

Children with Disabilities and Other Special Needs



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California Childcare Health Program
Administered by the University of California, San Francisco School of Nursing,
Department of Family Health Care Nursing
(510) 839-1195 • (800) 333-3212 Healthline
www.ucsfchildcarehealth.org



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The names are listed in alphabetical order:

Main Contributors

Abbey Alkon, RN, PhD
Jane Bernzweig, PhD
Lynda Boyer-Chu, RN, MPH
Judy Calder, RN, MS
Lyn Dailey, RN, PHN
Robert Frank, MS
Lauren Heim Goldstein, PhD
Gail D. Gonzalez, RN
Susan Jensen, RN, MSN, PNP
Judith Kunitz, MA
Mardi Lucich, MA
Cheryl Oku, BA
Pamm Shaw, MS, EdD
Marsha Sherman, MA, MFCC
Eileen Walsh, RN, MPH
Sharon Douglass Ware, RN, EdD
Rahman Zamani, MD, MPH

Additional Contributors

Robert Bates, Vella Black-Roberts, Judy Blanding, Terry Holybee, Karen Sokal-Gutierrez

Outside Reviewers, 2003 Edition

Jan Gross, RN, BSN, Greenbank, WA
Jacqueline Quirk, RN, BSN, Chapel Hill, NC
Angelique M. White, RNC, MA, MN, CNS, New Orleans, LA

CCHP Staff

Ellen Bepp, Robin Calo, Catherine Cao, Sara Evinger, Joanna Farrer, Krishna Gopalan, Maleya Joseph, Cathy Miller, Dara Nelson, Bobbie Rose, Griselda Thomas, Kim To, Mimi Wolff

Graphic Designers

Edi Berton (2006), Eva Guralnick (2001-2005)

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California Childcare Health Program

The mission of the California Childcare Health Program is to improve the quality of child care by initiating and strengthening linkages between the health, safety and child care communities and the families they serve.

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LEARNING OBJECTIVES

To describe typical development as a foundation for understanding children with special needs.

To identify children with disabilities and other special needs.

To describe developmentally appropriate practices (DAP) that form a foundation for early childhood inclusion in early care and education (ECE) programs.

To identify the benefits of early childhood inclusion.

To identify the challenges of early childhood inclusion.

To understand the process used when referring a child for medical or developmental screening and/or formal assessments.

To identify at least three ways a Child Care Health Consultant (CCHC) can assist ECE programs in meeting the needs of young children with disabilities and other special needs.

To identify special needs resources available to assist and support ECE providers and families.

WHY IS CARING FOR CHILDREN WITH DISABILITIES AND OTHER SPECIAL NEEDS IMPORTANT?

Increasing numbers of parents of young children with disabilities are placing their young children in a variety of ECE programs. Although integrating such children in the ECE environments is mandated by both federal law, via the Americans with Disabilities Act (ADA), and California state law, via the Unruh Civil Rights Act, in addition to being considered best practice, this can place heavy demands on ECE professionals, and families. Learning about the unique needs of young children with disabilities and their families, and accessing specialized services in the community, may present challenges to ECE programs. ECE providers need adequate training, ongoing support, technical assistance, and access to resources so they can expand their ability to meet the caregiving needs of these children. The inclusion of children with varying abilities and their families in these programs can enhance professional growth and improve the quality of services for all children.

Another important role ECE providers play is identifying children with special needs. Since ECE professionals see young children on a daily basis, they may be the first to recognize when a child is not developing on a normal trajectory. ECE providers can have a primary role in encouraging a family to obtain help. It is important for ECE providers to recognize early warning signs that may indicate developmental delays or disabilities.

WHAT THE CCHC NEEDS TO KNOW

What Is Normative Development?

To be able to identify children with disabilities and special needs, it is important to have a general understanding of normative development in early childhood. See Table 1 for an overview of normative signs of development from birth to five years. Each child develops at a different pace, so it is difficult to predict exactly when a child will perfect a given skill. Children vary a lot as they grow and develop. They may not develop at the same pace in all areas. Although developmental milestones will give ECE providers, CCHCs, and parents a general idea of the changes to expect as children develop, some children develop on a slightly different course (Shelov & Hannemann, 1999). Often it is the absence of a developmental skill that may signal a developmental delay or disability. For example, if a child displays any of the following signs of possible developmental delay in the 8- to 12-month age range, ECE providers should encourage parents to seek help from a health care professional:

- does not crawl
- drags one side of body while crawling (for over one month)
- cannot stand when supported
- does not search for objects that are hidden while he watches
- says no single words (“mama” or “dada”)
- does not learn to use gestures, such as waving or shaking head
- does not point to objects or pictures

If a child who is 18 months old cannot walk well by him or herself, does not seem curious and interested in exploring, does not use even one word at a time, then ECE providers should encourage parents to seek help from a health care professional.

Identifying Children with Undiagnosed Special Needs

Many children enter ECE programs with special needs that have not yet been diagnosed. An ECE provider may be the first person to become concerned about the child’s behavior, development or health (Sokal-Guiterrez, 2001). Some developmental delays and disabilities only become apparent as children develop and some are difficult to identify. ECE providers who suspect a child in their care may have an undiagnosed special need are encouraged to: observe the child closely over time, document any concerns about the child’s development, consult with a mentor or supervisor to receive feedback about the concern, diplomatically address the issue with the parents, and refer the child for assessment. Communicating concerns about a child to the parents is often a difficult step. When talking with parents, CCHCs can help ECE providers by role playing the discussion. Sokal-Guiterrez (2001) suggests the following tips for ECE providers when talking with parents about concerns:

- Set up a meeting at a convenient time and a comfortable, private place.
- If there are any cultural or language differences, get assistance to ensure good communication.
- Emphasize your commitment to working as a team with the family to meet their child’s needs.
- Explain your concerns briefly and calmly, citing specific observations you have made.
- Allow the parents to respond to your concerns and ask questions.
- Ask the parents to consider talking with the child’s health care provider.

Assessing Children’s Needs for Special Services

Assessing a child’s developmental progress is an on-going process that provides information about the child’s interests, preferences, strengths, and needs. This information is used to plan appropriate and meaningful activities to promote each child’s development and learning.

TABLE 1: AGES AND STAGES: SIGNS OF DEVELOPMENT OVER TIME

	By 4- Months	By 8-Months	By 12- Months	By 18- Months	By 24-Months
Physical Development	<ul style="list-style-type: none"> • Holds head up when held upright • Rolls from side to back • Sits when supported • Reaches for and grasps objects 	<ul style="list-style-type: none"> • Rolls over, sits up, may begin to crawl • Transfers object from one hand to the other • Uses finger and thumb to pick up objects 	<ul style="list-style-type: none"> • Stands alone • Climbs • Can remove lids from containers • May prefer one hand over the other 	<ul style="list-style-type: none"> • Walks without help • Waves bye-bye and claps hands • Carries small objects while walking 	<ul style="list-style-type: none"> • Walks well • Eats with spoon • Rolls a large ball • Picks up toys without falling over
Cognitive Development	<ul style="list-style-type: none"> • Explores objects with mouth • Distinguishes familiar faces • Fascinated by moving objects 	<ul style="list-style-type: none"> • Experiments with simple physical relationships, like gravity and one object hitting another • Can match a happy sounding voice to a picture of a smiling face • Can imitate actions 	<ul style="list-style-type: none"> • Can group objects that are alike • Curious about small openings, objects that turn • Can solve problems through trial and error 	<ul style="list-style-type: none"> • Takes things apart • Enjoys playing peek-a-boo • Identifies objects in a book 	<ul style="list-style-type: none"> • Shows preference between toys • Points to eyes, ears, nose when asked • Is able to listen to short stories
Communication/ Language Development	<ul style="list-style-type: none"> • Responds to familiar voice • Follows face with eyes • Communicates needs primarily through crying 	<ul style="list-style-type: none"> • Follows your face with her gaze • Laughs in response to playful interaction • Uses gestures, eye contact, and verbal sounds to communicate 	<ul style="list-style-type: none"> • Can follow your line of vision and looks at what you are looking at • May begin saying first words, experimenting with word sounds • Follows conversational turn-taking when interacting with others 	<ul style="list-style-type: none"> • Points or uses single words • Looks at person talking to him • Says hi or bye if encouraged 	<ul style="list-style-type: none"> • Uses 2-3 word sentences • Tries to sing • Says please and thank you when prompted

(Adapted from Barber, Reschke, & Longo, 2002)

TABLE 1: AGES AND STAGES: SIGNS OF DEVELOPMENT OVER TIME, continued

	By 36-Months	By end of 3rd year	By end of 4th year	By end of 5th year
Physical Development	<ul style="list-style-type: none"> • Has almost a full set of teeth • Walks backwards • Likes to push, pull, fill, and dump 	<ul style="list-style-type: none"> • Develops a taller, thinner, adult-like appearance • Sleeps through most nights without wetting the bed • Uses the toilet with some help 	<ul style="list-style-type: none"> • Uses spoon, fork, and dinner knife skillfully • Dresses self without much help • Hops on one foot 	<ul style="list-style-type: none"> • Learns to skip • May begin to lose baby teeth • Throws ball overhead • Catches bounced balls • Hand dominance is established
Cognitive Development	<ul style="list-style-type: none"> • Enjoys stories, songs, and rhymes • Wants to learn how to use things • Likes to look at books 	<ul style="list-style-type: none"> • Understands “now,” “soon,” and “later” • Draws a circle and a square • Matches object and picture 	<ul style="list-style-type: none"> • Places object in a line from largest to smallest • Can recognize some letters if taught • Counts 1-7 objects out loud 	<ul style="list-style-type: none"> • Knows basic colors like red, yellow, blue, green • Understands that stories have a beginning, middle, and end • Understands that books are read from left to right, top to bottom
Communication/ Language Development	<ul style="list-style-type: none"> • Uses 2-3 word sentences • Repeats words others say • Says names of items when asked 	<ul style="list-style-type: none"> • 75-80 percent of speech is understandable • Talks in complete sentences of 3-5 words • Stumbles over words sometimes 	<ul style="list-style-type: none"> • Speaks fairly complex sentences • Enjoys singing simple songs, rhymes, and nonsense words • Follows two unrelated directions: “Put the milk on the table and get your coat on.” 	<ul style="list-style-type: none"> • Enjoys telling his or her own stories • Enjoys riddles and jokes • Identifies some letters of the alphabet and some numbers

(Adapted from Barber, Reschke, & Longo, 2002)

The assessment process includes the following elements (Dennis & Laveck, 2004):

Observing the Child

While children may have different timetables for their development, most will acquire skills and demonstrate behaviors in a predictable sequence and within certain age ranges. Some children who do not follow these widely accepted developmental stages may be developmentally delayed or at risk for developmental delay or disability. CCHCs should have knowledge of typical child development and be able to share resources on this topic with ECE providers as appropriate.

Gathering Information from the Family

As a basis for meeting a child's developmental needs in the ECE setting, each family in the ECE program should complete a history form about the child upon admission, preferably with staff involvement. Staff may obtain information about the child's growth and development from birth to the present, as well as how the child responds in various settings and information about his/her routines, through conversations and informal inventories or questionnaires. See *Handout: Infant/Toddler (Birth to 36 Months) Development & Routine* and *Handout: Preschool (3-5 Years Old) Development & Routine*, two useful California Childcare Health Program (CCHP) forms for recording such information. The family may have additional written information about the child's development if screenings or evaluations have occurred previously.

Screening the Child's Development

Screening typically consists of a brief health exam including hearing and vision tests, and a checklist to determine how the child is developing in other areas of development, including gross motor, fine motor, cognitive, communication, social and emotional, and self-help skills. Screenings may occur in ECE programs, doctors' offices, health clinics, hospitals, and during local health fairs.

CCHCs should be aware of screening tools useful in the evaluation of young children's development. The administration of some screening tools requires formal training. Other screenings may not require formal instruction, but CCHCs are strongly encouraged to

seek training and/or consultation before teaching or using any screening instruments with children. CCHCs should also bear in mind that screening instruments do not form the basis for diagnosis for a child suspected of a disability or special need, but rather should be used to assess a potential need for more formal assessment/evaluation. Examples of screening instruments for young children include:

- Ages and Stages Questionnaire (ASQ) (Bricker & Squires, 1999)
- Desired Results for Children (California SDE/CDD)
- Devereux Early Childhood Assessment Program (DECA) (Devereux Early Childhood Initiative, 1999)
- Parents' Evaluation of Developmental Status (PEDS) (Glascoe, 1997)

CCHCs should be aware of and recognize the early warning signs that may indicate a child's need for a formal assessment/evaluation. See *Handout: Early Warning Signs* to use as a resource guide.

Generally, children who should be referred for a formal assessment/evaluation are developing very slowly (delayed development) or atypically, suggesting that the child's progress differs in some qualitative way from what is expected (see *Handout: Health and Safety Notes: How to Get a Child Tested: Guidelines for Special Education Assessment*; and *Handout: Health and Safety Notes: Hearing Evaluations in Young Children*).

Professionals trained in the assessment methodology and in typical and atypical development administer these formal assessments/evaluations. In addition, each assessor has training in a specific professional discipline such as special education, psychology, speech and language, physical or occupational therapy, nursing or medicine. Depending upon the issues a child may have, one professional or a team of professionals might be needed to assess a child. There are three reasons to conduct a formal assessment of a child: (1) to learn more about the child's strengths and needs; (2) to determine if a child is eligible for special services; and (3) to make a formal diagnosis (Kuschner, Cranor, & Brekken, 1996).

CCHCs should be knowledgeable about the early intervention and special education system in their state, including names and telephone numbers for local contacts. See *Handout: Map to Services for Children with Special Needs and their Families*. CCHCs should be familiar with the lead agencies serving young children with disabilities and special needs, options for screening and assessment/evaluation, the eligibility requirements for children to be identified as having special needs, and the various service delivery and support service options. The California Department of Developmental Services is responsible for designing and coordinating a wide array of services for children with developmental disabilities. These services are provided through a statewide system of 21 locally based regional centers. Regional centers are nonprofit private corporations with offices throughout California which provide a local resource to help find and access the many services available to individuals with developmental disabilities and their families.

Written plans are developed for children with disabilities and other special needs to identify goals for the child, and services needed. For children with disabilities and other special needs from birth to 3-years, an Individualized Family Service Plan (IFSP) is developed as an early intervention plan describing the child's current level of development; the family's strengths and needs related to enhancement of the infant's or toddler's development; goals for the child and the other family members, including criteria, procedures and time lines used to evaluate progress; and the specific early intervention services needed to meet the goals. The IFSP is developed and implemented by the child's parents and a multidisciplinary early intervention team. An Individual Education Program (IEP) is written for children 3-21 years. The IFSP and the IEP are legal contracts developed with an agency (often a public school district or social services agency). ECE providers are commonly involved in these written plans.

Identifying Children with Disabilities and Other Special Needs

Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home

Child Care Programs, Second Edition (CFOC) (American Academy of Pediatrics [AAP], American Public Health Association, & National Resource Center for Health and Safety in Child Care, 2002) defines children with special needs as "those children with developmental disabilities, mental retardation, emotional disturbance, sensory or motor impairment, or significant chronic illness who require special health surveillance or specialized programs, interventions, technologies, or facilities" (p. 481). CCHCs should become well acquainted with the *Children With Special Needs Applicable Standards* from CFOC, as well as *Chapter 7: Children Who are Eligible for Services Under IDEA*, and pages 326-327, which list additional standards relevant to children with special needs that have been integrated into other chapters of the document.

Other terms frequently used by programs and agencies to describe children who have been identified as having a disability or other special needs include (Dennis & Laveck, 2004):

- children who are developmentally disabled, developmentally delayed, or at risk for developmental delays
- children with cognitive delays or disabilities
- children who are behaviorally and/or emotionally challenged
- children with hearing loss or who are hearing impaired
- children with visual impairment or who are visually impaired
- children who are deafblind (both deaf and blind)
- children with speech-language delays or disorders
- children who are speech-language impaired
- children with traumatic brain injury
- children with special health care needs
- children with autism and pervasive developmental disorder (PDD)
- children with physical disabilities
- children who are orthopedically impaired

Children with special needs must be understood and treated as *children*, first. Most children with special needs require only minor accommodations in the ECE settings. Some children with special needs, for example, a child with multiple disabilities, might require more extensive accommodations (Sokal-Guiterrez, 2001).

What Is Early Childhood Inclusion?

Inclusion is when children with special needs are provided equal opportunity to participate in the same types of programs and activities as children without disabilities or special needs (Dennis & Laveck, 2004). Inclusion means serving children with disabilities together with other children who are developing in a typical way. Previous words used to describe these opportunities have included mainstreaming, reverse mainstreaming, integration, and integrated programs. All of these opportunities could be described as inclusive.

Inclusion is children learning and growing together regardless of their abilities. What inclusion looks like in practice is the same as what it looks like in typical early childhood programs, as best practice for young children is best practice regardless of the abilities of the children and families participating in the program. The inclusion of children with disabilities or special needs should not change the nature of the program itself. See *Handout: Health and Safety Notes: Including Children with Special Needs: Tips for Child Care Providers*. Inclusion means that the early childhood professionals have created a program where children's individual needs are met through appropriate practices and high quality care and education. Children with disabilities enjoy routines and activities that are challenging and interesting, not because routines and activities are *specialized* for their disability, but rather because they are *individualized* for each child (Mulligan, Morris, Green, & Harper-Whalen, 1999).

Legal Rights of Children with Disabilities and Other Special Needs

Two acts of federal legislation mandate the inclusion of young children with disabilities and other special needs in community services such as ECE programs.

Individuals with Disabilities Education Act (IDEA)

IDEA is an entitlement to services for children with disabilities. In 1986, and in subsequent reauthorizations of Public Law 99-457, special education services provided by the public school system were extended to include 3- to 5-year-old children with special needs. This program is commonly referred to as "Part B." States were encouraged to create early intervention services for children birth through 36-months who are identified as having developmental delays or being at risk for developmental delays. This program is known as "Part C." Other major provisions of IDEA include:

- Significant shift in terminology from "handicapped child" to "a child with a disability."
- Outreach and identification of children with special needs (i.e., "Child Find" or "Search and Serve").
- Assessment by qualified professionals.
- Parental involvement in all aspects of assessment, planning, and intervention.
- Development of an Individualized Family Service Plan (IFSP) for children birth to 36 months or an Individual Education Program (IEP) for children 3-21 years.
- Services are to be provided in the "natural environment" or "least restrictive environment" (LRE) (settings where children who are typically developing may be found, such as ECE programs).

CFOC Standards 7.003-7.011, 2.002, 2.044, 2.051, 2.053, 2.057, 2.058, 8.013, 8.016, 8.046, 8.053 (AAP et al, 2002) are consistent with the requirements of IDEA.

The Americans with Disabilities Act (ADA)

Passed in 1991, the ADA prohibits the discrimination of persons with disabilities in employment, public services, *public accommodations*, and transportation. The part of this law that affects ECE programs is the section on public accommodations. In addition to hotels, theaters and restaurants, public accommodations refers to private programs that are "open to

the public,” such as family child care homes, child care centers, after school programs, and recreational programs. Programs do not have to receive public funding to be considered public accommodations as defined by the ADA. ADA requires ECE programs to consider making changes in the following areas:

- Programs must eliminate eligibility criteria that screen out or tend to screen out a child with a disability. For example, an ECE program should eliminate a provision in the admissions policy which refuses enrollment to children who have not been toilet trained. Such a policy discriminates against children who because of their disability have not yet been toilet trained or may never be toilet trained.
- Programs must make reasonable modifications in their policies, practices and procedures in order to accommodate the child with a disability. For example, a program may make a schedule change for a child who takes medication and needs a morning nap.
- Programs are required to provide auxiliary aids and services for those children with disabilities affecting hearing, vision or speech. Auxiliary aids and services refer to services and devices designed to ensure effective communication. Examples include learning some sign language to improve communication with a child who has a hearing impairment, and putting a Braille label on the cubby of a child who is blind.
- Programs must remove architectural barriers that prevent access to services if removal is *readily achievable*. For example, furniture may need to be rearranged to enable a child in a wheelchair to access all areas of the program.

Further Rationales for Inclusion

Ethical Reasons

Children with disabilities have the right to access the same opportunities and to participate in the typical activities of daily life available to other children. Many people view inclusion as a moral value and therefore need no legal or empirical foundation on which to stand. Inclusion is simply the right thing to do (Bailey, McWilliam, Buysse, & Wesley, 1998).

Social Reasons

Inclusion supports families and maintains children in their communities. Participating in activities with their peers who are typically developing is important for children with disabilities as they learn skills that will help them function in the world. The focus of inclusion for preschool children with special needs should include the development of social competence as a central mission (Guralnick, 1990; Strain, 1990). In a review of the research on the outcomes for children with special needs, Buysse and Bailey (1993) found that children in inclusive settings tend to have an advantage in social and behavioral areas over children in segregated settings. Children without disabilities continue to grow and develop in a typical way and can learn much about themselves by being around children who have disabilities. They may have a greater understanding of disabilities and increase their acceptance of others who are different from them (Diamond, Hestenes, & O'Connor, 1994).

Educational Reasons

Young children with disabilities need the same enriching early experiences as children who are typically developing. When compared to segregated programs or settings, inclusive program and settings offer more opportunities for children to learn naturally through play, use a greater variety of materials in new and different ways, interact with other children, and explore the environment (Wesley, 1992).

Benefits of Inclusive Programs

For Children with Disabilities

With appropriate support and guidance, children with disabilities and special needs in inclusive settings maintain their rate of developmental growth. In fact, research shows an increase in their social skills as compared to children in segregated settings (Buysse & Bailey, 1993). The stimulation of an inclusive environment increases social interaction with peers, and promotes more complex play with toys and materials (Bailey & Winton, 1987). Children with disabilities become part of their community in inclusive settings, where they engage with peers who serve as role models and are supported by opportunities to learn motor skills and social skills, and to communicate in natural environments and situations.

For Children without Disabilities

An inclusive environment provides opportunities for young children who are typically developing to learn about differences in human growth and development. They gain a greater understanding of disabilities and their effects on development (Diamond et al., 1994). Their experiences with children who have a range of abilities may lead them to become more accepting of people who are different, which assists all children in becoming more resourceful and creative thinkers. Engaging with children without disabilities also encourages cooperation and peer support, which exposes all children to diversity in friendships.

For Families of Children with Disabilities

The family may develop more positive attitudes toward their child with disabilities or special needs who is enrolled in a “regular” ECE program. An inclusive setting provides the family a “real world” perspective for interpreting their child’s growth and development. Being able to observe their child’s peers who are typically developing may increase the family’s knowledge of typical child development. Furthermore, opportunities to participate in activities with families of children without disabilities may decrease feelings of social isolation (Bailey & Winton, 1987). And when families with children with disabilities are included as part of the larger community, avenues of support and information become more readily available to them.

For Families of Children without Disabilities

An inclusive program provides families and their children an opportunity to learn about differences in human growth and development. Positive experiences with children with disabilities may increase their knowledge and understanding of persons with special needs. Opportunities to meet and get to know the families of children with disabilities or special needs may increase their sensitivity to the challenges of caring for a child with a disability (Bailey & Winton, 1987).

For ECE Providers

Experience in inclusive settings may help ECE providers develop more positive attitudes toward inclusion. They may become more aware and attuned to the individual needs of all children (Giangreco, Dennis, Cloninger, Edelman & Schattman, 1993). Some

ECE professionals may receive additional training for supporting the inclusion of children with disabilities that is beneficial to all children, such as promoting social interactions (Wesley, 1992). Collaboration with specialized professionals such as speech-language pathologists, inclusion specialists, behavioral specialists, occupational/physical therapists, and special educators may provide ECE professionals with opportunities to increase their knowledge about specific developmental areas and to learn from hands-on training in a team approach.

For the Community

As communities become more diverse ethnically, linguistically and culturally, the inclusion of children with disabilities may influence society to be more accepting of persons who are different. The “real world” experience for persons with disabilities or special needs may help them to become contributing members of society rather than dependent on society (Dennis & Laveck, 2004).

Challenges of Inclusive Programs (from Dennis & Laveck, 2004)

Values and Beliefs

The values and beliefs of individuals may influence the development of negative attitudes and/or fears about inclusion. For example, a family’s feelings of guilt regarding their child with disabilities, or feelings of inadequacy in their ability to care for them, may lead them to accept any placement or program. Some families may be concerned for their child’s safety in settings where the staff is not specialized in a specific disability or the special needs of their child. Some families may fear that children who are typically developing will mock their child who has a disability or special need. ECE professionals may fear that typically developing children will imitate inappropriate behaviors of children with disabilities, resulting in behavior problems. Attitudes and beliefs about persons with disabilities or special needs may be reflected in the words that individuals use to talk about them.

Personnel Preparation

Several issues related to personnel preparation present challenges to effective inclusion. Many ECE professionals know little about developmental disabilities

and other special needs. Fear of the unknown often becomes the greatest obstacle to including a child with disabilities or special needs. Often special educators and specialized therapists receive minimal training in providing services in the natural setting of the ECE program or in consulting with ECE providers about the child's intervention goals. Successful inclusion requires a team approach and frequently involves many people from various agencies in addition to the family. Few ECE professionals have received adequate training on building successful teams and partnerships with families.

Policies

Policies at the state, local and program level may present challenges to inclusion. For example, public school systems struggle with blending funding sources to create classes for preschool children with and without disabilities. An ECE program may not have a diapering area in the 4-year-old classroom, resulting in refusal of admission of a 4-year-old child with spina bifida who may never be able to control urination and bowel movements.

Resources

A lack of resources may present challenges to inclusion. Unfortunately, there is a lack of quality placement slots for children with disabilities. Parents frequently have limited options and funding constraints may prevent special services from being provided in the ECE setting. Early childhood special educators, early interventionists, and specialized therapists frequently have unmanageable caseloads that prevent them from providing the amount of support needed to ensure the successful inclusion of some children. Finally, a lack of transportation to an inclusive program may result in the child being enrolled in a special, separate program that offers transportation.

Developmentally Appropriate Practices and Inclusion

When children enter an ECE program, regardless of their age, the environment should speak directly to them. It should tell children that they are welcome, safe and secure, and it should provide clear messages about where to go and what to do (NAEYC, 1997). Developmentally appropriate practices such as well-defined activity areas, clearly labeled shelves,

accessible materials, and an established and consistent daily routine are necessary for both an effective ECE setting and effective inclusion (Dennis & Laveck, 2004). Developmentally appropriate practices result from decisions made about the care and education of young children based on what is known about how children develop and learn, the strengths, interests, and needs of each individual child, and the social and cultural contexts in which children live (Bredekamp & Copple, 1997). This developmental approach to setting up the early childhood environment and designing curriculum ensures that children have many opportunities to engage in child-initiated activities that support their development and learning (Bredekamp & Copple, 1997).

CCHCs should have knowledge about developmentally appropriate early childhood practices and be able to share resources on these topics with early childhood professionals and families as appropriate. NAEYC has a position statement on *Developmentally Appropriate Practice in Early Childhood Programs Serving Children from Birth through Age 8*:

“Developmentally appropriate practices result from the process of professionals making decisions about the well-being and education of children based on at least three important kinds of information or knowledge:

1. *What is known about child development and learning*—knowledge of age-related human characteristics that permits general predictions within an age range about what activities, materials, interactions, or experiences will be safe, healthy, interesting, achievable, and also challenging to children.
2. *What is known about the strengths, interests, and needs of each individual child in the group* to be able to adapt for and be responsive to inevitable individual variation.
3. *Knowledge of the social and cultural contexts in which children live* to ensure that learning experiences are meaningful, relevant, and respectful for the participating children and their families” (NAEYC, 1997).

Family-Centered Care

Children with disabilities and other special needs and their families thrive when the care they receive is family-centered (National Center for Family-Centered Care, 1989). The Division of Services for Children with Special Health Needs of the Maternal and Child Health Bureau (2005) define family-centered care as follows: “Family-Centered Care assures the health and well-being of children and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-Centered Care is the standard of practice which results in high quality services.”

The foundation of family-centered care is the partnership between families, CCHCs, ECE providers, and other health care professionals. Key to this partnership are the following principles:

- Families and professionals work together in the best interest of the child and the family.
- Everyone respects the skills and expertise brought to the relationship.
- Trust is acknowledged as fundamental.
- Communication and information sharing are open and objective.
- Participants make decisions together.
- There is a willingness to negotiate.

Based on this partnership, family-centered care:

- Acknowledges the family as the constant in a child’s life.
- Builds on family strengths.
- Honors cultural diversity and family traditions.
- Recognizes the importance of community-based services.
- Promotes an individual and developmental approach.
- Encourages family-to-family and peer support.
- Supports youth as they transition to adulthood.

- Develops policies, practices, and systems that are family-friendly and family-centered in all settings.
- Celebrates successes.

Integrated Therapy

Many times a child will receive services from one or more specialized therapists in addition to services provided by an early interventionist or preschool special education teacher. Traditionally, this therapy has been provided to each child individually in a therapy room or some space outside of the regular classroom. A recent approach to providing therapy promotes the provision of therapy within the daily routines and activities of the child. This approach is called integrated therapy.

Integrated therapy works best when the family, early childhood educator and/or caregiver, and therapists collaborate to embed the child’s therapy goals in naturally occurring activities, interactions and environments. Therapists work with the child in the ECE setting during the daily routines and activities. This approach allows ECE staff to observe strategies, modifications and adaptations used by the therapists to help children practice targeted skills. In addition, consultation provided by the therapists to the staff ensures that opportunities for the child to use and practice new skills occur daily, not just on days when the therapist is present. Integrated therapy increases the opportunities for communication between the ECE staff and therapists regarding the child’s goals and progress.

WHAT THE CCHC NEEDS TO DO

Observe Programs

The CCHC can observe whether children with disabilities and other special needs are enrolled in the ECE program. If children with disabilities and other special needs are included in the ECE program, observe whether the children with special needs are included socially and engaged in meaningful activities throughout the day. Are children with disabilities or other special needs given support and assistance when needed? CCHCs can help ECE providers to meet the individual needs of all children in the program. CCHCs can identify necessary changes that can be made to the physical environment and to program policies, practices, and procedures to accommodate children, family members, and staff with special needs.

Review Policies and Procedures

The CCHC can review inclusion policies and procedures, and developmentally appropriate practices. If no policies exist, the CCHC can work with the ECE provider to develop inclusion policies relevant to children with disabilities and other special needs.

Educate ECE Staff

- The CCHC should be able to teach ECE staff the definition of children with special needs and be familiar with the eligibility requirements of lead agencies providing services to young children with special needs and their families. See *Handout: Early Care and Education of Children with Special Needs: Definition of Terms*; and *Handout: Map to Services for Children with Special Needs*.
- The CCHC should be able to share the benefits of inclusion with ECE programs that are hesitant to enroll children with disabilities and special needs.

- CCHCs can use their knowledge of the challenges of inclusion to assist programs in addressing these issues as appropriate.
- ECE providers may feel unprepared to serve children with disabilities and other special needs. The CCHC can be a conduit and a facilitator to help reduce resistance for serving these children and families and help staff feel competent and confident including children with disabilities and other special needs.

Provide Resources

The CCHC should develop a directory of local agencies providing services to young children with disabilities and other special needs and refer ECE professionals to these agencies as appropriate. See *Handout: Children with Special Needs Resources*. The CCHC can also compile a list of books about children with disabilities and other special needs for ECE staff, parents, and children. The National Dissemination Center for Children with Disabilities (NICHCY) has a resource list of children's literature and disability which can be downloaded from www.nichcy.org/pubs/bibliog/bib5.pdf.

Help Develop an IFSP or IEP

The CCHC can help ECE providers in the process of developing an IFSP or IEP. ECE staff must be involved in Individualized Education Planning (IEP) for preschoolers and Individualized Family Service Planning (IFSP) for infants/toddler teams when the special needs child is enrolled in an ECE program. The ECE provider will usually be on the planning team to ensure that the plan is consistent and implemented in the ECE setting as well as other environments.

Help Develop a Special Health Care Plan

CCHCs can be part of the process of welcoming a child with disabilities or other special needs into an ECE program from the first step. This might include attending meetings with the parents to learn about

the child, working with ECE staff to make certain they understand the child's strengths and needs, and what accommodations the program may have to make. After enrollment, but prior to the child's first day, CCHCs can work closely with the parents and the ECE provider in the development of a special health care plan to meet the needs of the child while in the ECE program. (See *Handout: Special Health Care Plan*).

Train ECE Staff

- The CCHC can train ECE staff to make referrals and access services when needed.
- The CCHC should train ECE staff on proper medication administration techniques. The CCHC should train ECE staff in the use of equipment and apparatus needed for children with disabilities and other special needs.

Act as a Liaison

Collaboration with the child's family, special education teacher or early interventionist, and specialized therapists to develop goals and interventions that help the child enjoy the natural routines and activities of the classroom is critical. If the child is working with additional therapists, schools, or assessment/evaluation teams, the CCHC should provide technical assistance, resources, guidance, and support the coordinated efforts with the team of professionals involved in the life of the child and his/her family. A sample form to assist with information exchange and the consent for release of information is included in the handout section of the module (see *Handout: Forms: Information Exchange & Consent for Release of Information*).

Link Programs with Community and Professional Resources

The CCHC should be familiar with the services and resources available to families through the Individuals with Disability Education Act (IDEA), the federal special education law that requires services to be pro-

vided to children with disabilities and their families. The CCHC can link ECE programs with state inter-agency councils, local child care planning councils, and regional centers.

Be Culturally Aware and Sensitive

Cultural aspects of caring for children with disabilities and other special needs cover not only ethnic and cultural perspectives of children and families, but also the unique culture related to each child with disabilities or other special needs. It is important to understand each individual family's approach and perspective about their child and the care they envision for that child. These may reflect their ethnic culture and the culture around a child with special needs.

WAYS TO WORK WITH CCHAs

The CCHC will help the Child Care Health Advocate (CCHA) to monitor the daily care and education children in the ECE program with special needs receive. The CCHA can provide on-going observations and documentation to verify the implementation of the special health care plan, the IFSP, and/or the IEP. The CCHC can help keep lines of communication open among the CCHA, the ECE staff, and the child's health care provider and therapists. Reevaluation of the care being given can be frequent in order to meet the child's changing needs. CCHAs appreciate having child and parent education materials at appropriate reading levels and in languages relevant to the families they serve. Seek feedback about the materials to assure relevancy. Monitor the quality and accuracy of information being conveyed by CCHAs to parents and staff. Maintain and disseminate resource lists and educational materials for parents and staff (see *Handout: Children with Special Needs Resources*).

ACTIVITY 1: BENEFITS OF INCLUSION

The facilitator will hang two signs. One that reads “YES” and one that reads “NO” in opposite locations in the training room.

Participants will be asked to stand and move to one of the signs.

The facilitator will read a statement. If you believe that the statement is a benefit of inclusion, move to the ‘YES’ sign. If you believe that the statement is not a benefit of inclusion, move to the ‘NO’ sign.”

Statements:

1. Children with special needs in inclusive settings show an increase in their rate of learning in all developmental areas.
2. The stimulation of an inclusive environment may increase social interaction between children with special needs and their peers.
3. When compared to children in segregated settings, children with special needs in inclusive settings show an increase in their social skills.
4. Children without special needs in inclusive settings show an increase in their social skills.
5. Positive experiences in inclusive settings may lead children without special needs to become more accepting of people who are different from them.
6. For families of children with special needs, opportunities to participate in activities with families of children without special needs eliminates all feelings that their family is different.
7. Families of children with special needs in inclusive settings may develop more positive attitudes about their child.
8. For families of children without special needs, positive experiences with children with special needs may increase their knowledge and understanding of persons with disabilities.
9. Teachers who work in inclusive settings become strong advocates for inclusion.
10. Experiences in inclusive settings will ensure that persons with disabilities become contributing members of society.

(Dennis & Laveck, 2004)

ACTIVITY 2: HELEN KELLER

The objective for this activity is for participants:

- to examine their own feelings and beliefs about persons with disabilities
- to understand the significance of person first language
- to demonstrate the use of person first language

Participants will be divided into two groups and asked to describe the phrase assigned to the group. Both groups will share their descriptions and discuss how we associate limitations and prejudices with developmental disabilities.

(Dennis & Laveck, 2004)

ACTIVITY 3: CASE STUDIES

Case 1: Managing Severe Allergies in Child Care

Cesar, a four-year-old boy, will be enrolled in your program, starting one week from today. He will be in an ECE program every day from 12:00 noon to 5:00 p.m. Cesar is severely allergic to peanuts.

A few months ago, he was exposed to peanuts when eating a cookie. Cesar ate the cookie because he was “sharing his snack” with another child at a playground, and the child shared her cookie with him. He had a severe allergic reaction within five minutes of eating the cookie, and his mother had to take him to the Emergency Room due to difficulty breathing. By the time Cesar’s mother got him to the Emergency Room, his airway was obstructed, and he needed rescue medications, respiratory support, and observation overnight in the hospital.

A pediatric allergist has prescribed an Epi-Pen for Cesar’s use in case of exposure to peanuts or signs of allergic reaction. His mother has obtained an extra Epi-Pen, to be kept at the ECE program.

Discuss and answer the following questions about caring for Cesar:

- Who should be present when you develop the care plan (who is on Cesar’s Care Team)?
- What specific questions do you have for Cesar’s parents about his allergy?
- How can you be sure Cesar is not exposed to peanuts during participation in your program?
- Will Cesar’s allergy have an effect on the other children and their families who also attend your program?
- Where will you keep the Epi-Pen?
- Which staff will be trained to use the Epi-Pen? Who will conduct the training(s)?
- What forms should be kept in Cesar’s personal file?
- What would you do if you discovered that Cesar had just eaten a food containing peanuts a few moments ago?

Case 2: Managing Asthma in Child Care

Two-year-old Sabrina has been enrolled in your ECE program for the past six months. She comes to your ECE program every day, full-time. Like many toddlers, she often has a mild cold, with a runny nose and light cough.

Recently, her coughing became more serious. When she coughed, you noticed a wheezing sound, and sometimes she seemed to be struggling to catch her breath. Her parents also noticed this, and about three weeks ago they took her to see her pediatrician. The doctor diagnosed Sabrina with asthma.

Since the diagnosis, Sabrina’s parents are giving her a steroid medication (budesonide) through an inhaler every night at bedtime. In addition, they use a nebulizer to deliver rescue medications (Albuterol) when Sabrina has flare-ups. The mother brings the nebulizer to your ECE program with Sabrina every day, in case she has a flare-up during the day. The mother has shown you how to fit the mask on Sabrina, and how to give her a treatment.

Discuss and answer the following questions about caring for Sabrina:

- What specific questions do you have for Sabrina's parents about her asthma?
- Will Sabrina's asthma have an effect on the other children and their families who also attend your program?
- Which staff should be trained in the use of the nebulizer? Who will conduct the training(s)?
- Where will you keep the nebulizer?
- What forms should be kept in Sabrina's personal file?
- What should you do if the family forgets to bring the nebulizer?
- Can Sabrina participate in play with the other children in the program?
- How can you improve the ECE environment to decrease Sabrina's risk of a flare-up?

Case 3: Managing Diabetes in Child Care

Tyler, a five-year old child with diabetes, will be enrolled in your program starting in two weeks. He will be participating three days per week, Monday, Wednesday and Friday, from 9:30am to 4:00pm.

Tyler's father gives him insulin every morning at breakfast time before arriving at your ECE program. He does not normally need insulin injections during program hours. In case Tyler ever needs insulin unexpectedly during care hours, his father, mother, and a neighbor are on the call list, and they all have been trained in giving the injections.

It is important that Tyler eat regular balanced meals and snacks. His parents send a packed lunch, and your program provides snacks for Tyler at the regular children's snack times, 10:00am and 2:30pm. Tyler's father has shared with you a list of acceptable foods that Tyler can have for snack. These include:

- 4 whole grain crackers
- one piece of fresh fruit
- ½ cup flavored lowfat yogurt
- one slice whole grain bread, toast, or ½ bagel
- ½ cup sliced or mini carrots
- one stalk celery with peanut butter or cream cheese
- one piece string cheese
- one cup lowfat milk or unsweetened soy milk
- one mini pizza (4 inch diameter)
- ¾ cup pretzels

You are permitted to use your good judgment to give other low sugar, minimally processed foods to Tyler for snack. He *cannot* have ice cream, soda, cupcakes, candy, or cookies.

Tyler's doctor has instructed that his blood sugar should be checked daily at 11:45am, just before lunch. His father has shown you how to do the blood sugar check, and has given you a meter and a supply of the strips and other equipment you will need. The doctor has given these directions to follow anytime you check Tyler's blood sugar:

Tyler's Blood Sugar Action Plan	
Blood Sugar Reading	Action
Normal (70-140)	Follow routine schedule for snacks and meals. No further testing necessary during day <i>unless he has symptoms of low blood sugar or high blood sugar.</i>
Low (less than 70)	Give 8 ounces orange juice and lunch. Check blood sugar again 30 minutes after lunch.
Slightly high (140-180)	Give Tyler his regular lunch. Recheck blood sugar in one hour.
High (over 180)	Call parent – Tyler needs additional insulin ASAP.

Discuss and answer the following questions about caring for Tyler:

- Who do you call if Tyler needs insulin? What are some ways you can ensure that there is always a designated person available?
- To check Tyler's blood sugar, you must use a sterile sharp object called a lancet, to prick his finger and draw a drop of blood. What universal precautions should be observed?
- What do you do with the lancet after it has been used?
- One day around 3:00pm, during outside play time, Tyler comes over and tells you he feels dizzy. He is pale and sweaty. What do you do?
- Tyler's 11:45pm blood sugar reading (just before lunch time) is 225. What do you do?
- A girl in your program is turning 5 years old at the end of the month. Her mother tells you she wants to bring chocolate cupcakes with chocolate icing for the children to celebrate her daughter's birthday. What do you do?
- A boy in your program is turning 4 years old today. Without warning you ahead of time, his father has brought in an ice cream cake for the children to share at afternoon snack time. What do you do?
- What forms should you keep in Tyler's personal file?

Case 4: Managing a Child with a G-tube in Child Care

Dimitri is a six-month-old infant who has been attending your program since he was three months old. He comes daily between the hours of 9:00am—3:00pm, while his mother attends high school.

Dimitri was born two months prematurely, and he is very small for his age. He has a history of feeding problems. He is very difficult to feed: he spits up and gags frequently. He will often turn his head away from you while you try to coax him to finish his bottle. Because it has been so hard to keep him fed, his weight gain since birth has been very slow. He presently weighs nine pounds.

Due to his difficulties with feeding and growing, Dimitri's doctor and family have put in a G-tube. Their plan is to keep the G-tube in for six months, or longer if necessary, to help him gain weight.

The dietician recommends that three times per day, Dimitri should be offered thin rice cereal by spoon, to be followed by a six ounce bottle of high calorie formula. In addition, he is to have a G-tube feeding of six ounces of formula during his afternoon nap, and again while asleep at night. You will give the Dimitri one of the spoon/bottle feedings, at 11:00am. You will also give him a G-tube feeding during his afternoon nap (nap time is between 1:00 and 3:00).

Discuss and answer the following questions about caring for Dimitri:

- How do you prepare for a G-tube feeding? What supplies should you have ready?
- How do you know if the G-tube is in place?
- How do you keep Dimitri from pulling out the G-tube?
- How do you keep the other children from hurting the G-tube?
- What do you do if Dimitri throws up during a G-tube feeding?
- What do you do if the G-tube site looks red and swollen?
- What forms should be kept in Dimitri's personal file?

Case 5: Managing Seizures in Child Care

In the past week, two toddlers in your program have been kept home due to a roseola outbreak. The children had a rosy, blotchy pink rash, and very high fevers. Isaac, an eighteen-month-old boy in full time care, has a mildly runny nose when his mother brings him to the program in the morning. However, he seems bright and happy, and he has no fever, so you are not worried about him.

Later in the morning, Isaac seems tired and he has no appetite at snack time. He sits by the blocks but is not interested in playing with them, and then he lies down on the floor. You go over to check on him and notice that his cheeks are bright red. You touch his face and he feels very hot, like he is “burning up”.

Before you have time to check Isaac’s temperature, you notice that his entire body is experiencing small convulsive waves as he lies in the toy area. His legs are shaking, and his fingers are clenching and unclenching rhythmically. His face is rigid and his teeth are clenched tightly. You kneel down beside him and call his name, but he does not respond and his movements continue in this way for two or three minutes.

Discuss and answer the following questions:

- What is happening?
- What do you do when you find this happening?
- What do you do when the seizure stops?
- Twenty minutes later, Isaac is calm, but still hot and tired. You offer him some juice and he drinks it. Sitting on your lap, he falls asleep. What should you do?
- Twenty minutes later, Isaac is unresponsive, as if in a stupor. He does not focus and does not look up when you speak to him. What do you do?
- How does this experience change the way you will care for Isaac in the future?

NATIONAL STANDARDS

From *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, Second Edition*

See page 326 for a list of Additional Standards for Providers Caring for Children with Special Needs

- 2.002 Program of Activities Including Special Interventions
- 2.044 Mutual Responsibility of Parents and Staff
- 2.051 Support Services for Parents
- 2.053 Parent Consent
- 2.057 Enabling Parents as Child Advocates
- 2.058 On-Site Services for Children with Special Health Needs
- 5.097 Therapeutic and Recreational Equipment
- 5.098 Adaptive Equipment
- 5.099 Prosthetic Devices
- 7.003 Initial Assessment
- 7.004 Determining the Type and Frequency of Services
- 7.005 Formulation of an Action Plan
- 7.006 Determination of Eligibility for Special Services
- 7.007 Designation and Role of Staff Person Responsible for Coordinating Care
- 7.008 Development of Measurable Objectives
- 7.009 Contracts and Reimbursement
- 7.010 Coordinating and Documenting Services
- 7.011 Written Reports to Child Care Providers
- 7.016 Review of Plan for Serving Children with Special Needs
- 8.013 Written Procedure for Obtaining Preventive Health Service Information
- 8.016 Information Sharing on Therapies and Treatments Needed
- 8.046 Contents of Child Records
- 8.053 Parental Informed Consent Before Sharing Child's Health Records

Appendix T: Adaptive Equipment for children with Special Needs

Appendix X: Emergency Information Form for Children with Special Needs

CALIFORNIA REGULATIONS

From *Manual of Policies and Procedures for Community Care Licensing Division*

- 101226 Provisions for Children with Special Medical Conditions
- 101223.1 Postural Supports/Protective Devices
- 101226 Health Related Services

RESOURCES

Organizations and Resources	
Organization and Contact Information	Description of Resources
<p>American Academy of Pediatrics 141 Northwest Point Blvd. Box 927 Elk Grove, IL 60009 (800) 433-9016 www.aap.org</p>	<p>The mission of the AAP Division of Children with Special Needs is to improve the system of care for Children with Special Health Care Needs (CSHCN) by connecting them to a medical home. A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. www.aap.org/healthtopics/specialneeds.cfm.</p>
<p>The Arc of the United States 1010 Wayne Avenue, Suite 650 Silver Spring, MD 20910 (301) 565-3842 (301) 565-3843 fax www.thearc.org</p>	<p>The Arc of the United States works to include all children and adults with cognitive, intellectual, and developmental disabilities in every community</p> <p>The individuals with disabilities act (IDEA): Eligibility, IEPs and placement www.thearc.org/faqs/qa-idea.html</p> <p>All Kids Count: Child Care and the Americans with Disabilities Act (ADA), by The Arc. A resource manual to help child care center operators comply with Title III (public accommodations) of the ADA. 89 pgs. 1996. Can be downloaded from http://209.183.228.233/index.asp</p>
<p>Asthma and Allergy Foundation of America 1233 20th Street, NW, Suite 402 Washington, DC 20036 (800) 7.ASTHMA (800-727-8462) www.aafa.org</p>	<p>AAFA provides a national toll free information line to help consumers and patients learn more about asthma and allergies. This line is staffed Monday thru Friday from 10 a.m. to 3 p.m. EST.</p>
<p>California Map to Inclusive Child Care Project 751 Rancheros Dr., Suite 2 San Marcos, CA 92069 (760) 682-0271 phone (760) 471-3862 fax map@cihs-south.org www.sonoma.edu/cihs/camap/index.html</p>	<p>The Map Project works under the umbrella of the California Institute on Human Services (CIHS) at Sonoma State University and is funded by the California Department of Education's Child Development Division. The California Map to Inclusive Child Care Project seeks to expand opportunities for children with disabilities and other special needs in child care and development programs.</p>
<p>Child Care Law Center 221 Pine St., 3rd Floor San Francisco, California 94104 (415) 394.7144 phone (415) 394.7140 fax info@childcarelaw.org www.childcarelaw.org</p>	<p>The Child Care Law Center (CCLC) is a national nonprofit legal services organization that uses legal tools to make high quality, affordable child care available to every child, every family, and every community. Publications about child care and disabilities can be downloaded from www.childcarelaw.org/publications.cfm#disabilities</p>

Organization and Contact Information	Description of Resources
<p>Circle of Inclusion Project University of Kansas http://circleofinclusion.org</p>	<p>Circle of inclusion Web site offers demonstrations of and information about the effective practices of inclusive educational programs for children from birth through age eight.</p>
<p>Desired Results: Access for Children with Disabilities (DR Access) 311 Professional Center Drive Rohnert Park, CA 94928 (707) 285-2591 phone (707) 285-2590 fax www.sonoma.edu/cihs/desiredresults/access/about.html</p>	<p>DR Access is funded by the Special Education Division (SED) of the California Department of Education (CDE) to develop a system of child outcomes and assessment methodologies that can be used to assess the progress of children with disabilities from birth to five years of age.</p>
<p>Frank Porter Graham (FPG) Child Development Institute University of North Carolina at Chapel Hill CB#8180 Chapel Hill, NC 27599-8180 (919) 966.2622 www.fpg.unc.edu</p>	<p>FPG is one of the nation's oldest multidisciplinary institutes for the study of young children and their families.</p> <p>Inclusion for young children with disabilities www.fpg.unc.edu/~ecrii/index.html The Early Childhood Research Institute on Inclusion (ECRII) was a five year national research project to study the inclusion of preschool children with disabilities in typical preschool, day care and community settings.</p> <p>Individualizing Inclusion in Child Care retrieved March 23, 2005, from www.fpg.unc.edu/~inclusion/index.htm</p>
<p>National Early Childhood Technical Assistance Center Campus Box 8040, UNC-CH Chapel Hill, NC 27599-8040 (919) 962-2001 phone (919) 843-3269 TDD (919) 966-7463 fax www.nectac.org</p>	<p>A national technical assistance effort that supports programs for young children with disabilities and their families under the Individuals with Disabilities Education Act (IDEA).</p>
<p>National Dissemination Center for Children with Disabilities (NICHCY) P. O. Box 1492, Washington, D.C. 20013 (800) 695-0285 (voice/TTY) www.nichcy.org</p>	<p>List of children's literature relevant to disability www.nichcy.org/pubs/bibliog/bib5.pdf</p>
<p>Paraquad, Inc. 311 North Lindbergh St. Louis, MO 63111 (314) 567-1558 phone (314) 567-1552 TTY (314) 567-1559 fax www.paraquad.org</p>	<p>A nonprofit community-based Center for Independent Living. Paraquad was founded in 1970 and is a St. Louis organization where professional independent living services are provided by staff members with disabilities. Web site provides basic guidelines on disability etiquette including common courtesies, conversation, and people first language.</p>

Organization and Contact Information	Description of Resources
U.S. Department of Justice, Civil Rights Division, Disability Rights Section 950 Pennsylvania Avenue, NW Civil Rights Division Disability Rights Section - NYAV Washington, D.C. 20530 (800) 514-0301 phone (800) 514-0383 TTY	For information and technical assistance about the Americans with Disabilities Act (ADA) contact the ADA Information Line Child care centers and the Americans with Disabilities Act www.usdoj.gov/crt/ada/chcaflyr.htm Commonly asked questions about child care centers and the Americans with Disabilities Act www.usdoj.gov/crt/ada/childq%26a.htm

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Audio/Visual

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HANDOUTS FOR CHILDREN WITH DISABILITIES AND OTHER SPECIAL NEEDS MODULE

Handouts from California Childcare Health Program (CCHP), Oakland, CA

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Handouts from Other Sources

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- 61 *Map to Services for Children with Special Needs and Their Families*. California Head Start-State Collaboration Office (CHSSCO). (Summer 2005). Bridges, The Map to Services for Children with Special Needs and their Families. 10 (2) p. 12-15.
- 65 *Early Warning Signs*. California Department of Education and California Childcare Health Program. Oakland, CA.



Including Children with Special Needs: Tips for Child Care Providers

The following suggestions are intended to help include children with disabilities and other special needs in your care. It is important to remember that children are children first and each child is different, regardless of whether or not he or she has a disability. When considering adaptations and modifications, it may be helpful to take into account the severity of the disability, the child's age and the child's developmental level. Each child with special needs requires a "Special Care Plan" to identify how you will meet the child's individual needs in your program. A sample special care plan is available at the CCHP Web site at www.ucsfchildcarehealth.org, or by calling the Healthline at (800) 333-3212.

Developmental delays

- Teach in small steps.
- Give clear directions, speaking slowly, clearly and using only a few words.
- Move the child physically through the task, so she can feel what to do.
- Stand or sit close to the child so you can help as needed.
- Help the child organize his world by providing structure and consistency and by labeling things with pictures and words.
- When moving from one activity to the next, let the child know ahead of time and allow plenty of time for the transition.
- Work closely with other agencies and personnel who provide specialized services (such as early interventionists, therapists and psychologists). These specialists are a great resource for answering questions and brainstorming when problems arise.

Speech and language delays

- Be a good listener and observer.
- Engage infants and toddlers in back and forth conversations by reading their sound, gestures, facial expressions and body language.
- Give directions using as few, simple words as possible and in complete sentences.
- Talk about what you or the child is doing as you do it.
- Use everyday activities such as singing songs, read-

ing books and dramatic play to encourage language development.

- Encourage the child to talk about what she or he is doing by asking specific questions.
- Repeat what the child says and add missing words, or ask the child to repeat what you are saying.
- Expand the child's language skills—build on what the child says by adding new information.
- Praise the child's efforts at communicating even if he or she doesn't do it exactly right.

Visual disabilities

- Use lots of communication during activities such as dressing and eating to help the child orient to the activity.
- Think about the physical space of the room: be wary of sharp edges on tables, curled up edges of rugs and other potential hazards.
- Once you've found an arrangement of furniture that works for the room, try not to change it too much as the child may rely on furniture to help navigate the room.
- Give specific directions and use descriptive language.
- Call children by their names. Address them directly, not through someone else ("Juan, do you want some banana?" not "Do you think Juan wants some banana?").
- Avoid glaring lights. Increase or decrease the room lights gradually and try not to change the light suddenly.
- Display simple, clear, uncluttered pictures that are easy to see.
- Avoid standing with your back to windows: the glare may make you look like a silhouette.
- Encourage hands-on and sensory experiences such as touching, holding, exploring, tasting, smelling and manipulating.
- Ask first if the child needs assistance—try not to assume you should help.

Physical/neurological issues

- Consider the physical space: are there any obstacles that prevent the child from moving safely in the area?

Are the pathways wide enough to accommodate special equipment such as walkers or wheelchairs?

- Know the child's strengths and needs so that independence is realistically encouraged and supported.
- Assist the child with activities she or he may not be able to do alone, such as kicking a ball.
- Ask any therapists involved with the child to show you proper positioning techniques and how to use and care for any special equipment.
- If you are having difficulty with positioning, feeding, etc., consult with the child's parents or guardians for suggestions they have found helpful at home.
- Give all staff opportunities to hold and position the child to ensure everyone is comfortable.
- Help other children understand why "Lauren can't walk" and emphasize what Lauren can do.
- Try to experience the disability yourself so that you can better understand the child's perspective.
- Work closely with other agencies and personnel who provide specialized services such as early interventionists and therapists.
- Ensure that the child's positioning is similar to what other children in the class are doing whenever possible (such as floor time).
- If the child is unable to use playground equipment, schedule some other outdoor activities that the child with a disability can participate in such as blowing bubbles, flying kites, etc.

Deaf or hard of hearing children

- Find out from the parents/guardians the degree of the child's hearing loss and what that means for the child.
- Ask the child's parent or guardian how to use and care for the hearing aid or other special equipment.
- Support the child socially.
- Be sure you have the child's attention before giving instructions.
- Speak in full sentences, at normal speed, to the child's face—and smile.
- Use visual cues such as pictures or gestures as you talk.
- Encourage the child to let you know when he or she doesn't understand by using a special signal.
- If the child doesn't understand at first, rephrase your comment rather than repeating it.
- If the child uses sign language, learn some simple sign language symbols.
- Provide opportunities for the child to talk.

Social/emotional/behavioral issues

- Try not to change activities abruptly. Warn the child

of any changes in schedule ahead of time.

- Provide routine and structure for the child. Use cues such as timers, bells and lights.
- Allow the child time to practice new activities away from the group or allow withdrawn children to watch new activities first.
- Seat the child close to you. Give occasional physical and verbal reassurances and encouragement.
- Let the child bring a familiar object when entering new situations or beginning a new activity.
- Help the child make choices by limiting the number of choices available.
- Allow the child to have a safe emotional outlet for anger, fear or frustration.

Techniques for managing behavior

- Ignore negative behavior when you can.
- Notice and praise positive behavior as much as possible. Focus on what the child can do and accentuate the positive.
- Acknowledge the child's feelings.
- Children follow your example: model the kind of behavior you want to see in them.
- Prevent problems when possible by considering how the schedule, structure and physical space support your goals for children.
- Help children to talk about, act out and understand their strong feelings and behaviors.
- Follow through with realistic consequences.
- Be aware of what behaviors are your "hot buttons" and work with other staff to make sure you have the support you need. Seek additional help if the behavior persists or you feel the need for support.
- Give children reasonable choices.
- Provide developmentally appropriate activities in a safe, nurturing environment.
- Give the child enough time to comply with your request.
- Develop a plan for how you will handle difficult behavior the next time.
- Try to be consistent with the way the child's family and culture handles behavioral issues and their social and emotional goals for the child.
- Remember to have fun with the children!

Resources

National Network for Child Care at www.nncc.org.

Circle of Inclusion at www.circleofinclusion.org.

By Pamm Shaw, MS, Disabilities Specialist (rev. 04/2003)

California Childcare Health Program • 1333 Broadway, Suite 1010 • Oakland, CA 94612-1926

Telephone 510-839-1195 • Fax 510-839-0339 • Healthline 1-800-333-3212 • www.ucsfchildcarehealth.org



How to Get a Child Tested: Guidelines for Special Education Assessment

If you suspect a child may be having difficulties, the following guideline will help you understand the screening and assessment process. Only parents or guardians may initiate this process.

Children ages 0 – 3

Children birth to three who have or who are at risk of having a developmental delay may be eligible for early intervention services provided by a regional center or a local education agency (school district). School districts are primarily responsible for providing services to children who are blind, deaf, deaf-blind, or have a severe orthopedic disability (low-incidence disabilities). The parents or legal guardian should contact their local regional center for assistance or call 800-515-BABY (800-515-2229) for local California Early Start services and Family Resource Centers and Networks.

Early intervention services are provided based on the developmental needs of the child, the concerns and priorities of the family, and the resources available to them. Services are provided within the context of the child and family's daily activities and routines. Early Start services are provided at no-cost to eligible families. Early intervention services can:

- Improve both developmental and educational gains
- Reduce the future costs of special education, rehabilitation and health care needs
- Reduce feelings of isolation, stress and frustration that families may experience
- Help children with disabilities grow up to become productive, independent individuals
- Strengthen families' capacity to advocate and care for their children with special needs

Children ages 3 – 21

In order to determine whether a child 3 to 21 years old qualifies for special education services, she or he must be tested by the school district. Child care providers concerned about how a child moves, thinks, communicates,

hears or sees should talk to the parent. The parent then contacts the school district, as well as their health care provider if appropriate, since the parent or legal guardian may make the initial referral and must sign the forms.

1. To initiate the process the parent or legal guardian should contact their local school district, ideally in writing. If writing a letter, it should state specific concerns and if possible, include observations made by the child care provider. The parents should date the letter and make a copy for their records. The parent may also want to provide a copy of the letter to the child care provider.
2. The school district must contact the parent within fifteen calendar days to sign an assessment plan and any releases of information to talk to other professionals involved with the child. The parent may also want to sign a release of information between the schools and the child care program to enable open communication and input.
3. The assessment plan is the written permission to allow the child to be tested. It should indicate which areas of development will be tested and the types of tests that will be used. Once the assessment plan is signed, a legal timeline begins for the school district to test the child.
4. Testing can take several hours, and young children may need to be assessed in phases, over a period of days or weeks. Parents should encourage the school district staff to observe the child in all settings, including in the child care setting and the home. Testing should be done in the primary language of the family and at no cost to the family.
5. If the child qualifies for special education, the school district has 50 calendar days to develop an Individualized Education Plan. Generally, a pre-schooler must have a significant delay in one developmental area or a moderate delay in two areas compared to their chronological age, or have a disabling condition or established medical disability.

Assessment includes the following developmental areas and should identify strengths and abilities as well as delays:

Adaptive: how children take care of themselves, including toileting, feeding, and dressing.

Communication: how children understand, speak and use language.

Cognitive: how children think and solve problems.

Fine and gross motor: how children use their muscles, eye-hand coordination, and other large and small motor tasks, including walking, running, jumping, and writing.

Social-emotional: how children interact with adults and peers, how they feel about themselves, how they make their needs known.

The child's health history is also taken into account and vision and hearing screenings may be recommended depending on the child's needs.

6. The IEP team determines the most appropriate services to meet the child's needs. The parents can invite anyone to attend the IEP with them, including the child care provider. Participating in these meetings may help child care providers coordinate services for the child and better understand the child's strengths and needs.
7. Special education services can be provided in a variety of settings, including a child care center, family child care home or in the child's home. The IEP team determines the type and quantity of services.
8. Once the parents sign the IEP, services can begin.
9. Even if the child does not qualify for special education services, the parents can ask the school district to make recommendations as to how the parent and child care provider can help improve the child's skills—suggested programs, activities, etc. The child's health insurance or another agency may cover services that could help, such as occupational therapy or counseling.
10. Parents should always request and keep copies of all reports, test results, and any other completed forms. With permission from the parents, child care providers may also want to keep copies of these forms on record.

The assessment process itself may help answer questions about the child's development and how to work with him or her. Assessment should be an ongoing collaborative effort between professionals and parents to understand warning signs.

Resources

Handbook on Developing Individualized Family Service Plans and Individualized Education Programs in Early Childhood Special Education Programs, and Handbook on Developing and Implementing Early Childhood Special Education Programs and Services, California Department of Education, Sacramento (2001). These handbooks may be ordered at (800) 995-4099 or www.cde.ca.gov/cdepress.

Early Warning Signs, California Department of Education, in collaboration with the California Childcare Health Program. Free pamphlet describing indicators which suggest that a child may need help.

Special Education Resources on the Internet at <http://seriweb.com>. This site offers a collection of Internet accessible information for those involved in fields related to special education.

The National Dissemination Center for Children with Disabilities at www.nichcy.org. NICHCY is the national information and referral center that provides information on disabilities and disability-related issues for families, educators and other professionals.

Idea Practices at www.ideapractices.org. This Web site has technical information about the federal law that guides special education, including the process of assessment, IEPs, and services.

The Healthline at (800) 333-3212 is a toll-free number available to the child care community for consultation on a number of different health and safety issues, including children with disabilities and other special needs.

Early Start for Infants and Toddlers with Disabilities and their Families at (800) 515-BABY.

Special Education Division, California Dept of Education at (916) 445-4613.

References

Handbook on Developing Individualized Family Service Plans and Individualized Education Programs in Early Childhood Special Education, California Department of Education, Sacramento, 2001.

By Pamm Shaw, MS, Disabilities Specialist (June 15, 1999) (Revised April 2003)

01/06

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INFANT/TODDLER (BIRTH TO 36 MONTHS) DEVELOPMENT & ROUTINE

We want to provide your child with the best care possible. Please help us to get to know your child by filling out this questionnaire. Thank you!

Child's Name _____ Date of Birth _____

Facility _____ Room _____

DAILY ROUTINES

SLEEPING

Please describe your child's usual bedtime routine (including what *time* and *where* he/she usually sleeps). _____

How do you know that your child is sleepy/tired? _____

Does your child have any difficulties falling asleep? _____ If yes, what is helpful? _____

About how many hours of uninterrupted sleep does your child get each night? _____

How many times per day does your child nap? _____ How many hours on average? _____

Does your child sleep with a special blanket, toy, pacifier, song? _____

Do you have any concerns about your child's sleep habits? _____ If yes, please explain: _____

EATING

Does your child generally enjoy eating? _____ Do *you* consider your child a good eater? _____

What are some of your child's favorite foods (temperatures, textures, etc.)? _____

Is your child on any special diet? _____

If your child has any food allergies, please list here: _____

① If child has food allergies, ensure a **Feeding and Nutrition Care Plan** is established and on file.

Are there any other foods you do not want us to offer your child? _____

Are there foods from your home/culture that you would like us to offer? _____

Do you breastfeed your child? Yes No If yes, how often? _____

What does your child eat with? hands spoon fork Does your child eat independently? Yes No

What does your child use to drink? bottle (type of nipple: _____) tippy cup regular cup

Do you have any concerns or questions about your child's eating habits? _____ If yes, please explain: _____

TOILETING

Does your child wear diapers? _____ If yes, what kind? disposable cloth Pull-ups For naps? _____

If no, does your child use the toilet regularly? _____ Please explain: _____

Families use a variety of words to describe bathroom activities. Indicate the words your family uses for:

urine _____ bowel movement _____ genital area _____

Do you have any questions or concerns about your child's toileting habits? _____ If yes, please explain: _____

PLAY

Does your child have a favorite toy/object or song? _____

Does your child enjoy playing with others? _____ Does your child enjoy playing alone? _____

What activities and/or toys does your child enjoy? _____

HEALTH

Does your child have any health problems? _____ If yes, please explain: _____

Is your child taking any medication(s) regularly? _____ If yes, please list: _____

ⓘ If medications are to be given while in care, ensure a **Medication Administration Form** is utilized and on file for your child.

Does your child have a chronic health condition or specific health needs? (please be specific) _____

ⓘ If yes, ensure a **Special Health Care Plan** is established and on file for your child.

Does your child have frequent ear infections? _____ diarrhea? _____

Do you have any concerns about your child's health? _____ If yes, please explain: _____

Children in group care may become ill with colds, viruses, etc. several times per year. At times, we are required to ask parents to keep their children out of child care until treatment begins or there are no symptoms. Please see our *Exclusion* policy.

GENERAL DEVELOPMENT

Do you have any concerns about your child's:

- hearing and/or vision? _____
- speech and language development? _____
- ability to move? _____
- overall development? _____

What languages are spoken at home? _____

What is your family's cultural identification (values, traditions)? _____

SOCIAL AND EMOTIONAL DEVELOPMENT

Has your child ever been in group care? Yes No If yes, how many different settings? _____

How does your child respond in group situations? _____

What can we do to help your child adjust to child care? _____

How would you describe your child's temperament? _____

How does your child communicate his/her needs? _____

How do you comfort your child? _____

Does your child use a special comforting item (such as a blanket, stuffed animal, doll)? _____

Does your child fear certain things? _____

How is your child disciplined? _____

What works best when you discipline your child? _____

Do you have any concerns about your child's social-emotional development or behavior? _____ If yes, please explain: _____

What educational/developmental experiences would you like us to emphasize with your child (for example, language development, social relationships, kindergarten readiness skills, physical or self-help skills, etc.)? _____

Parent's Signature: _____ **Date:** _____

PRESCHOOL (3-5 YEARS OLD) DEVELOPMENT & ROUTINE

We want to provide your child with the best care possible. Please help us to get to know your child by filling out this questionnaire. Thank you!

Child's Name _____ Date of Birth _____
Facility _____ Room _____

DAILY ROUTINES

SLEEPING

Please describe your child's usual bedtime routine (including what *time* and *where* he/she usually sleeps). _____

How do you know that your child is sleepy/tired? _____

Does your child have any difficulties falling asleep? _____ If yes, what is helpful? _____

About how many hours of uninterrupted sleep does your child get each night? _____

Does your child nap? _____ How many hours on average? _____

Does your child sleep with a special blanket, toy, pacifier, song? _____

Do you have any concerns about your child's sleep habits? _____ If yes, please explain: _____

EATING

Does your child generally enjoy eating? _____ Do you consider your child a good eater? _____

What are some of your child's favorite foods (temperatures, textures, etc.)? _____

Is your child on any special diet? _____

If your child has any food allergies, please list here: _____

① If child has food allergies, ensure a **Feeding and Nutrition Care Plan** is established and on file.

Are there any other foods you do not want us to offer your child? _____

Are there foods from your home/culture that you would like us to offer? _____

What does your child eat with? hands spoon fork

What does your child use to drink? bottle tippy cup regular cup

Do you have any concerns or questions about your child's eating habits? _____ If yes, please explain: _____

TOILETING

What does your child usually wear during the day? underwear diaper Pull-ups For naps? _____

Families use a variety of words to describe bathroom activities. Indicate the words your family uses for:

urine _____ bowel movement _____ genital area _____

Do you have any questions or concerns about your child's toileting habits? _____ If yes, please explain: _____

PLAY

What is your child's favorite toy/object or song? _____

Does your child enjoy playing with others? _____ Does your child do well playing alone? _____

What activities and toys does your child enjoy? _____

HEALTH

Does your child have any health problems? _____ If yes, please explain: _____

Is your child taking any medication(s) regularly? _____ If yes, please list: _____

① If medications are to be given while in care, ensure a **Medication Administration Form** is utilized and on file for your child.

Does your child have a chronic health condition or specific health needs? (please be specific) _____

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Children in group care may become ill with colds, viruses, etc. several times per year. At times, we are required to ask parents to keep their children out of child care until treatment begins or there are no symptoms. Please see our *Exclusion* policy.

GENERAL DEVELOPMENT

Do you have any concerns about your child's:

- hearing and/or vision? _____
- speech and language development? _____
- ability to move? _____
- overall development? _____

What languages are spoken at home? _____

What is your family's cultural identification (values, traditions)? _____

SOCIAL AND EMOTIONAL DEVELOPMENT

Has your child ever been in group child care? Yes No If yes, how many different settings? _____

How does your child respond in group situations? _____

What can we do to help your child adjust to child care? _____

How would you describe your child's temperament and personality? _____

How do you comfort your child? _____

Does your child use a special comforting item (such as a blanket, stuffed animal, doll)? _____

Does your child fear certain things? _____

How is your child disciplined? _____

What works best when you discipline your child? _____

Do you have any questions or concerns about your child's social/emotional development or behavior? _____ If yes, please explain:

What educational/developmental experiences would you like us to emphasize with your child (for example, language development, social relationships, kindergarten readiness skills, physical or self-help skills, etc.)? _____

Parent's Signature: _____

Date: _____

California Childcare Health Program (CCHP) 07/03 www.ucsfchildcarehealth.org

Special Health Care Plan

The special health care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on appropriately accommodating the special health concerns and needs of this child while in child care.

Name of Child: _____ **Date:** _____

Facility Name: _____

.....
Description of condition(s): (include description of difficulties associated with each condition) _____

Team Member Names and Titles (parents of the child are to be included)

Care Coordinator (responsible for developing and administering the Special Health Care Plan): _____

❗ If training is necessary, then all team members will be trained.

Individualized Family Service Plan (IFSP) attached Individualized Education Plan (IEP) attached

Outside Professionals Involved

Telephone

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: _____

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 medications, 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: _____

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)

Additional Information (include any unusual episodes that might arise while in care and how the situation should be handled)

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: _____

Emergency contact: _____ Telephone: _____

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: _____

Information Exchange on Children with Health Concerns Form

Dear Health Care Provider:

We are sending you this Information Exchange Form along with a Consent for Release of Information Form (see back) because we have a concern about the following signs and symptoms that we and/or the parents have noted in this child, who is in our care. We appreciate any information you can share with us on this child in order to help us care for him/her more appropriately, and to assist us to work more effectively with the child and family. Thank you!

To be filled out by Child Care Provider:

Facility Name: _____ Telephone: _____

Address: _____

We would like you to evaluate and give us information on the following signs and symptoms: _____

Questions we have regarding these signs and symptoms are: _____

Date ___ / ___ / ___ Child Care Provider Signature: _____

Child Care Provider Printed Name: _____

To be filled out by Health Care Provider:

Health Care Provider's Name: _____ Telephone: _____

Address: _____

Diagnosis for this child: _____

Recommended Treatment: _____

Major side effects of any medication prescribed that we should be aware of: _____

Should the child be temporarily excluded from care, and if so, for how long? _____

What should we be aware of in caring for this child at our facility (special diet, treatment, education for parents to reinforce your instructions, signs and symptoms to watch for, etc.)?

Please attach additional pages for any other information, if necessary.

Date ___ / ___ / ___ Health Care Provider Signature: _____

Health Care Provider Printed Name: _____

Consent for Release of Information Form

I, _____, give my permission for
(parent/guardian)

_____ to exchange health information with
(sending professional/agency)

(receiving professional/agency)

This includes access to information from my child's medical record that is pertinent to my child's health and safety. This consent is voluntary and I understand that I can withdraw my consent for my child at any time.

This information will be used to plan and coordinate the care of:

Name of Child: _____

Date of Birth: _____

Parent/Guardian Name: _____
(print full name)

Parent/Guardian Signature: _____

Parents or Guardians signing this document have a legal right to receive a copy of this authorization.

Note: In accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable California laws, all personal and health information is private and must be protected.

Adapted from : Pennsylvania Chapter of the American Academy of Pediatrics (1993). Model Child Care Health Policies.
Bryn Mawr: PA: Authors.

California Childcare Health Program www.ucsfchildcarehealth.org rev. 10/03

CONSENT FOR HEALTH CONSULTATION SERVICES FOR THE CHILD

I, _____, give permission for my child, _____
full name of parent/guardian full name of child

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

full name of Child Care Health Consultant

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

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

Further, _____
full name of child care program name of Child Care Health Consultant
is authorized to share the information gained with his/her supervisor(s) and/or child care health consulting staff working directly with her/him. Consent for release of information and authorization of communication shall be for the purpose of understanding and addressing my child's needs.

This consent is voluntary and I understand that I can withdraw my consent for my child at any time. Unless I withdraw this consent, this authorization will be effective for the period my child is continuously enrolled in the _____.

name of child care program

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

Parent/Guardian Name: _____
print full name

Parent/Guardian Signature: _____ **Date:** _____

NOTE: In accordance with the Health Insurance Portability and Accountability Act (HIPPA) and applicable California laws, all personal and health information is private and must be protected.

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Hearing Evaluations in Young Children

Good hearing is necessary for a child to learn to talk. Newborn infants can hear a full range of sounds from the moment they are born (and even before)! Infants demonstrate that they hear as they quickly learn to recognize and respond to familiar voices. Hearing children turn to new sounds and their language development generally progresses along a predictable course.

What causes hearing loss?

Hearing loss is one of the most common birth defects in the United States. Permanent childhood hearing loss can also be due to exposure to loud noise, certain medications, diseases such as meningitis and rubella, head or ear injury, and other causes. Temporary hearing loss can be caused by a build-up of wax in the ear canal, severe colds, sinus infections or ear infections, which can be resolved with medical treatment.

If a permanent hearing loss is discovered, there are treatments and programs that can help a child of any age, including hearing aids (even for infants), sign language classes and support groups.

What if I think a child has a hearing loss?

An infant or child suspected of having a hearing loss should be evaluated by a trained professional. If a child does not seem to be meeting language development milestones, if there are risk factors for hearing problems, or if a child fails a hearing screening, he or she may be referred for a more complete medical and hearing evaluation.

To arrange for a hearing assessment for a child, parents or guardians should contact their health care provider. The health care provider may want to examine the child before recommending the appropriate hearing test for the developmental age of the child.

Infants or children who fail a hearing screening should be referred for a physical exam and more comprehensive testing as necessary.

What are the warning signs of hearing loss?

Some factors put a child at risk for a hearing loss. It is recommended that children with one of the following risk factors have a hearing test as early as possible:

- Family member with a permanent childhood hearing loss.
- Serious infection at birth.
- Infection or disorder affecting the brain, such as bacterial meningitis, measles or mumps.
- Mother was exposed to or had infections while pregnant such as cytomegalovirus (CMV), herpes, rubella, syphilis, and/or toxoplasmosis.
- Difficult birth which affected the baby's breathing or APGAR scores (low.)
- Baby required neonatal intensive care for more than two days after birth or required mechanical ventilation.
- Neonatal jaundice (hyperbilirubinemia) which required an exchange transfusion.
- Low birth weight.
- Treatment with drugs, such as certain antibiotics, that can cause damage to hearing.
- Syndromes associated with progressive hearing loss such as neurofibromatosis, neuro-degenerative disorders such as Hunter syndrome, or sensory motor neuropathies such as Charcot-Marie-Tooth syndrome.
- Recurrent or persistent ear infections for at least three months.
- Unusual appearance of child's head, face or ear including cleft lip and/or palate.
- Down's syndrome.
- Head trauma.

When are infants and children usually tested?

Infants

In California, a law was passed in 1998 that requires most hospitals (those approved for California Chil-

dren Services funding) to offer hearing screenings to all infants born in their facilities. If a child is diagnosed with a hearing loss, parents should receive information about community resources and appropriate follow-up services.

Young Children

Many preschools have hearing screening programs. In California, state regulations require hearing screening for each student in kindergarten or first grade, second, fifth, eighth, tenth or eleventh grades and also at first entry to public school. Children in special education services should receive hearing screening tests as part of their individualized plan.

What are the types of hearing evaluations?

With the help of modern technology hearing tests for newborn infants and children are done with great accuracy. Unlike hearing tests for older children, which require the child to respond to a sound by raising a hand, hearing tests for infants and children measure vibrations produced in the inner ear.

Otoacoustic Emissions (OAE) Testing

OAE testing is simple, painless, inexpensive and fast. In this test a small microphone resembling an earplug with an attached cord is placed in the ear canal. The infant or child hears a series of rapid clicks or tones about the loudness of a telephone dial tone. The microphone picks up vibrations and sends them to the computer for processing. Results are displayed as a computer graph. This test does not require the child's active participation.

Auditory Brainstem Response (ABR) or Brainstem Auditory Evoked Response (BAER)

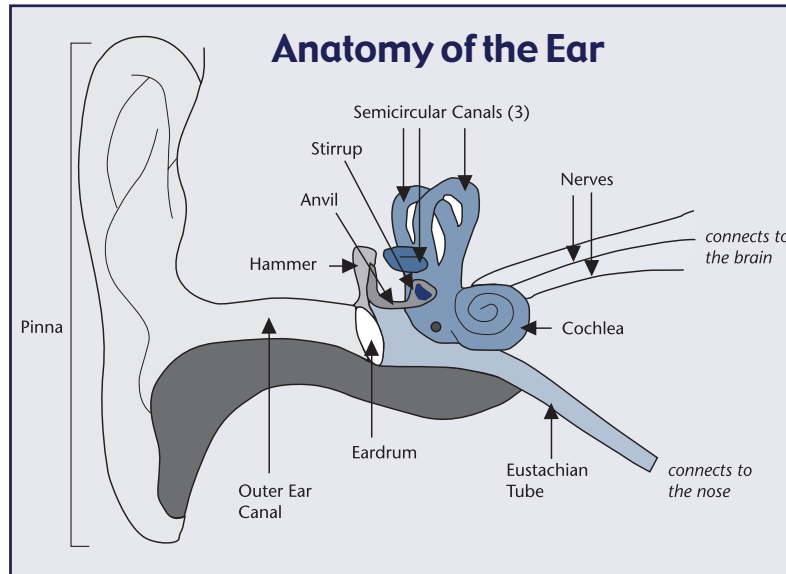
This test involves placing electrodes on the child's head while he or she is very still or sleeping. Clicking sounds are presented to the child through earphones.

A computer records the brain waves generated by the auditory nerve and auditory brain pathways in response to the clicking sounds. Children who fail the ABR or BSEER test are referred for more comprehensive testing.

Behavioral Hearing Tests

These types of hearing tests are used with children who are able to respond to sounds. These tests measure the degree of hearing loss, assist in locating the source of problem, and can indicate how the hearing loss will affect the child's ability to communicate. These tests involve observing a child's responses to sound and are useful in infants and those with limited language skills. The behavioral response might be an infant's eye movements, a head-turn by a toddler, placement of a game piece by a

preschooler, or a hand-raise by a school-age child. Very young children can respond to a number of behavioral tests.



Resources

Developed by a team of professionals at Boys Town National Research Hospital, this Web site contains information about infant hearing screening and infants with hearing loss: www.babyhearing.org.

The National Campaign for Hearing Health: www.hearinghealth.net.

American Speech and Hearing Association: (800) 638-8255, www.asha.org.

Alexander Graham Bell Association for the Deaf and Hard of Hearing: (202) 337-5220, www.agbell.org.

California Department of Health Services Children's Medical Services Branch: (916) 323-8087.

California Department of Education, Special Education Division: (916) 445-4570.

by Lisa Frost, MS, RN, PNP, PHN 05/03

California Childcare Health Program • 1333 Broadway, Suite 1010 • Oakland, CA 94612-1926
Telephone 510-839-1195 • Fax 510-839-0339 • Healthline 1-800-333-3212 • www.ucsfchildcarehealth.org



Asthma in Child Care Settings



Normal bronchial tube

Bronchial tube during
asthma episode

Asthma is the most common chronic disease among children who use child care. It occurs in 7 to 10 percent of all preschool and school-aged children. Therefore, it is highly likely that you will have at least one child with asthma in your program at some time. With appropriate care at the doctor's office, home and child care, most children with asthma do extremely well in child care settings and can participate in all activities.

Asthma is a condition in which the air passages of the lungs become temporarily narrowed and swollen and produce a thick, clear mucous, causing the child to have difficulty breathing. The symptoms can disappear temporarily with treatment and/or removal from whatever is causing the asthma. Asthma cannot be cured and it has been recently learned that repeated attacks can cause permanent damage to the lungs. Asthma *can* be controlled with appropriate care.

Signs and symptoms of asthma

Each child may have different asthma symptoms. The parents and physician should tell you what to watch for.

- Coughing (children often have cough as an early or only symptom of asthma)
- Complaint of tightness in the chest
- Wheezing
- Rapid breathing or difficulty breathing
- Decrease in peak flow meter reading
- Unusual tiredness
- Difficulty playing, eating or talking

Indications of severe asthma episode:

- Flaring nostrils or mouth open
- Bluish color to the lips or nails (late sign: call 9-1-1)
- Sucking in chest or neck muscles (retractions)

Asthma triggers

Asthma episodes are usually started by “triggers,” events that begin an asthma attack. Each child will have different triggers. Not every child has identified triggers.

- Allergies to substances such as pollen, mold, cockroaches, animal dander or dust mites
- Allergies to a particular food
- Infections such as colds or other viruses
- Irritants such as cigarette smoke, cleaning supplies, air pollutants or other airborne substances
- Cold air or sudden temperature or weather changes
- Exercise or overexertion
- Very strong emotions such as laughing, crying and stress

Responsibilities of providers

Learn the basics. Read this health note and a few simple pamphlets about asthma.

Consult with the child's parents, physician and your health consultant. Learn about the child's triggers, symptoms and treatment. Find out the following:

- How severe is the child's asthma? Has he or she ever been hospitalized or gone to the emergency room due to asthma? How many attacks this year?
- How can you judge the severity of an episode? How will you know if the child just needs to rest, if treatment is needed, whether the parents should be called, or whether to call 9-1-1?
- What are the triggers for asthma for this child and how can they be reduced?
- What medicines does the child routinely take, and which additional medications are to be given when asthma worsens?
- How do you correctly use a nebulizer, an inhaler and spacer, and a peak flow meter if the child needs them?
- What do you need to do in an emergency (for example, administer inhaler or nebulized medications, and call the child's physician or 9-1-1)?

Collect and record information as required by licensing.

- California law allows licensed child care providers to administer inhaled medication for respiratory problems such as asthma.
- Have a form completed by a physician or their representative that gives you exact dosing information, including side effects and other possible concerns for each particular child. Have the asthma management plan updated every six months.
- Develop an individualized care plan with the parent and involve the child if he or she is old enough (use Licensing Form 9166).
- Develop a program-wide asthma plan (for a sample Special Care Plan check Appendix M, *Caring for Our Children: National Health and Safety Performance Standard*, Second Edition, 2002 at <http://nrc.uchsc.edu/CFOC/index.html>).
- Enforce the non-smoking policy.
- Record medication use and your observations of the child. Share them with the parent/guardian. Call the Healthline at (800) 333-3212 for sample forms.

Provide staff training on asthma, including signs and symptoms of asthma, administration of medications, and the asthma emergency plan.

Modify the environment as needed. Reduce triggers.

Become familiar with signs and symptoms of worsening asthma.

Encourage the child to drink lots of fluids daily. This helps prevent “plugged” airways in asthma, especially when an episode occurs.

When an asthma episode occurs

- Remove the child from known triggers, if possible.
- Help the child rest in a sitting position (sitting allows the child to breathe more easily).
- Keep the child relaxed by staying calm yourself and calming other children present.
- Administer medications as directed.
- Have the child blow into the peak flow meter, if possible, to gauge improvement as recommended by the medical provider.
- Call emergency contacts if the child gets worse or does not respond to medication in 15 minutes (parents, physician and emergency response system, if necessary).
- Stay with the child; observe closely until help arrives.
- Document the episode and use of medication.

Responsibilities of the physician or other health care provider

- Health care providers should assess the patient’s child care setting and child care staff knowledge about asthma control and request that an extra set of supplies (peak flow meter, nebulizer, spacer, medications, etc.) be kept at child care.
- Health care providers should train the parent/guardian and child care provider in observation of the child for asthma, routine medication administration, what to do if asthma worsens, what to do in an emergency situation, and the use of an asthma diary (if needed).
- Health care providers should review and approve medications, update medications/care plan at least annually, and give a signed copy to the child care provider.
- Health care providers should be a resource to the child care provider and parent/guardian and answer their ongoing questions regarding asthma management.

Responsibilities of the parent/guardian and child

- Parents should understand their child’s asthma management.
- Parents should keep a record of the child’s asthma, including daily treatment and changes in response or need for medication, and share this information with the child care provider.
- Parents should ensure that their child care provider is thoroughly trained and make sure their physician knows the child is in child care and has signed a special care plan for their child.
- Parents should provide a set of equipment and medications to be kept at child care.
- Parents should regularly update their schedule, emergency contact phone numbers and special care plan.
- Parents should help their children describe their symptoms. This helps the child care provider monitor their condition and involves them in the process.

Sources

The American Lung Association, Project Exceptional, PA Chapter of the American Academy of Pediatrics, The Allergy & Asthma Network, Mothers of Asthmatics, and *Asthma Charts & Forms* by Thomas F. Plant and Carla Brennan, NEA Health Information Network, *Caring for Our Children: National Health and Safety Performance Standards*, Second Edition, 2002.

by Lyn Dailey, PHN (rev. 06/04)

California Childcare Health Program • 1333 Broadway, Suite 1010 • Oakland, CA 94612-1926

Telephone 510-839-1195 • Fax 510-839-0339 • Healthline 1-800-333-3212 • www.ucsfchildcarehealth.org



Diabetes in the Child Care Setting

What is it?

Diabetes is a serious illness in which the body is unable to properly change sugar from food into energy. A simple sugar called glucose is the main source of energy for our body. Insulin, a hormone produced by the pancreas—a large gland behind the stomach—helps the body to use the glucose for energy.

Diabetes happens when the body does not produce enough insulin (Type 1 or insulin-dependent), or use it properly (Type 2 or non-insulin-dependent). As a result glucose begins to build up in the blood, creating high sugar levels in the body.

Children with diabetes usually have Type 1 diabetes, in which the body does not make insulin. They therefore need daily injections of insulin.

Who gets it and how?

Approximately 127,000 American children, including 15,000 in California, have Type I diabetes. At some time, child care providers are likely to have a child with diabetes in their care.

Diabetes is not contagious. People cannot catch it from each other. At present, scientists do not know exactly what causes diabetes, but they believe that both genetic factors and viruses are involved. Diabetes can run in families.

What are the symptoms?

Two kinds of problems occur when the body does not make insulin:

1. ***Hyperglycemia, or high blood sugar***, occurs with both types of diabetes when the body does not have enough insulin. Symptoms include frequent urination, excessive thirst, extreme hunger, unusual weight loss, irritability and poor sleep, nausea and vomiting, and weakness and blurred vision.

2. ***Hypoglycemia, or low blood sugar***, is more common in people with Type 1 diabetes. It is also sometimes called “insulin reaction” or “insulin shock.” Symptoms may include hunger, pale skin, weakness, dizziness, headache, shakiness, changes in mood or behavior (irritability, crying, poor coordination), sweating, and rapid pulse. Treatment commonly involves quickly restoring glucose levels to normal with a sugary food or drink such as cola, orange juice, candy, or glucose tablets.

If not treated properly, it can result in loss of consciousness and life-threatening coma.

What factors affect blood glucose level?

The amount of blood sugar changes and can be affected by many factors such as diet, exercise, emotional stress, illness, and medicine.

Exercise helps to lower blood sugar. Regular exercise is important because of the need to balance the effect of exercise with food and insulin. If possible, the child should test blood glucose levels before taking part in a game or sport to determine when to eat a snack and how much food to eat.

Types, amount, and frequency of meals and snacks have different effects on blood sugar. Children with diabetes need special diets in reasonable amounts, and on regular schedules. Crackers with peanut butter or cheese, pretzels, apples, and juice make ideal snacks.

A child with diabetes may need to eat a snack before, during, or after energetic exercise.

Stress from a cold, sore throat, or other illness may increase the level of blood glucose.

The law and diabetes

The Americans with Disabilities Act, a federal law, considers diabetes a disability, forbids discrimination against the disabled, and puts legal responsibility on child care providers to care for the special needs of children with diabetes.

Effective January 1, 1998, child care providers in California are allowed to perform a blood-glucose test (using a finger-stick test) on a child in their care. However, they are not required to give an insulin injection to any child in a child care facility.

Blood glucose testing

Regular testing of blood glucose levels is a very important part of diabetes care. Testing is done by taking a drop of blood, usually from a finger, and placing it on a special test strip in a glucose meter. Glucose meters are easy to use, and most children quickly learn how to do their own blood glucose tests. A normal blood glucose level is between 70 and 120 mg/dl. Keeping blood glucose levels within this range is rarely possible in children with diabetes. A health care provider will often identify a target range for blood glucose levels – for example, 80 to 180 mg/dl.

How is it managed?

Care for diabetes is more flexible than it used to be. It requires self care or assistance with care if the child is very young. Children with diabetes can participate in all child care activities. Except for paying attention to their special care plan, you do not need to treat them differently just because they have diabetes.

The goals for treatment of diabetes in children are to:

- (a) Maintain normal growth and development
- (b) Keep blood glucose levels within a target range (not too high, not too low)
- (c) Promote healthy emotional well being.

Child care providers in coordination with parents and health care providers can prepare a special care plan to meet the special needs of children with diabetes, and help them lead healthy, active, and fulfilled lives without having to change their regular program. A written, special care plan should include:

- When to test blood glucose and take insulin
- Regular meal and snack times
- Preferred snacks and party foods
- Usual symptoms of hypoglycemia and preferred treatments
- When and how to notify the child's parents of problems
- When and how to contact the child's health care provider
- Who will give insulin injections when needed

Preschool-age children with diabetes often need frequent blood glucose tests

because they have not yet learned to recognize the symptoms of low blood sugar, can't tell what they feel, or may try to avoid or delay finger-prick and insulin injections. They may also drink and urinate a lot, so make sure they can go to the bathroom as often as they need.

Providers considering or already performing the finger-stick test must follow "universal precautions" at all times. For more information on diabetes, please call our toll-free

Healthline at 1-800-333-3212 or American Diabetes Association 1-800-DIABETES.

Summary of key points

Good diabetes care practices include:

- eating reasonably, consistently, and on schedule
- testing blood glucose levels regularly
- adjusting insulin as glucose levels and activities warrant
- exercising regularly

References

American Diabetes Association

Assembly Bill (AB) 221 Chapter 550, Statutes of 1997, Section 1596.797 of the Health and Safety Code.

By A. Rahman Zamani, MPH (2/27/98)

California Childcare Health Program • 1333 Broadway, Suite 1010 • Oakland, CA 94612-1926
Telephone 510-839-1195 • Fax 510-839-0339 • Healthline 1-800-333-3212 • www.ucsfchildcarehealth.org



Gastric Tubes in the Child Care Setting

What are gastric tubes?

Gastric tubes—also called gastrostomy tubes or G-tubes—are feeding tubes for the purpose of administering liquid nutrients, medications, or both. Unlike nasogastric tubes (plastic tubes that stretch from the nose down the back of the throat to the stomach) gastric tubes are surgically inserted directly into the stomach.

There are many types of gastric tubes. The most common, called button tubes, are level with the skin. A tube or syringe is attached to the button opening in order to deliver the formula or liquid nutrients and/or medication. Some children with gastric tubes may receive a slow, continuous infusion with the help of a small pump device.

How are gastric tubes inserted?

They are inserted into the stomach through a surgical opening in the abdomen. A gastric tube is kept in place by either sutures (stitches) or an inflated balloon, just inside of the stomach. One end of the tube is in the stomach and the other end is outside of the body. Once the incision is healed the child usually does not experience any discomfort at the tube site.

Who will need a gastric tube?

Infants or children who are not able to eat normally because of problems with their mouth, throat, stomach or intestines may require a gastric tube in order to take in enough nutrients to grow normally and stay healthy. Infants or children with sucking or swallowing difficulties could require a gastric tube as well.

Can gastric tubes come out accidentally?

Yes, they can be dislodged if pulled on and should be kept protected from hazards that could cause snag-

ging. Most gastric tubes have an anchoring device, but extreme care should always be taken to prevent trauma or accidental injury to the site. Gastric tubes should be kept away from the hands of young children and infants—including the child with the gastric tube—to avoid them accidentally pulling out the tube. It is recommended that the child wear a one-piece shirt with the gastric tube tucked inside. If the G-tube comes out accidentally, don't panic. Cover the site with a clean piece of gauze or a washcloth, and call the parent. The child care provider should not attempt to reinsert the G-tube.

Does the ADA cover gastric tubes in child care?

The Americans with Disabilities Act (ADA) gives children with special health care needs the right to participate fully in child care programs. The law mandates that child care programs make reasonable modifications in order to accommodate children with special health care needs so that they are fully included in the child care setting.

What should I do if I have a child with a gastric tube in my care?

Understand the reasoning for the gastric tube. Children that have a gastric tube usually have had some other medical problem requiring it. Respond to the whole child so that your focus is not only on this one area.

Develop a written daily plan for the special care of the child with a gastric tube. Involve the parents and all staff members who care for the child in the creation of this plan (a Special Health Care Plan form example is available on the CCHP Web site). If available, involve your Child Care Health Consultant or public health nurse for guidance, resources and continued consultation.

Daily assess the child as he or she enters into care to make sure the gastric tube is not dislodged, infected or causing local irritation of the skin.

Communicate with the child’s family about the gastric tube care on a regular basis. Your open and positive attitude will let them know that their child’s needs are being met and that their child is being cared for responsibly and lovingly. Let the family show you how to hold the child during feedings. Ask if they provide any sucking, texture or taste stimulation in the mouth during feeding that you might do as well.

Provide opportunities for the other children in care to be part of the planning for the participation of the child who uses a gastric tube. Children are naturally curious about a child who is different than themselves. Encourage them to share their anxieties and fears, explore their questions and interests, and discuss the issue with each other and in play. Answer their questions with simple and factual answers, using examples that they will understand. Share children’s books, songs and other materials that promote the acceptance of individual differences.

Does Community Care Licensing allow feeding by gastric tube in child care?

There is nothing in Community Care Licensing (CCL) in California to prohibit child care personnel from administering routine gastric tube feedings, or administering routine *liquid* medication through a gastric tube to a child in care, as it is not considered a medical procedure. However, child care personnel are prohibited from administering *crushed* medication (pills) to a child through a gastric tube.

Licensed facilities *must* notify CCL in writing of their intent and provide a plan of operation to provide gastric tube care. This must include information on how staff are to be trained in gastric tube care. The facility must obtain approval from CCL to provide gastric tube care for a child [Section 101173(c)].

Written permission from the child’s parent/guardian *must* be obtained to provide gastric tube care. It must include parental consent to be able to contact the child’s health care provider. Licensing form LIC

701B, “Gastrostomy-Tube Care Consent / Verification (Child Care Facilities)” is to be used to document this permission and must be kept on file at the facility [Section 101226(e)(3)(B)].

A qualified health care professional must properly instruct staff personnel who provide gastric tube care about the procedure for the child. This designated person may be the child’s parent/guardian if the physician approves. Licensed facilities must ensure that personnel who give gastric tube feedings are competent to do so and that there is written verification that the personnel completed the necessary training/instruction in gastric tube care. Form LIC 701A, “Gastrostomy-Tube Care: Physician’s Checklist (Child Care Facilities),” is to be used for this purpose and must be kept on file at the facility. A separate form must be used for each person who provides gastric tube care. It is important to ensure that there is trained back-up staff available to assist if necessary [Section 101216(a)].

Personnel who provide gastric tube care must follow specific written instructions from the child’s health care provider. The instructions including what to do, who to notify if complications occur, and how to receive training should be attached to the child’s LIC 701A form and kept on file at the facility. These instructions must include the exact steps needed to provide gastric tube feeding or liquid medication to the child and provide related necessary care. This includes, but may not be limited to: limitation or modifications to normal activity, frequency of feeding and amount/type of formula or liquid medication, hydration with water or other liquids, method of administering nutrients or medications, positioning of the child, potential side effects, how and when to flush the gastric tube and what to do if becomes clogged, proper sanitation/cleaning procedures, proper storage of equipment and emergency procedures and contact information. These instructions must be updated by the child’s health care provider annually, or whenever the child’s needs change, by the child’s physician or health care provider working with the physician [Section 101226(e)(3)].

Call the Healthline at (800) 333-3212 if you need additional information or materials.

California Childcare Health Program • 1333 Broadway, Suite 1010 • Oakland, CA 94612-1926
Telephone 510-839-1195 • Fax 510-839-0339 • Healthline 1-800-333-3212 • www.ucsfchildcarehealth.org



Maintaining Confidentiality in Child Care Settings

What is confidential information?

Confidential information is personal details from our lives which we may not want to share with others. It can include our address, phone number, birth date, employment history or other personal information. It may also include information about our past or present health and development. Individuals have the right to keep information of this type private.

Child care programs routinely handle confidential information about enrolled children, families and staff. When managing sensitive information, it is important for child care directors, administrators and staff to be aware of their ethical and legal responsibility to protect the privacy of individuals and families.

Legal requirements

California Community Care Licensing (CCL) Regulations for Child Care Centers require that licensed providers ensure the confidentiality of all records pertaining to enrolled children (CCL, 2002). Files containing confidential information should be accessible only to program staff who must know the information in order to care for the children. Each child's records must also be made available to that individual child's parent/guardian, CCL personnel, or police officers upon request. CCL further requires that programs must inform the parents/guardians of enrolled children that their information will be kept confidential. Programs must explain to enrolled families that their records will be shared only as described above, unless the family gives the program written consent to disclose specific information to others (CCL, 2002).

Confidential contents of records in child care settings

Programs keep individual files for each enrolled child, including but not limited to the following:

- enrollment forms
- family's health insurance information

- health screenings and records, including immunization records
- emergency contact information
- contact information for those authorized to pick up child
- emergency care consent forms
- consent forms (permission slips) for outings or special activities
- names of regular medical or dental providers who know the child
- nutritional restrictions
- progress reports
- child observation logs
- parent conference logs
- medication logs
- documentation of medical, behavioral or developmental evaluations, referrals or follow-ups, addressing issues relevant to the child's participation in the program
- documentation of any injury occurring at the program site and the steps taken to address the situation

How can child care programs ensure confidentiality?

Caring for Our Children, National Health and Safety Performance Standards (2002) recommends that programs create and abide by a written policy which describes how confidential information should be documented, stored and handled. All staff should be familiar with this policy, which should cover all of the specific types of confidential information kept at the program site. Below are some examples of how a program can protect confidential information while providing quality care.

Notification of communicable illnesses. When any child in care is diagnosed with a communicable illness or condition, such as chicken pox, impetigo, head lice and many others, programs are required to

notify the program staff and the families of any children who may have been exposed. Notified families should be instructed to monitor their own children for the development of any symptoms, and to seek medical attention if symptoms do occur. This type of notification can and should be done without mentioning the identity of the diagnosed child.

Children with special needs. Enrolled children may have special needs due to disabilities or chronic health conditions. To ensure their safety, programs often institute policies that have an effect on all of the families in the program. A common example of such a policy is one that prohibits families from bringing some types of food to the program site, to accommodate the restricted diet of another child. A program may institute a peanut-free policy, to protect a child with a life-threatening reaction to peanuts. Or, a program may create a policy prohibiting sugar-laden cakes and cookies at birthday celebrations, to accommodate a child with diabetes, for whom such foods are dangerous.

When creating such policies and notifying other families, keep the affected child's right to confidentiality in mind. Notifications of policies should explain that there is a child in the program whose serious health condition makes the policy necessary. The notification need not mention the affected child by name.

When is it appropriate to disclose personal information?

While the rights and desires of families to keep their personal details private are important, there are also some circumstances under which identifying information should be shared.

Program staff and the "need to know." To ensure the health and safety of children with special needs, teachers, caregivers, and other program staff who interact with the children should be informed of the identities of children with special health concerns on a "need to know" basis (AAP, 2002).

For example, staff who prepare and serve food should be fully aware of which children have food allergies and what each affected child is allergic to. Staff members who monitor the children in the playground should be aware if any children are allergic to bee stings, or if any children have a chronic

condition which warrants especially close monitoring during play (such as poorly controlled epilepsy, or diabetes treated by insulin injection). Primary caregivers and back-up staff need to know if any children in care have been prescribed medications, for what reasons, and what the possible side effects are, since they are likely to be administering the medications and monitoring the reaction. Program directors and teachers need to know if there are any un- or under-immunized children in care, so that appropriate measures can be taken in the event of exposure to a vaccine-preventable illness.

Outbreaks of reportable illness. Community Care Licensing Regulations provide a list of certain serious infectious diseases which are reportable in California (CCL, 2005). This means that a child care program *must* report to both the local Public Health Department and to Community Care Licensing whenever there is a known or suspected outbreak of any of these illnesses. During such reporting, identifying information about the affected child, including name, age, and how to contact the family, should be reported.

Known or suspected child abuse. Licensed child care providers are mandated reporters of child abuse. If a child in your care shows evidence of abuse or neglect, you must call Child Protective Services and report the situation. The CPS intake process requires disclosure of the child's name, address, parents or guardian's names, and possible additional details. In this situation, the child's safety and welfare come before the family's right to confidentiality.

References and resources

California Department of Social Services, Community Care Licensing (2004). *Title 22 Regulations for Child Care Centers*. Accessed May 6, 2005 at www.dss.cahwnet.gov/ord/CCRTITLE22_715.htm.

American Academy of Pediatrics (2002). *Caring for our children; Health and Safety performance standards for out-of-home child care programs*, 2nd edition.

California Childcare Health Program (2003). *Child Abuse Prevention*. Accessed May 6, 2005 at www.ucsfchildcarehealth.org/pdfs/healthandsafety/childaben081803.pdf.

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by Eileen Walsh, RN, MPH (06/05)

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Seizure Care Plan

The seizure care plan defines all members of the team, communication guidelines (how, when, and how often), and all information necessary to support a child who may experience seizures while in child care.

Name of Child: _____ Date: _____

Facility Name: _____

Description of seizure condition/disorder: _____

Describe what the child’s seizures look like: (1) what part of the body is affected? (2) How long do the seizure episodes usually last?

Describe any know “triggers” (behaviors and/or symptoms) **for seizure activity:** _____

Detail the frequency and duration of child’s typical seizure activity: _____

Has the child been treated in the emergency room due to their seizures? _____ How many times? _____

Has the child stayed overnight in the hospital due to their seizures? _____ How many times? _____

Team Member Names and Titles (parents of the child are to be included)

Care Coordinator (responsible for developing and administering the Seizure Care Plan): _____

① If training is necessary, then ALL team members will be trained.

Planned strategies to support the child’s needs and safety issues when the child has a seizure:

(e.g., diapering/toileting, outdoor play, nap/sleeping, etc) _____

- Individualized Family Service Plan (IFSP) attached. Individualized Education Plan (IEP) attached.

PROBLEM	TREATMENT	EXPECTED RESPONSE
At risk for injury due to uncontrolled seizure activity.	If a seizure occurs, staff will remove objects from the area and place a folded towel/clothing beneath the child’s head. Protective helmet is worn as prescribed.	Injuries related to seizure activity will be prevented.
At risk for aspiration of respiratory secretions or vomitus during seizure activity.	If a seizure occurs, staff will roll the child onto his/her side.	Child will not aspirate during seizure activity.
Self-esteem disturbance related to occurrence of seizure or use of protective helmet.	Provide many opportunities for success. Praise achievements and accomplishments. Provide opportunities for child to express feelings about seizures and any activity restrictions. Reassure the other children in the group that the child will be OK if a seizure occurs.	The child will successfully adapt to requirements of living with a seizure disorder. The child will demonstrate a positive attitude toward learning activities. Other children will feel safe.
Parent and child may not be aware of possible triggers.	Staff will document the occurrence of any seizure activity on attached <i>Seizure Activity Log</i> .	Parents, staff and the child will learn to identify triggers and how to avoid them.
Child may be very sleepy, but not unresponsive after a seizure occurs.	Staff will make sure that the child is responsive after a seizure, then will allow the child to sleep/rest after the seizure.	The child may safely sleep/rest, if needed, after seizure occurs.

Communication

What is the team’s communication goal and how will it be achieved (e.g., notes, communication log, phone calls, meetings, etc.): _____

How often will team communication occur: Daily Weekly Monthly Bi-monthly

Date and time specifics: _____

Other Professionals Involved

Telephone

Health Care Provider (MD, NP, etc.): _____
Occupational Therapist: _____
Physical Therapist: _____
Neurology Specialist: _____
Other: _____

Specific Medical Information

❖ Medical documentation provided & attached: Yes No

Information Exchange Form completed by Health Care Provider on-file.

Any known allergies to food and/or medications: _____

❖ Medication to be administered: Yes No

Medication Administration Form completed by Health Care Provider and parents is on file (including: type of medications, method, amount, time schedule, potential side effects, etc.)

Special Staff Training Needs

Type (be specific): _____

Training done by: _____ Date of Training: _____

Additional Information (include any unusual episodes/behavior changes that might arise while in care and how the situation should be handled)

Support Program the Child is Involved With Outside of Child Care

Name of program: _____

Address and telephone: _____

Contact person: _____

Emergency Procedures

Special emergency and/or medical procedure required. Emergency instructions: _____

❖ Call 911 if: Seizure lasts longer than ____ minutes. Child is unresponsive after seizure.
 Other: _____

Emergency contact: _____ Telephone: _____

Follow-up: Updates/Revisions

This *Seizure Care Plan* will be updated/revised whenever medications or child's health status changes, or at least every 12 months as a result of the collective input from team members.

Date for revision and team meeting: _____

SEIZURE ACTIVITY LOG

NOTE: This should be accompanied by a Seizure Care Plan established and on-file for this child.

Name of Child: _____ Room: _____

DATE	TIME	CIRCUMSTANCES PRECEEDING <small>(activity participating in)</small>	DESCRIBE SEIZURE*	LENGTH OF SEIZURE	ACTIONS TAKEN BY STAFF	CHILD'S BEHAVIOR AFTER SEIZURE	STAFF INITIALS

***What To Look For and Note Above:**
*How did the seizure start? Did the seizure start in just one part of the body and then spread, or did it involve the whole body from the beginning?
 Was there smacking or licking of the lips? Eyelid fluttering? Picking or fumbling movements of the hands?
 Was the child able to respond to any outside stimulus (for example, name called, gently shaking shoulder)? Was the response normal/confused/No response?
 Were there stiff and/or jerking movements?
 Was the jaw clenched or the tongue bitten?
 Was there any color change or breathing problem?
 How long did the actual seizure last?*

The Map to Services for Children with Special Needs and Their Families




QUESTIONS OR CONCERNS	REFERRAL	EVALUATION AND ASSESSMENT
<p>Age: Birth to Three Years</p> <p>Child appears to have difficulty relating to caregiver or does not meet typical developmental milestones or demonstrate age-appropriate behavior.</p> <p>Child care providers can:</p> <ul style="list-style-type: none"> • Observe the child and provide developmental information to the parent. • Share information regarding the child’s interests, interactions, and behaviors at home and in the child care setting. • Work closely with families to identify specific areas of concern. • Refer to a medical provider to rule out any physical causes, including vision and hearing problems. • Discuss with the family the option to refer their child to the California Early Start Program. Call the Babyline at 800-515-BABY for information and referral sources. • Call the California Child Care Healthline at 800-333-3212 for more information. 	<p>Children from birth to three years may qualify for early intervention services in the Early Start Program.</p> <p>The parents may refer their child directly to an Early Start Program or have their health care provider or other professional make the referral. Parents <i>do not</i> have to make that first call. After the referral, the parents will be contacted, informed of their rights as parents under the law, and asked whether they wish to initiate services. A service coordinator will be assigned to assist the family.</p> <p>Parents have the right to an evaluation of their child’s performance. Referrals should be made to the local regional center or school district. Call the Department of Developmental Services at 800-515-2229 to obtain the phone numbers in your area.</p>	<p>Evaluation may determine whether the child has a delay or disability; identify the child’s strengths and concerns about development; and help in planning for intervention.</p> <p>Children referred to the Early Start Program are evaluated by means that are not racially or culturally discriminatory. Evaluation is conducted in the following developmental areas: physical (includes vision, hearing, and health status), cognitive, communication, social or emotional, and adaptive skills.</p> <p>Evaluation and assessment:</p> <ul style="list-style-type: none"> • Are conducted by a multidisciplinary team of qualified personnel that consists of a nurse, a psychologist, an educator, or therapists. • Identify the infant or toddler’s unique strengths and needs. • With family consent, identify family resources, priorities, and concerns in the language of the parents’ choice. • Must be completed within 45 days of referral. • Should be ongoing as the child develops and grows.

Many families and child care providers have questions about children’s development. Although many resources are available to both families and providers, trying to navigate and understand the system for delivering services can be confusing and overwhelming. Both legal and practical information is provided to help you. This chart has been developed and reviewed by parents, providers, and professionals to help other parents understand the system for delivering services to children with special needs. Please call the California Child Care Healthline at 800-333-3212 if you have questions or comments about the information or have a concern about your child.

ELIGIBILITY	PROGRAM PLANNING	SERVICES	TRANSITION OR PERIODIC REVIEW
<p>Eligibility for services is based on the results of the evaluation and includes one or more of the following conditions:</p> <ol style="list-style-type: none"> 1. Significant delays in one or more of the following developmental areas: cognitive; physical and motor, including vision and hearing; communication; social or emotional; or adaptive (self-help) 2. “Established risk conditions,” which means having a high probability of leading to developmental delay (e.g., Down syndrome) 3. High risk of having a developmental disability due to a combination of biomedical risk factors (e.g., low birth weight, prematurity, or medical complications) <p>For children who do <i>not</i> qualify for services, a meeting is held to discuss the evaluation results. Families and providers may make specific suggestions for working with the child. The child care provider may attend the meeting if the parent so requests.</p>	<p>Individualized family service plans (IFSPs) are developed for infants and toddlers who qualify for the Early Start Program and include the following information:</p> <ul style="list-style-type: none"> • Child’s present level of development • If the family consents, the resources, priorities, and concerns of the family • Major outcomes desired for the child/family • Specific early intervention and other appropriate services necessary • Dates for initiation and duration of services • Name of the service coordinator responsible for implementation and coordination with other agencies and persons • Planning for the child’s transition at age three to a preschool program or other community services • Informed written consent of parents or guardian <p>Child care providers may attend IFSP meetings if the parent requests their presence.</p> <p>The IFSP meeting is conducted in the language of the family or through the use of interpreters.</p>	<p>A variety of services may be offered to promote the child’s development and support the family.</p> <p>Services are provided in <i>natural environments</i>, such as:</p> <ul style="list-style-type: none"> • The child’s home • The child care center and/or family child care homes • Other settings where there are typically developing children <p>A listing of services for children who are eligible can be found on page 18.</p>	<p>The IFSP must be reviewed every six months or as needed or requested.</p> <p>The Early Start Program ends when the child turns three. A transition plan to preschool is written as part of the IFSP when the child is two years, nine months (or earlier if needed) to prepare for the change in program.</p> <p>The service coordinator facilitates the transition and the exchange of information between regional centers, schools, and other agencies.</p> <p>Transition steps may include:</p> <ul style="list-style-type: none"> • Obtaining parental consent for a referral to the school district for special education services • Obtaining parental consent for referrals to other community agencies • Arranging for evaluations to determine eligibility for special education services at age three • Developing an individualized education program (IEP) to be implemented by age three <p>At the request of parents, child care providers may give recommendations for the transition process, information to preschool programs, and support to families.</p>

Map to Services (Continued)

QUESTIONS OR CONCERNS	REFERRAL	EVALUATION AND ASSESSMENT
<p>Age: Three to Five Years</p> <p>Child is having difficulty at home or in child care and is not developing as are other children of the same age.</p> <p>Child care providers can:</p> <p>Use the brochure <i>Reasons for Concern</i> as a guide. Concerns for preschool children may include the following signs. The child—</p> <ul style="list-style-type: none"> • Has limited understanding and use of language • Does not play with other children • Has a <i>very</i> short attention span • Is overly aggressive or frequently hurts self or others • Falls frequently, is clumsy, has poor motor coordination <p>Discuss parents' perception of the child's strengths and any concerns.</p> <p>Have parents observe their child in the child care program.</p> <p>Maintain open and ongoing communication with the family and school.</p>	<p>Parents should call the local school district or county office of education to make a referral. Other agencies and child care programs may contact the school, but <i>only</i> with the written consent of the family.</p> <ul style="list-style-type: none"> • The family should contact the regional center (call 800-515-BABY for the local contact) if a developmental disability is suspected. Regional centers have 15 working days to complete the intake process. • A referral to the health care provider should be made to rule out physical or health causes. 	<p>School districts evaluate children to determine whether they qualify for special education and related services. Written parental permission is required for the evaluation.</p> <p>Health care and other professionals should stay informed and involved. Information from child care staff may be included as part of the assessment.</p> <p>Assessment:</p> <ul style="list-style-type: none"> • Must be done in the primary language of the child by a team of professionals. • May be conducted in group care settings, including child care. • Should be unbiased. • Should be completed in all areas of the suspected disability. <p>Parents have the right to request an assessment of their child for eligibility with the regional center if a disability is present. There are legal timelines to the process. For information regarding all parental rights and entitled services in the regional center system, call Protection & Advocacy, Inc., at 800-776-5746.</p>
		

Map to Services (Continued)

ELIGIBILITY	PROGRAM PLANNING	SERVICES	TRANSITION OR PERIODIC REVIEW
<p>To qualify for special education services, children three to five years of age must meet one of the following criteria:</p> <ol style="list-style-type: none"> 1. The child has a <i>significant delay</i> in one of the following skill areas: gross or fine motor development, receptive or expressive language, social or emotional development, cognitive development, or visual development. 2. The child has a <i>moderate delay</i> in any <i>two</i> areas noted above. 3. The child has a disabling condition or established medical disability that can include autism, deaf-blindness, deafness, hearing impairment, mental retardation, multiple disabilities, orthopedic impairment, other health impairment, serious emotional disturbance, specific learning disability, speech or language impairment, traumatic brain injury, or visual impairment. 	<p>Individualized education programs (IEPs) are developed for children who qualify for special education and contain the following information:</p> <ul style="list-style-type: none"> • Present levels of educational performance • Measurable annual goals and short-term objectives • Services related to special education • Supplementary aids and services and program modifications or supports provided for school personnel • Explanation of why the child will <i>not</i> participate in the regular class • Individual modifications needed to participate in state and districtwide assessments • Projected dates to begin services and the frequency, location, and duration; dates of modifications • How the child’s progress is measured and how parents will be regularly informed <p>School districts develop a “504 Plan” for children with a disability who require adaptation or services but do not qualify for special education. This can be used for children with health problems (e.g., asthma, diabetes, seizures) and attention deficit disorder.</p> <p>Regional centers develop an individualized program plan (IPP) for children who qualify for their services.</p>	<p>Services are provided in the least restrictive environment, as decided by the IEP team, which may include the home, preschool, or child care setting.</p> <p>A listing of preschool special education services for children who qualify may be found on page 18.</p> <p>Regional center services are based on the child/family needs as identified on the IPP. The services are listed on page 18.</p> <p>Child care providers may invite special education and other specialist staff to observe the child in your program, show you what to do, and give you information on how to best improve the child’s skills and meet his/her needs. The specialists can also learn by seeing the child in a “typical” setting with “typical” children.</p>	<p>An appropriate reassessment should be conducted before the child enters kindergarten to determine whether she or he still needs special education and to plan for the appropriate services and supports.</p> <p>Families should visit sites and determine the best program based on the child’s strengths and family concerns.</p> <p>Child care providers help families by:</p> <ul style="list-style-type: none"> • Providing support • Preparing the child/family for change • Accompanying the parent on site visits • Talking with staff of special education and other programs regarding the child’s strengths and needs

Early Warning Signs

All children develop at different rates and in different ways. Some children are born with special needs that can affect their growth and development. Other children may not show developmental problems, delays, or differences until later in childhood. Fortunately, many of these children can get the support they need to reach their potential if parents and child care providers recognize the signs of need early and get help.

The *Early Warning Signs* described on these pages are only a few of the indicators that a child may need further observation and assessment. If, for any reason, you suspect that your child or a child in your care may have special needs, we urge you to seek help immediately. The period from birth to age three is the best time to help the child and you may prevent more serious problems from occurring later. **DON'T WAIT** until the child enters kindergarten before you ask for assistance!

If you suspect that your child or a child in your care may have special needs, call or help the child's parents call the local school district or the special education program of the county office of education. Representatives of those agencies may schedule an assessment to see if the child qualifies for services. Parents must give written permission for the child to be tested and receive special education. All services are confidential and provided at no cost to the family.

For concerns regarding children birth to age three, call the California Department of Developmental Services at 1-800-515-BABY (2229). You will be provided with information on resources in your local community or your Family Resource Center for parent-to-parent support.

Risk Factors

The following situations place children at greater risk for health and developmental difficulties:

- Prematurity and/or low birth weight
- Prenatal or other exposure to drugs, alcohol, or tobacco
- Violence in the community or home
- Poor nutrition
- Family stress (for example, poverty, poor housing, homelessness, death in the family)



General Behavior

Some behaviors may be causes for concern or just part of the child's temperament or personality. The following behaviors should be looked at in light of the whole child.

The child...

- By six months of age, avoids being held or talked to or resists being soothed and comforted.
- Does not pay attention or stay focused on an activity for as long a time as other children of the same age do.
- Avoids or rarely makes eye contact with others.
- Gets unusually frustrated when trying to do simple tasks that most children of the same age can do.
- Often acts out; appears to be very stubborn or aggressive.
- Acts extremely shy or withdrawn.
- Does not like being touched.

- Does not like having certain types of materials or clothing next to body.
- Treats other children, animals, or objects cruelly or destructively.
- Tends to break things a lot.
- Displays violent behavior (tantrums, fighting, screaming, or hitting other children) on a daily basis.
- Stares into space, rocks body, or talks to self more often than other children of the same age.
- Often bangs head against an object, floor, or wall.
- Does not recognize dangerous situations, such as walking in traffic or jumping from high places.
- Tends to be sick often; complains of headaches or stomachaches.
- Has sleeping, feeding, eating or toileting problems.
- Is overly impulsive, active, or distractible.
- Does not respond to discipline as well as children of the same age.
- Has difficulty putting thoughts, actions, and movements together.
- Does not seek approval from parent or caregiver.

Hearing

The child...

- Has frequent earaches.
- Has had many ear, nose, or throat infections or allergies.
- By four months, does not look at the source of sounds or voices or react to loud noises.
- Talks in a very loud or very soft voice.
- Seems to have difficulty responding when called from across the room, even when it is for something interesting.
- Turns body so that the same ear is always turned toward a sound.
- Breathes through mouth.
- Has difficulty understanding what is said.



That your child or a child in your care may need help

Moving

The child...

- Has stiff arms or legs.
- Has floppy or limp body posture.
- Uses one side of the body more than the other.
- Has poor coordination or moves in a disorganized, clumsy manner compared with other children of the same age.
- At three months, still has difficulty holding head up.
- By age one, has difficulty sitting without help, standing up, reaching for objects, or picking up objects with thumb and index finger.
- By age two, has difficulty walking without help, kicking a large ball, scribbling, or building a tower with two or three blocks.
- By age three, does not walk up or down stairs, run without falling frequently, or turn pages of a book.
- By age four, has difficulty with such activities as standing on one foot, jumping from a bottom step, pedaling a tricycle, catching a large bounced ball, closing a fist, or wiggling a thumb.
- By age five, has difficulty skipping using alternate feet, pumping self on a swing, or cutting with scissors.



Seeing

The child...

- Rubs eyes frequently.
- Seems to have difficulty following objects or people with eyes.
- Has reddened, watering, or crusty eyelids.
- Holds head in a strained or unusual position when trying to look at an object.
- Has difficulty focusing or making eye contact.



- Seems to have difficulty finding or picking up small objects dropped on the floor.
- Closes one eye when trying to look at distant objects.

Communicating

The child...

- By age six months, rarely makes sounds like cooing or gurgling.
- Is unusually quiet.
- Does not shake head *no*.
- By age one, does not understand first words, such as *milk*, *bottle*, or *bye-bye*.
- By age one, does not say *mama* or *dada*.
- By age two, rarely names family members and /or common objects.
- By age two, does not speak in two-word phrases.
- By age two, does not point to objects or people to express want or need.
- By age three, does not know last name, gender, or common rhymes.
- By age three, does not follow simple directions or speak in three- or four-word sentences.
- By age four, does not tell stories, either real or make-believe, or ask frequent questions.
- By age four, does not speak in four- or five-word sentences and has speech that is not understandable by adults.
- By age five, does not know age and cannot answer *who*, *what*, *where*, *when* or *why* questions or use various types of sentences.



Thinking

The child...

- By age one, has a hard time figuring out simple problems, such as finding an object after seeing it hidden.
- By age two, does not identify simple body parts by pointing, match

similar objects, or recognize self in a mirror.

- By age three, does not understand simple stories and ideas.
- By age three, does not understand simple mathematical concepts such as *one*, *more*, *less*, or count 1-2-3.
- By age four, does not give correct answers to questions, such as *What do you do when you are sleepy or hungry?*
- By age four, cannot tell the difference between different shapes or colors.
- By age five, does not understand the concepts of *today*, *tomorrow*, or *yesterday*.



Playing

The child...

- By three months, does not coo or smile.
- By age one, does not play games like *peek-a-boo* or *pat-a-cake* or wave *bye-bye*.
- By age two, does not imitate parent or caregiver doing routine tasks such as washing dishes, cooking, or going to work.
- By age three, tends to play alone more than with other children.
- By age three, does not play purposefully or initiates play through pushing and hitting.
- By age three, does not interact with adults and children outside the family.
- By age four, does not play make-believe games and group games such as hide-and-seek with other children.
- By age five, does not share and take turns.
- By age five, does not express concern or compassion, when appropriate.
- By age five, does not show off occasionally.

