Preventive Health and Safety in the Child Care Setting

A Curriculum for the Training of Child Care Providers

SIXTH EDITION

TRAINER VERSION

DEVELOPED WITH FUNDING FROM THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

UCSF California Childcare Health Program

DEVELOPED BY:

University of California, San Francisco (UCSF), School of Nursing, Department of Family Health Care Nursing

California Childcare Health Program (CCHP)

The California Childcare Health Program is a community-oriented, multidisciplinary team dedicated to enhancing the quality of child care for California's children by strengthening linkages between the health, safety and child care communities and the families they serve.

UCSF School of Nursing

CALIFORNIA CCHP CHILDCARE HEALTH PROGRAM

Background and Acknowledgements

This curriculum was first published in June 1998 and updated in 2001, 2018, 2020, 2022 and 2024. It is meant to be used by a qualified health and safety trainer to meet the preventive health and safety training requirements to become a licensed child care provider (Health and Safety Code, Section 1596.866) in California. We wish to acknowledge funding from the California Department of Social Services and the following people who contributed their time and expertise to the development of the original curriculum:

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NOTE: The content of this curriculum is for informational purposes only and does not constitute medical advice, diagnosis, or treatment. It is not intended to replace a clinical visit with a qualified healthcare provider who will complete a medical evaluation, make a diagnosis, and arrive at a treatment plan. You must seek the advice of a qualified health care provider with any questions you may have regarding your medical condition.

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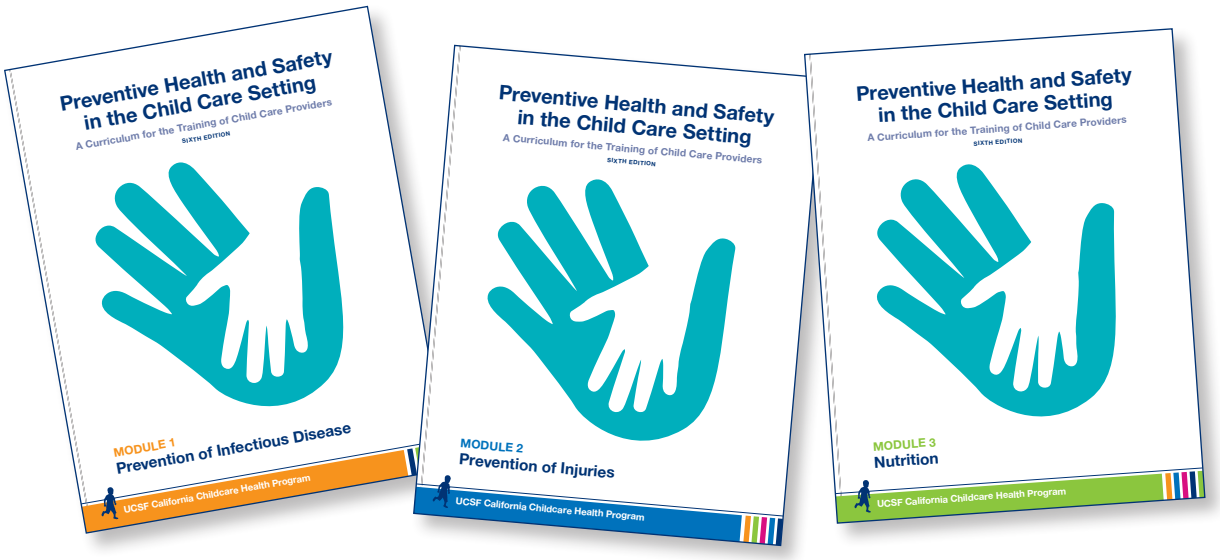
INTRODUCTION: The core content of the Preventive Health and Safety training curriculum (excluding Pediatric CPR and First Aid) is arranged into three modules:



Module 1: Prevention of Infectious Disease

Module 2: Prevention of Injuries

Module 3: Nutrition

Each module stands on its own and has its own educational objectives and handouts. The three modules cover the required content of the Emergency Medical Services Authority Child Care 7 Hours Preventive Health and Safety Training Course and 1 hour of Nutrition training (total of 8 hours) and provide information and guidance on how to control infectious disease in the child care setting, prevent injuries, and provide healthy nutrition. Contents of the curriculum and handouts are in agreement with Title 22 regulations. The course is based on best practice evidence and expert opinion from the Caring for Our Children National Health and Safety Performance Standards Guidance for Early Care and Education Online Data Base, Managing Infectious Diseases in Child Care and Schools, 6th Edition, the Centers for Disease Control and Prevention, the California Department of Public Health, the United States Department of Agriculture, and the Environmental Protection Agency as of the date of EMSA-approval.

The target audience for the training curriculum is child care providers. Trainers with questions on child health issues in these modules are encouraged to contact the California Childcare Health Program. **For technical assistance, call 415-502-2825 or visit cchp.ucsf.edu.**

Curriculum Overview

Include Families in Creating a Healthy Environment

Families are the primary teachers and role models for young children. Families will often say the most important thing they look for when seeking child care is a healthy and safe environment. With this in mind, child care providers must include families, with cultural awareness and sensitivity, in their efforts to create healthy environments and promote healthy habits.

The child care providers enrolled in the health and safety class may be new to the field or experienced providers who are taking the course to refresh their knowledge and assure they are up-to-date. Whatever their knowledge level is, encourage participants to engage families in the health and safety messages in this curriculum.

You will find a short time period at the end of each section for the instructor to ask the class how and when they would communicate the concepts learned to the families in their programs. This will not only stimulate students' understanding of the importance of communicating with families, but will also assure that they understand the concepts themselves.

Use Developmentally Appropriate Practices when Teaching Children Healthy Habits

Developmentally appropriate practices are an important part of a quality child care program. Child care providers should keep the ability of the children in their care in mind. As children develop differently, the actual age of the child is less important than the ability of the child to act and understand concepts and tasks.

Infants and toddlers whose hands must be washed after diaper-changing may need a different approach, depending on how independent they are. Some 24-month-olds may be able to step up to a sink, turn the water on, and wash their hands with minimal supervision; while others may need to be assisted at each step in the process. Both will probably want to spend a great deal of time learning from their experience with the water.

Children respond to a positive and constructive manner and learn best from consistent, clear, gentle and timely reminders that are pleasant and fun. For example, rather than irritably repeating "wash your hands," try singing a song about hand washing. Because children love to

TIPS FOR COMMUNICATING WITH FAMILIES

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

All of these steps will demonstrate to families that you are working in the best interest of their children.

sing and respond well to positive reminders, your task will be easier, and the children will feel good about washing their hands. Incorporating action songs and blending health practices into the natural flow of the daily program makes it easier on everyone. Don't forget to have fun!

Knowledge of the child care context and child care issues are woven into all content areas of the Preventive Health Training curriculum, including information on child development; up-to-date information on the required Preventive Health topics in Community Care Regulations 100000.30 b and California Health and Safety Code Section 1596.866; and information about cultural awareness and cultural sensitivity to address the rich diversity of children and families in California.

TARGET AUDIENCE: Child care providers

GROUP SIZE: 15 to 20 (ideal). No more than 30 students per instructor.

Who Can Train?

Experienced health and safety trainers, child care health consultants and other registered nurses, licensed physicians, or other health care workers with professional experience in infection control and child care knowledge may use this curriculum.

Materials and Equipment for In-Person Training:

- Presentation slides, laptop, LCD projector
- Copies of student handouts
- Flip chart/whiteboard
- Materials for demonstrations and group activities
- Internet connection if streaming video or accessing internet

Materials and Equipment for Virtual Training:

- Reliable and fast internet connection
- Computer with camera
- Computer-compatible microphone and speaker or headphones
- Virtual meeting/training software or application

Length of Training

Title 22 California child care regulations require 16 hours of health and safety training to become licensed: eight hours for CPR and First Aid (not included in this class); seven hours for prevention of infectious disease and prevention of injuries; and one hour of child care nutrition. This curriculum is designed to assist the trainer in meeting the licensing requirements, best practices, and providing sufficient information and resources for eight hours of prevention of infectious disease (four hours), prevention of injuries (three hours), and child care nutrition (one hour).

Class Completion Cards and Emergency Medical Services Authority (EMSA) Stickers

To become licensed, participants must earn a class completion card with a valid EMSA sticker attached as proof of successfully completing eight hours of Preventive Health training. For access to class completion cards and EMSA stickers, trainers are required to use an EMSA approved curriculum that covers the required topics.

Reference

Preventive Health and Safety in the Child Care Setting, A Curriculum for the Training of Child Care Providers, Sixth Edition, Developed by the UCSF California Childcare Health Program with funding from the California Department of Social Services.

CURRICULUM LEARNING OBJECTIVES

Module 1: Four-hour course content includes:

- Section 1: Understanding the Spread of Disease
- Section 2: Preventing the Spread of Infectious Disease
- Section 3: Policies to Prevent the Spread of Infectious Disease
- Section 4: Information on Specific Diseases

By the end of this module, participants will:

- Be aware of the ways illnesses spread in the child care setting.
- Understand how to reduce the spread of illness.
- Understand how to follow standard precautions and other key preventive health practices.
- Understand how to establish, communicate, and promote written policies regarding health and safety in child care programs.
- Be familiar with local health and safety resources for child care providers and families.
- Understand how to protect child care staff from exposure to infectious diseases including HIV/AIDS, CMV, and hepatitis B and C.

Module 2: Three-hour course content includes:

- Section 1: Understanding Childhood Injuries
- Section 2: Preventing Childhood Injuries
- Section 3: Safety Policies and Routines

By the end of this module, participants will:

- Understand how child development influences the risk of injury.
- Be aware of conditions in which common childhood injuries occur.
- Understand how safety practices and routines reduce the risk of children's injuries.
- Understand how to establish, communicate, and promote written policies for and safety in child care programs.
- Be familiar with tools and resources to keep child care programs safe for children.
- Understand practices to reduce the risk of injuries for child care staff.

Module 3: One-hour course content includes:

- Understanding Why Child Nutrition Is Important
- Serving Healthy Food and Drinks to Children in Child Care Programs
- Nutrition Policies and the Child and Adult Care Food Program (CACFP)

By the end of this module, participants will:

- Understand why nutrition is important for children's health.
- Understand the basics of nutrition for growing children according to current Dietary Guidelines for Americans.
- Have access to CACFP information and resources and contact information to participate in CACFP.
- Understand how to establish, communicate, and promote written policies for healthy eating and drinking in child care programs.
- Be familiar with food safety principles, choking prevention, and caring for children with special dietary needs.

Appendix: Additional Resources

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MODULE 1

Prevention of Infectious Disease

UCSF California Childcare Health Program

Prevention of Infectious Disease

MODULE CONTENTS:

ESTIMATED TRAINING TIME BY MODULE TOPIC

SECTIONS	TOPICS	TIME (Minutes)
1. Understanding the Spread of Disease	What Is a Communicable Disease?	5
	How To Prevent the Spread of Illness	15
2. Preventing the Spread of Infectious Disease	The Daily Health Check	5
	Standard Precautions	5
	Hand Washing	10
	Use of Disposable Gloves	5
	Cleaning, Sanitizing, and Disinfecting	10
	Disposal of Garbage	10
	Diapering/Toileting	10
	Food Safety	10
	Oral Health	10
	Open Space and Healthy Air	5
	Water Supply	15
	Pets/Pests/Integrated Pest Management (IPM)	10
	Sandboxes and Play Areas	5
3. Policies to Prevent the Spread of Infectious Disease	Health and Safety Policies	5
	Health History and Emergency Information Policy	5
	Immunization Requirements and Policy	15
	Keeping Health Records	5
	Excluding Children Due to Illness	10
	Staff Health Policies	5
	Communicating about Illness in Child Care	10
	Caring for Children with Mild Illness	10
	Medication Administration Policy	15
	Children with Disabilities or Special Health Needs	10
	Emergency Illness and Injury Procedures	10
	No Smoking or Use of Alcohol or Illegal drugs	10

Total Training Time Recommended for Module 1: 4 hours

Training Tip: Remember to plan for breaks to stretch, drink water, and use the restroom.

Understanding the Spread of Disease

TRAINER GUIDE

SECTION TOPICS

- What Is a Communicable Disease?
- How to Prevent the Spread of Illness

Rationale: Illnesses are common among young children, and children in the child care setting are at higher risk of getting sick. This risk can be reduced through creating a healthy environment and healthy practices and policies.

Time: 20 minutes

Learning Objectives

Participants will:

1. Understand what a communicable disease is
2. Know why children in child care settings have more infectious diseases
3. Identify four major ways infectious diseases are spread
4. Know how to reduce the spread of common childhood illnesses

Teaching Methods/Suggested Activities

- **Icebreaking:** Ask providers to introduce themselves and say what diseases they expect to see in the child care setting.
- **Lecture:** Review the ways that diseases are spread in the child care setting. Review the practices and procedures that help to reduce the spread of common illnesses.
- **Questions/Answers:** Respond to any questions that the group may have, and ask questions and emphasize important points that highlight the key concepts.

Materials and Equipment Required

- Student Handouts
- Flip Chart/Chalkboard/Whiteboard
- Presentation Slides (if using a computer and LCD projector)
- Supplies and equipment for hands-on and group activities

Questions/Comments

- Ask participants to identify factors (places, people, and conditions) in their child care setting that increase the risk of disease.
- Ask participants to describe practices and procedures that reduce the spread of illnesses in the child care setting.
- Ask the class how they would communicate the concepts learned to the families.

What Is a Communicable Disease?

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

Illnesses caused by infection with specific germs such as viruses, bacteria, funguses, and parasites are called infectious diseases. Communicable diseases are those illnesses that can be spread from one person to another either directly or indirectly. Infectious diseases that commonly occur among children are often communicable and may spread very easily from person to person. The word "contagious" is also used to describe communicable disease.

Most illnesses are contagious before their signs and symptoms appear. Some people may pass the germs without having the symptoms or continue passing them even after the symptoms of illness are gone.

Why Do Children in Child Care Settings Have More Illnesses?

Anyone at any age can be infected with communicable illnesses, but young children are at greater risk because:

- They have not yet been exposed to many of the most common germs. Therefore, they have not yet built up resistance or immunity to them.
- They also have many habits that promote the spread of germs. For example, they play on the floor and often put their fingers, toys, and other objects in their mouths. In this way, germs enter and leave the body can be passed on to others.
- They have close contact with other children and adults.

How to Prevent the Spread of Illness

How Are Illnesses Spread?

Communicable diseases are spread from the source of infection to the exposed, vulnerable person (host). For this transmission to happen, three things are necessary.

1. Source of germs must be present.
2. Route or (ways) of transmission along which germs can be carried must be present.
3. A host or vulnerable person who is not immune to the germ must be present and come in contact with the germs.

What Can You Do to Keep the Children and Adults in Your Program Healthy?

Break the chain of transmission by breaking at least one of the three links. For best results, use more than one method of control in order to reduce the transmission of infectious disease.

You can control the spread of communicable disease in three ways:

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

At the route of transmission or the "second link" through personal hygiene practices; proper cleaning, sanitizing, and disinfecting of objects and surfaces; using proper diapering techniques; washing hands properly and at the right times; and by providing adequate ventilation.

By protecting the vulnerable person or the "third link" through immunization and healthy habits, for example: hand washing, good nutrition, exercise, and getting enough sleep.

Four Major Ways for the Spread of Illnesses or "Routes of Transmission"

1. Through direct contact with people or objects:

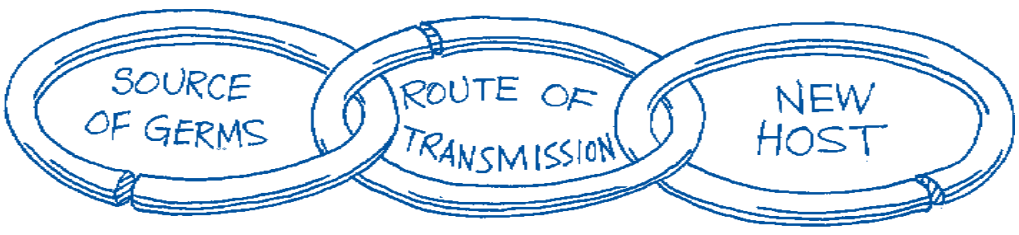
Infections can spread by direct contact with an infected area of someone's body (for example, an open sore) or by contact with a surface that has infectious material on it. Bacteria, viruses, fungi, or parasites cause illnesses. Because young children are constantly touching their surroundings and the people around them, infections can spread easily among children and their caregivers in the child care setting.

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

Respiratory illnesses are spread through microscopic, contagious droplets of fluids from the nose, eyes, or throat. When an infected person talks, sings, coughs, sneezes, or blows their nose, infectious droplets get into the air where they can be breathed in by another person. Droplets can also land on hands or objects such as toys or food, and can be touched, mouthed, or eaten by other persons. When the germs in these infected droplets come in contact with the nose, eyes, or mouth of an uninfected person, they can multiply and cause illness. COVID-19 is an example of an illness that spreads mainly by respiratory transmission.

3. Through stool or "fecal-oral" transmission (transfer of a germ from an infected person's stool into another person's mouth):

Some diseases are spread through exposure to germs in the stool (feces, bowel movement) or by what is known as the fecal-oral route. This means that germs leave the body of the infected person in their stool and enter the body of another person through their mouth.



In most situations this happens when hands or objects that have become contaminated with a very small amount of stool (usually too small to be seen) are placed in the mouth. Or when food or water is contaminated with a very small amount of human or animal stool and then is eaten or drunk. Improperly prepared foods made from animals (for example, meat, milk, and eggs) can be the source of infection. Some infections, such as salmonella, may be spread through direct exposure to infected animals.

4. Through contact with blood and body fluids:

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

How to Reduce the Risk of Spreading Illnesses through Direct Contact

- Make sure staff and children wash their hands after contact with any body fluids.
- Wear disposable gloves when touching body fluids (including feces) or objects and surfaces contaminated with body fluids.
- Use running water for hand washing. Do not use basins or stoppered sinks, which can become contaminated with the germs.
- Use plain liquid soap and single-use disposable paper towels or single-use cloth towels.
- Wipe runny noses and eyes promptly, and wash hands afterwards.
- Always use single-use disposable tissues for wiping noses. Never use the same tissue for more than one child.
- Dispose of used tissues, wipes, and paper towels in a lined, covered, trash container with a foot pedal kept away from food and supplies.
- Follow recommended procedures for cleaning, sanitizing, and disinfecting toys and surfaces.
- Follow recommended procedures for diapering.
- Make sure that each child has their own crib or nap mat, sheets, pillow cases, and blankets.
- Do not allow children to share personal items such as combs, brushes, blankets, pillows, hats, or clothing.
- Store each child's dirty clothing separately in plastic bags and send it home for laundering.
- Wash and cover sores, boils, blisters, cuts, or scrapes promptly and wipe away eye discharge.
- Report rashes, sores, eye discharge, and severe itching to the family so they can contact their health care provider(s).
- Don't allow pacifiers, food, or eating utensils to be shared.
- Clean and sanitize mouthed toys.
- Clean eating utensils carefully in soapy water; then rinse, sanitize, and air dry (known as the three sink method) or use a dishwasher to sanitize dishes and utensils.
- Use single-use disposable cups, or reusable cups that are cleaned and sanitized after each use.

How to Reduce the Risk of Spreading Respiratory Illnesses

- Provide ventilation by safely opening windows.
- Spend more time outdoors.
- Maintain your heating, ventilation, and air conditioning (HVAC) system. Change filters according to manufacturer's directions.
- Filter your indoor air using a portable filtration device.
- Teach children and staff to cough or sneeze into their elbow or sleeve. Or sneeze or cough into a tissue, and wash hands after throwing away the tissue.
- Ensure that staff and children wash their hands after wiping or blowing noses; after contact with any fluids from nose, throat, or eye; and before preparing or eating food.
- Don't kiss children on the lips; instead give children hugs.
- Wear a properly fitted face mask if recommended by local health authorities.

How to Reduce the Risk of Spreading Infections through the Fecal-Oral Route

Since children and staff who have digestive illnesses don't always feel sick or have diarrhea, the best method for preventing the spread of these diseases is to have standard precautions in place at your program. Many germs can survive on surfaces for periods ranging from hours to weeks.

PRACTICE THE FOLLOWING:

- Proper hand washing for adults and children.
- Environmental cleaning, sanitizing, and disinfecting with focus on diapering, toileting, food service and preparation areas, and mouthed toys.
- **Exclusion for diarrhea:** Excluded children and staff may come back after treatment and when the diarrhea improves such that stool doesn't leak from the diaper and/or there are no toileting accidents. With some diarrheal illnesses, approval of the child's health provider may be needed.

How to Reduce the Risk of Spreading Diseases through Contact with Blood and Body Fluids

Treat blood and other body fluids as if they were contagious. Wear protective gloves when handling blood, urine, and saliva.

Transmission of illnesses spread through blood is very rare in the child care setting, and illnesses such as HIV/AIDS are not spread by casual, daily contact with infected persons. However, HIV can be transmitted where there is blood contact. For example:

- Touching blood while giving first aid with hands or body surfaces that have cuts or open sores
- Collision accidents where the skin of both people is broken and blood is exchanged
- Cleaning up blood after an accident with hands that have cuts or open sores
- Biting. The only way blood-to-blood exchange can happen through biting is for the following events to occur:
  - There is an injury to the mouth of the biter.
  - The bite creates a wound so serious that the skin is broken and blood flows.
  - Blood is exchanged.
  - One of the children involved is infected with HIV.

STANDARD PRECAUTIONS:

The infection control practices listed below should be followed for all children, whether or not they are infected with blood borne illnesses.

- Proper hand washing
- Proper use of gloves
- Proper disposal of waste and contaminated materials such as gloves, paper towels, and bandages
- Proper cleaning, sanitizing, and disinfection.
- Proper care of soiled clothing
- Immunization for all children and staff against Hepatitis B
- Teaching all children not to touch any blood except their own

EXAMPLES: How Some Childhood Infectious Diseases Are Spread

Transmission	How the disease is spread	Behaviors that spread	Examples of diseases	Possible symptoms
Air or Respiratory	• Breathing germs in the air • Contact with infected saliva and mucus	• Coughing or sneezing into the air • Kissing on the mouth • Sharing mouthed toys • Wiping noses without thorough hand washing • Poor ventilation	• Cold • COVID-19 • Flu • RSV • Measles • Tuberculosis (TB) • Chickenpox	• Coughing • Fever • Rash • Runny nose • Sore throat
Stool or Fecal-Oral	• Mouth contact with items and hands contaminated by infected stool	• Diapering and toileting or food preparation without thorough hand washing • Sharing mouthed toys • Unsafe food preparation • Unsafe diapering procedures	• Salmonella • Shigella • Giardia • Pinworms • Hand, foot and mouth disease • Hepatitis A • Polio • *E. coli* • *Noro virus*	• Stomach ache • Nausea • Vomiting • Diarrhea
Direct Contact	• Contact with infected hair, skin and objects	• Touching skin or hair which is infected • Sharing clothing, hats and brushes which are infected	• Herpes • Ringworm • Scabies • Head lice • Impetigo • Chickenpox	• Rash • Oozing sores • Itching • Visible nits or eggs
Contact with Blood and Bodily Fluids	• Contact with infected blood and sometimes other body fluids	• Sexual contact • Changing bloody diapers without gloves • Providing first aid without gloves • Getting infected blood or body fluids into broken skin, eyes or mouth	• HIV/AIDS • Hepatitis B & C • Cytomegalovirus (CMV) • Herpes	• Fatigue • Weight loss • Yellow skin • Weakened immune system • Sores • Fever • Swollen lymph nodes

Preventing the Spread of Infectious Disease

TRAINER GUIDE

SECTION TOPICS

- The Daily Health Check
- Standard Precautions
- Hand Washing
- When to Wash Hands
- Use of Disposable Gloves
- Cleaning, Sanitizing, and Disinfecting
- Disposal of Garbage
- Diapering/Toileting
- Food Safety
- Oral Health
- Open Space and Healthy Air
- Water Supply
- Pets, Pests, Pesticides, and Integrated Pest Management (IPM)
- Sandboxes and Sand Play Areas

Rationale: Intentional practices can prevent the spread of diseases and reduce the risk of illness among children and adults in child care settings.

Time: 1 hour, 50 minutes

Learning Objectives

Participants will:

1. Describe at least six practices that prevent the spread of disease.
2. Describe what is meant by "standard precautions."
3. Understand how to prevent the spread of infectious disease through environmental cleaning, sanitizing, and disinfecting.
4. Describe best practices for hand washing.
5. List times to wash hands.

Teaching Methods/Suggested Activities

See Resources for a list of hands-on and group activities:

- **Brainstorming:** Ask providers to list the signs to be observed when conducting a morning health check. Review the symptoms that require exclusion from child care.
- **Role-play:** Have participants role-play a morning health check and practice making a decision on whether to include or exclude a child from care that day. Have one participant role-play a parent who is eager to leave his or her child and get to work. The other participant should role-play the child care provider.
- **Lecture:** Review the steps that can be taken to avoid the spread of infections in the child care setting. Refer to Student Handouts.
- **Questions/Answers:** Respond to any questions. Ask clarifying questions, and emphasize points that highlight important concepts.

Materials and Equipment Required

STUDENT HANDOUTS:

Student handouts can be found on the CCHP website: http://cchp.ucsf.edu/content/topics/preventive-health-training

- Morning Health Check Poster
- Standard Precautions Health and Safety Note
- Wash Your Hands Properly Poster
- When to Wash Your Hands Poster
- Gloving Poster
- Safe and Effective Cleaning, Sanitizing, Disinfecting Health and Safety Note
- Safer Cleaning, Sanitizing, and Disinfecting Posters
- Green Cleaning
- Diapering Procedures Poster
- USDA Clean, Separate, Cook, Chill
- No Water Toothbrushing Poster
- Healthy Air in Your Child Care Facility Health and Safety Note
- How to Find Out if Your Drinking Water is Safe
- Pets in the Child Care Setting Health and Safety Note
- Keeping Children Safe from Pests and Pesticides
- Healthy Schools Act Requirements for K-12 Schools and Child Care Centers
- IPM Caring for Your Outdoor Environment

OTHER MATERIALS:

- Flip Chart/Chalkboard/Whiteboard
- Presentation Slides (if using a computer and LCD projector)
- Demonstration supplies

Questions/Comments

Ask the class how they would communicate the concepts that they have learned about preventing the spread of illness in child care to families.

The Daily Health Check

California child care licensing regulations require daily health checks. Children with obvious symptoms of illness (including, but not limited to, fever or vomiting) are not to be accepted into care. Pay special attention to children who have been absent due to illness or have been recently exposed to a contagious disease.

Perform a health check for each child every day upon arrival and before the family leaves. The daily health check is not a formal medical exam. The routine is a more casual observation of the child as you welcome them to your program each day. You are checking for simple signs of illness that are easy to observe and report. The daily health check helps you understand what is normal for each child rather than diagnose an illness. While you may send a child home because of an illness observed during the daily health check, the overall goal is to know your children better and ensure they are feeling well enough to participate in your program.

In a child care setting where children may be arriving at the same time, it's challenging to take a moment with each child. However, this personal contact allows you to better understand each child, helps children feel comfortable, eases the transition to your program, reduces the spread of illness by excluding children with obvious signs of illness, and fosters better communication with families. It also helps to identify any health or developmental problems early.

Signs to Observe

When conducting a daily health check, you should

watch for the following:

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

Use All Your Senses to Check for Signs of Illness

Listen to what the child and parents tell you about how the child is feeling. Is the child's voice hoarse, are they having trouble breathing, or are they coughing?

Look at the child from their level. Observe for signs of crankiness, pain, discomfort or being tired. Does the child look pale, have a rash or sores, a runny nose or eyes?

Feel the child for warmth or clamminess as a casual way of greeting. Is the child sweaty, do they have chills?

Smell the child for unusual odors. Is the child's breath fruity or does it smell bad? Do you notice any other foul smells?

Using Findings to Make Decisions

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

Contrary to popular belief and practice, only a few illnesses require exclusion of sick children to ensure protection of other children and staff (see Exclusion for Illness Policy, page 1.83).

When your child care setting agrees to allow mildly ill children to attend, take these steps to better meet their needs, and be sure to follow California regulations:

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

POSTER

STOP DISEASE

DAILY HEALTH CHECK

Signs to Observe:

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

Use all of your senses . . .

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

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Standard Precautions

Faced with concerns about the spread of serious infections, hospitals and health centers use a successful technique that is also appropriate for child care settings. Rather than waiting to find out who is contagious, they treat everyone as a potentially infected person. The name of this infection control method is "standard precautions," and it gives a set of guidelines to follow when you come into contact with blood and body fluids and waste that carry germs. It is not a lot of extra work, and it really pays off.

Many of us in the child care field are used to reacting to infections only when we notice the signs or symptoms of illness. We then rely on exclusion policies to control disease. But the germs causing disease have been spreading for days before children appear ill. Illnesses like colds, diarrhea, and skin and eye infections are often contagious 3-10 days before you might notice symptoms. Hepatitis and HIV/AIDS take an even longer period to develop symptoms.

To effectively prevent the spread of communicable disease, the Occupational Safety and Health Administration (OSHA) requires workers who might come into contact with blood and other body fluids to practice the following infection control practices at all times with everyone:

- Hand washing
- Use of non-permeable gloves
- Environmental disinfection
- Proper disposal of waste materials

OSHA requires a facility plan and annual training of staff members who may be exposed to blood as a condition of their employment. These rules apply only to child care workers who are employees.

STANDARD AND UNIVERSAL PRECAUTIONS IN THE CHILD CARE SETTING

What Are Standard and Universal Precautions?

UNIVERSAL PRECAUTIONS is the term used for the guidelines that were developed by the Centers for Disease Control and Prevention in the 1980s to reduce the spread of infection to health care providers and patients in health care settings.

STANDARD PRECAUTIONS is the new term used for an expansion of universal precautions, recognizing that blood and body fluids may hold contagious germs. They are still primarily designed to prevent the spread of bloodborne disease (disease carried by blood or other body fluids), but are also excellent measures to prevent the spread of infectious disease in group care settings such as child care facilities.

Why Are Standard Precautions Needed?

Standard precautions are designed to reduce the risk of spreading infectious disease from both known and unknown sources of infections. Germs that are spread through blood and body fluids can come at any time from any person. You may not know if someone is infected with a virus such as hepatitis B or HIV, and the infected person may not even know. This is why you must behave as if every individual might be infected with any germ in all situations that place you in contact with blood or body fluids.

What Do Standard Precautions Consist of?

Standard precautions include the following:

HAND WASHING:

- after diapering or toileting children
- after handling body fluids of any kind
- before and after giving first aid (such as cleaning cuts and scratches or bloody noses)
- after cleaning up spills or objects contaminated with body fluids
- after taking off your disposable gloves
- remember that wearing gloves does not mean that you don't have to wash your hands!

WEAR NON-PERMEABLE, DISPOSABLE GLOVES:

- during contact with blood or body fluids which contain blood (such as vomit or feces which contain blood you can see)
- when individuals have cuts, scratches or rashes which cause breaks in the skin of their hands

ENVIRONMENTAL DISINFECTING should be done regularly and as needed. In the child care setting this means cleaning surfaces and objects that are soiled with blood or body fluids with soap and water, and then applying an EPA registered disinfectant according to label instructions. Wear gloves whenever handling blood.

PROPER DISPOSAL OF MATERIALS that are soaked in or caked with blood requires double bagging in plastic bags that are securely tied. Send these items home with the child, or if you wash them, wash them separately from other items. Items used for procedures on children with special needs (such as lancets for finger sticks, or syringes for injections given by parents) require a special container for safe disposal. Parents can provide what is called a "sharps container" which safely stores the lancets or needles until the parent can take them home for disposal.

Standard Precautions in Child Care Settings vs. Hospitals and Clinics

Child care facilities follow the standard precautions in clinic and hospital settings with the following exceptions:

- Use of nonporous gloves is optional except when blood or blood-containing body fluids may be involved.
- Gowns and masks are not required.
- Appropriate barriers include materials such as disposable diaper table paper, disposable towels, and surfaces that can be sanitized in group care settings.

What Else Am I Required To Do?

The Occupational Safety and Health Administration (OSHA) also requires that all child care programs with staff (even family child care homes with assistants or volunteers) have an *Exposure Control Plan for Bloodborne Pathogens.* This plan must be in writing and include:

EXPOSURE DETERMINATION. This is a list of the job titles or duties which might put an individual in contact with blood or blood-containing fluids (such as first aid, nose blowing, or diapering).

METHODS OF COMPLIANCE. These are the ways you will assure your plan will work and which include written standard precautions and cleaning plans, training of staff in their use, and the availability of gloves.

HEPATITIS B VACCINATION. This must be offered by the employer at no cost to staff. The vaccine series can begin either:

- Within 10 days of employment
- Within 24 hours after a potential blood exposure (for example, accidental contact with blood while administering first aid or diapering an infant with a bloody stool).

Note: Hepatitis B is a series of three shots which must be given on a specific schedule. Now that all children are required to have the series before entering care, child care providers should be at a reduced risk of getting hepatitis B in a child care setting.

EXPOSURE REPORTING PROCEDURES. These are required and will tell staff what to do if something happens which puts an employee in contact with blood on their broken skin (cuts, scratches, open rashes, or chapped skin) or on their mucous membranes (in the eye, mouth, or nose). There are also record-keeping requirements to document the exposure situation, whether or not the employee received a free medical exam and follow-up, and that the employee was offered the hepatitis B vaccination if they did not already have the series.

TRAINING ON OSHA REGULATIONS. This must be provided to all staff at the time that they start work and must include:

- An explanation of how HIV (which causes AIDS) and HBV (which causes hepatitis B) are transmitted.
- An explanation of standard precautions and the exposure control plan for your program.

For more information on OSHA requirements, contact the Cal/OSHA Consultation Service office.

Hand Washing

HAND WASHING: The Most Important Infection Control Measure To Prevent Illness

When caregivers, children and parents wash their hands at the proper times and with the proper technique, the amount of illness in child care can be drastically reduced.

You may want to use liquid soap in your child care setting, as it is both easier and cheaper to use for hand washing. Bar soap is often left sitting in a pool of water, especially when many people are using it frequently. A soap bar, which is always wet, is a good place for germs to grow and multiply.

When Should Hands Be Washed?

When and how often hands are washed is more important than what they are washed with.

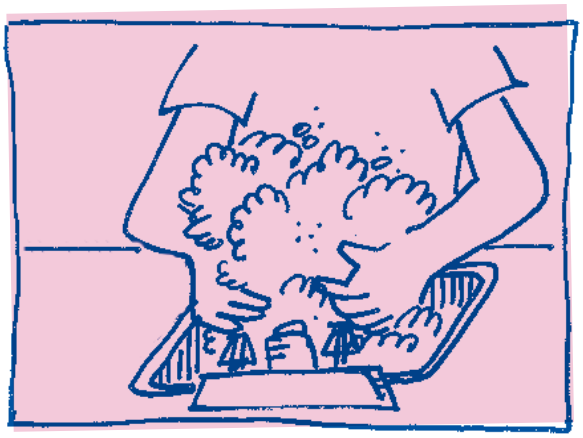
Caregivers, children and parents should wash their hands upon arrival at the program, and at least:

BEFORE AND AFTER:

- Eating/drinking or handling food (especially raw meat and poultry)
- Feeding a child
- Giving medication (particularly eye drops/ointment, etc.)
- Playing in water that is used by more than one person

AFTER:

- Toileting, diapering and assisting a child in the toilet
- Handling body fluids such as blood, urine, stool, vomit, saliva, mucus, etc. (including wiping noses)
- Cleaning up or handling garbage
- Playing or working outdoors
- Handling pets and other animals, their cages, or other pet objects
- Touching sick children, especially those with sores, cuts, or scrapes
- Removing gloves used for any purpose
- Hands are visibly dirty
- Applying sunscreen or insect repellent



Most Important Concepts about Hand Washing

The most important concepts to remember about hand washing are:

- Use running water which drains out — not a stoppered sink or container. A container of water spreads germs!
- Use plain, liquid soap. Antibacterial soap is not recommended:
  - Both bacteria and viruses are common causes of illnesses, and antibacterial soaps are designed to kill bacteria — not viruses or fungus.
  - They are not usually applied in a way that allows them to work properly, since they are not left on the skin long enough before being rinsed off.
  - Studies have shown that there is little or no evidence of the antibacterial products offering any additional protection against bacteria. On the contrary, antibacterial products may add to the existing problem of antibiotic-resistant bacteria.

- Wet your hands and apply soap. Rub your hands together for 20 seconds. This helps remove the germs. Rinse hands well under running water until all the soil and soap are gone.
- Turn off the faucet with a paper towel. The faucet is considered "dirty" at all times. If you touch it with clean hands, you will be re-contaminated. Then throw the paper towel into a lined, covered trash container with a foot pedal.
- Frequent hand washing can worsen sores and cuts on the hands or cause cracked, dry skin. These areas are hard to clean and can contain germs. Cuts should be washed well with soap and water and kept covered with a dry, clean bandage. Having hand lotion at the sink for staff who must frequently wash their hands is a good way to prevent skin dryness and cracking.
- When assisting a child in hand washing, either hold the child (if an infant) or have the child stand on a safety step at a height at which the child's hands can hang freely under the running water. Assist the child in performing all the steps for proper hand washing and then wash your own hands.
- Hot water is not necessary, but warm water can be used for comfort and will help increase duration of hand washing.

Hand Sanitizers

Adults and children over age two years may use an alcohol based hand sanitizer, containing 60-95% alcohol, for visibly clean hands when there is no access to hand washing facilities (for example, when on a field trip). Follow manufacturer's directions on the product label. Keep hand sanitizers out of children's reach.

Carefully supervise children using hand sanitizers and monitor for skin reactions. Hand sanitizers can make some skin conditions (for example, eczema) worse

Please note: hand sanitizer does not remove allergens or toxins from hands. Washing hands with soap and running water is the first choice.

HAND WASHING TIPS

Children love water play. If you make hand washing a pleasant time (sing songs such as "Wash, wash, wash your hands"), they will be more willing to wash regularly. Teach the children in your care good hand washing practices. Be sure their hands are washed when they arrive at the child care setting, before they eat or drink, after they use the toilet or have their diaper changed, and after they've touched a child who may be sick.

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

HAND WASHING SONG

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

Wash, wash, wash your hands.
Play our handy game.

Rub and scrub, and scrub and rub. Germs go down the drain. HEY!

Wash, wash, wash your hands
Play our handy game.

Rub and scrub, and scrub and rub.
Dirt goes down the drain. HEY!

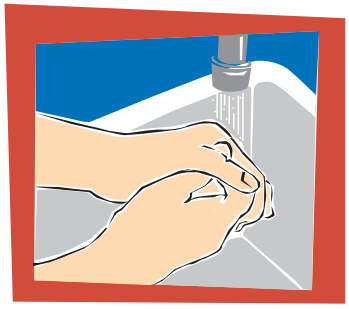
POSTER

STOP DISEASE

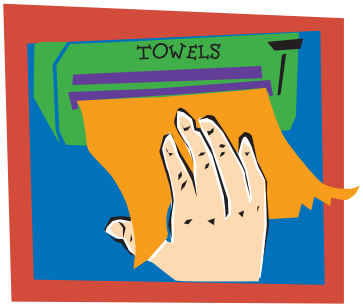
WASH YOUR HANDS PROPERLY

1. Wet hands and apply soap. Use warm running water; liquid soap is best.

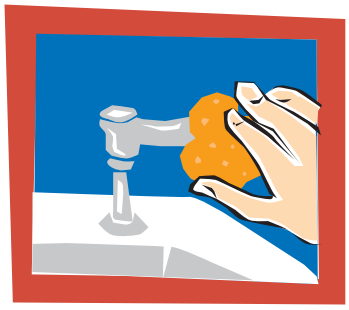
2. Rub hands together vigorously for at least 20 seconds, scrubbing all surfaces.



3. Rinse hands well under running water until all the soil and soap are gone.



4. Dry hands with a fresh paper towel.



5. Turn off water with a paper towel—not with your clean hands.

6. Discard the used paper towels in a lined, foot-pedal canister.

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POSTER

WHEN TO WASH YOUR HANDS

✔ **Upon arrival for the day, after breaks, or when moving from one child care group to another;**

✔ **Before and after:**

- Preparing food or beverages;
- Eating, handling food, or feeding a child;
- Giving medication or applying a medical ointment or cream in which a break in the skin (e.g., sores, cuts, or scrapes) may be encountered;
- Playing in water that is used by more than one person;

✔ **After:**

- Using the toilet or helping a child use a toilet;
- Diapering;
- Handling bodily fluid (mucus, blood, vomit), from sneezing, wiping and blowing noses, from mouths, or from sores;
- Handling animals or cleaning up animal waste;
- Playing in sand, on wooden play sets, and outdoors;
- Cleaning or handling the garbage.
- Applying sunscreen and/or insect repellent.

Based on: *Caring for Our Children*, Online Database,2019, Standard 3.2.2.1

Rev. 06/2021

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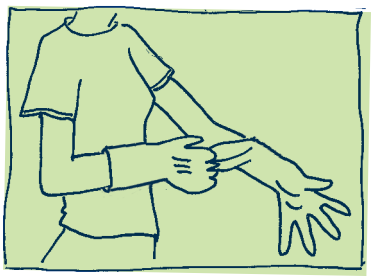
Use of Disposable Gloves

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

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

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

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



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

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

What Kind of Gloves Should I Use?

Non-permeable, single-use, disposable gloves provide protection from blood-borne pathogens and infectious body fluids. Do not use food service or housekeeping gloves when handling blood or infectious body fluids because they might leak or tear. Avoid latex gloves as they can cause allergy, particularly for those who use them often. Nitrile gloves can be used with less risk of allergy.

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

POSTER

STOP DISEASE

GLOVING

1. Put on a clean pair of gloves.

2. Provide appropriate care.

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

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

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

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

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Cleaning, Sanitizing, and Disinfecting

WHAT ARE CLEANING, SANITIZING, AND DISINFECTING?

Sometimes these terms are used interchangeably, but they are not the same. They have different outcomes which the United States Environmental Protection Agency (EPA) defines as follows:

- To clean means to physically remove dirt, debris, and sticky film from the surface by scrubbing, washing, wiping, and rinsing. You can clean with a mild soap or detergent, and water.
- To sanitize means to apply a product that reduces germs to safer levels. Sanitizing surfaces destroys enough germs to reduce the risk of becoming ill from contact with those surfaces.
- To disinfect means to apply a product that destroys nearly all germs, including viruses, when applied to hard, nonporous surfaces. Disinfecting is a higher level of germ killing.

What Should I Sanitize?

Sanitizing is recommended for food surfaces (dishes, utensils, cutting boards, high chair trays) and other objects intended for the mouth like pacifiers and teething toys.

What Should I Disinfect?

Disinfecting is recommended for hard non-porous surfaces such as toilets, changing tables, and other bathroom surfaces; blood spills and other potentially infectious body fluids like vomit, urine, and feces.

How Do I Know Which Product to Use?

Sanitizing and disinfecting products are called antimicrobials. These products kill bacteria, viruses, fungi and mold on hard surfaces. The EPA sets standards for products to make sure that they kill germs and don't pose serious immediate health hazards to people.

All products used to sanitize or disinfect must be registered with the EPA. Only products with EPA registration numbers on the label can claim they the kill germs if used as directed. Product labels have information about how to use it to sanitize or disinfect, and which germs are killed.

WHAT ABOUT BLEACH?

Bleach is the most common product used for sanitizing and disinfecting in Early Care and Education (ECE) programs. If used correctly, bleach reliably sanitizes and disinfects hard, non-porous surfaces of most common and harmful bacteria and viruses. A small amount of bleach can be diluted with water and it is inexpensive.

Are There Problems with Bleach?

There are concerns about the health effects of bleach especially for children and staff with asthma. When bleach is applied to surfaces, fumes get into the air and can irritate the lungs, eyes, and the inside of the nose. For staff who mix bleach solutions, contact with full strength bleach can be even more harmful and can damage skin, eyes, and clothing.

SAFER WAYS TO DILUTE BLEACH

- **Use only EPA registered bleach** and follow the directions on the label.
- Select a bottle made of opaque material.
- Dilute bleach with cool water and do not use more than the recommended amount of bleach.
- Make a fresh bleach solution daily; label the bottle with contents and the date mixed.
- Wear gloves and eye protection when diluting bleach.
- Use a funnel.
- Add bleach to the water rather than water to bleach to reduce fumes.
- Make sure the room is well ventilated.

Always clean before sanitizing or disinfecting!

SAFER USE OF BLEACH SOLUTIONS

- Before applying bleach, clean off dirt and debris with soap and water.
- If using a spray bottle, apply bleach using a heavy spray instead of a fine mist setting.
- Keep the surface wet with bleach according to label instructions (use a timer). This is called contact time or dwell time.
- Sanitize when children are not present.
- Ventilate the room and allow surfaces to dry completely before allowing children back.
- Store all chemicals out of reach of children in a way that will not tip or spill.
- Never mix or store ammonia with bleach or products that contain bleach.

Caution: Always follow label instructions! Undiluted bleach comes in different concentrations (e.g. 8.25%, 6%, 5.25% sodium hypochlorite).
Read the label for exact dilution instructions.

Are There Alternatives to Bleach?

Commercial products registered with the EPA as sanitizers or disinfectants may be used according to the directions on the label. Look for an EPA registration number. Follow instructions for dilution (different for sanitizing vs. disinfecting) and contact time. Check if the product is safe for food surfaces, if pre-cleaning is needed, and if rinsing is needed.

Some child care programs are using EPA registered products with hydrogen peroxide, citric acid, ethanol, or lactic acid as the active ingredient because they have fewer irritating fumes. In response to consumer demand, more of these products can be found in stores and online.

Non-chemical equipment, like dishwashers and steam cleaners, can be used to sanitize in certain situations. New methods and technologies like high-quality microfiber cloths and mops used with soap and water can also reduce germs. More studies need to be done to see if these alternative methods work as well as chemicals to sanitize in ECE (early care and education) environments.

Routine Cleaning Is Important

The everyday, routine cleaning activities of sweeping, wiping, vacuuming and scrubbing remove dirt, oils and moisture that germs need to thrive. When there is less buildup of dirt and germs, there is less need for strong chemicals to clean and sanitize.

- Routine cleaning keeps dust, pollen, pesticides, and other particles out of the indoor environment and improves indoor air quality.
- Sanitizers and disinfectants are more effective at killing germs when the surface is clean.

Please note that cleaning alone does not disinfect or sanitize surfaces.

Steps to Keep Your Child Care Environment Clean

- Choose the right equipment and clean regularly to reduce the need for chemicals to clean, sanitize and disinfect.
- Create a plan and schedule for routine cleaning.
- Use a vacuum cleaner with a high efficiency particulate air (HEPA) filter. HEPA filtration vacuum cleaners trap mold spores, dust, dust mites, pet dander, and other irritating allergens from surfaces.
- Use microfiber mops and cloths. Microfiber mops and cloths are made from a strong, lint free synthetic fiber that is very absorbent. Dust, dirt and germs are attracted to and held tightly by the microfiber, so they are not spread from one area to another. Microfiber mop heads and cleaning cloths hold sufficient water for cleaning, yet don't drip, and so less cleaning product is needed. Microfiber mops are also lighter and easier to use than conventional mops.
- Place floor mats at building entryways. Teach children to clean their feet when entering the building. This may capture 80% of soil entering indoor areas and reduces the amount of soil that must be cleaned.
- Consider a policy that encourages people to remove their shoes when they come indoors. Ask staff and families to provide a pair of "indoor" shoes or slippers.
- Decrease clutter to make cleaning easier. Store equipment and supplies in plastic boxes with tight-fitting lids.
- Repair hard surfaces that have cracks, pits, or chips to reduce the buildup of dirt and germs.

- Encourage frequent hand washing using gentle soap and running water. Hand washing may play a larger role in preventing the spread of infectious illnesses than sanitizing and disinfecting.
- Choose cleaning products that are less toxic. This includes floor-care products used to maintain floor finishes since they are some of the most toxic products used in building maintenance.
- Minimize the number of cleaning products you keep on site. Most cleaners can be used on multiple surfaces.
- Safely open windows and change filters in your heating, ventilation and air-conditioning (HVAC) system to increase air circulation and improve indoor air quality. Many illnesses are spread by breathing in germs that linger in the air, rather than by contact with germs on surfaces.So be sure to provide good ventilation in your program. Check with your building manager to make sure the heating and ventilations systems are maintained. If you don't have a HVAC system, you can clean the air using a portable air filtration device.

Safer Cleaning, Sanitizing, and Disinfecting Products

Many cleaning, sanitizing, and disinfecting products have chemicals that could be harmful. When cleaning your home or child care facility, it is safer to use products that do not cause harm to people and the environment. Products with safer ingredients are less likely to hurt your skin and eyes, cause chemical poisoning, or lead to breathing problems. Safer ingredients are gentler on clothes and don't leave behind harmful residues. Keeping harsh chemicals out of our sewer systems also protects living things in our streams, rivers, and other waterways.

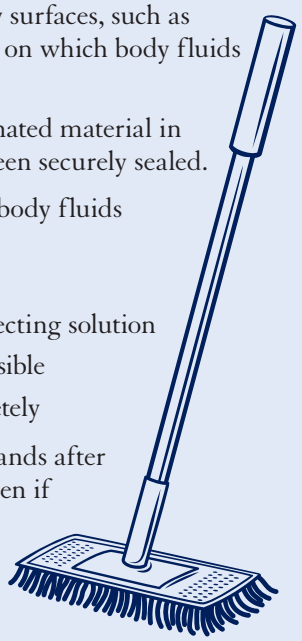
CHILDREN ARE VULNERABLE

Young children play on the floor where chemicals can collect. They often put their hands and objects in their mouths and could swallow any chemicals that are left on them. They have softer, more absorbent skin, and their bodies have a harder time breaking down toxins. Young children are growing and developing and chemicals have a stronger effect on them. They breathe more per body weight than adults, and they have smaller airways. Vapors from chemicals can cause breathing problems, especially for children with asthma.

CLEANING UP BLOOD AND BODY FLUIDS

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

- Wear gloves. Be careful not to get any of the fluid you are cleaning up in your eyes, nose, mouth or any open sores you may have.
- Clean and disinfect any surfaces, such as countertops and floors, on which body fluids have been spilled.
- Discard fluid-contaminated material in a plastic bag that has been securely sealed.
- Mops used to clean up body fluids should be:
  - Cleaned
  - Rinsed with a disinfecting solution
  - Wrung as dry as possible
  - Hung to dry completely
- Be sure to wash your hands after cleaning up any spill even if you wore gloves.



Remember:

- Don't use sanitizing and disinfecting products when children are around.
- Keep all cleaning, sanitizing, and disinfecting products out of children's reach.
- Follow product label instructions.

POSTER

Safer Cleaning, Sanitizing, and Disinfecting

Use the Right Tool for the Job

THE JOB: Remove dirt, grime, and some germs from most surfaces and objects.

THE RIGHT TOOL:
A Cleaner

- Remove clutter to make cleaning easier.
- Use a mild soap, detergent, or cleaning product.
- Use microfiber cloths and mops.
- Use a vacuum cleaner with a HEPA filter for carpets and other soft surfaces.

Routine cleaning is enough for most surfaces and objects.

THE JOB: Kill most germs on kitchen and food surfaces, utensils, and mouthed toys.

THE RIGHT TOOL:
A Sanitizer

- Use an EPA registered sanitizer after cleaning kitchen and food surfaces.
- Use a dishwasher with a sanitizing cycle for dishes, utensils, and mouthed toys.
- If you don't have a dishwasher, use an EPA registered sanitizer after cleaning dishes, utensils, and mouthed toys.

THE JOB: Kill nearly all the germs on surfaces soiled with blood or body fluids.

THE RIGHT TOOL:
A Disinfectant

- Use an EPA registered disinfectant for:
  - toilet and diapering areas and surfaces.
  - any surfaces soiled with blood, feces, or body fluids.
  - high-touch surfaces during a disease outbreak.

Always clean surfaces before applying a sanitizer or disinfectant!

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2/2022

POSTER

Safer Cleaning, Sanitizing, and Disinfecting

Choose Safer Products

Cleaners

- *Look for:*
  - A Safer Choice,
  - A UL ECOLOGO, or
  - A Green Seal logo
- *Avoid:*
  - Perfumes and dyes
  - Antibacterial ingredients

Sanitizers and Disinfectants

- *Look for:*
  - An EPA Registration Number
  - A Design for the Environment (DfE) logo https://tinyurl.com/DfElist
  - Safer active ingredients: citric acid, lactic acid, ethanol, or hydrogen peroxide
- *Avoid:*
  - Pressurized containers that spray fine mist
  - WARNING, DANGER, or POISON on the label

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POSTER

Safer Cleaning, Sanitizing, and Disinfecting

Read and Follow the Label Directions

The most important source of information for using a cleaning, sanitizing or disinfecting product is the label on the product's container. Always follow label directions.

Check the label for:

- An **EPA Registration Number** to know if the product is a registered sanitizer or disinfectant
- **Dilution Instructions** to know if the product needs to be mixed with water and how much
- **Contact Time** to know how long the product needs to stay wet on the surface to kill germs
- A **Toxicity Signal Word** to know the product's toxicity level:
  - **Caution** — slightly toxic
  - **Warning** — moderately toxic
  - **Danger** — highly toxic
- **Personal Protective Equipment** (for example, gloves, eye protection) to know how to protect yourself from injury when using the product
- Sanitizer and disinfectant labels will say: **KEEP OUT OF REACH OF CHILDREN.**

Sanitizers and Disinfectants

Check the label for **storage**, **disposal**, and **first aid directions** to know how to prevent unintended exposure and perform first aid in an emergency.

DESIGN for the ENVIRONMENT Meets U.S. EPA DfE Product Criteria™ epa.gov/dfe

ECOLOGO

GREEN SEAL CERTIFIED

These logos mean the product meets the organization's standards to protect people and the environment.

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Disposal of Garbage

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

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

Diapering/Toileting

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

The Diapering Area

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

Don't wash or rinse diapers or clothes soiled with stool in the child care setting. Because of the risk of splashing and gross contamination of hands, sinks, and bathroom surfaces, rinsing increases the risk that you, other providers and the children would be exposed to germs that cause infection. All soiled clothing should be put in a plastic bag, securely closed, and sent home with the child without rinsing. (You may dump solid stool into a toilet.) You need to tell parents about this procedure and why it is important. They often request that diapers and training pants be rinsed out to avoid staining.

Using Toilet-Training Equipment

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

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

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

IMPORTANT RULES ABOUT DIAPERING

- Use the area only for diapering.
- Set up the diapering area as far as possible from any food handling area, ideally near a hand washing sink.
- Provide running water so hands can be washed immediately after a diaper is changed.
- Construct a diapering surface which is flat, safe and preferably at least three feet above the floor.
- Be sure this surface is clean, waterproof and free of cracks and crevices. Cover it with a disposable cover.
- Keep all creams, lotions and cleaning items out of reach of children. Never give a child any of these to play with while being diapered since they could be poisoned.
- Baby powder is not recommended because of risks of inhaling small talc particles.
- Use a guardrail or recessed area as an extra safety measure. Always keep a hand on the child.

Never leave the child, even for a second.

POSTER

STOP DISEASE

DIAPERING PROCEDURES

1. **Get prepared.**
   - Gather all diapering supplies so they are within reach, including a diaper, wipes, a plastic bag for soiled clothes, and a plastic-lined, hands-free, covered can.
   - If diaper cream is needed, put some on a piece of facial tissue before you begin.
   - Cover the diapering surface with disposable paper.
   - Put on disposable gloves.

2. **Place the child on the diapering table.**
   - Remove bottom clothes and any soiled clothing.
   - Remove socks and shoes that cannot be kept clean.
   - Avoid contact with soiled items.
   - ALWAYS KEEP ONE HAND ON THE CHILD.

3. **Unfasten the diaper and clean the child's diaper area.**
   - With the soiled diaper under the child, lift the child's legs to clean the child's bottom.
   - Clean from front to back with a fresh wipe each time.

4. **Dispose of the diaper and soiled items.**
   - Put soiled wipes in the soiled diaper.
   - Remove the diaper and dispose of it in a plastic-lined, handsfree, covered can.
   - If the disposable paper is soiled, use the paper that extends under the child's feet to fold up under the child's bottom.
   - Remove gloves and dispose of them in hands-free can.
   - Use a fresh wipe to clean your hands.
   - Use a fresh wipe to clean the child's hands.

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POSTER

STOP DISEASE

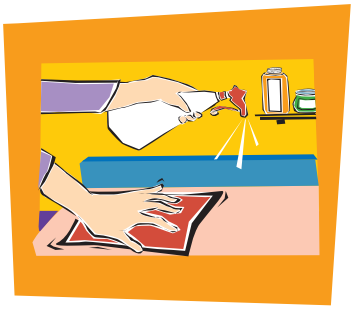
DIAPERING PROCEDURES

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

- Put a clean diaper under the child.
- Apply diaper cream with a tissue as needed.
- Fasten the diaper, and dress the child.

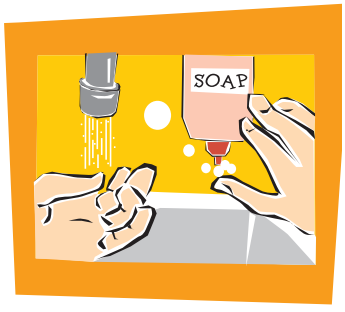
6. Wash the child's hands.

- Moisten hands and apply liquid or foam soap to hand surfaces from finger tips to wrists.
- Rinse with running water.
- Dry with a single use paper or cloth towel.
- Return the child to a supervised area away from the diapering table.



7. Clean and disinfect the diaper changing surface.

- Discard the paper liner.
- Remove any visible soil with soap and water.
- Apply EPA-registered disinfectant and use according to label instructions.
- Be sure to leave the disinfectant on the surface for the required contact time.



8. Wash your hands with soap and running water, and record the diaper change in a report for parents.

- Include the time of diaper change and diaper contents.
- Note any problems such as skin redness, rashes, or loose stool.

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Food Safety

FOOD PREPARATION, HANDLING, AND STORAGE

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

When You Purchase Food

- Don't buy food in poor condition. Make sure that refrigerated food is cold to the touch, that frozen food is rock-solid, and canned goods are free of dents, cracks or bulging lids.
- Check the "use by," "sell by" or "expiration date" on foods before purchase.
- Be sure that the meats and poultry you purchase have been inspected and passed for wholesomeness by federal or state inspectors.
- Keep packages of raw meat separate from other foods, particularly foods that are eaten fresh.
- Use only pasteurized milks, milk products and fruit juices.
- Do not use home-canned foods.
- Shop for meat, fish, poultry, and cold food last. Take foods straight home to the refrigerator; never leave food in a hot car.

When You Store Food

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

When You Prepare Food

Keep everything clean by following these hygiene procedures:

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

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

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

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

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

When You Serve the Food

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

When You Handle the Leftovers

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

HANDLING EQUIPMENT

When You Clean and Care for Equipment

PROVIDE EASY-TO-CLEAN EQUIPMENT AND UTENSILS:

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

WASH EQUIPMENT FREQUENTLY:

- Clean range tops during food preparation as needed and on a daily basis.
- Clean ovens and overhead hoods according to the manufacturer's instructions.
- Wash the inside and outside of refrigerators monthly.
- Clean and sanitize mixed-use tables before and after meals and snacks.

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

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

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

When You Are Hand Washing Dishes

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

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

TO WASH, RINSE, AND SANITIZE DISHES BY HAND:

- Fill one sink compartment or dishpan with hot tap water and dishwashing soap.
- Fill the second compartment or dishpan with hot water.
- Fill the third compartment or dishpan with a sanitizing product diluted according to the manufacturer's instructions.
- Scrape dishes and utensils, and dispose of excess food.
- Dip scraped dish or utensil in the first sink compartment and wash thoroughly.
- Rinse dish or utensil in the second dishpan of clear water.
- Dip dish or utensil in the third dishpan of water and sanitizing solution according to label directions.
- Place the dish or utensil in the rack to air-dry.
- Pick up and touch clean spoons, knives and forks only by the handles, not by any part that will be in contact with food.
- Handle clean cups, glasses, and bowls so that fingers and thumbs do not touch the inside or the lip.

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

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

FOOD-BORNE DISEASE

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

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

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

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

Unpasteurized juices. Children should only drink pasteurized juice products unless the fruit is washed and freshly squeezed (i.e., orange juice) immediately before consumption. Consumption of packaged fruit and

vegetable juices that have not undergone pasteurization or a comparable treatment has been associated with foodborne illness due to E. coli O157:H7 and salmonella.

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

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

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

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

SAFE STORAGE, HANDLING, AND FEEDING OF BREAST MILK AND INFANT FORMULA

General Guidelines

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

BREAST MILK

Breastfeeding provides numerous health benefits to young infants, including protection against infectious diseases caused by bacteria, viruses and parasites. It is an ideal source of infant nutrition, largely uncontaminated by environmental pathogens, and reduces some of the risks that are greater for infants in group care such as diarrhea, lower respiratory disease, otitis media, and SIDS. Breast milk is the best food to meet the nutritional needs of an infant from birth until 12 months of age.

The clear advantage of breast milk over any formula suggests that child care providers promote breastfeeding for working mothers who are willing to nurse their babies and pump and supply their milk to child care facilities. It's important to store breast milk carefully.

Use the following guidelines for storing breast milk:

- Label bottles of breast milk with the child's name and date.
- Breast milk can be stored in a refrigerator for up to 3 days from the time it was expressed.
- Place breast milk toward the back of the refrigerator where it is coldest.
- Keep a back-up supply of breast milk in the freezer.
- Breast milk can be frozen for up to 3 months from when it was expressed.
- Once frozen breast milk is thawed, use it within 24 hours and do not refreeze.
- Rotate fresh and frozen breast milk, using the oldest milk first.
- Promptly refrigerate. Store each child's breast milk in a separate container in the refrigerator.
- Never give breast milk intended for one child to another.

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

If expressed human milk is given to another child: Breast milk from a mother is specific to her own child and should be used only with the intended child. Risk of HIV transmission from breast milk that another child has drunk is believed to be low. However, if one child is mistakenly fed another child's bottle, or one child fed from a bottle that another child has dropped or put down, this should be seen as an accidental exposure to a potential HIV-contaminating body fluid. In such cases providers should:

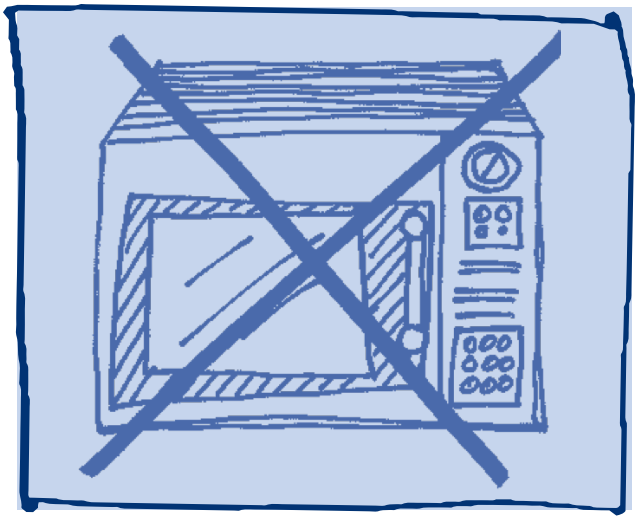
- Inform the parents of the child who was given the wrong bottle and notify the child's health care provider of the exposure.
- Inform the mother who supplied the breast milk and ask if she has ever had an HIV test and, if so, would she be willing to share the results with the parents of the exposed child.

INFANT FORMULA

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

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

Concentrated and powdered infant formula should be sent from the child's home in its original factory-sealed container and prepared according to package directions. If mixing formula with tap water, use only cold water. To prevent illness from shared bottles or giving incorrect formula, label each child's bottles and formula with the child's name and the date the formula was prepared. Refrigerate the bottles as soon as they arrive or are made, and discard formula after 12 hours.



DO NOT warm infant formula or breast milk in a microwave oven.

Oral Health

Oral hygiene is the practice of keeping teeth and gums healthy. With good oral hygiene, the teeth will be clean and the mouth will have a clean and sweet odor. Tooth decay is the most common infectious disease in childhood, and bacteria in the mouth contribute to cavities. Fortunately, with good oral hygiene, regular dental care, and a healthy diet, children can lay the foundation for life long dental health.

How To Promote Oral Health

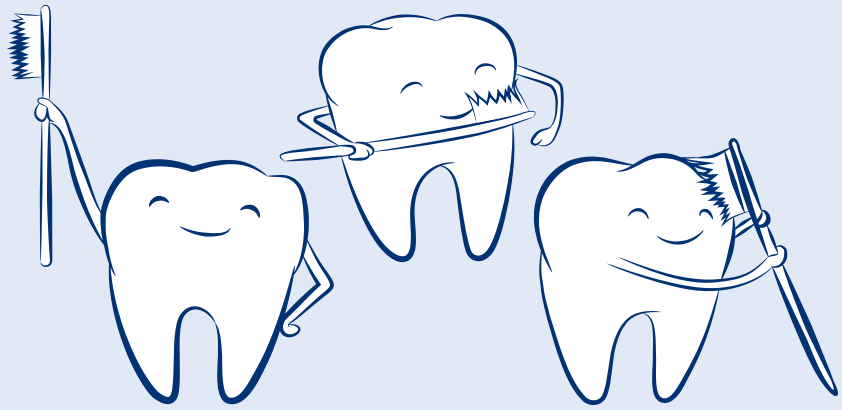
Your program can help prevent tooth decay by serving well-balanced nutritious food and by limiting sugary and sticky foods. You will be teaching preschool children dental health by helping them to brush their teeth and encouraging parents to get regular dental care for their children.

- **Healthy Food for Teeth:** Fresh fruit and vegetables make a great snack or dessert. Food with high amounts of sugar is linked to tooth decay. Germs in the mouth change the sugar in food to acid, which can eat a cavity in the tooth. Avoid serving candy, jelly, jam, cake, cookies, sugared gelatin and sweetened canned fruit. According to the Healthy Beverages in Child Care Act, serving sweetened drinks (for example, sweet tea, juice drinks, soda, flavored milk) to children is prohibited in licensed child care in California.
- **Prevention of Baby Bottle Tooth Decay:** Baby bottle tooth decay (BBTD) is one form of early childhood tooth decay which can result from the overuse of a baby bottle feeding of milk, formula, and juices. Babies should not be put to bed with a bottle at nap time or at night. And juice should never be served in a baby bottle.
- **Brushing Teeth:** Although it can be difficult, brushing teeth in the child care setting helps children to develop good habits. To brush teeth properly and to prevent the spread of germs found in saliva and blood on toothbrushes:
  - Always supervise children when they are brushing their teeth.
  - Make sure that each child has their own toothbrush clearly labeled with their name. Do not allow children to share or borrow toothbrushes.
  - Use fluoride toothpaste: Infants and toddlers: grain of rice-size amount; Preschoolers: pea-size amount.
  - Instruct each child to brush their teeth.
  - If using a paper cup, children can spit out the toothpaste into the cup. Rinsing with water is optional.

  - Children need supervision and assistance brushing their teeth until at least 8 years old.
  - Store each toothbrush so it cannot touch any other toothbrush, and allow it to air dry.
  - Never “disinfect” toothbrushes. If a child uses another child’s toothbrush or if two toothbrushes come in contact, throw them away and give the children new toothbrushes.
  - If a child uses the toothbrush of another child who is known to be ill or to have a chronic bloodborne infection (such as hepatitis B and C or HIV), parents of the child who used the ill child’s brush should be notified.
  - Replace toothbrushes every three to four months or sooner if bristles are damaged or worn down.

TIPS FOR PREVENTING DENTAL DECAY (CAVITIES, CARIES)

- Cleaning teeth and gums is the single most important way to prevent dental and gum disease.
- Good nutrition, which is good for the body, is also good for the mouth. The most harmful foods are those containing sugar and refined carbohydrates.
- Regular dental visits will ensure early detection and correction of oral/dental problems. If not previously referred by a health care provider, children should get regular dental checkups starting when they get their first tooth, usually by their first birthday.
- Use of fluoride reduces tooth decay. Research shows that fluoride reduces cavities by up to 25 percent in children and adults. Toothpaste and drinking water may have fluoride. Children between 6 months and 16 years of age living in non-fluoridated areas may have fluoride prescribed by a dentist or health care provider.
- Use of sealants (plastic coatings applied to teeth by a dental professional) will help prevent tooth decay by creating a physical barrier between the teeth and plaque and food. Since permanent molars are the most at risk for decay, the six-year and 12-year molars need sealants.
- Avoid frequent exposure to sugary liquids such as milk (including breast milk) fruit juice and other sweet liquids to help prevent baby bottle tooth decay.
- Learn how to handle dental emergencies: You can help a child avoid losing a tooth.
- Help parents find a dental provider in their area.



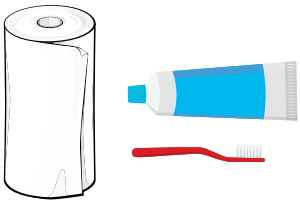
POSTER

STOP DENTAL DISEASE

TOOTHBRUSHING

No Water Toothbrushing in Your Child Care Program

Build good oral health habits and reduce the risk of cavities by ending meal or snack time with this simple toothbrushing routine. *This method does not require spitting into a sink or rinsing with water.*



GATHER

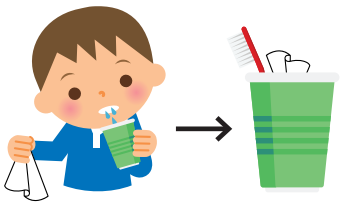
- Small paper cups
- Fluoride toothpaste
- Soft bristle child-sized toothbrush labeled with the child's name
- Paper towels

SET UP

- Seat children in chairs at a table.
- Set a cup, the child's toothbrush, and a paper towel at each child's place.
- Place a dab of fluoride toothpaste (pea sized for children ages 3 years and up, rice grain sized for toddlers) on the rim of each child's cup.

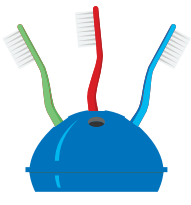
BRUSH

- Children pick up the dab of toothpaste with their toothbrush.
- Encourage children to brush making small circles or using a back and forth motion.
- Encourage children to brush all tooth surfaces and tongue gently and thoroughly.



CLEAN UP

- Children spit any extra toothpaste into their cups. No rinsing is needed.
- Children wipe their mouths with their paper towels, and place the paper towels in their cups.
- Children put their toothbrushes in their cups.



STORE

- Wear gloves to rinse each of the toothbrushes separately with running water. Throw away the paper cup and paper towel.
- Place toothbrushes upright in a holder with at least two inches of space between slots so that toothbrushes do not touch each other. Remove gloves. Wash hands.

Note: Label each child's toothbrush with their name. Replace toothbrushes every three months or sooner if bristles are frayed, used by a sick child, or dropped on the floor.

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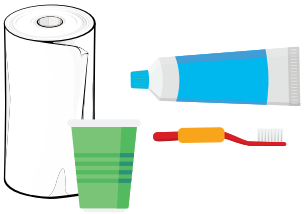
POSTER

STOP DENTAL DISEASE

TOOTHBRUSHING

No Water Toothbrushing for Children with Special Needs

Children with disabilities are especially vulnerable to tooth decay and may need assistance or an adaptive toothbrush. A toothbrush with a special handle or grip makes it easier for the child to grasp. There are a variety of adaptive toothbrushes available to meet every child's needs. Check with the child's family to see what they use at home. *This method does not require spitting into a sink or rinsing with water.*



GATHER

A toothbrush that is easy for the child to grasp labeled with the child's name, fluoride toothpaste, a small paper cup, a paper towel.

SET UP

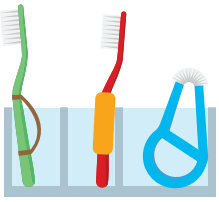
Hand the child their toothbrush with a small amount of fluoride toothpaste (pea sized for preschoolers and a grain of rice size for toddlers). Stand by to assist as needed.

BRUSH

Assist the child as needed to brush all surfaces of the teeth. Allow the child to be as independent as possible.

CLEAN UP

Assist the child to spit excess toothpaste into the cup. Wipe excess toothpaste from the child's mouth with the paper towel. Place the toothbrush and paper towel in the cup.



STORE

Wear gloves to rinse each of the toothbrushes separately with running water. Throw away the paper cup and paper towel. Place toothbrushes upright in a holder with at least two inches of space between slots so that toothbrushes do not touch each other. Remove gloves. Wash hands.

Note: Label each child's toothbrush with their name. Replace toothbrushes every three months or sooner if bristles are frayed, used by a sick child, or dropped on the floor.

California Childcare Health Program • University of California, San Francisco School of Nursing
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09/21

POSTER

STOP DENTAL DISEASE

TOOTHBRUSHING

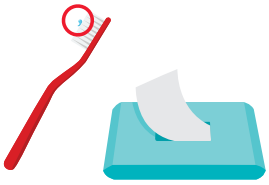
Oral Care for Infants and Toddlers in Child Care Programs

Build healthy habits and reduce the risk of cavities by ending a meal or snack with oral care for infants and toddlers. *This method does not require spitting into a sink or rinsing with water.*

GATHER

Gloves, paper towels, fluoride toothpaste, and a small paper cup.
For infants: disposable dental wipes or a soft infant toothbrush.
For toddlers: an easy-grip toddler toothbrush.

BRUSH:

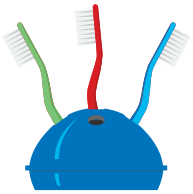


Infants

- **Position:** Place the infant on your lap facing you, or sit or stand behind the infant with the infant looking up at you, or cradle the infant in your arms to one side.
- **Wipe/Brush:** Wear gloves. Gently wipe the infant's gums and/or teeth using an infant dental wipe or brush the infant's teeth with a soft bristle toothbrush and a rice sized amount of fluoride toothpaste. Wipe excess toothpaste with a paper towel.

Toddlers

- **Position:** Hold younger toddlers on your lap. Seat older toddlers in a chair at a table.
- **Brush:** Wear gloves. Place a dab of toothpaste the size of a grain of rice on rim of a paper cup. Pick up the dab of toothpaste with the toothbrush. Help the child brush their teeth. Have the child spit extra toothpaste into the paper cup and/or wipe their mouth with the paper towel.



CLEAN UP AND STORE

Dispose of infant dental wipes. Throw away cup and paper towel. Rinse individual toothbrushes in running water and place upright in labeled rack to air dry. Allow at least two inches between toothbrushes so they do not touch. Remove gloves. Wash hands.

Note: Label each child's toothbrush with their name. Replace toothbrushes every three months or sooner if bristles are frayed, used by a sick child, or dropped on the floor.

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09/21

Open Space and Healthy Air

ACTIVE OUTDOOR PLAY

Studies show that regular physical activity helps children be fit and healthy, improves self-esteem, and decreases the risk of serious illnesses such as heart disease and stroke later in life. Active outdoor play enhances children's senses of smell, touch and taste, and the sense of motion through space, which are powerful ways of learning. Children's perceptual abilities may suffer when they experience the world mainly through television, computers and books. Their social abilities to cooperate, help, share and solve problems with other children are fostered when playing together outdoors. And when they have access to the outdoors, they gain the ability to navigate their immediate environment safely, and lay the foundation for the courage that will enable them eventually to lead their own lives.

Ideas for Active Play

Infants count on you to set up a safe space away from more mobile children where they can explore with their senses, practice using their muscles and move freely. A large blanket on the floor with some colorful toys or objects of different sizes, shapes, and textures will keep them active and interested. Try to take infants outdoors each day, even for a short walk in the yard.

Toddlers explore and learn about the world through unstructured play time. Running, climbing, and playing in a sandbox are all fun and offer opportunities to develop and practice new skills. You can lead movement activities such as jumping with two feet, skipping, and running. Explore the crunchy leaves, bare tree limbs, and what can float in puddles.

Preschool-age children can enjoy simple games, such as Simon Says. They can roll large balls, play catch and ride wheel toys, dance, sing, or move to music. Unstructured time allows them to learn important skills, use their imaginations, and offers time to wind down. Gardening or simple science activities can encourage their enjoyment of the outdoors while using all their senses.

School-age children are ready for new learning experiences and both team and individual sports. Children who prefer not to participate in organized teams need regular exercise, such as running, walking, skating, bicycling, dance, and nonviolent martial arts.

Children with chronic health conditions and disabilities should be included in outdoor play activities; they receive the same positive benefits from exercise and exploration. Some activities may need to be modified or adapted.

Outdoor Play in Winter

Winter brings many wonderful opportunities for children to delight in seasonal changes while playing outdoors. But all too often cold or rainy days mean that many young children spend their day indoors engaged in quiet activities. Keep the following in mind:

- Playing outdoors in cold weather doesn't cause colds — germs do. Playing outdoors will reduce the amount of time children and adults are exposed to germs while cooped up inside.
- Dress in layers and keep extra dry clothing for children who get wet or muddy.
- Open a window and let in the fresh air periodically. Overheated rooms with stale, dry air can be a health hazard. Change your furnace and air filters regularly and watch for mold.
- Use sunscreen to prevent sunburn and decrease the risk of developing skin cancer at a later age whenever your child is playing outdoors. Unless it's actually raining, sun damage can occur whether it's sunny or cloudy.
- The American Academy of Pediatrics advises against trampoline use due to the high number of injuries.
- Prevent slips and falls by wiping down wet outdoor equipment. Check for adequate cushioning under climbing equipment, as sand and bark may compact when wet.
- Never let toddlers play around water without constant supervision. It takes very little time and only a few inches of water for a puddle to become a drowning hazard.
- Follow EPA's Air Quality Index (AQI). The AQI provides information on common air pollutants and what to do to protect your health. https://www.airnow.gov/aqi-and-health

Air Quality During Wildfires and Smoke Emergencies

Children are more at risk for health effects from breathing in wildfire smoke and ash since their lungs are small and still growing. Children can have trouble breathing, chest tightness, coughing, burning of the eyes, nose or throat, dizziness, wheezing and other symptoms. Children with chronic health conditions like asthma, allergies and other conditions can have even more trouble breathing. All children may need to stay indoors or spend less active time outdoors during a wildfire or smoke emergency. Children may need to visit their health care professional if they are having breathing problems or other health issues.

It is important to limit exposure to unhealthy air when breathing, because it can be a health risk to young children. The Air Quality Index (AQI) is a tool that can be used to tell you when the air may be unhealthy to breathe. Look up your zip code's Air Quality Index (AQI) on https://www.airnow.gov/.

Be prepared to respond to smoky or unhealthy air that occurs because of wildfires.

- Close the doors and windows.
- Use your HVAC system and portable air cleaners.
- Bring children indoors or limit the amount and type of outdoor play when the outside air is unhealthy to breathe.
- Consider wearing a well-fitting mask that protects the lungs from ash for anyone over 2 years of age. Cloth masks usually do not protect against smoke and air pollution. N95 masks with or without a valve offer the best protection, but may not fit young children.

Never let children play with or clean up ash from a wildfire.

Follow the instructions of local officials before, during and after a wildfire or smoke emergency.

HEALTHY AIR IN YOUR CHILD CARE FACILITY

What Is Healthy Air?

We breathe so often, it's easy to forget the air we breathe is important to our health. Breathing in provides the body with oxygen, and breathing out rids the body of waste like carbon dioxide.

The quality of the air we breathe affects the health and well-being of both children and adults. As we learned from the COVID-19 pandemic, viruses can spread through the air and make us sick. In addition, smoke and chemicals from cleaning products, furnishings, pesticides, air fresheners, and cosmetics can linger in the air and trigger breathing problems, allergies, and asthma. Poor air quality can also affect children's learning and behavior.

The easiest and most affordable way to increase fresh air is to go outside. You can adapt many activities to the outside environment. A sheltered space, like under a pergola, a shade sail, or a pop-up shelter offers protection from sun and weather so you can spend more time outdoors.

What Is Ventilation?

Ventilation moves fresh air from outside to replace stale or stuffy air inside. Ventilation clears odors, germs, and other harmful particles from the air. There are several ways to provide ventilation. Some are simple and low-cost. Others require big investments.

SIMPLE STEPS TO IMPROVE THE AIR IN YOUR FACILITY

Safely open your windows: Opening windows is a simple and low-cost way to bring fresh outside air in and move stale inside air out. Open windows and doors on opposite sides of the rooms to create cross ventilation. Windows accessible to children should only open four inches or have a properly installed window guard.

Turn on a fan so it blows air away from people:

- Place a fan next to an open window, or use a fan designed to be safely secured in an open window, to blow the inside air out.
- Set ceiling fans to draw air upward. You may need to change the direction the blades turn.
- Use bathroom fans and kitchen fans that vent air to the outdoors.
- Address safety concerns for portable fans including tripping on cords, tipping, collisions, and other possible injuries.

Identify and manage sources of odors and unhealthy air: For example, use safer cleaning products; consider a policy for fragrance-free personal care products and perfumes; take out garbage daily; stay home when sick so you don't add germs to the air; and wear face masks according to public health advice.

What Is Filtered Air?

Air filters block and catch small particles and make the air healthier to breathe. Many buildings filter outdoor air through a heating, ventilation, air conditioning (HVAC) system. A new HVAC system is costly but may be a good long-term investment. If your building already has a HVAC system, make sure it works properly and gets regular upkeep. Refer to your HVAC system service manual for:

- What type of filter the system uses (use the highest rated filter possible);
- When to change the filter and how to check the fit of the filter;
- How to adjust the settings to maximize outdoor air intake;
- How to adjust the settings to circulate and filter the air without heating or cooling;
- How to disable demand-control so the system doesn't turn on and off according to room temperature;
- How to adjust the settings or keep outdoor air out (if the outdoor air is unhealthy).

Filter Rating: A filter's Minimum Efficiency Reporting Values (MERV) rating reflects the size of the particles it can trap. Filters with higher MERV ratings block out smaller particles and clean the air better than those with lower ratings. A filter with a MERV rating of 13 or above is designed to block viruses that cling to exhaled droplets in the air. High efficiency particulate air (HEPA) filters trap even smaller particles.

How Can I Learn More about My Building's HVAC System?

Consult a qualified engineer or HVAC professional to check if your HVAC system is functioning properly. A licensed HVAC professional can check the air change per hour (ACH), advise on settings to maximize outdoor air intake or close the outdoor air intake, and make recommendations for regular upkeep.

Can I Use a Portable Air Cleaner?

Many homes and buildings do not have an adequate HVAC system, and some child care rooms do not have windows that open or can be safely opened. In this case, a portable air filtering device can be used to remove harmful particles in the air. There are many types of air cleaning devices. Check product information for the room size it can clean, the particle size that the filter traps, and its clean air delivery rate (CADR).

Some electronic air cleaners (ionizers) create ozone as a biproduct. Breathing ozone poses serious health risks. A mechanical air cleaning device that pulls air through a filter is a safer choice.

Will My Window Air Conditioner Clean the Air?

No. A window air conditioner is designed to cool the air. Most window units do not draw in outdoor air or have an adequate filter (MERV 13 or higher) to clean the air of viruses and other particles. Check your window air conditioner's operating manual to learn how it works and what kind of filter it uses.

Will Spraying Air Freshener Clean the Air?

No. Spraying air freshener adds chemicals to the air rather than clearing them. Air freshener sprays do not ventilate, do not take away the source of the odor, and do not filter the air.

Safety Tips

- Do not open windows if the outside air is unhealthy to breathe. For example, if the air outside is polluted with smoke from fires or with pesticides from agricultural spraying it could trigger asthma or have other adverse health effects.
- If portable fans are not safe to use when children are present, consider using them before children arrive, when children are playing outside, and at the end of the day after children are gone.
- Keep portable air cleaners out of children's reach by using barriers or protective screens.

Water Supply

National Health and Safety Performance Standards in *Caring for Our Children* recommend that every child care setting be supplied with piped running water under pressure, from a source approved by the Environmental Protection Agency (EPA) and/or the state or local health authority. The water should be sufficient in quantity and pressure to supply water for cooking, cleaning, drinking, toilets and outside uses.

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

Child care centers not served by a public water supply shall keep documentation of approval of the water supply on file.

Drinking Water Must Be Safe for Consumption

Exposure to toxic levels of lead can cause problems with learning, behavior, and growth. Testing your water is the only way to be sure that tap water is free from lead. Licensed child care centers in facilities built before 2010 are required to have their tap water tested for lead by January, 2023 and every five years thereafter. This requirement does not apply to Family Child Care Homes.

Running Water for Hand Washing Is Important

Use soap and running water for hand washing. When plumbing is not available to provide a hand washing sink, the child care facility should provide an approved hand washing sink using a portable water supply that flows by gravity or pumping action during use. Children must not wash in a communal basin or stoppered sink because those who wash in the same water share contamination.

Drinking Water Is Essential for Children's Health

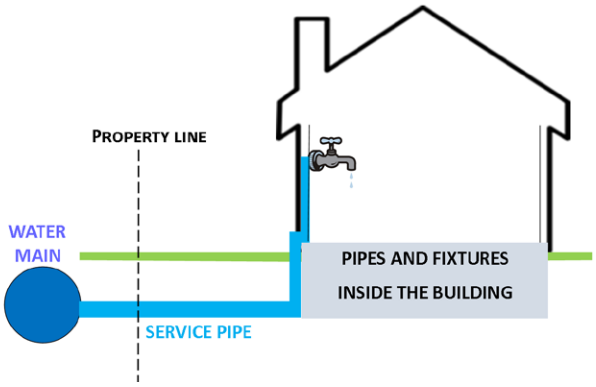
According to the Healthy Beverages in Child Care Act (AB 2084), all licensed child care programs in California are required to have clean, safe, and accessible water readily available for children to drink throughout the day. Also, as of October 2017, all licensed child care centers in California and any family child care homes participating in the Child and Adult Care Food Program (CACFP) must offer water to children throughout the day.

What is done to ensure that drinking water is safe?

Tap water in the United States is generally safe. The Safe Drinking Water Act is a federal law that requires public water companies to test water regularly and meet strict federal standards. Water quality standards in California are even more rigorous than federal standards. Testing for water quality is done annually, and the results are sent to every customer in a Consumer Confidence Report (CCR). You can check the website of your local public water system for a current CCR.

How does tap water get to the faucet?

In most California communities, drinking water comes from a public water system where the water is collected, stored, tested for contaminants, and treated. The water then travels through large pipes (mains). Service lines (laterals) carry water from the mains to the building. Plumbing pipes carry water to the faucets (taps) inside the building.



What if I get my water from a privately-owned water source?

Some child care providers get their water from groundwater wells, springs, or surface water instead of a public water system. California Community Care Licensing (CCL) regulations require an on-site inspection of privately-owned water sources and a laboratory report that shows the water is safe to drink. Contact your local public health department, the California Department of Public Health, or a licensed commercial laboratory for information about testing your water. Contact your regional child care licensing office for more information about child care regulations: https://cdss.ca.gov/Portals/9/CCLD/Community%20Care%20Licensing%20Division%20Child%20Care%20Offices.pdf

How can water get contaminated?

Water can be contaminated at its source (for example, in reservoirs, groundwater, and rivers). However, public water systems treat this water to make it safe to drink. Water treatment includes removing contaminants and making the water less corrosive to pipes. When water leaves a public water system it is considered safe.

Water can be contaminated after it leaves the public water system. As water flows through older plumbing, small pieces of lead can flake off of pipes and lead can leach into the water. Also, water standing in pipes or fixtures with lead solder can absorb lead. Homes and buildings built before 1986 are more likely to have pipes, solder, or fixtures that contain lead.

What are the health risks of drinking contaminated water?

Regular exposure to contaminants can cause serious illnesses and developmental problems in children. For example, lead can cause children to have lower IQ scores, learning disabilities, and difficulty paying attention. There is no known level of lead exposure that is considered safe, especially for children under age 6. Fortunately, you can test a water sample to find out if it has lead.

How can I get my water tested?

If you are concerned about the safety of the drinking water in your building or need to have it tested to meet licensing requirements, a certified laboratory can test the water from individual faucets. The laboratory will either mail you supplies to collect water samples or send a technician to collect samples. Funding for water testing and fixture replacement is available for qualified child care centers from a State Water Board grant. Contact your local Child Care Resource and Referral program or Regional Child Care Licensing office for more information.

To find out more about testing your water:

- Visit the Child Care Licensing website: www.cdss.ca.gov/inforesources/child-care-licensing/water-testing-information,
- Contact your local community water system, or
- For a list of Certified Laboratories visit: https://www.epa.gov/dwlabcert/contact-information-certification-programs-and-certified-laboratories-drinking-water
- Lead in Drinking Water Testing Assistance Program for Child Care Centers California State Water Resources Control Board): https://ab2370assistance.owp.csus.edu/

What else can I do if I'm not sure the water from my tap is safe?

- Use only cold tap water from your faucet. Hot water dissolves lead from pipes more quickly. Generally, it is safer to use only cold tap water for drinking, cooking, and mixing infant formula.
- Clean your faucet screens and aerators which can collect particles and debris.
- If you haven't run the water for six hours, flush the faucets used for cooking or drinking by running the water for 30 seconds. Flush for up to two minutes (or until the water feels cooler) if the building is large or if the water has been sitting in the pipes for days or weeks. Water used to flush pipes can be collected and used for other purposes, such as watering non-edible plants and lawns.
- Consider using a water filter. Filters that are certified for National Safety Foundation (NSF) American National Standards Institute (ANSI) standard 53 remove lead and copper from drinking water. Always check product information labeling, and change filters according to the manufacturer's instructions.

What about drinking bottled water instead of tap water?

If your tap water is safe, there is no reason to buy bottled water. In fact, there are fewer regulations for testing bottled water than tap water. Many resources go into producing and transporting bottled water. After the water is consumed, even more resources are used in the recycling and disposal process. These activities can harm our environment. In addition, most bottled water does not contain fluoride. Fluoride reduces the risk of tooth decay (cavities).

What about water filters?

Most people do not need to filter their tap water. However, water filters can be used to make water taste better or remove contaminants. Many devices for filtering water are available to consumers including: filter pitchers, small faucet-mounted filters, and "whole-house" filter systems.

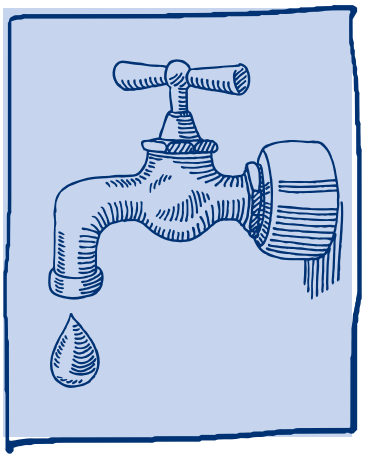
If your water is safe but you simply prefer the taste of filtered water, filter pitchers or faucet-mounted filters may be used. Some filters remove fluoride and other minerals such as calcium and magnesium.

If you need to filter out contaminants, use a device that is certified by NSF. Not all water filters remove lead. (NSF certified product listings with information about specific contaminants can be found at http://info.nsf.org/Certified/DWTU/listings_leadreduction.asp?ProductFunction=053|Lead+Reduction&ProductFunction=058|Lead+Reduction&ProductType)

What about water vending machines?

Some consumers use water vending machines to fill their own containers. A water vending machine dispenses tap water with some extra filtering. These machines may become contaminated if they are not properly maintained and inspected. Water from water vending machines may not contain fluoride.

What do I do if my tap water is contaminated?



Do not use contaminated water for drinking, cooking, making formula, or making ice. Instead, use bottled water until you have a reliable filtering system or the underlying problem is fixed (for example, lead free plumbing is installed).

If you participate in CACFP, bottled water or filtering equipment may be allowable costs, but be sure to get approval from your CACFP sponsor or California Department of Education nutrition consultant before making any purchases. If you find your water contains lead, notify the families of the children you care for so that their blood lead levels can be tested. Your local public health department can assist with testing children for lead.

Pets, Pests, Pesticides, and Integrated Pest Management

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

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

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

Keeping Children Safe from Pests and Pesticides

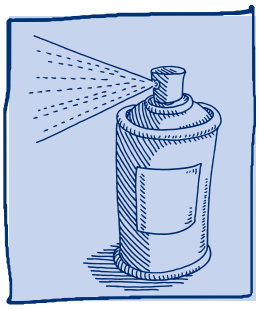
California State Licensing regulations for child care state that child care settings should take measures to be free from rats and insects. The national standards in *Caring for our Children* tell us that the potential health hazards to children caused by the presence of pests should be reduced. What does this mean to the child care provider? Since pesticides can also pose a health threat to young children, finding ways to reduce or eliminate exposure to pests while reducing or eliminating exposure to pesticides is an environmental concern that every early care and education professional needs to address.

WHY CONTROL PESTS IN CHILD CARE?

Diseases that are spread by insects and rodents can be passed to young children. Normal behaviors in young children such as crawling, mouthing toys and other objects along with natural curiosity and exploration make toddlers particularly vulnerable to diseases carried by pests. Common pest-related hazards in child care settings include:

- Flies and cockroaches may spread disease.
- Mosquitoes may carry disease.
- Cockroaches can cause allergies and asthma attacks.
- Yellow jacket stings are painful and can be life threatening to those with allergies.
- Spiders may inflict painful bites and some may pose a health risk.
- Mice and rats may contaminate food, trigger asthma attacks, carry disease and cause structural damage to buildings, pipes and electrical wiring.
- Termites cause structural damage to buildings and wood furniture.

Why are Children Vulnerable to Pesticide Exposure?



The behaviors that make young children vulnerable to diseases carried by pests (crawling, mouthing toys, etc.) can also expose children to the pesticides that have been applied to control pests. Pound for pound, children eat, drink and breathe more than adults. Thus, if pesticides are in their environment, they can have higher exposures than adults. Combined with the fact that their brains, immune systems and organs are immature and still developing, children can suffer both short-term and long-term health problems from pesticide exposure.

What Health Risks are Associated with Pesticide Use?

With the exception of poison baits, as little as 1 percent of pesticides applied indoors reach the targeted pest (AAP, 2003). As a result, pesticide residues are left on surfaces and in the air of the treated building. Outdoor application of pesticides may fall on non-targeted organisms, outdoor furniture and play areas and be tracked indoors. Acute symptoms such as nausea, headache, dizziness and respiratory irritation may occur from exposure to pesticides. Studies have shown that children who are exposed to pesticides also have a higher incidence of chronic health problems such as neurological disorders, leukemia and other cancers and have a greater risk of developing asthma (IPM Institute, 2004).

Integrated Pest Management (IPM)

Integrated Pest Management (IPM) is a pest control program that minimizes pesticide exposure. Despite the convenience and availability of pesticides, there are many ways to control pests without the use of chemicals. IPM controls pests by combining biological, mechanical, cultural, physical and chemical methods in a way that minimizes health and environmental risks. IPM provides the least toxic alternative. It is based on inspection and knowledge of the pests' biology and habits to determine the methods that would best control the pests with the lowest possible exposure to pesticides. Chemicals are only used as a last resort. IPM is endorsed and promoted by the Environmental Protection Agency.

Why Are Education and Communication Important?

The common sense strategies of IPM require the combined efforts of teachers, kitchen staff, parents, custodians and groundskeepers. Education and communication are essential to promote the necessary changes in habits and attitudes. A licensed IPM professional can suggest the best strategies for controlling pests in your child care setting.

Cultural controls and sanitation. Modify the activities in the child care facility to make the environment less hospitable to pests.

- Restrict food consumption to certain areas.
- Empty trash cans at the end of the day rather than letting them sit over night.
- Store food in containers with tightly fitting lids.
- Clean dishes, utensils, and surfaces soiled with food as soon as possible after use and at the end of each day.
- Clean garbage cans and dumpsters regularly.
- Collect and dispose of litter daily.

Physical controls. Use barriers or other materials to exclude pests from an area.

- Caulk cracks and openings.
- Fill in access holes in walls.
- Seal around electrical outlets.
- Use trash cans with tightly fitting lids.
- Empty and thoroughly clean cubbies and storage areas at least twice a year.
- Reduce clutter in which pests can hide.
- Keep vegetation, shrubs and wood mulch at least one foot away from structures.
- Keep window and door screens in good repair.
- Use physical traps. Be aware that in the child care setting, traps can be a hazard and must be placed out of reach of children. This includes sticky traps, snap traps and fly traps.

Biological controls. Identify the problem or pest before taking action.

- Look for the root of the problem, not just the symptoms of a pest problem.
- Inspect and monitor pest populations.
- It is very important to reduce pests' access to food, water and shelter.

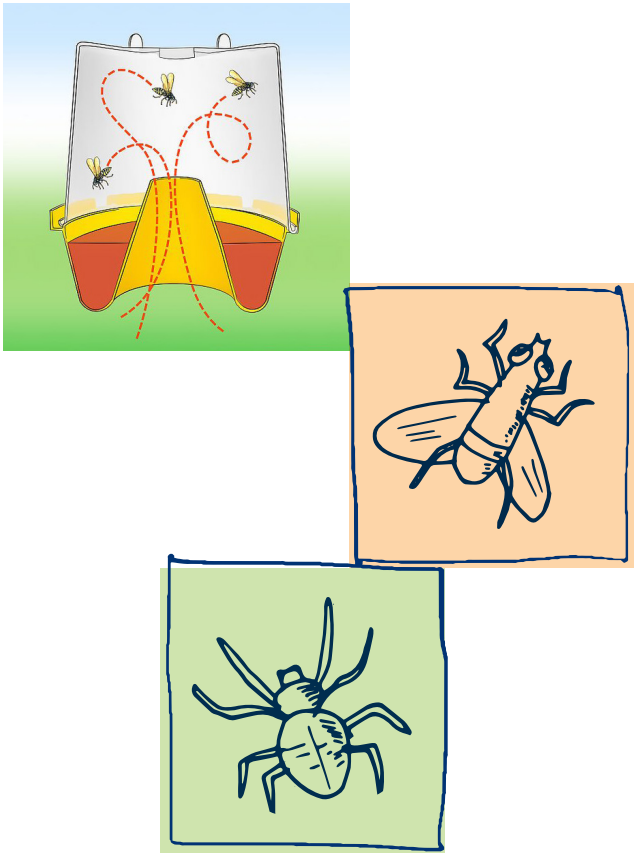
Chemical controls. As a last resort, the careful use of pesticides may be necessary.

- Always use a licensed professional with experience in IPM when applying chemicals.
- Use bait, traps or gels in cracks, wall voids, and in spots that are out of reach of children. Avoid sprays, powders and "bomb" applicators.
- Schedule pesticide application for times when the building and grounds are not occupied.
- Use spot treatments as needed, rather than area-wide applications or regularly scheduled applications.
- Store all chemicals in a locked cabinet.

Attitude Adjustment

Increase your tolerance for pests that are just a nuisance and don't spread disease. To control these pests, always make use of non-chemical strategies first. Pests that do not pose immediate health threats but are a nuisance include:

- Weeds may invade playing fields or playgrounds or be aesthetically unpleasing. Pull by hand.
- Ants may gather in eating and play areas. Keep areas clean. Use non-toxic alternatives.
- Fruit flies may appear in kitchens. Keep food and garbage covered.
- Meal moths may infest food storage. Dispose of infested food. Store food in containers with tightly fitting lids.
- Head lice may appear on children. Have parents consult their health care provider for treatment.



HEALTHY SCHOOLS ACT OF 2000 EXTENDED TO CHILD CARE

The Healthy Schools Act of 2000 is a California state law that:

- established the right of parents and school staff to know when pesticides are used in California public schools
- mandated using least toxic pest management methods in schools as state policy
- required school districts to designate an integrated pest management (IPM) coordinator
- required the California Department of Pesticide Regulation (DPR) to collect pesticide use information from schools and support schools in their use of IPM

The Healthy Schools Act is Extended to Child Care

In the 2007 California Law AB 2865, the Healthy Schools Act was extended to child care centers. This extension of the Healthy Schools Act ensures that parents and staff in child care centers are notified of pesticide use and it promotes safer pest prevention practices in child care centers. The Healthy Schools Act helps parents and ECE staff be better informed about what pesticides are being used in their ECE centers and helps ECE providers prevent pest infestations and use safer ways to control pests when they do become a problem. The Healthy Schools Act only applies to child care centers, not family child care homes.

The law was prompted by concern about the health risks that pesticides pose to young children. Research suggests that pesticides are commonly found in child care environments. These pesticides may have toxic effects on the developing brain and nervous system of a young child. They are also associated with an increased risk of developing asthma and cancer. Acute pesticide poisoning can cause breathing difficulties, vomiting, diarrhea, headaches and dizziness.

What Is a Pesticide?

A pesticide is any substance that controls, destroys, repels, or attracts a pest. Some common pesticides include:

- Insecticides (kill insects like ants and mosquitoes),
- Insect repellants (a substance applied to skin or clothing which discourages insects from landing or climbing on that surface)
- Miticides (kill mites, for example, dust mites that can cause asthma and eczema)
- Herbicides (kill unwanted plants/weeds)
- Fumigants (gaseous pesticides that fill a space and poison the pests within; for example, fleas)
- Rodenticides (chemicals intended to kill rodents)
- Avicides (substances used to kill birds)
- Antimicrobials (substances such as sanitizers and disinfectants that kill bacteria and viruses)
- Algicides (kill and prevent the growth of algae)

The Healthy Schools Act (HSA) regulates the use of pesticides on school sites an in child care centers including buildings or structures, playgrounds, vehicles, or any other area of the property visited or used by children.

The California Department of Pesticide Regulation (DPR) is responsible for helping schools and child care centers implement the Healthy Schools Act. DPR's website has many helpful resources. Visit the website at https://apps.cdpr.ca.gov/schoolipm/

Who Needs Training on the Healthy Schools Act?

Anyone who applies pesticides in child care centers, including HSA exempt pesticides* such as antimicrobials and disinfectants, must complete annual Healthy Schools Act training. Online training is available at no charge on the DPR website.

**Some pesticides, such as antimicrobials and bait stations, are exempt from the Posting, Notification, and Record Keeping Requirements of the Healthy Schools Act. For more information on exempt pesticides, visit the DPR website.*

POSTER

Healthy Schools Act Requirements for Public K-12 Schools and Child Care Centers

IDENTIFY

Choose an IPM coordinator who will make sure the requirements of the HSA are met.

PLAN

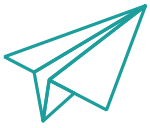
Create a plan for IPM and publish it on the school, district, or child care center website. If a website does not exist, include the plan in the annual written notification.

TRAIN

Provide annual Healthy Schools Act training to all teachers, staff, and volunteers who use any pesticides, including exempt pesticides.

POST

Post warning signs in the area where a pesticide will be applied, at least 24 hours before and 72 hours after the application.



NOTIFY

Send an annual notification to all parents, guardians, and staff of all pesticides expected to be applied during the year.

RECORD

Keep records of pesticide applications, and file these records for at least 4 years.

REGISTER

Give parents, guardians, and staff the opportunity to register to be notified 72 hours in advance of individual pesticide applications.

REPORT

Submit annual pesticide use reports to DPR by January 30 for the previous year's applications. Only report pesticide use by school personnel.

Visit our website: http://apps.cdpr.ca.gov/schoolipm/

Questions? Email us at: school-ipm@cdpr.ca.gov

dpr Department of Pesticide Regulation

[SCCIPM 08 (05/2019)]

California School & Child Care IPM

Sandboxes and Sand Play Areas

Keeping Sandbox and Sand Play Areas Safe

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

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

- Separate the sandbox from other play equipment such as slides or swings.
- Keep the sandbox covered when not in use. Fasten the cover to prevent children or animals and pests from getting under it.
- Make sure the sandbox has adequate drainage so water does not puddle or pool.
- Use smooth-surfaced, fine pea gravel or washed sand that is labeled for sandboxes. Sand that is used as building material or collected from a site containing toxic materials may be harmful.
- If you see or smell urine, feces, pests, or other hazards in the sand, replace the sand with fresh sand.
- Treatment of sand with chemicals to attempt to disinfect it within the sandbox is not recommended.
- Before each use, make sure sand play areas are free of pests and other dangers like sharp objects and cat and other animal feces.
- Keep the play area clear of food, garbage, and standing water because these attract pests.
- Replace sand as often as necessary to keep the sand clean of pests, feces, and other hazards.
- Place sandboxes away from prevailing winds. If this is not possible, provide windbreaks using bushes, trees, or fences.
- Keep surrounding pavement free of sand. Sweep pavement regularly to reduce the risk of sliding and slipping.

POSTER

INTEGRATED PEST MANAGEMENT:
CARING FOR YOUR OUTDOOR ENVIRONMENT

Sandboxes

- Separate the sandbox from other play equipment such as slides or swings.
- Make sure the sandbox has adequate drainage so water does not puddle or pool.
- Use smooth-surfaced, fine pea gravel or washed sand that's labeled for sandboxes. Do not use sand that's used as construction material or collected from a site that uses harmful materials.
- When not in use, keep the sandbox covered with a lid or other covering that keeps pests out.

Garbage and Recycling

- Use the outdoor waste bins provided by your local waste hauler. Request more bins if your garbage or recycling regularly overflows.
- Set bins at least 50 feet away from entrances to home or play yard and keep on pest-proof pavement such as concrete.
- Keep the bin area free from spilled liquids or waste.
- Make sure that every outdoor waste bin has a tight-fitting lid.
- Rinse your recycling and bins regularly.
- Regularly rinse green waste bins for food scraps and yard trimmings that are collected by your waste hauler.

PESTS IN THE SANDBOX

- Don't use sprays or foggers in the sandbox. These are dangerous for children and don't kill pests hiding in the sand.
- Avoid using chemicals to clean or disinfect the sandbox.
- If you see or smell urine, feces, pests, or other hazards, replace the sand with fresh sand or fresh fine pea gravel.

PREVENT FUTURE PEST PROBLEMS

- Before each use, make sure sand play areas are free of pests and other dangers like sharp objects, cat, and other animal feces.
- Keep the play area clear of food, garbage, and standing water because these attract pests.
- Replace sand as often as necessary to keep the sand clean and free of pests, feces, and other hazards.

ON-SITE COMPOSTING

Composting provides a wonderful opportunity to teach children about environmental sustainability. Unfortunately, compost left in the open can attract unwanted pests. Instead, choose a closed compost bin.

- Closed compost systems make it more difficult for pests to access the contents and have fewer odors.
- They often come with handles that make turning the compost easy, even for children.
- As with waste bins, set the closed compost bin system on a pest-proof surface such as concrete.

PESTS IN GARBAGE AREA

- If you use rodent bait stations or yellowjacket traps, make sure they're placed out of children's reach.

Policies to Prevent the Spread of Infectious Diseases

TRAINER GUIDE

SECTION TOPICS

- Health and Safety Policies
- Health History and Emergency Information Policy
- Immunization Requirements and Policy
- Keeping Health Records
- Excluding Children Due to Illness
- Staff Health Policies
- Communicating about Illness in Child Care
- Caring for Children with Mild Illness
- Medication Administration Policy
- Children with Disabilities or Special Health Needs
- Emergency Illness and Injury Procedures
- No Smoking or Use of Alcohol or Illegal Drugs

Rationale: Health and safety policies are important because they improve communication and provide clear guidelines about how to prevent the spread of contagious diseases in the child care setting.

Time: 1 hour, 50 minutes

Learning Objectives

Participants will:

1. Understand the importance of written health policies.
2. Identify the components of policies regarding health and safety.
3. Understand the role of administrators, child care providers, health consultants, parents, and non-teaching staff in developing, implementing, and reviewing health and safety policies.

Teaching Methods/Suggested Activities

See Resources for a list of hands-on and group activities:

- **Brainstorming:** Ask providers to list some of the topics for which they need to establish written policies.
- **Lecture:** Review the importance of written preventive health policies and the topics to include in your health policies. Review the role of administrators, care givers, health consultants, parents, and non-teaching staff in developing, implementing, and reviewing health and safety policies. Review the sample format for preventive health policies.
- **Questions/Answers:** Respond to any questions that the group may have, and ask questions and emphasize important points that highlight the important concepts.

Materials and Equipment Required

STUDENT HANDOUTS:

- Sample illness policy
- LIC-702 form
- LIC-701 form
- LIC-627 form
- LIC-700 form
- IMM-230 Immunization required for child care or preschool
- CDPH-236 Immunization Record (Blue Card)
- IMM-1140 Notice of Immunizations Needed
- IMM-1233 Vaccine Acronyms, and Abbreviations
- Maintaining Confidentiality in Child Care Setting
- Notice of Exposure to Communicable Disease
- Runny Nose in the Child Care Setting
- Fever Fact Sheet for Families
- LIC-9221
- Five Rights of Medication Administration Poster

OTHER MATERIALS:

- Flip Chart/Chalkboard/Whiteboard
- Presentation Slides (if using a computer and LCD projector)
- Demonstration supplies

Questions/Comments

- Have participants identify areas in their settings which lack specific policies.
- Generate ideas on how a policy could be implemented.
- Ask the class when they would communicate the concepts they have learned to the families whose children they care for.

Health and Safety Policies

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

Which Written Policies Are Recommended?

The *Caring for Our Children National Health and Safety Performances Standards*, Guidelines for Early Care and Education, recommends that you establish written policies. Some of these policies include:

- Health History
- Emergency Information
- Immunization Policy (children and staff)
- Exclusion for Illness
- Reporting Requirements
- Emergency Illness or Injury Procedures
- Children with Special Needs
- Medication Administration
- Nutrition/Foods Brought from Home
- No Smoking or Use of Alcohol or Illegal Drugs

Other Topics for Policies Include:

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

Some policies may not be needed in a family child care home setting where fewer children are in care or in centers that do not care for infants and toddlers. An electronic copy of Model Child Care Health Policies is available on the ECELS webpage of the Pennsylvania Chapter of American Academy of Pediatrics. www.ecels-healthychildcarepa.org

For a direct link to Model Child Care Health Policies 5th edition visit: http://ecels-healthychildcarepa.org/publications/manuals-pamphlets-policies/item/248-model-child-care-health-policies.html

When developing policies:

- Have the equipment, supplies, and staff necessary to carry out the policies.
- Organize the child care program to support the policies.
- Use proper procedures to support the policies.
- Keep lines of communication open with everyone involved: staff members, parents, and children. Ensure that all staff, parents and others are educated about the policies.
- Have a list of resources to assist families and staff in meeting your policies.
- Consider:
  - What should be done?
  - Why should it be done?
  - Who is responsible?
  - When will it be done?
  - How will it be done?
  - How will it be communicated, enforced, and monitored?

To Prevent the Spread of Infectious Diseases, Keep in Mind:

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

Clearly Define the Roles of Caregivers

The qualifications and requirements for each of these roles are defined by the child care license and type of program. Centers that receive public subsidies have different requirements than private centers. Infant programs may have different roles than school age programs. And large and small family child care programs may define the following roles according to their program's needs.

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

2. **Teaching Staff and Licensed Child Care Providers, and Child Care Assistants.** Staff will receive training on the program's health and safety policies and will follow them accordingly.

3. **Other Staff.** These include food handlers, janitorial staff, landscapers, maintenance workers, etc.

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

5. **Families.** Clearly communicate your health and safety policies with families at enrollment. Families are responsible for communicating about their child's health even if the child stays home due to illness.

Sample Policy for Mild Illness

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

PURPOSE:

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

PROCEDURE:

Understand the reason for excluding a child.

- The illness prevents the child from comfortably participating in daily activities.
- The illness requires more care than the child care staff are able to provide without compromising the health and safety of the other children.
- The illness poses a risk of spreading a harmful illness to others.

Conditions for which we would not automatically exclude a child:

- Certain conditions, in the absence of symptoms listed on Inclusion/Exclusion Guidelines, do not require exclusion unless recommended by the child's health care provider or if symptoms appear
- CMV or HIV infection or hepatitis B and C virus carrier state
- Pink eye
- Rash without temperature or behavior changes
- Non-contagious conditions such as chronic medical conditions or disabilities
- Common cold without behavior changes and the child feels well enough to participate.

The final decision to exclude a child from care is made by the child care provider.

LIC 701

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____ . This Child Care Center/School provides a program which extends from _____ : ____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician:_____ Date of Physical Exam: _____
Address:_____ Date This Form Completed: _____
Telephone: _____ Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

* Have a family member or contacts with a history of confirmed or suspected TB.
* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
* Live in out-of-home placements.
* Have, or are suspected to have, HIV infection.
* Live with an adult with HIV seropositivity.
* Live with an adult who has been incarcerated in the last five years.
* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
* Have abnormalities on chest X-ray suggestive of TB.
* Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

State of California – Health and Human Services Agency California Department of Social Services

CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
IS / HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?	DATE OF LAST PHYSICAL/ MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY *(*For infants and preschool-age children only)*

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
_____ MONTHS	_____ MONTHS	_____ MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping Cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES *(*For infants and preschool-age children only)*

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST	
	LUNCH	
	DINNER	
WHAT ARE USUAL EATING HOURS?	BREAKFAST	
	LUNCH	
	DINNER	

ANY FOOD DISLIKES?		ANY EATING PROBLEMS?	
IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT / AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT/AUTHORIZED REPRESENTATIVE SIGNATURE	DATE

LIC 627

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

LIC 627 (9/08) (CONFIDENTIAL)

LIC 700

State of California – Health and Human Services Agency | California Department of Social Services

IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST		MIDDLE	FIRST		SEX	TELEPHONE ( )
ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE	FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	HOME TELEPHONE ( )
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE	FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD	LAST	MIDDLE		FIRST		HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	LAST DATE OF ENROLLMENT

Health History and Emergency Information Policy

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

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

California Title 22 regulations require that each child accepted for care in centers has a written medical assessment. (LIC 701) The medical assessment can inform the child care provider about any necessary health related services the child may need. If special care is needed, the child care provider will create a special health care plan with the family and the health care provider.

California Title 22 regulations also require that each child accepted for care has emergency contact information (LIC 700). Emergency contact information should be updated regularly and should include the best way to reach family and back-up emergency contacts in case the family cannot be reached.

Immunization Requirements and Policy

IMMUNIZATION FOR CHILDREN IN CHILD CARE

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

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

Personal beliefs exemptions: Parents or guardians of students in any school or child-care facility, whether public or private, are not allowed to submit a personal beliefs exemption to a currently-required vaccine.

Medical exemptions: Some children cannot get vaccinated for medical reasons. For example, if the child is being treated for cancer. A child who cannot be vaccinated needs a letter from their doctor stating they have a medical exemption. The doctor uploads the letter to the California Immunization Registry. Starting January 1, 2021, child care providers must go to the California Immunization Registry to find the doctor's letter.

A temporary medical exemption will expire within a year. After it expires, the child must either get the vaccine or get a new medical exemption letter.

There is no longer a personal beliefs exemption. Only medical exemptions are allowed.

Staff immunization requirements: A person may not be employed or volunteer at a child care center or a family child care home unless he or she has been immunized against influenza, pertussis, and measles or qualifies for an exemption. In order to qualify for an exemption, a person must submit one of the following to the child care center or family child care home:

- a determination by a licensed physician, in writing, that immunization is not safe for them because of their physical condition or medical circumstances; or
- a determination by a licensed physician, in writing, that they have evidence of current immunity; or
- in regard to the influenza vaccine only, a signed declaration that the employee has declined the vaccine. A person is also considered exempt from the influenza vaccine requirement if they were hired or began volunteering after December 1 of the previous year or before August 1 of the current year.

California Immunization Requirements for

Pre-Kindergarten

(any private or public child care center, day nursery, nursery school, family day care home, or development center)

Doses required by age when admitted and at each age checkpoint after entry[1]:

Age When Admitted	Total Number of Doses Required of Each Immunization[2,3]				
2 through 3 months	1 Polio	1 DTaP	1 Hep B	1 Hib	
4 through 5 months	2 Polio	2 DTaP	2 Hep B	2 Hib	
6 through 14 months	2 Polio	3 DTaP	2 Hep B	2 Hib	
15 through 17 months	3 Polio	3 DTaP	2 Hep B		1 Varicella
		On or after the 1st birthday:		1 Hib[4]	1 MMR
18 months through 5 years	3 Polio	4 DTaP	3 Hep B		1 Varicella
		On or after the 1st birthday:		1 Hib[4]	1 MMR

1. A pupil's parent or guardian must provide documentation of a pupil's proof of immunization to the governing authority no more than 30 days after a pupil becomes subject to any additional requirement(s) based on age, as indicated in the table above (Table A).
2. Combination vaccines (e.g., MMRV) meet the requirements for individual component vaccines. Doses of DTP count towards the DTaP requirement.
3. Any vaccine administered four or fewer days prior to the minimum required age is valid.
4. One Hib dose must be given on or after the first birthday regardless of previous doses. Required only for children who have not reached the age of five years.

DTaP = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine
Hib = Haemophilus influenzae, type B vaccine
Hep B = hepatitis B vaccine
MMR = measles, mumps, and rubella vaccine
Varicella = chickenpox vaccine

Instructions:

California pre-kindergarten (child care or preschool) facilities are required to check immunizations for all new admissions and at each age checkpoint.

Unconditionally Admit a pupil age 18 months or older whose parent or guardian has provided documentation of any of the following for each immunization required for the pupil's age as defined in the table above:

- Receipt of immunization.
- A permanent medical exemption.*

Conditional Admission Schedule for Pre-Kindergarten

Before admission a child must obtain the first dose of each required vaccine and any subsequent doses that are due because the period of time allowed before exclusion has elapsed.

Dose	Earliest Dose May Be Given	Exclude If Not Given By
Polio #2	4 weeks after 1st dose	8 weeks after 1st dose
Polio #3	4 weeks after 2nd dose	12 months after 2nd dose
DTaP #2, #3	4 weeks after previous dose	8 weeks after previous dose
DTaP #4	6 months after 3rd dose	12 months after 3rd dose
Hib #2	4 weeks after 1st dose	8 weeks after 1st dose
Hep B #2	4 weeks after 1st dose	8 weeks after 1st dose
Hep B #3	8 weeks after 2nd dose and at least 4 months after 1st dose	12 months after 2nd dose

Conditionally Admit any pupil who lacks documentation for unconditional admission if the pupil:

- has commenced receiving doses of all the vaccines required for the pupil's age (table on page 1) and is not currently due for any doses at the time of admission (as determined by intervals listed in the Conditional Admission Schedule, column entitled "EXCLUDE IF NOT GIVEN BY"), or
- is younger than 18 months and has received all the immunizations required for the pupil's age (table on page 1) but will require additional vaccine doses at an older age (i.e., at next age checkpoint), or
- has a temporary medical exemption from some or all required immunizations.*

Continued attendance after conditional admission is contingent upon documentation of receipt of the remaining required immunizations. The pre-kindergarten facility shall notify the pupil's parent or guardian of the date by which the pupil must complete all remaining doses.

*In accordance with 17 CCR sections 6050-6051 and Health and Safety Code sections 120370-120372.

Questions?

See the California Immunization Handbook at ShotsForSchool.org

State of California—Health and Human Services Agency

California Department of Public Health

California Pre-Kindergarten and School Immunization Record

Staff must record the required vaccine dose information and status of requirements for each pupil. See reverse side for guidance.

Pupil Name (Last, First, Middle):	**Statewide Student Identifier** (SSID):	**Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino	**Race:** ☐ African American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other
Name of Parent/Guardian (Last, First):	**Birthdate** (Month/Day/Year):	**Gender:**	

Required Vaccine	**Date Each Dose Was Given** (MM/DD/YY)					Permanent Medical Exemption	**Notes for School Requirements**
	1ST	**2ND**	**3RD**	**4TH**	**5TH**		
IPV / OPV (Polio)			Age: ____ yrs.			☐	4 doses meet TK/K-12 requirement, as do: 3 doses, if ≥1 dose given at age ≥4 years.
DTaP / DTP – Age 0-6 years **Tdap / Td** – Age 7+ years (Diphtheria, Tetanus, Pertussis)			Age: ____ yrs.	Age: ____ yrs.		☐	5 doses meet TK/K-12 requirement, as do: 4 doses, if ≥1 dose given at age ≥4 years; 3 doses, if ≥1 Tdap dose at age ≥7 years; Tdap dose may meet 7th Grade requirement.
MMR (Measles, Mumps, Rubella)	Age: ____ mo.					☐	2 doses meet TK/K-12 requirement. Doses must be given at age ≥1 year.
Hib (*Haemophilus influenzae* type b)						☐	Required for pre-kindergarten only. At least 1 dose must be given at age ≥1 year.
Hep B (Hepatitis B)						☐	3 doses meet TK/K–12 requirement.
VAR / VZV (Varicella/Chickenpox)						☐	2 doses meet TK/K–12 requirement.
Tdap – 7th Grade (Tetanus, Diphtheria, Pertussis)	Age: ____ yrs.					☐	1 dose given at age ≥7 years meets requirement for 7th grade advancement and 7th–12th grade admission.

Status of Requirements	**Staff Initials** *I reviewed pupil's immunization record*	**Has All Required Vaccine Doses**	**Requires Follow-up**			**Follow-up Date(s)** (See conditional admission schedule or exemption end)	**Other** *See codes on reverse side*	**Date Requirements Met**
			Temporary Medical Exemption	**Missing Doses Not Currently Due—Conditional**	**Missing Doses Are Overdue—Needs Doses Now**			
Pre-Kindergarten (Child Care or Preschool)		☐	☐	☐	☐		☐ IEP	
TK/K-12		☐	☐	☐	☐		☐ IEP ☐ IND ☐ Home	
7th Grade (Advancement or Admission)		☐	☐	☐	☐		☐ IEP ☐ IND ☐ Home	

CDPH 286 (10/23)

NOTICE OF IMMUNIZATIONS NEEDED

Dear Parent/Guardian of: _____

Our records show that your child needs the following immunization(s) (shots) to meet the requirements of the California School Immunization Law, Health and Safety Code Sections 120325-120375.

VACCINE	MISSING DOSE(S) MARKED BELOW					DEADLINE
Polio	☐ #1	☐ #2	☐ #3	☐ #4		_____
DTaP (Tdap/Td if 7 years or older)	☐ #1	☐ #2	☐ #3	☐ #4	☐ #5	_____
MMR	☐ #1	☐ #2				_____
Hib (preschool only)	☐ #1	☐ #2	☐ #3	☐ #4		_____
Hepatitis B	☐ #1	☐ #2	☐ #3			_____
Varicella (chickenpox)	☐ #1	☐ #2				_____
Tdap (for 7th-12th grade)	☐ #1					_____

YOU NEED TO DO ONE OR MORE OF THE FOLLOWING IMMEDIATELY:

1. If your child has already received all of these immunizations marked above, bring us the immunization record so that we can update our files. Your child's record must include a date for the immunizations checked above and the doctor's/clinic's name.

2. If your child has not received the immunizations marked above, bring this form along with your child's immunization record to your doctor or local health department to get the missing doses. Bring us your child's updated immunization record after every immunization visit until all of the required immunizations have been received.

3. If any of these immunizations were not given to your child because of medical reasons, please bring us a medical exemption form issued using the CAIR-Medical Exemption website by your child's doctor (MD or DO licensed in California).

According to state law, we cannot allow your child to attend unless we receive proof that the above requirements are met by this date: _____

For more information on pre-kindergarten and school immunization requirements, visit ShotsForSchool.org. If you have any questions or require additional information, please call _____.

Sincerely,

IMM-1140 (11-14-22)

Vaccine Acronyms & Abbreviations for Providers

Vaccine names are often abbreviated. Here are some common ones. California Immunization Registry (CAIR2) codes may differ for certain vaccines. Use this chart as a reference.*

CDC Abbreviation	CAIR2 Code	Brand Name	Vaccine
BCG	BCG-TB		Bacillus Calmette-Guérin (Tuberculosis)
DT	DT-Peds	several manufacturers	Diphtheria & Tetanus
DTaP	DTaP	Daptacel®, Infanrix®	Diphtheria, Tetanus, & Pertussis
DTP	DTP		Diphtheria, Tetanus, & Pertussis
DTaP-HepB-IPV	DTaP-HepB-IPV	Pediarix®	Diphtheria, Tetanus, Pertussis, Hepatitis B, & Polio
DTaP-IPV	DTaP-IPV	Kinrix™, Quadracel™	Diphtheria, Tetanus, Pertussis, & Polio
DTaP-IPV/Hib	DTaP-IPV/Hib	Pentacel®	Diphtheria, Tetanus, Pertussis, Polio, & *Haemophilus influenzae* type b
HepA	HepA	Havrix®, VAQTA®	Hepatitis A
HepB	HepB	Engerix-B®, Recombivax HB®, HEPLISAV-B	Hepatitis B
HepA-HepB	HepA-HepB	Twinrix®, Twinrix Junior®	Hepatitis A & Hepatitis B
Hib	Hib	ActHIB®, Hiberix®, PedvaxHIB®	*Haemophilus influenzae* type b
Hib-HepB	HepB-Hib	Comvax®	*Haemophilus influenzae* type b & Hepatitis B
HPV9, 9vHPV	HPV	Gardasil®9	Human papillomavirus (9-valent)
IIV4, ccIIV4, IIV3, aIIV3, HD-IIV3	Flu	several manufacturers	Inactivated Influenza Vaccine (injectable)
LAIV 4	Flu (nasal)	FluMist®	Live Attenuated Influenza (nasal spray)
RIV4	Flu	FluBlok	Recombinant Influenza Vaccine (injectable)
IPV	Polio	IPOL®	Polio
MenB	MeningB	Bexsero®, Trumenba®	Meningococcal serogroup B
MMR	MMR	M-M-R®II	Measles, Mumps, & Rubella
MMRV	MMRV	ProQuad®	Measles, Mumps, Rubella, and Varicella
MenACWY	Men ACWY	Menactra®, Menveo®, Men-Quadfi™	Meningococcal conjugate (quadrivalent)
MPSV4	MPSV4	Menomune™	Meningococcal polysaccharide (quadrivalent)
OPV	Polio-oral	Orimune®	Polio
PCV13	PCV13	Prevnar13®	Pneumococcal conjugate (13-valent)
PPSV23	Pneumonia Polysaccharide	Pneumovax®23	Pneumococcal polysaccharide (23-valent)
RV1	Rotavirus, Monovalent	Rotarix®	Rotavirus
RV5	Rotavirus, Pent	RotaTeq™	Rotavirus
Td	Td	Tenivac™, Td Vaccine (Grifols)	Tetanus & Diphtheria
Tdap	Tdap	Adacel®, Boostrix®	Tetanus, Diphtheria, & Pertussis
VAR	Varicella	Varivax®	Varicella
HZV, RZV, ZVL	Zoster	Shingrix, Zostavax®	Shingles/Zoster

Note: Refer to the most recent version of CDC's Vaccine Abbreviations (cdc.gov/vaccines/terms/vacc-abbrev.html)

***Disclaimer:** Abbreviations may vary across medical practices.

www.eziz.org

California Department of Public Health, Immunization Branch IMM-895 (12/22)

IMMUNIZATION FOR CHILD CARE PROVIDERS

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

Tuberculosis (TB) Testing

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

Recommended Immunizations for Child Care Providers

Child care providers should have received all immunizations routinely recommended for adults. Licensed child care providers in California are required to show proof of at least one dose of Measles (MMR) and at least one dose of Pertussis, also known as Whooping Cough (Tdap), and receive an annual Influenza vaccination.

- **Influenza (Flu):** All child care providers are required to be annually vaccinated against influenza. The law provides for child care providers to opt out of this annual requirement, however, it is good policy for all staff who care for young children to receive this important vaccination.
- **Measles, Mumps, Rubella (MMR):** Providers born before 1957 can be considered immune to measles and mumps. Others can be considered immune if they have a history of measles or mumps disease proven with a blood test, or have received at least one dose of the MMR vaccine on or after their first birthday.
- **Tetanus, Diphtheria, acellular Pertussis (Tdap):** Child care providers should have a record of receiving a series of three doses (usually given in childhood) and a booster dose given within the past 10 years.
- **Polio:** Child care providers, especially those working with children who are not toilet-trained, should have a record of a primary series of three doses (usually given in childhood) and a supplementary dose given at least six months after the third dose in the primary series.
- **Hepatitis A:** Hepatitis A vaccine is not routinely recommended for child care providers but may be indicated if the local health department determines that the risk of hepatitis A in the community is high.
- **Chickenpox:** Child care providers who know they have had chickenpox can assume they are immune. All other providers should consider getting vaccinated because of the risk of exposure to chickenpox.
- **Hepatitis B:** Child care providers who may have contact with blood or blood-contaminated body fluids (such as bloody noses or cuts), or who work with developmentally disabled or aggressive children, should be vaccinated against hepatitis B with one series of three doses of vaccine.
- **COVID-19:** Child care providers can protect themselves, their families, and their communities by getting the COVID-19 vaccine and boosters.

Keeping Health Records

MAINTAINING RECORDS

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

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

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

The medical record on file for each child should include a medical report completed and signed by the child's health care provider, preferably prior to enrollment. The medical report shall include the following medical and developmental information:

- Records of the child's immunizations
- A description of any disability, sensory impairment, developmental variation, seizure disorder, or emotional or behavioral disturbance that may affect adaptation to child care
- An assessment of the child's growth
- A description of health problems or findings from an examination or screening that need follow-up
- Results of screenings–vision, hearing, dental, nutrition, developmental, tuberculosis*, hemoglobin, urine, lead, etc.
- Dates of significant communicable diseases
- Prescribed medication(s), including information on recognizing, documenting, and reporting potential side effects
- A description of current acute or chronic health problems.
- A description of past serious injuries that required medical attention or hospitalization

Note: Keep an up-to-date special health care plan with clear instructions for the provider for each individual child with a special health care need on file.

**The skin test for tuberculosis (Mantoux) is not required for children unless the child's medical provider concludes that they are at risk for TB.*

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. 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.

Confidential Contents of Records in Child Care Settings

Keep individual confidential 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 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 COVID-19, chicken pox, impetigo, head lice and many others, programs should 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.

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. 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 case or outbreak of any of these illnesses. Outbreaks involving two or more children of any communicable disease not on the list (such as head lice) must also be reported. During such reporting, identifying information about the affected child, including name, age, and how to contact the family, should be reported. See pages 1.84–1.86 for a list of reportable illnesses.

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.

Excluding Children Due to Illness

FOUR STEPS TO A HEALTHIER PROGRAM

STEP 1. Start the day with a health check. Perform a brief and casual assessment of each child every day upon arrival and before the parent leaves. You are familiar with what is typical for each child and can identify "red flags."

- **Listen** to what the child and parent tell you about how the child is feeling. Is the child hoarse, having trouble breathing, or coughing? Did he or she eat breakfast?
- **Look** at children from their level. Observe for signs of crankiness, pain, discomfort, or fatigue. Does the child look pale, have a rash, sores, or runny nose or eyes?
- **Feel** the child's cheek and neck with the back of your hand for warmth, clamminess, or bumps.
- **Smell** for unusual odors in their breath or diaper.

STEP 2. Distribute and explain your exclusion policies to parents and staff. Have a clear, up-to-date exclusion policy for illness and provide parents with a copy. Ask your health consultant or a health professional to review it periodically. Writing a sound policy and enforcing it consistently will help reduce conflicts. Make sure all staff persons understand the policies and how to enforce them. Have an orientation for staff and parents and explain your exclusion policy.

STEP 3. Understand the reasons for exclusion.

- The child doesn't feel well enough to participate comfortably in routine activities.
- The ill child requires more care than staff is able to provide without compromising the health and safety of the other children.
- The child poses a risk of spreading a harmful disease to others.

STEP 4. Notify parents. Inform parents of observed signs or symptoms, and promptly notify all families when a diagnosed communicable condition arises. Post a notice that includes the signs and symptoms to watch for, what to do, and when children with the condition can return.

EXCLUDING CHILDREN

Conditions for Which Exclusion Is NOT Recommended

Certain conditions, by themselves, do not require exclusion unless recommended by the child's health care provider or the public health department. However, the reasons listed in step 3 still apply.

- Common colds, runny noses (regardless of color or consistency of nasal discharge), and cough.
- Fever in the absence of any other signs or symptoms of illness.
- Presence of germs in urine or stool in the absence of symptoms of illness. Exceptions include potentially serious organisms such as *E. coli* 0157:H7, shigella or salmonella.
- Watery eyes with a clear, watery discharge and without fever, eye pain, or eyelid redness.
- Rash without fever and without behavior changes.
- Diagnosed CMV infection.
- Carrier of hepatitis B virus, if they have no behavioral or medical risk factors such as unusually aggressive behavior (biting), oozing rashes or bleeding.
- HIV infection, provided the child's health, immune status and behavior are appropriate as determined by that child's health care provider.

Symptoms or Conditions for Which Exclusion *Is* Recommended

For some conditions, exclusion can significantly reduce the spread of infection or allow children time to recover to the point where you can safely care for them:

- Fever along with behavior change or other signs of illness such as sore throat, rash, vomiting, diarrhea, earache, etc. Get medical attention when infants younger than 4 months have unexplained fever. In an infant younger than 2 months, a temperature above 100.4° F requires immediate medical attention.
- Symptoms and signs of possible severe illness such as unusual tiredness, uncontrolled coughing or wheezing, continuous crying, difficulty breathing, or severe abdominal pain.

- Positive COVID-19 test along with COVID-19 symptoms such as fever or chills, cough, shortness of breath, fatigue, muscle or body aches, headache sore throat, congestion or runny nose, etc. Return when symptoms are mild and improving.
- Diarrhea — runny, watery or bloody stools when the stool cannot be contained in a diaper or is causing accidents in a toilet trained child or the child is having more stools than is typical for that child in a day.
- Vomiting — more than two times in the past 24-hour period.
- Strep throat — until 24 hours after treatment has been started.
- Impetigo — until 24 hours after treatment has started.
- Mouth sores with drooling — until evaluated by a health care provider.
- Scabies — until 24 hours after treatment is applied.
- Any child determined by the local health department to be contributing to transmission of illness during an outbreak. For a list of reportable diseases see CCHP Health and Safety Note: Exposure to Communicable Disease.

WHAT TO DO WHEN A CHILD BECOMES ILL IN YOUR PROGRAM

- Attempt to keep the child from intimate contact with other children and staff. Remove and sanitize toys and other items they may have put into their mouth. WASH HANDS!
- Contact the parents to have the child picked up as soon as possible. Make the child as comfortable as possible. Do not isolate them in such a way that you cannot provide supervision at all times.
- Continue to observe the child for new or worsening symptoms.
- If the child does not respond to you, is having trouble breathing, or is having a seizure, call 9-1-1.
- Document your actions in the child's file with date, time, symptoms, actions taken, by whom, and be sure to add your signature.

When to Get Immediate Help

Some conditions require immediate medical help. If the parent can be reached, tell them to come right away and to notify their medical provider.

Call Emergency Medical services (9-1-1) immediately and also notify parents if any of the following happens:

- You believe a child needs immediate medical assessment and treatment that cannot wait for parents to take the child for care.
- A child has a stiff neck (that limits his ability to put his chin to his chest) or severe headache and fever.
- A child has a seizure for the first time.
- A child has a fever as well as difficulty breathing.
- A child looks or acts very ill, or seems to be getting worse quickly.
- A child's skin or lips look blue, purple or gray.
- A child is having difficulty breathing or breathes so fast or hard that he or she cannot play, talk, cry or drink.
- A child is vomiting blood.
- A child complains of a headache or feeling nauseous, or is less alert or more confused, after a hard blow to the head.
- Multiple children have injuries or serious illness at the same time.
- A child has a large volume of blood in the stools.
- A child has a suddenly spreading blood-red or purple rash.
- A child acts unusually confused.
- A child is unresponsive or has decreasing responsiveness.

Tell the parent to come right away, and get medical help immediately, when any of the following things happen. If the parent or the child's medical provider is not immediately available, call 9-1-1 (EMS) for immediate help:

- A fever in any child who appears more than mildly ill.
- An infant under 2 months of age has an auxiliary ("armpit") temperature above 100.4° F.
- An infant under four months of age has two or more forceful vomiting episodes (not the simple return of swallowed milk or spit-up) after eating.
- A child has neck pain when the head is moved or touched.
- A child has a severe stomach ache that causes the child to double up and scream.
- A child has a stomach ache without vomiting or diarrhea after a recent injury, blow to the abdomen or hard fall.

- A child has stools that are black or have blood mixed through them.
- A child has not urinated in more than eight hours, and the mouth and tongue look dry.
- A child has continuous, clear drainage from the nose after a hard blow to the head.
- A child has a medical condition outlined in his special care plan as requiring medical attention.
- A child has an injury that may require medical treatment such as a cut that does not hold together after it is cleaned.

EXPOSURE TO COMMUNICABLE DISEASE

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

The form on the next page will help you prepare a written notice to parents about exposure of their children to a communicable disease. The notice will alert them to watch for signs of that illness and seek medical advice when necessary.

Confidentiality

Please keep in mind that when notifying parents about exposure, the confidentiality of the ill person should be maintained. You should not report the name of the child, other family member, or staff member who is ill to other parents. Let the parents of an ill child know ahead of time that you will be sending exposure notices to other parents but will not mention any names.

Reporting Communicable Diseases to Outside Agencies

All licensed child care programs are required to report a case or outbreaks of some communicable diseases to both Community Care Licensing and the local public health department. A list of those diseases which are reportable in California is included on pages 1.84–1.86. An outbreak is defined as two or more known or suspected cases of a disease. However, the American Academy of Pediatrics strongly recommends that child care providers report even if there is only a single case, to ensure that the local public health department is aware that this serious illness is present in a child care setting.

Licensed child care providers are also required to report outbreaks of any disease, including diseases not on the list, such as head lice.

When you report to licensing and your local health department, the parents of the children must be informed that you are required to report the disease. The children's health care providers are also required to report communicable disease to the health department. We encourage you to work closely with the local health department to reassure and inform parents and staff.

The requirement to report communicable diseases to the local health department applies to any licensed facility, whether it is a center or family child care home. However, we strongly encourage unlicensed providers to report communicable diseases as well and work closely with their local health department. Include the telephone number of your local health department on your list of emergency contacts.

Parental Responsibilities

Just as child care providers have an obligation to report when children in care are exposed to a communicable disease, parents have the same obligation to report diseases to the child care program within 24 hours of a diagnosis, even if they keep their child at home. That way, the child care provider can alert other parents to watch for signs of that illness in their children and seek medical advice when necessary.

Exclusion Policies

Distribute and explain your exclusion policies to parents and staff before illness arises. Have a clear, up-to-date exclusion policy for illness and provide parents with a copy when they enroll their child in your program. Ask your health consultant or a health professional to review it periodically. Writing a sound policy and enforcing it consistently will help reduce conflicts. Make sure all staff understand the policies and how to enforce them.

Here is an example: The California Department of Public Health (CDPH) has issued up-to-date guidance for schools and child care on children with head lice. Community Care Licensing then posted a Provider Information Notice (PIN). https://www.cdss.ca.gov/Portals/9/CCLD/CCP%20PINs/PIN_19-09-CCP_Head_Lice_Information.pdf

Child care providers can use this reliable information when writing policies on caring for children with head lice.

Notice of Exposure to Communicable Disease

NAME OF CHILD CARE PROGRAM _____

ADDRESS OF CHILD CARE PROGRAM _____

TELEPHONE NUMBER OF CHILD CARE PROGRAM _____

DATE _____

Dear Parent or Legal Guardian:

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

INFORMATION ABOUT THIS DISEASE

The disease is spread by: _____

The symptoms are: _____

_____

_____

The disease can be prevented by: _____

_____

What the program is doing to reduce the spread: _____

_____

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

_____

_____

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

_____ at _____

(CAREGIVER'S NAME) (TELEPHONE NUMBER)

Suspected Illness or Communicable Disease Exclusion Form

NAME OF CHILD _____

FACILITY _____ DATE _____

Dear Parent or Legal Guardian:

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

- ☐ Diarrhea (more than one abnormally loose stool)
- ☐ Difficult or rapid breathing
- ☐ Earache
- ☐ Fever
- ☐ Gray or white stool
- ☐ Headache and stiff neck
- ☐ Infected skin patches
- ☐ Crusty, bright yellow, dry or gummy areas of skin
- ☐ Loss of appetite
- ☐ Puffy red eyes with discharge
- ☐ Tears, redness of eyelid lining
- ☐ Irritation
- ☐ Swelling and/or discharge of pus
- ☐ Severe coughing
- ☐ Child gets red or blue in the face
- ☐ Child makes a high-pitched croupy or whooping sound after they cough
- ☐ Severe itching of body/scalp
- ☐ Sore throat or trouble swallowing
- ☐ Unusual behavior
- ☐ Child cries more than usual
- ☐ Child feels general discomfort
- ☐ Cranky or less active
- ☐ Just seems unwell
- ☐ Unusual spots or rashes
- ☐ Unusually dark, tea-colored urine
- ☐ Vomiting
- ☐ Yellow skin or eyes
- ☐ Head lice or nits (wait until the end of the day to inform parent/guardian)

Contact your health care provider if there is:

- ☐ Persistent fever
- ☐ Breathing so hard child cannot play, talk, cry or drink
- ☐ Severe coughing
- ☐ Earache
- ☐ Sore throat with fever
- ☐ Rash accompanied by fever
- ☐ Persistent diarrhea
- ☐ Severe headache and stiff neck with fever
- ☐ Yellow skin and/or eyes
- ☐ Unusual confusion
- ☐ Rash, hives or welts that appear quickly
- ☐ Severe stomach ache that causes the child to double up and scream
- ☐ No urination over an 8 hour period; the mouth and tongue look dry
- ☐ Black stool or blood mixed with the stool
- ☐ Any child who looks or acts very ill or seems to be getting worse quickly

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

- ☐ The child can comfortably participate in the program
- ☐ We can provide the level of care your child needs
- ☐ Other: _____

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions *

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆! = Report immediately by telephone (designated by a ♦ in regulations).
† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations).
✆ = Report by telephone within one working day of identification (designated by a + in regulations).
FAX ✆✉ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
WEEK = All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)

Disease Name	Urgency	Disease Name	Urgency
Anaplasmosis	WEEK	Listeriosis	FAX ✆✉
Anthrax, human or animal	✆!	Lyme Disease	WEEK
Babesiosis	FAX ✆✉	Malaria	FAX ✆✉
Botulism (Infant, Foodborne, Wound, Other)	✆!	Measles (Rubeola)	✆!
Brucellosis, animal (except infections due to *Brucella canis*)	WEEK	Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic	FAX ✆✉
Brucellosis, human	✆!	Meningococcal Infections	✆!
Campylobacteriosis	FAX ✆✉	Middle East Respiratory Syndrome (MERS)	✆!
Candida auris, colonization or infection	✆	Monkeypox or orthopox virus infection	✆
Chancroid	WEEK	Mumps	WEEK
Chickenpox (Varicella)(Outbreaks, hospitalizations and deaths)	FAX ✆✉	Novel Coronavirus Infection	✆!

Disease Name	Urgency	Disease Name	Urgency
Chikungunya Virus Infection	FAX ✆✉	Novel Virus Infection with Pandemic Potential	✆!
Cholera	✆!	Paralytic Shellfish Poisoning	✆!
Ciguatera Fish Poisoning	✆!	Paratyphoid Fever	FAX ✆✉
Coccidioidomycosis	WEEK	Pertussis (Whooping Cough)	FAX ✆✉
Coronavirus Disease 2019 (COVID-19)	✆	Plague, human or animal	✆!
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)	WEEK	Poliovirus Infection	FAX ✆✉
Cryptosporidiosis	FAX ✆✉	Psittacosis	FAX ✆✉
Cyclosporiasis	WEEK	Q Fever	FAX ✆✉
Cysticercosis or taeniasis	WEEK	Rabies, human or animal	✆!
Dengue Virus Infection	FAX ✆✉	Relapsing Fever	FAX ✆✉
Diphtheria	✆!	Respiratory Syncytial Virus-associated deaths in laboratory-confirmed cases less than five years of age	WEEK
Domoic Acid Poisoning (Amnesic Shellfish Poisoning)	✆!	Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like illnesses	WEEK
Ehrlichiosis	WEEK	Rocky Mountain Spotted Fever	WEEK
Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic	FAX ✆✉	Rubella (German Measles)	WEEK
Escherichia coli: shiga toxin producing (STEC) including *E. coli* O157	FAX ✆✉	Rubella Syndrome, Congenital	WEEK
Flavivirus infection of undetermined species	✆!	Salmonellosis (Other than Typhoid Fever)	FAX ✆✉
Foodborne Disease	†FAX ✆✉	Scombroid Fish Poisoning	✆!
Giardiasis	WEEK	Shiga toxin (detected in feces)	✆!
Gonococcal Infections	WEEK	Shigellosis	FAX ✆✉
Haemophilus influenzae, invasive disease, all serotypes (report an incident less than 5 years of age)	FAX ✆✉	Smallpox(Variola)	✆!
Hantavirus Infections	FAX ✆✉	Syphilis (all stages, including congenital)	FAX ✆✉
Hemolytic Uremic Syndrome	✆!	Tetanus	WEEK
Hepatitis A, acute infection	FAX ✆✉	Trichinosis	FAX ✆✉
Hepatitis B (specify acute, chronic, or perinatal)	WEEK	Tuberculosis	FAX ✆✉
Hepatitis C (specify acute, chronic, or perinatal)	WEEK	Tularemia, animal	WEEK
Hepatitis D (Delta) (specify acute case or chronic)	WEEK	Tularemia, human	✆!
Hepatitis E, acute infection	WEEK	Typhoid Fever, Cases and Carriers	FAX ✆✉

Disease Name	Urgency	Disease Name	Urgency
Human Immunodeficiency Virus (HIV), acute infection	✆	*Vibrio* Infections	FAX ✆✉
Human Immunodeficiency Virus (HIV) infection, any stage	WEEK	Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)	✆!
Human Immunodeficiency Virus (HIV) infection, progression to stage 3 (AIDS)	WEEK	West Nile Virus (WNV) Infection	FAX ✆✉
Influenza-associated deaths in laboratory- confirmed cases less than 18 years of age	WEEK	Yellow Fever	FAX ✆✉
Influenza due to novel strains (human)	✆!	Yersiniosis	FAX ✆✉
Legionellosis	WEEK	Zika Virus Infection	FAX ✆✉
Leprosy (Hansen Disease)	WEEK	OCCURRENCE of ANY UNUSUAL DISEASE	✆!
Leptospirosis	WEEK	OUTBREAKS of ANY DISEASE (Including diseases not listed in **§2500**). Specify if institutional and/or open community.	✆!

HIV REPORTING BY HEALTH CARE PROVIDERS §2641.30-2643.20

Human Immunodeficiency Virus (HIV) infection at all stages is reportable by traceable mail, person-to-person transfer, or electronically within seven calendar days. For complete HIV-specific reporting requirements, see Title 17, CCR, §2641.30-2643.20 and the California Department of Public Health's HIV Surveillance and Case Reporting Resource page (https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_case_surveillance_resources.aspx)

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)

Pesticide-related illness or injury (known or suspected cases) **

Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593) ***

LOCALLY REPORTABLE DISEASES (If Applicable):

* The Confidential Morbidity Report (CMR) is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). The CMR form can be found here: Communicable Disease Reporting Forms. Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).

*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA on the California Cancer Registry website (www.ccrcal.org).

Revised 08/2022

RUNNY NOSE IN THE CHILD CARE SETTING

What Is It?

The child with a runny nose and stuffiness is a familiar problem in the child care setting. The nose is lined or covered by a delicate tissue called "mucosa" which produces mucus (sticky, slippery secretions) to protect the nose. If this tissue is irritated, it swells up, causing blockage and a lot of mucus. Sometimes children get repeated runny noses or permanent sniffles and a green nasal discharge, which are uncomfortable conditions for the child as well as child care provider.

What Causes the Runny Nose?

THE COMMON COLD is the most typical cause of a runny nose and chronic runny nose. This is generally a mild illness, and the child feels and looks well otherwise. The child usually gets better on his own within a week. The runny nose is usually accompanied by a mild fever. There may also be other symptoms such as headache, sore throat, coughing, sneezing, watery eyes, and fatigue.

Children with the common cold usually get better on their own within a week.

ALLERGIES can also cause a runny nose. They usually occur after two years of age and after the child has had plenty of exposure to allergens (the substances that can produce allergic reaction in the body). They might occur during a specific season or after a particular exposure — for example, after being around grass or animals. The child may also have watery and itchy eyes, sneezing, asthma, rubbing of the nose and a lot of clear mucus.

With allergies, the runny nose may last for weeks or months, but there is no fever or spread of disease to others.

BACTERIAL INFECTION (sinus infection) may occasionally develop and contribute to the continuation of illness. Young children with sinusitis may have some or all of these symptoms: a runny nose lasting for more than 10 to 14 days that may be clear or thick and green or yellow, postnasal drip, foul smelling breath, a daytime cough which may worsen at night, and swelling around the eyes.

Remember that yellow or green mucus does not always mean that a child has a bacterial infection. It is normal for the mucus to get thick and change color as the common viral cold progresses.

Is Green Mucus More of a Concern than Clear Mucus?

Children with clear mucous at the beginning of a cold are most contagious. Green nasal mucus (usually found toward the end of the cold) is less contagious than clear mucus. A runny nose usually starts with clear mucus which then becomes whitish or greenish as the cold dries up and gets better. This happens because as the body mounts its defenses against the virus, the white blood cells enter the mucus and give it the green color. Usually the green mucus is in smaller amounts and thicker, a sign that the cold is "drying up" and ending.

A child with a green runny nose that lasts for more than 10 to 14 days, and that may be accompanied by fever, headache, cough and foul-smelling breath, might be a sign of sinus infection. The child should have a medical evaluation.

When are Children Contagious?

The amount of virus present is usually highest two to three days before a person develops symptoms of the illness and continues to be present for two to three days after symptoms begin. As a result, infected children have already spread viruses before they begin to feel ill.

If a Person Is Infected, How Is the Infection Spread?

Germs may be spread to others by:

- Wiping a nose and then touching other people and objects before washing hands
- Sharing of mouthed toys by infants and toddlers;
- Coughing and sneezing into the air
- Kissing on the mouth
- Poor ventilation

How Can We Limit the Spread of Infection?

To prevent the spread of infection from respiratory illnesses and runny noses, follow routine preventive health practices:

- Avoid contact with mucus as much as possible.
- Make sure that all children and staff use good hand washing practices, especially after wiping or blowing noses, after contact with any nose, throat or eye secretions, and before preparing or eating food.
- Do not allow food to be shared.
- Clean and sanitize all mouthed toys and objects and surfaces used to prepare or eat meals and snacks.
- Wash eating utensils carefully in soapy water, then sanitize and air dry. Use a dishwasher whenever possible. Use disposable cups if you don't have a dishwasher or equipment and supplies to properly sanitize cups.
- Make sure that the facility is well ventilated and that children are not crowded together, especially during naps on floor mats or cots. Open the windows and play outside as much as possible, even in the winter.
- Teach children to cough and sneeze into their elbow, wipe noses using disposable tissues, throw the tissue into the wastebasket, and wash their hands.

When Should a Child with a Runny Nose Stay Home?

Exclusion policies should be based on your general illness policies, not merely the color of the mucus. For example, you might decide to exclude any child who is too sick to participate, no matter what the cause or color of the discharge.

Excluding children with runny noses and mild respiratory infections and colds is generally not recommended. As long as the child feels well, can participate comfortably and does not require a level of care that would jeopardize the health and safety of other children, he or she can be included.

Exclusion is of little benefit since viruses are likely to be spread even before symptoms have appeared.

When Should a Child with a Runny Nose Be Sent Home or Seen by a Health Provider?

- When a child with a runny nose looks more than mildly ill, has a rash, fever, difficulty breathing or seems to be in pain.
- When a child complains of earache and/or is pulling at his or her ears, which might be accompanied by fever and fussiness (all possible signs of ear infection).
- When a child has a green runny nose that lasts for more than 10 to 14 days accompanied by fever, headache, cough and foul-smelling breath.
- When a child has redness, sores and crusting of the skin around the nose and mouth.
- When an infant, especially under 4 months of age, has a fever, does not get better in a couple of days or gets worse.

Fever Fact Sheet for Families

What is a fever?

A fever is a rise in body temperature that is above normal. Fevers are common in young children and are most often a sign that the body is fighting an infection. Usually a fever is not harmful, and it may help your child fight an illness.

How do I know if my child has a fever?

If your child's forehead, chest or face feels warm you can take your child's temperature using a thermometer. Normal body temperature is about 98.6° F. A temperature higher than 100° F (38° C), taken under the arm, is usually considered a fever.

How do I take my child's temperature?

Electric, digital thermometers are most often used because they are accurate, low-cost, and easy to use. Temperatures can be taken:

- In the armpit (under the arm) — recommended for infants and toddlers.
- By mouth (under the tongue) — okay for children older than 4 years.
- Rectally (in the bottom) recommended for infants under 3 months.

In-ear and no-touch forehead thermometers are easy to use but may be less accurate. Temperature strips and pacifier thermometers are not recommended because they are less reliable. Mercury glass thermometers should not be used because they are breakable and the mercury is toxic.

How do I manage my child's fever?

WITHOUT MEDICATION:

A child with a fever, who is active and playful, usually does not require medication. Instead, focus on keeping your child comfortable:

- Dress your child in light weight clothing; do not overdress.
- Keep the room at a temperature that is not too hot or cold.
- Give extra fluids to prevent dehydration.

WITH MEDICATION:

Fever reducing medication is sometimes given to help a child feel more comfortable, and/or when a fever is very high. Check with your child's health care provider before giving medications such as Acetaminophen (Tylenol®/Tempra®) or Ibuprofen (Motrin®/Advil®)*. Always give medication according to instructions and use the measuring device that comes with the medication. **Don't give your child aspirin because of its association with Reye's syndrome.** Keep all medications out of children's reach.

When should I call a health care provider?

High or rapidly rising fevers can be a sign of a serious infection. Depending on your child's age, behavior, and other symptoms, you may need to seek medical help. Call your child's doctor if:

- Your child under 3 months has any fever, call your baby's health care provider immediately.
- Your child between 3 and 6 months has a fever above 101° F.
- Your child over 6 months has a fever above 103° F.
- Your child's fever lasts more than a few days.
- Your child has a fever and is not eating or playing or is having difficulty breathing.
- Your child has a stiff neck or rash.
- Your child has other signs of illness such as persistent diarrhea or vomiting, a cough or a severe sore throat.
- Your child has a seizure.
- Your child seems very sick or you have a question about your child's fever and are not sure what to do.

**The California Childcare Health Program does not endorse or promote any commercial products.*

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:

Name of Child Care Program: _____

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: _____

_____

_____

_____

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

_____

Should the child be temporarily excluded from care? Yes ☐ No ☐

If yes, 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 or Agency)

_____.
(Receiving Professional or 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:_____
(Print full name)

Date of Birth: ____ /____/ ____

Parent/Guardian Signature:_____

Parent/Guardian Name:_____ Date ____ /_____/ _____
(Print full name)

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 Health Care Health Policies. Bryn Mawr: PA: Authors

Staff Health Policies

An important part of setting health policies is to include those persons who keep the child care service going: yourself and your staff or family. A healthy staff is a key ingredient in high-quality child care. By paying attention to staff health issues, you will create a healthy workplace and a healthy place for children to play, learn, and grow.

WAYS TO PROMOTE GOOD ADULT HEALTH

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

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

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

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

Pre-Employment Screenings

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

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

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

Infectious Disease in Child Care Employees

Infectious diseases are common in child care programs. Most are not serious and would probably spread at a similar rate from children to adults in a large family setting. However, since child care staff care for a number of young children, many of whom cannot control their secretions and have not yet learned principles of hygiene, there is the potential for the spread of infections to the employee. Employees may infect other employees, children, family members, and in the case of a pregnant employee, the fetus. Therefore, it is important that employees be familiar with the infections that are common in the child care setting, and the measures they can take to prevent them. For details on these infections and ways to reduce their spread, see "Information on Specific Diseases" (Section 4).

Two important strategies which help prevent the spread of infection are immunization and standard precautions.

Health Risks for Pregnant Child Care Providers

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

- **Chickenpox (Varicella Virus):** First-time exposure to this virus during pregnancy may cause miscarriage, multiple birth defects or severe disease in newborns. Chickenpox can be a serious illness in adults. Most people (90 to 95 percent of adults) have had chickenpox or have been immunized against chickenpox and are immune. For women who do not know if they had chickenpox as a child, a blood test can verify their immune status.
- **Cytomegalovirus (CMV):** First-time exposure to CMV during pregnancy may cause hearing loss, seizures, mental retardation, deafness and/or blindness in the newborn. In the United States, CMV is a common infection passed from mother to child at birth. Providers who care for children under two years of age are at increased risk of exposure to CMV. Most people (and 40 to 70 percent of women of childbearing age) have been exposed to CMV and are immune. Pregnant staff should discuss their risk of CMV exposure with their health care provider.
- **Fifth Disease (Slapped Cheek):** First-time exposure to fifth disease during pregnancy may increase the risk of fetal damage or death. Most people (and 30 to 60 percent of women of childbearing age) have been exposed to the virus and are immune.
- **Rubella (German or Three Day Measles):** First-time exposure to rubella during the first three months of pregnancy may cause fetal deafness, cataracts, heart damage, mental retardation, miscarriage or stillbirth. Rubella can also be a severe illness in adults.

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

STAFF ILLNESS AND EXCLUSION POLICY

Conditions for Which Exclusion IS Required

See the table on the following page for a list of conditions requiring exclusion.

Health Limitations of Child Care Staff

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

- When they have experienced conditions that may affect their ability to do their job (such as pregnancy specific injuries or infectious disease).
- After serious or prolonged illness.
- Before return from a job-related injury.
- During the course of an identified outbreak of any communicable illness in the child care setting, if the health department or health consultant determines that they are contributing to the transmission of the illness at the setting.

Note: The Americans with Disabilities Act (ADA) requires that reasonable accommodations are made for people with disabilities in the workplace.

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

Condition	Exclude from Child Care Setting
Chickenpox	Until six days after the start of rash or when sores have dried/ crusted.
COVID-19	Check with your local public health department for exclusion criteria.
Shingles	Only if sores cannot be covered by clothing or a dressing; if not, exclude until sores have crusted and are dry. A person with active shingles should not care for immune-suppressed children, or work with immune-suppressed staff or parents.
Rash with fever or joint pain	Until six days after rash starts.
Measles and Rubella	Until diagnosed not to be measles or rubella, or as directed by the health department.
Vomiting	If two or more episodes of vomiting during the previous 24 hours, or if accompanied by a fever, until vomiting resolves or is determined to be due to such noninfectious conditions as pregnancy or a digestive disorder.
Pertussis (whooping cough)	Until after five days of prescribed antibiotic therapy, or as directed by the health department.
Mumps	Until nine days after glands begin to swell, or as directed by the health department.
Diarrheal illness	If three or more episodes of loose stools during previous 24 hours, or if diarrhea is accompanied by fever, until diarrhea resolves.
Hepatitis A	For one week after jaundice appears or as directed by health department, espec ially when no symptoms are present.
Impetigo (a skin infection)	Until 24 hours after prescribed antibiotic treatment begins and lesions are not draining.
Active Tuberculosis (TB) [not a positive skin test only]	Until the local health department approves return to the setting.
Strep throat (or other streptococcal infection)	Until 24 hours after initial antibiotic treatment, and fever has ended.
Scabies/head lice/etc.	Until after the first treatment; scabies until treatment has been completed.
Haemophilus Influenza Type b (Hib)	Until the prescribed antibiotic treatment has begun.
Meningococal Infection	As directed by the health department.
Respiratory Illness	If the illness limits the staff member's ability to provide an acceptable level of child care and compromises the health and safety of children or other staff.
Herpes cold sores	Should cover and not touch their lesions, carefully observe hand washing policies and must not kiss or nuzzle infants and children, especially those with dermatitis.
Other conditions mandated by state public health law	As required by law (consult your local health department).

Communicating about Illness in Child Care

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

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

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

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

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

Communication with the Child Care Health Consultant

Since few child care staff are trained as health professionals, each child care program should have access to a child care health consultant who can provide consultation and technical assistance on child health issues. This consultant should have expertise in child health and development, knowledge about the special needs of children in out-of- home child care settings, and the ability to link with public health resources.

The child care health consultant's basic function is to enhance the quality of child care programs by promoting optimal health and safety standards. The health consultant should seek to establish a relationship with child care providers; identify, implement, and evaluate strategies to achieve quality child care; establish basic health and safety operational guidelines and plans for the child care program and provider; and serve in a liaison capacity to other health professionals and community organizations. The child care health consultant service can range from providing information over the telephone to more extensive services on-site. The health consultant must work closely with the local public health, and in some cases, may be employed by the local public health department. Child Care Resource and Referral agencies may also employ child care health consultants or child care health advocates.

The child care health consultant can:

- Underscore the importance of a primary health care provider to serve as the "medical home" for each child.
- Link staff, families, and children with community health resources.
- Ensure a system for communication among the child care provider, parent, and primary health care provider and consult when health issues arise.
- Perform on-site assessments of health and safety in the child care environment and/or program policies and procedures.
- Assist child care providers in developing and reviewing policies (e.g. management of infectious diseases, fevers, use of medications, exclusion policies, injury prevention, and nutrition guidelines) and emergency preparedness plans for the child care program.

- Provide telephone consultation to child care providers as health and safety issues arise concerning specific policies and procedures.
- Help child care providers obtain, understand, and use information about the health status of individual children and staff.
- Educate children, their families, and child care providers about child development, mental and physical health, safety, nutrition, and oral health issues.
- Help identify and implement health and safety improvement plans.
- Educate and collaborate with licensing staff and policy makers to improve regulations, inspections, resources, and policies that promote inclusive, safe and healthy child care.

Communication with the Health Care Provider

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

Usually confidentiality limits your talking directly to a child's doctor or clinic. So if you want specific information about a child's acute or chronic condition, you must get written authorization to do so (see the "Consent for Exchange of Information" form).

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

Parent-Provider Communication

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

Reporting Requirements

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

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

Caring for Children with Mild Illness

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

BASIC ISSUES FOR DECISION-MAKING

Set Policies and Know When to Be Flexible

Fair exclusion policies weigh the risks of mildly ill children attending your program with the risks to other children and staff. Some illnesses do not pose a health threat to others while other illnesses may cause harm. Keeping mildly ill children at home or isolated at the child care setting may or may not prevent other children from becoming ill.

Appropriate reasons to exclude mildly ill children are:

- The child does not feel well enough to participate.
- The staff is not able to care for the sick child in the child care setting.
- The child's illness poses a risk of spreading a harmful disease to others.

Severity Level

Decisions should be made on a case-by-case basis. Child care facilities should specify in their policies what severity levels of illness they can handle and their plan of care should be approved by their health consultant.

SEVERITY LEVEL 1: Child is active and shows interest in participating in activities and has no symptoms of illness such as when recovering from pink eye or a rash. Appropriate activities for this level include most of the normal activities for the child's age and developmental level, including both indoor and outdoor play. For full recovery, children at this level need no special care other than medication administration (according to the policy) and observation.

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

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

For more information and recommendations for controlling the spread of specific infectious diseases, please see Module 1, Section 4, page 1.114.

Issues for Providers to Consider

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

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

Issues for Parents to Consider

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

Medication Administration Policy

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

Have a Written Policy

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

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

In the child care setting, you may be asked to give medications if:

- The dosage cannot be adjusted so that it can be taken before and after child care.
- A child has a chronic health condition (e.g. asthma, diabetes, allergies) which may require administration of medicine.

Disability rights laws (ADA) prohibit child care providers from excluding children solely because they have a disability-related need for medication. For a child with a disability (and diabetes, for example, meets the definition of disability) a child care center must take steps to "reasonably accommodate" the child's medical needs so that the child may fully participate.

Medications Which Can Be Given Safely

Limit medications given in your program to:

- Prescribed medications ordered by a health care provider for a specific child and a specific illness,
- Nonprescription medications recommended by a health care provider for a specific child, with written permission of the parent or legal guardian, referencing a written or telephone instruction received by the child care program from the health care provider,
- Medications which responsible staff have been trained to administer,
- Medications which bear their original prescription label or a manufacturer's label and which are provided in safety lock containers, transported and stored safely according to temperature, light and other requirements,
- Medications for which all the criteria on the program's approval form have been met.

Medication Which You Can Accept To Administer

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

- The first and last name of the child are on the container.
- The medication has been prescribed by a licensed health professional. Check to see that the name and phone number of the health professional who ordered the medication are on the container.
- The medication is in the original package or container.
- The container shows the date the prescription was filled.
- The container has a current expiration date.
- The container has specific instructions for administering, storing and disposing of the medication.
- The container is childproof.

- The medication is for the current episode of illness.

All medications, refrigerated or unrefrigerated, shall:

- Be kept in an orderly fashion.
- Be stored away from food.
- Be stored at the proper temperature.
- Be inaccessible to children.
- Not be used beyond the date of expiration.
- Be given only for the purpose identified in the label/prescription.

Who Should Be the Person Responsible for Administering Medication?

Someone who:

- Has designated time for administering medications.
- Has been trained to administer the type of medication.
- Will safely store and dispose of medication.
- Has access to locations where medication is stored and administration records are kept.
- Knows the child who will receive the medication.
- Knows about the potential reactions to the medications to be administered, and how to respond to such reactions.
- Knows when and how to contact parents, pharmacists or health providers to clarify the need and instructions for administration of medication in child care.

Which Records Should Be Maintained?

Maintain medication records that include the following:

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

Remember These Five "Rights" When You Give Medicines:

- The right MEDICINE
- The right CHILD
- The right DOSE
- The right TIME
- The right ROUTE (by mouth, or on skin, etc.)

Rational Use of Antibiotics

Antibiotics are powerful drugs that kill bacteria that cause disease. If a child in your care has a bacterial infection, his/her health care provider may prescribe a specific type of antibiotic for a specific period of time.

Antibiotic resistance is a growing concern and a major public health problem. The rise in antibiotic resistance prolongs illness, increases illness rates and results in higher and unnecessary health care costs.

Health care providers report that many parents, often asked by child care providers, try to pressure them into dispensing unnecessary antibiotics. Children treated with an antibiotic are at increased risk of becoming carriers of resistant bacteria. Carriers of a resistant strain who develop illness from that strain are more likely to fail antibiotic therapy. In some conditions, therefore, such as ear infection with fluid, observation without antibiotic therapy is the preferable option, while in other conditions such as the common cold or cough, antibiotic therapy is not indicated.

Child care providers can play a very important role in changing parents' awareness and understanding regarding the responsible use of antibiotics by having exclusion policies that do not exclude children unnecessarily or until a prescription is obtained.

POSTER

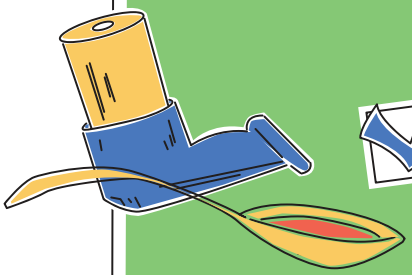
STOP INJURIES

MEDICATION ADMINISTRATION

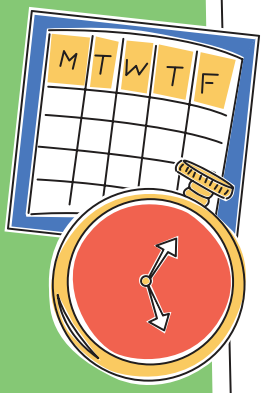
THE FIVE R's

- Right medication
- Right child

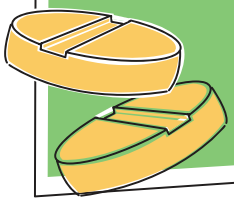
- Right amount



- Right time



- Right route



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MEDICATION ADMINISTRATION IN CHILD CARE PROGRAMS

If you care for children, especially infants and toddlers, it's more than likely that you will care for a child with an acute or chronic health condition that requires giving medication. If a child has a mild illness or a non-contagious illness that requires medication there is no reason to exclude that child from your program. However, it is important to develop plans to assure that medications are given safely and stored correctly, and to seek advice when needed. All staff who work with children should have training on these practices.

- Check that the name of the child listed on the medication and the child receiving the medication are the same.
- Read and understand the label/prescription instructions related to measured dose, frequency, and other circumstances related to administration (such as in relation to meals).
- Administer the medication according to the prescribed methods and prescribed dose.
- Observe and report any side effects from medications.
- Document the administration of each dose by recording time and amount given.

Medication should be given at home whenever possible, but there will be times when it must be given while the child is in child care. States have different regulations; be sure you understand the regulations for your state. California Community Care Licensing (CCL) regulations permit child care providers to administer medications under the following conditions:

- All prescription and nonprescription medications must bear the child's name and date.
- All medications must be administered according to the label direction. Permission and instructions must be provided by the parent for each medication. The instructions should not conflict with the label directions and should be filed in the child's record.

Nonprescription medications do not require approval of the child's health care provider if administered according to the product label and if parental approval and instructions are provided in writing from the parent. The instructions from the parent cannot conflict with the product label and must be filed with the child's records. (Please note that *Caring for Our Children* recommends obtaining a written approval or instruction from the child's health care provider.)

- Record administration of medication and inform the parent of daily medication administration.
- When no longer needed, return all medications to the parent.
- Always store medications in their childproof containers out of children's reach.

Most Frequently Given Medications in Child Care Programs

- **Antibiotics** (given by mouth) — used to treat bacterial infections of the ear, respiratory tract, urinary tract or skin.
- **Acetaminophen** (e.g. Children's Tylenol or Panadol)– used to treat fever and pain.
- **Antihistamines** (e.g. Benadryl) — used to treat allergic reactions such as runny nose or hives.
- **Bronchodilators** — used to prevent or treat asthma attacks. Special equipment such as inhalers or nebulizers is also needed to give bronchodilators. When a nebulizer is needed, a special form from CCL must be completed by the parent and child care provider.
- **Eye medication** (liquid or ointment administered directly into the eye) — used to treat bacterial eye infections or "pink eye."
- **Iron** (by mouth) — used to treat anemia.
- **Topical medications** — used to treat skin conditions such as diaper rash, infections.
- **Medications for chronic conditions** — used to treat seizure disorders, cystic fibrosis, and other chronic illnesses.

LIC 9221

California Health & Human Services Agency | California Department of Social Services

PARENT CONSENT FOR ADMINISTRATION OF MEDICATIONS AND MEDICATION CHART

NOTE: *Regulation Section 101221 requires the following information be on file.*

Child Care Center Name:	License Number:	Date:

PARENT'S INSTRUCTIONS:

1. All prescription and nonprescription medications shall be maintained with the child's name and shall be dated.
2. Prescription and nonprescription medications must be stored in the original bottle with unaltered label. Medications requiring refrigeration must be properly stored.
3. Prescription and nonprescription medication shall be administered in accordance with the label directions.
4. Written consent must be provided from the parent, permitting child care facility personnel to administer medications to the child. Instructions shall not conflict with the prescription label or product label directions.

Child's Name:	Date Of Birth:
Medication Name:	Dosage:
I authorize child care personnel to assist in the administration of medications described above to the child named above for the following medical condition/s:	
From _____ to _____ at _____ daily while in attendance. Beginning Date Ending Date Time of Day	
Parent's Signature:	Date:

MEDICATION CHART
Staff Documentation of Medication Administration

Date:	Time Given:	Staff Signature:
Date:	Time Given:	Staff Signature:
Date:	Time Given:	Staff Signature:
Date:	Time Given:	Staff Signature:
Date:	Time Given:	Staff Signature:

Upon completion, return medicine to parent or destroy, and place form in child's record.

Staff:	Date:

LIC 9221 (5/22)

Common Routes (Ways) Medication Is Given

Oral medication can be solid such as tablets or capsules or can be liquid such as elixirs or suspensions. All oral medications should be followed by two to four ounces of water unless otherwise indicated.

Eye drops require some preparation. First gather supplies (medications, tissue, gloves) and wash hands. Clean eyelids, if necessary, wearing gloves. Position child on back or if seated, with head tilted back. Gently but firmly pull down lower lid and insert medication drops into pocket formed by lower lid. Be careful not to touch the eye or eyelid with container. Wipe closed eye with tissue. Praise the child for helping and wash your hands after removing the gloves. To apply eye ointment, follow the same procedure but drop a line of ointment along the lower lid, again without touching the container to the eye.

Topical medications are applied to skin. First, clean the skin where you will be applying the medication. Wear gloves. Apply medication using applicator, gauze or gloves. Cover area if directed.

Inhaled medication is delivered by a spray bottle, inhaler or nebulizer. The medication forms a fine mist to be inhaled. A nasal spray is fairly easy to administer in older children who can cooperate. Ask them to hold one nostril closed while you squirt and they inhale the medication into the open nostril. Medication delivered by an inhaler or nebulizer requires special training from the parent or health care provider and specific written instruction and warnings. The nebulizer is a machine that requires special cleaning after each use and instructions on its use must be provided by the parent and health care provider. There is a form available from CCL that discusses the appropriate training.

Injected medication is delivered through a syringe/needle. Special training and written procedures are required when providing incidental medical services in licensed child care settings (such as insulin injections and blood glucose testing for diabetes).

Tips for Administering Medication by Age

FOR INFANTS

Assemble all supplies within reach — medication, tissues, measuring devices — and wash your hands. Measure the correct amount of medication. If you are not able to hold the infant and give the medication at the same time, ask for help. Talk to the infant and gently touch his or her mouth with the dropper or medication syringe. If his or her mouth doesn't open, gently pull down the chin. Make smacking sounds with your mouth to model what you want. When the infant's mouth is open, place the dropper or syringe on the middle of the tongue and slowly drop the medication a little at a time. If the infant does not cooperate, gently slide the dropper or syringe between the inside of cheek and gums and slowly drop in medication. Or, try dropping premeasured amount of medication into a bottle nipple and let the infant suck it up.

FOR TODDLERS AND PRESCHOOLERS

Follow the same preparation as for infants, but try to prepare toddlers by letting them know you are going to be giving medication and you will need their help. Pre-measured medication may be placed in a spoon or in a small cup. If they are cooperative they may not need your help and will do it themselves; if not, you may have to firmly hold them while you use a dropper or medication syringe to place medication in the mouth between cheek and gums. Allow time for the medication to be slowly swallowed. Always praise children for their cooperation.

Medication Storage

Medications should always be stored in their original container in a secure place out of the reach of children. Refrigerated medication should be stored separate from food in a plastic container or zip-lock bag in the refrigerator. Storing medication in clear plastic containers where it can be seen will help providers remember to give it. Do not freeze medication. If the medication is left unrefrigerated for a long period of time, check with a pharmacist to see if it is still effective.

Reactions

Children may react to the medications you administer. Typical reactions include rashes, tiredness and irritability. It's also very common for children to have diarrhea during antibiotic treatment, although as long as it can be contained in the pants or diaper there is no reason to exclude a child for this kind of diarrhea. If you have any concerns about a reaction, notify the parent and seek advice from the health care provider or pharmacist.

Special Situations

A number of situations may arise related to administering medication in child care:

- Parents may ask you to give their child herbal remedies. Because many remedies are not standardized, it's best not to give them. Suggest that parents administer these at home instead.
- Parents may not want to reveal what condition their child has. You must respect their desire for confidentiality, but you still need to know if there are any medication reactions to watch for. Remember that a child's medication or health condition cannot be discussed with anyone without the parent's permission.
- You may unexpectedly need to give children a fever-reducing medication or something for pain if they become sick during the day. In these cases, it's acceptable to get permission from a parent by text message or email and follow the manufacturers' instructions for over-the-counter medication. You must then get written permission when the parent picks up the child.

Working with a Pharmacist or Health Care Provider

Patient information sheets on medications provide a wealth of information. They may be obtained free from pharmacies with each prescription and for nonprescription drugs upon request, or downloaded from www.nlm.nih.gov/medlineplus/druginformation.html. The sheets describe how the drug works, what to do if a dose is forgotten, and which side effects might occur. Request that parents bring the information sheet with the medication so the child care staff will be more informed, but don't hesitate to ask questions of the prescribing health care provider or pharmacist if you need more information.

Safeguards to Prevent Errors

- Assign a staff member to administer medications at the right time.
- Consult with the parent, pharmacist or health care provider if uncertain about the next dose.
- If a medication is crucial and has been left at home, ask the parent to return home and get medication before the child is admitted for the day. Establish a system for ensuring that medications are returned each day to the family for use at home.
- Develop systems to alert all staff members that a child has medication — something as simple as a red dot next to a child's name on the sign-in sheet can be a good reminder.
- Set an alarm clock for the times of administration.
- Use measuring devices that come with the medication, rather than household utensils, which are not accurate. Read the measured amount at eye level.
- Do not accept medication without written, understandable instructions. Check with a pharmacist or the child's health care provider if the instructions conflict with the label.
- Require that prescribed medication must have the child's name and current date.
- Make certain that medication is always administered by trained staff who know the children.
- Always provide written notification of medication administered so that the parent or other caregivers will know when to give the next dose.
- If a medication error is made, notify the parent immediately and consider seeking advice from the child's pharmacist or health care provider.

REMEMBER THE FIVE Rs

Right Medication is given to the **Right Child** using the **Right Amount** at the **Right Time** given by the **Right Route**

ALWAYS CHECK

Parental Permission — must be in writing and filed in the child's record, see LIC-9221

Medication Label — the child's name, dosing instructions, special instructions

Parent Notification — use standard form to notify parents of medication given

Allergies and Reactions — check before giving medication if the child has allergies and watch for reactions afterward

Children with Disabilities or Special Health Needs

Children with developmental disabilities, chronic illness or weak immune systems warrant special consideration either because they are unusually susceptible to infection or because they may infect other children.

Children with Developmental Disabilities

In general, children with developmental disabilities are not particularly vulnerable to infection and require no special precautions or procedures. A few categories of disabilities are associated with higher rates of infection, however, such as children with spina bifida, cerebral palsy or Down syndrome.

The *Americans with Disabilities Act* (ADA) protects individuals with disabilities and requires that every effort be made to reasonably accommodate disabilities. Child care providers are expected to modify their basic policies, practices and procedures to make reasonable accommodation to include children with disabilities in their programs. In most cases, such accommodation is compatible with a safe and healthy environment from which all the children in the child care setting can benefit.

Child care providers must offer services in the most natural setting appropriate to the needs of the individual. In addition to making physical changes such as installing ramps, wide doors and restrooms that can accommodate children in wheel chairs, you may need to provide for a child's special physical, emotional or psychological needs. Other special needs may include assistance in feeding, following special dietary requirements, giving medicines and/or performing medical procedures, and ensuring that special equipment is functional or is used properly. There is help available through many different programs to assist providers in properly caring for children with special needs.

Before you admit a child with developmental disabilities, make sure that you can comfortably answer the following questions:

- Does the child's disability require more care than you are reasonably able to provide?
- Do you have the skills and abilities needed to perform medical or other duties required for the child's care, or can you readily acquire those skills?
- Is your child care program equipped to meet the health and safety needs of this child? Is the extra time you will need to devote to taking care of this child more than you can handle without putting the other children in your care at increased risk for illness or injury, or without causing you to neglect their needs?

The *Americans with Disabilities Act* requires that as a provider responsible for all the children in your care, you should ensure that the extra demands on your time to care for a child with special needs are supported with additional resources, including help from experts. You should work with the child's parents and health care professionals to make sure that you have the support you need.

Many child care providers are concerned that certain infections acquired before or around the time of birth (e.g., rubella, CMV, herpes simplex, hepatitis, and AIDS) may persist and be spread to other children or staff members. In some cases, these congenital infections pose a very small risk to others, and with proper precautions, affected children may safely participate in most child care or educational programs. In other cases, special precautions are warranted.

Children with Chronic Illness

Children with chronic illnesses, weakness or malnutrition are particularly vulnerable to infection. For example, infants who were premature, children who have chronic lung disease and children with cystic fibrosis frequently have a higher than average incidence of respiratory infections. Similarly, children with congenital heart disease may have unusual difficulty with some respiratory viruses. Children with diseases or structural abnormalities of the urinary tract are highly vulnerable to infections of the bladder and kidneys. Although it is not always possible to prevent these diseases, providers should be alert to the symptoms of infection and notify the child's parents and/or health care provider if they occur. Once treatment is initiated, these children should be able to participate in regular group care activities.

Children with Weak Immune Systems

Certain diseases or treatments can lower the body's natural defenses against infection. AIDS, cancer of the blood and some other diseases of the immune system significantly change the body's ability to fight infection, allowing even common organisms to quickly become life threatening. In children with previously normal immune systems, some drugs that are used to treat chronic conditions (e.g., steroids) suppress the body's ability to fight infection. Drugs used to prevent rejection of organ transplants or to temper the body's attack on its own organs can also interfere with the normal immune response. In a child with cancer, both the disease itself and the drugs used to treat it inhibit the body's defense mechanisms.

Children with diseases or treatments that affect the immune system may need to be isolated from other children during periods of particular sensitivity. Their health care providers may prescribe special precautions regarding limited exposure to infection, particularly to chickenpox, since this disease can be fatal for people with suppressed immunity. Keep in mind that vaccines with live viruses such as measles, rubella, chickenpox and polio (OPV) are not recommended for people with known weak immune systems.

Despite the risks of spreading or getting infections, children in these special population groups need to have opportunities for learning and socialization that are as normal as possible. With care and planning, the majority of these children can be safely integrated into child care and school settings. Administrators, teachers and child care providers should work closely with parents and health care providers to establish a safe environment for these children, their peers and staff members who care for them.

Special Health Care Plan

To be completed by the Child Care Health Consultant or Health Advocate. The Special Health Care Plan provides information on how to accommodate the special health concerns and needs of this child while attending an early care and education program.

Name of Child:_____Date:____/____/_____

Name of Child Care Program: _____

Description of Health Condition(s)

List description each health condition:

_____

_____

Team Member Names and Titles (include parents)

Parent/Guardian_____

Health Care Provider (MD, NP)_____

On-site Care Coordinator_____

_____

Team Members; Other Support Programs Outside of Child Care (name, program, contact information, frequency)

□ Physical Therapist (PT)_____

□ Occupational Therapist (OT) _____

□ Speech & Language Therapist: _____

□ Social Worker: _____

□ Mental Health Professional/Consultant: _____

□ Family-Child Advocate: _____

Other:_____

Communication

The team will communicate: □ Daily □ Weekly □ Monthly Other_____

The team will communicate by: □ Notes, □ Communication log, □ Phone, □ E mail, □ In Person Meetings,

□ Other_____Dates and times_____

Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) is attached. □ Yes □ No

Staff Training Needs

Type of training:_____

Training will be provided by:_____

Training will be monitored by:_____

Staff who will receive training:_____

Dates for training:_____

Plan for absences of trained personnel responsible for health-related procedure(s):

_____

_____

Special Health Care Plan

Medical Information

Medical information from the Health Care Provider is attached: □ Yes □ No

Information Exchange Form cchp.ucsf.edu/InfoExchangeForm has been completed

by Health Care Provider: □ Yes □ No

Medication to be given: □ Yes □ No

Medication Administration Form has been completed by health care provider and parents: □ Yes □ No

Allergies: □ Yes □ No if yes, list:_____

Safety

Strategies to support the child's needs and safety issues while in child care: (e.g., diapering/toileting, outdoor play, circle time, field trips, transportation, nap/sleeping)_____

_____

_____

Special equipment:_____
Positioning requirements:_____
Equipment care/maintenance:_____

Nutrition and Feeding Needs

A Nutrition and Feeding Care Plan has been completed □ Yes □ No
Allergies to food: □ Yes □ No if yes, list:_____
Other feeding concerns:_____

Behavior Concerns

List specific changes in behavior that arise as a result of the health-related condition/concerns _____

_____

_____

Emergencies

Emergency contact:_____Telephone: _____
Health Care Provider:_____Telephone:_____
Emergency Information Form Completed □ Yes □ No

Follow-up, Updates, and 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:_____/_____/_____.

Attach additional information if needed. Include unusual episodes that might arise while the child is in care, how the situation should be handled, and special emergency or medical procedures that may be required.

Quality Inclusive Child Care Checklist

- ☐ Are families and children welcomed, and are children greeted in a loving, respected way? Are parents welcome at anytime during the day?
- ☐ Is the overall atmosphere bright, cheerful and child-focused, without being overwhelming?
- ☐ Do you notice caregivers/teachers really listening to children and families?
- ☐ Are caregiving and teaching practices responsive to differences in children's abilities, interests and experiences?
- ☐ Are the sounds of children predominantly happy? Does it appear that the adults and children enjoy being together?
- ☐ Is the physical environment safe, secure and free of barriers that limit or prevent access and mobility (e.g., ramps, outside play area, bathrooms)?
- ☐ Is there a fenced-in outdoor play area with a variety of safe equipment? Can the caregivers/teachers see the entire play yard at all times?
- ☐ Are learning materials and toys sufficient, safe, clean and within reach of all children? Are there enough for the number of children?
- ☐ Are there different areas for resting, quiet play and active play? Is there enough space for the children in all of these areas?
- ☐ Is there a daily balance of active and quiet activities (e.g., play time, story time, activity time and nap time)? Are the activities appropriate for each ability and age level?
- ☐ Are the majority of planned developmental activities individualized or in small groups?
- ☐ Do learning materials, books and pictures reflect diversity, including children with special needs?
- ☐ Do caregivers/teachers use a variety of instructional strategies to meet the individual needs of children?
- ☐ Do caregivers/teachers facilitate or enhance interactions between children with and without disabilities?
- ☐ Are children with disabilities included socially and engaged in meaningful activities throughout the day?
- ☐ Are children with disabilities given support and assistance when needed, and is it unobtrusive?
- ☐ Does the program accept children who are not yet walking or toilet-trained?
- ☐ Are therapeutic and/or support services such as OT, PT and Speech Therapy welcomed and provided on-site?
- ☐ Are parent's ideas welcomed? Are there ways for families to be involved in the program?
- ☐ Does communication between parents and staff seem open and ongoing? Are events and information shared with families regularly?
- ☐ Is the program licensed by the state? Is the program accredited or working towards national accreditation?

When observing and listening, pay particular attention to these five key indicators of quality inclusive child care:

A Positive and Happy Learning Environment

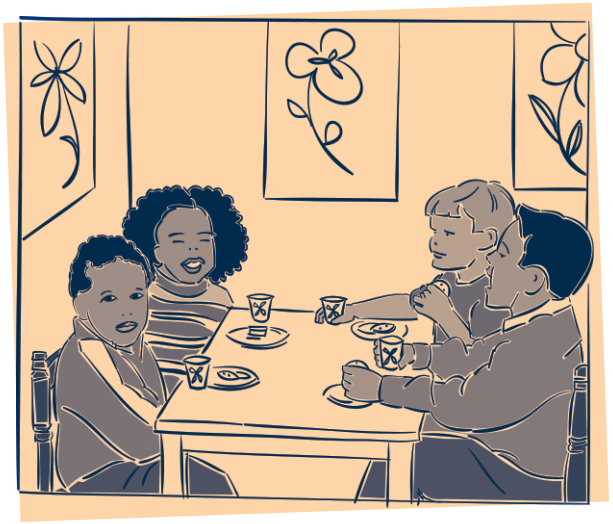
- Are the children engaged?
- Are staff involved with children at eye-level?
- Are the rooms bright and cheerful without being overwhelming with too many sights and sounds?
- Do the adults speak positively about all children?

The Right Number and Mix of Children and Adults

- Are all children receiving individual attention?
- Do adults call children by name?
- Are children comforted, when needed, by staff or other children?
- Does staff overuse the "time-out" tactic?

Trained and Supported Personnel

- Are caregivers trained in early childhood education and special needs?
- Are teaching staff available to attend school district educational meetings with families who have children in their program who are receiving special education services?
- Do those who work with children themselves receive positive support?



A Developmental Focus on the Child

- Do you see and hear a variety of developmental activities taking place?
- Do the children have opportunities to control objects and events in their environment?
- Are activities based on the children's level of functioning?
- Are learning materials accessible to children with special needs?

Parents Treated as Partners

- Does child care personnel help families develop goals for children and plans to achieve them?
- Does the program provide families with regular schedules of activities and events?
- Does the child care staff describe their communication practices as "open"?
- Do families actively participate with the children?

Emergency Illness and Injury Procedures

When families enroll their child, they should provide you with the contact information and consent that you will need if there is an emergency involving that child.

All families of children in your care should know your emergency procedures. Let families know that you are trained in first aid and CPR as taught by a California approved training program. Tell parents how often you take refresher courses. Tell them that in the event of an emergency, you will:

- Quickly assess the child's health.
- Call 9-1-1 or other appropriate emergency help as needed.
- Give first aid and CPR, if necessary.
- Contact families or the person they have listed to call in an emergency.
- Call Poison Control if their child is exposed to toxic substances.

At All Times, You Should:

- Have emergency numbers posted by the phone: police and ambulance (9-1-1), and the poison control center (1-800-222-1222).
- Keep families' consent forms for emergency treatment and numbers for emergency contacts on file, and take a copy with you whenever you leave the facility.
- Maintain a current CPR and first aid certificate.
- Post first aid procedures where they can be easily seen.
- Write up an emergency procedure and evacuation route. Make sure you are familiar with it.
- Keep a fully stocked first aid kit in easy reach of all providers, but out of reach of children. Check the first aid kit regularly and restock it as necessary.
- In addition to the supplies listed for your first aid kit, you should also keep ice cubes or ice bags in the freezer to use to reduce swelling of some injuries.
- Place a stocked first aid kit in every vehicle used to transport the children. In addition to the items in your child care program's first aid kit, your vehicle kit should also include a bottle of water (refreshed on a regular basis), soap, and a first aid guide.
- Don't use first aid sprays and ointments. They may cause allergic reactions or skin damage.
- Wear gloves if you might come in contact with blood.
- Have first aid supplies handy on the playground. Consider keeping a zip-lock plastic bag stocked with disposable gloves, sterile wipes, gauze wrap and bandage strips in your pocket.

If an Injury Occurs:

1. Stay calm.
2. Check for life-threatening situations (choking, severe bleeding, or shock). Do not move a seriously injured child.
3. Call 9-1-1 or your local emergency number, if the child is seriously hurt. Make sure other children are safe.
4. Give CPR or first aid, if necessary.
5. Contact the family/emergency contact.
6. Record all injuries on a standard form developed for that purpose.

No Smoking or Use of Alcohol or Illegal Drugs

Smoking is prohibited in licensed child care programs in California. A policy that prohibits electronic cigarettes, alcohol, and using or having illegal drugs in your setting should be in place. The use of some legal drugs (for example, marijuana and prescribed narcotics) that can diminish the ability to properly supervise and care for children should also be prohibited.

No children, especially those with respiratory problems, should be exposed to additional risk from the air they breathe. Inhaling secondhand cigarette smoke has been linked to respiratory problems in children and is especially dangerous for young infants. Children exposed to cigarette smoke are at increased risk of dying of sudden infant death syndrome (SIDS) and developing bronchitis, pneumonia and ear infections when they get common respiratory infections such as colds. Children with asthma are at risk of having their conditions get worse when they are exposed to cigarette smoke. Smoking tobacco is prohibited in licensed child care centers and family child care homes.

As more states legalize marijuana use for recreational and/or medicinal purposes, it is important for caregivers/teachers to be aware of the impact marijuana used medicinally and/or recreationally has on their ability to provide safe care. Modeling healthy and safe behavior at all times is essential to the care and education of young children. (*Caring for Our Children*, 2017)

Information on Specific Diseases

You can find up-to-date information sheets on the following illnesses at https://cchp.ucsf.edu/content/illness-sheets

- Amebiasis
- Campylobacter
- Chickenpox
- Common Cold (Upper Respiratory Infections)
- Conjunctivitis (Pink Eye)
- Cytomegalovirus (CMV)
- Ear Infections (Otitis Media)
- Fifth Disease (Slapped Cheek Disease)
- German Measles (Rubella)
- Giardiasis (Giardia)
- Haemophilis Influenzae Infections
- Hand-Foot-and-Mouth Disease (Coxsackie Virus A16)
- Head Lice (Pediculosis)
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Herpes (“Cold Sores” or “Fever Blisters”)
- HIV/AIDS
- Impetigo
- Influenza
- Kawasaki Disease
- Measles
- Meningitis
- Molluscum Contagiosum
- Monilia (Candida) or Yeast Infections (Thrush)
- Pinworms
- Respiratory Syncytial Virus (RSV)
- Ringworm (Tinea)
- Roseola (Sixth Disease)
- Rotavirus Infections
- Salmonella
- Scabies
- Shigellosis
- Strep Throat and Scarlet Fever
- Tuberculosis (TB)
- Whooping Cough (Pertussis)

Preventive Health and Safety in the Child Care Setting

A Curriculum for the Training of Child Care Providers

SIXTH EDITION

MODULE 2
Prevention of Injuries

UCSF California Childcare Health Program

Prevention of Injuries

MODULE CONTENTS:

ESTIMATED TRAINING TIME BY MODULE TOPIC

SECTIONS	TOPICS	TIME (Minutes)
1. Understanding Childhood Injuries	Understanding Injuries in the Child Care Setting	5
	Risk of Injury at Developmental Stages	10
2. Preventing Childhood Injuries	SIDS and Other Sleep-Related Infant Deaths	30
	Shaken Baby Syndrome/Abusive Head Trauma	10
	Brain Injury and Concussion	5
	Child Abuse Prevention	10
	Burns and Fire	5
	Heat-related Illness	5
	Choking, Suffocation, Strangulation, Entrapment	5
	Falls	5
	Poisoning, Lead Poisoning	15
	Drowning	5
	Young Children and Disasters	5
	Child Passenger Safety	5
	Field Trip Safety	5
	School Bus Safety	5
3. Safety Policies and Routines	Active Supervision	10
	Regular Safety Checks Inside and Outside	5
	Safe Playground Habits	10
	Safety Policies and Behavior Management	5
	Back Injury Among Providers	10
	Forms and Checklists	10

Total Training Time Recommended for Module 2: 3 hours

Training Tip: Remember to plan for breaks to stretch, drink water, and use the restroom.

Understanding Childhood Injuries

TRAINER GUIDE

SECTION TOPICS

- Understanding Injuries in the Child Care Setting
- Risk of Injury at Developmental Stages

Rationale: Young children are at risk for injuries because they are learning and curious. The various risks of injury change as children grow and develop.

Time: 15 minutes

Learning Objectives

Participants will:

1. Understand how child development influences the risk of injury.
2. Be aware of conditions in which common childhood injuries occur.

Teaching Methods/Suggested Activities

- **Brainstorming or Small Group Activity:** Ask participants to list potential injuries based on children's developmental stages.
- **Lecture:** Review and discuss what a child care provider needs to know about childhood injuries and what to do to reduce the risk of injury.
- **Questions/Answers:** Respond to any questions that the group may have. Ask questions and emphasize important points that highlight the main concepts.

Materials and Equipment Required

STUDENT HANDOUT:

- Risk of Injuries and Stages of Development Table

OTHER MATERIALS:

- Flip Chart/Chalkboard/Whiteboard
- Presentation Slides (if using a computer and LCD projector)

Questions/Comments: Stress that child care providers should use all measures possible to protect the children and prevent injury. Active supervision, environmental safety, developmentally appropriate activities, and clear polices work together to reduce the risk of injury.

Understanding Injuries in the Child Care Setting

INJURY PREVENTION

Unintentional injuries are the leading threat to the lives and health of children. These injuries do not happen because of fate, chance or bad luck. Child care providers should realize that injuries to children are understandable, predictable and preventable. Injury prevention is an essential part of quality child care programs, and a major responsibility of child care providers. By understanding how injuries happen, planning ahead and taking simple precautions, most injuries can be avoided.

National standards developed by the American Public Health Association and the American Academy of Pediatrics stress injury prevention in the development of policies and procedures and in daily practices.

The goal of injury prevention is to reduce the number and seriousness of injuries. It is important to identify potential hazards in the child care environment and to promote preventive actions such as environmental modifications, enforcement of safety policies and behavioral changes.

Prevention Strategies

Strategies for prevention of injuries in the child care setting can be translated into practice by:

- Conducting regular safety checks to identify hazards
- Modifying the environment to reduce hazards
- Supervising children
- Setting and enforcing rules for playground activities
- Educating children, parents and staff members about the importance of injury prevention

INJURIES IN THE CHILD CARE SETTING

Injuries occur as a result of unsafe conditions in the environment, participation in activities which are not developmentally appropriate, and/or a lack of adult supervision. Age and sex of children, size of the facility, adult-to-child ratio, specific program offerings (e.g., swimming and field trips), playground equipment, supervision, and enforcement of policies and regulations are some of the factors that may influence the risk of injury in child care settings.

Successful strategies for preventing child care injuries require a better understanding of injuries—what injuries happen, to whom, where, how, and when.

What Types of Injuries Are Common?

Children attending child care are most likely to face the following types of injuries:

- Minor injuries such as cuts, scrapes and bruises
- Severe injuries such as head injuries, broken bones, internal injuries, dislocations, or dental injuries
- Poisoning
- Drowning
- Burns
- Choking and suffocation

Who Gets Injured? Studies Show That:

- Injury rates are low for infants and increase with the age of the child. Injuries are most frequent among two- to five-year-olds.
- The difference in rates of injuries for boys and girls in preschool is small.

How Are Children Injured?

The following factors contribute to injuries and may be divided between child-related factors and environment-related factors:

- Falls are the leading cause of serious injuries. The playground is the major site of injury in the child care setting and accounts for 50 to 60 percent of all child care injuries. Sometimes furniture, stairs or windows are also involved.
- Another child is involved (fighting, pushing, colliding, throwing, or biting).

- The child collides with objects such as moving playground equipment, furniture, part of the building, plants, toys, a fence or gate, etc.
- The child is cut by a sharp edge, burned by a hot surface, hot tap water or heater, or poisoned by toxic materials or substances.
- Injuries occur related to transportation and cars.

When Do Injuries Happen?

- Injuries happen more often during outdoor play
- Injuries happen more often when children are hungry or tired, and when providers are busy or distracted.

Why Are Children at Risk of Being Injured?

- They imitate others without having the skills.
- They are naturally curious and like to explore.
- They don't know about hazards in the environment.
- They can't read safety warnings.
- They haven't learned how to avoid getting hurt.
- They don't understand cause and effect.

CHILDHOOD INJURIES:

What

- Minor injuries (such as cuts, scrapes, and bruises)
- Severe injuries (such as head injuries, broken bones, internal injuries, dislocations, or dental injuries)
- Poisoning
- Drowning
- Burns
- Choking and suffocation

Who

- Most frequent among 2- to 5-year-olds.

How

- Falls
- Colliding with objects or other children
- Contact with hazardous objects
- Motor vehicle accidents
- Bicycle accidents
- Drowning
- Exposure/access to toxic substances
- Unsafe environments

When

- During outdoor play
- When children are hungry or tired

Why

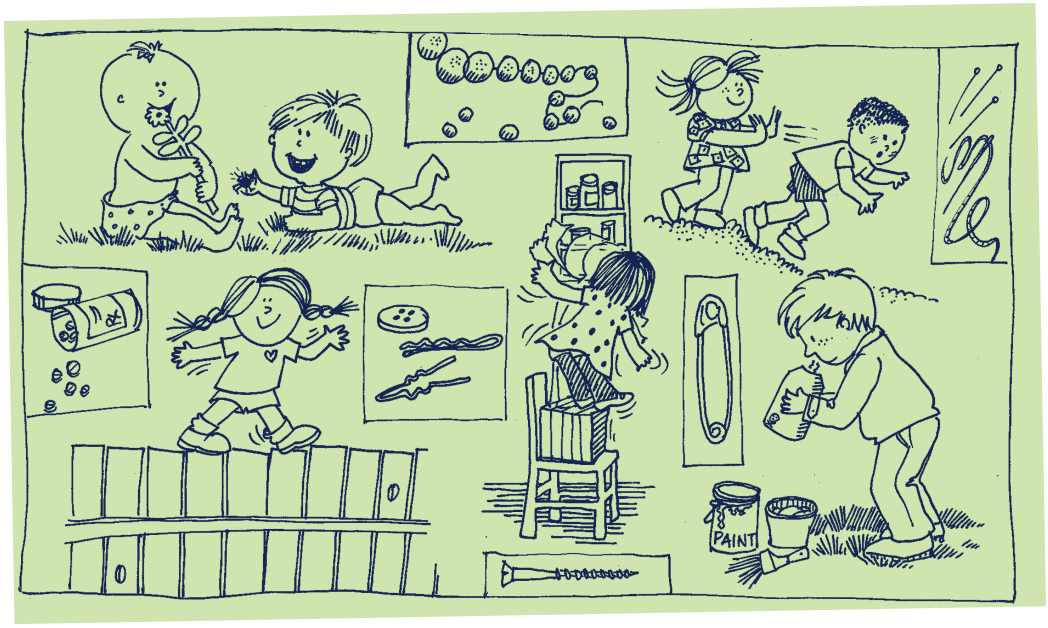
- Lack of safety knowledge and precautions
- Lack of child's ability, imitation of others more physically advanced
- Hazards in the environment
- Access to toxic materials
- Safety devices are not used
- Supervision is not adequate

Risk of Injury at Developmental Stages

Children are at risk for injuries because developmental factors limit their physical, mental and emotional abilities. They grow quickly and want to test and master their environment. Their curiosity, fearlessness and lack of safety knowledge put them at risk when exploring and attempting actions for which they may lack the skills and physical capabilities.

The type of injuries children may incur is related to their development. For example, an infant's neck is too weak to support the weight of his head, so he will be at risk of serious injury and even death if shaken. Infants and toddlers explore their surroundings by putting objects in their mouths, and therefore are at risk of choking. Toddlers like to walk fast, climb and reach for objects, and therefore are at risk of falling or poisoning. Motor vehicle accidents are the leading cause of injury in all age groups.

As child care providers, we want to assure that children are challenged by their environment and can explore safely. Knowing the children in your care and being careful to remove hazards and set up the environment with their abilities in mind can prevent injuries. Because each child develops at her own rate and not according to any exact age, the examples on the following pages are only a framework. One child may crawl at six months, another at one year.



STAGES OF GROWTH AND DEVELOPMENT, RISK OF INJURY, AND PREVENTION TIPS

Stage of Development	Characteristics	Types of Injuries	Prevention Tips
Young Infants (birth to 6 months old)	• Eat, sleep, cry • Have strong sucking reflexes • Begin grasping and rolling over unexpectedly • Need support of head and neck • Sit with support	• Falls from couches, tables, changing tables and bed • Burns from hot liquids • Choking and suffocation • SIDS (Sudden Infant Death Syndrome) • Heat-related illness	• Never leave infants alone on beds, changing tables, sofas, chairs or any other high surface. • Always check water temperature before bathing infant. Set hot tap water temperature below 120° F. • Install smoke alarms and check the batteries twice a year. • Don't drink hot liquids around infants. • Keep small objects and toys away from infants. • Place infants on their backs to sleep, on a firm mattress, in an empty crib. • Do not use soft bedding in a baby's sleeping area. • Properly install and use approved child passenger safety seats in the back seat facing the back of the car. • Never leave infants in a car. • Keep infants out of direct sunlight.
Mobile Infants (6-12 months old)	• Sit with minimal or no support • Play with open hands • Reach for objects • Mouth objects and toys • Are increasingly curious • Want to test, touch and shake objects • Become increasingly mobile from crawling to cruising to walking. • Want to explore • Pull and push objects • Spend more time outside • Imitate older children and adults • Begin eating table food.	• Vehicle occupant injury • Falls • Burns from hot liquids • Choking and suffocation • SIDS (Sudden Infant Death Syndrome) • Shaken Baby Syndrome • Heat-related illness • Drowning	• Properly install and use approved child passenger safety seats in the back seat, facing the back of the car. • Never leave infants alone on beds, changing tables, sofas, chairs or any other high surface. • Always check water temperature before bathing infant. Set hot tap water temperature below 120° F. • Keep small objects and toys away from the baby. • Place infants on their backs to sleep, on a firm mattress, in an empty crib. • Do not use soft bedding in a baby's sleeping area. • Never shake a baby, even playfully. • Never leave infants in a car. • Do not use walkers and other walker-type equipment. • Keep hot foods and liquids out of the reach of children. • Put guards around radiators, hot pipes and other hot surfaces. • Always carefully supervise; never leave a child alone in or near any water (including tubs, toilets, buckets, swimming pool or any other containers of water) even for a few seconds. • Provide shade in outdoor areas. • Ask families to try new foods at home first

Stage of Development	Characteristics	Types of Injuries	Prevention Tips
Toddlers (1-3 years old)	• Like to go fast • Are unsteady • Try to reach objects • Run • Walk up and down stairs • Like to climb • Push and pull objects • Can open doors, drawers, gates and windows • Throw balls and others objects • Begin talking, but cannot express needs • Begin to eat a greater variety of foods	• Motor vehicle injuries • Falls • Burns • Poisoning • Choking • Drowning • Child abuse • Heat-related illness • Pull over accidents • Collisions with objects and other children	• Put toddler gates on stairways and keep any doors to cellars and porches locked. • Show child how to climb up and down stairs. • Remove sharp-edged furniture from frequently used areas. • Turn handles to back of stove while cooking. • Teach child the meaning of "hot." • Keep electric cords out of child's reach. • Use electric outlet covers or furniture to cover used and unused outlets. • Store household products such as cleaners, chemicals, medicines and cosmetics in high places and locked cabinets. • Check for sources of lead in the environment. • Avoid giving child peanuts, popcorn, raw vegetables and any other food that could cause choking. • Toys should not have small parts. • Watch children carefully during arts and crafts projects for mouthing of paints, brushes, paste and other materials. Use nontoxic supplies. • Always carefully supervise; never leave a child alone in or near any body of water even for a few seconds. • Check floors and reachable areas carefully for small objects such as pins, buttons, coins, etc. • Never leave toddlers in a car. • Provide shade in outdoor areas. • Take water breaks.
Preschoolers (3-5 years old)	• Begin making choices • Have lots of energy • Seek approval and attention	• Traffic injuries • Burns • Playground injuries • Poisoning • Tools and equipment • Heat-related illness	• Check and maintain playground equipment and the outdoor environment. • Provide age and weight-appropriate equipment. • Provide an impact surface under and around play equipment to absorb shock. Use specifically approved surface materials. • Check that children are dressed appropriately to avoid strangulation (e.g., no drawstrings on shirt, jackets, etc.). • Store household products, medicines and cosmetics out of children's sight and reach. • Check for sources of lead in the environment. • Teach child the difference between food and nonfood. • Use nontoxic supplies. • Store garden equipment, scissors and sharp knives out of reach. • Teach child the safe use of tools and other equipment, and supervise carefully when using. • Never leave children in a car. • Provide shade in outdoor areas. • Take water breaks.

Preventing Childhood Injuries

TRAINER GUIDE

SECTION TOPICS

- SIDS and Other Sleep-Related Infant Deaths
- Shaken Baby Syndrome/Abusive Head Trauma
- Brain Injury and Concussion
- Child Abuse Prevention
- Burns and Fire
- Heat-related Illness
- Choking, Suffocation, Strangulation, Entrapment
- Falls
- Poisoning, Lead Poisoning
- Drowning
- Young Children and Disasters
- Child Passenger Safety
- Field Trip Safety
- School Bus Safety

Rationale: You can prevent injuries by providing developmentally appropriate activities, active supervision, and safe environments for children.

Time: 115 minutes

Learning Objectives

Participants will:

1 Be familiar with tools and resources to keep child care programs safe for children.

2. Understand practices to reduce the risk of injuries for child care staff.

Teaching Methods/Suggested Activities

- **Lecture:** Review and discuss what a child care provider needs to know about childhood injuries and what to do to reduce the risk of injury.
- **Question/Answers:** Respond to any questions that the group may have. Ask questions and emphasize important points that highlight the main concepts.
- **Demonstration/Hands-on Activities:** Demonstrate the proper use of safety equipment such as a car seat, electric plugs, infant safe sleep environments etc.

Materials and Equipment Required

STUDENT HANDOUTS:

Student handouts are posted on the CCHP website: https://cchp.ucsf.edu/content/topics/preventive-health-training

- Safe Infant Sleep: Reducing the Risk of SIDS and Other Sleep-Related Infant Deaths
- Safe Sleep Policy for Infants in Child Care Programs
- Protecting Infants and Young Children from Shaken Baby Syndrome/Abusive Head Trauma
- Child Abuse Prevention CCHP Health and Safety Note
- How to Handle Dental Injuries CCHP Poster
- CDSS Effects of Lead Exposure Handout
- Young Children and Disasters CCHP Health and Safety Note
- California Car Seat Law Poster
- Never Leave Your Child Alone in a Car Handout
- School Bus Safety Tips
- Field Trip Safety CCHP Health and Safety Note

OTHER MATERIALS:

- Flip Chart/Chalkboard/Whiteboard
- Presentation Slides (if using a computer and LCD projector)
- Demonstration Supplies

Questions/Comments: Stress that child care providers should use all measures possible to protect the children and prevent injury. Active supervision, environmental safety, developmentally appropriate activities, and clear polices work together to reduce the risk of injury.

SIDS and Other Sleep-Related Infant Deaths

When a seemingly healthy infant dies suddenly and unexpectedly in a child care program, it can be devastating; not only for the family of the child, but also for the child care provider and other families in the program. Safe infant sleep practices and environments reduce the risk of Sudden Infant Death Syndrome (SIDS) and other sleep-related infant deaths.

SIDS is the death of an infant younger than 1 year of age that can't be explained after a thorough scene investigation, autopsy, and review of the clinical history. Ninety percent of SIDS deaths occur before an infant reaches 6 months of age. SIDS deaths peak between 1 and 4 months of age. Risk factors for SIDS include: unsafe sleep practices and environments; a critical period of development; and the individual vulnerability of an infant. Other sleep-related infant deaths (such as suffocation, asphyxia, entrapment, and strangulation) have similar risk factors.

Studies show that deaths from SIDS in child care programs were more likely to occur during the first week. SIDS deaths were more likely to occur when infants were:

- used to sleeping on their backs at home and were placed on their stomachs for sleep in child care,
- allowed to sleep in an unsafe sleep environment in child care (for example: a car seat, stroller, futon, pillow, or bean bag) (Kassa, Moon, Colvin, 2016).

The American Academy of Pediatrics (AAP) recommends a safe infant sleep environment and safe infant sleep practices to reduce the risk for SIDS and other sleep-related infant deaths. (AAP, 2016)

Infant Sleep in Licensed Child Care Programs in California

To reduce the risk of SIDS and other sleep-related infant deaths, licensed child care providers in California are required to:

- Place infants up to 12 months old on their backs for sleeping.
- Use a crib or portable crib (play yard) that meets the United States Consumer Product Safety Commission (CPSC) safety standards with a firm mattress made for that size crib. Cover it with a tightly-fitted sheet that is the correct size for the mattress.
- Assign a crib or play yard to each infant, and place only one infant in a crib.
- Remove any loose articles or objects, including blankets, pillows, toys and stuffed animals in, attached to, or draped over the side crib. Do not use bumper pads. Remove bibs, clothing with ties or hoods, and jewelry. Do not cover an infant's head while sleeping.
- If an infant falls asleep before being placed in a crib, move the infant to a crib as soon as possible. Do not allow infants to sleep on a couch, sofa, armchair, cushion, futon, bed, or pillow; or in a car seat, stroller, swing or bouncy chair.
- Observe sleeping infants by sight and sound at all times.
- Physically check sleeping infants aged 0-24 months every 15 minutes for signs of distress or overheating. Keep a log of the time, date, and infant's name for each 15-minute check.
- Offer a pacifier, if provided by the infant's family. Do not attach a pacifier to a string or ribbon to be worn around an infant's neck or fastened to an infant's clothing. Infants may not share pacifiers.
- Do not swaddle infants for sleep. Do not dress infants in clothing that is meant to swaddle them, for example clothing that uses weights or Velcro to restrict their movement.
- Sleep sacks can not be used in Family Child Care Homes and require a waiver in Child Care Centers. Use a footed sleeper instead.
- Complete an Individual Infant Sleeping Plan (LIC 9227) for all infants up to 12 months old. This plan must be signed and dated by the infant's parent or guardian.
- Once an infant can roll from their back to their stomach and stomach to their back, fill out Section D of the Individual Infant Sleeping Plan (LIC 9227), and notify the parent or guardian to sign and date the form. Continue to place the infant on their back for sleep. If the infant changes position, the infant may remain in the position.

What Else Can Child Care Providers Do?

ENFORCE NO-SMOKING LAWS AND REGULATIONS

Infants who are exposed to smoke have a higher risk of dying from SIDS. California Child Care Licensing

Regulations prohibit smoking in licensed child care centers and in family child care homes. California law prohibits smoking in a car when children are present.

PROVIDE HEALTHY AIR

Provide a sleeping area that is well ventilated (the air should not be stuffy and stale) and at a temperature that is comfortable for a lightly clothed adult.

BE BREASTFEEDING FRIENDLY

Breastfeeding is associated with a lower risk of SIDS. In many cases, returning to work is a barrier to breastfeeding. Support mothers to continue breastfeeding after their maternity leave is over and they return to their work or school schedules. For detailed information on how to support breastfeeding families (including a sample policy; an infant feeding plan template; and information on safely handling, storing, and feeding breastmilk), see *Supporting Breastfeeding Families, a Toolkit for Child Care Providers* (http://www.publichealth.lacounty.gov/mch/CAH/Breastfeeding_toolkit_May2016_C.pdf)

EDUCATE FAMILIES AND PROVIDE PROFESSIONAL DEVELOPMENT FOR STAFF

Discuss safe infant sleep practices with families. Include information about: room-sharing without bed-sharing, breastfeeding, not allowing infants to routinely sleep in car seats, not smoking around infants, and keeping up with scheduled immunizations.

Distribute written handouts, and put up posters on your walls or bulletin boards. Provide information about safe sleep upon enrolling new families.

Provide staff development on the principles of safe infant sleep. Closely monitor staff compliance with your safe sleep policy. Review your emergency response system with all staff members on a regular basis.

Reach out to the SIDS Coordinator at your local health department for support with family education and staff development.

PROVIDE SUPERVISED "TUMMY TIME" WHEN INFANTS ARE AWAKE

Tummy time is important for infant growth and development. It builds muscle strength and coordination in the head, neck, shoulders, abdomen, and back that are needed to reach important developmental milestones (such as how to push up, roll over, sit up, crawl, and pull to a stand). Infants must be awake and supervised for Tummy Time. See the CCHP Health & Safety Note, Tummy Time for Infants.

ENSURE CRIB SAFETY

Do not resell, donate or give away a crib that does not meet the current crib standards. CPSC recommends disassembling an old crib before discarding it. Local public health departments and advocacy groups can help provide low-cost or free cribs or play yards for families and child care providers with financial need.

If a baby is found unresponsive with no breathing or pulse, begin CPR and call 9-1-1.

Your local SIDS Coordinator can also provide grief counselling for families and child care providers who experience a SIDS death in their program.

State of California – Health and Human Services Agency | California Department of Social Services

INDIVIDUAL INFANT SLEEPING PLAN

Date of plan: _____

SECTION A: INFANT'S INFORMATION

Infant's Name	Gender	Birth Date

Authorized Representative's Name (Primary Contact)	Phone Number

Authorized Representative's Name (Secondary Contact)	Phone Number

SECTION B: SLEEPING ENVIRONMENT INFORMATION

At home, the infant sleeps in:

☐ Crib ☐ Play Yard ☐ Other (Specify) _____

What are the Infant's usual sleeping hours?

_____ _____

_____ _____

What is the infant's average length of the Infant's nap(s) during the day time?

_____ minutes _____ hours

Does the infant use a pacifier?

☐ Yes ☐ No ☐ Sometimes

If **yes**, brand: _____

SECTION C: INFANT'S ABILITY TO ROLL

My child, _____ is able to roll from their back to their stomach and stomach to their back beginning _____ / _____ / _____.

Authorized Representative Signature	Date

SECTION D: INFANT'S ABILITY TO ROLL IN CHILD CARE

Provider observed the infant is capable of rolling from their back to their stomach and stomach to their back.

Provider Signature	Date

Authorized Representative Signature (To be completed no later than the next business day following observation)	Date

SECTION E: MEDICAL EXEMPTION

Does the infant have a medical exemption? ☐ Yes ☐ No

If the infant has a medical exemption to sleep in a position other than on their back a licensed physician must provide instruction on an alternate sleeping position.

The following shall be included with the medical exemption:

- Instructions on how the infant shall be placed to sleep, including sleep position.
- Duration the exemption is to be in place
- The licensed physician's contact information
- Signature of the licensed physician and date of signature

ATTACH REQUIRED DOCUMENTS TO THIS FORM AND MAINTAIN IN THE INFANT'S FILE PURSUANT TO TITLE 22, SECTION 101429(a)(2)(c) FOR CHILD CARE CENTERS OR SECTION 102425(c)(2) FOR FAMILY CHILD CARE HOMES.

I certify that all information contained in this form is complete and accurate to the best of my ability.

Authorized Representative Signature	Date

SAMPLE

INFANT SLEEP OBSERVATION FORM

Instructions: Write the infant's name at the top of the page. Check sleeping infants *every 15 minutes* for signs of distress or overheating including: labored breathing, flushed skin color, increased body temperature, restlessness, or any other signs of distress. Write the date and time. Initial for no signs of distress.

Infant's Name (First, Last) ____

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials
	___:___	______		___:___	______		___:___	______
	___:___	______		___:___	______		___:___	______
	___:___	______		___:___	______		___:___	______
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	___:___	______		___:___	______		___:___	______

CALIFORNIA CHILDCARE HEALTH PROGRAM

Model Health & Safety Policies

Safe Sleep Policy for Infants in Child Care Programs

All child care providers at _____ [program name] will follow safe sleep recommendations for infants to reduce the risk of Sudden Infant Death Syndrome (SIDS), other sleep-related infant death, and the spread of contagious diseases:

1. Infants will always be put to sleep on their backs until one year of age.
2. Infants will be placed on a firm, flat mattress, with a fitted crib sheet, in a crib that meets the Consumer Product Safety Commission safety standards.
3. No toys, mobiles, soft objects, stuffed animals, pillows, bumper pads, blankets, positioning devices or extra bedding will be in the crib or draped over the side of the crib.
4. Sleeping areas will be ventilated and at a temperature that is comfortable for a lightly clothed adult. Infants will not be dressed in more than one extra layer than an adult.
5. The infant's head will remain uncovered for sleep. Bibs and clothing with hoods or ties will be removed.
6. Swaddling is not allowed in child care, per Child Care Licensing regulations.
7. Infants will be actively observed by sight and sound.
8. Sleeping infants up to 24 months of age will be physically checked every 15 minutes for signs of distress or overheating. The checks will be recorded in a log.
9. Infants will not be allowed to sleep on a sofa/couch, chair cushion, bed, pillow, or in a car seat, stroller, swing or bouncy chair. If an infant falls asleep anyplace other than a crib, the infant will be moved to a crib right away.
10. An infant who arrives asleep in a car seat will be moved to a crib.
11. Infants will not share cribs, and cribs will be spaced 3 feet apart.
12. Infants may be offered a pacifier for sleep, if provided by the parent. Pacifiers will not be attached by a string to the infant's clothing and will not be reinserted if they fall out after the infant is asleep.
13. Each infant up to 12 months will have an Individual Infant Sleeping Plan (LIC 9227). When the infant is able to roll back and forth from back to front, the parent will update and sign Section C, and parent and provider will sign Section D. Once Sections C and D are filled and signed, the infant will be put to sleep on their back and allowed to assume a preferred sleep position.
14. Our child care program is a smoke-free and vape-free environment.
15. Our child care program supports breastfeeding.
16. Awake infants will have supervised "Tummy Time".

Image from Eunice Kennedy Shriver National Institute of Child Development (NICHD)

References & Resources

Caring for Our Children National Health and Safety Performance Standards at http://nrckids.org/CFOC/Database/3.1.4.1

Moon, R., Carlin, R., Hand, I. and The Task Force on Sudden Infant Death Syndrome and the Committee on Fetus and Newborn. (2022). Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment. Pediatrics, 150(1): e2022057990. Accessed at https://publications.aap.org/pediatrics/article/150/1/e2022057990/188304/Sleep-Related-Infant-Deaths-Updated-2022

California Department of Social Services (2020). Provider Information Notice 20-24-CCP "Recently Approved Safe Sleep Regulations in Effect." Accessed at https://www.cdss.ca.gov/Portals/9/CCLD/PINs/2020/CCP/PIN%2020-24-CCP.pdf

** This policy reflects the safe sleep research as of February 2024*

CALIFORNIA CHILDCARE HEALTH PROGRAM

Health & Safety Notes

Tummy Time for Infants

In June, 1994, a national "Back to Sleep Campaign" was initiated in the United States to reduce the risk of Sudden Infant Death Syndrome (SIDS). Since that time the number of infants dying of SIDS has dropped by more than half. Putting infants to sleep on their backs is a simple and effective practice for reducing the risk of SIDS. But the other part of the "Back to Sleep Campaign" message is "Tummy to Play." Many infants are not getting enough "tummy time."

Why is "Tummy Time" important?

Infants now miss out on the 12 hours of tummy time that they used to get when sleeping on their tummies. Many infants also spend long hours in swings, car and infant seats when awake. Because of these practices, some infants are developing motor delays. Tummy time is important because it helps infants:

- stretch and strengthen the head, neck, shoulder and back muscles they will need to learn important motor skills (for instance, how to push up, roll over, sit up, crawl, and pull to a stand).
- develop their sensory-perceptual, social-emotional, problem solving, balance, visual, and hearing abilities.
- develop normally-shaped heads (infants who spend most of their time on their backs when asleep and in infant seats when awake are at risk for developing flat spots on the backs of their heads).

How can we make sure infants get enough "Tummy Time" when they are awake?

The way to prevent these problems is to make sure infants spend plenty of time on their tummies, in the "prone" position, starting when they are newborns. Some infants get fussy when they are put on their tummies because they are not used to it, and it is hard work for an infant to hold his head up. Unless babies are put on their tummies (prone) to play from the first days and week of life, they may not easily accept "tummy time."

Tips for making tummy time more interesting:

- Lay the infant over your leg while you are sitting on the floor
- Buy an exercise ball* that is 60 centimeters in diameter. Lay the infant over the ball on his tummy and move him gently back and forth and from side to side by rolling the ball carefully, and move him up and down by pushing down gently on his back.

- Put the infant on her tummy on a blanket on the floor. Make the floor interesting by choosing a blanket with an interesting pattern or texture, or a special tummy time mat. Lie down on the floor with the infant. She will enjoy exploring you as well as the toys on the floor.
- Lie down with the infant on your chest tummy-side down.

- Carry the infant around on his tummy instead of upright.

- Make a bolster by rolling up a towel. Place the bolster under the infant's chest and armpits with her arms over the bolster. You can move the infant gently back and forth on the bolster.
- Older infants can be placed lengthwise on the bolster (with an arm and a leg on either side of the bolster) and rolled gently from side to side.

Remember, a happy infant develops best.

If an infant starts to fuss, try to make tummy time more interesting through gentle movement or a change of toys. Rhythm and movement together work wonders for infants' development, so turn on some music for tummy time. At first, you may have to try tummy time for several short periods during the day until the infant gets used to being on his tummy.

When to seek help

Infants should be holding up their heads and pushing up on their arms by the end of three months. Infants who are getting enough tummy time and are still delayed in reaching these milestones should be evaluated by their health care provider.

* Make sure that the infant doesn't pull the plug on the ball that holds the air in as the plug could be a choking hazard

Vickie Leonard, RN, FNP, PhD and
Alanna Freeman, OTR

Prepared by the UCSF California Childcare Health Program with support from the CJ Foundation.

Shaken Baby Syndrome/Abusive Head Trauma

Pediatric abusive head trauma is an injury to the skull or brain of an infant or young child due to inflicted blunt impact and/or shaking. The term "shaken baby syndrome" describes a set of symptoms seen in infants who have sustained a head injury from shaking. Medical professionals have recommended replacing the term "shaken baby syndrome" with the term "abusive head trauma" because it includes the various ways a child could suffer a head injury as a result of abuse such as: shaking; dropping; throwing; hitting; or hitting child's head against a surface or object while shaking.

Long-term Effects of Abusive Head Trauma

Children who are victims of abusive head trauma may experience mild to severe injuries. The following may occur as a result of the bleeding or damage caused by abusive head trauma: partial or total blindness; hearing loss; paralysis; problems with motor development; seizure disorders; cerebral palsy; sucking and/or swallowing disorders; intellectual disabilities; speech and language delay or disability; problems with executive function; and attention, memory, and behavior problems. Because of the serious nature of these injuries, it is crucial that child care providers have policies in place for preventing and identifying shaken baby syndrome/abusive head trauma.

Developmental Vulnerabilities and Abusive Head Trauma

Infants are especially vulnerable to abusive head trauma. Their fragile brains and skulls are rapidly developing and a sudden impact can cause irreversible injury. In addition, infants are unable to express their needs and feelings using words. Instead, they cry. A phase of alarming crying is considered a normal developmental phase in young infants. Caregiver anger or frustration over prolonged crying is associated with the risk for shaking that can result in serious injury or death. Other risk factors for abusive head trauma in infants and young children include: having a disability; having multiple siblings; living in poverty; and having colic or other kinds of pain and discomfort.

Caregiver Training

The first step to protect young children from shaken baby syndrome/abusive head trauma is to raise awareness through education. All child care providers who work with infants and young children need periodic training in preventing abusive head trauma. Training should include 1) strategies for coping with a crying, fussy, or distraught infant or child and 2) information on how to recognize the signs of shaken baby syndrome/abusive head trauma.

Strategies for Coping with a Crying Infant or Child

All babies cry. While it can be difficult to hear, the following strategies can help a caregiver act safely when faced with a persistently crying baby.

Manage your stress and practice self-care. Be aware of your feelings of increasing frustration or anger, and use a calming strategy that works for you. For example, take a few deep breaths or breathe deeply while counting to ten. If you are unable to bring your frustration under control on your own, then find a way to take a break from the situation without leaving children unsupervised, such as:

- Asking a coworker to take over with a challenging child
- Asking for another assignment
- Taking a short break

Learn about typical infant development and how to manage infant crying. Try different techniques for soothing crying infants. Some babies cry more and other babies cry less, but it is normal for babies to cry. For more information about managing crying see: *Tips for Child Care Providers to Soothe a Crying Baby* https://childcare.extension.org/tips-for-child-care-providers-to-soothe-a-crying-baby/

The following child care setting actions to reduce shaken baby syndrome/abusive head trauma are acceptable per California Child Care Licensing Regulations for providers who may be alone in family child care homes:

- The child care provider may designate a qualified substitute provider who can provide relief to a child care provider who is stressed by a baby's crying. It is appropriate to ask someone to help take care of a crying baby while the care provider gets some respite. In licensed child care, the only acceptable substitutes are those who have been fingerprint-cleared and meet all necessary requirements established by Title 22 and the Health and Safety Code.
- The parent/guardian may also designate an emergency contact, in addition to themselves who can be called if the baby's crying is alarming.
- If a child care provider realizes that a baby's crying is a trigger for the provider's negative stress reactions, that provider should consider not providing care to infants.

Remember: It is never okay to shake or strike a child.

Signs of Shaken Baby Syndrome/Abusive Head Trauma

As a child care provider, you may be the first to recognize when a child has been a victim of abusive head trauma. It's important to know the signs and respond so that the child can receive medical attention as quickly as possible. In many cases there are no symptoms at all, but in more severe cases an infant or young child may have:

- Difficulty staying awake,
- Irritability, lack of smiling,
- Poor sucking or swallowing, decreased appetite, or vomiting
- Decreased muscle tone,
- Inability to lift the head,
- Difficulty breathing, blue color (due to lack of oxygen),
- Unequal pupil size,
- Inability to focus the eyes or track movement,
- Bleeding around the eyes,
- Bulging or swelling of the head, forehead, or soft spot
- Bruises on the face, eye, head, neck, or chest
- Rigidity of the body,
- Tremors, seizures,
- Coma.

Provide first aid, and call 9-1-1 for signs of severe abusive head trauma.

Playground Safety Tips for **PARENTS**

HEADS UP CONCUSSION

As a parent, you play an important role in keeping your child safe on the playground. This sheet will help you learn how to spot a concussion and protect your child from concussion or other serious brain injury each time you take your child on an outdoor play adventure.

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.

HOW CAN I HELP KEEP MY CHILD SAFE?

Playgrounds are important places for children to have fun, explore, and grow. Children learn through play and need opportunities to take risks, test their limits, and learn new skills through free play. Playgrounds can also put children at risk for concussion.

On the playground, children are more likely to get a concussion or other serious brain injury when using:

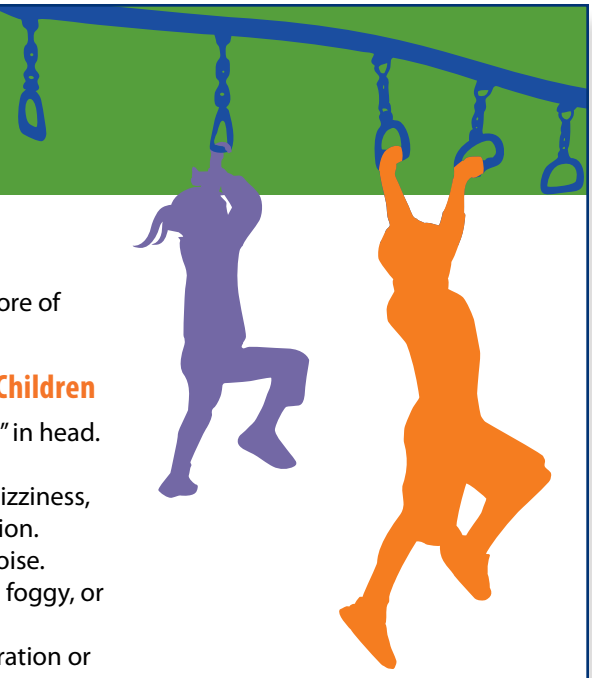
1. Monkey Bars 
2. Climbing Equipment 
3. Swings[1] 

[1] Cheng T et al. Nonfatal playground-related traumatic brain injuries among children, 2001-2013. *Pediatrics*, 2015.

To help keep children safe:

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Be HEADS UP on the Playground



HOW CAN I SPOT A POSSIBLE CONCUSSION?

After a fall or a bump, blow, or jolt to the head or body, look for one or more of these signs and symptoms of a concussion:

Signs Observed by Parents

- Appears dazed or stunned.
- Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent.
- Moves clumsily.
- Answers questions slowly.
- Loses consciousness (even briefly).
- Shows mood, behavior, or personality changes.
- Can't recall events prior to or after a hit or fall.

Symptoms Reported by Children

- Headache or "pressure" in head.
- Nausea or vomiting.
- Balance problems or dizziness, or double or blurry vision.
- Bothered by light or noise.
- Feeling sluggish, hazy, foggy, or groggy.
- Confusion, or concentration or memory problems.
- Just not "feeling right," or "feeling down."

If you see any of these signs or symptoms and think your child has a concussion, or other serious brain injury, seek medical attention right away. Remember, signs and symptoms may show up right after the injury, or may not appear or be noticed until hours or days after the injury. While most children with a concussion feel better within a couple of weeks, some will have symptoms for months or longer.

How can you help your child lower their chance of getting a concussion?
Plan ahead. ✓

WHAT ARE SOME MORE SERIOUS DANGER SIGNS TO LOOK OUT FOR?

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body and can squeeze the brain against the skull. Call 9-1-1 or ensure that the child is taken to the emergency department right away if, after a bump, blow, or jolt to the head or body, he or she has one or more of these danger signs:

- One pupil larger than the other.
- Drowsiness or inability to wake up.
- A headache that gets worse and does not go away.
- Slurred speech, weakness, numbness, or decreased coordination.
- Repeated vomiting or nausea, convulsions, or seizures (shaking or twitching).
- Unusual behavior, increased confusion, restlessness, or agitation.
- Loss of consciousness (passed out/knocked out). Even a brief loss of consciousness should be taken seriously.

You can download the CDC *HEADS UP* app to get concussion information at your fingertips. Just scan the QR code pictured at left with your smartphone.

The information provided in this fact sheet or through linkages to other sites is not a substitute for medical or professional care. Questions about diagnosis and treatment for concussion should be directed to your physician or other health care provider.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

To learn more, go to www.cdc.gov/HEADSUP

Child Abuse Prevention

What Is Child Abuse?

Child abuse is a non-accidental injury or pattern of injuries to a child for which there is no reasonable explanation. It is a very sensitive issue that needs to be carefully handled.

There are different types of child abuse. In physical abuse, children are slapped, hit, kicked or pushed, or have objects thrown at them, causing wounds, bruises, broken bones or other injuries. Severe physical abuse can cause major injury, permanent physical or emotional damage, or even death. Sexual abuse includes a wide range of sexual behavior, including fondling, masturbation, intercourse or involving children in pornography. Emotional abuse involves humiliation, dishonoring or other acts carried out over time that terrorize or frighten the child. Neglect means not feeding or caring for a child's basic needs or not adequately supervising a child.

Child abuse is usually a pattern of behavior, not a single act. Children are most often abused by parents, stepparents or other caregivers.

You Can Protect Children from Abuse

Reporting suspected child abuse is difficult, but the children you care for trust you to protect them from people who might hurt them. *Respond to your "gut" feeling and take actions that may save a child from harm!*

All child care providers are required by law (mandated) to make a report to their local Child Protective Services agency if they have a reasonable suspicion that a child in their care has been abused or neglected. This includes child care center directors, teachers and aides, family child care providers, and school-age child care providers. The center or agency you work for is not allowed to fire or discipline you for making a report, even if your supervisor disagrees with you.

What Is Reasonable Suspicion?

Reasonable suspicion is the legal term used in California's child abuse reporting law. Reasonable suspicion means the suspicion is based on facts that would cause a reasonable person to suspect child abuse.

Remember, **you don't have to be sure that abuse or neglect has occurred, but you must have a reasonable suspicion. You cannot be punished for reporting child abuse, but if you do not report, you can be punished. You can call your local Child Protective Services agency for advice if you are not sure. Call 9-1-1 if the child is in immediate danger or if the child needs urgent medical care.**

The following behaviors could indicate abuse or neglect. *Remember that all children occasionally act in these ways.*

- Mood swings.
- Fear of certain people.
- Grouchiness or irritability.
- Is "too good," does not test boundaries.
- Uses manipulative behavior to get attention.
- Low self-esteem.
- Unexplained developmental delays.
- Inability to get along with other children.
- Is wary of adult contact, rejects affection.
- Has a vacant expression, cannot be drawn out.
- Seeks constant affection from anyone; is very clingy.
- Complains frequently of stomach aches or other pains; vomits.

What should you do if you suspect abuse?

You must report it.

1. It may help to talk to other staff members to see what they think. But even if they disagree with your opinion, *if you have a reasonable suspicion of abuse or neglect, you must report it.* It is your legal responsibility. Remember, you cannot get in legal trouble for making a report, only for not making one when you have reason to suspect abuse.

2. Make a report by phoning the local Child Protective Services agency (CPS) or, in an emergency, call the police. You will also need to fill out a form and send it to CPS within 36 hours. You have the right to get information from CPS about what happens to the family after the report is made.

3. Tell the CPS worker about your relationship with the family and ways you can support the family.

4. After making your report, be sure to call your Community Care Licensing program analyst and tell them about the situation. This protects you from possible complaints by the parents and lets the evaluator know you are acting responsibly.

Reporting Suspected Child Abuse Can Be Difficult

Thinking about child abuse can feel bad, and taking action can be difficult. Even though you care very much about the child and know your legal duty, you may still:

- Doubt your own judgment and feel disbelief that this family could commit child abuse.
- Fear that the parents may threaten or harm you or the child.
- Fear that you will lose your job or that the child will be withdrawn from your program.
- Feel nervous about dealing with authorities because of bad past experiences.
- Have strong emotions about child abuse because of your own family experiences.

All of these feelings are normal reactions to a stressful situation. While carrying out your responsibility to report suspected abuse, don't forget your own feelings. Find the emotional support you need.

Should You Talk to the Child's Parents?

Whether you talk to the child's parents will depend on the situation, your relationship with the family, and where the abuse occurred. Think about whether talking to the parents might put the child in danger. If you are unsure, talk it over with a social worker at the Child Protective Services agency.

If you do talk to the parents, tell them that you made a report and what you said. Explain that you were required by law to do this. Tell them how the process works and what might happen next. Even though you may feel angry or scared, remember the parents need help and support to find a way out of the abuse cycle. Ask what you can do to help and offer information about local support services.

What Should You Say to the Staff, the Other Families and the Children?

When you make a report, talk to the people at the Child Protective Services agency to find out what will happen next. You can tell staff members who work with the child that a report has been made and what to expect, but do not share confidential information.

Other parents may be aware of the problem. You can reassure them that their children are not in danger without telling them any confidential information. You can simply say that you have concerns about the child and are doing whatever you can to help. If the child has left your care, you can say that they have gone on to another program; you don't need to say why.

You may also need to say something to the other children in your program. If the child leaves, you can simply tell the other children that they have left, and that you will miss them. If the child is receiving extra attention, you can explain to the others that you are helping make sure that they are okay, which takes extra time. You should add that you would do the same for them if they needed help.

What You Can Do to Prevent Child Abuse

Child care settings are the only places where young children are seen day after day by people trained to observe their appearance, behavior, and development. You may be the first person to suspect and report abuse and neglect. You also may be the biggest source of support and information available to the parents you serve. You can:

- Give families information on child development and appropriate discipline.
- Model good child care practices.
- Build a trusting relationship with families and discuss concerns.
- Help families establish positive relationships with their children.
- Refer families to community resources and support services.
- Inform parents that you are required to report suspected child abuse.
- Know the signs of parent burnout so you can offer support.
- Have a parent-staff workshop at your center with information about the issues.
- Educate young children about their right to say no.

THREE INDICATORS OF THE THREE TYPES OF CHILD ABUSE*

	Neglect and Emotional Abuse	Physical Abuse	Sexual Abuse
Physical Signs	The child: ● Is underweight or small for age ● Is always hungry ● Is not kept clean ● Is inappropriately dressed for weather ● Has not received needed medical care	The child: ● Has unexplained bruises or welts in unusual places ● Has several bruises or welts in different stages of healing, in unusual shapes, or in clusters ● Has unexplained burns ● Has unexplained broken bones or dislocations ● Has unexplained bites or explanation for injury differs from that of a parent or caretaker	The child: ● Has difficulty walking or sitting ● Is wearing torn, stained or bloody underwear ● Has pain, swelling or itching of genitals ● Has bruises, cuts or bleeding on genitals or anal area ● Feels pain when urinating or defecating ● Has a discharge from the vagina or penis, or a sexually transmitted disease
Behavioral Signs	The child: ● Begs for or steals food ● Frequently arrives at child care early and leaves later than expected ● Has frequent, unexplained absences ● Is overtired or listless	The child: ● Tells you they have been hurt by parents or others ● Becomes frightened when other children cry ● Says the parents or caretakers deserve to be punished ● Is afraid of certain people	The child: ● Acts withdrawn, over-involved in fantasy, or much younger than age ● Displays sophisticated or bizarre sexual knowledge or behavior ● Exhibits excessive or unusual touching of genitals ● Tells you they have a secret they are not allowed to tell anyone. ● Tries to hurt themselves

*Many of these indicators also occur with children who have not been abused. Look for clusters of indicators, and do not reach the conclusion that a child has been abused too quickly. Remember, you must report your reasonable suspicion of abuse.

Produced by the California Childcare Health Program and the California Consortium to Prevent Child Abuse through a grant from the Pacific Mutual Foundation

Local Resources on Child Abuse Reporting and Prevention

(fill in the phone numbers of your local resources and post)

Child Protective Services Agency: _____

Child Abuse Prevention Council: _____

Hot or Warm Line for Counseling: _____

Note: A warm line may be run by peers or volunteers. Warm lines do not provide urgent, professional, mental health service.

Domestic Violence/Rape Crisis: _____

Counseling/Mental Health Services: _____

Other Child Abuse Counseling/Parent Support Services: _____

Remember:

- Never hit or physically injure a child, physically restrain a child, belittle a child, or deprive a child of food, sleep or toileting.
- If you feel you may hurt a child—take a break, talk to a co-worker, call your local child abuse prevention program, council or warm line.
- If you are working with families from a different culture, you might consult with a local resource, i.e. Asian Resources, Indian Health Services, etc.
- It is always a good idea to keep very careful notes when you are concerned about a child. Record your observations, the circumstances, time and date. Date and sign all notes.
- Note any significant changes in the child's contacts with others.
- And above all, remember—if you suspect abuse, you *must* report it.

Be Prepared...

Before anything happens, complete this resource sheet and put it by your phone. Call your local Child Protective Services (CPS) agency to learn more about their procedures and ask them to send you report forms to keep in your file. Inform parents when they enroll their child that you are a mandated reporter.

Free online training

Mandated child abuse reporting training is required for all licensed child care providers in California (AB 1207). *Mandated Reporter Training for Child Care Workers* satisfies the requirements.

Please visit: https://www.mandatedreporterca.com for the free online training.

Burns and Fire

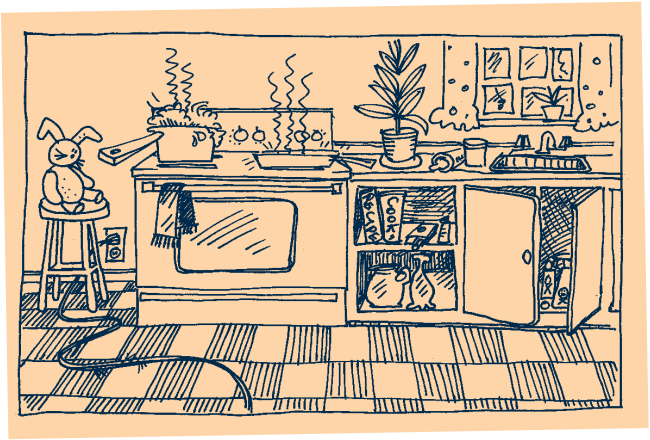
What a Child Care Provider Needs to Know

Children are very vulnerable to fires and burns because of their curiosity and not knowing the danger of fire. Hundreds of children in the United States die and countless others are injured every year as a result of burns. Children ages five or younger are especially vulnerable to burns and have one of the highest fire death rates.

Hot liquids—not fire—are the most common cause of burns to young children. Hot liquids burn like fire and can cause serious and painful burns. However, fires caused by playing with matches and lighters are the number one cause of fire-related deaths among young children.

In the child care environment, four types of hazards contribute to the risk of fire and burns: scalding from hot liquids, contact with fire or hot objects, electrical, and chemical.

Planning ahead and practicing fire prevention skills can reduce the chances of a fire occurring, protect children and adults, and reduce property damage.



What a Child Care Provider Can Do to Reduce Burn Injuries

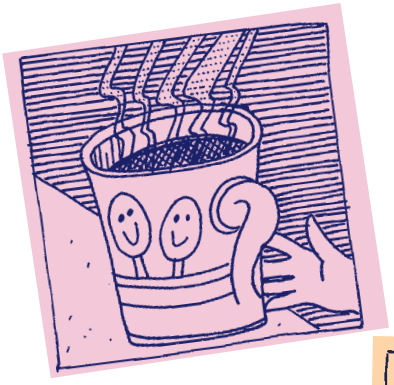
As a child care provider, you can take the following steps to reduce the risk of fires and burns in your facility:

1. Provide safety education. Help the children learn about hazards that can cause fires and burns. They should be taught that some objects are off-limits for play.
2. Check for environmental hazards and limit access to burn-producing objects.
3. Safety devices such as smoke alarms and fire extinguishers should be present and in working condition.
4. Plan the escape routes in advance. Children should have regular practice drills for fire evacuation. Practice how to crawl low under smoke, and how to stop, drop to the ground, and roll if their clothes catch fire.
5. Model preventive behaviors that will reinforce fire and burn accident prevention.
6. Communicate your prevention activities to parents so they can support your efforts and prevent burns and fires at home.
7. Invite a first responder from the local fire depart-ment to your program for a safety workshop.

CAUSES OF FIRE AND BURNS IN THE CHILD CARE ENVIRONMENT

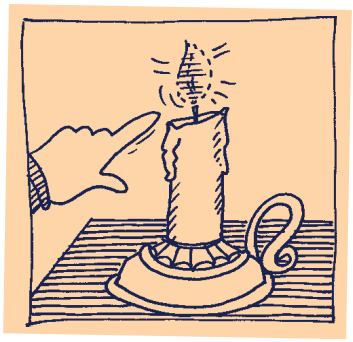
1. Scalding:

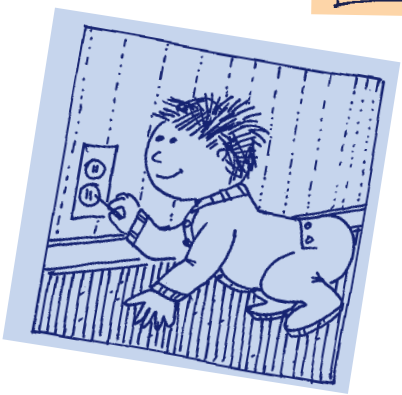
- Boiling liquids or food
- Steam
- Hot coffee, tea or cocoa
- Hot tap water



2. Contact

- Hot pan on stove
- Touching fire in fireplace
- Matches, lighters
- Candles or candle wax
- Cigarettes, cigars, pipes
- Flammable clothing, sleeping materials
- Hot playground equipment
- Clothes iron
- Heaters
- Curling irons and hair appliances



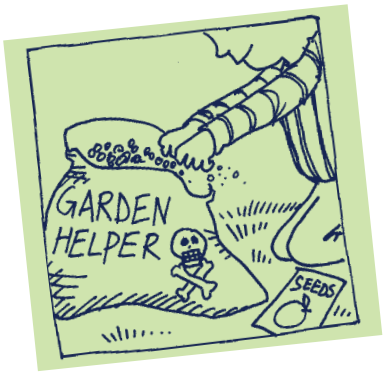


3. Electrical

- Sticking a foreign object into an electrical outlet
- Touching a live wire
- Water contact with an electrical appliance

4. Chemical

- Strong household chemicals
- Automobile chemicals
- Lawn and garden chemicals



BURN AND FIRE PREVENTION IN THE CHILD CARE ENVIRONMENT

- Install and regularly check smoke detectors. Check batteries frequently.
- Keep a fire extinguisher on hand, know how to use it and refill it immediately after each use.
- Do not allow children in cooking areas without supervision. Teach them that there are areas of the facilities that are "off-limits" for play and exploration.
- Do not drink or carry anything hot near a child.
- Keep hot foods and drinks away from the edge of tables and counters.
- Do not leave them on a tablecloth that a child can grab.
- Use the rear burners for cooking. Turn the handles of pots towards the rear or center of the stove.
- Test hot food before giving it to a child. This includes food from a microwave oven.
- Never warm bottles in a microwave oven.
- Put barriers around fireplaces, radiators and hot pipes.
- Teach children to stay away from hot things and not to play with matches, lighters, chemicals and electric equipment.
- Plan a fire escape route and practice it. Train children how to properly respond to a fire (they should know the sound of a smoke alarm, two ways out of every room, how stop, drop and roll, etc.)
- Never use portable, open flame or space heaters.
- Use safety devices to cover electrical outlets. Avoid overloading electrical wiring.
- Lower the temperature of your hot water heater to 120° F or lower.
- Always check the water temperature before placing your child in the tub. Supervise children in the tub.
- Store matches, lighters, chemicals and other hazardous items out of the reach of children. Check for fire and burn dangers, and make the necessary changes.

Heat-related Illness

California's climate is changing. Heat waves are becoming more common, and the state is becoming warmer. (EPA, 2016) Infants and young children are especially vulnerable to heat-related illness. They become overheated and dehydrated more easily and may not have the words to describe how they are feeling. Preventing heat illness is part of keeping children safe while in your care.

Follow these steps to keep children safe from heat illness:

- Plan outdoor activities during the cooler times of the day, such as early in the morning or later in the evening.
- Provide shade outside with umbrellas, shade-sails, sun-shelters, and/or trees.
- Schedule frequent water breaks to cool off and avoid dehydration.
- Choose clothing that is loose-fitting and light-colored.
- Observe children for signs of heat exhaustion including:
  - An elevated body temperature
  - Cool, clammy skin despite the heat
  - Goose bumps
  - Fainting, dizziness or weakness
  - Headache
  - Increased sweating
  - Increased thirst
  - Irritability
  - Muscle cramps
  - Nausea and/or vomiting

Children may be at a higher risk for heat exhaustion if they have a sunburn or are sick. It's important to treat heat exhaustion as it can develop into heat stroke. **Call 9-1-1 immediately.**

Symptoms of Heat Stroke in Children

Heat stroke is a severe type of heat illness that occurs when a child's body creates more heat than it can release. Heat stroke can lead to brain damage or death if not promptly treated. Heat stroke is a medical emergency.

Signs of heat stroke in children may include:

- A body temperature that rises dangerously high – above 104° Fahrenheit
- Absence of sweating
- Confusion, disorientation
- Flushed, hot and dry skin (skin may be wet)
- Loss of consciousness
- Nausea, vomiting, diarrhea
- Rapid heartbeat and breathing
- Severe headache
- Seizures
- Weakness and/or dizziness

If a child shows symptoms of heat stroke, **call 9-1-1 immediately.**

Hot Weather Emergencies

Notify families to pick up their children in the event you are unable to maintain a safe temperature inside your child care facility (a maximum of 85 degrees F, in areas of extreme heat, a maximum of 20 degrees F less than the outside temperature).

HEAT-RELATED ILLNESSES

WHAT TO LOOK FOR	WHAT TO DO
HEAT STROKE	
• High body temperature (103°F or higher) • Hot, red, dry, or damp skin • Fast, strong pulse • Headache • Dizziness • Nausea • Confusion • Losing consciousness (passing out)	• Call 911 right away-heat stroke is a medical emergency • Move the person to a cooler place • Help lower the person's temperature with cool cloths or a cool bath • Do not give the person anything to drink
HEAT EXHAUSTION	
• Heavy sweating • Cold, pale, and clammy skin • Fast, weak pulse • Nausea or vomiting • Muscle cramps • Tiredness or weakness • Dizziness • Headache • Fainting (passing out)	• Move to a cool place • Loosen your clothes • Put cool, wet cloths on your body or take a cool bath • Sip water **Get medical help right away if:** • You are throwing up • Your symptoms get worse • Your symptoms last longer than 1 hour
HEAT CRAMPS	
• Heavy sweating during intense exercise • Muscle pain or spasms	• Stop physical activity and move to a cool place • Drink water or a sports drink • Wait for cramps to go away before you do any more physical activity **Get medical help right away if:** • Cramps last longer than 1 hour • You're on a low-sodium diet • You have heart problems
SUNBURN	
• Painful, red, and warm skin • Blisters on the skin	• Stay out of the sun until your sunburn heals • Put cool cloths on sunburned areas or take a cool bath • Put moisturizing lotion on sunburned areas • Do not break blisters
HEAT RASH	
• Red clusters of small blisters that look like pimples on the skin (usually on the neck, chest, groin, or in elbow creases)	• Stay in a cool, dry place • Keep the rash dry • Use powder (like baby powder) to soothe the rash

CS280226

Choking, Suffocation, Strangulation, Entrapment

What a Child Care Provider Needs to Know

Young children in their first three years of life are at greater risk of choking and suffocation. They may choke during meals or during playtime because they use their mouths to explore and experiment with unfamiliar objects. Some situations that are likely to lead to choking on food include eating while rushed, running and laughing. Food, small toys, and coins are the most common causes of choking in children.

Each year, thousands of children in the United States experience choking, strangulation, suffocation, or entrapment leading to hospitalization or death.

Children younger than five years old are most at risk for these injuries. Children have been strangled by clothing or string around their neck that becomes caught on furniture, playground equipment or some other object. Some consumer products that have strangled children include window-blind cords.

Entrapment and asphyxiation can occur in unsafe cribs as well as other household items such as refrigerators, ice chests and clothes dryers. Suffocation can occur if children have access to plastic bags.

Choking and suffocation are frightening because they occur suddenly. It only takes a few minutes without oxygen due to a blocked airway to cause brain damage in children. The signs of choking and suffocation in children are difficulty speaking or breathing, the inability to cough, wheezing sounds, clutching of throat or gesturing, a bluish face, confusion and unexplained loss of consciousness (this is a very late sign).

What a Child Care Provider Can Do to Reduce This Type of Injury

Take the following steps to reduce the risk of mechanical airway obstruction:

- Learn the proper response and techniques for helping choking or suffocating infants and children.
- Foods that are round, hard, small, thick, sticky, smooth or slippery should not be offered to children younger than four years of age. For infants, foods should be cut in small pieces no longer than ¼" cubes; for toddlers, pieces no longer than ½" cubes. Children should not be allowed to eat while walking, running, playing, lying down or riding in a vehicle.
- Objects smaller than 1 ¼" in diameter should not be accessible to children who put things in their mouths.
- Check toys and equipment regularly for small parts that may break off, such as eyes and noses on stuffed animals, buttons on doll clothes or plastic hats or shoes on miniature people. Remove or securely attach these items.
- Plastic bags, balloons, marbles, pins, nails and toothpicks should not be accessible to children younger than four years.
- Only use cribs that meet current federal safety standards. Cribs sold after June 28, 2011 must meet these standards. Never place a crib near window blinds. No toys, blankets, bumpers, hanging toys, mobiles, or other objects should be in or on the crib.
- Secure or shorten cords on window blinds, or replace with cordless blinds.
- Be aware of the needs and protections for children with developmental delays, swallowing or other disabilities.
- Actively supervise children at all times.

POSSIBLE CHOKING AND SUFFOCATION HAZARDS

Foods

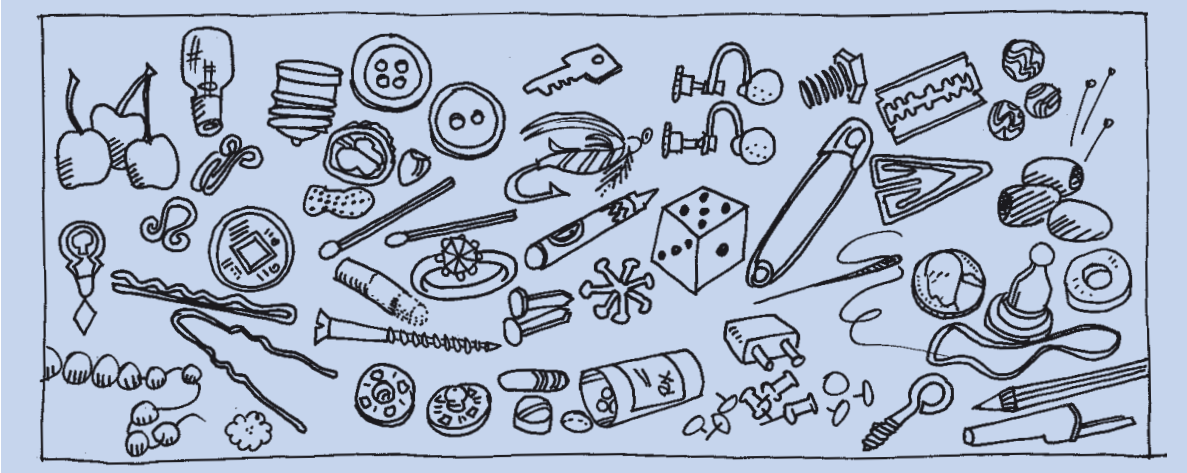
- Big chunks of meat
- Whole olives
- Whole grapes and raisins
- Peanuts, nuts
- Gum
- Popcorn
- Hard candy and cough drops
- Raw vegetables (carrots, etc.)
- Hot dogs and sausages
- Watermelon seeds cut in rounds
- Spoons full of peanut butter
- Lollipops
- Dried fruit

Toys

- Balloons
- Plastic bags
- Game pieces
- Play jewelry
- Game tokens
- Small objects
- Jacks
- Small toys (less than 1 1/2")
- Marbles
- Toy chests with no air holes

Objects

- Pins and nails
- Staples
- Toothpicks
- Coins
- Pencils and pens
- Jewelry
- Crayons



Can you think of more?

Falls

What a Child Care Provider Needs to Know

Falls are the single greatest cause of injury in the child care environment and the most common injury requiring medical care. Thus, the prevention of falls will pose one of the greatest challenges to a safe environment.

Although many injuries resulting from falls are minor (cuts and scrapes), many others such as heavy bleeding, broken bones, and head and eye injuries will be more severe and could be potentially life-threatening.

The most common type of fall leading to hospitalization is a fall from one level to another, such as from playground equipment, beds, tables, chairs and stairs. Falls resulting in severe or fatal injuries are usually due to falls from second story (or higher) windows.

Children are capable of falling or hurting themselves at any age. A tiny baby can wiggle, move and push. An older baby can roll over, crawl and creep. Toddlers can climb to get to places that were formerly inaccessible to them.

Indoor furniture and playground equipment are frequently related to injuries from falls. Changing tables vary greatly and can be the cause of an infant's fall if the infant is left unattended. Although baby walkers are tested, they are the cause of more injuries than any other infant equipment. Injuries occur when young children in walkers fall down stairs or off porches. (Walkers are outlawed in licensed child care in California.)

What a Child Care Provider Can Do to Reduce Falls

You know well, as a child care provider, that there is not much you can do to block the activity levels of children in your care. However, you can reduce the risk of injuries through control of the children's environment, by teaching appropriate behaviors (both indoors and outdoors) and by careful supervision.

Modification of equipment and environment:

- Use infant and child equipment that is in good repair, inspected for safety, and meets the developmental needs of the children in your program.
- Use durable, balanced furniture that will not tip over easily.
- Get rid of baby walkers.
- Place safety gates at the top and bottom of stairs. Remove all objects from stairs.
- Make needed adjustments to the environment for children with mobility or other developmental needs.
- Keep windows screened and latched. Install window guards on upstairs windows.
- Pick up toys when play is finished.
- Pick up other objects from the floor and clean up spills quickly.
- Avoid highly waxed floors and stairways.
- Secure or remove loose mats and rugs.
- Use skid-proof mats or stickers in the bath.
- Keep the area well lit.
- Maintain safe playgrounds. The surface under and around play equipment where children can fall should be shock absorbent and soft (e.g., rubber, sand, pea gravel, or wood chips).

Bring about a change of behavior through education and supervision:

- Do not allow children to climb on furniture, stools or ladders.
- Never leave toddlers and infants unattended on beds, on changing tables, or in play areas.
- Discourage indoor running.
- Teach children how to play safely, involve them in making rules for playground behavior, and enforce these rules consistently.
- Actively supervise children at all times.

POSTER

November 2022

Active Supervision at-a-Glance

SIX STRATEGIES TO KEEP CHILDREN SAFE

The following strategies allow children to explore their environments safely. Infants, toddlers, and preschoolers must be directly supervised at all times.

Set Up the Environment

Set up the environment so you can supervise children and are always able to reach them if necessary. Keep spaces clutter-free and place furniture so you can observe the whole room.

Position Staff

Plan where you and other staff position yourselves to see and hear all children. Make sure there are clear paths to where children are playing, sleeping, and eating. This allows you to react quickly when necessary and stay close to children who may need additional support.

Scan and Count

Always be aware of where every child is and what they are doing. Scan the entire environment and count children frequently, especially during transitions when moving from one location to another.

Listen

Listen closely to children to identify signs of potential danger. Specific sounds or the absence of them may be reason for concern. Listen for signs that a child is getting upset or for sounds in the environment, such as bells on the door that alert you when a child leaves or enters the room.

Anticipate Children's Behavior

Use what you know about each child's temperament, developmental abilities, interests, and skills to predict what the child may do next. Pay attention to changes in a child's mood or health and anticipate when they may wander off, get upset, or take a dangerous risk.

Engage and Redirect

Offer support by using what you know about each child's individual needs and development. Encourage children to solve problems on their own and help them develop solutions if needed. Offer different levels of assistance or redirection depending on each child's needs.

Office of Head Start National Center

National Center on
Health, Behavioral Health, and Safety

1-888-227-5125
health@ecetta.info
https://eclkc.ohs.acf.hhs.gov/health

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Poisoning, Lead Poisoning

What a Child Care Provider Needs to Know

Children younger than 6 years old are the most likely to get poisoned, making up nearly half of all poisonings. Children who are 1 and 2 years old have the highest risk of poisoning. Young children are curious and will eat and drink almost anything—even if it does not taste good.

Although most poisoning occurs in the child's home, it can also occur in the child care setting. Poisons can be found in any room of the house or center, and poisonings can happen anywhere. However, most poisonings occur in the kitchen, bathroom or bedroom and in the presence of parents or providers, when products are not in their usual storage area and are in direct reach of young children.

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

Poisoning can occur by ingestion (eating or drinking), absorption (contact with skin, getting in the eyes), inhalation (breathing the fumes), injection (puncture wounds), and animal and insect bites.

What a Child Care Provider Can Do to Reduce Poisoning

Unintentional poisonings can be prevented. Methods of prevention include modification of the environment, education, and supervision.

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. Poisons should be kept out of sight and reach of children, and in a locked cabinet. Remember what good climbers children can be! Parents and teachers should always put their purses, diaper bags, backpacks, etc. out of reach of the children. Create a special place for parents to place their items when they are just there for a short period. Store medications in their original childproof containers out of children's reach.

Supervision

Remember that no area is 100 percent safe. Good safety practices and supervision help prevent accidents involving poisoning. Adult supervision is the number one method of preventing poisonings among small children. Discourage children from mouthing paint brushes, crayons or other objects and materials. Never call medicine "candy."

Education

Teach poison prevention to children and staff. Teach children never to put anything other than clean food into their mouths.

Be Prepared

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

1. Attach the phone number of the Poison Center to the telephone (call 800-222-1222).

2. If a poisoning occurs, do not panic. Do not follow the first-aid procedures recommended on the product as they may be incorrect. If the child is in obvious distress, call 9-1-1 for help. Otherwise, call the Poison Center for advice and document the incident and your actions. Call the parent.

WAYS IN WHICH POISONING CAN OCCUR

1. **Ingestion** occurs by eating or drinking. Children are attracted to bright colorful packages, pills and odd shapes. They often mistake pills and vitamins for candy. Approximately 85 percent of poisonings occur through ingestion.

2. **Absorption** occurs when poisonous substances such as pesticides or plants come in contact with a person's skin or eyes. In this type of indirect poisoning, the poison is absorbed through the skin or mucous membrane into the blood stream.

3. **Inhalation** occurs when children breathe fumes from carbon monoxide, pesticides, certain types of art materials or dust that may contain lead. The air is exchanged in the lungs and comes in direct contact with the blood stream.

4. **Animal and insect bites** can cause an allergic reaction, but they can also be very toxic and can lead to death. These include ticks which cause Lyme disease or Rocky Mountain spotted fever, and reptiles such as rattlesnakes.

5. **Injection** occurs when there is a puncture wound. The danger may come from the substance that was injected or from the threat of tetanus. Today there is an extra threat of children finding needles that have been used to inject drugs. An incident like this can cause the child to be exposed to HIV, hepatitis B or other infections.

COMMON HAZARDOUS HOUSEHOLD SUBSTANCES

Check for these poisonous products . . . then lock them up or throw them away

Kitchen

- ammonia
- carpet and upholstery cleaners
- cleaning fluid
- cleansers and scouring powders
- drain cleaner
- furniture polish
- metal cleaners
- oven cleaners
- powder and liquid detergents
- rust remover
- vitamins

Bedroom

- cologne/perfume
- cosmetics
- medications

Garage, Basement, Workshop

- antifreeze
- arts and crafts supplies
- adhesives/ glues
- fertilizer
- gasoline and oil
- kerosene
- lighter fluid
- lime, cement, mortar
- paint, remover and thinner
- pesticides/garden sprays
- turpentine
- windshield cleaner

Bathroom

- aftershave
- bath oil
- deodorant
- hair dyes
- hair remover
- nail polish and remover
- permanent wave solution
- room deodorizer
- rubbing alcohol
- shampoo
- shaving lotion
- toilet bowl cleaner

General

- alcoholic beverages
- batteries
- flaking lead-based paint

Closets, Attic, Storage Places

- moth balls and sprays
- rat, mouse and ant poisons

Purse

- cigarettes
- cigarette lighters
- medicines
- perfume

Laundry

- bleach
- bluing, dyes
- disinfectants
- powder and liquid detergents
- stain remover

Disposal of Household Products

= Considered Hazardous Waste. Your County Health Department should be able to advise you on proper disposal.

= Product can be put in the garbage can.

= Product can be flushed down the toilet or poured down the drain, diluted with lots of water.

Courtesy of the California Poison Control System

There's a little-known risk to small children.

Inside small electronic devices may be very powerful coin-sized button batteries. When swallowed, these batteries can get stuck in the throat and cause severe burns or death.

1. Keep devices with button batteries out of reach if the battery compartments aren't secure, and lock away loose batteries.
2. If a child swallows a button battery, go to the emergency room right away. Do not let the child eat or drink and do not induce vomiting.
3. Share this information with other parents and caregivers.

Coin lithium button batteries can cause severe injuries when swallowed.

Each year, there are about 3,200 calls to U.S. Poison Control Centers about a button battery being swallowed. Nearly 6 out of 10 of these cases are for children under the age of 6.

Many slim, sleek electronic devices have button battery compartments that are easy to open and most parents do not know there is a risk.

If a child swallows a button battery, symptoms may be similar to other illnesses, such as coughing, drooling, and discomfort. Kids can usually breathe with the battery in their throat, making the problem hard to spot.

National Battery Ingestion Hotline: 1-800-498-8666

SAFE KIDS WORLDWIDE

Lead Poisoning Prevention

Lead poisoning is one of the most common environmental illnesses among young children. Around 1 in 100 children under age 6 years old in California are found to have blood lead levels that could be harmful. (CDPH, 2015). Childhood lead poisoning can lead to problems with learning, behavior, and growth.

YOUNG CHILDREN ARE AT RISK

Young children are naturally curious. They explore by crawling around, touching, and putting toys and objects in their mouths. They spend a lot of time on the floor and ground where sources of lead may be found. Children absorb more lead than adults, and the toxic effects are greater because they are growing and developing.

LEAD TESTING FOR CHILDREN

Most children with lead poisoning do not look or act sick. Testing is the only way to know. Health care providers should assess young children for risk of lead exposure at every well-child visit up to age 6 years. Children with risk factors (for example, living in a building built before 1978 that has peeling or chipped paint or has recently been remodeled, or having recently moved from a country with high levels of environmental lead) should have a blood test. Publicly funded programs for low-income children (for example, Medi-Cal, Child Health and Disability Prevention Program (CHDP), Head Start, WIC) are required to test children for lead at 1 and 2 years old.

HOW YOU CAN HELP PROTECT CHILDREN FROM LEAD

Prevention is the most important way to protect children from lead poisoning. The following steps help to protect children from lead poisoning:

Raise awareness

Child care providers are required to give enrolling families written information about childhood lead poisoning, including the risks and effects of lead exposure and options for blood lead testing. A brochure with this information is available on the Community Care Licensing (CCL) website or by calling your regional CCL office. Encourage families to ask their child's health care provider about lead screening and testing. Educational posters, flyers, and brochures are also available in many languages on the California Department of Public Health (CDPH) website.

Reduce exposure. Eliminate possible sources of lead:

- Lead-based paint in homes built before 1978, especially if it is chipping, peeling, or generating dust from friction caused by opening windows and doors
- Vinyl mini-blinds
- Bare dirt
- Artificial play surfaces, including turf and rubber mulch
- Water from wells or running through plumbing that contains lead
- Old painted toys, old vinyl toys, or toys imported from outside the USA
- Some foods, including candy, spices, and seasonings, imported from outside the USA
- Some home remedies, make-up, and jewelry
- Some handmade or imported pottery*, dishes, and water crocks
- Lead brought home on clothes and shoes by parents who may be exposed at work
- Some hobbies such as making stained glass (lead solder), hunting or firing ranges (lead bullets), or fishing (lead sinkers)
- Property near busy highways and some industries

**Test kits for pottery are available in hardware stores.*

Provide good nutrition

Anemia and lead poisoning may occur together. Feed children healthy meals and snacks on a regular basis. See Module 3 for more information on healthy nutrition for young children.

Use lead-safe toys

Only use toys that are safe for children. Check toys for chipping paint and do not use old or imported toys unless you know they do not contain lead. You can check the Consumer Products Safety Commission (CPSC) for toys that have been recalled: www.cpsc.gov/Recalls/. Also, do not let young children play with keys, as they may contain lead.

Use the Lead Poisoning Prevention Checklist on page 2.73 to perform monthly inspections for sources of lead.

Wash children's hands

Hands can carry germs and other harmful substances, like lead dust, to children's mouths. See pages 1.19–1.20 for detailed instruction on when and how to wash children's hands. Children who self-soothe by sucking fingers and thumbs may need to wash their hands more often and when going to sleep (nap and bedtime).

Provide safe drinking water

Most tap water in California does not contain lead. However, testing your water is the only way to be sure that tap water is free from lead. See Module 1 for more information on drinking water safety. Licensed child care centers in buildings built before 2010 are required to have their tap water tested for lead between January 1, 2020 and January 1, 2023, and every five years thereafter. Centers must also inform parents of testing results.

You can reduce potential exposure to lead in tap water by:

Flushing the pipes in your home or center. Run water until it feels coldest, usually at least 30 seconds and up to a few minutes. This may take longer if the taps have been off for 6 or more hours.

Using only cold tap water for cooking, drinking, and mixing baby formula (if used as an alternative to breastfeeding).

If using a water filter, be sure to use an NSF-certified filter that removes lead. Change water filter according to manufacturer's instructions.

Paint, repair, and remodel your facility safely

If your child care facility was built before 1978, there is a risk for contamination when painting, repairing, or remodeling. The EPA's Renovation, Repair and Painting (RRP) rule requires renovations of child-occupied facilities to be carried out by Lead-Safe Certified contractors with special training in lead-safe work practices. This ensures renovations do not expose children to harmful lead dust.

Facilities with play yards exposed to heavy automobile traffic or located near an industrial area where lead products have been used or produced may also expose children to lead. In this case, have your facility evaluated by a lead-certified inspector. A list of lead certified contractors and inspectors is available on the CDPH website. Contact your local Lead Poisoning Prevention Program at your local Public Health Department for further information about lead inspections, including testing the soil, paint, and any old artificial turf at your facility.

Clean surfaces

Damp mop your floors and wipe down furniture, window sills, and other surfaces with a damp cloth regularly. Wash toys regularly. See Module 1 for detailed information on cleaning, sanitizing, and disinfecting.

Resources

Local Childhood Lead Poisoning Prevention Program:

(_____) _____

(Instructors should customize this section by placing their local Lead Poisoning Prevention Program telephone number here.)

California State Water Resources Control Board's Lead in Drinking Water Testing Assistance Program for Child Care Centers
https://ab2370assistance.owp.csus.edu/

CDPH Childhood Lead Poisoning Branch:
(510) 620-5600
www.cdph.ca.gov/Programs/CLPPB

Link to the one-hour Child Care Lead Poisoning Prevention Curricula:
https://cchp.ucsf.edu/content/child-care-lead-poisoning-prevention-curricula

CDC: Lead in Toys
https://www.cdc.gov/nceh/features/leadintoys/index.html

CDC Childhood Lead Poisoning Prevention Program
https://www.cdc.gov/nceh/lead

EPA Toolkit: Reducing Lead in Drinking Water https://www.epa.gov/ground-water-and-drinking-water/3ts-reducing-lead-drinking-water

Food and Drug Administration (FDA):
Lead in Food and Dishware
https://www.fda.gov/food/metals-and-your-food/lead-food-foodwares-and-dietary-supplements

An index of lead-certified professionals in California is available on the CDPH website. https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/LRCcertlist.aspx

California State Water Resources Control Board's Lead in Drinking Water Testing Assistance Program for Child Care Centers
https://ab2370assistance.owp.csus.edu/

EFFECTS OF LEAD EXPOSURE

Children 1-6 years old are the most at risk for lead poisoning.

- Lead poisoning can harm a child's nervous system and brain when they are still forming, causing learning and behavior problems that may last a lifetime.
- Lead can lead to a low blood count (anemia).
- Even small amounts of lead in the body can make it hard for children to learn, pay attention, and succeed in school.
- Higher amounts of lead exposure can damage the nervous system, kidneys, and other major organs. Very high exposure can lead to seizures or death.

LEAD POISONING FACTS

- Buildup of lead in the body is referred to as lead poisoning.
- Lead is a naturally occurring metal that has been used in many products and is harmful to the human body.
- There is no known safe level of lead in the body.
- Small amounts of lead in the body can cause lifelong learning and behavior problems.
- Lead poisoning is one of the most common environmental illnesses in California children.
- The United States has taken many steps to remove sources of lead, but lead is still around us.

IN THE US:

- Lead in house paint was severely reduced in 1978.
- Lead solder in food cans was banned in the 1980s.
- Lead in gasoline was removed in the early 1990s.

LEAD IN TAP WATER

The only way to know if tap water has lead is to have it tested.

Tap water is more likely to have lead if:

- Plumbing materials, including fixtures, solder (used for joining metals), or service lines have lead in them.
- Water does not come from a public water system (e.g., a private well).

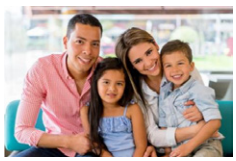
To reduce any potential exposure to lead in tap water:

- **Flush the pipes in your home**
  Let water run at least 30 seconds before using it for cooking, drinking, or baby formula (if used). If water has not been used for 6 hours or longer, let water run until it feels cold (1 to 5 minutes.)*
- **Use only cold tap water for cooking, drinking, or baby formula (if used)**
  If water needs to be heated, use cold water and heat on stove or in microwave.
- **Care for your plumbing**
  Lead solder should not be used for plumbing work. Periodically remove faucet strainers and run water for 3-5 minutes.*
- **Filter your water**
  Consider using a water filter certified to remove lead.

WARNING! Some water crocks have lead. Do not give a child water from a water crock unless you know the crock does not have lead.

(*Water saving tip: Collect your running water and use it to water plants not intended for eating.)

- For information on testing your water for lead, visit the Environmental Protection Agency at https://www.epa.gov or call (800) 426-4791. You can also visit the California Department of Public Health's website at www.cdph.ca.gov.

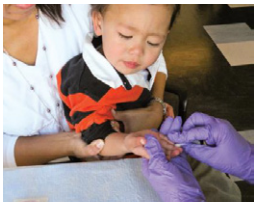


POTENTIAL SOURCES OF LEAD

- Old paint, especially if it is chipped or peeling or if the home has been recently repaired or remodeled
- House dust
- Soil
- Some imported dishes, pots and water crocks. Some older dishware, especially if it is cracked, chipped, or worn
- Work clothes and shoes worn if working with lead
- Some food, candies and spices from other countries
- Some jewelry, toys, and other consumer products
- Some traditional home remedies and traditional make-up
- Lead fishing weights and lead bullets
- Water, especially if plumbing materials contain lead

SYMPTOMS OF LEAD EXPOSURE

Most children who have lead poisoning do not look or act sick. Symptoms, if any, may be confused with common childhood complaints such as stomachache, crankiness, headaches, or loss of appetite.



A blood lead test is free if you have Medi-Cal or if you are in the Child Health and Disability Prevention Program (CHDP). Children on Medi-Cal, CHDP, Head Start, WIC, or at risk for lead poisoning, should be tested at age 1 and 2. Health insurance plans also will pay for this test. Ask your child's doctor about blood lead testing.

For more information, go to the California Childhood Lead Poisoning Prevention Branch's website at https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/CLPPBhome.aspx, or call them at (510) 620-5600.

The information and images found on this publication are adapted from the California Department of Public Health Childhood Lead Poisoning Prevention Program.

PUB 515 10/2019

Drowning

What a Child Care Provider Needs to Know

Drowning is a major cause of death among children under five years of age in California. Water safety presents a particular challenge to California child care providers. Most drownings in this age group occur in home swimming pools. Water-filled bathtubs, wading pools, toilets, buckets or other containers are also places where young children can drown.

Children between the ages of one and four years are at greatest risk from drowning. These children are just learning to walk and explore. They excel at getting out from under the watchful eye of the provider.

Small children are top-heavy; they tend to fall forward and head first when they lose their balance. They do not have enough muscle development in their upper body to pull themselves up out of a bucket, toilet or bathtub, or for that matter, any body of water. Even a bucket containing only a few inches of water can be dangerous for a small child.

Wading in bodies of fresh water may carry the additional risk of injury from cuts, puncture wounds and infections. Standing bodies of water such as swimming pools, wading pools and hot tubs also have the potential for spreading disease, so they are not recommended for use with young children. Instead, the use of sprinklers is recommended.

What a Child Care Provider Can Do to Reduce the Risk of Drowning

Reduce water hazards and prevent access to water.

Safety precautions must be taken to keep any water in the child care environment as risk-free as possible. Since any body of water poses a threat and young children can drown in as little as one inch of water, the outdoor environment should be thoroughly screened to detect hazards that may lead to the risk of drowning.

Promote safe behaviors.

Children themselves pose a threat when a body of water is present in the outdoor environment. They move fast, are curious and do not understand their physical abilities. The majority of drownings occur within a surprisingly short period of time. Never, ever, leave a child alone, even for a moment, when there is a body of water in the outdoor environment. When outdoors and near the water, always reinforce safety for the children. If the children are allowed to play in water, plan this activity for the time when they are the least tired and the most alert. Teach children safe practices for swimming and playing in the water to further protect them. Have a telephone within easy reach at all times. Never leave the area when children are present for a moment, even to answer the phone.

PREVENTING DROWNINGS

- *Constant adult supervision is the most important water safety measure. Make a plan so that you can maintain proper adult-to-child ratios at all times.*
- Never leave a child alone in or near any body of water (tub, wading pools, shower, pool or even a bucket).
- Latch toilet-seat covers down when not in use.
- If a portable wading pool is used in child care (although it is not recommended), it should be filled with water, used immediately and drained and put away as soon as children leave the pool.
- Never leave infants or children unattended around five-gallon buckets containing even a small amount of liquid. Empty all buckets when not in use.
- Always provide careful, direct and constant supervision of young children if there is a body of water present in the outdoor environment.
- Never expect swimming instruction to eliminate the risk of drowning in children. Keep in mind that young children who have had swimming lessons are more at risk because of over-confidence.
- Supervise children in the water even if they are wearing flotation devices. These devices are not substitutes for constant supervision.
- Any hazard, such as a swimming pool, should be enclosed.
  - The fence, or enclosure, must be at least 60 inches tall.
  - There must be no more than 2 inches of space between the bottom of the fence and the ground.
  - A door or sliding-glass door is not a safe substitute for a fence or enclosure.
- Any gates must:
  - open away from the pool,
  - be self-closing,
  - have a self-latching device at least 60 inches above the ground.
  - Keep gate keys in a safe place away from children.
- Never leave pool covers partially in place because children can become trapped beneath them. Pool covers are not a substitute for fencing.
- Keep chairs, tables and climbing equipment away from pool fences to prevent children from climbing over the fence into the pool. Inspect the area around the pool or body of water daily when children are present, to ensure they can not access it.
- Learn CPR and keep rescue equipment at poolside, including a life preserver, shepherd's crook and cordless telephone.
- Children with seizure disorders are particularly vulnerable to drowning. Know your children's medical history.
- Teach your children water safety behaviors (e.g., not to run, push or play around swimming areas; not to bring glass or bottles near swimming or wading areas; not to swim with anything in their mouths; not to swim in very cold water because it increases the risk of drowning; to be on the lookout for other children who might be in danger; not to go near a pool unless supervised; not to scream for help unless they mean it; not to roughhouse or fool around in water, etc.).

Young Children and Disasters

Disasters and Trauma

After experiencing a disaster—whether it is a flood, earthquake, fire, or human caused event, children may react in ways that are difficult to understand. Even if children are not physically injured, the emotional response can be strong. They may act clingy, irritable or distant, and although they are very young and do not seem to understand what is going on, they are affected as much as adults. Adult fears and anxieties are communicated to children in many ways. The experience is more difficult for them, as they do not understand the connection between the disaster and all the upheaval that follows. They need reassurance that everything is all right.

There is a wide range of "normal" reactions for children following a disaster, most of which can be handled with extra support at home, child care and school. In some cases, professional intervention may be needed, despite everyone's best efforts. Early intervention can help a child avoid more severe problems.

Message to Parents

Some ways to provide reassurance after a disaster are:

- Try to remain calm.
- Remember the effect and anxiety produced by watching television coverage or listening to the radio. Keep TV/radio/adult conversations about the disaster at a minimum around young children.
- Spend extra time being close to your child(ren).
- Answer all questions as honestly and simply as possible.
- Be prepared to answer the same questions over and over. Children need reassurance to master their fears.
- Spend extra time with your child at bedtime—soothing and relaxing time—talking, reading or singing quietly.
- Spend extra time with your child when bringing them to child care—they may be afraid you will not come back.
- Try to return to a normal routine as soon as possible to restore a sense of normalcy and security.
- Don't promise there won't be another disaster. Instead, encourage children to talk about their fears and what they can do to help in case of disaster. Tell them you will do everything you can to keep them safe.
- Be patient and understanding if your child is having difficulties.
- Never use threats. Saying, "If you don't behave an earthquake will swallow you up," will only add to the fear and not help your child behave more acceptably.
- Consider how you and your child can help. Children are better able to regain their sense of security if they can help in some way.
- Share your concerns with your child's teacher or child care provider. Consider assistance from professionals trained to work with disaster victims.

Message to Child Care Providers

You can be a support and resource to parents by helping them understand behavioral and emotional responses. Be sensitive to how parents feel when they are separated from their children in a disaster. It may be very helpful for parents, children and you to take some extra time when dropping off children in the morning. A group meeting to reassure parents, discuss your response to their children's reactions, and review your emergency plan will help everyone feel more secure.

Help children cope by talking about their fears. Talk about being afraid, and practice what you will do if a disaster strikes again. Because young children think the world revolves around them, children may need reassurance that they did not cause the disaster.

Consider referring a family for professional help if any of the behaviors on the following page persists two to four weeks after the disaster. Children who have lost family members or friends, or who were physically injured or felt they were in life-threatening danger, are at special risk for emotional disturbance. Children who have been in previous disasters or who are involved in a family crisis may also have more difficulty coping.

TYPICAL REACTIONS OF CHILDREN FOLLOWING DISASTER

Children Ages 1 to 5: Children in this age group are particularly vulnerable to changes in their routines and disruption of their environments. Dependent on family members for comfort, they may be affected as much by the reactions of family members as by the disaster. Focus on reestablishing comforting routines, providing opportunity for nonverbal and verbal expression of feelings, and reassurance.

Regressive Reactions	Emotional/Behavioral Reactions	Physiological	How to Help
• Bedwetting • Thumbsucking • Fear of darkness • Fear of animals • Fear of "monsters" • Fear of strangers	• Nervousness • Irritability • Uncooperative • Hyperactivity • Tics • Speech difficulties • Anxiety about separation from parents • Shorter attention span • Aggressive behavior • Exaggeration or distortion of disaster experience • Repetitive talking about experiences • Exaggeration of behavior problems	• Loss of appetite • Overeating • Indigestion • Vomiting • Bowel or bladder problems • Sleep disorders and nightmares	• Give additional verbal assurance and ample physical comforting. • Provide comforting bedtime routines. • Permit the child to sleep in the parents' room on a temporary basis. • Encourage expression of emotions through play activities including drawing, dramatic play, or telling stories about the experience. • Resume normal routines as soon as possible.

Children Ages 5 to 11: Regressive behaviors are especially common in this age group. Children may become more withdrawn or more aggressive. They might be particularly affected by the loss of prized objects or pets. Encourage verbalization and play enactment of their experiences. While routines might be temporarily relaxed, the goal should be to resume normal routines as soon possible.

Regressive Reactions	Emotional/Behavioral Reactions	Physiological	How to Help
• Increased competition with younger siblings • Excessive clinging • Crying or whimpering • Wanting to be fed or dressed • Engaging in habits they had previously given up	• School phobia • Withdrawal from play group and friends • Withdrawal from family contacts • Irritability • Uncooperative • Fear of wind, rain, etc. • Inability to concentrate and drop in level of school achievement • Aggressive behavior • Repetitive talking about their experiences • Sadness over losses • Overreaction to crises or changes in the environment	• Headaches • Complaints of visual or hearing problems • Persistent itching and scratching • Nausea • Sleep disturbance, nightmares, night terrors	• Give additional attention and ample physical comforting. • Insist gently but firmly that the child accept more responsibility than younger siblings; positively reinforce age-appropriate behavior. • Reduce pressure on the child to perform at his or her best in school and while doing chores at home. • Reassure the child that his competence will return. • Provide structured but not demanding chores and responsibilities. • Encourage physical activity. • Encourage verbal and written expression of thoughts and feelings about the disaster; encourage the child to grieve the loss of pets or toys. • Schedule play sessions with adults and peers.

POSTER

new! California Car Seat Law Changes

EFFECTIVE JANUARY 1, 2017

Most children will outgrow an infant seat before age 1

- The next step is a convertible car seat.
- Rear facing is 5 times safer than forward facing.
- The American Academy of Pediatrics recommends that children ride rear facing to the highest weight or height allowed by the car seat manufacturer.

Kaitlyn's Law

It's against California law to leave a child who is 6 years of age or younger alone in the car without the supervision of a person at least 12 years old if:

1. The keys are in the ignition or the car is running, or
2. There is a significant risk to the child.

NEW ADDITION

Starting January 1, 2017, children under 2 years old must be rear facing unless they weigh 40 pounds or more, or are 40 inches tall or more.

Children must be properly buckled in a car seat which is rear facing until age 2

CURRENT LAW

Children under age 8 must be buckled into a car seat or booster in the back seat.

Children age 8 or older, or who are 4'9" or taller, may use the vehicle seat belt if it fits properly with the lap belt low on the hips, touching the upper thighs, and the shoulder belt crossing the center of the chest. If children are not tall enough for proper belt fit, they must ride in a booster or car seat.

Everyone in the car must be properly buckled up.

FINES & PENALTIES

For each child under 16 who is not properly secured, parents (if in the car) or drivers can be fined more than **$500** and get a point on their driving records.

Keep your children safe. It's the law!

For answers to your child safety seat questions, contact your local health department or **visit cdph.ca.gov/vosp**.

POSTER

PARK. LOOK. LOCK.

Never leave a child alone in a car.
Remember to A-C-T.

A Avoid Heatstroke

Avoid heatstroke-related injury and death by never leaving a child alone in a car, not even for a minute. And make sure to keep your car locked when you're not inside so kids don't get in on their own.

C Create Reminders

Keep a stuffed animal or other memento in your child's car seat when it's empty, and move it to the front seat as a visual reminder when your child is in the back seat. Or place and secure your phone, briefcase or purse in the backseat when traveling with your child.

T Take Action

If you see a child alone in a car, call 911.
Emergency personnel want you to call.
They are trained to respond to these situations.

SAFE KIDS WORLDWIDE®

POSTER

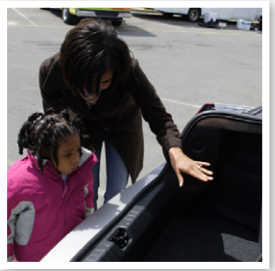
SAFE KIDS WORLDWIDE™

Trunk Entrapment Safety Tips

Everything you need to know to keep your kids safe from trunk entrapment.

Learn how to keep the car trunk off limits and teach children to be cautious in and around cars with some basic tips.

- Make sure to lock your vehicle, including doors and trunk, when you're not using it. Keep keys and remote entry fobs out of children's sight and reach.
- Teach kids that trunks are for transporting cargo and are not safe places to play.



- Show older kids how to locate and use the emergency trunk release found in cars manufactured after Sept. 1, 2001. Very young children may not have the strength or ability to open the release bar.

- Keep rear fold-down seats closed to help prevent kids from climbing into the trunk from inside your car.
- If your child is missing, get help and check swimming pools, vehicles and trunks. If your child is locked in a car, get him or her out as quickly as possible and dial 911 immediately. Emergency personnel are trained to evaluate and check for signs of heatstroke.

A combination of poor ventilation and high temperatures make trunk space a dangerous place for children. From 2005 to 2009, trunk entrapment resulted in the death of 16 children in the United States.

POSTER

SAFE KIDS WORLDWIDE™

Driveway Safety Tips

Everything you need to know to keep your kids safe around driveways.

Kids love cars, and when they see a parked car, they don't even think about the possibility of getting hurt or seriously injured. That's why parents have to. Many preventable injuries and deaths occur in driveways or parking lots when drivers are unaware that children are near vehicles. Tragically, these drivers are often family members or friends of the injured child. But these injuries are easily prevented by following a few simple tips.

Check Your Car and Driveway for Kids

- We know you're often in a hurry, but before you drive away, take a few seconds to walk all the way around your parked car to check for children.
- When checking for kids around your vehicle, see if anything that could attract a child such as a pet, bike or toy, is under or behind your vehicle before getting in and starting the engine.
- Designate an adult to supervise and find a safe spot for children to wait when nearby vehicles are about to move and make sure the drivers can see them.

Lend a Hand to Younger Kids

- Accompany little kids when they get in and out of a vehicle. Hold their hands while walking near moving vehicles or in driveways and parking lots or on sidewalks.

Each year, more than 9,000 children are treated in emergency rooms for injuries that occurred while they were unattended in or around motor vehicles.

Limit Play in the Driveway

- Work with your kids to pick up toys, bikes, chalk or any type of equipment around the driveway so that these items don't entice kids to play.
- Identify and use safe play areas for children, away from parked or moving vehicles. Teach kids to play in these areas instead of in, around or behind a car. Consider making your driveway a toy-free zone.
- Don't allow children to play unattended in parking lots when cars are present.

Field Trip Safety

Taking a field trip with young children can provide wonderful learning opportunities to enrich and extend your curriculum—but field trips be challenging! With careful planning, adequate staffing, and a spirit of adventure, adults and children can safely enjoy outings. Below is important information to consider when planning and making field trips with young children.

Research Your Destination Before You Take a Trip

Before selecting a field trip site, providers/teachers should consider why they are taking children on this field trip. Is this an activity that can only take place away from the child care program, such as a visit to a children's theater? Or could this experience occur just as well at the program site? For example, if you want children to learn about firefighters, you can visit the local fire station or instead you might ask your local fire department to come to your site with their equipment and a firetruck.

Be sure the destination you have chosen is safe and appropriate for young children. If possible, visit the site in advance of announcing the trip. Look at the site from a safety perspective, such as potential falls, entrapments, and choking/poisoning hazards. Remember, destinations such as parks, zoos, or landmarks are usually not "childproofed." Talk to others who have visited already, preferably those who have gone there with young children.

Find out if there are accessible restrooms and a supply of running water. What are the best times to visit to avoid large crowds? Are there generally many other groups of children at the same time? Are there hazards such as unfenced bodies of water, loose animals, poisonous plants, or stairs without secure railings? Does the trip require a long walk through a parking lot or along a busy street? Gathering this type of information ahead of time will help you choose an appropriate destination.

Obtain Written Consent for Each Participating Child

A permission slip specific to the trip should be distributed to families ahead of time, to be completed by the parents or guardians. The permission slip should include details about the trip, the date on which it will occur, the destination and its address, the mode(s) of transportation to be used, and the estimated times of the group's departure and return.

In addition to permission to attend, the permission slip should also include consent for emergency care if required during the trip. Parents must provide contact information so that the parent or a designated contact can be reached immediately to assume responsibility in the event of an emergency. Make sure the information you take with you is current.

Only children whose parents have signed and returned a permission slip should participate.

Maintain Staffing Requirements

During travel and at your destination, maintain the appropriate ratio of staff to children at all times. Parents should be welcome, and having additional adults around will certainly make the logistics of travel easier. However, parent participation must comply with current licensing regulations, and parent volunteers are not to be counted as substitutes for trained child care staff.

Use Child Safety Restraints

If your trip requires traveling in cars or vans, each participating child must travel in a car safety seat or booster that is appropriate for their age and weight. Preferably, parents will provide a seat that is already set up to fit the child to minimize the amount of time spent fidgeting and adjusting straps and buckles on the day of the trip.

Older children should buckle the lap belt and shoulder belt. Never double-buckle children in seat belts; each child should have his or her own seat belt to provide the best possible protection.

Bring Important Health and Safety Materials with You

Assemble a first aid kit and designate one staff member to carry it in a backpack or fanny pack. Contents should include:

- Disposable nonporous gloves
- Adhesive bandages of assorted shapes/sizes
- Gauze pads/rolls and bandage tape
- Scissors and tweezers
- Thermometer (not made of glass)
- Eye dressing
- Cold pack
- Bottled water
- Sunscreen
- Small splints
- Soap or disposable hand wipes
- Plastic bags for disposal of soiled materials
- A simple first aid guide or chart
- Any emergency medications potentially needed by participants
- List of emergency phone numbers, parent contact information, and poison control numbers
- A functional cell phone or coins for pay phones
- A pen or pencil and a small notepad, for taking down emergency notes or instructions

In addition, carry with you the care plans describing any special health needs of participating children. For example, if a participating child has asthma, the kit should contain the care plan as well as any medications or equipment he or she may need. Transport medications in a back pack, and keep them at the appropriate temperature. Check medications for special storage instructions (for example, does it need to be refrigerated or kept out of sunlight?). Ice packs may be used if medications need to be kept cool. Do not leave medications in vehicles as they can reach high temperatures in a short time.

Plan for Safe and Nutritious Food

If your trip will include a meal or snack, be sure to prepare food safely. Perishable items are generally not practical, since they require refrigeration or packing in ice. If the destination doesn't offer drinking fountains, participants will need to carry water to drink to prevent dehydration. The ability of children to carry their own backpacks or lunch sacks will depend on their ages and developmental levels. At the very least, for a short trip, a nutritious snack should be carried by the adults and distributed to the children at an appropriate time.

Maintain Basic Hygiene

Practice hand washing prior to eating, even when you are away from your site. It may be necessary to carry hand sanitizer to accomplish this, if there is no access to clean running water on your trip.

Identifying Labels and Apparel

Identify the children in your group with a special sticker, or even matching tee-shirts. Ready visual identification of the children in your group is especially helpful where there are many groups of young children present.

Bring a Roster Sheet of Participants

Bring a roster sheet of participants. An accurate list of children who have been signed in on the day of the trip is crucial. Use this list to conduct frequent exact head counts. Count the children as you leave the program, once they are in the vehicle(s), as they exit the vehicle(s), and when they get into the designated building or area. The roster should also allow for a parent or designated contact to sign out a child during the trip, if necessary.

School Bus Safety

POSTER

SAFE KIDS WORLDWIDE™

School Bus Safety Tips

Everything you need to know to keep your kids safe in and around the school bus.

Taking the bus for the first time is a big step for your child. Help your kids get a gold star in bus safety by following these tips.

- Walk with your kids to the bus stop and wait with them until it arrives. Tell kids to stand at least three giant steps back from the curb as the bus approaches and board the bus one at a time.
- Teach kids to wait for the bus to come to a complete stop before getting off and never to walk behind the bus.

- If your child needs to cross the street after exiting the bus, he or she should take five giant steps in front of the bus, make eye contact with the bus driver and cross when the driver indicates it's safe. Teach kids to look left, right and left again before crossing the street.
- Instruct younger kids to use handrails when boarding or exiting the bus. Be careful of straps or drawstrings that could get caught in the door. If your children drop something, they should tell the bus driver and make sure the bus driver is able to see them before they pick it up.
- Drivers should always follow the speed limit and slow down in school zones and near bus stops. Remember to stay alert and look for kids who may be trying to get to or from the school bus.
- Slow down and stop if you're driving near a school bus that is flashing yellow or red lights. This means the bus is either preparing to stop (yellow) or already stopped (red), and children are getting on or off.

School buses are the safest mode of motorized transportation for getting children to and from school, but injuries can occur if kids are not careful and aware when getting on and off the bus.

Safety Policies and Routines

TRAINER GUIDE

SECTION TOPICS

- Active Supervision
- Regular Safety Checks Inside and Outside
- Safe Playground Habits
- Safety Policies and Behavior Management
- Back Injury among Providers
- Forms and Checklists

Rationale: Clearly communicate your commitment to keeping children safe by providing written policies for staff, families, and children.

Time: 50 minutes

Learning Objectives

Participants will:

1. Understand how to establish, communicate, and promote written policies for and safety in child care programs.
2. Understand how safety routines reduce the risk of children's injuries.

Teaching Methods/Suggested Activities

- **Lecture:** Review and discuss what a child care provider needs to know about childhood injuries and what to do to reduce the risk of injury.
- **Question/Answers:** Respond to any questions that the group may have. Ask questions and emphasize important points that highlight the main concepts.
- **Case Studies:** Provide scenarios for students to problem solve how they would reduce the risk of injury for children.

Materials and Equipment Required

STUDENT HANDOUTS:

- Injury Report Form
- LIC 610 Centers, LIC 610A Homes
- LIC 624 Centers, LIC 624B Homes
- Lead Poisoning Prevention Checklist

OTHER MATERIALS:

- Flip Chart/Chalkboard/Whiteboard
- Case Studies
- Presentation Slides (if using a computer and LCD projector)

Questions/Comments: Stress that child care providers should use all measures possible to protect the children and prevent injury. Active supervision, environmental safety, developmentally appropriate activities, and clear polices work together to reduce the risk of injury.

Active Supervision

Active supervision means you are always watching so you can step in quickly in order to prevent injury or harm to a child. Here are some strategies that support active supervision.

- **Set up your space** so that it's free of clutter and hazards and you have easy access to children.
- **Position yourself** so you can see and hear every child and respond quickly if necessary.
- **Scan and count** so you know where everyone is. Count children regularly, especially during transitions.
- **Listen** for sounds of potential danger or warning.
- **Anticipate children's behavior** so you are aware of when they might do something dangerous.
- **Pay attention** to when children are unable to solve problems on their own so you can redirect.

Regular Safety Checks Inside and Outside

Each room and area of your child care facility contains potential hazards. Sometimes hazards are not obvious to the untrained eye, but children always find them. Examining the indoor and outdoor environments for safety hazards allows the child care provider to offer protection for the children and prevent unnecessary accidents. When we modify an environment for increased safety, we call it "childproofing."

In your facility, many environmental changes can and do occur almost daily—new children enter, others leave, you purchase new furniture and equipment, bring in pets, seasons change. Every change in your facility's environment should initiate an evaluation to see if it is safe and effective. This process is called "monitoring."

The indoor child care environment can include many physical hazards that pose risks through choking, poisoning, burns, falls, and other ways. Many of you control environmental hazards in your facility by instinct, but monitoring your facility for safety should be a deliberate and serious task. One way to accomplish this is by regularly using your safety checklists to insure that your environment is still childproof.

Childproofing Does Not Replace Supervision — It Enhances It

Your program must follow certain safety standards and practices in order to be licensed. Local building, sanitary, and fire safety codes must also be observed. You can create a safe environment by carefully following these additional guidelines:

- Know the licensing regulations for your child care setting.
- Know all applicable safety practices for the child care environment (such as not shaking a baby, always checking water temperature, putting babies on their back to sleep, keeping hot food and liquids out of reach).
- Be alert to hazards both indoors and outdoors, and eliminate or avoid them.
- Use safety devices where applicable (e.g., smoke alarms and safety guards around hot surfaces).
- Use a checklist to conduct safety checks of outdoor areas, indoor areas, and first aid kits on a regularly scheduled basis. Some features need to be checked daily, others weekly or monthly. Programs need to build safety checks into their daily, weekly, and monthly schedules.
- Encourage all staff to participate in conducting the checks and in the planning of ways to deal with hazards.
- Be aware of conditions that contribute to injuries. Whenever a hazard is found, fix it if you can. If you cannot fix it, make a note of it and follow up with plans to get it fixed.
- Know what you are buying or what is being donated to your program. Read labels and instructions carefully. If you have any questions or complaints about the safety of any product, call the Consumer Product Safety Commission (CPSC) at (800) 638-2772.

Remember: Childproofing a room does not make that room 100 percent safe!

SAFETY CHECKLIST

General Indoor Areas

- ☐ Guns are not allowed or kept in the child care setting.
- ☐ Areas are kept clean and unobstructed (to prevent physical injuries and fire hazards).
- ☐ Stairways are carpeted and have a child-height railing on the right side for descending.
- ☐ Smoke alarms are working.
- ☐ No peeling paint is visible; no lead-based paint is used.
- ☐ Electrical sockets are high and out of reach, or securely covered.
- ☐ No dangling or covered electrical extension cords are present.
- ☐ Medications and cleaning solutions are never kept in the classroom or playroom.
- ☐ All hardware on cribs, tables and bookcases is checked monthly (screws and bolts are tight).
- ☐ Chairs or tables are not used as ladders to hang items.
- ☐ No sharp corners are exposed on tables or other furniture.
- ☐ Toys are safe, with no sharp areas, pinch points or small parts.
- ☐ Fire exit from the room requires only one turn or pull-down action to open the door or gate.
- ☐ Accessible above-ground-level windows are protected with adequate grills or screens.
- ☐ Children cannot reach hot surfaces, hot pipes, heaters or vents.
- ☐ Freestanding space heaters are not used.
- ☐ Temperature of tap water for hand washing is maintained at 120° F or less.
- ☐ Lighting is adequate in all rooms.
- ☐ Walkways are clear between sleeping cots for children and staff.
- ☐ Children are never left alone in high chairs, chairs, or on changing tables.
- ☐ Infant walkers are never used.
- ☐ Pacifiers do not have anything attached to them.
- ☐ Secure heavy furniture that can tip, such as televisions and bookcases, to the walls with bolts or securing kits.
- ☐ Emergency phone is accessible.
- ☐ Trash cans are covered and secured.
- ☐ No smoking is allowed.
- ☐ Floors are smooth, clean and not slippery.

Kitchen

- ☐ Only authorized personnel are allowed in the kitchen.
- ☐ Sharp utensils are kept out of reach.
- ☐ All containers are clearly marked and have secure lids.
- ☐ Fire extinguishers are easily accessible.
- ☐ Items on shelving units, such as cans of food, are neatly organized, secured, and not piled high.
- ☐ Separate sinks are used for hand washing and food preparation.
- ☐ All medicines are out of reach of children.

Bathrooms

- ☐ Cleaning supplies and medicines are not accessible.
- ☐ Toilets and sinks are appropriate for use by children; step stools are provided.
- ☐ Water temperature for hand washing is maintained at 120° F or less.
- ☐ Floors are non-skid.

Outdoor Playground

- ☐ Equipment is checked weekly for sharp protrusions.
- ☐ Bolts are covered; swings have soft seats.
- ☐ Ground is covered with loose-fill surface material.
- ☐ Play area is fenced; gate has safety locks.
- ☐ Equipment is developmentally appropriate.
- ☐ Slides are enclosed or have handrails.
- ☐ Only one child at a time uses the equipment.
- ☐ There are no spaces where a child's head, leg or arm could be trapped (3 ½ to 9 inches).
- ☐ Constant supervision is provided.
- ☐ No poisonous plants, trash or sharp objects are in the area surrounding the playground.
- ☐ Sandboxes are kept covered when not in use.

Toxic Chemicals

- ☐ Kitchen and cleaning supplies should have their own locked storage unit.
- ☐ Cleaning solutions for use in classrooms and playrooms are stored in a locked cabinet.
- ☐ Pesticides and herbicides are stored in a locked cabinet.

Computers, Televisions and Electrical Equipment

- ☐ Ensure that the equipment is flush against the wall so that the electrical outlet is not exposed.
- ☐ Only authorized people provide service for equipment.
- ☐ Liquids are not allowed near equipment.
- ☐ Children are supervised while equipment is in use.
- ☐ Secure heavy furniture that can tip, such as televisions and bookcases, to the walls with bolts or securing kits.

Vans and Other Vehicles

- ☐ First aid kit is available.
- ☐ Child restraint devices are appropriate for the child's size, weight and development.
- ☐ Seat belts are used and maintained.
- ☐ Radio sound level is kept at a minimum, and the program content is appropriate for children.
- ☐ Vehicle tires, oil and brakes are maintained regularly.
- ☐ Driver has a current driver's license and is properly trained.
- ☐ Children are not allowed in the front seat.
- ☐ Vehicle is checked for sharp or rusty metal.
- ☐ An adult trained in CPR and first aid is available when traveling.
- ☐ Bike helmets are available when needed.

Training

- ☐ A person certified in pediatric first aid, rescue breathing and first aid for choking is on site at all times.
- ☐ Children are taught safety and emergency procedures.
- ☐ Staff is fully trained in emergency procedures for all children, including those with special health and/or developmental needs.

Art Supplies

- ☐ Nontoxic and natural materials such as dyes and water-based products are used.
- ☐ Use of scissors is supervised.
- ☐ Aerosol sprays and solvent-based glues are avoided.

Field Trips

- ☐ Adequate supervision is provided.
- ☐ Each child wears identification.
- ☐ Young children hold hands in pairs or hold onto a rope when walking in a group.
- ☐ Emergency medications are taken along

Equipment

- ☐ First aid kit is appropriately stocked.
- ☐ Sports equipment is safe and soft.

Emergency and Severe Weather Drills

- ☐ All children are safely evacuated to a safe area within three minutes.
- ☐ Monthly emergency drills are held.
- ☐ Smoke detectors and the alarm system are in place and working.
- ☐ Earthquake kits are well stocked and available.

Safe Playground Habits

Swings

- Sit in the center of the swing. Never stand or kneel.
- Hold on with both hands.
- Stop the swing before getting off.
- Stay far away from moving swings.
- Be sure only one person is in on a swing at a time.
- Do not swing empty swings or twist unoccupied rings.
- Keep head and feet out of the exercise rings.

Slides

- Wait your turn. Give the person ahead lots of room.
- Hold on with both hands when climbing up.
- Before sliding down, make sure no one is in front.
- Slide down feet first, sitting up, one at a time, unless the slide is double or triple width.
- After sliding down, get away from the front of the slide.

Climbing Apparatus

- Only _____ people at a time. (Fill in your limit.)
- Use both hands and use a lock grip (fingers and thumbs).
- Stay away from other climbers.
- Do not use when wet or hot.

Horizontal Ladders and Bars

- Only _____ people at a time. (Fill in your limit.)
- Everybody starts at the same end and goes in the same direction.
- Use a lock grip (fingers and thumbs).
- Keep a big space between you and the person in front.
- Do not use when wet or hot.
- Drop down with knees bent. Try to land on both feet.

Safety Policies and Behavior Management

Because of developmental factors that limit children's physical, mental and emotional abilities, they may lack the capacity to judge whether or not an activity is safe. It is the responsibility of child care providers to provide children with a safe environment and to ensure their well-being and protection. Safety policies for modifying the environment, modifying behavior, monitoring children and teaching injury-preventive behaviors to children will help the provider offer more safety protection and prevention in every child care situation.

The action of a child is the most common behavior leading to injury. The majority of behaviors displayed by a child are related to his or her developmental level. Adult behaviors contributing to a child's injury can be intentional (such as child abuse or violence) or unintentional (associated with a lack of supervision, a lack of knowledge or miscommunication). Most injuries are preventable.

In designing safety policies, understand the safety hazards in the child care environment and know what hazards are addressed by local licensing regulations and fire prevention boards. Providers need to check both inside and outside for hazards while applying special safety considerations to small children. Viewing the environment through the eyes of a child will help the provider find safety hazards and create safety checklists that offer maximum protection. Get down at the child's level so that you can see what the child sees.

Each type of safety hazard should have steps to follow to avoid risk. For example, if a field trip is scheduled, there should be a definite policy for travel with children. This would include trip planning and preparation, assuring enough adults for proper supervision, and procedures to follow during the trip and at its completion.

It is essential to have knowledge of the developmental abilities of the children in child care. The abilities of the children will affect the types of safety policies. These policies should be clearly written, based on standard safety practices and licensing regulations, specific to the hazard involved, and applicable to the specific child care environment. Additionally, if the child has a disability or other special need, such as behavior issues, there should be a special care plan on file.

Safety policies include guidelines, checklists and charts that help to protect the child care environment from hazards. These policies will guide the child care providers in methods of practicing safety and should name the person who is responsible for carrying out the safety process that is developed. The guidelines should address the areas where risks are anticipated, and how the environment should be modified and monitored for safety. Be sure to consider children who have sight or mobility restrictions.

Be a positive role model: keep in mind that your own attitudes and behaviors are as important as the physical environment of your facility. Role modeling should reflect the behaviors the child care provider wishes to pass on to the children. Education and supervision also help providers maintain a safe child care environment.

To prevent injuries in the child care setting, a safety policy and plan should be implemented.

Examples of Safety Policies

- Explaining safety actions to the children
- Prioritizing safety in the child care and community environments
- Using safety devices such as smoke alarms, carbon monoxide detectors, and electrical outlet plugs
- Creating a culture of safety, being sensitive to unsafe conditions
- Having daily routines for safety checks
- Removing hazards to ensure a safe physical environment
- Professional development on safety issues and practices
- Communicating with parents about safety measures
- Teaching what to do in an emergency and conducting practice drills and role-play
- Using special care plans for children with disabilities, behavior issues, and/or special health care needs.

Back Injury Among Providers

What a Child Care Provider Needs to Know

Back injury is the most common cause of occupational injury for child care providers, and can cause a great deal of pain, medical expenses, lost work time, and inconvenience. Providers need to exercise and practice good body mechanics to stay healthy.

Researchers who studied health risks for child care providers found the following work-related activities are associated with back injury:

1. Incorrect lifting of children, toys, and equipment.
2. Inadequate work heights (e.g., child-sized tables and chairs)
3. Lowering and lifting in and out of cribs
4. Frequent sitting on the floor with back unsupported
5. Excessive reaching above shoulder height to obtain stored supplies
6. Frequent lifting of children on and off the diaper changing tables
7. Awkward positions and forceful motions needed to open windows
8. Carrying garbage diaper bags to dumpster

What a Child Care Provider Can Do to Reduce Back Injury

You can prevent back injury in the following ways:

- Learn proper lifting and carrying techniques, such as keeping the child as close as possible to you and avoiding any twisting motion as you lift the child. Encourage independence in children—for example, walk up stairs with toddlers, rather than carrying them.
- Use adult furniture, not child-sized chairs, tables or desks. Use sit/kneel chairs.
- Always use proper body mechanics when lifting.
- Sit up against a wall or furniture for back support when possible. Perform stretching exercises.
- Redesign the kitchen area so that the heaviest items are at waist height. Reorganize snacks and supplies to simplify procedures for preparation of snacks. Use step stools when retrieving items above cupboard height.
- Use adult-height changing tables. Use a ramp or small, stable stepladders or stairs to allow children, with constant supervision, to climb up to changing tables or other places to which they would be lifted.
- Use step stools for better leverage. Have maintenance staff improve the quality of window slides.
- Use a cart to transport trash. Reduce the size and weight of loads.

POSTER

Protect Your Back

Follow these recommendations to reduce the risk of injury while you care for young children.

National Center on
Health, Behavioral Health, and Safety
1-888-227-5125
health@ecetta.info
https://eclkc.ohs.acf.hhs.gov/health

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1 USE BACK SUPPORT AND STRETCH

Avoid sitting on the floor too long without back support

Use the wall, furniture, or large pillow for back support

Do stretching exercises

2 LIFT SMART

Don't lift children with your back

As you lift, bend your knees and keep the child close to you

3 AVOID TWISTING WHILE LIFTING

Avoid twisting your body when lifting

Point your feet in the direction of the lift

4 AVOID CARRYING HEAVY LOADS

Don't carry heavy loads by yourself

Carry lighter loads

Use a cart, or get a co-worker to help you

Forms and Checklists

Injury Report Form

Fill in all blanks and boxes that apply

Name of Program: _____ Phone: _____

Address of Facility: _____

Child's Name: _____ Sex: M F Birthdate:___/___/___ Incident Date:___/___/___

Time of Incident: _____:_____ am/pm Witnesses: _____

Name of Legal Guardian/Parent Notified: _____ Notified by: _____ Time Notified: _____:_____ am/pm

EMS (911) or other medical professional ❑ Not notified ❑ Notified Time Notified: _____:_____ am/pm

Location where incident occurred: ❑ playground ❑ classroom ❑ bathroom ❑ hall ❑ kitchen ❑ doorway
❑ large muscle room or gym ❑ office ❑ dining room ❑ unknown ❑ other (specify) _____

Equipment/product involved: ❑ climber ❑ slide ❑ swing ❑ playground surface ❑ sandbox ❑ trike/bike ❑ hand toy

(specify):_____

❑ other equipment (specify): _____

Cause of injury: (describe) _____

❑ fall to surface; estimated height of fall _____ feet; type of surface: _____
❑ fall from running or tripping ❑ bitten by child ❑ motor vehicle ❑ hit or pushed by child ❑ injured by object
❑ eating or choking ❑ insect sting/bite ❑ animal bite ❑ injury from exposure to cold ❑ other (specify):_____

_____

Parts of body injured: ❑ eye ❑ ear ❑ nose ❑ mouth ❑ tooth ❑ other part of face ❑ other part of head ❑ neck
❑ arm/wrist/hand ❑ leg/ankle/foot ❑ trunk other (specify):_____

Type of injury: ❑ cut ❑ bruise or swelling ❑ puncture ❑ scrape ❑ broken bone or dislocation ❑ sprain
❑ crushing injury ❑ burn ❑ loss of consciousness ❑ unknown ❑ other (specify): _____

First aide given at the facility: (e.g., comfort, pressure, elevation, cold pack, washing, bandage): _____

_____

Treatment provided by:_____

❑ no doctor's or dentist's treatment required
❑ treated as an outpatient (e.g., office or emergency room)
❑ hospitalized (overnight) # of days: _____

Number of days of limited activity from this incident: _____ Follow-up plan for care of the child: _____

_____

Corrective action needed to prevent reoccurrence: _____

Name of official/agency notified: _____ Date: _____

Signature of staff member: _____ Date: _____

Signature of Legal Guardian/Parent: _____ Date: _____

copies: 1) child's folder 2) parent 3) injury log

LIC 610

EMERGENCY DISASTER PLAN FOR CHILD CARE CENTERS

INSTRUCTIONS:
Post a copy in a prominent location in facility, near telephone. Licensee is responsible for updating information as required. Return a copy to the licensing office.

Name of Facility			Administrator of facility	
Facility address (Number, Street	City,	State,	Zip Code,)	Telephone Number ( )

I. ASSIGNMENTS DURING AN EMERGENCY (Use reverse side if additional space is required)

Name(s) of staff	Title	Assignment
1.		Direct evacuation and person count
2.		Handle First Aid
3.		Telephone emergency numbers
4.		Transportation:
5.		Other (Describe):
6.		

II. EMERGENCY NAMES AND TELEPHONE NUMBERS (In addition to 9-1-1)

Police or Sheriff:	Office of Emergency Services:
Red Cross:	Poison Control:
Hospital(s):	Other Agency/Person:
Child Protective Services:	

III. FACILITY EXIT LOCATIONS (Using s copy of the facility sketch [LIC 999] indicate exits by numbers)

1.	2.
3.	4.

IV. TEMPORARY RELOCATION SITE(S) (If available, submit letter of permission from renter/leassor/ manager/property owner)

Name:	Address:	Telephone Number: ( )
Name:	Address:	Telephone Number: ( )

V. UTILITY SHUT—OFF LOCATIONS (Indicate location(s) on the facility sketch [LIC 999])

Electricity:
Water:
Gas:

VI. FIRST AID KIT (LOCATION):

VII. EQUIPMENT

Smoke Detector location (If required):
Fire Extinguisher location (If required):
Type of fire alarm sounding device (If Required):
Location of device:

VIII. AFFIRMATION STATEMENT

As administrator of this facility, I assume responsibility for this plan for providing emergency services as indicated below. I shall instruct all clients/residents, age and abilities permitting, any staff and/or household members as needed in their duties and responsibilities under this plan.

Signature	Date

LIC 610 (11/23) (PUBLIC)

LIC 610A

California Health and Human Services Agency | California Department of Social Services

EMERGENCY DISASTER PLAN FOR FAMILY CHILD CARE HOMES

Type or print clearly. Post next to phone. Keep Current - Return a copy to the licensing office.

Licensee Name:	Date:

1. EMERGENCIES - LIFE THREATENING - Call 9-1-1 - Tell them: Number Calling from:

Home Address:

Major Crossroad:

Home Direction from Crossroad:

2. EMERGENCY NAMES AND TELEPHONE NUMBERS (In addition to 9-1-1)

Fire/Paramedics:		Office of Emergency Services:	
Red Cross:	Licensing:	Ambulance:	Other:
Hospital:	Police/Sheriff:	Child Protective Services:	
	Poison Control:		

3. FACILITY EVACUATION - Some disasters require evacuation of the building. Using a copy of the Facility Sketch (LIC 999A), show arrows for the safest way to exit rooms. Be sure that exit doors are not locked from the inside. In the event of a fire, get everyone out, follow the escape routes, meet at a prearranged location, account for everyone, do not let anyone return to the building and call the fire department.

4. TEMPORARY RELOCATION SITE(S) - Some disasters require moving to a safe location. When relocating, determine whether you need food, water, blankets and flashlight and meet at a prearranged easily accessible location. Be sure to obtain permission from the property owner.

Name:	Phone: (____)_____
Address:	
Name:	Phone: (____)_____
Address:	

5. UTILITY SHUT OFF -Indicate locations on the Facility Sketch (LIC 999A) with the exit routes.

Gas:	Gas Co. Phone: (____)_____
Electric:	Electric Co. Phone: (____)_____
Water:	Water Co. Phone: (____)_____

6. EQUIPMENT LOCATION - The fire department may help you with installation information.

Fire Extinguisher Location:	Smoke Detector Location:
Fire Alarm Location (If you have one):	Type:

7. OTHER EMERGENCY EQUIPMENT - Where appropriate identify location of first aid kit, blankets, food and water, flashlight, radio and other emergency equipment.

Location:

LIC 624B

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

UNUSUAL INCIDENT/INJURY REPORT - FAMILY CHILD CARE HOME

1. FACILITY LICENSE NUMBER:	2. LICENSEE NAME:
3. FACILITY NAME:	4. FACILITY ADDRESS:

5. Name of Child(ren) Involved	6. Birth Date/Age	7. Sex M / F	8. Admission Date	9. Primary Language	10. Date/Time of Incident/Injury

11. EVENT REPORTED TO THE DEPARTMENT *(CHECK ALL THAT APPLY)*

a. ☐ Death of any child from any cause.
b. ☐ Any injury to a child that requires treatment by a medical professional.
c. ☐ Any child absence meaning any instance where a child in care is missing.
d. ☐ Any suspected child abuse or neglect of any child in care. (Must also be reported to local law enforcement or Child Protective Services.)
e. ☐ Fires or explosions in or on the premises of the family child care home.
f. ☐ A communicable disease outbreak when determined by the local health authority.
g. ☐ Poisonings
h. ☐ Other incident that threatens the physical or emotional health and safety of any child.

12. DESCRIBE WHAT HAPPENED:

13. BRIEFLY DESCRIBE THE INJURY, IF ANY:

14. DESCRIBE STEPS TAKEN TO PREVENT THIS INCIDENT OR INJURY IN THE FUTURE:

15. NAME OF PHYSICIAN OR OTHER HEALTH CARE PROVIDER, IF APPLICABLE:	16. PHYSICIAN OR HEALTH CARE PROVIDER TELEPHONE NUMBER: ( )
17. NAME AND TELEPHONE NUMBER OF PARENT(S), OR AUTHORIZED REPRESENTATIVE:	18. DATE THE PARENT/AUTHORIZED REPRESENTATIVE OF THE AFFECTED CHILD WAS NOTIFIED:

19. Agency(ies) Notified	20. Name of Person(s) Contacted	21. Date	22. Telephone or Fax
☐ State Child Care Licensing			( )
☐ County Child Care Licensing			( )
☐ Child Protective Services			( )
☐ Law Enforcement			( )

23. LICENSEE SIGNATURE	24. TELEPHONE NUMBER. ( )	25. DATE:

(TO BE COMPLETED BY DEPARTMENT)

Date report received in Licensing Office: _____ Date report reviewed and logged : _____

EVALUATION OF REPORT:

Follow up inquiry required ☐ Yes ☐ No Investigation required ☐ Yes ☐ No

REFERRED TO:

☐ Licensing Program Analyst Date Reviewed:_____ Case Management Visit ☐ Yes ☐ No
☐ Licensing Program Manager/Sup Date Reviewed:_____
☐ Regional/Program Manager Date Reviewed:_____ Other _____

DISPOSITION:

UNUSUAL INCIDENT/INJURY REPORT - FAMILY CHILD CARE HOME

EVENTS THAT MUST BE REPORTED TO PARENTS/AUTHORIZED REPRESENTATIVES AND/OR THE DEPARTMENT:

A. No later than the same business day, notify a child's parent or authorized representative of the events listed in #11 that affect that child.
B. Within the next business day, notify the Department by telephone or fax of the events listed in #11.
C. If reported to the Department by telephone, submit written report within 7 calendar days of the event.
D. Keep a copy of the report submitted to the Department in the (affected) child's record.

GENERAL INSTRUCTIONS FOR COMPLETION

1. Enter the facility number as shown on the license
2. Enter the licensee's name as shown on license.
3. Enter the name of the facility as shown on the license.
4. Enter the number and street address, city, and zip code.
5. Enter the first and last name of each child involved in the incident or injury.
6. Enter the child's age or the month, date, and year of birth.
7. Enter the gender of each child as M for Male or F for Female.
8. Enter the month, date, and year each child was accepted into the family child care home.
9. Enter the language that the child or parent speaks*(i.e., English, Spanish, etc.*).
10. Enter the month, date, year and the time of day that the incident or injury happened.
11. Event to be reported:
    a. Check if any child has died from any cause.
    b. Check if a child was injured, and the injury required treatment by a medical professional.
    c. Check if a child in care leaves or wanders (is missing) from the facility without permission or supervision, including when a child is missing during any outing or special event away from the facility, or a child does not return from school.
    d. Check if it is suspected that a child has been abused or neglected.
    e. Check if there is a fire or explosion in or on the premises of the family child care home.
    f. Check if there is a communicable disease outbreak when determined by the local health authority.
    g. Check if any child is poisoned while in care.
    h. Check if there is some other incident that threatens the physical or emotional health and safety of any child.
12. Describe what happened. Be specific. Include name of person(s) involved in or suspected of causing the injury.
13. Include medical findings and treatment.
14. Describe how this incident or injury will be prevented in the future.
15. Enter the first and last name and title of the physician or other health care provider providing care to child, if known.
16. Enter the area code and telephone number of the physician or other health care provider.
17. Enter the name(s) and telephone number of the child's parent(s), or authorized representative(s).
18. Enter the month, date, and year that the child's parent(s), or authorized representative(s) were notified.
19. Check one or more of the agencies notified of the incident or injury.
20. Enter the name of the person *(for each agency)* with whom you spoke when reporting the event.
21. Enter the month, day, and year next to the agency person's name that was contacted.
22. Enter the area code and telephone or fax number of the agency contacted.
23. Enter your signature here.
24. Enter your area code and telephone number.
25. Enter the month, date, and year this report is signed.

LIC 624

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

UNUSUAL INCIDENT/INJURY REPORT

INSTRUCTIONS : NOTIFY LICENSING AGENCY, PLACEMENT AGENCY AND RESPONSIBLE PERSONS, IF ANY, BY NEXT WORKING DAY.

SUBMIT WRITTEN REPORT WITHIN 7 DAYS OF OCCURRENCE.

RETAIN COPY OF REPORT IN CLIENT'S FILE.

NAME OF FACILITY	FACILITY FILE NUMBER	TELEPHONE NUMBER
		( )
ADDRESS	CITY, STATE, ZIP	

CLIENTS/RESIDENTS INVOLVED	DATE OCCURRED	AGE	SEX	DATE OF ADMISSION

TYPE OF INCIDENT

- ☐ Unauthorized Absence
- ☐ Aggressive Act/Self
- ☐ Aggressive Act/Another Client
- ☐ Aggressive Act/Staff
- ☐ Aggressive Act/Family, Visitors
- ☐ Alleged Violation of Rights

Alleged Client Abuse

- ☐ Sexual
- ☐ Physical
- ☐ Psychological
- ☐ Financial
- ☐ Neglect

- ☐ Rape
- ☐ Pregnancy
- ☐ Suicide Attempt
- ☐ Other

- ☐ Injury-Accident
- ☐ Injury-Unknown Origin
- ☐ Injury-From another Client
- ☐ Injury-From behavior episode
- ☐ Epidemic Outbreak
- ☐ Hospitalization

- ☐ Medical Emergency
- ☐ Other Sexual Incident
- ☐ Theft
- ☐ Fire
- ☐ Property Damage
- ☐ Other *(explain)*

DESCRIBE EVENT OR INCIDENT (INCLUDE DATE, TIME, LOCATION, PERPETRATOR, NATURE OF INCIDENT, ANY ANTECEDENTS LEADING UP TO INCIDENT AND HOW CLIENTS WERE AFFECTED, INCLUDING ANY INJURIES:

PERSON(S) WHO OBSERVED THE INCIDENT/INJURY:

EXPLAIN WHAT IMMEDIATE ACTION WAS TAKEN (INCLUDE PERSONS CONTACTED):

LIC 624 (4/99)

OVER

MEDICAL TREATMENT NECESSARY? ☐ YES ☐ NO IF YES, GIVE NATURE OF TREATMENT:

WHERE ADMINISTERED:	ADMINISTERED BY:

FOLLOW-UP TREATMENT, IF ANY:

ACTION TAKEN OR PLANNED (BY WHOM AND ANTICIPATED RESULTS:

LICENSEE/SUPERVISOR COMMENTS:

NAME OF ATTENDING PHYSICIAN

	NAME AND TITLE	DATE
REPORT SUBMITTED BY:		
REPORT REVIEWED/APPROVED BY:	NAME AND TITLE	DATE

AGENCIES/INDIVIDUALS NOTIFIED *(SPECIFY NAME AND TELEPHONE NUMBER)*

☐ LICENSING_____ ☐ ADULT/CHILD PROTECTIVE SERVICES_____

☐ LONG TERM CARE OMBUDSMAN_____ ☐ PARENT/GUARDIAN/CONSERVATOR_____

☐ LAW ENFORCEMENT_____ ☐ PLACEMENT AGENCY_____

LIC 700

State of California – Health and Human Services Agency | California Department of Social Services

IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST		MIDDLE	FIRST		SEX	TELEPHONE ( )
ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE	FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	HOME TELEPHONE ( )
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE	FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD	LAST	MIDDLE		FIRST	HOME TELEPHONE ( )		BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	LAST DATE OF ENROLLMENT

Lead Poisoning Prevention Checklist

YES	NO	
		Was the property built before 1978? If yes, have the paint tested.
		Is the paint in poor condition? Check often for cracked, damaged, or peeling paint in the interior and exterior of your structure. Check the windows, stairs, doorways, floors, and porches. Move cribs and other furniture away from the walls and other possible sources of lead. If yes, choose painting contractors who follow lead-safety practices.
		Has your property (built before 1978) been recently painted or renovated? If yes, children may be at risk for lead exposure from dust and paint chips.
		Will your property (built before 1978) be renovated soon? If yes, choose contractors who follow lead-safety practices.
		Was your facility built before 1986? Pipes in buildings built before 1986 are more likely to have pipes, solder, or fixtures that contain lead. If yes: ● Consider replacing older brass fixtures with new ones that meet the January 1, 2010, requirements. Items that carry the NSF 61, Annex G designation meet this designation. ● Let your water run until it feels coldest (usually 30 seconds to a few minutes depending on how long the water has been sitting in the pipes) before use to get any potential lead out. Use only cold water from the tap to cook with, drink, or mix with infant formula.
		Is the property near a busy roadside that may have been contaminated with leaded gasoline emitted by cars? If yes, ● Don't let children play on bare soil. ● Plant grass, shrubs or other ground cover to prevent direct contact with the soil. ● Remove shoes when coming inside.
		Does your property have bare soil? If yes, ● Don't let children play on bare soil. ● Plant grass, shrubs or other ground cover to prevent direct contact with the soil. ● Remove shoes when coming inside.
		Does the property have lead dust? Check high friction areas like windows and doors. If yes, clean floors and window sills often with soap and water and then rinse with fresh water. Wash children's hands before and after eating, after playing outside and before napping.
		Do you have older imported vinyl mini-blinds? If yes, remove them or have them tested to make sure they don't contain lead.
		Do you own imported or homemade china or ceramic dishware or water crocks? If yes, have it tested to make sure it does not contain lead.
		Do you have painted or plastic furniture or toys from an unknown origin? If yes, have them tested to make sure they are lead-free. Don't let children chew on painted furniture or toys.

Health and Safety Checklist for Early Care and Education Programs:

Based on *Caring for Our Children* National Health and Safety Performance Standards

Child Care Center: _____

Classroom: _____

Classroom type (infant/toddler, preschool): _____

Date: (month/day/year) __ __/ __ __ / __ __ __ __

Observer Name: _____

Time Begin: __ __:__ __AM/PM

Time End: __ __:__ __AM/PM

Ratings:

Code	Meaning	Definition
1	Never	None of the components of the item are met.
2	Sometimes	Less than or 50% (≤50%) of the components in the item are met.
3	Usually	More than 50% (>50%) but less than 100% of the components in the item are met.
4	Always	Every component in the item is met (100%).
NA	Not Applicable	The item is not applicable (NA) to the classroom/program. Explain why it is rated NA in the 'notes' section.
N Op	No Opportunity to Observe	There was no opportunity (N Op) to observe this item. Explain why it is rated N Op in the 'notes' section.

Notes:

- An asterisk (*) means you may need to talk to the director or a staff member to ask where to find an item or product.
- At the end of each subscale there is a space to list and rate other related standards and/or regulations that may apply.
- When a field/box is shaded grey, the rating choice is not an option.

This checklist does not cover all health and safety concerns or replace each child care program's responsibility to meet local, state, and federal health and safety requirements.

FACILITIES: Emergencies, Medications, Equipment and Furnishings

Emergencies

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
1. A sign-in/sign-out system tracks who (other than children) enters and exits the facility. It includes name, contact number, purpose of visit (for example, parent/guardian, vendor, guest, consultant) and time in and out. (Std. 9.2.4.7)	1	2	3	4		
NOTES						
2. Phone numbers to report child abuse and neglect (Child Protective Services) are clearly posted where any adult can easily see them. (Std. 3.4.4.1)	1	2	3	4		
NOTES						
3. Phone number for the Poison Center is posted where it can be seen in an emergency (for example, next to the phone). (Stds. 5.2.9.1, 5.2.9.2)	1	2	3	4		
NOTES						
4. Fire extinguishers are inspected annually. Check date on fire extinguisher tag. (Std. 5.1.1.3)	1	2	3	4		
NOTES						
5. Each building or structure has at least two unobstructed exits, at different sides of the building or home, leading to an open space at the ground floor. (Std. 5.1.4.1)	1	2	3	4		
NOTES						
6. A smoke detector system or alarm in working order is in each room or place where children spend time. (Std. 5.2.5.1)	1	2	3	4		
NOTES						
7. *Carbon monoxide detectors are outside of sleeping areas. (Std. 5.2.9.5)	1	2	3	4	NA	
NOTES						
8. *First aid supplies are well-stocked in each location where children spend time. (Std. 5.6.0.1)	1	2	3	4		
NOTES						
9. *First aid supplies are kept in a closed container, cabinet or drawer that is labeled. They are stored out of children's reach and within easy reach of staff. (Std. 5.6.0.1)	1	2	3	4		
NOTES						
10. *A well-stocked first aid kit is ready for staff to take along when they leave the facility with children (for example, when going on a walk, a field trip or to another location). (Std. 5.6.0.1)	1	2	3	4	NA	
NOTES						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
NOTES						

Medications

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
11. *Medications are stored in an organized fashion and are not expired. They are stored at the proper temperature, (for example, in the refrigerator or at room temperature according to instructions) out of children's reach and separated from food. (Std. 3.6.3.2)	1	2	3	4	NA	
NOTES						
12. *Over-the-counter medications are in the original containers. They are labeled with the child's name. Clear written instructions from the child's health care provider are with the medication. (Stds. 3.6.3.1, 3.6.3.2)	1	2	3	4	NA	N Op
NOTES						
13. *Prescription medications are in their original, child resistant container, labeled with child's name, date filled, prescribing health care provider's name, pharmacy name and phone number, dosage, instructions and warnings. (Stds. 3.6.3.1, 3.6.3.2)	1	2	3	4	NA	N Op
NOTES						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
NOTES						

Equipment and Furnishings — Indoors and Outdoors

14. There is fresh air provided by windows or a ventilation system. There are no odors or fumes (for example, mold, urine, excrement, air fresheners, chemicals, pesticides.) (Stds. 5.2.1.1, 3.3.0.1, 5.2.8.1)	1	2	3	4		
NOTES						
15. Windows accessible to children open less than 4 inches or have window guards so that children cannot climb out. (Std. 5.1.3.2)	1	2	3	4	NA	
NOTES						
16. There are no unvented gas or oil heaters or portable kerosene space heaters. (Std. 5.2.1.10)	1			4		
NOTES						
17. Gas cooking appliances are not used for heating purposes. Charcoal grills are not used indoors. (Std. 5.2.1.10)	1			4	NA	
NOTES						
18. Portable electric space heaters are not used with an extension cord and are not left on when unattended. They are placed on the floor at least three feet from curtains, papers, furniture and/or any flammable object and are out of children's reach. (Std. 5.2.1.11)	1	2	3	4	NA	N Op
NOTES						
19. All electrical outlets within children's reach are tamper resistant or have safety covers attached by a screw or other means that cannot be removed by a child. (Std. 5.2.4.2)	1	2	3	4	NA	
NOTES						
20. All cords from electrical devices or appliances are out of children's reach. (Stds. 4.5.0.9, 5.2.4.4)	1	2	3	4		
NOTES						

Equipment and Furnishings — Indoors and Outdoors — *Continued*

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
21. There are no firearms, pellet or BB guns, darts, bows and arrows, cap pistols, stun guns, paint ball guns or objects manufactured for play as toy guns visible. (Std. 5.5.0.8)	1 ○			4 ○		
NOTES						
22. Plastic bags, matches, candles and lighters are stored out of children's reach. (Stds. 5.5.0.7, 5.5.0.6)	1 ○	2 ○	3 ○	4 ○		
NOTES						
23. There are no latex balloons (inflated, underinflated, or not inflated) or inflated objects that are treated as balloons (for example, inflated latex gloves) on site. (Stds. 6.4.1.5, 6.4.1.2)	1 ○			4 ○		
NOTES						
24. Bathtubs, buckets, diaper pails and other open containers of water are emptied immediately after use. (Std. 6.3.5.2)	1 ○	2 ○	3 ○	4 ○	NA ○	
NOTES						
25. Children do not play in areas where there is a body of water unless a caregiver/teacher is within an arm's length providing "touch supervision". Bodies of water include tubs, pails, sinks, toilets, swimming pools, ponds, irrigation ditches and built-in wading pools. (Std. 2.2.0.4)	1 ○			4 ○	NA ○	N Op ○
NOTES						
26. Hot liquids and food (more than 120°F) are kept out of children's reach. Adults do not consume hot liquids in child care areas. (Std. 4.5.0.9)	1 ○	2 ○	3 ○	4 ○		
NOTES						
27. Equipment and play areas (including water play areas) do not have sharp points or corners, splinters, glass, protrusions that may catch a child's clothing (for example, nails, pipes, wood ends, long bolts), flaking paint, loose or rusty parts, small parts that may become detached or present a choking, aspiration, or ingestion hazard, strangulation hazards (for example, straps or strings), or components that can snag skin, pinch, or sheer or crush body tissues. (Stds. 5.3.1.1, 6.2.1.9, 6.3.1.1)	1 ○	2 ○	3 ○	4 ○		
NOTES						
28. All openings in play or other equipment are smaller than 3.5 inches or larger than 9 inches. There are no rings on long chains. (Stds. 6.2.1.9, 5.3.1.1)	1 ○	2 ○	3 ○	4 ○		
NOTES						
29. All openings in play or other equipment are smaller than 3/8 of an inch or larger than 1 inch. (Std. 6.2.1.9)	1 ○	2 ○	3 ○	4 ○		
NOTES						
30. Climbing equipment is placed over and surrounded by a shock-absorbing surface. Loose fill materials (for example, sand, wood chips) are raked to maintain proper depth/distribution. Unitary shock-absorbing surfaces meet current ASTM International standards and/or CPSC Standards. http://www.astm.org/Standards/F2223.htm http://www.cpsc.gov//PageFiles/122149/325.pdf (Std. 6.2.3.1, Appendix Z)	1 ○	2 ○	3 ○	4 ○	NA ○	N Op ○
NOTES						
31. Fall zones extend at least six feet beyond the perimeter of stationary climbing equipment. (Std. 6.2.3.1)	1 ○	2 ○	3 ○	4 ○	NA ○	N Op ○
NOTES						
32. Equipment and furnishings are sturdy and in good repair. There are no tip-over or tripping hazards. (Std. 5.3.1.1)	1 ○	2 ○	3 ○	4 ○		
NOTES						

Equipment and Furnishings — Indoors and Outdoors — *Continued*

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
33. There is no hazardous equipment (for example, broken equipment, lawn mowers, tools, tractors, trampolines) accessible to children. (Std. 5.7.0.4, 6.2.4.4)	1 ○			4 ○		
NOTES						
34. Open sides of stairs, ramps, porches, balconies and other walking surfaces, with more than 30 inches to fall, have guardrails or protective barriers. The guardrails are at least 36 inches high. (Std. 5.1.6.6)	1 ○	2 ○	3 ○	4 ○	NA ○	
NOTES						
35. Children one year of age and older wear helmets when riding toys with wheels (for example, tricycles, bikes) or using any wheeled equipment (for example, rollerblades, skateboards). Helmets fit properly and meet CPSC standards. Children take off helmets after riding or using wheeled toys or equipment. (Std. 6.4.2.2)	1 ○	2 ○	3 ○	4 ○	NA ○	N Op ○
NOTES						

Equipment and Furnishings — Outdoors Only

36. Children play outdoors each day. Children stay inside only if weather poses a health risk (for example, wind chill factor at or below minus 15°F, heat index at or above 90°F). (Std. 3.1.3.2)	1 ○	2 ○	3 ○	4 ○		N Op ○
NOTES						
37. Outdoor play areas are enclosed with a fence or natural barriers that allow caregivers/teachers to see children. Openings in fences and gates are no larger than 3.5 inches. (Std. 6.1.0.8)	1 ○	2 ○	3 ○	4 ○	NA ○	N Op ○
NOTES						
38. Enclosures outside have at least two exits, one being remote from the building. (Std. 6.1.0.8)	1 ○	2 ○	3 ○	4 ○	NA ○	N Op ○
NOTES						
39. Each gate has a latch that cannot be opened by children. Outdoor exit gates are equipped with self-closing, positive latching closure mechanisms that cannot be opened by children. (Std. 6.1.0.8)	1 ○	2 ○	3 ○	4 ○	NA ○	N Op ○
NOTES						
40. Shade is provided outside (for example, trees, tarps, umbrellas). Children wear hats or caps with a brim to protect their faces from the sun if they are not in a shaded area. (Std. 3.4.5.1)	1 ○	2 ○	3 ○	4 ○	NA ○	N Op ○
NOTES						
41. Broad spectrum sun screen with SPF of 15 or higher is available for use. (Std. 3.4.5.1)	1 ○			4 ○		
NOTES						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1 ○	2 ○	3 ○	4 ○		N Op ○
NOTES						

SUPERVISION: Interaction, Physical Activity, and Nutrition (Eating and Drinking)

Interaction and Physical Activity

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

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
42. Ratios: Indoors: Time (hour/min): ____ /____ Ages of children observed: (check all that apply) ☐≤12 months ☐13-35 mo ☐ 3 years ☐4 years☐ 5 years # of children ____ # of staff ____ child/staff ratio: ____:____ (Std. 1.1.1.2) For Family Child Care Programs, see CFOC3 Stds. 1.1.1.1, 1.1.1.2	1 ○			4 ○		
NOTES						
43. Ratios: Outdoors: Time (hour/min): ____ /____ Ages of children observed: (check all that apply) ☐≤12 months ☐13-35 mo ☐ 3 years ☐4 years☐ 5 years # of children ____ # of staff ____ child/staff ratio: ____:____ (Std. 1.1.1.2) For Family Child Care Programs, see CFOC3 Stds. 1.1.1.1, 1.1.1.2	1 ○			4 ○		N Op ○
NOTES						
44. Caregivers/Teachers directly supervise children by sight and hearing at all times. This includes indoors, outdoors and when children are sleeping, going to sleep or waking up. (Std. 2.2.0.1)	1 ○	2 ○	3 ○	4 ○		
NOTES						
45. Caregivers/Teachers encourage positive behavior and guide children to develop self-control. Caregivers/Teachers model desired behavior. "Time-out" is only used for persistent, unacceptable behavior. (Std. 2.2.0.6)	1 ○	2 ○	3 ○	4 ○		
NOTES						
46. Caregivers/Teachers support children to learn appropriate social skills and emotional responses. There are daily routines and schedules. (Std. 2.2.0.6)	1 ○	2 ○	3 ○	4 ○		
NOTES						
47. There is no physical or emotional abuse or maltreatment of a child. There is no physical punishment or threat of physical punishment of a child. (Std. 2.2.0.9)	1 ○			4 ○		
NOTES						
48. Caregivers/Teachers do not use threats or humiliation (public or private). There is no profane or sarcastic language. There are no derogatory remarks made about a child or a child's family. (Std. 2.2.0.9)	1 ○	2 ○	3 ○	4 ○		
NOTES						
49. Children are not physically restrained unless their safety or that of others is at risk. (Std. 2.2.0.10)	1 ○			4 ○		
NOTES						
50. Physical activity/outdoor time are not taken away as punishment. (Std. 2.2.0.9)	1 ○			4 ○		
NOTES						
51. Children engage in moderate to vigorous physical activities such as running, climbing, dancing, skipping and jumping. All children (including infants) have opportunities to develop and practice gross motor and movement skills. (Std. 3.1.3.1) (Appendix S)	1 ○	2 ○	3 ○	4 ○		
NOTES						

Interaction and Physical Activity — *Continued*

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
52. There are structured or adult-led physical activities and games that promote movement for children. (Std. 3.1.3.1)	1	2	3	4		
NOTES						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
NOTES						

Nutrition: Eating and Drinking

53. Individual children's food allergies are posted where they can be seen in the classroom and wherever food is served. (Std. 4.2.0.10)	1	2	3	4	NA	
NOTES						
54. Children two years of age and older are served skim or 1% milk. (Std. 4.9.0.3)	1	2	3	4	NA	N Op
NOTES						
55. Drinking water is available and offered, indoors and outdoors, throughout the day for children over six months of age. (Std. 4.2.0.6)	1	2	3	4		
NOTES						
56. A variety of nourishing foods is served at meals and snacks. Nourishing foods include fruits, vegetables, whole and enriched grains, protein and dairy. (Std. 4.2.0.3) (Appendix Q)	1	2	3	4	NA	N Op
NOTES						
57. Foods that are choking hazards are not served to children under four years of age. This includes hot dogs and other meat sticks (whole or sliced into rounds), raw carrot rounds, whole grapes, hard candy, nuts, seeds, raw peas, hard pretzels, chips, peanuts, popcorn, rice cakes, marshmallows, spoonfuls of peanut butter or chunks of meat larger than can be swallowed whole. (Std. 4.5.0.10)	1			4	NA	
NOTES						
58. Children are always seated while eating. (Std. 4.5.0.10)	1	2	3	4		
NOTES						
59. Food is not used or withheld as a bribe, reward or punishment. (Std.2.2.0.9)	1			4		
NOTES						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
NOTES						

SANITATION: Personal Hygiene, Food Safey/Food Handling, Environmental Health

Personal Hygiene — Handwashing

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
60. Situations or times that children and staff should perform hand hygiene are posted in all food preparation, hand hygiene, diapering and toileting areas. (Std.3.2.2.1)	1 ○	2 ○	3 ○	4 ○		
NOTES						
61. Handwashing Procedures — *Staff* – Moisten hands with water and apply soap (not antibacterial). – Rub hands together into a soapy lather for 20 seconds. – All hand surfaces are washed including fronts and backs and between fingers from wrists to finger tips. – Hands are rinsed with running water and dried with a paper or single use cloth towel. (Std. 3.2.2.2)	1 ○	2 ○	3 ○	4 ○		
NOTES						
62. Handwashing Procedures — *Children* Children wash their hands or have their hands washed. – Moisten hands with water and apply soap (not antibacterial). – Rub hands together into a soapy lather for 10 to 20 seconds. – All hand surfaces are washed including fronts and backs and between fingers from wrists to finger tips. – Hands are rinsed with running water and dried with a paper or single use cloth towel. (Std. 3.2.2.2)	1 ○	2 ○	3 ○	4 ○		
NOTES						
63. Caregivers/Teachers help children wash their hands when children can stand but cannot wash their hands by themselves. Children's hands hang freely under the running water either at a child level sink or at a sink with a safety step. (Std. 3.2.2.3)	1 ○	2 ○	3 ○	4 ○	NA ○	
NOTES						
64. Adults and children only use alcohol-based hand sanitizers as an alternative to handwashing with soap and water if hands are not visibly soiled. Hand sanitizers are only used for children over 24 months with adult supervision. (Stds. 3.2.2.2, 3.2.2.3)	1 ○	2 ○	3 ○	4 ○	NA ○	N Op ○
NOTES						

Personal Hygiene — Toothbrushing

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
65. When toothbrushes are present, they are not worn or frayed. Fluoride toothpaste is present. (Std. 3.1.5.1)	1	2	3	4	NA	
NOTES						
66. *Except in the case of children who are known to brush their teeth twice a day at home, caregivers/teachers brush children's teeth or monitor tooth brushing activities at least once during the hours that the child is in child care. (Std. 3.1.5.1)	1	2	3	4	NA	N Op
NOTES						

Food Safety/Food Handling

67. The food preparation area of the kitchen is separate from eating, play, laundry, toilet, bathroom and diapering areas. No animals are allowed in the food preparation area. (Std. 4.8.0.1)	1	2	3	4	NA	
NOTES						
68. The food preparation area is separated from child care areas by a door, gate, counter or room divider. (Std. 4.8.0.1)	1			4	NA	
NOTES						
69. There is no home-canned food or food in cans without labels. Food from dented, rusted, bulging or leaking cans is not used. (Std. 4.9.0.3)	1	2	3	4	NA	
NOTES						
70. Meat, fish, poultry, milk and egg products are refrigerated or frozen before use. Refrigerators have a thermometer and are kept at 41°F or lower. (Std. 4.9.0.3)	1	2	3	4	NA	
NOTES						
71. Meat product labels state they are from government-inspected sources and/or dairy product labels state that they are pasteurized. (Std. 4.9.0.3)	1	2	3	4	NA	N Op
NOTES						
72. All fruits and vegetables are washed thoroughly with water prior to use. (Std. 4.9.0.3)	1	2	3	4	NA	N Op
NOTES						
73. Store bought fruit juice labels state the juice is pasteurized. Fruit and vegetable juices squeezed on-site are squeezed just prior to serving. (Std. 4.9.0.3)	1	2	3	4	NA	
NOTES						
74. Food surfaces (for example, dishes, utensils, dining tables, high chair trays, cutting boards) and/or objects intended for the mouth (for example, pacifiers and teething toys) are sanitized. A dishwasher is used or an EPA registered sanitizer is used according to label instructions for sanitizing. (Std. 3.3.0.1)	1	2	3	4		
NOTES						

Environmental Health

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
75. Kitchen equipment is clean and in working order. Food surfaces are in good repair and free of cracks and crevices. Food surfaces are made of non-porous, smooth material and are kept clean and sanitized. (Std. 4.8.0.3)	1	2	3	4	NA	N Op
NOTES						
76. There are no cracks or holes in walls, ceilings, floors or screens. (Std. 5.2.8.1)	1	2	3	4		
NOTES						
77. There is no clutter, trash, water damage or standing water. Leaking pipes and pest breeding areas are not on site. (Std. 5.2.8.1)	1	2	3	4		
NOTES						
78. Objects and surfaces are kept clean of dirt, debris and sticky films. (Std. 3.3.0.1)	1	2	3	4		
NOTES						
79. Hard, non-porous surfaces soiled with potentially infectious body fluid (for example, toilets, diaper changing tables, blood spills) are disinfected. An EPA registered disinfectant is used according to label instructions. (Std. 3.3.0.1)	1	2	3	4		N Op
NOTES						
80. There are disposable gloves available for handling blood and blood containing body fluids. (Std. 3.2.3.4)	1			4		
NOTES						
81. *Infectious waste (for example soiled diapers, blood) and toxic waste (for example, used batteries, fluorescent light bulbs) are stored separately from other waste. (Stds. 5.2.7.6, 5.2.9.1)	1	2	3	4		N Op
NOTES						
82. Sanitizing and disinfecting are not done when children are nearby. (Std. 3.3.0.1)	1	2	3	4		N Op
NOTES						
83.*Pesticides are not applied when children are present. (Std. 5.2.8.1)	1	2	3	4		
NOTES						
84. *Toxic substances are stored in the original, labeled containers. Safety Data Sheets (SDS) are on site for each toxic substance/chemical. (Std. 5.2.9.1)	1	2	3	4	NA	N Op
NOTES						
85. *Toxic substances are inaccessible to children and in a locked room or cabinet. Bleach solutions are labeled with contents and date mixed. (Stds. 5.2.9.1, 5.2.8.1, 3.2.3.4, Appendix J)	1	2	3	4		
NOTES						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
NOTES						

POOLS, SPAS and HOT TUBS

Does this program have a pool, spa or hot tub or other water hazard?
Yes: ◯ If yes, complete the items below. No: ◯ If no, go to the Infants and Toddlers Section.
This facility has the following water hazards: (check all that apply)
☐ Swimming Pool ☐ Hot Tub ☐ Stationary Wading Pool ☐ Pond ☐ Other_____

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

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
86. Ratios: Ages of children observed: (check all that apply) ☐ ≤12 months ☐ 13-36 mo ☐ 3 years ☐ 4 years ☐ 5 years ☐ 5+ years Location_____ Time of Day (hour/min): ____ /____ # of children ____ # of staff ____ child/staff ratio: ____:____ (Std. 1.1.1.5)	1 ◯			4 ◯		N Op ◯
NOTES						
87. All outdoor water hazards are enclosed with a fence at least 4-6 feet high that comes within 2 inches from the ground. Exits and entrances around bodies of water have self-closing, positive latching gates or doors. The locking devices are a minimum of 54 inches from the ground or floor. (Stds. 6.1.0.6, 6.3.1.1)	1 ◯	2 ◯	3 ◯	4 ◯		N Op ◯
NOTES						
88. When not in use, in-ground and above-ground swimming pools, spas, hot tubs or wading pools are covered with a safety cover. The cover meets the ASTM International standards. (Std. 6.3.1.4)	1 ◯			4 ◯	NA ◯	N Op ◯
NOTES						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1 ◯	2 ◯	3 ◯	4 ◯		N Op ◯
NOTES						

INFANTS and TODDLERS: Personal Relationships, Diapering, Injury Prevention

Are there children under 36 months of age in this program?
Yes: ◯ If yes, complete the items below. No: ◯ If no, you have completed the Checklist.

Infants and Toddlers — Personal Relationships

89. Caregivers/Teachers smile, talk, touch, hold, sing and/or play with children during daily routines, such as diapering, feeding and eating. (Std. 2.1.2.1)	1 ◯	2 ◯	3 ◯	4 ◯		
NOTES						
90. Caregivers/Teachers comfort children who are upset. Caregivers/Teachers are aware of and respond to children's feelings. (Std. 2.1.2.1)	1 ◯	2 ◯	3 ◯	4 ◯		
NOTES						

Infants and Toddlers — Diapering

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
91. Caregivers/Teachers follow diaper changing procedures below: – Caregiver/Teacher has one hand on the child at all times. – Non-absorbent paper liner, large enough to cover the changing surface from the child's shoulders to beyond the child's feet, is used. – Clothing is removed or otherwise kept from contact with the contents of the diaper during the change. – Child is cleaned of stool and urine, front to back, with a fresh wipe for each swipe. – Soiled diapers are placed in a plastic-lined, covered, hands-free can. – If reusable cloth diapers are used, soiled diaper is put in a plastic bag or into a plastic-lined, hands-free covered can. – A fresh wipe is used to clean the hands of the caregiver and another fresh wipe to clean the hands of the child before putting on a new diaper and dressing the child. – The child's hands are washed according to the procedure in item #62 before returning the child to a supervised area. – Diaper changing surface is cleaned and disinfected with an EPA registered disinfectant after each diaper change. – Disinfectant is put away, out of children's reach. – Caregivers'/Teachers' hands are washed after diapering procedure is complete according to the procedure in item #61. (Stds. 3.2.1.4, 3.2.3.4)	1 ○	2 ○	3 ○	4 ○	NA ○	N Op ○
NOTES						
92. Current diaper changing procedures as listed in item #91 are posted in the diaper changing area(s). (Std. 3.2.1.4)	1 ○	2 ○	3 ○	4 ○	NA ○	N Op ○
NOTES						

Infants and/or Toddlers — Injury Prevention

93. Strings, cords, ribbons, ties and straps long enough to encircle a child's neck are out of children's reach. (Std. 3.4.6.1)	1 ○	2 ○	3 ○	4 ○		
NOTES						
94. The following are not within children's reach: small objects, toys, and toy parts that have a diameter less than 1¼ inch and a length between 1 inch and 2¼ inches; balls and toys with spherical, egg shaped, or elliptical parts that are smaller than 1¾ inches in diameter; toys with sharp points and edges; plastic bags; Styrofoam® objects; coins; rubber or latex balloons; safety pins; marbles; magnets; foam blocks, books, or objects; latex gloves; bulletin board tacks or glitter. (Std. 6.4.1.2)	1 ○	2 ○	3 ○	4 ○		
NOTES						
95. Securely installed guards (for example, gates) are at the top and bottom of each open stairway where infants and toddlers are in care. (Std. 5.1.5.4)	1 ○	2 ○	3 ○	4 ○	NA ○	
NOTES						
96. Children over 12 months of age who can feed themselves are actively supervised by a caregiver/teacher. The caregiver/teacher is within arm's reach of the child's high chair or feeding table or is seated at the same table. (Std. 4.5.0.6)	1 ○	2 ○	3 ○	4 ○	NA ○	
NOTES						
97. Foods that are choking hazards are not served to toddlers. Food for toddlers is served in pieces ½ inch or smaller. (Std. 4.5.0.10)	1 ○	2 ○	3 ○	4 ○	NA ○	
NOTES						

Infants and/or Toddlers — Injury Prevention — *Continued*

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1 ○	2 ○	3 ○	4 ○		N Op ○
NOTES						

INFANTS ONLY: Activity, Sleep, Safety, Nutrition

Are there infants under 12 months of age in this program?

Yes: ○ If yes, complete items below No: ○ If no, you have completed the Checklist.

Infants Only — Activity, Sleep, Safety

98. Sunscreen is not applied to infants younger than six months. Infants younger than six months are not in direct sunlight. (Std. 3.4.5.1)	1 ○	2 ○	3 ○	4 ○	NA ○	N Op ○
NOTES						
99. Infants have supervised tummy time while awake at least once each day. (Std. 3.1.3.1)	1 ○	2 ○	3 ○	4 ○		N Op ○
NOTES						
100. Infants are not seated more than 15 minutes at a time except during meals. (Std. 3.1.3.1)	1 ○	2 ○	3 ○	4 ○		
NOTES						
101. All infants are placed to sleep on their backs, in a crib, on a firm mattress, with a tightly fitting sheet. Only one infant is placed in each crib. (Std. 3.1.4.1)	1 ○	2 ○	3 ○	4 ○		N Op ○
NOTES						
102. Soft or loose bedding and other objects are kept away from sleeping infants and are not in safe sleep environments (for example, not in cribs). This includes bumpers, pillows, positioners, blankets, quilts, bibs, diapers, flat sheets, sheepskins, toys and stuffed animals. One-piece blanket sleepers may be used for warmth. (Std. 3.1.4.1)	1 ○	2 ○	3 ○	4 ○		
NOTES						
103. The room temperature where infants sleep is comfortable for a lightly clothed adult. (Std. 3.1.4.1)	1 ○			4 ○		
NOTES						
104. Infants who fall asleep any place that is not a crib are moved and placed to sleep on their backs in a crib. Examples of places where infants may not be left to sleep are car seats, high chairs, swings, infant seats, beanbag chairs and futons. (Std. 3.1.4.1)	1 ○			4 ○		N Op ○
NOTES						
105. *Cribs meet the current guidelines approved by CPSC and ASTM International standards. Crib slats are spaced no more than 2 3/8 inches apart. The crib has a firm mattress that is fitted so that no more than two fingers can fit between the mattress and the crib side in the lowest position. Cribs with drop sides are not used. Cribs are placed away from window blinds or draperies. (Std. 5.4.5.2)	1 ○	2 ○	3 ○	4 ○	NA ○	
NOTES						
106. Infants mobile enough to potentially climb out of a crib sleep on cots or mats. (Std. 5.4.5.2)	1 ○	2 ○	3 ○	4 ○	NA ○	N Op ○
NOTES						

Infants Only — Nutrition

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
107. Bottles or containers with human milk are labeled with the infant's full name and date the milk was expressed. Human milk is stored in the refrigerator or freezer. (Std. 4.3.1.3)	1 ○	2 ○	3 ○	4 ○	NA ○	
notes						
108. Bottles of formula prepared from powder or concentrate or ready-to-feed formula are labeled with the child's full name and the time and date of preparation. (Std. 4.3.1.5)	1 ○	2 ○	3 ○	4 ○	NA ○	
notes						
109. If caregivers/teachers warm bottles and infant foods, bottles are warmed under running warm tap water or by placing in a container of water no warmer than 120°F. Bottles and infant foods are not thawed or warmed in microwave ovens. The temperature of warmed milk does not exceed 98.6 F. (Stds. 4.3.1.3, 4.3.1.9)	1 ○	2 ○	3 ○	4 ○	NA ○	
notes						
110. Infants are not fed solid foods sooner than four months of age (preferably six months of age). Introductory foods are single ingredient. (Std. 4.3.1.11)	1 ○			4 ○	NA ○	N Op ○
notes						
111. Infants who are learning to feed themselves are actively supervised by a caregiver/teacher. Infants are seated within arm's reach of caregiver/teacher at all times while being fed or eating. (Std. 4.5.0.6)	1 ○	2 ○	3 ○	4 ○		N Op ○
notes						
112. Foods that are choking hazards are not served to infants. Food for infants is served in pieces ¼ inch or smaller. (Std. 4.5.0.10)	1 ○			4 ○		N Op ○
notes						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1 ○	2 ○	3 ○	4 ○		N Op ○
notes						

NOTES:

Preventive Health and Safety in the Child Care Setting

A Curriculum for the Training of Child Care Providers

SIXTH EDITION

MODULE 3
Nutrition

UCSF California Childcare Health Program

Nutrition

MODULE CONTENTS:

ESTIMATED TRAINING TIME BY MODULE TOPIC

SECTION	TOPICS	TIME (Minutes)
Nutrition	**Understanding Why Child Nutrition Is Important**	**5**
	Nutrition Laws and Regulations for Child Care	**5**
	Infant Feeding	**5**
	Serving Age Appropriate Healthy Food and Drinks to Children	**5**
	Food Safety	**5**
	Nutrition Facts Labels and Ingredients Lists	**5**
	Children with Special Dietary Needs	**5**
	Healthy Feeding, Eating Behaviors, and Habits	**5**
	Individual and Cultural Preferences	**2**
	Child Engagement	**3**
	Policies for Feeding Children in Child Care	**5**
	The Child and Adult Food Care Program (CACFP)	**5**
	Nutrition Resources	**5**

Total Training Time Recommended for Module 3: 1 hour (60 minutes)

Training Tip: Plan for a hands-on activity to support active learning.

Information in this 1 hour class is consistent with the Dietary Guidelines for Americans. This presentation includes basic nutrition information for children ages birth to 12 years old. Additional resources for the child care community can be found on the Emergency Medical Services Authority (EMSA) website: https://emsa.ca.gov/childcare-nutrition/

Nutrition

TRAINER GUIDE

SECTION TOPICS

- Understanding Why Child Nutrition Is Important
- Nutrition Laws and Regulations for Child Care
- Infant Feeding
- Serving Age Appropriate Healthy Food and Drinks to Children
- Food Safety
- Nutrition Facts Labels and Ingredients Lists
- Children with Special Dietary Needs
- Healthy Feeding, Eating Behaviors, and Habits
- Individual and Cultural Preferences
- Child Engagement
- Policies for Feeding Children in Child Care
- The Child and Adult Care Food Program (CACFP)
- Nutrition Resources

Rationale: Serving healthy food and drinks has a positive effect on children's development and overall health.

Time: 1 hour

Learning Objectives

Participants will:

1. Understand why nutrition is important for children's health and development.
2. Understand healthy feeding practices for infants and toddlers.
3. Understand the basics of healthy eating for children up to age 12 years old according to current USDA Dietary Guidelines for Americans.
4. Know the laws and regulations guiding food and drink in licensed child care programs in California.
5. Have access to nutrition resources, including their local CACFP Sponsor.

Teaching Methods/Suggested Activities

- **Lecture:** Using Power Point Slides
- **Label Reading Activity**
- **Question/Answers:** Respond to any questions that the group may have.

Materials and Equipment Required

STUDENT HANDOUTS:

- Healthy Beverages in Child Care Poster

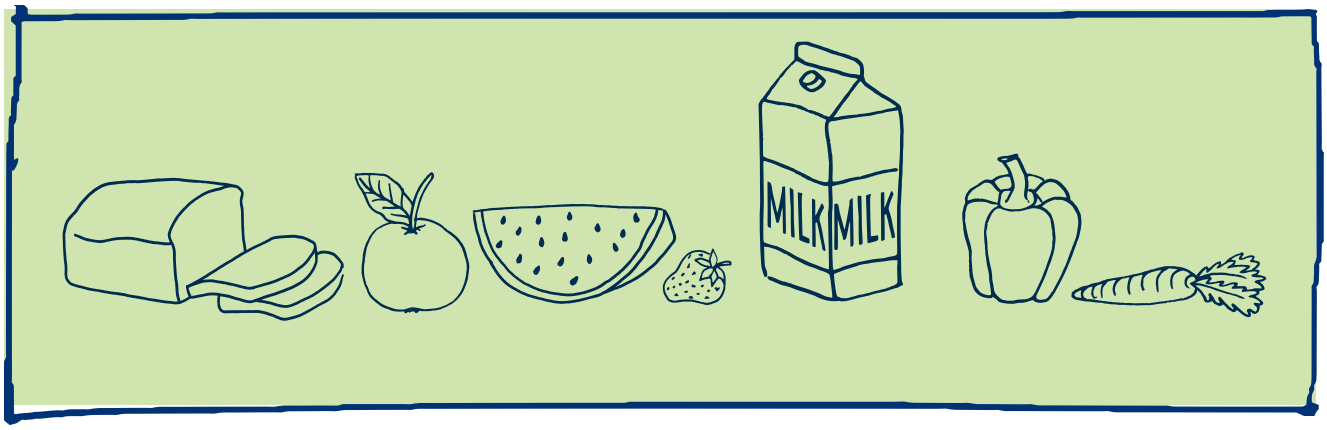
OTHER MATERIALS:

- Sample food labels (enlarged if possible)
- Sample foods with surprising amounts of sugar or salt
- Visual of what various amounts of sugar (in grams) look like – test tubes with various amounts, baby food jars with various amounts of sugar, or sugar cubes can be used.

Questions/Comments: Refer to the USDA Dietary Guidelines for Americans for best practice recommendations. Encourage participation and provide local resources for the Child and Adult Care Food Program (CACFP).

Understanding Why Child Nutrition Is Important

Good nutrition helps children grow strong and at a healthy weight. It is crucial to brain growth and development, especially in a child's first few years. Children need nutrients found in healthy food and drinks to grow. Obesity, heart disease, liver disease, tooth decay, and some kinds of cancer, are linked to diet. It's easier and less costly to prevent these diseases. Children's eating habits form when they are young, so let's get them off to a good start!



Nutrition Laws and Regulations for Child Care

Licensed child care providers in California must follow the laws and regulations for serving food and drinks in child care programs. First, child care center providers must follow the Federal Child and Adult Care Food Program (CACFP) meal plan requirements. Second, all newly licensed child care providers (Centers and Family Child Care Homes) must complete 16 hours of EMSA approved Preventive Health and Safety Training. This includes one hour on nutrition. And all licensed child care providers (Centers and Family Child Care Homes) must follow the Healthy Beverages in Child Care Act. The four key messages in the Healthy Beverages in Child Care Act are:

1. Only unflavored, unsweetened, non-fat (fat free, skim, 0%) or low fat (1%) milk can be served to children 2 years of age or older.
2. No beverages with added sweeteners, natural or artificial, can be served, including sports drinks, sweet teas, juice drinks with added sugars, flavored milk, soda, and diet drinks.
3. A maximum of one serving of 100% juice is allowed per day.
4. Clean and safe drinking water must be readily available at all times; indoors and outdoors and with meals and snacks.

Infant Feeding

Breastfeeding

Breast milk provides the most easily digested food for infants. It has the right amount of fat, sugar, water, and protein that is needed for an infant's growth and development. Breast milk is the best source of nutrition for infants for at least the first twelve months, and, thereafter, for as long as both mother and child desire. Breast milk contains antibodies that protect infants against common illnesses and allergies. Also, infants who are fed breast milk experience less spit up, constipation, and illness.

There are also many benefits for breastfeeding moms. For example, breastfeeding helps mothers to bond with their infants, saves money, and lowers their risk of developing diabetes, breast cancer, and heart disease.

Supporting a mother when she wants to breastfeed demonstrates your commitment to the best nutrition for infants. Provide a quiet, comfortable, and private place for mothers to breastfeed and encourage mothers to provide a back-up supply of frozen or refrigerated expressed human milk. Label bottles with the infant's full name and date.

Provide information to families about other places in the community that further support mothers who are breastfeeding. Examples of resources include local lactation consultants and breastfeeding support groups (such as La Leche League).

Key Messages:

- Breast milk contains all of the nutrients infants need and is easiest to digest.
- Breast milk protects infants from common illnesses, allergies, and obesity.
- Breast milk promotes good health for mothers and babies.
- Let parents know you support breastfeeding.
- Provide a quiet, comfortable, private place for mothers to breastfeed.
- Learn how to safely handle, store, and feed infant breast milk.
- Additional support for breastfeeding families and child care providers is available.

Formula Feeding

Iron-fortified infant formula is recommended for infants who are not fed breast milk. It contains the balanced nutrition that growing infants need. Infants under six months of age do not need any other beverages besides breast milk or iron-fortified formula. (A medical statement would be needed to serve infants under six months of age anything other than breastmilk or iron fortified formula.) Do not use a microwave to heat infant formula or breast milk. Microwaves do not heat liquids evenly and could burn the infant. In addition, bottles can explode if left in the microwave too long. Instead, warm bottles under warm running water or in a warm water bath. Follow the instructions given by the manufacturer when mixing the formula with water, and make sure the water is from a clean and safe source. If mixing with tap water, use cold water. Goat milk, soy milk, evaporated or whole cow's milk, rice milk and other milk products are not recommended for infants under 12 months of age because they cannot digest them and they do not provide the balanced nutrition growing infants need.

Key Messages:

- Iron-fortified formula is the best substitute for breast milk.
- Infants under six months of age don't need any other foods or liquids besides breast milk or iron fortified formula.
- Don't use a microwave oven to heat bottles.
- Follow the manufacturer's instructions when mixing formula.

FEED INFANTS ON DEMAND (WHEN THEY ARE HUNGRY)

Discuss the infant's typical feeding patterns with families. Look for infants' feeding cues letting you know they are hungry. Feed infants when they are hungry. Responsive feeding (where the providers recognize and respond to infant feeding cues) helps foster trust and reduces overfeeding. Responding to the infant's early signs of hunger can reduce crying. Continue to feed a baby until they indicate fullness. Never force an infant to finish what is in the bottle. Babies are the best judge of how much they need. Babies may want to eat less if they are not feeling well and more if they are growing.

Signs of Hunger	Signs of Fullness
• Fussing and tossing • Looking like they are going to cry • Rooting (sucking motion with the mouth)	• Sealing their lips together • A decrease in sucking • Spitting out the nipple • Turning away from the nipple • Pushing the bottle away

Infants and Other Beverages

Sugary, sweetened drinks should not be given to infants. They take the place of the more nutritious breast milk or formula that infants need for growth and good health. Offering fruit juice may replace nutrients they need to grow. Do not put juice or sweetened beverages in a bottle.

Key Messages:

- Infants from birth to 6 months old drink only breastmilk or formula.
- Offer infants 6 to 12 months only water from a cup.
- Don't give juice or sweetened drinks to infants.
- Serve children ages 1–2 years up to 4 ounces of unflavored whole milk.

Introducing Solid Food

Before introducing solid food, communicate with the infant's family to make sure the infant is ready for solid food. Ask the family what foods have been tried at home. At about 6 months, begin to introduce ground or pureed food, one food at a time. Work with the family to decide what foods to provide. It's best to have the family try feeding their baby a new food at home first. Wait for at least 3 to 5 days before introducing another new food. Start with iron-fortified infant cereal or pureed meats. Next, try pureed vegetables and fruits, and then offer other protein rich foods.

Infants who are ready to start solid foods:

- can hold their heads steady,
- can sit with minimal support,
- swallow when presented with a spoon,
- show interest in food and watch intently as others eat.

Serving Age-Appropriate Healthy Food and Drinks to Children

(Based on *Dietary Guidelines for Americans, 2020-2025,* 9th Edition. The *Guidelines* suggest following a healthy eating pattern at every stage of life by focusing on nutrient-dense foods that match personal preferences, cultural traditions, and your budget.)

Offer children a variety of healthy foods at meals and snacks. Plan your menu around what's in season—seasonal foods are often the most delicious and usually cost less. Colorful foods with varying textures are attractive and appealing to children.

Grains

Foods such as rice, oats, cornmeal, wheat, barley or another cereal grain are known as grains. Grains are an important food group and provide many important nutrients, vitamins, and minerals. Whole grain products contain all the parts of the grain, meaning none of the fiber or nutritious parts have been removed. Whole grains help children have healthy elimination; help them feel fuller longer; and support growth at a healthy weight. Whole grains contain B vitamins (essential for growth, metabolism, and a healthy nervous system) and magnesium (used to build bones and release energy from muscles).

Key Messages:

- Grains provide many important nutrients, vitamins, and minerals for growing children.
- Eating whole grains reduces the risk of heart disease, helps children grow at a healthy weight, and prevents constipation.
- Pasta, cereal, bread, tortillas, and other baked goods are made using grains. Rice, oats, corn, wheat, barley, quinoa, millet, and kamut are examples of grains.

SERVE WHOLE GRAINS

- Oatmeal
- Brown bread, labeled whole grain or multi-grain
- Brown rice
- Whole wheat pasta
- Quinoa
- Barley

AVOID OR LIMIT NON-WHOLE GRAINS

- White or enriched bread
- White rice
- Flour tortillas
- Pasta or noodles made from white flour

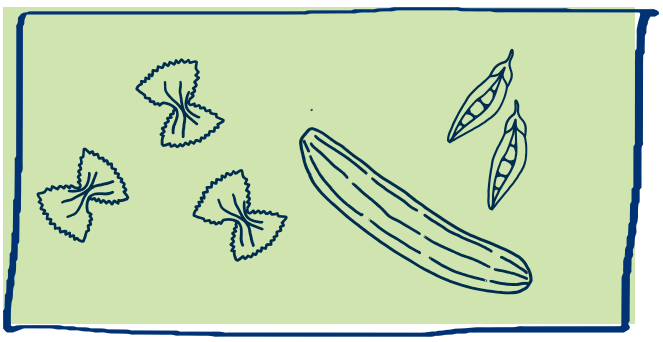
Vegetables

Vegetables are a plant or part of a plant used as food. Vegetables provide many nutrients such as fiber, folic acid, and other vitamins and minerals that nurture growing children. For example, folic acid helps the body make red blood cells, fiber helps with bowel function and helps children feel full when eating, and vitamins such as Vitamin A from carrots can help strengthen the immune system. Vegetables are also low in calories and help children grow at a healthy weight. Introducing a variety of vegetables helps to develop healthy eating patterns that benefit children their entire lives.

Each vegetable has different levels of nutrients, so including a variety of vegetables will help make sure children get the nutrition they need while they are rapidly growing. Many processed food products contain unhealthy amounts of salt, fat, or sugar. Offering children plain vegetables is the healthiest. If serving commercially prepared vegetables, read the label carefully, making sure that the vegetable is the first ingredient listed on the label.

Key Messages:

- Vegetables provide minerals, vitamins, and other nutrients to support children's rapid growth and development.
- Diets rich in vegetables have been shown to reduce the risks of heart disease, stroke, and certain cancers.
- Vegetables can be served fresh, frozen, or canned (with no added salt, fat, or sugar).
- For commercially prepared vegetables, the first ingredient on the ingredients list should be the vegetable.



Fruit

A fruit is the part of a plant that has seeds in it. Fruits are an important source of food for growing children. Fruits provide many nutrients such as folic acid, fiber, and vitamins. For example, Vitamin C from oranges helps in the growth and repair of all body tissues, keeps teeth and gums healthy, and can strengthen the immune system. Diets rich in fruits, such as bananas with potassium, have been shown to reduce the risks of high blood pressure and other illnesses. Include a variety of fruits in your menu. If feeding commercially prepared fruits such as applesauce, peaches, or pears, read the label carefully to check for added sweeteners.

Key Messages:

- Fruit provides minerals, vitamins, and other nutrients that support children's growth and development.
- Different colors and textures help develop sensory skills. Include a variety of colors: try a rainbow of fruits!
- Offer unsweetened whole, mashed, or pureed fruits, as developmentally appropriate. Do not add sugar or sweeteners.
- Fruit can be fresh, frozen, or canned (with no added sugars). For commercially prepared fruits, the fruit should be the first ingredient.

SAFETY TIP: To reduce the risk of choking, do not feed young children whole pieces or hard pieces of fruit or vegetables such as apples, carrots, melon, uncooked dried fruit (including raisins), whole grapes, berries, cherries, and cherry tomatoes. Instead, cut these foods into smaller pieces, or quarters, with pits and seeds removed.

- Serve fruits and vegetables ground, mashed, pureed, chopped, cut into small pieces, or shredded.
- Remove pits and seeds for children under age 4 years.
- Do not serve whole grapes or whole cherry tomatoes to young children

Oils

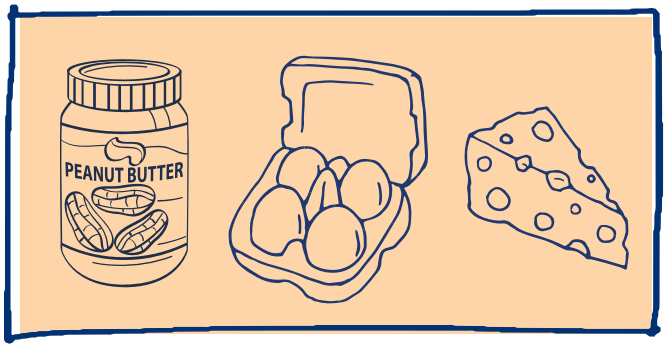
Vegetable oils and oils in food, such as seafood and nuts are healthy choices.

Protein

Protein in foods such as meat, milk, eggs, and beans is needed for healthy growth. Protein helps build bones, muscles, cartilage, skin and blood. Protein also helps your body make hormones and vitamins. Meat, poultry, fish without bones, yogurt, cottage cheese, cheese, nut butters, tofu, beans, legumes, and cooked eggs are all examples of protein-rich foods. Avoid serving hot dogs, sausages, or chicken nuggets, because they are high in salt and fat and may contain food additives.

SAFETY TIPS

- Ask parents to try common allergen foods at home first: nuts and nut butter, fish and shell fish, and soy products like tofu.
- Do not serve fish with bones, chunks of meat, whole nuts or seeds, or spoonfuls of nut butter to young children since these foods can cause choking.
- Do not serve hot dogs or meat products shaped like hot dogs, whole or cut into round slices because they are a leading cause of choking in children.



Iron

Dietary iron is important for young children so they don't become anemic.* Sources of iron include meat, poultry, seafood, legumes (beans and peas) and dark-green vegetables, as well as foods enriched or fortified with iron, such as many breads and ready-to-eat cereals.

Absorption of iron is enhanced by eating vitamin C-rich foods. Foods with Vitamin C include fruits and vegetables such as kiwi, oranges, red pepper, broccoli, grapefruit, Brussels sprouts, potatoes, and tomatoes.

Be sure to offer children a variety of nutrient-dense foods to meet their nutritional needs.

**Anemia and lead poisoning may occur together.*

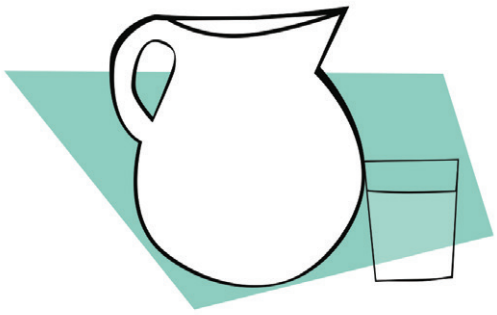
Healthy Beverages in Child Care

Research shows that unhealthy beverages are a big part of the childhood obesity problem. In 2010, California passed legislation to establish nutrition standards for beverages served in licensed child care centers and family child care homes. These standards went into effect on January 1, 2012.

Only unflavored, unsweetened, **nonfat** (fat free, skim, 0%) or **lowfat** (1%) **milk** can be served to children 2 years of age or older.

No beverages with added sweeteners, natural or artificial, can be served, including sodas, sweet teas, juice drinks with added sugars, flavored milk and diet drinks.

A maximum of **one serving** (4 to 6 ounces for 1–6 year olds*) of **100% juice** is allowed per day.



Clean and safe drinking water must be available at all times, including meals and snacks.

*serving size as per *Preventing Childhood Obesity in Early Care and Education Programs,* American Academy of Pediatrics

CALIFORNIA FOOD POLICY ADVOCATES

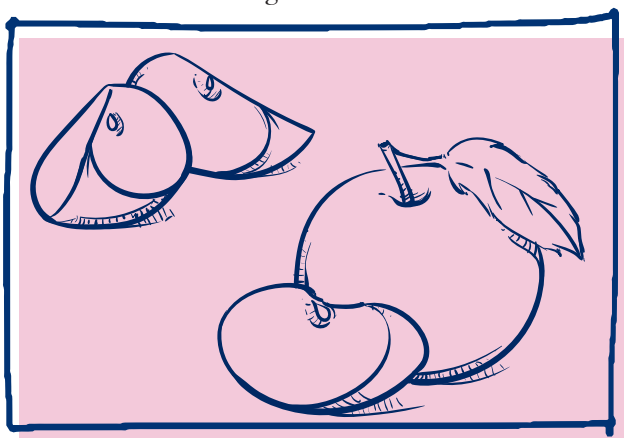
California Childcare Health Program
cchp.ucsf.edu

Rev. 06/2018

Food Safety

Preventing Foodborne Illness

- Check your refrigerator thermometer to make sure the temperature is 41 °F or lower.
- Fully cook eggs, meat, and fish.
- Wash your hands before preparing, serving, and eating food and after handling raw fish, eggs, and meat.
- Pay careful attention to sanitizing surfaces and utensils after handling raw meat and fish.



Food Allergies and Choking Prevention

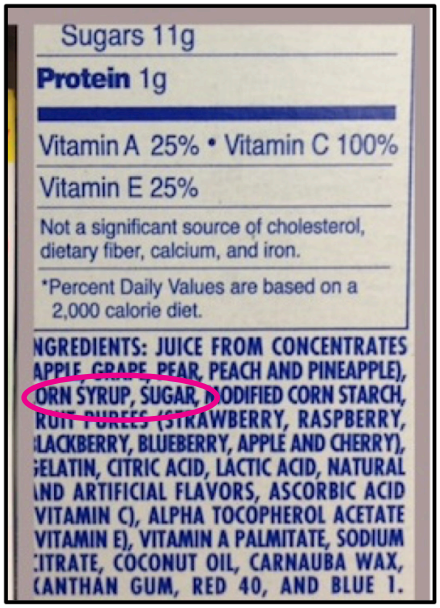
- Avoid choking hazards by cutting whole fruit and vegetables into pieces smaller than 1/4 inch for infants and 1/2 inch for toddlers.
- Have children sit when they eat or drink.
- Watch for allergic reactions such as vomiting, diarrhea, rash, or swelling of the lips or eyes, nasal congestion, coughing, wheezing, asthma-like symptoms, or trouble breathing.
- For more information on allergies and food safety visit the EMSA Child Care Nutrition Training webpage: https://emsa.ca.gov/childcare-nutrition/
- Eggs, milk, and peanuts are the most common causes of food allergies in children. Wheat, soy, tree nuts, fish, shellfish, and sesame also are common food allergies. Peanuts, tree nuts, fish, and shellfish commonly cause the most severe reactions. Nearly 5 percent of children under the age of five years have food allergies.

Nutrition Facts Labels and Ingredients Lists

The Nutrition Facts panel can help you choose foods lower in total fat, saturated fat, and *trans* fat, salt, and sugar. Avoid serving children food with trans fat (partially-hydrogenated and hydrogenated oils). Also, to know how much salt is in a product, look for "Sodium" on the label. Choose foods that have less Sodium to reduce the amount of salt you are serving children. The updated nutrition facts label is designed to make it easier for consumers to make healthy choices and includes clearer information about added sugars and serving size.

Ingredients List

The U.S. Food and Drug Administration (FDA) requires food producers to list all ingredients in their foods. Added sugar and fat comes in many forms – and can be hard to find on the ingredients label. There are many different names for sugar listed on food labels. Some of the more common names are sucrose, cane sugar, sugar, corn syrup, fruit juice concentrate, barley malt, dextrose, maltose, and rice syrup.



Sugar Sweetened Beverages

Juices that are not 100% fruit have names like juice drink, juice cocktail, fruit punch, and lemonade. It will say on the label that these drinks have added sweeteners such as sugar, corn syrup, sugar cane.

Don't serve drinks with added sugar or these sugar equivalents on Ingredients Lists: High fructose corn syrup, fructose, corn syrup, honey, cane sugar, evaporated cane juice, sucrose, and sucralose.

Nutrition Facts

8 servings per container

Serving size **2/3 cup (55g)**

Amount per serving

Calories **230**

	% Daily Value*
Total Fat 8g	**10%**
Saturated Fat 1g	**5%**
Trans Fat 0g	
Cholesterol 0mg	**0%**
Sodium 160mg	**7%**
Total Carbohydrate 37g	**13%**
Dietary Fiber 4g	**14%**
Total Sugars 12g	
Includes 10g Added Sugars	**20%**
Protein 3g	
Vitamin D 2mcg	10%
Calcium 260mg	20%
Iron 8mg	45%
Potassium 235mg	6%

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

Contents on the Ingredients List are listed from most to least. This Ingredients List has just one ingredient: White Corn. That tells you there are no added sugars, salt, or fats.

Children with Special Dietary Needs

Some children have cultural, religious, medical, or developmental concerns which may impact their dietary needs. Work closely with families to develop a feeding plan to promote healthy growth. For families from different cultures, it is important to learn about their needs and special dietary considerations. For medical and behavioral concerns, get instructions from the child's family and health care provider. Develop a written feeding plan. Under the Americans with Disabilities Act (ADA), licensed child care centers are expected to provide care and make reasonable accommodations for a child who has special dietary needs.

Key Messages:

- Consult with the child's family on any special dietary needs.
- Follow the written instructions from the child's primary health care provider.
- Develop a special health care needs plan in partnership with the family and primary health care provider.

Healthy Feeding, Eating Behaviors, and Habits

Research shows that dietary habits are fairly established at a young age. Create a positive eating experience. Don't force or pressure children to eat all the food that is offered. Creating a positive experience and having a positive attitude towards food will encourage healthy eating patterns.

It's okay to encourage children to taste a new food, but don't force or reward them to eat it. And don't insist that children eat everything on their plates. It is normal for children to prefer some foods and reject others. You may need to offer a new food as many as 10 to 20 times before a child is willing to try it.

One method that teaches heathy eating behaviors and habits was developed by Ellyn Satter. It is called the Division of Responsibility in Feeding Method. This feeding method builds on children's natural abilities regulate how much to eat.

The Division of Responsibility describes how the child care provider or parent is responsible for *what, where, when to eat.* And the child is responsible for *how much,* or whether or not to eat.

The parent/caregiver is responsible for:	The child is responsible for:
• What food is offered • Where it is served and eaten • When it is offered	• How much to eat • Whether or not to eat

Family Style Meals

For family style meals, teachers and children sit at a table together and eat the same food. Foods are passed on serving platters or bowls so children can help themselves. Drinks are served in child-sized pitchers and passed, or placed on the table, so children can pour their own. Adults encourage, but don't force, children to help themselves to all food offered at the meal. One goal of Family Style eating is to make eating an enjoyable experience. Children who cannot self-serve (such as very young children and children with special needs) may need accommodations in order to join the group.

Key Messages:

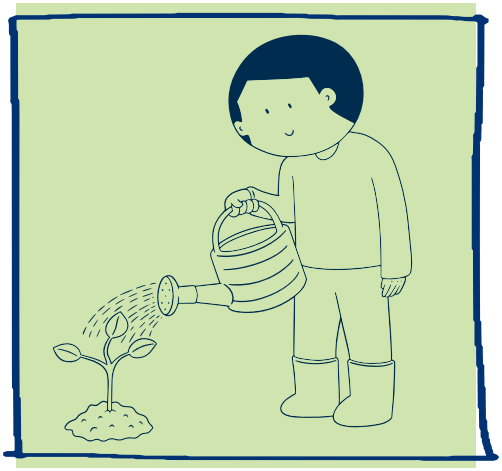
- Child care providers are role models for healthy eating.
- Eating at the same table provides an opportunity to have a pleasant conversation at mealtime.
- Family style meals give teachers an opportunity to talk to children about healthy food.

Individual and Cultural Preferences

California is home to many cultures and is home to a variety of food traditions. Celebrate the rich culinary customs of the children and families in your program. Respect individual preferences and be sensitive to cultural and family traditions.

Child Engagement

Keep it fun! There are lots of good ways to include messages about healthy eating in your lessons with children. Take the opportunity to help children understand that healthy food helps them grow strong and healthy!



Policies for Feeding Children in Child Care Settings

Written policies help child care providers and families understand what will be served and how it will be served in a child care program. Writing policies is the first step for child care providers to provide healthier meals and snacks to the children in their care. Share your written policies with staff and families. This sends a message that nutrition is a priority in your child care program.

Clear policies prevent misunderstanding about what food and drinks will be served or can be brought into your child care program for meals, snacks, and celebrations. Make sure that new staff members receive training on your nutrition policies and that parents receive information about your nutrition policies upon enrollment. Consistent practices for feeding children at child care and at home help children to grow strong and healthy with good habits for eating and drinking.

Make sure you have policies for how you will keep children with food allergies and special dietary needs safe in your child care setting. Work closely with parents and the child's health care provider when children have special dietary needs. Develop a written special nutrition plan with clear instructions about which foods cause a child to have an allergic reaction and what actions to take in case a child has an allergic reaction.

Sunshine Child Development Program Nutrition Policy

SUNSHINE CDP

FOOD SERVED

Sunshine CDP is enrolled in the Child and Adult Care Food Program (CACFP). Meals and snacks served at Sunshine CDP follow the CACFP meal pattern.

Meals are served at:

- 8:00am Breakfast
- 10:30am Snack
- 12:30pm Lunch
- 4:00pm Snack

Weekly menus are posted. We follow a three week menu cycle to provide a variety of food options.

We encourage children to try new foods, but do not force nor bribe children to eat.

Food is not used as a reward or punishment.

A staff member eats with children to model and promote healthy eating behaviors.

Holidays are celebrated with healthy foods or non-food activities.

In keeping with California law for licensed child care, sweetened beverages are not served to children.

FOOD BROUGHT FROM HOME

We encourage families to provide healthy food, including fruits, vegetables, and whole grains in meals and snacks brought from home.

Birthdays are celebrated with healthy foods or non-food activities. Families are invited to share a favorite story, song, game, or family tradition. Talk to the director for ideas to make your child feel special on their birthday!

FOOD ALLERGIES

If a child enrolled in our program has a life-threatening food allergy confirmed by a health care provider, we ask families not to bring the food into the facility. We discard food that could cause an allergic reaction if it is brought in. We work with the child's family and their health care provider to develop an allergy action plan for all children with food allergies.

The Child and Adult Care Food Program (CACFP)

CACFP is a federally funded food program administered through the California Department of Education, Nutrition Services Division. CACFP provides money and informational resources to help child care providers provide high quality meals for children in child care. CACFP provides ideas for recipes, menu planning, food preparation, and nutrition education. Planning menus helps to provide a healthy variety of foods and can help save money.

Meal Patterns for infants up to age one and children aged 1-13 years:

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

Contact your local CACFP sponsor for information about eligibility, enrollment, reimbursement rates.

If you are not currently participating; consider enrolling!

Contact information for local sponsors can be found at https://www.cdss.ca.gov/child-care-and-nutrition/data-statistics/student-health-support/food-programs

NOTE TO TRAINERS:

Provide the referral telephone number and link to contact information for local CACFP sponsors in your county.

Nutrition Resources

Visit the **California Emergency Medical Services Authority (EMSA) Child Care Nutrition Training** webpage for resources and additional information about children's nutrition.
https://emsa.ca.gov/childcare-nutrition/

Tips for Providers: Solid Foods in Early Care and Education (ECE):
https://www.cdc.gov/obesity/strategies/early-care-education/pdf/solid-foods-ece-062022.pdf

Supporting Breastfeeding Families in Early ECE Programs:
https://www.cdc.gov/obesity/strategies/early-care-education/pdf/breastfeed-ece-082022-508.pdf

Ellyn Satter's Division of Responsibility in Feeding:
https://www.ellynsatterinstitute.org/how-to-feed/the-division-of-responsibility-in-feeding/

NAP SACC Sample Nutrition Polices:
https://healthyapple.arewehealthy.com/documents/Nutrtion_PA_PolicyExamples.pdf

Dietary Guidelines for Americans:
https://www.dietaryguidelines.gov/resources/2020-2025-dietary-guidelines-online-materials

CACFP Nutrition Resources for Child Care:
https://www.fns.usda.gov/tn/child-care-organization

Sample Menus for Child Care:
https://theicn.org/icn-resources-a-z/menus-for-child-care/

Institute of Child Nutrition, Menu Planning Basics: A Guide for CACFP Operators in Child Care
https://theicn.org/icn-resources-a-z/menu-planning-basics-a-guide-for-cacfp-operators-in-child-care/

Institute of Child Nutrition, Child Nutrition Recipe Box
https://theicn.org/cnrb/

USDA, Multicultural Recipes for Child Care
https://www.fns.usda.gov/tn/recipes-cacfp

Preventive Health and Safety in the Child Care Setting

A Curriculum for the Training of Child Care Providers

SIXTH EDITION

APPENDIX
Resources

UCSF California Childcare Health Program

Resources

Administration for Children and Families (ACF): www.acf.hhs.gov/

American Academy of Pediatric Dentistry: www.aapd.org

American Academy of Pediatrics (AAP): www.aap.org

American Lung Association: http://www.lung.org/

American Heart Association: www.heart.org

American Public Health Association (APHA): www.apha.org

American Red Cross: www.redcross.org

ASTM International: www.astm.org

Cal-OSHA (Division of Occupational Safety and Health): www.dir.ca.gov/dosh

California Air Resources Board: https://ww2.arb.ca.gov/

California Breathing Asthma Advocates: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/EHIB/CPE/Pages/CaliforniaBreathing.aspx

California Child Care Disaster Plan: https://cchp.ucsf.edu/content/disaster-preparedness

California Child Care Resource & Referral Network: www.rrnetwork.org

California Childcare Health Program (UCSF): http://cchp.ucsf.edu

California Department of Education (CDE) Early Education Division: www.cde.ca.gov/re/di/or/cdd.asp

California Department of Health Care Services (DHCS) Child Health and Disability Prevention (CHDP) County Offices: https://www.dhcs.ca.gov/services/chdp/Pages/countyoffices.aspx

California Department of Pesticide Regulation School and Child Care IPM: https://apps.cdpr.ca.gov/schoolipm

California Department of Public Health (CDPH): www.cdph.ca.gov

CDPH Childhood Lead Poisoning Prevention Branch: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/CLPPBhome.aspx

CDPH Immunization Branch, Shots for School: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/School/shotsforschool.aspx

CDPH Local Health Department Contact: www.cdph.ca.gov/Pages/LocalHealthServicesAndOffices.aspx

CDPH SIDS Coordinators: https://www.cdph.ca.gov/Programs/CFH/DMCAH/SIDS/Pages/Sites.aspx

California Department of Social Services (CDSS), Community Care Licensing: Community Care Licensing Division (CCLD): http://ccld.ca.gov.

CDSS Child and Adult Care Food Program: https://cdss.ca.gov/cacfp

California Early Childhood Educator Competencies: www.cde.ca.gov/sp/cd/re/ececomps.asp

California Environmental Protection Agency (EPA): https://calepa.ca.gov/

California Governor's Office of Emergency Preparedness (Cal OES): www.caloes.ca.gov

California Highway Patrol (CHP): www.chp.ca.gov

California Immunization Handbook: School and Child Care Entry Health: Requirements, 10th Edition, 2019:
https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Immunization/IMM-365.pdf

California Poison Control: www.calpoison.org

Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Online database: https://nrckids.org/CFOC

Centers for Disease Control and Prevention (CDC): www.cdc.gov

CDC Vaccines: http://www.cdc.gov/vaccines/

Child Care Aware® of America: http://childcareaware.org/

Child Care Law Center: http://childcarelaw.org/

Emergency Medical Services Authority (EMSA): www.emsa.ca.gov

EMSA Child Care Provider Training: https://emsa.ca.gov/childcare_provider/

Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD): www.nichd.nih.gov

Federal Emergency Management Agency (FEMA): www.fema.gov

Head Start Program Performance Standards: https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii

Licensing Forms: https://www.cdss.ca.gov/inforesources/forms-brochures

Managing Infectious Diseases in Child Care and Schools, 6th Edition, AAP Bookstore:
Book: https://www.aap.org/en/catalog/categories/infectious-diseases/managing-infectious-diseases-in-child-care-and-schools-6th-edition-paperback/
eBook: https://www.aap.org/en/catalog/categories/infectious-diseases/managing-infectious-diseases-in-child-care-and-schools-6th-edition-ebook/

Model Child Care Health Policies, 5th Edition, Pennsylvania ECELS:
http://ecels-healthychildcarepa.org/publications/manuals-pamphlets-policies/item/248-model-child-care-health-policies.html

National Association for the Education of Young Children (NAEYC): www.naeyc.org

National Child Traumatic Stress Network: www.nctsn.org

National Highway and Traffic Safety Administration: www.nhtsa.gov

Office of Disease Prevention and Health Promotion: www.health.gov

Office of Head Start: http://eclkc.ohs.acf.hhs.gov/hslc

Safe Kids Worldwide: www.safekids.org

Substance Abuse and Mental Health Services Administration (SAMHSA): www.samhsa.gov

Supporting Breastfeeding Families: A Toolkit for Child Care Providers, Los Angeles County Department of Public Health:
http://www.publichealth.lacounty.gov/mch/CAH/Breastfeeding_toolkit_May2016_C.PDF

United States Consumer Products Safety Commission: www.cpsc.gov

United States Environmental Protection Agency (EPA): https://www.epa.gov/

University of California, Agricultural and Natural Resources IPM: http://ipm.ucanr.edu/

UCSF School of Nursing