

child care health connections

A HEALTH AND SAFETY NEWSLETTER FOR CALIFORNIA CHILD CARE PROFESSIONALS

Published by the California Childcare Health Program (CCHP), a program of the University of California, San Francisco School of Nursing (UCSF)



MRSA Infections in Child Care

Staphylococcus aureus (staph) are bacteria that are commonly found in the noses and on the skin of healthy people without causing infection (colonization.) Occasionally, these bacteria get through the skin barrier and cause a skin or soft tissue infection. Most infections are mild, but staph bacteria can also get into the bloodstream or lungs and cause severe illness.

What is MRSA?

Methicillin Resistant Staph Aureus (MRSA) are staph bacteria that have a resistance to common antibiotics. Infections caused by MRSA are harder to treat since there are fewer antibiotic choices. MRSA infections can be seen in hospitals and health care facilities where the wounds of patients weakened by disease or injury may be infected. MRSA can also cause infections outside of health care facilities in otherwise healthy people. This is called Community Acquired MRSA.



What do MRSA infections look like?

The skin is the most common site of staph infections. The infections may look like redness with warmth, boils, pimples, spider bites, insect bites or infected wounds. Drainage may or may not be present. Complicated MRSA infections can be infections of the lungs, bone or blood.

How is MRSA spread?

MRSA is usually spread by direct contact with the hands, skin, drainage, or secretions from a person who is infected or colonized. It may also be spread through contaminated objects or surfaces.

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California Child Care

Healthline



Call 800.333.3212

for free consultations on
health and safety in child care

health + safety tips

Assistive Technology (p. 8) improves the lives of children and their families by:

- Helping the child develop communication skills; developing social and adaptive skills; engaging in daily life skills; promoting health and safety; finding a position that makes it easy to play.
- Increasing the child's ability to participate in activities in different environments—including early childhood programs, after-school programs, recreational activities, transportation and social environments.
- Facilitating the child's participation in age-appropriate and developmentally appropriate activities.
- Assessing the child's development, understanding of concepts, and ability to participate in typical routines and activities.

Source: Highlights from DEC's (Division for Early Childhood) Recommended Practices in Early Intervention/Early Childhood Special Education.



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Health and Safety Course Regulations

Q I'm getting licensed to do family child care and need to take the 15-hour health and safety course required by regulations. How do I find these courses?

A The health and safety course has three components: pediatric CPR, pediatric first aid including asthma management, and preventive health practices which address illness and injury prevention and management in the child care setting. All family child care providers and sufficient number of teachers from child care centers must take this course to provide coverage when children are present. They must also have up-to-date first aid and CPR certificates.

Courses that qualify must either be offered at an accredited college or university; taught by an instructor who has been approved by EMSA (Emergency Medical Services Authority) in pediatric first aid, pediatric CPR and/or preventive health and safety; or, exempt.

Exempt training programs are the American Heart Association (AHA) pediatric CPR course, and American Red Cross (ARC) pediatric first aid and pediatric CPR. EMSA approved instructors must issue an EMSA sticker for the components they teach. It's very important to keep records on file that include the stickers,



the course outlines, or the ARC or AHA certificates.

You can locate approved instructors or courses in several ways. Your local Child Care Resource and Referral service (R&R) will have a listing of colleges, American Red Cross and Heart Association offices, and local EMSA approved instructors. The R&R may also sponsor approved courses or can refer you to family child care associations which may offer courses. To find your local R&R visit the R&R Network website at www.rnetwork.org. You can also visit the EMSA website www.emsa.ca.gov for a list of trainers as well as the training requirements and the asthma management curriculum you must have on file. The California Child Care Healthline (800-333-3212) can also respond to your questions related to training and other concerns related to health and safety, and can help you find a trainer in your vicinity.

by Judy Calder, RN, MS

Plan and Practice Evacuation to Minimize Risk in an Emergency

When an unexpected event puts the staff and children of a child care program at risk for injury or other harm, the setting should be evacuated and everyone moved to a safe location. Among the events that might render a setting unsafe are earthquake (if strong enough to cause building damage), fire, flood, industrial accidents with environmental contamination, or police orders given for the protection of the community.

In emergencies, young children are not able to assess risk and make sound decisions. They rely on adult caregivers to be prepared and to take whatever steps are necessary for safety. With good planning, education of staff about roles and responsibilities and routine practice drills including evacuation, programs increase the likelihood that staff and children will survive emergencies unharmed.

How can we prepare for emergencies?

Create a disaster plan. All licensed child care sites, including child care centers and family child care homes, are required by Community Care Licensing (CCL) regulations to have a disaster plan in writing. The plan should designate a leader who will direct the evacuation and should assign other important roles to key staff. The plan should include a description of the routes to be taken in an evacuation, including a diagram or sketch of the facility, and should designate a relocation point. The plan should also describe in detail how infants, toddlers, and any children with impaired mobility or other special needs will be protected and transported.

CCL publishes forms to facilitate disaster planning. These forms, called LIC 610 (for centers) and LIC 610A (for family child care homes) are available online at www.dss.cahwnet.gov/cdssweb/On-lineFor_293.htm.

CCL also publishes tools for programs who want to measure how well prepared they are and identify ways to improve. These self-assessment guides are online at http://ccl.ca.gov/Self-Asses_2031.htm.

Prepare the children. Children may not fully understand the risks in an emergency, but they can be taught simple and important safety messages. For example, during a disaster drill, teach children to duck and cover under tables or other sturdy furniture. Teach them to crawl or shimmy on the ground, in case they ever need to evacuate through smoke-filled rooms or corridors. Emergency drills should be practiced *at least every six months*, and more often if possible.

Keep supplies ready. When a program relocates, children will need food, milk, water, diapers, clean clothes and other necessities. Some programs ask parents to pack a small backpack with provisions along with a special toy, a blanket and a family picture. These backpacks are stored at the program, to be worn only during drills or during an evacuation. Alternatively, a program may keep necessities in the planned relocation site.

Tips for success

- Practice evacuations *at least every 6 months*.
- Maintain current first aid and CPR certifications.
- Check emergency supplies at least every 6 months for expiration dates on food items or outgrown clothes/diapers.
- Consider children with special needs and make arrangements for any medications or therapeutic devices to be evacuated with the child.
- Assess your program's disaster preparedness by using the tools made available by Community Care Licensing or call the Healthline at (800) 333-3212 for additional assistance.

Eileen Walsh, RN, MPH

BOX OF FUN

Music time

Incorporating music into your day is enjoyable for young children and for staff. Music improves rhythm and coordination and helps children learn new words. You can plan to have "music time" each day, but you can also add music and songs to other activities such as hand washing and clean up time. Try this musical activity:

Instrument Parade Give the children instruments such as drums, shakers, and tambourines. Sing or play a recording of a song as you lead them around the facility. Allow each child to enjoy the music in their own way and at their own time. After the parade, collect the instruments for the next time.

Adapted from *Active Learning for Twos*, 1998, by Debby Cryer, Thelma Harms, and Beth Bourland

Caring for Children with Food Allergies

A food allergy is an abnormal response to a food by the body's immune system. Allergic reactions range from mild to life threatening. Food intolerance can be confused with a food allergy. The most common food intolerance is lactose intolerance which affects digestion but does not involve the immune system.

Signs that a child may have a food allergy

An allergic reaction to food can occur within a few minutes to an hour after consuming the food. You may see:

- Skin reactions. Hives are the most common allergic reaction to food. They are red, very itchy, swollen areas of the skin that may arise suddenly and leave quickly.
- Itching and swelling of the nose, mouth and throat.
- Asthma-like symptoms such as coughing, wheezing, or difficulty breathing.
- Digestive symptoms such as vomiting, diarrhea and abdominal cramping, a red rash around the mouth, nausea, abdominal pain, swelling of the stomach and gas.

Common food allergies

The most common food allergies are to milk, eggs, peanuts, tree nuts, wheat, soy, fish and shellfish. Children will often outgrow allergies to eggs and milk but allergies to peanuts are usually life long. Tree nuts and peanuts are the most common cause of serious allergic reactions that call for emergency treatment.

How to prevent an allergic reaction?

- Avoid the food that triggers the reaction.
- Read labels for ingredients.
- Post a food allergy notice in food preparation and eating areas.
- Don't allow children to share food.
- For a child with severe allergies, consider limiting foods that can be brought in by other parents in your program.

How to reduce the risk of allergies in young children?

- Promote breastfeeding.
- Dairy should not be introduced until age one.
- Eggs should not be given to children until age two.
- Peanuts, tree nuts and fish should not be given to children until age three (AAP, 2000).

Care plans for children with allergies:

Child care settings must have a detailed care plan written specifically for each child with a food allergy. Training for all staff members must be provided. The plan must include what to do in an emergency and specific symptoms that indicate the need for intervention.

Emergency intervention:

Severe allergic reactions such as: severe vomiting, breathing difficulty, loss of consciousness, will need medical intervention.

- Administer epi-pen if prescribed, as per care plan.
- Call 9-1-1, *then* notify parent.

References and Resources

American Academy of Allergy, Asthma and Immunology, 2003, Tips to Remember: Food Allergy, at www.aaaai.org/patients/publicedmat/tips/foodallergy.stm

National Institute of Health, National Institute of Allergies and Infectious Diseases, Food Allergy, An Overview, July 2004 at www.niaid.nih.gov/publications/pdf/foodallergy.pdf

American Academy of Pediatrics (AAP), Guide to Your Child's Allergies and Asthma, 2000, Food Allergies

AAP, 2000, Hypoallergenic Infant Formulas

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

by Bobbie Rose, RN

**BOX
OF
FUN**

Bean Bag Toss

Cut three or four holes into a large box. Decorate with contact paper. Put a basket with several beanbags on the floor near the box. Have a child stand by the basket and toss each beanbag at the box. When finished,

have the child collect the beanbags in the basket for the next child to have a turn. As the children become more skilled, move the basket a step or two back. This activity will aid in eye-hand coordination, and will help children learn to follow directions and take turns.



Eating Non-Food Items— A Problem Called Pica

Pica is the act of eating non-food items. Although young children are curious about their environment and predictably put everything in their mouths, children with pica go beyond this simple exploration of their surroundings.

The eating disorder of pica is typically defined as the compulsive eating of non-food items for a period of at least one month at an age for which this behavior is developmentally inappropriate (after age 18 to 24 months). It is different from geophagy, the intentional eating of soil associated with cultural practices.

Which non-food items are consumed?

What people consider unfit for food varies by region and ethnicity. People with pica frequently crave and consume items such as clay, dirt, sand, stones, hair, feces, lead, laundry starch, vinyl gloves, plastic, pencil erasers, ice, fingernails, paper, paint chips, coal, chalk, wood, plaster, light bulbs, toothpaste, needles, string and burnt matches.

What causes pica?

Although the specific causes of pica are unknown, numerous theories have been proposed ranging from nutrition deficiency (e.g., iron, calcium or zinc deficiency) to emotional distress and developmental disorders.

How dangerous is eating dirt?

Continuous eating of non-food items can be harmful to your child's health. Depending on the nature and amount of ingested objects, it may cause the following health problems:

- *Lead poisoning.* Eating soils contaminated with lead is a recognized cause of lead poisoning.
- *Malnutrition.* Consuming non-food items leaves less opportunity to eat nutritious foods.
- *Bowel problems.* Eating objects that could get lodged in the intestines may lead to intestinal obstruction or damage.

- *Dental injury.* Consuming hard substances may harm the teeth.
- *Parasitic infections.* Eating soil has been shown to be a significant risk factor for exposure to soil-transmitted parasites and infections.

What are other ways in which children ingest considerable amounts of soil?

Contaminated food, soiled hands, and inhaled dust add soil to our diets. Observations show that normal behaviors in young children (e.g., putting objects in their mouths, playing with pets, handling food, eating after playing outdoors, sucking thumbs, biting fingernails, playing in sandboxes, and engaging in other hand-to-mouth activities) may also contribute to soil and dust exposures. However, the extent of exposure depends on factors such as where children play, what they wear, and how often they wash their hands.



When should you call your health care provider?

Professional help may be needed if:

- Your child is constantly eating non-food objects.
- You have concerns about your child's growth.
- Your child is unwell, tired and not eating.
- Mealtimes are causing lots of stress and anxiety.

If your child has consumed a harmful object, seek medical care immediately. If you think your child has ingested something poisonous, call Poison Control at (800) 222-1222.

References and Resources

Pediatrics, Apr 2004. Children's Behavior and Physiology and How It Affects Exposure to Environmental Contaminants. Online at <http://pediatrics.aappublications.org/cgi/search?qbe=pediatrics;29/6/1012&journalcode=pediatrics&minscore=5000>

by A. Rahman Zamani, MD, MPH



Infant Feeding in Child Care



Families with a new baby face important and sometimes confusing choices about feeding their infant. When an infant is enrolled in child care, the situation is even more challenging. Questions to consider include: Should the infant breastfeed exclusively? When and how often should the baby also drink from a bottle? Should the family ever give formula? Should we feed on demand or on a schedule? When is it time to wean, or to introduce cereals, fruits and other solids?

Whatever a family's choice, it is sure to impact not only the baby, but the mother, the family and the program staff too. Here's a review of infant feeding choices with a summary of the considerations for each type and best practice recommendations for infant caregivers.

Breastfeeding

Breastfeeding offers many benefits to infants and mothers. Both the American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP) recommend that all babies be exclusively breastfed for the first six months of life, with rare exceptions. After six months, breastfeeding should continue until at least age 1 year, with the gradual addition of complementary foods. Breastfeeding is still beneficial to mother and child after the first year, and should continue as long as mutually desired.

Benefits of breastfeeding. Breastfeeding is the natural way to feed a baby and offers many health advantages. The nutrients in breastmilk are easily digested and absorbed by most infants. Additionally, breastfed babies have lower rates of respiratory and intestinal infections during infancy, and also enjoy long-term positive effects such as decreased risk of diabetes, allergies and asthma later in childhood. Breastfeeding also offers health advantages to mothers. Some studies show that women who breastfeed

have lower risk for ovarian, endometrial and breast cancer compared with the general population.

Considerations when breastfeeding. According to the AAP, breastfed infants need dietary supplementation of Vitamin D, and may need supplementation of iron, both of which are present in very low amounts in breastmilk. The need for supplementation and the dosage should be determined by the infant's medical provider.

Who shouldn't breastfeed? A woman should not breastfeed her infant under the following circumstances:

- She is infected with human immunodeficiency virus;
- She is being treated with radiation or chemotherapy for cancer;
- She is an abuser of alcohol or recreational drugs, which are passed to a baby in breastmilk.

Breastfeeding and child care. An infant who attends a child care program can still enjoy the benefits of breastmilk. With careful planning and support from her employer, family and child care staff, a mother can pump and store her milk for use during child care hours. For more information, including recommendations for storing and handling breastmilk in child care, refer to the CCHP document *Health & Safety Note: Supporting Breastfeeding Families*.

Infant formula

There are many types of infant formula available. Formula made from cow's milk is the most common type. Soy formula is also popular and accounts for about 25 percent of all formula sales. In addition, formulas are available for infants with special dietary needs.

Why some families choose formula. Formulas meet the recommended nutrient intakes for infants. In

addition, formulas are fortified with iron and Vitamin D. Formula-fed infants usually don't need dietary supplementation of vitamins or minerals. Additionally, some families choose formula because they feel that bottle-feeding gives a mother more opportunities for her time, and allows other family members to share in feeding the baby. Some mothers returning to work choose formula feeding in anticipation of enrolling their infant in child care.

Considerations for formula feeding. Compared to breastmilk, formula is less easily digested. The incidence of constipation or diarrhea is greater in formula-fed infants than breastfed infants. Formula offers no protective components, such as antibodies and antibacterial properties, which help infants fight infection. Formula feeding is also more costly to families than breastfeeding. Families need to purchase the formula as well as supplies, including bottles and nipples. They also need to replace supplies which become worn or are lost.

Introducing complementary foods

When an infant is ready, soft foods other than breastmilk or formula should be added to the diet. The AAP and World Health Organization recommend that complementary foods rich in iron should be added starting at around 6 months of age.

What are the cues of readiness for complementary foods? There are many physical signs that an infant is ready. Before starting solids, infants should be able to control their head movement. They should be able to accept a small infant-sized spoon into their mouth without reflexively pushing it out with the tongue. Behavioral cues include hunger shortly after breastmilk or formula feedings, indicating that the baby needs more calories than he or she is getting from milk alone. Infants at this stage may act interested in the foods being eaten by others, reaching out for or staring at the food on parents' or siblings' plates. When these signs appear, parents should discuss introducing solids with the baby's medical provider, and if there is an agreement, it's time to start!

Practical tips for baby's first solids. Iron-fortified infant cereal made from rice or barley is the most common first solid food. Cereal provides energy, protein and, if fortified, vitamins and minerals too.

Cereal should be prepared using formula or breastmilk, according to package directions. Mix cereal to a thin consistency and use an infant-sized spoon.

A variety of cereals should be introduced gradually, one at a time. Most infants start with rice cereal, followed by oats and barley, with wheat-based cereals added last (since children may develop an allergic reaction to wheat if it is introduced too early). Each time a new food is added, parents and caregivers should wait a few days before adding another. Monitor the baby for reactions such as gas, diarrhea or diaper rash after each addition. After cereals, a baby may be given pureed vegetables and fruits, including carrots, yams, potatoes, mashed bananas and applesauce. These are also added gradually, with a few days' wait between new additions.

Solids for older infants. Once an infant begins teething, chewable finger foods can be started. A baby who is ready for these foods is able to grasp and hold small items. To prevent possible choking, parents and caregivers must carefully prepare foods and must also keep watch when the baby is eating. Among the common early finger foods for infants ages 8 to 12 months are bite-sized pieces of toast, bits of banana, pea-sized chunks of chicken or meat, and scrambled egg yolk. Never offer a baby any round, hard foods, which are choking hazards. These include: grapes, hot dogs, popcorn, chunks of peanut butter or carrots.

Infancy is a time of joy and discovery in all aspects of living, including food! Child care professionals have the opportunity to help all children establish healthy, happy food habits, with a lifetime of positive results.

References and Resources

American Academy of Pediatrics. www.aap.org.

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

California Childcare Health Program (2005). *Health & Safety Note: Supporting Breastfeeding Families*. www.ucsfchildcarehealth.org.

by Patricia Chang, CCHP Student Intern (05/05)



Use of Assistive Technology for Children with Special Needs

Over the past decades technology has changed our lives significantly, including improving the lives of individuals with disabilities. From braces to adapted vehicles, from a piece of tape to Braille typewriters and computers, assistive technology has given people the special tools to be mobile, to communicate, connect, read and write. It also has helped children and adults to see, walk, play and hear. Ultimately, assistive technology has helped them to become independent and productive members of society.

What is assistive technology?

Assistive technology is any device or equipment that compensates for skills or abilities that an individual lacks. It enables individuals with disabilities to be more independent, productive, self-confident, and better integrated into the mainstream of society. Assistive technology can be high-tech, mid-tech and low-tech—from a simple piece of Velcro or tape, to highly complicated equipment, or, anything in between.

How do children benefit from assistive technology?

Assistive technology makes it possible for children with disabilities to do more for themselves from the beginning of their lives. Many types of assistive technology are readily available and easy to obtain.

Who is eligible for assistive technology?

Any child with a disability who is enrolled in Special Education services is entitled by law to obtain the assistive technology devices that the child may need. For example, children with hearing and speech problems can communicate by using a portable electronic device that “speaks,” and children who are not able to feed themselves benefit from modified utensils to feed themselves independently.

Do children automatically receive assistive technology?

No. Assistive technology does not become part of a child’s special education plan automatically. It is often up to the child’s parents and advocates identifying and requesting this type of assistance at the initial Individual Family Services Plan (IFSP)



review or annual Individualized Educational Plan (IEP) meeting. However, in accordance with the Individuals with Disabilities Education Act (IDEA), public agencies must ensure that assistive technology devices or services are made available to children with identified disabilities. Moreover, under the Free Appropriate Public Education (FAPE), assistive technology devices or equipment are **free of charge** for children with disabilities.

For more information or if you have any questions on how to obtain assistive technology for children, please contact the toll-free Healthline at (800) 333-3212, or contact the National Information Center for Handicapped Children and Youth (NICHCY) program at (800) 695-0285.

References & Resources

Council for Exceptional Children’s at www.cec.sped.org

Child Development Council, CDC, Department of Health and Human Services: www.cdc.gov/search.do?action=search&queryText=Assistive+Technology

National Association for the Education of Young Children (NAEYC) www.naeyc.org/about/positions/PSTECH98.asp

National Organization Caring for Kids, www.nockonline.org

Tahereh Garakani MAEd

Young Children and Poison Oak

Poison oak is a plant found in parks and open spaces throughout the western United States. The leaves of the poison oak plant are coated with an oily substance (urushiol) to which many people are allergic. Because the plant grows low on the ground and thrives in California, young children who play outdoors are at risk for contact with poison oak.

Some people can touch the leaves of poison oak and experience no reaction because they are not allergic to it. But in allergic persons, contact with poison oak causes a reaction that can be very uncomfortable and even dangerous.

What is poison oak dermatitis?

Poison oak dermatitis is the rash which emerges in allergic persons after contact with the oily leaves of the poison oak plant. The rash appears as itchy, blistering hives which appear on the areas of the skin that touched the oily leaves, usually within two to three days of exposure. The hives may be a small area of red, raised

bumps, or if widespread, may run together and ooze clear fluid. Oil from the leaves can remain on clothes, and later contact between the skin and unwashed, contaminated clothes can cause additional rash.

Poison oak can also cause a severe reaction that is not confined to the skin. This extreme reaction is rare but can be life threatening. Symptoms of extreme allergic reaction include itching all over the body, swelling of the tongue or throat, and difficulty breathing. This situation is a medical emergency.

Can a child with poison oak rash attend child care?

A child with poison oak rash can attend a child care program, provided that the rash is not infected and the child feels well enough to participate in program activities. The child may benefit from soothing treatments, such as lotions, for the itching. Program staff must obtain complete documentation and instructions from parents regarding the use of any over-the-counter or prescription treatments, in accordance with Community

Care Licensing Regulations.

Contrary to myth, poison oak rash is *not* contagious. A caregiver or another child will not contract the rash if they touch the hives of an affected child. However, the rash can be contracted by touching the oily residue of the leaves, either on a plant or on the clothes of a person who has recently been in contact with the plant.

Because the rash is so intensely itchy, affected persons tend to scratch frequently, even while asleep. Constant scratching can result in skin trauma and vulnerability to skin infection. Other complications include irritability from discomfort and inability to sleep soundly, resulting in fatigue. Children with poison oak should be monitored for any of these complications. Fingernails should be trimmed to minimize trauma to the skin from scratching. It's also important to educate staff, families and children about the appearance and presence of poison oak in the community and environment, to prevent contact before it happens.

Eileen Walsh, RN, MPH

MRSA Infections, continued from page 1

Individuals who have draining infections are more infectious than those who are only colonized with MRSA.

How do you limit the spread?

- Hand washing is the most effective method of preventing the spread of staph.
- Cover infected wounds.
- Sanitize surfaces and items that may be soiled with body fluids or secretions.
- Don't share personal items such as towels and bedding.
- Follow the advice of a primary care provider about infected children and/or staff attending work or child care.

References and Resources

Colorado Department of Public Health, 2003, Recommendations for Placement of Children with Methicillin Resistant Staphylococcus aureus (MRSA) in School and Child Care Settings at www.cdph.state.co.us/dc/epidemiology/CO_MRSA_schools5_03.pdf

Centers for Disease Control, 2005, CA-MRSA Information for the Public at www.cdc.gov/ncidod/hip/Aresist/ca_mrsa_public.htm

Centers for Disease Control, 2005, CA-MRSA Information for Clinicians at www.cdc.gov/ncidod/hip/Aresist/ca_mrsa_clinician.htm

Navy Environmental Health Center, May 2005, Methicillin-Resistant Staphylococcus aureus (MRSA) Fact Sheet, at www-nehc.med.navy.mil

Bobbie Rose, RN

Prevention of Poisoning

Children under five years of age are the most likely to get poisoned. They are curious and will eat and drink almost anything—even if it does not taste good. Although most childhood poisoning occurs at home, it can also occur in the child care setting. Poisons can be found in any room of the house or center, and poisonings can happen anywhere. However, most poisonings occur in the kitchen, bathroom or bedroom, in the presence of parents or caregivers, and when products are not in their usual storage area and are within reach of young children.

Poisonings occur from many common items found in a household or in the child care environment. Items that can be poisonous to a child include medicines (both prescription and non-prescription such as aspirin, cough and cold preparations, vitamins and iron), household cleaning products (such as furniture polishes, detergents and drain cleaners), substances stored in the garage (such as car and gardening products), mushrooms, plants (such as castor beans, foxglove and oleander), cosmetics, batteries, arts and crafts materials, and lead-containing paint, dust and pottery.

Poisoning can occur by ingestion (eating or drinking), absorption (contact with skin, getting in the eyes), inhalation

(breathing the fumes), injection (puncture wounds), and animal and insect bites.

What you can do to reduce the risk?

Modification of environment. Child care providers should make a room-by-room inspection and evaluate the outdoor play area for potential poisons in the child care environment. Removing all hazards and risks for exposure to poisons provides a protected environment.

Supervision. Remember that no area is 100 percent safe. Good safety practices and supervision help prevent accidents involving poisoning. Discourage children from mouthing paintbrushes, crayons or other objects and materials.

Education. Teach children never to put anything other than clean food into their mouths.

Be prepared. Children act fast, and so do poisons. Even when people are very careful, poisoning exposures can occur. It is important to be prepared before something happens:

1. If a poisoning exposure occurs, call the emergency number (800) 222-1222; document the incident and your actions.
2. If the child is in obvious distress, call 9-1-1 for help.
3. Call the parent.

by A. Rahman Zamani, MD, MPH

publications updates

The **Asthma Information Packet** was developed to assist early care and education (ECE) providers to learn about asthma and how to better care for children with asthma. The Asthma Information Packet is comprised of three major components:

1. Information Handbook—basic information about asthma.
2. DVD containing the Asthma Care Training film for Child Care Providers (in English and Spanish), developed by the California Emergency Medical Services Authority and an electronic file of the Information Handbook so that you can print additional copies of the handbook or selected pages.
3. Posters covering emergency management of asthma in child care and how to reduce asthma triggers.

The packet can be downloaded from the California Childcare Health Program's web site at www.ucsfchildcarehealth.org.

Promoting Children's Oral Health is an oral health curriculum for workers in the field of early care and education, including

Child Care Health Consultants and Advocates, and others in training/leadership positions. This curriculum provides up-to-date information and strategies about oral health that are specific to infants and young children. It also provides practical lesson plans for child care providers and families. Available online at <http://ucsfchildcarehealth.org/html/pandr/training/currmain.htm> or from the Healthline at (800) 333-3212.

CCHP Health and Safety Checklist—Revised. The CCHP Health and Safety Checklist-Revised was developed to: 1) assess the health and safety status in early care and education (ECE) programs; 2) assess compliance with key national health and safety performance standard; and 3) assist users to develop interventions to address the health and safety needs identified on the CCHP H & S Checklist. Available online at <http://ucsfchildcarehealth.org/html/research/researchmain.htm> or from the Healthline at (800) 333-3212.



health + safety calendar

november 4–6

Zero To Three's 20th National Training Institute

Washington, DC
Zero To Three
(202) 638-1144; www.zerotothree.org

november 16–21

Birth and the 21st Century Family

San Diego
Association for Prenatal and Perinatal Psychology and Health
(707) 887-2838; www.birthpsychology.com/congress/05/index.html

november 18–19

Healthy Schools, Healthy People X

Sacramento
California Association for Health, Physical Education, Recreation, and Dance
(916) 443-0218; www.cahperd.org/index.html

december 10

California Training Institute for Early Care and Education Providers

Culver City, California
Topics to be covered:
• Role of the Child Care Health Advocate
• School Readiness and Health
• Preventive Health Care for Children in a Medical a Medical Home

december 10–14

American Public Health Association Annual Meeting & Exposition

Philadelphia
www.apha.org/meetings/index.htm

december 8–9

California Training Institute for Health Care Professionals

Downtown Los Angeles, California
Topics to be covered:
• History and Evolution of the Field of Child Care Health Consultation
• Field of Early Childhood Education
• Quality Early Care and Education
• Policy Development, Consultation Plans and Documentation
• Nutrition and Physical Activity
• Behavioral Health

november 2005 native american indian heritage month



health + safety resources

Careful, That's Hot! is a burn prevention presentation for parents, caregivers and babysitters of young children. The presentation is available in English or Spanish and is approximately 45 minutes in length. It teaches participants about burn risks in the home and how to protect young children from the trauma of a burn injury.

For a free Home Safety Program presented by a prevention educator from the Grossman Burn Center, call (818) 907-2857.

Caring Across Cultures: Achieving Cultural Competence in Health Programs at School Survey Results from the Center for Health and Health Care in Schools. Issues include language differences about behavioral and mental health issues and trust in the providers. In response, school health providers offer materials in languages other than English and interpreter services, consult with administrators and community resources, and talk with parents. Other recommendations include hiring diverse staff and outreach workers, developing a parent advisory committees, and providing staff training. Online at www.healthinschools.org/sh/cultresults.asp

The First Years Institute is a community collaborative in Memphis working to improve the health and welfare for children in Shelby County, prenatal to age 5. www.firstyearsinstitute.org

Diagnostic Classification of 0-3 Mental Health & Developmental Disorders, ZERO TO THREE addresses the need for a systematic, developmentally based approach to the classification of mental health and developmental disorders in the first four years of life. It continues the multi-axial classification system that has been useful in clinical formulation and incorporates new knowledge and clinical experiences, as well as classifications from the *American Academy of Child and Adolescent Psychiatry's Research Diagnostic Criteria—Preschool Age (RDC-PA)*. For details, please go to www.zerotothree.org/imh/

Psychosocial Implications of Disaster or Terrorism on Children: A Guide for the Pediatrician describes specific responses, discusses risk factors for adverse reactions, and gives advice for pediatricians to improve the effects of disaster on children and adolescents. Online at <http://pediatrics.aappublications.org/cgi/content/full/116/3/787>

My Pyramid for Kids is a child-friendly version of the new *MyPyramid* Food Guidance System by the U.S. Department of Agriculture, designed especially for elementary school children, along with a computer game, *MyPyramid Blast Off*. Both are available at www.mypyramid.gov



Routine Health Visits for Children from Birth to 5 Years

First 5 California's School Readiness Initiative is comprised of five elements, one of which is Health and Social Services. Ensuring that children have access to routine health visits is one way to support the overall health of young children. Even children who do not have special needs or a current health problem



should have routine visits with a health care provider. Children with special health problems or an acute health problem may need more frequent visits to a health care provider.

The American Academy of Pediatrics (AAP) recommends fourteen well-child visits in the first five years of a child's life. Each well-child visit should include a review of the child's health and developmental history, a complete physical exam, including height and weight, hearing and vision screening,

developmental and behavioral assessment, immunizations, and communication with caregivers about issues such as nutrition, injury and violence prevention. There are additional screenings and procedures recommended throughout the first five years, depending on age and risk factors.

In California, the California Department of Health Services Child Health and Disability Prevention Program (CHDP) offers health care to children from birth to 21 years old who meet certain eligibility criteria. CHDP recommends eleven well-child health visits in the first five years of life and refers to the AAP's guidelines for the visits.

A full schedule of the recommended ages and elements of each health visit can be found on-line at <http://aappolicy.aap.org/cgi/content/full/pediatrics;105/3/645>. Information for eligibility can be found at www.dhs.ca.gov/pcfh/cms/chdp.

References and Resources

American Academy of Pediatrics Committee on Practice and Ambulatory Medicine (2000). Recommendations for Preventative Pediatric Health Care.

State of California, Department of Health Services, Child Health and Disability Prevention Program. 2004.

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