthed by children.

**How to Find EPA Registration Information**

*The following information is intended to serve as a visual guide to locating EPA registration numbers and product label information. Any products featured in the examples below are used for illustrative purpose only, and do not represent an endorsement by the National Resource Center for Health and Safety in Child Care and Early Education (NRC). **The NRC does not endorse specific products.***

1. Locate the EPA Registration number on the product label:



## Appendix J

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2. Go to <http://iaspub.epa.gov/apex/pesticides/?p=PPLS:1>. Enter this number into the box titled "EPA Registration Number" and click the Search button:

**EPA** United States Environmental Protection Agency

LEARN THE ISSUES SCIENCE & TECHNOLOGY LAWS & REGULATIONS ABOUT EPA

Advanced Search A-Z Index

**Pesticide Product Label System**

You are here: EPA Home > Pesticides > Pesticide Product Labels > Pesticide Product Label System (PPLS)

**Product Labeling**  
Pesticide Product Label System (PPLS)

The Pesticide Product Label System (PPLS) provides a collection of pesticide product labels (Adobe PDF format) that have been approved by EPA under Section 3 of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA). New labels were added to PPLS on December 03, 2012. [View More](#)

*PPLS has many new features!*

**Find a Pesticide Product Label**  
Below are three options to help you locate labels.

**Product Name:**

Enter the name of the product. As you type, options will be presented to you. Keep in mind that product names may vary, so if you don't find the product you are looking for, try the *EPA Registration Number Search* below.

**Company Name:**

Enter the name of the company. Some companies may have several divisions that manufacture and market pesticides products. You can select among these divisions using the drop-down list or choose the root of the company name (e.g., "Bayer" or "3M") to see products associated with all of the divisions.

**EPA Registration Number:**

5813-100

The EPA Registration Number (EPA Reg. No.) appears on all registered pesticides sold in the United States. It is usually found on the back panel of the label along with the detailed instructions for use. Enter the company number (the first set of digits before the dash) to see all products marketed by the company or the entire number (including the dash) to view the label for a particular product. [More...](#)

Search Clear

Information for Webmasters  
EPA Registration Number

## J

## Appendix J

3. You should see the details about the product, and beneath that, a portable document file (PDF) bearing the date that this product was registered by the EPA (if there is a list, the PDF at the top of the list should show the most recent approval). Click on that most recently-approved PDF. You will need a PDF file reader to access this file. There are a variety of readers available and most are free.

You will need Adobe Reader to view some of the files on this page. See EPA's PDF page to learn more.

Provided below is the information for the product you selected. To view the label, click on the date in the **Approved Date** Field. The latest label is at the top of the list.

[Search Again](#)

### Details for PUMA

EPA Registration Number: 5813-100

Company Name: CLOROX CO., THE

Division Name: C/O PS&RC

P.O. Box: 493

City, State Zip: PLEASANTON, CA 945660803

Current Status (Date): Active (JANUARY 12, 2011)

Alternate Name(s): CLOROX DISINFECTING BLEACH1; CLOROX GERMICIDAL BLEACH2; CLOROX MULTI-PURPOSE BLEACH1; CLOROX REGULAR-BLEACH1; CONCENTRATED CLOROX DISINFECTING BLEACH1; CONCENTRATED CLOROX GERMICIDAL BLEACH1; CONCENTRATED CLOROX MULTI-PURPOSE BLEACH1; CONCENTRATED CLOROX REGULAR-BLEACH

Labels and Amendments

EPA Reg. No.	Product Name	Approved Date
5813-100	PUMA	February 13, 2012 (PDF)
5813-100	PUMA	December 22, 2011 (PDF)
5813-100	PUMA	September 21, 2011 (PDF)
5813-100	PUMA	April 27, 2011 (PDF)
5813-100	PUMA	January 12, 2011 (PDF)

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## Appendix J

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4. The PDF should come up on your screen. Scroll down to the section that shows the directions for using the product as a sanitizer or disinfectant. Follow the directions listed for your intended use.

For Sanitizing -or- To Sanitize			
Work Surfaces	2 tsp [1/3 oz]	1 Gallon	Wash, rinse, wipe surface area with bleach solution for [at least] 2 minutes. Let air dry. or- To sanitize work surfaces, wash, rinse and wipe surface area with a solution of 2 teaspoons of bleach per 1 gallon of water for [at least] 2 minutes. Let air dry.
Dishes, Glassware, Utensils	2 tsp [1/3 oz]	1 Gallon	Wash and rinse. [After washing,] soak for [at least] 2 minutes in bleach solution, [drain] and [let] air dry. or- To sanitize dishes, glassware, and utensils, wash and rinse. [After washing,] soak for [at least] 2 minutes in a solution of 2 teaspoons of bleach per 1 gallon of water, [drain] and air dry.
Refrigerators, Freezers	2 tsp [1/3 oz]	1 Gallon	Remove food [from refrigerator -and/or- freezer]. Wash, rinse, wipe surface area with bleach solution for [at least] 2 minutes. Let air dry.
Plastic Cutting Boards	2 tsp [1/3 oz]	1 Gallon	Wash and rinse. [After washing,] soak for [at least] 2 minutes in bleach solution, let air dry.
Wooden Cutting Boards	2 Tbsp [1 oz]	1 Gallon	Wash, wipe, or rinse with detergent and water, then apply sanitizing -or- bleach solution. Let stand 2 minutes. Rinse with a solution of 2 teaspoons of this product per gallon of water. Do not rinse or soak equipment overnight.
Baby Bottles	2 tsp [1/3 oz]	1 Gallon	Wash and rinse. [After washing,] soak for [at least] 2 minutes in bleach solution, let air dry.
Garbage Cans	1/2 cup [4 oz]	1 Gallon	After washing and rinsing, brush inside with bleach solution. Let stand for 5 minutes before rinsing.
Pot [Food -and/or- Water] Bowls	2 tsp [1/3 oz]	1 Gallon	Wash and rinse. [After washing,] soak for [at least] 2 minutes in bleach solution, let air dry.
[Kitchen] [Dish]cloths & Rags	1/2 cup [4 oz]	1 Gallon	[Pre-]wash items, then soak in solution for [at least] 5 minutes. Rinse and air dry.

For Disinfecting -or- To Disinfect			
Floors, Walls, Vinyl, Glazed Tiles -and/or- [insert relevant use site(s)] [see I (et S)]	1/2 cup [4 oz]	1 Gallon	[Pre-]wash surface, [mop or] wipe with bleach solution. Allow solution to contact surface for [at least] 5 minutes. Rinse well and air dry. or- To disinfect floors, vinyl, and glazed tiles, pre-wash surface, then mop or wipe with a solution of 1/2 cup of bleach per 1 gallon of water. Allow solution to contact surface for [at least] 5 minutes. Rinse well and air dry. [For <i>Pseudomonas aeruginosa</i> , <i>Cytomegalovirus</i> and <i>Feline parvovirus</i> let stand for -or- contact time is 10 minutes.]
Bathtubs, Showers [ & Kitchen] Sinks	1/2 cup [4 oz]	1 Gallon	[Pre-]wash surface [and] wipe with bleach solution. Allow solution to contact surface for [at least] 5 minutes. Rinse well and air dry.
Nonporous Baby Toys [ & Furniture]	1/2 cup [4 oz]	1 Gallon	[Pre-]wash surface, soak or wipe with bleach solution. Allow solution to contact surface for [at least] 5 minutes. Rinse well and air dry.
Nonporous pet toys -and/or- accessories -or- pet areas	1/2 cup [4 oz]	1 Gallon	[Pre-]wash surface, soak or wipe with bleach solution. Allow solution to contact surface for [at least] 5 minutes. Rinse well and air dry.
Toilet Bowl	3/4 cup	Toilet	Flush toilet. Pour this solution into bowl. Brush bowl. Flush again.

## J

## Appendix J

**A Final Note**

Remember that any cleaning, sanitizing or disinfecting product must always be safely stored out of reach of children. Always follow the manufacturer's instruction for safe handling to protect yourselves and those in your care.

## References:

1. California Childcare Health Program. 2009. Sanitize safely and effectively: Bleach and alternatives in child care programs. *Health and Safety Notes* (July). [http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/SanitizeSafely\\_En0709.pdf](http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/SanitizeSafely_En0709.pdf).
2. U.S. Environmental Protection Agency. 2012. Pesticide Product Label System Website. <http://iaspub.epa.gov/apex/pesticides/f?p=PPLS:1>.
3. U.S. Environmental Protection Agency. 2012. What are antimicrobial pesticides? Pesticides Website. [http://www.epa.gov/oppad001/ad\\_info.htm](http://www.epa.gov/oppad001/ad_info.htm).
4. U.S. Environmental Protection Agency. 2012. Selected EPA-registered disinfectants. Pesticides Website. [www.epa.gov/oppad001/chemregindex.htm](http://www.epa.gov/oppad001/chemregindex.htm).
5. Grenier, D., D. Leduc, eds. 2008. *Well beings: A guide to health in child care*. 3rd ed. Ottawa: Canadian Paediatric Society.
6. Rutala, W. A., D. J. Weber, the Healthcare Infection Control Practices Advisory Committee (HICPAC). 2008. *Guideline for disinfection and sterilization in healthcare facilities, 2008*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Preparedness, Detection, and Control of Infectious Diseases, Division of Healthcare Quality Promotion. [http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection\\_Nov\\_2008.pdf](http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf).
7. U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration. 2009. *Food code*. College Park, MD: Food and Drug Administration. <http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/FoodCode/FoodCode2009/default.htm>

## Routine Schedule\*\* for Cleaning, Sanitizing, and Disinfecting

Areas	Before Each Use	After Each Use	Daily (At the End of the Day)	Weekly	Monthly	Comments
<b>Food Areas</b>						
• Food preparation surfaces	Clean, Sanitize	Clean, Sanitize				Use a sanitizer safe for food contact
• Eating utensils & dishes		Clean, Sanitize				If washing the dishes and utensils by hand, use a sanitizer safe for food contact as the final step in the process; Use of an automated dishwasher will sanitize
• Tables & highchair trays	Clean, Sanitize	Clean, Sanitize				
• Countertops		Clean	Clean, Sanitize			Use a sanitizer safe for food contact
• Food preparation appliances		Clean	Clean, Sanitize			
• Mixed use tables	Clean, Sanitize					Before serving food
• Refrigerator					Clean	
<b>Child Care Areas</b>						
• Plastic mouthed toys		Clean	Clean, Sanitize			
• Pacifiers		Clean	Clean, Sanitize			Reserve for use by only one child; Use dishwasher or boil for one minute
• Hats			Clean			Clean after each use if head lice present
• Door & cabinet handles			Clean, Disinfect			

\*\*Corrected to "Routine Schedule" from "Guide" in second printing, August 2011.

## Appendix K

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• Floors			Clean			Sweep or vacuum, then damp mop, (consider micro fiber damp mop to pick up most particles)
• Machine washable cloth toys				Clean		Laundry
• Dress-up clothes				Clean		Laundry
• Play activity centers				Clean		
• Drinking Fountains			Clean, Disinfect			
• Computer keyboards		Clean, Sanitize				Use sanitizing wipes, do not use spray
• Phone receivers			Clean			
<b>Toilet &amp; Diapering Areas</b>						
• Changing tables		Clean, Disinfect				Clean with detergent, rinse, disinfect
• Potty chairs		Clean, Disinfect				
• Handwashing sinks & faucets			Clean, Disinfect			
• Countertops			Clean, Disinfect			
• Toilets			Clean, Disinfect			
• Diaper pails			Clean, Disinfect			
• Floors			Clean, Disinfect			Damp mop with a floor cleaner/ disinfectant
<b>Sleeping Areas</b>						
• Bed sheets & pillow cases				Clean		Clean before use by another child
• Cribs, cots, & mats				Clean		Clean before use by another child
• Blankets					Clean	

## Appendix O



## CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS

-To be completed by a Health Care Provider-

					Today's Date
Child's Full Name					Date of Birth
Parent's/Guardian's Name					Telephone No. (     )
Primary Health Care Provider					Telephone No. (     )
Specialty Provider					Telephone No. (     )
Specialty Provider					Telephone No. (     )
Diagnosis(es)					
Allergies					
ROUTINE CARE					
Medication To Be Given at Child Care	Schedule/Dose (When and How Much?)	Route (How?)	Reason Prescribed	Possible Side Effects	
List medications given at home:					
NEEDED ACCOMMODATION(S)					
Describe any needed accommodation(s) the child needs in daily activities and why:					
Diet or Feeding: _____					
Classroom Activities: _____					
Naptime/Sleeping: _____					
Toileting: _____					
Outdoor or Field Trips: _____					
Transportation: _____					
Other: _____					
Additional comments: _____					





CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS  
Continued

SPECIAL EQUIPMENT / MEDICAL SUPPLIES	
1. _____	
2. _____	
3. _____	
EMERGENCY CARE	
CALL PARENTS/GUARDIANS	If the following symptoms are present: _____ _____
CALL 911 (EMERGENCY MEDICAL SERVICES)	If the following symptoms are present, as well as contacting the parents/guardians: _____ _____
TAKE THESE MEASURES while waiting for parents or medical help to arrive: _____ _____ _____	
SUGGESTED SPECIAL TRAINING FOR STAFF	
_____ _____ _____	
Health Care Provider Signature	Date

PARENT NOTES (OPTIONAL)	
_____ _____ _____	
I hereby give consent for my child's health care provider or specialist to communicate with my child's child care provider or school nurse to discuss any of the information contained in this care plan.	
Parent/Guardian Signature	Date

Important: In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of your child's special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child's special health needs.

## Appendix O



### 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): \_\_\_\_\_

③ 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

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: \_\_\_\_\_

## Appendix O

**Specific Medical Information**

\* Medical documentation provided and attached: ☐ Yes ☐ No

☐ **Information Exchange Form** completed by health care provider is in child's file on site

\* Medication to be administered: ☐ Yes ☐ No

☐ **Medication Administration Form** completed by health care provider and parents are in child's file on site (including type of medication, method, amount, time schedule, potential side effects, etc.)

Any known allergies to foods and/or medications: \_\_\_\_\_

Specific health-related needs: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Planned strategies to support the child's needs and any safety issues while in child care: (diapering/toileting, outdoor play, circle time, nap/sleeping, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Plan for absences of personnel trained and responsible for health-related procedure(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other (i.e., transportation, field trips, etc.): \_\_\_\_\_

\_\_\_\_\_

**Special Staff Training Needs**

Training monitored by: \_\_\_\_\_

1) Type (be specific): \_\_\_\_\_

Training done by: \_\_\_\_\_ Date of Training: \_\_\_\_\_

2) Type (be specific): \_\_\_\_\_

Training done by: \_\_\_\_\_ Date of Training: \_\_\_\_\_

3) Type (be specific): \_\_\_\_\_

Training done by: \_\_\_\_\_ Date of Training: \_\_\_\_\_

**Equipment/Positioning**

\* Physical Therapist (PT) and/or Occupational Therapist (OT) consult provided: ☐ Yes ☐ No ☐ Not Needed

Special equipment needed to be used: \_\_\_\_\_

\_\_\_\_\_

Positioning requirements (attach additional documentation as necessary): \_\_\_\_\_

\_\_\_\_\_

Equipment care/maintenance notes: \_\_\_\_\_

## Appendix O



### Nutrition and Feeding Needs

- ☐ Nutrition and Feeding Care Plan Form completed by team is in child's file on-site. (See for detailed requirements/needs.)

### Behavior Changes (be specific when listing changes in behavior that arise as a result of the health-related condition/concerns)

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### Additional Information (include any unusual episodes that might arise while in care and how the situation should be handled)

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### Support Programs the Child Is Involved with Outside of Child Care

1. Name of program: \_\_\_\_\_ Contact person: \_\_\_\_\_  
 Address and telephone: \_\_\_\_\_  
 Frequency of attendance: \_\_\_\_\_
2. Name of program: \_\_\_\_\_ Contact person: \_\_\_\_\_  
 Address and telephone: \_\_\_\_\_  
 Frequency of attendance: \_\_\_\_\_  
☐
3. Name of program: \_\_\_\_\_ Contact person: \_\_\_\_\_  
 Address and telephone: \_\_\_\_\_  
 Frequency of attendance: \_\_\_\_\_

### Emergency Procedures

- ☐ Special emergency and/or medical procedure required (additional documentation attached)

Emergency instructions: \_\_\_\_\_

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Emergency contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

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### Follow-up: Updates/Revisions

This Special Health Care Plan is to be updated/revised whenever child's health status changes or at least every \_\_\_\_\_ months as a result of the collective input from team members.

Due date for revision and team meeting: \_\_\_\_\_

## Appendix O

**Nutrition and Feeding Care Plan**

The nutrition and feeding care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on a child's diet and feeding needs for this child while in child care.

Name of Child: \_\_\_\_\_ Date: \_\_\_\_\_

Facility Name: \_\_\_\_\_

**Team Member Names and Titles** (parents of the child are to be included)

Care Coordinator (responsible for developing and administering Nutrition and Feeding Care Plan): \_\_\_\_\_

① If training is necessary, then all team members will be trained.

☐ Individualized Family Service Plan (IFSP) attached ☐ Individualized Education Plan (IEP) attached

**Communication**

What is the team's communication goal and how will it be achieved (notes, communication log, phone calls, meetings, etc.):

\_\_\_\_\_

How often will team communication occur: ☐ Daily ☐ Weekly ☐ Monthly ☐ Bi-monthly ☐ Other \_\_\_\_\_

Date and time specifics: \_\_\_\_\_

**Specific Diet Information**

\* Medical documentation provided and attached: ☐ Yes ☐ No ☐ Not Needed

Specific nutrition/feeding-related needs and any safety issues: \_\_\_\_\_

\_\_\_\_\_

\* Foods to avoid (allergies and/or intolerances): \_\_\_\_\_

Planned strategies to support the child's needs: \_\_\_\_\_

\_\_\_\_\_

Plan for absences of personnel trained and responsible for nutrition/feeding-related procedure(s): \_\_\_\_\_

\_\_\_\_\_

\* Food texture/consistency needs: \_\_\_\_\_

\* Special dietary needs: \_\_\_\_\_

\* Other: \_\_\_\_\_

**Eating Equipment/Positioning**

\* Physical Therapist (PT) and/or Occupational Therapist (OT) consult provided: ☐ Yes ☐ No ☐ Not Needed

Special equipment needed: \_\_\_\_\_

Specific body positioning for feeding (attach additional documentation as necessary): \_\_\_\_\_

\_\_\_\_\_

## Appendix O

**Behavior Changes** (be specific when listing changes in behavior that arise before, during, or after feeding/eating)

\_\_\_\_\_

\_\_\_\_\_

**Medical Information**

☐ **Information Exchange Form** completed by Health Care Provider is in child's file on-site.

\* Medication to be administered as part of feeding routine: ☐ Yes ☐ No

☐ **Medication Administration Form** completed by health care provider and parents is in child's file on-site (including type of medication, who administers, when administered, potential side effects, etc.)

**Tube Feeding Information**

Primary person responsible for daily feeding: \_\_\_\_\_

Additional person to support feeding: \_\_\_\_\_

☐ Breast Milk ☐ Formula (list brand information): \_\_\_\_\_

Time(s) of day: \_\_\_\_\_

Volume (how much to feed): \_\_\_\_\_ Rate of flow: \_\_\_\_\_ Length of feeding: \_\_\_\_\_

Position of child: \_\_\_\_\_

☐ Oral feeding and/or stimulation (attach detailed instructions as necessary): \_\_\_\_\_

**Special Training Needed by Staff**

Training monitored by: \_\_\_\_\_

1) Type (be specific): \_\_\_\_\_

Training done by: \_\_\_\_\_ Date of Training: \_\_\_\_\_

2) Type (be specific): \_\_\_\_\_

Training done by: \_\_\_\_\_ Date of Training: \_\_\_\_\_

**Additional Information** (include any unusual episodes that might arise while in care and how the situation should be handled)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Emergency Procedures**

☐ Special emergency and/or medical procedure required (additional documentation attached)

Emergency instructions: \_\_\_\_\_

\_\_\_\_\_

Emergency contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_\_

**Follow-up: Updates/Revisions**

This Nutrition and Feeding Care Plan is to be updated/revised whenever child's health status changes or at least every \_\_\_\_ months as a result of the collective input from team members.

Due date for revision and team meeting: \_\_\_\_\_



# America's Playgrounds

## Safety Report Card



### DOES YOUR PLAYGROUND MAKE THE GRADE?

Evaluate your playground using the following criteria.  
A full explanation of the criteria is on the following page.

	Yes	No
<b>SUPERVISION</b>		
Adults present when children are on equipment		
Children can be easily viewed on equipment		
Children can be viewed in crawl spaces		
Rules posted regarding expected behavior		
<b>AGE-APPROPRIATE DESIGN</b>		
Playgrounds have separate areas for ages 2-5 and 5-12		
Platforms have appropriate guardrails		
Platforms allow change of directions to get on/off structure		
Signage indicating age group for equipment provided		
Equipment design prevents climbing outside the structure		
Supporting structure prevents climbing on it		
<b>FALL SURFACING</b>		
Suitable surfacing materials provided		
Height of all equipment is 8 feet or lower		
Appropriate depth of loose fill provided		
Six foot use zone has appropriate surfacing		
Concrete footings are covered		
Surface free of foreign objects		
<b>EQUIPMENT MAINTENANCE</b>		
Equipment is free of noticeable gaps		
Equipment is free of head entrapments		
Equipment is free of broken parts		
Equipment is free of missing parts		
Equipment is free of protruding bolts		
Equipment is free of rust		
Equipment is free of splinters		
Equipment is free of cracks/holes		
<b>TOTAL POINTS</b>		

### SCORING SYSTEM

Total the number of "Yes" answers in the "Total Points" box in the table.

#### 24 – 20 = A

Congratulations on having a SAFE playground. Please continue to maintain this excellence.

#### 19 – 17 = B

Your playground is on its way to providing a safe environment for children. Work on the areas checked 'No'.

#### 16 – 13 = C

Your playground is potentially hazardous for children. Take corrective measures.

#### 12 – 8 = D

Children are at risk on this playground. Start to make improvements.

#### 7 & = F

Do not allow children on this playground. Make changes immediately.

\*\*If any of the gray boxes are marked 'NO', the potential of a life-threatening injury is significantly increased. Contact the owner of the playground.

For Additional Resources and Information Contact:

National Program for Playground Safety: 1-800-554-PLAY (7529) ~ [www.playgroundsafety.org](http://www.playgroundsafety.org)

Reference: National Program for Playground Safety, 2006.

## Appendix EE

EE

Explanation of Risk Factor CriteriaSUPERVISION

- \*1. Since equipment can't supervise children, it is important that adult supervision is present when children are playing on the playground.
- \*2. In order to properly supervise, children need to be seen. This question is asking if there are any blind spots where children can hide out of the sight of the supervisor.
- \*3. Many crawl spaces, tunnels, and boxed areas have plexiglas or some type of transparent material present to allow the supervisor to see that a child is inside the space. When blind tunnels are present, children cannot be properly supervised.
- \*4. Rules help reinforce expected behavior. Therefore, the posting of playground rules is recommended. For children, ages 2-5, no more than three rules should be posted. Children over the age of five will remember five rules. These rules should be general in nature, such as "respect each other and take turns."

AGE APPROPRIATE DESIGN

- \*1. It is recommended that playgrounds have separate areas with appropriately sized equipment and materials to serve ages 2-5 and ages 5-12. Further, the intended user group should be obvious from the design and scale of equipment. In playgrounds designed to serve children of all ages, the layout of pathways and the landscaping of the playground should show the distinct areas for the different age groups. The areas should be separated at least by a buffer zone, which could be an area with shrubs or benches.
- \*2. Either guardrails or protective barriers may be used to prevent inadvertent or unintentional falls off elevated platforms. However, to provide greater protection, protective barriers should be designed to prevent intentional attempts by children.
- \*3. Platforms over six feet in height should provide an intermediate standing surface where a decision can be made to halt the ascent or to pursue an alternative means of descent.
- \*4. Signs posted in the playground area can be used to give some guidance to adults as to the age appropriateness of equipment.
- \*5. Children use equipment in creative ways which are not necessarily what the manufacturer intended when designing the piece. Certain equipment pieces, like high tube slides, can put the child at risk if they can easily climb on the outside of the piece. The answer to this question is a judgment on your part as to whether the piece was designed to minimize risk to the child for injury from a fall.
- \*6. Support structures such as long poles, bars, swing frames, etc. become the play activity. The problem is that many times these structures have no safe surfacing underneath and children fall from dangerous heights to hard surfaces.

FALL SURFACING

- \*1. Appropriate surfaces are either loose fill (engineered wood fiber, sand, pea gravel, or shredded tires) or unitary surfaces (rubber tiles, rubber mats, and poured in place rubber). Inappropriate surface materials are asphalt, concrete, dirt, and grass. It should be noted that falls from 1 ft. onto concrete could cause a concussion. Falls from a height of eight feet onto dirt is the same as a child hitting a brick wall traveling 30 mph.
- \*2. Research has shown that equipment heights can double the probability of a child getting injured. We recommend that the height of equipment for pre-school age children be no higher than 6 feet and the height of equipment for school age children be limited to 8 feet.
- \*3. Proper loose fill surfacing must be at the appropriate depth to cushion falls. An inch of sand upon hard packed dirt will not provide any protection. We recommend 12 inches of loose fill material under and around playground equipment.
- \*4. Appropriate surfacing should be located directly underneath equipment and extend six feet in all directions with the exception of slides and swings, which have a longer use zone.
- \*5. You should not be able to see concrete footings around any of the equipment. Deaths or permanent disabilities have occurred from children falling off equipment and striking their heads on exposed footings.
- \*6. Glass, bottle caps, needles, trash, etc. can also cause injury if present on playground surfaces.

EQUIPMENT MAINTENANCE

- \*1. Strangulation is the leading cause of playground fatalities. Some of these deaths occur when drawstrings on sweatshirts, coats, and other clothing get caught in gaps in the equipment. The area on top of slides is one potential trouble spot.
- \*2. Entrapment places include between guardrails and underneath merry-go-rounds. Head entrapment occurs when the body fits through a space but the child's head cannot pass through the same space. This occurs because generally, young children's heads are larger than their bodies. If the space between two parts (usually guardrails) is more than three and a half inches then it must be greater than nine inches to avoid potential entrapment.
- \*3. Broken equipment pieces are accidents waiting to happen. If a piece of equipment is broken, measures need to be taken to repair the piece. In the meantime, children should be kept off the equipment.
- \*4. Missing parts also create a playground hazard. A rung missing from a ladder, which is the major access point onto a piece of equipment, poses an unnecessary injury hazard for the child.
- \*5. Protruding bolts or fixtures can cause problems with children running into equipment or catching clothing. Therefore, they pose a potential safety hazard.
- \*6. Exposed metal will rust. This weakens the equipment and will eventually create a serious playground hazard.
- \*7. Wood structures must be treated on a regular basis to avoid weather-related problems such as splinters. Splintering can cause serious injuries to children.
- \*8. Plastic equipment may crack or develop holes due to temperature extremes and/or vandalism. This is a playground hazard.

\*If these risk factors are missing, the potential for a life-threatening injury is significantly increased.

2006 National Program For Playground Safety



## Playground Safety Report Card Follow-up

For any item checked NO on the Playground Safety (PS) Report card, indicate how the item will be remedied and the date of completion.

Highlight any item checked NO from the PS Report Card	How Item will be fixed	Date completed
<b>SUPERVISION</b>		
Adults present when children are on equipment		
Children can be easily viewed on equipment		
Children can be viewed in crawl spaces		
Rules posted regarding expected behavior		
<b>AGE-APPROPRIATE DESIGN</b>		
Playgrounds have separate areas for ages 2-5 and 5-12		
Platforms have appropriate guardrails		
Platforms allow change of directions to get on/off structure		
Signage indicating age group for equipment provided		
Equipment design prevents climbing outside the structure		
Supporting structure prevents climbing on it		
<b>FALL SURFACING</b>		
Suitable surfacing materials provided		
Height of all equipment is 8 feet or lower		
Appropriate depth of loose fill provided		
Six foot use zone has appropriate surfacing		
Concrete footings are covered		
Surface free of foreign objects		
<b>EQUIPMENT MAINTENANCE</b>		
Equipment is free of noticeable gaps		
Equipment is free of head entrapments		
Equipment is free of broken parts		
Equipment is free of missing parts		
Equipment is free of protruding bolts		
Equipment is free of rust		
Equipment is free of splinters		
Equipment is free of cracks/holes		

Adapted from National Playground Safety Program, 2006, America's Playgrounds Safety Report Card.

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## Third Edition Methodology

*Stepping Stones to Caring for Our Children*, Third Edition (SS3), is a companion document to *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs* (CFOC3), published in 2011. *Stepping Stones* is the collection of standards from CFOC3 most likely to prevent serious adverse outcomes in child care and early education settings. Development of SS3 was initiated in 2012 and completed in 2013 under the leadership of Marilyn J. Krajicek, EdD, RN, FAAN, Director of the National Resource Center for Health and Safety in Child Care (NRC). More than 120 outside experts also contributed to the development of SS3.

The NRC SS3 process was informed by the advice of an external Methodology Committee, convened to provide guidance on the standard selection procedures, while retaining the emphasis on prevention of serious harm. The Methodology Committee was composed of three experts in research methods, two of whom were also national experts in child care health and safety.<sup>1</sup>

**Preliminary Focus Group:** National stakeholders in early care and education and users of *Stepping Stones to Caring for Our Children*, Second Edition (SS2) participated in discussions of methods to enhance the format and usability of SS3. These focus group findings were used to influence both the format and dissemination of SS3. For example, a significant number of stakeholders preferred a more concise document when compared to SS2. While recognizing that every SS2 standard served to reduce morbidity and mortality, the charge in SS3 was to more directly target standards that are critical to prevent the most severe outcomes. The third edition reflects that concern in that the number of standards is reduced from the 233 in SS3 to the current 138.

### **Stages of SS3 Development**

**1) Identified standards as candidates for SS3:** The initial pool of potential SS3 standards consisted of:

- a. 211 SS2 standards that were retained or combined in CFOC3;
- b. 56 Standards new to CFOC3;
- c. 36 Standards significantly revised for CFOC3; and
- d. 41 Additional CFOC3 standards identified by a key term/word search (i.e., abuse, death, infectious, injure, injuries, injury,

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<sup>1</sup> The Methodology Committee included Abbey Alkon, RN, PNP, PhD, Professor, University of California, San Francisco School of Nursing Director, California Childcare Health Program; Dr Richard Fiene, Director, Research Institute for Key Indicators & Retired HDFS Professor, Penn State University; and Paul Cook, PhD, Director, Center for Nursing Research, College of Nursing, University of Colorado Denver.



concuss, disable, disease(s), drowning, fatal, neglect, organisms, poisoning, risk, and spread).

**2) Rated candidate standards.** Each of the 344 candidate standards identified through the methods listed above was rated on the severity and frequency of adverse outcomes if the standard were not followed in the child care environment. Ratings were conducted by 10 subject-specific Technical Panels, consisting of 61 experts overall who previously worked on development of *CFOC3*. All standards were rated by multiple people and most standards were rated by multiple panels.

**3) Analyzed ratings and selected standards.** Since each Panel rated a different number of standards, the highest-rated standards were selected from each of the 10 Panels' results in proportion to the number of standards each Panel rated. The objective range was a total number between 100 and 150 standards. This process resulted in 127 standards for the first draft of SS3.

**4) Reviewed first draft of SS3.** National stakeholders were invited to review the 127 standards. The stakeholders included representatives of national organizations, caregivers/teachers, regulators/licensing specialists, early care and education advocates, health professionals, safety specialists, early childhood educators, health and mental health consultants, and federal, military, and state agencies that promote and implement health and safety in the child care field. Reviewers were asked to recommend additional key evidence-based standards from *CFOC3* that were not included in the list, with accompanying rationale and evidence-based research, or the deletion of *CFOC3* standards based on compelling rationale.

**5: Analyzed and considered reviewer comments and recommendations.** The Methodology Committee and NRC staff evaluated the stakeholder comments, recommendations, and evidence using a comparative rating method. Evaluation of reviewers' recommendations for additions and deletions resulted in the 138 standards selected for SS3.

**6: Final review and release.** The final draft of SS3 was reviewed by the Steering Committee of the NRC and the partner organizations, AAP, APHA, and MCHB prior to its release online in April, 2013.

## SS3 Methodology Timeline



**Conversion Table: Third Edition to Second Edition**

Chapter 1 - Staffing		
3rd Ed. #	2nd Ed. #	Standard Title
1.1.1.1	1.001	Ratios for Small Family Child Care Homes
1.1.1.2	1.002	Ratios for Large Family Child Care Homes and Centers
1.1.1.3	1.003	Ratios for Facilities Serving Children with Special Health Care Needs and Disabilities
1.1.1.4	1.004	Ratios and Supervision During Transportation
1.1.1.5	1.005	Ratios and Supervision for Swimming, Wading, and Water Play
1.2.0.2	1.008	Background Screening
1.3.1.1	1.014	General Qualifications of Directors
1.3.2.2	1.017	Qualifications of Lead Teachers and Teachers
1.3.3.1	1.019	General Qualifications of Family Child Care Caregivers/Teachers to Operate a Family Child Care Home
1.4.1.1	1.006/1.009	Pre-service Training
1.4.2.2	1.024	Orientation for Care of Children with Special Health Care Needs
1.4.2.3	1.025	Additional Orientation Topics
1.4.3.1	1.026	First Aid and CPR Training for Staff
1.4.3.2	1.027	Topics Covered in First Aid Training
1.4.3.3	1.028	CPR Training for Swimming and Water Play
1.4.5.1	1.031	Training of Staff Who Handle Food
1.4.5.2	1.032	Child Abuse and Neglect Education
1.5.0.1	1.037	Employment of Substitutes
1.5.0.2	1.038	Orientation of Substitutes
1.6.0.1	1.040/1.041/ 8.020	Child Care Health Consultants
Chapter 2 - Program Activities for Healthy Development		
2.1.1.4	2.053	Monitoring Children's Development/ Obtaining Consent for Screening
2.1.2.1	2.010	Personal Caregiver/Teacher Relationships for Infants and Toddlers
2.2.0.1	2.028	Methods of Supervision of Children
2.2.0.4	3.045	Supervision Near Bodies of Water

3rd Ed. #	2nd Ed. #	Standard Title
2.2.0.6	2.039	Discipline Measures
2.2.0.8	New	Preventing Expulsions, Suspensions, and Other Limitations in Services
2.2.0.9	2.042	Prohibited Caregiver/Teacher Behaviors
2.2.0.10	2.043	Using Physical Restraint
2.3.3.1	2.054	Parents'/Guardians' Provision of Information on their Child's Health and Behavior
<b>Chapter 3 - Health Promotion and Protection</b>		
3.1.2.1	3.003	Routine Health Supervision and Growth Monitoring
3.1.3.1	New	Active Opportunities for Physical Activity
3.1.3.2	2.009	Playing Outdoors
3.1.4.1	5.143/5.146	Safe Sleep Practices and SIDS Risk Reduction
3.1.5.1	3.010	Routine Oral Hygiene Activities
3.2.1.4	3.014	Diaper Changing Procedure
3.2.2.1	3.020	Situations that Require Hand Hygiene
3.2.2.2	3.021	Handwashing Procedure
3.2.2.3	3.022	Assisting Children with Hand Hygiene
3.2.3.4	3.026	Prevention of Exposure to Blood and Body Fluids
3.3.0.1	3.028	Routine Cleaning, Sanitizing, and Disinfecting
3.4.1.1	2.035 split	Use of Tobacco, Alcohol, and Illegal Drugs
3.4.3.1	3.018	Emergency Procedures
3.4.3.3	New	Response to Fire and Burns
3.4.4.1	3.053/3.054/ 3.056	Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation
3.4.4.3	New	Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma
3.4.5.1	New	Sun Safety Including Sunscreen
3.4.6.1	5.160	Strangulation Hazards
3.5.0.1	3.049	Care Plan for Children with Special Health Care Needs
3.5.0.2	1.044/3.063/ 3.066	Caring for Children Who Require Medical Procedures
3.6.1.1	3.065/3.068	Inclusion/Exclusion/Dismissal of Children
3.6.1.2	3.069	Staff Exclusion for Illness
3.6.1.4	3.067	Infectious Disease Outbreak Control

3rd Ed. #	2nd Ed. #	Standard Title
3.6.3.1	3.081	Medication Administration
3.6.3.2	3.082	Labeling, Storage, and Disposal of Medications
3.6.3.3	3.083	Training of Caregivers/Teachers to Administer Medication
<b>Chapter 4 - Nutrition and Food Service</b>		
4.2.0.3	1.002	Use of USDA - CACFP Guidelines
4.2.0.6	4.006/5.136	Availability of Drinking Water
4.2.0.8	4.007/4.009	Feeding Plans and Dietary Modifications
4.2.0.10	4.010	Care for Children with Food Allergies
4.3.1.3	4.015	Preparing, Feeding, and Storing Human Milk
4.3.1.5	4.016/4.017	Preparing, Feeding, and Storing Infant Formula
4.3.1.9	4.018	Warming Bottles and Infant Foods
4.3.1.11	4.012	Introduction of Age-Appropriate Solid Foods to Infants
4.5.0.6	4.036	Adult Supervision of Children Who Are Learning to Feed themselves
4.5.0.9	4.034	Hot Liquids and Foods
4.5.0.10	4.037	Foods that Are Choking Hazards
4.8.0.1	4.042	Food Preparation Area
4.8.0.3	4.044	Maintenance of Food Service Surfaces and Equipment
4.9.0.2	4.051	Staff Restricted From Food Preparation and Handling
4.9.0.3	4.052	Precautions for a Safe Food Supply
<b>Chapter 5 - Facilities, Supplies, Equipment, and Environmental Health</b>		
5.1.1.2	5.002	Inspection of Buildings
5.1.1.3	5.003	Compliance with Fire Prevention Code
5.1.1.5	5.005 /5.109/ 5.169/5.179	Environmental Audit of Site Location
5.1.3.2	5.014	Possibility of Exit From Windows
5.1.4.1	5.020	Alternate Exits and Emergency Shelter
5.1.5.4	5.225	Guards At Stairway Access Openings
5.1.6.6	5.221	Guardrails and Protective Barriers
5.2.1.1	5.027	Fresh Air
5.2.1.10	5.034	Gas, Oil or Kerosene Heaters, Generators, Portable Gas Stoves, and Charcoal and Gas Grills

3rd Ed. #	2nd Ed. #	Standard Title
5.2.1.11	5.035	Portable Electric Space Heaters
5.2.4.2	5.048	Safety Covers and Shock Protection Devices for Electrical Outlets
5.2.4.4	5.050	Location of Electrical Devices Near Water
5.2.5.1	5.053	Smoke Detection Systems and Smoke Alarms
5.2.6.3	5.061	Testing for Lead and Copper Levels in Drinking Water
5.2.6.3	5.138	Testing for Lead and Copper Levels in Drinking Water
5.2.7.6	5.069	Storage and Disposal of Infectious and Toxic Wastes
5.2.8.1	5.070/5.071/ 5.072/5.073	Integrated Pest Management
5.2.9.1	4.060/5.100	Use and Storage of Toxic Substances
5.2.9.2	5.101	Use of a Poison Center
5.2.9.3	5.102	Informing Staff Regarding Presence of Toxic Substances
5.2.9.4	5.103	Radon Concentrations
5.2.9.5	New	Carbon Monoxide Detectors
5.2.9.13	5.110	Testing for Lead
5.3.1.1	5.075	Safety of Equipment, Materials, and Furnishings
5.3.1.12	2.038/5.084	Availability and Use of a Telephone or Wireless Communication Device
5.4.5.2	5.145	Cribs
5.5.0.6	5.157	Inaccessibility to Matches, Candles and Lighters
5.5.0.7	5.159	Storage of Plastic Bags
5.5.0.8	5.167	Firearms
5.6.0.1	2.038/5.093/ 5.237	First Aid and Emergency Supplies
5.7.0.4	5.086	Inaccessibility of Hazardous Equipment
<b>Chapter 6 - Play Areas/Playgrounds and Transportation</b>		
6.1.0.6	5.176	Location of Play Areas Near Bodies of Water
6.1.0.8	5.178	Enclosures for Outdoor Play Areas
6.2.1.9	5.186	Entrapment Hazards of Play Equipment
6.2.3.1	5.183	Prohibited Surfaces for Placing Climbing Equipment
6.2.4.4	New	Trampolines
6.2.5.1	3.085/5.160/ 5.196	Inspection of Indoor and Outdoor Play Areas and Equipment

3rd Ed. #	2nd Ed. #	Standard Title
6.3.1.1	5.198	Enclosure of Bodies of Water
6.3.1.4	5.201	Safety Covers for Swimming Pools
6.3.1.6	5.205	Pool Drain Covers
6.3.2.1	5.208	Lifesaving Equipment
6.3.5.1	5.211	Hot Tubs, Spas, and Saunas
6.3.5.2	5.212	Water in Containers
6.4.1.2	5.087	Inaccessibility of Toys or Objects to Children Under Three Years of Age
6.4.1.5	5.089	Balloons
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