Caring for Our Children

National Health and Safety Performance Standards Guidelines for Early Care and Education Programs

FOURTH EDITION

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

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

Caring for Our Children

National Health and Safety Performance Standards Guidelines for Early Care and Education Programs

FOURTH EDITION

A Joint Collaborative Project of

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Their leadership and dedication in setting the bar high for quality health and safety standards in early care and education ensured that children experienced healthier and safer lives and environments in child care and provided a valuable and nationally recognized resource for all in the field. We are pleased to build upon their foundational work in this Third Edition with new science and research.

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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. The American Academy of Pediatrics (AAP), the American Public Health Association (APHA), and the National Resource Center for Health and Safety in Child Care and Early Education (NRC) are pleased to release the fourth edition of *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*. These national standards represent the best evidence, expertise, and experience in the country on quality health and safety practices and policies that should be followed in today's early care and education settings.

Caring for Our Children is an innovative, continually updated set of standards for early care and education programs. The most up-to-date version of the standards may be accessed at www.nrckids.org/CFOC.

The third print edition, the 2011 publication, was the result of an extensive process that benefited from the contributions of 86 technical experts in the field of health and safety in early care and education. (The history of past revisions appears in the following section.) Since the publication of the third edition, the standards are continually reviewed by the AAP, APHA, and NRC, with new and updated standards posted online as they become available, year-round.

Many users of the *Caring for Our Children* standards like to have a print reference on-hand, and because the third edition preceded the online updates, the AAP, APHA, and NRC are publishing new print editions that reflect updated standards. The fourth print edition of *Caring for Our Children* builds upon the foundation of the first three editions and includes online updates since 2011.

Important note about edition terminology: The online version of *Caring for Our Children* no longer will be labeled with "edition" terminology. It is the latest version, updated as new or revised standards are posted. The suggested citation for the online standards at www.nrckids.org/CFOC is as follows:

American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs.* http://cfoc.nrckids.org. Updated <date>. Accessed <date>

Print publications will be labeled by edition numbers to identify the latest print edition for readers, programs, bookstores, and libraries. The suggested citation for this fourth print edition is as follows:

American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs.* 4th ed. Itasca, IL: American Academy of Pediatrics; 2019

History

In 1992, the American Public Health Association (APHA) and the American Academy of Pediatrics (AAP) jointly published *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Out-of-Home Child Care Programs* (1). The publication was the product of a five year national project funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB). This comprehensive set of health and safety standards was a response to many years of effort by advocates for quality child care. In 1976, Aronson and Pizzo recommended development and use of national health and safety standards as part of a report to Congress in association with the *Federal Interagency Day Care Requirements* (FIDCR) *Appropriateness Study* (2). In the years that followed, experts repeatedly reaffirmed the need for these standards. For example, while the work to prepare *Caring for Our Children* was underway, the National Research Council's report, *Who Cares for America's Children? Child Care Policy for the 1990s*, called for uniform national child care standards (3). Subsequently a second edition of *Caring for Our Children* was published in 2002 addressing new knowledge generated by increasing research into health and safety in early care and education programs. The increased use of the standards both in practical onsite applications and in research documents the value of the standards and validates the importance of keeping the standards up-to-date (4). *Caring for Our Children* has been a yardstick for measuring what has been done and what still needs to be done, as well as a technical manual on how to do it.

Third Edition Review Process

The Maternal and Child Health Bureau's continuing funding since 1995 of a National Resource Center for Health and Safety in Child Care and Early Education (NRC) at the University of Colorado, College of Nursing supported the work to coordinate the development of the second and third editions.

The standards in the third edition of *Caring for Our Children* were revised by eighty-six technical experts. Critical reviews and recommendations were then provided by 184 stakeholder individuals - those representing consumers of the information and organizations representing major constituents of the early care and education community. Caregivers/teachers, parents/guardians, families, health care professionals, safety specialists, early childhood educators, early care and education advocates, regulators, and federal, military, and state agencies all brought their expertise and experience to the revision process. A complete listing of the Steering Committee, Lead Organizations' reviewers, Technical Panel members, and Stakeholder contributors appears on the Acknowledgment pages.

The process of revising the standards and the consensus building was organized in stages:

1. Technical panel chairs recruited members to their panels and reviewed the standards from the second edition. Using the best evidence available (peer reviewed scientific studies, published reports, and best practice information) they removed standards that were no longer applicable or out-of-date, identified those that were still applicable (in their original or in a revised form), and formulated many new standards that were deemed appropriate and necessary.
2. Telephone conference calls were convened among technical panel chairs to bring consensus on standards that bridge several technical areas.
3. A draft of these revised standards was sent to a national and state constituency of stakeholders for their comments and suggestions.
4. This feedback was subsequently reviewed and considered by the technical panels and a decision was made to further revise or not to revise a standard. It should be noted that the national review called attention to many important points of view and new information for additional discussion and debate.
5. The edited standards were then sent to review teams of the AAP, the APHA and the MCHB. Final copy was approved by the Steering Committee representing the four organizations (AAP, APHA, NRC and MCHB).

In projects of this scope and magnitude, the end product is only as good as the persons who participate in the effort. It is hard to enumerate in this introduction the countless hours of dedication and effort from contributors and reviewers. The project owes each of them a huge debt of gratitude. Their reward will come when high-quality early care and education services become available to all children and their families!

CFOC Standard Revision Process

In collaboration with the National Center for Early Childhood Health and Wellness (NCECHW), the NRC updates *CFOC* Standards using the following process:

1. The NRC continually monitors and prioritizes standards for revision based on the following criteria:
   - Impact on child and/or staff morbidity/mortality
   - Publication of new/updated science-based evidence or best practices that necessitate a standard change
   - Assessment of new/updated publications, requirements, or applicable policy statements that are related to CFOC standards (eg, the AAP *Red Book, Managing Infectious Diseases in Child Care and Schools, Child and Adult Care Food Programs)*
   - Analysis of relationship to the Child Care Development Block Grant health and safety priority areas
   - Receipt and analysis of nominations from subject matter experts and other stakeholders
   - Contact from stakeholders via direct communication with the NRC or via the NCECHW Info line
   - Inclusion in *CFOC Basics*
2. The NRC proposes revisions to individual standards based on current research-based evidence.
3. The NRC conducts the following steps to revise standards identified above:
   - Develops timeline for review
   - Identifies and invites potential subject matter experts (SMEs) based on content area to serve as reviewers of the proposed changes
   - Assigns SMEs to revision subgroups based on specific area of expertise
   - Facilitates communication with the SMEs throughout the revision process
   - Assesses the quality of SME feedback based on current research/best practice
   - Submits final SME-approved revisions to the NRC Expert Advisory Group (EAG)
   - Incorporates EAG feedback and prepares the revised standards for copyediting by the AAP.
   - Sends the copyedited version of standards to the NCECHW Steering Committee for final review
   - Incorporates final revisions into the searchable CFOC database
   - Communicates with the NCECHW and the AAP to disseminate information on revised standards

Requirements of Other Organizations

We recognize that many organizations have requirements and recommendations that apply to out-of home early care and education. For example, the National Association for the Education of Young Children (NAEYC) publishes requirements for developmentally appropriate practice and accreditation of child care centers; Head Start follows Performance Standards; the AAP has many standards related to child health; the U.S. Department of Defense has standards for military child care; the Office of Child Care (OCC) produces health and safety standards for tribal child care; the National Fire Protection Association has standards for fire safety in child care settings. The Office of Child Care administers the Child Care and Development Fund (CCDF) which provides funds to states, territories, and tribes to assist low-income families, families receiving temporary public assistance, and those transitioning from public assistance in obtaining child care so that they can work or attend training/education. Caregivers/teachers serving children funded by CCDF must meet basic health and safety requirements set by states and tribes. All of these are valuable resources, as are many excellent state publications. By addressing health and safety as an integrated component of early care and education, contributors to *Caring for Our Children* have made every effort to ensure that these standards are consistent with and complement other child care requirements and recommendations.

Continuing Improvement

Standards are never static. Each year the knowledge base increases, and new scientific findings become available. New areas of concern and interest arise. These standards will assist individuals and organizations who are involved in the continuing work of standards improvement at every level: in early care and education practice, in regulatory

administration, in research in early childhood systems building, in academic curricula, and in the professional performance of the relevant disciplines.

Each of these areas affects the others in the ongoing process of improving the way we meet the needs of children. Possibly the most important use of these standards will be to raise the level of understanding about what those needs are, and to contribute to a greater willingness to commit more resources to achieve quality early care and education where children can grow and develop in a healthy and safe environment.

References

1. American Public Health Association, American Academy of Pediatrics. 1992. *Caring for our children. National health and safety performance standards: Guidelines for out-of-home child care programs.* Washington, DC: APHA.
2. USDHEW, Office of the Assistant Secretary for Planning and Evaluation. 1977. *Policy issues in day care: Summaries of 21 papers,* 109-15.
3. National Research Council, National Academy of Sciences. 1990. *Who Cares for America's Children? Child Care Policy in the 1990s.* Washington, DC: National Academy Press.
4. Crowley, A. A., J. Kulikowich. 2009. Impact of training on child care health consultant knowledge and practice. *Ped Nurs* 35:93- 100.

Guiding Principles

The following are the guiding principles used in writing these standards:

1. The health and safety of all children in early care and education settings is essential. The child care setting offers many opportunities for incorporating health and safety education and life skills into everyday activities. Health education for children is an investment in a lifetime of good health practices and contributes to a healthier childhood and adult life. Modeling of good health habits, such as healthy eating and physical activity, by all staff in indoor and outdoor learning/play environments, is the most effective method of health education for young children.
2. Child care for infants, young children, and school-age children is anchored in a respect for the developmental needs, characteristics, and cultures of the children and their families; it recognizes the unique qualities of each individual and the importance of early brain development in young children and in particular children birth to three years of age.
3. To the extent possible, indoor and outdoor learning/play activities should be geared to the needs of all children.
4. The relationship between parent/guardian/family and child is of utmost importance for the child's current and future development and should be supported by caregivers/teachers. Those who care for children on a daily basis have abundant, rich observational information to share, as well as offer instruction and best practices to parents/guardians. Parents/guardians should share with caregivers/teachers the unique behavioral, medical and developmental aspects of their children. Ideally, parents/guardians can benefit from time spent in the child's caregiving environment and time for the child, parent/guardian and caregiver/teacher to be together should be encouraged. Daily communication, combined with at least yearly conferences between families and the principal caregiver/teacher, should occur. Communication with families should take place through a variety of means and ensure all families, regardless of language, literacy level, or special needs, receive all of the communication.
5. The nurturing of a child's development is based on knowledge of the child's general health, growth and development, learning style, and unique characteristics. This nurturing enhances the enjoyment of both child and parent/guardian as maturation and adaptation take place. As shown by studies of early brain development, trustworthy relationships with a small number of adults and an environment conducive to bonding and learning are essential to the healthy development of children. Staff selection, training, and support should be directed to the following goals:
   a. Promoting continuity of affective relationships;
   b. Encouraging staff capacity for identification with and empathy for the child;
   c. Emphasizing an attitude of involvement as an adult in the children's play without dominating the activity;
   d. Being sensitive to cultural differences; and
   e. Being sensitive to stressors in the home environment.
6. Children with special health care needs encompass 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 generally required by children. This includes children who have intermittent and continuous needs in all aspects of health. No child with special health care needs should be denied access to child care because of his/her disability(ies), unless one of the four reasons for denying care exists: level of care required; physical limitations of the site; limited resources in the community, or unavailability of specialized, trained staff. Whenever possible, children with special health care needs should be cared for and provided services in settings including children without special health care needs.
7. Developmental programs and care should be based on a child's functional status, and the child's needs should be described in behavioral or functional terms. Children with special needs should have a comprehensive interdisciplinary or multidisciplinary evaluation if determined necessary.
8. Written policies and procedures should identify facility requirements and persons and/or entities responsible for implementing such requirements including clear guidance as to when the policy does or does not apply.
9. Whenever possible, written information about facility policies and procedures should be provided in the native language of parents/guardians, in a form appropriate for parents/guardians who are visually impaired, and also in an appropriate literacy/readability level for parents/

guardians who may have difficulty with reading. However, processes should never become more important than the care and education of children.

10. Confidentiality of records and shared verbal information must be maintained to protect the child, family, and staff. The information obtained at early care and education programs should be used to plan for a child's safe and appropriate participation. Parents/guardians must be assured of the vigilance of the staff in protecting such information. When sharing information, such as referrals to services that would benefit the child, attainment of parental consent to share information must be obtained in writing. It is also important to document key communication (verbal and written) between staff and parents/guardians.
11. The facility's nutrition activities complement and supplement those of home and community. Food provided in a child care setting should help to meet the child's daily nutritional needs while reflecting individual, cultural, religious, and philosophical differences and providing an opportunity for learning. Facilities can contribute to overall child development goals by helping the child and family understand the relationship of nutrition to health, the importance of positive child feeding practices, the factors that influence food practices, and the variety of ways to meet nutritional needs. All children should engage in daily physical activity in a safe environment that promotes developmentally appropriate movement skills and a healthy lifestyle.
12. The expression of, and exposure to, cultural and ethnic diversity enriches the experience of all children, families, and staff. Planning for cultural diversity through the provision of books, toys, activities and pictures and working with language differences should be encouraged.
13. Community resources should be identified and information about their services, eligibility requirements, and hours of operation should be available to the families and utilized as much as possible to provide consultation and related services as needed.
14. Programs should continuously strive for improvement in health and safety processes and policies for the improvement of the overall quality of care to children.
15. An emergency or disaster can happen at any time. Programs should be prepared for and equipped to respond to any type of emergency or disaster in order to ensure the safety and well-being of staff and children, and communicate effectively with parents/guardians.
16. Young children should receive optimal medical care in a family-centered medical home. Cooperation and collaboration between the medical home and caregivers/teachers lead to more successful outcomes.
17. Education is an ongoing, lifelong process and child care staff need continuous education about health and safety related subject matter. Staff members who are current on health related topics are better able to prevent, recognize, and correct health and safety problems. Subjects to be covered include the rationale for health promotion and information about physical and mental health problems in the children for whom the staff care. If staff turnover is high, training on health and safety related subjects should be repeated frequently.
18. Maintaining a healthy, toxic-free physical environment positively impacts the health and well-being of the children and staff served. Environmental responsibility is an important concept to teach and practice daily.

Advice to the User

The intended users of the standards include all who care for young children in early care and education settings and who work toward the goal of ensuring that all children from day one have the opportunity to grow and develop appropriately, to thrive in healthy and safe environments, and to develop healthy and safe behaviors that will last a lifetime.

All of the standards are attainable. Some may have al- ready been attained in individual settings; others can be implemented over time. For example, any organization that funds early care and education should, in our opinion, adopt these standards as funding requirements and should set a payment rate that covers the cost of meeting them.

Recommended Use

- **Caregivers/Teachers** can use the standards to develop and implement sound practices, policies, and staff training to ensure that their program is healthy, safe, age-appropriate for all children in their care.
- **Early Childhood Systems** can build integrated health and safety components into their systems that promote healthy lifestyles for all children.
- **Families** have sound 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 may also want to incorporate many of these healthy and safe practices at home.
- **Health Care Professionals** can assist families and consult with caregivers/teachers by using the standards as guidance on what makes a healthy and safe and age appropriate environment that encourages children's development of healthy and safe habits. Consultants may 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.
- **National Private 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** are equipped with sound science to meet emerging challenges to 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 standards for school operated child care and preschool facilities, 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** of early childhood education programs can instill healthy practices in their students to model and use with young children upon entering the early childhood workplace and transfer the latest research into their education.

Definitions

We have defined many terms in the Glossary. Some of these are so important to the user that we are emphasizing them here as well.

Types of Requirements

A **standard** is a statement that defines a goal of practice. It differs from a recommendation or a guideline in that it carries greater incentive for universal compliance. It differs from a regulation in that compliance is not necessarily required for legal operation. It usually is legitimized or validated based on scientific or epidemiological data, or when this evidence is lacking, it represents the widely agreed upon, state-of-the-art, high-quality level of practice.

The agency, program, or health practitioner that does not meet the standard may incur disapproval or sanction from within or without the organization. Thus, a standard is the strongest criterion for practice set by a health organization or association. For example, many manufacturers advertise that their products meet ASTM standards as evidence to the consumer of safety, while those products that cannot meet the standards are sold without such labeling to undiscerning purchasers.

A **guideline** is a statement of advice or instruction pertaining to practice. It originates in an organization with acknowledged professional standing. Although it may be unsolicited, a guideline often is developed in response to a stated request or perceived need for such advice or instruction. For example, the American Academy of Pediatrics (AAP) has a guideline for the elements necessary to make the diagnosis of Attention-Deficit/Hyperactivity Disorder.

A **regulation** takes a previous standard or guideline and makes it a requirement for legal operation. A regulation originates in an agency with either governmental or official authority and has the power of law. Such authority is usually accompanied by an enforcement activity. Examples of regulations are: State regulations pertaining to child:staff ratios in a licensed child care center, and immunizations required to enter an early care and education program. The components of the regulation will vary by topic addressed as well as by area of jurisdiction (e.g., municipality or state). Because a regulation prescribes a practice that every agency or program must comply with, it usually is the minimum or the floor below which no agency or program should operate.

Types of Facilities

Child care offers developmentally appropriate care and education for young children who receive care in out-of-home settings (not their own home). Several types of facilities are covered by the general definition of child care and education. Although there are generally understood definitions for child care facilities, states vary greatly in their legal definitions, and some overlap and confusion of terms still exists in defining child care facilities. Although the needs of children do not differ from one setting to another, the declared intent of different types of facilities may differ. Facilities that operate part-day, in the evening, during the traditional work day and work week, or during a specific part of the year may call themselves by different names. These standards recognize that while children's needs do not differ in any of these settings, the way children's needs are met may differ by whether the facility is in a residence or a non-residence and whether the child is expected to have a longer or only a very short-term arrangement for care.

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 child: staff ratio requirements.

A **Center** is a facility that provides care and education of **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.

For definitions of other special types of child care – drop-in, school-age, for the mildly ill – see Standard 10.4.1.1: Uniform Categories and Definitions.

The standards are to guide all the types of programs listed above.

Age Groups

Although we recognize that designated age groups and developmental levels must be used flexibly to meet the needs of individual children, many of the standards are applicable to specific age and developmental categories. The following categories are used in *Caring for Our Children*.

	Age	Functional Definition (By Developmental Level)
Infant	Birth-12 months	Birth to ambulation
Toddler	13-35 months	Ambulation to accomplishment of self-care routines such as use of the toilet
Pre-schooler	36-59 months	From achievement of self-care routines to entry into regular school
School-Age Child	5-12 years	Entry into regular school, including kindergarten through 6th grade

Format and Language

Each standard unit has at least three components: the **Standard** itself, the **Rationale**, and the applicable **Type of Facility**. Most standards also have a **Comment** section, a **Related Standards** section and a **References** section. The reader will find the scientific reference and/or epidemiological evidence for the standard in the rationale section of each standard. The Rationale explains the intent of and the need for the standard. Where no scientific evidence for a standard is available, the standard is based on the best available professional consensus. If such a professional consensus has been published, that reference is cited. The Rationale both justifies the standard and serves as an educational tool. The Comments section includes other explanatory information relevant to the standard, such as applicability of the standard and, in some cases, suggested ways to measure compliance with the standard. Although this document reflects the best information available at the time of publication, as was the case with the first and second editions, this third edition will need updating from time to time to reflect changes in knowledge affecting early care and education.

Caring for Our Children standards and appendixes are available at no cost online at http://nrckids.org. It is also available in print format for a fee from the American Academy of Pediatrics (AAP) and the American Public Health Association(APHA).

Standards have been written to be measurable and enforceable. Measurability is important for performance standards in a contractual relationship between a provider of service and a funding source. Concrete and specific language helps caregivers/teachers and facilities put the standards into practice. Where a standard is difficult to measure, we have provided guidance to make the requirement as specific as possible. Some standards required more technical terminology (e.g., certain infectious diseases, plumbing and heating terminology). We encourage readers to seek interpretation by appropriate specialists when needed. Where feasible, we have written the standards to be understood by readers from a wide variety of backgrounds.

The Steering Committee agreed to consistent use of the terms below to convey broader concepts instead of using a multitude of different terms.

- Caregiver/teacher—for the early care and education/child care professional that provides care and learning opportunities to children—instead of child care provider, just caregiver or just teacher;
- Parents/guardians—for those adults legally responsible for a child's welfare;
- Primary care provider—for the licensed health professional, to name a few: pediatrician, pediatric nurse practitioner, family physician, who has responsibility for the health supervision of an individual child;
- Child abuse and neglectfor all forms of child maltreatment;
- Children with special health care needs—to encompass children with special needs, children with disabilities, children with chronic illnesses, etc.

Relationship of the Standards to Laws, Ordinances, and Regulations

The members of the technical panels could not annotate the standards to address local laws, ordinances, and regulations. Many of these legal requirements have a different intent from that addressed by the standards. Users of this document should check legal requirements that may apply to facilities in particular locales.

In general, child care is regulated by at least three different legal entities or jurisdictions. The first is the building code jurisdiction. Building inspectors enforce building codes to protect life and property in all buildings, not just child care facilities. Some of the standards should be written into state or local building codes, rather than into the licensing requirements.

The second major legal entity that regulates child care is the health system. A number of different codes are intended to prevent the spread of disease in restaurants, hospitals, and other institutions where hazards and risky practices might exist. Many of these health codes are not specific to child care; however, specific provisions for child care might be found in a health code. Some of the provisions in the standards might be appropriate for incorporation into a health code.

The third legal jurisdiction applied to child care is child care licensing. Usually, before a child care operator receives a license, the operator must obtain approvals from health and building safety authorities. Sometimes a standard is not included as a child care licensing requirement because it is covered in another code. Sometimes, however, it is not covered in any code. Since children need full protection, the issues addressed in this document should be addressed in some aspect of public policy, and consistently addressed within a community. In an effective regulatory system, different inspectors do not try to regulate the same thing. Advocates should decide which codes to review in making sure that these standards are addressed appropriately in their regulatory systems. Although the licensing requirements are most usually affected, it may be more appropriate to revise the health or building codes to include certain standards, and it may be necessary to negotiate conflicts among applicable codes.

The National Standards are 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.

History of *Caring for Our Children* Standard Language Changes Since the 3rd Edition (Through July 2018)

The *Caring for Our Children* (CFOC) standards listed in this document have had revisions made to the Standard language since the 2011 publication of the third print edition. Revisions are based on new or updated research/evidence, policy statements, and/or best practices. These revisions, with the exception of those pending below, appear in this fourth print edition. The pending standard revisions and any future revisions may be found in the CFOC online database (http://nrckids.org/CFOC) and are designated by the Notes icon.

Standard Number and Title (Listed Numerically)		**Date of Change**
1.2.0.1	Staff Recruitment	Pending at time of publication
1.2.0.2	Background Screening	5/2018
1.4.5.2	Child Abuse and Neglect Education	5/2018
1.5.0.2	Orientation of Substitutes	5/2018
1.6.0.2	Frequency of Child Care Health Consultant Visits	8/2013
2.1.1.1	Written Daily Activity Program and Statement of Principles	5/2018
2.1.1.2	Health, Nutrition, Physical Activity, and Safety Awareness	5/2018
2.1.2.1	Personal Caregiver/Teacher Relationships for Infants and Toddlers	5/2018
2.2.0.1	Methods of Supervision of Children	Pending at time of publication
2.2.0.3	Screen Time/Digital Media Use	3/2012, 10/2017
2.2.0.9	Prohibited Caregiver/Teacher Behaviors	5/2018
2.3.1.2	Parent/Guardian Visits	Pending at time of publication
2.4.1.1	Health and Safety Education Topics for Children	1/2017, 5/2018
2.4.1.2	Staff Modeling of Healthy and Safe Behavior and Health and Safety Education Activities	1/2017
2.4.2.1	Health and Safety Education Topics for Staff	1/2017
2.4.3.2	Parent/Guardian Education Plan	1/2017
3.1.3.1	Active Opportunities for Physical Activity	5/2018
3.1.3.2	Playing Outdoors	8/2013, 5/2018
3.1.3.3	Protection from Air Pollution While Children Are Outside	8/2016
3.1.3.4	Caregivers'/Teachers' Encouragement of Physical Activity	5/2018
3.1.4.1	Safe Sleep Practices and Sudden Unexpected Infant Death (SUID)/SIDS Risk Reduction	12/2011, 12/2016
3.1.4.4	Scheduled Rest Periods and Sleep Arrangements	5/2018
3.1.5.1	Routine Oral Hygiene Activities	3/2016
3.1.5.2	Toothbrushes and Toothpaste	2/2013, 4/2013, 3/2016
3.2.1.1	Type of Diapers Worn	8/2017
3.2.1.4	Diaper Changing Procedure	1/2012, 7/2012, 5/2013, 8/2016
3.2.1.5	Procedure for Changing Children's Soiled Underwear/Pull-Ups and Clothing	1/2012, 7/2012, 11/2013, 8/2016
3.2.2.1	Situations that Require Hand Hygiene	8/2016, 8/2017
3.2.2.2	Handwashing Procedure	8/2017
3.2.2.5	Hand Sanitizers	4/2016, 4/2017
3.4.1.1	Use of Tobacco, Electronic Cigarettes, Alcohol, and Drugs	1/2017
3.4.4.1	Recognizing and Reporting Suspected Child Abuse, Neglect and Exploitation	5/2018
3.4.4.2	Immunity for Reporters of Child Abuse and Neglect	Pending at time of publication
3.4.4.3	Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma	5/2018
3.4.4.4	Care of Children Who Have Been Abused/Neglected	3/2013; Pending at time of publication
3.4.4.5	Facility Layout to Reduce Risk of Child Abuse and Neglect	Pending at time of publication
3.4.5.1	Sun Safety Including Sunscreen	8/2013
3.4.5.2	Insect Repellent and Protection from Vector-Borne Diseases	4/2017

History of *Caring for Our Children* Standard Language Changes Since the 3rd Edition (Through July 2018)

Standard Number and Title (Listed Numerically)	**Date of Change**
3.6.1.1 Inclusion/Exclusion/Dismissal of Children	4/2015, 8/2015, 4/2017
3.6.1.2 Staff Exclusion for Illness	4/2017
3.6.2.2 Space Requirements for Care of Children Who Are Ill	8/2017
3.6.2.10 Inclusion and Exclusion of Children from Facilities That Serve Children Who Are Ill	8/2017
4.2.0.1 Written Nutrition Plan	11/2017
4.2.0.2 Assessment and Planning of Nutrition for Individual Children	11/2017
4.2.0.3 Use of US Department of Agriculture Child and Adult Care Food Program Guidelines	11/2017
4.2.0.4 Categories of Foods	2/2012, 11/2017
4.2.0.5 Meal and Snack Patterns	11/2017
4.2.0.6 Availability of Drinking Water	11/2017
4.2.0.7 100% Fruit Juice	11/2017
4.2.0.8 Feeding Plans and Dietary Modifications	11/2017
4.2.0.9 Written Menus and Introduction of New Foods	11/2017
4.2.0.10 Care for Children with Food Allergies	11/2017
4.2.0.11 Ingestion of Substances that Do Not Provide Nutrition	8/2016, 11/2017
4.2.0.12 Vegetarian/Vegan Diets	11/2017
4.3.1.1 General Plan for Feeding Infants	5/2018
4.3.1.2 Feeding Infants on Cue by a Consistent Caregiver/Teacher	5/2018
4.3.1.3 Preparing, Feeding, and Storing Human Milk	8/2016
4.3.1.4 Feeding Human Milk to Another Mother's Child	8/2017
4.3.1.5 Preparing, Feeding, and Storing Infant Formula	11/2013, 8/2016
4.3.1.6 Use of Soy-Based Formula and Soy Milk	5/2018
4.3.1.7 Feeding Cow's Milk	5/2018
4.3.1.9 Warming Bottles and Infant Foods	11/2013, 8/2016, 5/2018
4.3.1.10 Cleaning and Sanitizing Equipment Used for Bottle Feeding	5/2018
4.3.1.11 Introduction of Age-Appropriate Solid Foods to Infants	5/2018
4.3.1.12 Feeding Age-Appropriate Solid Foods to Infants	5/2018
4.3.2.1 Meal and Snack Patterns for Toddlers and Preschoolers	5/2018
4.3.2.2 Serving Size for Toddlers and Preschoolers	5/2018
4.3.2.3 Encouraging Self-Feeding by Older Infants and Toddlers	5/2018
4.3.3.1 Meal and Snack Patterns for School-Age Children	5/2018
4.5.0.3 Activities that Are Incompatible with Eating	8/2016
4.7.0.2 Nutrition Education for Parents/Guardians	5/2018
4.9.0.13 Methods for Washing Dishes by Hand	8/2013
5.1.1.5 Environmental Audit of Site Location	8/2016
5.2.1.1 Ensuring Access to Fresh Air Indoors	8/2016
5.2.1.6 Ventilation to Control Odors	8/2016
5.2.6.1 Water Supply	5/2016
5.2.7.4 Containment of Soiled Diapers	8/2017
5.2.9.1 Use and Storage of Toxic Substances	1/2017
5.2.9.4 Radon Concentrations	5/2016
5.2.9.11 Chemicals Used to Control Odors	8/2016
5.2.9.12 Treatment of CCA Pressure-Treated Wood	8/2016
5.2.9.13 Testing for Lead	8/2015
5.2.9.15 Construction and Remodeling	5/2016
5.4.1.10 Handwashing Sinks	8/2017

Standard Number and Title (Listed Numerically)	**Date of Change**
5.4.5.1 Sleeping Equipment and Supplies	3/2017
5.5.0.5 Storage of Flammable Materials	8/2011
6.4.2.2 Helmets	3/2017
6.5.1.2 Qualifications for Drivers	1/2017
6.5.2.1 Drop-Off and Pick-Up	5/2016
7.3.1.1 Exclusion for Group A Streptococcal (GAS) Infections	8/2017
7.3.2.1 Immunization for *Haemophilus Influenzae* Type B (Hib)	8/2017
7.3.2.2 Informing Parents/Guardians of *Haemophilus Influenzae* Type B (Hib) Exposure	8/2017
7.3.11.1 Attendance of Children with Unspecified Respiratory Tract Infection	8/2017
7.4.0.1 Control of Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections	4/2017
7.4.0.2 Staff Education and Policies on Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections	4/2017
7.5.1.1 Conjunctivitis (Pinkeye)	3/2017
7.5.2.1 Enterovirus Infections	8/2017
7.5.8.1 Attendance of Children with Head Lice	8/2016
7.5.11.1 Attendance of Children with Scabies	8/2017
7.6.3.1 Attendance of Children with HIV	3/2017
7.7.1.1 Staff Education and Policies on Cytomegalovirus (CMV)	3/2017
9.2.3.1 Policies and Practices that Promote Physical Activity	8/2016, 5/2018
9.2.3.15 Policies Prohibiting Smoking, Tobacco, Alcohol, Illegal Drugs, and Toxic Substances	1/2017
9.4.1.11 Review and Accessibility of Injury and Illness Reports	Pending at time of publication
10.3.3.2 Background Screening	5/2018
10.3.3.3 Licensing Agency Role in Communicating the Importance of Reporting Suspected Child Abuse	Pending at time of publication
10.3.3.4 Licensing Agency Provision of Child Abuse Prevention Materials	Pending at time of publication
10.3.5.3 Training of Licensing Agency Personnel about Child Abuse	Pending at time of publication
10.4.3.3 Collection of Data on Illness or Harm to Children in Facilities	Pending at time of publication

Appendixes (Listed Alphabetically)	**Date of Change**
Appendix A: Signs and Symptoms Chart	1/2017
Appendix E: Child Care Staff Health Assessment	7/2018
Appendix G: Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger	Updated Annually Last Update: 4/2018
Appendix H: Recommended Immunization Schedule for Adults Aged 19 Years or Older	Updated Annually Last Update: 4/2018
Appendix I: Recommendations for Preventive Pediatric Health Care	7/2018
Appendix J: Selecting an Appropriate Sanitizer or Disinfectant	8/2011, 3/2013
Appendix II: Bike and Multi-sport Helmets: Quick-Fit Check	7/2018