

# CHILD CARE HEALTH CONSULTANTS

Applicable Standards from:

## **CARING FOR OUR CHILDREN**

National Health and Safety Performance Standards:  
Guidelines for Out-of-Home Child Care  
Second Edition

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## INTRODUCTION

*Caring for Our Children: National Health and Safety Performance Standards for Out-of-Home Child Care Programs, 2nd Edition*, was released by the American Academy of Pediatrics, American Public Health Association and the National Resource Center for Health and Safety in Child Care (NRC) in January 2002. The full edition of *Caring for Our Children, 2nd Ed.* contains 707 standards and recommendations on all aspects on the health and safety of children in child care settings. These standards were developed by leading health and safety experts over a period of four years. Each standard includes the rationale behind the need for such practices. The full edition is available on the NRC web site at <http://nrc.uchsc.edu/CFOC/index.html>. Print copies can be purchased from the American Academy of Pediatrics ([www.aap.org](http://www.aap.org)) and the American Public Health Association ([www.apha.org](http://www.apha.org)).

In an effort to make select subject areas more accessible to intended users, the NRC is developing smaller documents on specific subject areas. This document is a compilation of the standards related to the utilization of **child care health consultants** in child care settings.

### INTENDED AUDIENCES

The intended audiences for this document are:

- child care providers who want to know what skills and knowledge child care health consultants should have and what ways a child care health consultant can help them provide a healthy and safe child care setting;
- health professionals who want to know more about becoming a child care health consultant;

- state policy makers who are looking for guidance in setting state rules on this issue; and
- local health departments and resource and referral agencies who employ child care health consultants

Throughout this document there will be references to other standards contained in the full edition of *Caring for Our Children, 2nd Ed.* For example, in Standard 3.065 regarding the inclusion and exclusion criteria, the comments refer to general requirements for special facilities for ill children, STANDARD 3.070 through STANDARD 3.080 (which are in the full edition). In the web version, the user can click on the link to this standard to get to the full edition.

We would like to give special thanks to Phyllis Stubbs-Wynn, MD, MPH, for her leadership in the development of child care health consultant networks as part of the Healthy Child Care America Campaign. Thanks also goes to Jonathan Kotch, MD, MPH, Director of the National Training Institute for Child Care Health Consultants and Susan Aronson, MD, FAAP, Co-Chair of the *Caring for Our Children, 2nd Ed.* Steering Committee for reviewing this compilation of child care health consultant standards. We would also like to thank all those individuals who contributed to *Caring for Our Children, 2nd Ed.* A listing can be viewed at: <http://nrc.uchsc.edu/CFOC/PDFVersion/Acknowledgments.pdf>

Individuals interested in becoming a child care health consultant should contact the National Training Institute for Child Care Health Consultants (<http://www.sph.unc.edu/courses/childcare/>) to find out more on training opportunities. Many states have developed child care health consultant networks as part of their Healthy Child Care America Campaigns. For a contact in your state and resources available in your state, please

contact the Healthy Child Care America Campaign (<http://www.aap.org/advocacy/hcca/state.htm>)

For questions or assistance on these standards or *Caring for Our Children, 2nd Edition*, please contact:  
National Resource Center for Health and Safety in Child Care  
1-800-598-5437  
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## HEALTH CONSULTANTS

### STANDARD 1.040 USE OF CHILD CARE HEALTH CONSULTANTS

Each center, large family child care home, and small family child care home network shall use the services of a health consultant qualified to provide advice for child care as defined in STANDARD 1.041. Centers and large and small family child care home providers shall avail themselves of community resources established for health consultation to child care.

**RATIONALE:** Few child care staff are trained as health professionals and few health professionals have training about the community child care programs. When physical, mental, social, or health concerns are raised for the child or for the family, they should be addressed appropriately, often through consultation with or referral to resources available in the community.

Caregivers need to use health consultants in a variety of fields (such as physical and mental health care, nutrition, environmental safety and injury prevention, oral health care, and developmental disabilities). Health consultants should have specific training in the child care setting (3). Such training is more widely available through efforts such as state programs implementing the Healthy Child Care America Campaign, and national support funded by the Maternal and Child Health Bureau, Health Resources and Services Administration, including the National Resource Center for Health and Safety in Child Care, the national staff of the Healthy Child Care America Campaign at the American Academy of Pediatrics and the National Training Institute for Child Care Health Consultants. Contact information is located in Appendix BB.

In states where health consultation is mandatory, compliance is nearly universal (4).

**COMMENTS:** A health consultant should be a health professional who has an interest in and experience with children, has knowledge of resources and

regulations, and is comfortable linking health resources with facilities that provide primarily education and social services. State regulatory agencies should maintain or contract for the maintenance of a registry of health consultant resources in the community. For example, in Pennsylvania, the PA Chapter of the American Academy of Pediatrics (AAP) maintains and provides training and support for health professionals in such a registry under contracts with the child care regulatory agency and the state department of health. Additional registries are being developed by the National Resource Center for Health and Safety in Child Care, Healthy Child Care America Campaign from the Maternal and Child Health Bureau, Health Resources and Services Administration, and the National Training Institute for Child Care Health Consultants. Child care health consultants may be employed by public or non-profit agencies such as health departments or resource and referral agencies, other health institutions, or may work as independent health consultants. Caregivers also should not overlook health professionals with pediatric and health consultant experience who are parents of children enrolled in their facility. However, involving parents as health consultants requires caution to avoid crossing boundaries of confidentiality and conflict of interest. To foster access to and accountability of health consultants, some form of compensation should be offered.

**TYPE OF FACILITY:** *Center; Large Family Child Care Home; Small Family Child Care Home*

### STANDARD 1.041 KNOWLEDGE AND SKILLS OF CHILD CARE HEALTH CONSULTANTS

A facility shall have a health consultant who is a health professional with training and experience as a child care health consultant. Graduate students in a discipline related to child health shall be acceptable as child care health consultants supervised by faculty knowledgeable in child care. A child care health consultant shall either have the full knowledge base and skills required for this role, or arrange to partner with other health

professionals who can provide the necessary knowledge and skills.

The knowledge base of the child care health consultant (personally or by involving other health professionals) shall include:

- a) National health and safety standards for out-of-home child care;
- b) How child care facilities conduct their day-to-day operations;
- c) Child care licensing requirements;
- d) Disease reporting requirements for child care providers;
- e) Immunizations for children;
- f) Immunizations for child care providers;
- g) Injury prevention for children;
- h) Staff health, including occupational health risks for child care providers;
- i) Oral health for children;
- j) Nutrition for children;
- k) Inclusion of children with special health needs in child care;
- l) Recognition and reporting requirements for child abuse and neglect;
- m) Community health and mental health resources for child and parent health.

The skills of the child care health consultant shall include the ability to perform or arrange for performance of the following activities:

- a) Teaching child care providers about health and safety issues;
- b) Teaching parents about health and safety issues;
- c) Assessing child care providers' needs for health and safety training;
- d) Assessing parents' needs for health and safety training;
- e) Meeting on-site with child care providers about health and safety;
- f) Providing telephone advice to child care providers about health and safety;
- g) Providing referrals to community services;
- h) Developing or updating policies and procedures for child care facilities;
- i) Reviewing health records of children;
- j) Reviewing health records of child care providers;
- k) Helping to manage the care of children with special health care needs;
- l) Consulting with a child's health professional about medication;

- m) Interpreting standards or regulations and providing technical advice, separate and apart from the enforcement role of a regulation inspector.

Although the child care health consultant may have a dual role, such as providing direct care to some of the children or serving as a regulation inspector, these roles shall not be mixed with the child care health consultation role.

The child care health consultant shall have contact with the facility's administrative authority, the staff, and the parents in the facility. The administrative authority shall review, respond to, and implement the child care health consultant's recommendations. The child care health consultant shall review and approve the written health policies used by center-based facilities.

Programs with a significant number of non-English-speaking families shall seek a child care health consultant who is culturally sensitive and knowledgeable about community health resources for the parents' native culture and languages.

**RATIONALE:** The specific health and safety consultation needs for an individual facility depend on the characteristics of that facility (3). All facilities should have an overall child care health consultation.

The special circumstances of group care may not be part of the health professional's usual education. Therefore, child care providers should seek health consultants who have the necessary specialized training or experience. Such training is more readily available now as described in the previous standard.

To be effective, a child care health consultant should know the available resources in the community and should engage in a partnership with the administrative authority for the facility, the staff, and parents in the consultative and policy-setting process. Setting health and safety policies in cooperation with the staff, parents, health professionals, and public health authorities will help ensure successful implementation of a quality program (2).

Health professionals who serve as child care health consultants do not always have a public health perspective or the full range of knowledge and skills

required. Therefore, public health professionals and other health professionals with appropriate training and skills should serve as a resource to inform those who work in the private sector or whose health professional expertise is specialized and lacking in broader knowledge and skills that may be required. For example, while a sanitarian may provide excellent health consultation on hygiene and infectious disease control, another health professional may need to be consulted about medication administration or playground safety. A Certified Playground Safety Inspector would be able to provide consultation about gross motor play hazards, and would not likely be able to provide sound advice about food safety and nutrition.

COMMENTS: The policies and procedures reviewed for approval by child care health consultants should include, but not be limited to, the following:

- a) Admission and readmission after illness, including inclusion/exclusion criteria;
- b) Health evaluation and observation procedures on intake, including physical assessment of the child and other criteria used to determine the appropriateness of a child's attendance;
- c) Plans for health care and management of children with communicable diseases;
- d) Plans for surveillance and management of illnesses, injuries, and problems that arise in the care of children;
- e) Plans for caregiver training and for communication with parents and health care providers;
- f) Policies regarding nutrition, nutrition education, and oral health;
- g) Plans for the inclusion of children with special health needs;
- h) Emergency plans;
- i) Safety assessment of facility playground;
- j) Policies regarding staff health and safety;
- k) Policies for administration of medication.

See Identifiable Governing Body/Accountable Individual, STANDARD 8.001 through STANDARD 8.003, for additional information regarding administrative authority.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### **STANDARD I.042 SPECIALIZED CONSULTATION FOR FACILITIES SERVING CHILDREN WITH DISABILITIES**

When children at the facility include those with developmental delay or disabilities, the staff or documented consultants shall include any of the following, with prior informed, written parental consent and as appropriate to each child's needs:

- a) A physician;
- b) A registered dietitian;
- c) A registered nurse or pediatric nurse practitioner;
- d) A psychologist;
- e) A physical therapist;
- f) An occupational therapist;
- g) A speech pathologist;
- h) A respiratory therapist;
- i) A social worker;
- j) A parent of a child with special needs;
- k) The child care provider.

RATIONALE: The range of professionals needed may vary with the facility, but the listed professionals should be available as consultants when needed. These professionals need not be on staff at the facility, but may simply be available when needed through a variety of arrangements, including contracts, agreements, and affiliations. The parent's participation and written consent in the native language of the parent, including Braille/sign language, is required to include outside consultants.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### **STANDARD I.043 FREQUENCY OF CHILD CARE HEALTH CONSULTATION VISITS**

The health consultant shall visit each facility as needed to review and give advice on the facility's health component. Center-based facilities that serve any child younger than 2 years of age shall be visited at least once a month by a health professional with general knowledge and skills in child health and safety. Center-based facilities that are not open at least 5 days a week or that serve only children 2 years of age or older shall be

visited at least quarterly, on a schedule that meets the needs of the composite group of children. Small and large family child care homes shall be visited at least annually. Written documentation of health consultant visits shall be maintained at the facility.

**RATIONALE:** Almost everything that goes on in a facility and almost everything about the facility itself affects the health of the children it serves (1). Infants are particularly vulnerable to injuries, infections, and psychological harm. Their rapid changes in behavior make regular and frequent visits by the health consultant extremely important. In facilities where health and safety problems or a high turnover of staff occurs, more frequent visits by the health consultant should be arranged.

**COMMENTS:** For health consultants to facilities serving children with special needs, see STANDARD 1.003, STANDARD 1.042, and STANDARD 1.044. For health consultants serving special facilities for children who are ill, see STANDARD 3.075. For nutrition staffing and consultation, see STANDARD 4.026 and STANDARD 4.027. For additional information on health consultants, see Health Consultation, STANDARD 8.020; Consultation Records, STANDARD 8.073, on documentation of health consultant training and visits; and Consultants, RECOMMENDATION 9.033 and RECOMMENDATION 9.034.

**TYPE OF FACILITY:** *Center; Large Family Child Care Home; Small Family Child Care Home*

### **STANDARD 1.044 REGISTERED NURSES TO PROVIDE MEDICAL TREATMENT**

Child care facilities shall arrange for a registered nurse to provide staff training and ongoing supervision of the health needs and practices of staff and children and to ensure appropriate administration of medication and prescribed medical treatment if an individual assessment of a child reveals that such services are required.

**RATIONALE:** An on-site health care professional must be available to assess and manage the needs of children who require medical assistance.

**COMMENTS:** Small family child care home providers may arrange for the services of a registered nurse on an as-needed consultative basis.

**TYPE OF FACILITY:** *Center; Large Family Child Care Home; Small Family Child Care Home*

### **STANDARD 3.054 CONSULTANTS ON CHILD ABUSE AND NEGLECT**

Caregivers and health professionals shall establish linkages with physicians, child psychiatrists, nurses, nurse practitioners, physician's assistants, and child protective services who are knowledgeable about child abuse and neglect and are willing to provide them with consultation about suspicious injuries or other circumstances that may indicate abuse or neglect. The names of these consultants shall be available for inspection.

Child care workers are mandated to report suspected child abuse and neglect.

**RATIONALE:** Many mistakes in reporting can be avoided by working with an experienced consultant before a decision is made about what to do. When the child care worker's level of suspicion is high, a consultation with an outside expert may not be needed, and could delay the initiation of an effective investigation and adequate protection of the child.

**COMMENTS:** Many health departments will be willing to provide this service. The American Academy of Pediatrics (AAP) can also assist in recruiting and identifying physicians who are skilled in this work. Contact information for the AAP is located in Appendix BB.

See also Health Consultation, STANDARD 8.020; and Health Consultants, STANDARD 1.040 through STANDARD 1.044.

**TYPE OF FACILITY:** *Center; Large Family Child Care Home; Small Family Child Care Home*

### STANDARD 3.064 LEVELS OF ILLNESS

The facility shall specify in its policies what severity level(s) of illness the facility can manage and how much and what types of illness will be addressed. The plan of care shall be approved by the facility's **health consultant**.

- *Severity Level 1* consists of children whose health condition is accompanied by high interest and complete involvement in activity associated with an absence of symptoms of illness (such as children recovering from pink eye, rash, or chickenpox), but who need further recuperation time. 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 services offered at the facility.
- *Severity Level 2* encompasses children whose health condition is accompanied by a medium activity level because of symptoms (such as children with low-grade fever, children at the beginning of an illness, and children in the early recovery period of an illness). Appropriate activities for this level include crafts, puzzles, table games, fantasy play, and opportunities to move about the room freely.
- *Severity Level 3* is composed of children whose health condition is accompanied by a low activity level because of symptoms that preclude much involvement. Appropriate activities for this level 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 3 years of age).

Individuals and public and private organizations that provide child care for ill children shall develop and adhere to written guidelines for facilities for ill children that are consistent with the administrative procedures and staff policies, as specified in these standards, to reduce the introduction and transmission of communicable disease.

**RATIONALE:** Children enrolled in child care are of an age that places them at increased risk for acquiring infectious diseases. Many children with illness

(particularly mild respiratory tract illness without fever) can continue to attend and participate in activities in their usual facility. Excluding these children from child care is not recommended (5, 9). This perspective is reflected in the standards for excluding children from child care attendance. See Inclusion/Exclusion/Dismissal of Ill Children, STANDARD 3.065 through STANDARD 3.068.

Young children enrolled in facilities have a high incidence of illness (upper respiratory tract infections, otitis media, diarrhea, hepatitis A infections, skin conditions, and asthma) that may not allow them to participate in the usual facility activities. Because many state regulations now require that children with these conditions be excluded from their usual care arrangements several alternative care arrangements have been established, including (10):

- a) Care in the child's own home;
- b) Care in a small family child care home;
- c) Care in the child's own center with special provisions designed for the care of ill children (sometimes called the infirmary model);
- d) Care in a separate center that serves only children with illness or temporary conditions.

Clearly, when children with possible communicable diseases are present in the alternative care arrangements, emphasis on preventing further spread of disease is as important as in the usual facilities. In one study, no additional transmission of communicable disease occurred in children attending a sick child care center (11). Prevention of additional cases of communicable disease should be a key objective in these alternative care arrangements for children with minor illness and temporary disability.

Current state regulations concerning exclusion of children from facilities because of illness may be more restrictive than these standards. Some states currently require isolation of a child who becomes ill during the day while attending the facility and for an ill child who is not expected to return to the facility the following day. The most common alternative care arrangement is for a parent of the ill child to stay home from work and care for the child. Some states have established regulations governing child care for sick children (10, 15).

Data are inadequate by which to judge the impact of group care of ill children on their subsequent health and on the health of their families and community. The principles and standards proposed in this manual represent the most current views of pediatric and infectious disease experts on providing this special form of child care. These standards will require revision as new information on disease transmission in these facilities becomes available. The National Association for Sick Child Daycare (NASCD) conducts and sponsors original research on issues related to sick child care and helps establish sick care facilities across the nation. Contact information for the NASCD is located in Appendix BB.

COMMENTS: Technical expertise and guidance can be obtained from the health consultant. See Health Consultants, STANDARD 1.040 through STANDARD 1.043. For additional information on general requirements for special facilities for ill children, see STANDARD 3.070 through STANDARD 3.080. See also Health Department Role, RECOMMENDATION 9.025.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

**STANDARD 3.065  
INCLUSION/EXCLUSION/DISMISSAL  
OF CHILDREN**

The parent, legal guardian, or other person the parent authorizes shall be notified immediately when a child has any sign or symptom that requires exclusion from the facility. The facility shall ask the parents to consult with the child's health care provider. The child care provider shall ask the parents to inform them of the advice received from the health care provider. The advice of the child's health care provider shall be followed by the child care facility.

With the exception of head lice for which exclusion at the end of the day is appropriate, a facility shall temporarily exclude a child or send the child home as soon as possible if one or more of the following conditions exists:

- a) The illness prevents the child from participating comfortably in activities as determined by the child care provider;
- b) The illness results in a greater need for care than the child care staff can provide without compromising the health and safety of the other children as determined by the child care provider;
- c) The child has any of the following conditions:
  - 1) Fever, accompanied by behavior changes or other signs or symptoms of illness until medical professional evaluation finds the child able to be included at the facility;
  - 2) Symptoms and signs of possible severe illness until medical professional evaluation finds the child able to included at the facility. Symptoms and signs of possible severe illness shall include
    - lethargy that is more than expected tiredness,
    - uncontrolled coughing,
    - inexplicable irritability or persistent crying,
    - difficult breathing,
    - wheezing, or
    - other unusual signs for the child;
  - 3) Diarrhea, defined by more watery stools, decreased form of stool that is not associated with changes of diet, and increased frequency of passing stool, that is not contained by the child's ability to use the toilet. Children with diarrheal illness of infectious origin generally may be allowed to return to child care once the diarrhea resolves, except for children with diarrhea caused by *Salmonella typhi*, *Shigella* or *E. coli 0157:H7*. For *Salmonella typhi*, 3 negative stool cultures are required. For *Shigella* or *E. coli 0157:H7*, two negative stool cultures are required. Children whose stools remain loose but who, otherwise, seem well and whose stool cultures are negative, need not be excluded. See also Child-Specific Procedures for Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections, STANDARD 6.023, for additional separation and exclusion information for children with diarrhea; STANDARD 3.066, on separate care for these children; and STANDARD 3.084 and STANDARD 3.087, on notifying parents;

- 4) Blood in stools not explainable by dietary change, medication, or hard stools;
- 5) Vomiting illness (two or more episodes of vomiting in the previous 24 hours) until vomiting resolves or until a health care provider determines that the cause of the vomiting is not contagious and the child is not in danger of dehydration. See also STANDARD 3.066, on separate care for these children;
- 6) Persistent abdominal pain (continues more than 2 hours) or intermittent pain associated with fever or other signs or symptoms;
- 7) Mouth sores with drooling, unless a health care provider or health department official determines that the child is noninfectious;
- 8) Rash with fever or behavior change, until a physician determines that these symptoms do not indicate a communicable disease;
- 9) Purulent conjunctivitis (defined as pink or red conjunctiva with white or yellow eye discharge), until after treatment has been initiated. In epidemics of nonpurulent pink eye, exclusion shall be required only if the health authority recommends it;
- 10) Pediculosis (head lice), from the end of the day until after the first treatment. See STANDARD 6.038;
- 11) Scabies, until after treatment has been completed. See STANDARD 6.037;
- 12) Tuberculosis, until a health care provider or health official states that the child is on appropriate therapy and can attend child care. See STANDARD 6.014 and STANDARD 6.015;
- 13) Impetigo, until 24 hours after treatment has been initiated;
- 14) Strep throat or other streptococcal infection, until 24 hours after initial antibiotic treatment and cessation of fever. See also Group A Streptococcal (GAS) Infection, STANDARD 6.012 and STANDARD 6.013;
- 15) Varicella-Zoster (Chickenpox), until all sores have dried and crusted (usually 6 days). See also STANDARD 6.019 and STANDARD 6.020;
- 16) Pertussis, until 5 days of appropriate antibiotic treatment (currently, erythromycin, which is given for 14 consecutive days) has been completed. See STANDARD 6.009 and STANDARD 6.010;
- 17) Mumps, until 9 days after onset of parotid gland swelling;
- 18) Hepatitis A virus, until 1 week after onset of illness, jaundice, or as directed by the health department when passive immunoprophylaxis (currently, immune serum globulin) has been administered to appropriate children and staff members. See STANDARD 6.023 through STANDARD 6.026;
- 19) Measles, until 4 days after onset of rash;
- 20) Rubella, until 6 days after onset of rash;
- 21) Unspecified respiratory tract illness, see STANDARD 6.017;
- 22) Shingles (herpes zoster). See STANDARD 6.020;
- 23) Herpes simplex, see STANDARD 6.018.

Some states have regulations governing isolation of persons with communicable diseases including some of those listed here. Providers shall contact their **health consultant** or health department for information regarding isolation of children with diseases such as chickenpox, pertussis, mumps, hepatitis A, measles, rubella, and tuberculosis (5). If different health care professionals give conflicting opinions about the need to exclude an ill child on the basis of the risk of transmission of infection to other children, the health department shall make the determination.

The child care provider shall make the decision about whether a child meets or does not meet the exclusion criteria for participation and the child's need for care relative to the staff's ability to provide care. If parents and the child care staff disagree, and the reason for exclusion relates to the child's ability to participate or the caregiver's ability to provide care for the other children, the child care provider shall not be required by a parent to accept responsibility for the care of the child during the period in which the child meets the providers's criteria for exclusion.

**RATIONALE:** Short term exclusion of children with many mild infectious diseases is likely to have only a minor impact on the incidence of infection among other children in the group. Thus, when formulating exclusion policies, it is reasonable to focus on the needs and behavior of the ill child and the ability of

the staff in the out-of-home child care setting to meet those needs without compromising the care of other children in the group (8).

As states update their regulations, the trend has been to be much more specific about what diseases or conditions should be excluded, and what can be included. Isolation of a child in a child care setting is not an effective way to prevent the spread of disease, and is only used in certain circumstances, such as when an excluded child whose illness is considered to be contagious, who has not already exposed the child care group, and is waiting to be transported home, or when an included child needs a less stimulating environment than the child's usual care setting. Most ill children will rest in any setting if they are tired.

Fever is defined as an elevation of body temperature above normal. Oral temperatures above 101 degrees F, rectal temperatures above 102 degrees F, or axillary (armpit) temperatures above 100 degrees F usually are considered to be above normal in children. Children's temperatures may be elevated for a variety of reasons, all of which may not indicate serious illness or warrant exclusion from child care. For instance, a child's over exertion in a hot dry climate may produce a fever. Generally, children should be excluded whenever fever is accompanied by behavior changes, signs, or symptoms of illness that require parental evaluation of their illness and need for care.

Because very young infants may have serious illnesses without much change in behavior in the early stages of illness, rectal temperatures above 101 degrees F or axillary (armpit) temperatures above 100 degrees F without behavioral change is considered to be significant in infants 8 weeks of age and younger and a reason to seek immediate medical professional care for these young infants. Although health care professionals worry most about children under 8 weeks of age who have fever, concern for fever in infants under 4 months of age provides a wide margin of safety. No age standard for fever is included, but prudent practice would be to seek medical evaluation for infants under 4 months of age who have an unexplained fever. An infant under 4 months of age with a fever on the day following an immunization would not be considered to have an unexplained temperature elevation and need not be excluded as

long as the child is acting normally. The presence of fever alone has little relevance to the spread of disease and should not disallow a child's participation in child care. A small proportion of childhood illness with fever is caused by life-threatening diseases, such as meningitis. Except for very young infants, serious illnesses with fever are associated with recognizable behavior change. Facilities should inform parents promptly when their child is found to have a fever or behavior change in child care.

The presence of diarrhea, particularly in diapered children and the presence of vomiting increase the likelihood of exposing other children to the infectious agents that cause these illnesses. It may not be reasonable to routinely culture children who have fever and diarrhea. In some outbreak settings, however, identifying infected children and excluding or treating them may be necessary. Because these infections are easily transmitted and can be severe, exclusion of children with diarrhea because of *Shigella* and *E. coli O157:H7* is recommended until two stool cultures are negative and exclusion of children with diarrhea because of *Salmonella typhi* is recommended until three stool cultures are negative. For *Salmonella* species other than *S.typhi* stool cultures are not required from asymptomatic individuals (5).

Vomiting with symptoms such as lethargy and/or dry skin or mucous membranes, or reduced urine output, may indicate dehydration. A child with these symptoms should be evaluated medically (12). A child who vomits should be observed carefully for other signs of illness and for dehydration. If dehydration is not present, the child may continue to attend the facility.

If a child with abdominal pain is drowsy, irritable, and unhappy, has no appetite, and is unwilling to participate in usual activities, the child should be seen by that child's health care provider. Abdominal pain may be associated with viral, bacterial, or parasitic gastrointestinal tract illness, which is contagious, or with food poisoning. It also may be a manifestation of another disease or illness such as kidney disease. If the pain is severe or persistent, the child should be referred for medical evaluation.

Any rash that has open, weeping wounds and/or is not healing should be evaluated medically.

Not all conjunctivitis is infectious. Some is caused by allergies, or by chemical irritation (such as after swimming). Infectious nonpurulent conjunctivitis usually is accompanied by a clear, watery eye discharge, without fever, eye pain, or redness of the eyelid. This type of conjunctivitis usually can be managed without excluding a child from a facility, as in the case of children with mild infection of the respiratory tract. Such a child, however, might require exclusion if a responsible health department authority, the child's health care provider, or the facility's **health consultant** (see Health Consultants, STANDARD I.040 through STANDARD I.043) determines that the child's conjunctivitis was contributing to transmission of the infection within or outside the facility.

Purulent conjunctivitis is defined as pink or red conjunctiva with white or yellow eye discharge, often with matted eyelids after sleep, and including eye pain or redness of the eyelids or skin surrounding the eye. This type of conjunctivitis is more often caused by a bacterial infection, which may require antibiotic treatment. Children with purulent conjunctivitis, therefore, should be excluded until the child's health care provider has examined the child and cleared him or her for readmission to the facility, with or without treatment.

Lice and scabies are highly contagious, and all parents should be notified to watch for signs of infestation (5, 13). However, children discovered with lice need not be removed until the end of the day and may return after the first treatment.

Chickenpox, measles, rubella, mumps, and pertussis are highly communicable illnesses for which routine exclusion of infected children is warranted. Excluding children with treatable illnesses until appropriate treatment has reduced the risk of transmission is also appropriate.

A child may be included in the regular facility and his or her activities may be modified if the child is comfortable and the facility has enough caregivers to accommodate the adaptation. No child should be

forced to participate in activities when in ill health. Exclusion/dismissal should be for the comfort and safety of both the ill child and the rest of the children in the group, if the facility cannot meet the ill child's needs (11).

Parents and the child care staff may disagree about whether a child meets or does not meet the exclusion criteria. If the reason for exclusion relates to the child's ability to participate or the caregiver's ability to provide care for the other children, the child care provider is entitled to make this decision and cannot be forced by a parent to accept responsibility for the care of an ill child. The parent is neither in a position to assess the factors involved in care of the group, nor legally able to transfer responsibility for the care of the child to an unwilling caregiver. If the reason for exclusion relates to a decision about whether the child has a communicable disease that poses a risk to the other children in the group, different health care professionals in the community might give conflicting opinions. In these cases, the health department has the legal authority to make a determination.

**COMMENTS:** For all infectious diseases for which treatment has been initiated, continuing to include the child in care after treatment has been initiated should be conditional on completing the prescribed course of therapy and clinical improvement of the child's illness. When measles, rubella, mumps, invasive *H. influenzae* disease, or pertussis are diagnosed for a child in the facility, children in the facility who are not immunized for the disease must be excluded if they are exposed.

The lay term "pink eye" is used interchangeably with purulent conjunctivitis and nonpurulent conjunctivitis. The infectious characteristics of purulent and nonpurulent conjunctivitis, however, are quite different. As indicated in the rationale, not all pink eye (conjunctivitis) is infectious. If the caregiver is unable to contact the parent, medical advice should be sought until the parents can be located.

Diarrhea is considered resolved when the child seems well and has resumed a pre-illness stool pattern, or when the child seems well and has developed a new,

but regular pattern of non-watery bowel movements for more than a week, even if this new pattern is more frequent and loose bowel movements than was usual for the child before the diarrhea episode.

Oral temperatures should not be taken on children younger than 4 years of age unless a digital thermometer can be used successfully. Rectal temperature or aural (ear) equivalent to rectal temperature shall be taken only by persons with specific training in this technique. Instructions on how to take a child's temperature and a sample symptom record are provided in *Healthy Young Children*, available from the National Association for the Education of Young Children (NAEYC). See a sample symptom record in Appendix F. See Appendix N, for *Situations That Require Medical Attention Right Away*. Protocols for managing illness are provided in the *Child Care Health Handbook*, available from the Seattle King County Department of Public Health. Contact information for the organizations listed is located in Appendix BB.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### **STANDARD 3.075 HEALTH CONSULTANTS FOR FACILITIES THAT CARE FOR ILL CHILDREN**

Each special facility that provides care for ill children shall use the services of a health consultant for ongoing consultation on overall operation and development of written policies relating to health care. The health consultant (see STANDARD 1.040 through STANDARD 1.044) shall have training and experience with pediatric health issues.

The facility shall involve the consultant in development and/or implementation, review, and sign-off of the written policies and procedures for managing specific illnesses. The facility staff and the consultant shall review and update the written policies annually.

The facility shall assign the health consultant the responsibility for reviewing written policies and procedures for the following:

- a) Admission and readmission after illness, including inclusion/exclusion criteria;
- b) Health evaluation procedures on intake, including physical assessment of the child and other criteria used to determine the appropriateness of a child's attendance;
- c) Plans for health care and for managing children with communicable diseases;
- d) Plans for surveillance of illnesses that are admissible and problems that arise in the care of children with illness;
- e) Plans for staff training and communication with parents and health care providers;
- f) Plans for injury prevention;
- g) Situations that require medical care within an hour.

**RATIONALE:** Appropriate involvement of health consultants is especially important for facilities that care for ill children. Facilities should use the expertise of health professionals to design and provide a child care environment with sufficient staff and facilities to meet the needs of ill children (8, 14). The best interests of the child and family must be given primary consideration in the care of ill children. Consultation by physicians, especially pediatricians, is critical in planning facilities for the care of ill children (6).

**COMMENTS:** Caregivers should seek the services of a health consultant through state and local professional organizations, such as:

- a) Local chapters of the American Academy of Pediatrics (AAP);
- b) American Nurses Association (ANA);
- c) Visiting Nurse Association (VNA);
- d) American Academy of Family Physicians;
- e) National Association of Pediatric Nurse Practitioners (NAPNAP);
- f) National Association for the Education of Young Children (NAEYC);
- g) National Association for Family Child Care;
- h) Emergency Medical Services for Children (EMSC) National Resource Center;
- i) National Training Institute for Child Care Health Consultants;

- j) State or local health department (especially public health nursing, communicable disease, and epidemiology departments).

Caregivers also should not overlook health professionals with appropriate pediatric experience who are parents of children enrolled in their facility. A health professional (community health nurse, for example) may provide consultation, as a volunteer, or paid via a stipend, hourly rate, or honorarium. If a parent provides health consultation, conflicts of interest must be addressed in advance.

For additional information on health consultants, see also Health Consultation, STANDARD 8.020; Consultation Records, STANDARD 8.073, on documentation of health consultant visits; Health Consultants, STANDARD 1.040 and STANDARD 1.044, on general health consultant qualifications and responsibilities; and, STANDARD 3.072, on health consultants for special facilities for ill children.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### STANDARD 3.078 INCLUSION AND EXCLUSION OF CHILDREN FROM FACILITIES THAT SERVE ILL CHILDREN

Facilities that care for ill children who have conditions that require additional attention from the caregiver shall arrange for or ask the **health consultant** to arrange for a clinical health evaluation, by a licensed health care professional, for each child who is admitted to the facility. These facilities shall include children with conditions listed in STANDARD 3.065 if their policies and plans address the management of these conditions, except for the following conditions which require exclusion from all types of child care facilities that are not medical care institutions (such as hospitals or skilled nursing facilities):

- a) Fever and a stiff neck, lethargy, irritability, or persistent crying;
- b) Diarrhea (three or more loose stools in an 8-hour period or more stools compared to the child's normal pattern, with more stool water or less form) and one or more of the following:

- 1) Signs of dehydration;
- 2) Blood or mucus in the stool, unless at least one stool culture demonstrates absence of *Shigella*, *Salmonella*, *Campylobacter*, and *E. coli 0157:H7*. See STANDARD 3.065 and STANDARD 6.023;
- 3) Diarrhea attributable to *Salmonella*, *Campylobacter*, or *Giardia* except that a child with diarrhea attributable to *Campylobacter* or *Giardia* may be readmitted 24 hours after treatment has been initiated if cleared by the child's physician;
- c) Diarrhea attributable to *Shigella* and *E. coli 0157:H7*, until diarrhea resolves and two stool cultures taken 48 hours apart are negative (7);
- d) Vomiting three or more times, or signs of dehydration;
- e) Contagious stages of pertussis, measles, mumps, chickenpox, rubella, or diphtheria, unless the child is appropriately isolated from children with other illnesses and cared for only with children having the same illness;
- f) Untreated infestation of scabies or head lice;
- g) Untreated tuberculosis;
- h) Undiagnosed rash;
- i) Abdominal pain that is intermittent or persistent;
- j) Difficulty in breathing;
- k) Lethargy such that the child does not play;
- l) Undiagnosed jaundice (yellow skin and whites of eyes);
- m) Other conditions as may be determined by the director or health consultant.

RATIONALE: These signs may indicate a significant systemic infection that requires professional medical management and parental care. Because diarrheal illness caused by *Shigella*, *E. coli 0157:H7*, *Salmonella*, *Campylobacter*, *Cryptosporidium*, rotavirus and other enteric viruses, and *Giardia lamblia* may spread from child to child or from child to staff, children and staff with these infections, when accompanied by diarrhea, should be excluded from child care.

Antibiotic therapy of *Campylobacter* may not alter symptoms, but it does decrease shedding of the organism and, therefore, lowers the infectivity of these children. Antibiotic therapy for salmonella gastroenteritis is generally not recommended unless

diarrhea is severe, sepsis is present, or the child has a specific underlying medical condition that makes this illness problematic. Therefore, most children with *Salmonella gastroenteritis* will not be treated with antibiotics and should not be included in regular or special child care until the diarrheal illness has resolved. *Shigella* and *E. coli 0157:H7* both can produce severe illness and, therefore, exclusion recommendations are more stringent.

COMMENTS: For additional information regarding health consultants, see STANDARD 1.040 through STANDARD 1.044.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### STANDARD 3.080 PLAY EQUIPMENT IN FACILITIES THAT CARE FOR ILL CHILDREN

In a facility that cares for ill children, a varied supply of play equipment and materials shall be available that stimulate an ill child's interest and involvement and provide a match between an ill child's level of development and condition of health or illness, as defined by the facility's **health consultant** (see Health Consultants, STANDARD 1.040 through STANDARD 1.044) and the child's health care provider.

RATIONALE: Frequent mild illness is a normal condition of childhood, and the activity level of ill children is age dependent. Ill children, like well children, need to engage in activities that are suitable to their age and developmental level and consistent with their state of health or illness and their accompanying level of interest or responsiveness. A low level of responsiveness in the school-age child usually leads to sleeping and resting for much of the day, requiring a minimum of activities and stimulation. Infants, toddlers, and preschool-age children tend to be unable to rest for such long periods of time, and therefore require more attention from the caregiver in terms of providing activities and guidance.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### STANDARD 3.084 PROCEDURE FOR PARENT NOTIFICATION ABOUT EXPOSURE OF CHILDREN TO COMMUNICABLE DISEASE

The center director or large or small family home child caregiver shall follow the recommendations of these standards, the facility's **health consultant**, or the local health authority regarding notification of parents of children who attend the facility about exposure of their child to a communicable disease. When notification is recommended, it shall be oral or written and shall include the following information:

- a) The diagnosed disease to which the child was exposed, whether there is one case or an outbreak, and the nature of the exposure (such as a child in same room or facility);
- b) Signs and symptoms of the disease that the parent should watch for in the child;
- c) Mode of transmission for the disease;
- d) Period of communicability and how long to watch for signs and symptoms of the disease;
- e) Disease-prevention measures recommended by the health department (if appropriate);
- f) Control measures implemented at the facility;

The notice shall not identify the child who has the communicable disease.

RATIONALE: Effective control and prevention of infectious diseases in child care depends on affirmative relationships between parents, caregivers, public health authorities, and primary health care providers.

COMMENTS: For a sample letter to parents notifying them of illness of their child or other enrolled children, see *Healthy Young Children*, available from the National Association for the Education of Young Children (NAEYC). Contact information is located in Appendix BB.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### **STANDARD 4.026 FOOD SERVICE STAFF BY TYPE OF FACILITY AND FOOD SERVICE**

Each center-based facility shall employ trained staff and provide ongoing supervision and consultation in accordance with individual site needs as determined by the Child Care Nutrition Specialist (see Appendix C). In centers, prior work experience in food service shall be required for the solitary worker responsible for food preparation without the continuous on-site supervision of a food service manager. For facilities operating 6 or more hours a day or preparing and serving food on the premises, the following food service staff requirements shall apply:

<b>SETTING</b>	<b>FOOD SERVICE STAFF</b>
Small and large family child care homes	Caregiver
Centers serving up to 30 children	Full-time child care Food Service Worker (cook)
Centers serving up to 50 children	Full-time child care Food Service Worker (cook) and part-time child care Food Service Aide
Centers serving up to 125 children	Full-time child care Food Service Manager or full-time child care Food Service Worker (cook) and full-time child care Food Service Aide
Centers serving up to 200 children	Full-time child care Food Service Manager and full-time child care Food Service Worker (cook) and one full-time plus one part-time child care Food Service Aide
Vendor food service	One assigned staff member or one part-time staff member, depending on amount of food service preparation needed after delivery

**RATIONALE:** Trained personnel working in the food service component of facilities is essential to meet the nutrition standards required in these facilities (16, 17, 20, 21-23). Home cooking experience is not enough when large volumes of food must be served to children and adults. The type of food service, type of equipment, number of children to be fed, location of the facility, and food budget determine the staffing patterns. An adequate number of food service personnel is essential to meet the goals and objectives of the facility and ensure that children are fed according to the facility's daily schedule. If the facility serves only food brought from home, food service staff are needed to oversee the appropriate use of such food if the facility operates for 6 or more hours a day.

**COMMENTS:** The food service staff may not necessarily consist of full-time or regular staff members but may include some workers hired on a consulting or contractual basis. Resources for food service staff include vocational high school food preparation programs, university and community college food preparation programs, and trade schools that train cooks and chefs.

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

### **STANDARD 4.027 CHILD CARE NUTRITION SPECIALIST**

A local Child Care Nutrition Specialist (see Appendix C) or food service expert shall be employed to work with the architect or engineer on the design of the parts of the facility involved in food service, to develop and implement the facility's nutrition plan (see STANDARD 8.035) and to prepare the initial food service budget. The nutrition plan encompasses:

- a) Kitchen layout;
- b) Food procurement, preparation, and service;
- c) Staffing;
- d) Nutrition education.

When contemplating alterations in the nutrition plan, such as installing a new dishwasher or

expanding storage or dining areas, the procedure to be followed shall be the same as for new construction or renovation. The food service expert shall be involved in the decision-making and shall oversee carrying out completion of the plan.

**RATIONALE:** Efficient and cost-effective food service in a facility begins with a plan and evaluation of the physical components of the facility. Planning for the food service unit includes consideration of location and adequacy of space for receiving, storing, preparing, and serving areas; cleaning up; dish washing; dining areas, plus space for desk, telephone, records, and employee facilities (such as handwashing sinks, toilets, and lockers). All facets must be considered for new or existing sites, including remodeling or renovation of the unit (17-20).

TYPE OF FACILITY: *Center*

### **STANDARD 8.004 CONTENT OF POLICIES**

The facility shall have policies to specify how the caregiver addresses the developmental functioning and individual or special needs of children of different ages and abilities who can be served by the facility. These policies shall include, but not be limited to, the items described in STANDARD 8.005 and below:

- a) Admission and Enrollment;
- b) Supervision;
- c) Discipline;
- d) Care of Acutely Ill Children;
- e) Child Health Services;
- f) Use of **Health Consultants**
- g) Health Education
- h) Medications;
- i) Emergency Plan;
- j) Evacuation Plan, Drills, and Closings;
- k) Authorized Caregivers;
- l) Safety Surveillance;
- m) Transportation and Field Trips;
- n) Sanitation and Hygiene;
- o) Food Handling, Feeding, and Nutrition;
- p) Sleeping
- q) Evening and Night Care Plan;
- r) Smoking, Prohibited Substances, and Firearms;
- s) Staff Health, Training, Benefits, and Evaluation;
- t) Maintenance of the Facility and Equipment;

- u) Review and Revision of Policies, Plans, and Procedures, STANDARD 8.040 and STANDARD 8.041.

The facility shall have specific strategies for implementing each policy. For centers, all of these items shall be written.

**RATIONALE:** Facility policies should vary according to the ages and abilities of the children enrolled to accommodate individual or special needs. Program planning should precede, not follow, the enrollment and care of children at different developmental levels and with different abilities. Neither plans nor policies affect quality unless the program has devised a way to implement the plan or policy.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### **STANDARD 8.005 INITIAL PROVISION OF WRITTEN INFORMATION TO PARENTS AND CAREGIVERS**

At enrollment, and before assumption of supervision of children by caregivers at the facility, the facility shall provide parents and caregivers with a statement of services, policies, and procedures that shall include at least the following information along with the policies listed in STANDARD 8.004:

- a) The licensed capacity, child:staff ratios, ages and number of children in care. If names of children and parents are made available, parental permission for any release to others shall be obtained;
- b) Services offered to children including daily activities, sleep positioning policies and arrangements, napping routines, guidance and discipline policies, diaper changing and toilet learning/training methods, child handwashing, oral health, and health education. Any special requirements for a child shall be clearly defined in writing before enrollment;
- c) Hours and days of operation;
- d) Admissions criteria, enrollment procedures, and daily sign-in/out policies, including forms that must be completed;
- e) Policies for termination and notice by the parent or the facility;

- f) Policies regarding payments of fees, deposits, and refunds;
- g) Planned methods and schedules for conferences or other methods of communication between parents and staff;
- h) Plan for Urgent and Emergency Medical Care or Threatening Incidents. See Emergency Procedures, STANDARD 3.048 through STANDARD 3.052; and Plan for Urgent Medical Care or Threatening Incidents, STANDARD 8.022 and STANDARD 8.023.
- i) Evacuation procedures and alternate shelter arrangements for fire, natural disasters, and building emergencies. See Evacuation Plan, Drills, and Closings, STANDARD 8.024 through STANDARD 8.027;
- j) Nutrition. Schedule of meals and snacks. See General Requirements, STANDARD 4.001 through STANDARD 4.010; Requirements for Special Groups or Ages of Children, STANDARD 4.011 through STANDARD 4.025 and Plans and Policies for Food Handling, Feeding, and Nutrition, STANDARD 8.035 and STANDARD 8.036;
- k) Policy for food brought from home. See Food Brought from Home, STANDARD 4.040 and STANDARD 4.041;
- l) Policy on infant feeding. See Nutrition for Infants, STANDARD 4.011 through STANDARD 4.021 and Plans and Policies for Food Handling, Feeding, and Nutrition, STANDARD 8.035 and STANDARD 8.036;
- m) Policies for staffing including the use of volunteers, helpers, or substitute caregivers, child:staff ratios, deployment of staff for different activities, authorized caregivers, methods used to ensure continuous supervision of children. See Child:Staff Ratio and Group Size, STANDARD 1.001 through STANDARD 1.005;
- n) Policies for sanitation and hygiene. See Hygiene and Sanitation, Disinfection, and Maintenance, STANDARD 3.012 through STANDARD 3.040;
- o) Non-emergency transportation policies. See Transportation, STANDARD 2.029 through STANDARD 2.038;
- p) Presence and care of any pets or any other animals on the premises. See Animals, STANDARD 3.042 through STANDARD 3.044;
- q) Policy on health assessments and immunizations. See Daily Health Assessment, STANDARD 3.001 and STANDARD 3.002; Preventive Health Services, STANDARD 3.003 through STANDARD 3.004; and Immunizations, STANDARD 3.005 through STANDARD 3.007;
- r) Policy regarding care of acutely ill children, including exclusion or dismissal from the facility. See Child Inclusion/Exclusion/Dismissal, STANDARD 3.065 through STANDARD 3.068; Caring for Ill Children, STANDARD 3.070 through STANDARD 3.080; and Plan for the Care of Acutely Ill Children, STANDARD 8.011 and STANDARD 8.012;
- s) Policy on administration of medications. See Medications, STANDARD 3.081 through STANDARD 3.083; and Medication Policy, STANDARD 8.021;
- t) Policy on use of child care **health consultants**. See STANDARD 1.040 through STANDARD 1.044;
- u) Policy on health education. See STANDARD 2.060 through STANDARD 2.067.
- v) Policy on smoking, tobacco use, and prohibited substances. See Smoking and Prohibited Substances, STANDARD 3.041 and Policy on Smoking, Tobacco Use, Prohibited Substances, and Firearms, STANDARD 8.038 and STANDARD 8.039;
- w) Policy on confidentiality of records. See STANDARD 8.054.

Parents and caregivers shall sign that they have reviewed and accepted this statement of services, policies and procedures.

**RATIONALE:** The *Model Child Care Health Policies* has all of the necessary text to comply with this standard organized into a single document. Each policy has a place for the facility to fill in blanks to customize the policies for a specific site. The text of the policies can be edited to match individual program operations. Since the task of assembling all the items listed in this standard is formidable, starting with a template such as *Model Child Care Health Policies* can be helpful.

**COMMENTS:** Parents are encouraged to interact with their own children and other children at drop-off and pick-up times and during visits at the center. Parents and caregivers, including volunteers, may have different approaches to routines than those followed by the facility. Review of written policies and procedures by all adults prior to contact with the children in care helps ensure consistent

implementation of carefully considered decisions about how care should be provided at the facility.

For large and small family child care homes, a written statement of services, policies and procedures is recommended but not required. If the statement is provided orally, parents should sign a statement attesting to their acceptance of the statement of services, policies and procedures presented orally to them. *Model Child Care Health Policies* can be adapted to these smaller settings.

Copies of the current edition of *Model Child Care Health Policies* can be purchased from the National Association for the Education of Young Children (NAEYC) or from the American Academy of Pediatrics (AAP). Contact information for the NAEYC and the AAP is located in Appendix BB.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### **STANDARD 8.01 I CONTENT AND DEVELOPMENT OF THE PLAN FOR CARE OF ILL CHILDREN AND CAREGIVERS**

The facility's plan for the care of ill children and caregivers shall be developed in consultation with the facility's **health consultant**. See STANDARD 1.040 through STANDARD 1.044. This plan shall include:

- a) Policies and procedures for urgent and emergency care;
- b) Admission and inclusion/exclusion policies. Conditions that require that a child be excluded and sent home are specified in Child Inclusion/Exclusion/Dismissal, STANDARD 3.065 through STANDARD 3.068;
- c) A description of illnesses common to children in child care, their management, and precautions to address the needs and behavior of the ill child as well as to protect the health of other children and caregivers. See Infectious Diseases, STANDARD 6.001 through STANDARD 6.039;
- d) A procedure to obtain and maintain updated individual emergency care plans for children with special health care needs;

- e) A procedure for documenting the name of person affected, date and time of illness, a description of symptoms, the response of the caregiver to these symptoms, who was notified (such as a parent, legal guardian, nurse, physician, health department), and the response;
- f) The standards described in Reporting Illness, STANDARD 3.087 and STANDARD 3.088; and Notification of Parents, STANDARD 3.084 and STANDARD 3.085.
- g) Medication Policy. See STANDARD 8.021.

All child care facilities shall have written policies for the care of ill children and caregivers.

**RATIONALE:** The policy for the management of ill children should be developed in consultation with health care providers to address current understanding of the technical issues of contagion and other health risks. In group care, the facility must address the well-being of all those affected by illness: the ill child, the staff, parents of the ill child, other children in the facility and their parents, and the community. Where compromises must be made, the priority of the policy should be to meet the needs of the ill child. The policy should address the circumstances under which separation of the ill child from the group is required; the circumstances under which the caregiver, parents, legal guardian, or other designated persons need to be informed; and the procedures to be followed in these cases. The policy should take into consideration:

- a) The physical facility;
- b) The number and the qualifications of the facility's personnel;
- c) The fact that children do become ill frequently and at unpredictable times;
- d) The fact that working parents often are not given leave for their children's illnesses (24).

Infectious diseases are a major concern of parents and caregivers. Since children, especially those in group settings, can be a reservoir for many infectious agents, and since caregivers come into close and frequent contact with children, caregivers are at risk for developing a wide variety of infectious diseases. Following the infection control standards will help protect both children and caregivers from communicable disease. Recording the occurrence of illness in a facility and the response to the illness characterizes and defines the frequency of the illness, suggests whether an outbreak has occurred, may suggest an effective intervention, and provides documentation for administrative purposes.

COMMENTS: Facilities may comply by adopting a model policy and using reference materials as authoritative resources. The *Model Child Care Health Policies*, the print or internet version available from NAEYC and the AAP, may be helpful; or see the *Red Book* or *Preparing for Illness*, a booklet which translates the recommendations of the *Red Book* for child care providers, available from the AAP. Check for other materials provided by the licensing agency, resource and referral agency, or health department. Training for staff on management of illness can be facilitated by using *Part 6: Illness in Child Care*, of the video series developed to illustrate how to comply with the standards in *Caring for Children*. The video series is available from the AAP and NAEYC. See the sample symptom record in Appendix F. The sample symptom record is also provided in *Healthy Young Children* produced by the NAEYC. See also a sample document for permission for medical condition treatment in Appendix W. Contact information for the National Association for the Education of Young Children (NAEYC) and the American Academy of Pediatrics (AAP) can be found in Appendix BB.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### **STANDARD 8.020 ARRANGEMENTS FOR USE OF HEALTH CONSULTANTS**

Every facility shall seek the services of a health consultant. This health consultant will provide the facility with ongoing consultation to assist in the development of written policies relating to health and safety, as specified in Health Consultants, STANDARD 1.040 through STANDARD 1.044.

RATIONALE: Caregivers rarely are trained health care professionals. Health consultants can help develop and implement written policies for prevention and management of injury and disease. Advance planning in this area can reduce stress for caregivers, parents, and health professionals.

Use of health consultants for child care is becoming a reality. In 1998, 24 states and one city required regulated facilities to have a health consultant (25). Many states have been developing health consultation services due in part to a national program funded by

the Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA) to help every state implement the Healthy Child Care America Campaign. Training programs for health consultants have been developed by Early Childhood Education Linkage System (ECLS), American Public Health Association (APHA), and the National Training Institute for Child Care Health Consultants (NTI) at the University of North Carolina (UNC-CH).

COMMENTS: Unless provided through a public health system, the health consultant's services are difficult to obtain particularly for small family child care homes. Caregivers should seek services from the public health resources, pay for consultation from community nursing services, seek the services of a health consultant through state and local professional organizations, such as the following resources:

- a) Local chapters of the American Academy of Pediatrics;
- b) American Nurses' Association;
- c) Visiting Nurse Association;
- d) American Academy of Family Physicians;
- e) National Association of Pediatric Nurse Practitioners;
- f) National Association for the Education of Young Children;
- g) National Association for Family Child Care;
- h) National Resource Center for Health and Safety in Child Care;
- i) National Training Institute for Child Care Health Consultants;
- j) State and local health departments (especially the public health nursing departments, the environmental health departments, and the state communicable disease specialist's or epidemiologist's office);
- k) State Injury Prevention Director.

Caregivers should not overlook parents of children enrolled in their facilities who are health professionals capable of performing as child care health consultants. The specific policies for an individual facility depend on the resources available to that facility (25). To be effective, a health consultant should know what resources are available in the community and should involve caregivers and parents in setting policies. Setting policies in cooperation with both caregivers and parents will better ensure successful implementation (25). Licensing requirements for facilities increasingly require that facilities make

specific arrangements with a health consultant to assist in the development of written policies for the prevention and control of disease.

Child care facilities should offer health consultants some form of compensation for services to foster access and accountability.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### STANDARD 8.021 WRITTEN POLICY ON USE OF MEDICATIONS

The facility shall have a written policy for the use of any prescription medication that has been prescribed to a particular child by that child's primary health care provider. The facility shall also have a written policy for the use of any nonprescription oral or topical medication that the facility keeps on hand to use with parental consent when the medication may be indicated.

A medication record maintained on an ongoing basis by designated staff shall include the following:

- a) Specific, signed parental consent for the caregiver to administer medication;
- b) Prescription by a health care provider, if required;
- c) Administration log;
- d) Checklist information on medication, including possible side effects, brought to the facility by the parents.

The facility shall consult with the State Board of Nursing or their **health consultant** about required training and documentation for medication administration and develop a plan regarding medication administration training.

RATIONALE: Caregivers need to be aware of what medication the child is receiving and when, who prescribed the medicine, and what the known reactions or side effects may be in the event that a child has a negative reaction to the medicine (26). A child's reaction to medication may occasionally be extreme enough to initiate the protocol developed for emergencies. This medication record is especially important if medications are frequently prescribed or if long-term medications are being used.

COMMENTS: A sample medication administration policy is provided in *Model Child Care Health Policies*, from the National Association the Education of Young Children (NAEYC) and the American Academy of Pediatrics (AAP). The medication record contents and format, as well as policies on handling medications, are provided in the AAP publication *Health in Day Care: A Manual for Health Professionals*. A sample medication administration log is provided in *Healthy Young Children* from the NAEYC. Contact information for the AAP and the NAEYC is located in Appendix BB

For additional information on medications, see STANDARD 3.081 through STANDARD 3.083. See also a sample document for permission for medical condition treatment in Appendix W.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### STANDARD 8.029 POLICY ON ACTIONS TO BE FOLLOWED WHEN NO AUTHORIZED PERSON ARRIVES TO PICK UP A CHILD

Child care facilities shall have a written policy identifying actions to be taken when no authorized person arrives to pick up a child. The plan shall be developed in consultation with the child care **health consultant** and child protective services.

In the event of emergency situations arising that may make it impossible for a parent to pick up a child as scheduled or to notify the authorized contact to do so, the facility shall attempt to reach each authorized contact, as listed in the facility's records. If these efforts fail, the facility shall immediately implement the written policy on actions to be followed when no authorized person arrives to pick up a child.

RATIONALE: A natural disaster or tragic event such as a car crash or terrorist attack may lead to the parent being hurt or delayed due to transportation problems related to the event.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### **STANDARD 8.041 HEALTH CONSULTANT'S REVIEW OF HEALTH POLICIES**

At least annually or when changes are made in the health policies, the facility shall obtain a review of the policies from a health consultant.

**RATIONALE:** Changes in health information may require changes in the health policies of a child care facility. These changes are best known to health professionals who stay in touch with sources of updated information and can suggest how the new information applies to the operation of the child care program. For example, when the information on the importance of back-positioning for putting infants down to sleep became available, it needed to be added to child care policies. Frequent changes in recommended immunization schedules offer another example of the need for review and modification of health policies.

**COMMENTS:** For information on Health Consultants, see STANDARD 1.040 through STANDARD 1.044.

**TYPE OF FACILITY:** *Center*

### **STANDARD 8.042 PLAN FOR PROGRAM ACTIVITIES**

The facility shall have a written comprehensive and coordinated planned program of daily activities based on a statement of principles for the facility that sets out the elements from which the daily plan is to be built. The program of activities shall:

- a) Address each developmental age group served, that is, infants, toddlers, preschoolers, school-age children, and children with special needs;
- b) Cover the elements of developmental activities specified in STANDARD 2.001 through STANDARD 2.028;
- c) Maintain the child:staff ratios described in Child:Staff Ratio and Group Size, STANDARD 1.001 through STANDARD 1.005;
- d) Provide for incorporation of specific health, development, and safety education activities into the curriculum on a daily basis throughout the year. Topics of health education shall include health promotion and

- e) disease prevention strategies, physical, oral/dental, mental, and social health, and nutrition;
- e) Offer a parent education plan about child health. Such a plan shall have been reviewed and approved by a licensed health professional, who may also serve as the facility's **health consultant** (see Health Consultants, STANDARD 1.040 through STANDARD 1.044). This plan shall primarily involve personal contacts with parents by knowledgeable caregivers. The parent education plan shall include topics identified in Health Education for Parents, STANDARD 2.065 through STANDARD 2.067, and cover the importance of developmentally appropriate activities.

**RATIONALE:** Those who provide child care and early childhood education must themselves be clear about the components of their program. Child care is a "delivery of service" involving a contractual relationship between provider and consumer. A written plan helps to specify the components of the service and contributes to responsible operations that are conducive to sound child development and safety practices, and to positive consumer relations. The process of preparing plans promotes thinking about programming for children. Plans also allow for monitoring and for accountability. An increasing number of centers and homes are serving children with special needs.

Early childhood specialists and pediatricians agree that cognitive, emotional/social, and physical development are inseparable. The child's health influences all areas of development. Continuity of responsive, affectionate care must be coupled with recognition by the caregiver of the child's developmental phase or stage to provide opportunities for the child to learn and mature through play (27, 28). Young children learn better by experiencing an activity and observing behavior than through didactic training (28). There is a "reciprocal relationship" between learning and play. Play experiences are closely related to learning (29).

Parental behavior can be modified by education (29). Parents should be involved with the facility as much as possible. The concept of parent control and empowerment is key to successful parent education in the child care setting (29). Although research has not shown whether a child's eventual success in education or in society is related to parent education, support and education for parents lead to better parenting abilities (29).

COMMENTS: Examples of parental health education activities include the following topics:

- a) Importance of having a primary health care provider (medical home) for each child;
- b) Verbal explanation of principles of personal hygiene;
- c) Discussions about the nutritional value of snacks;
- d) The importance of implementing effective child passenger and other safety practices;
- e) The value of exercise.

Examples of child development activities include:

- a) Importance of talking and reading to children;
- b) Importance of creative play activities;
- c) Encouraging children to experience their natural environments.

Parents and staff can experience mutual learning in an open, supportive setting. Suggestions for topics and methods of presentation are widely available. For example, the publication catalogs of the National Association for the Education of Young Children (NAEYC) and of the American Academy of Pediatrics (AAP) contain many materials for child, parent and staff education on child development, the importance of attachment and temperament, and other health issues. A certified health education specialist can also be a source of assistance. The American Association for Health Education (AAHE) and the National Commission for Health Education Credentialing, Inc. (NCHEC) provide information on this speciality. Contact information for the NAEYC, AAP, AAHE, and NCHEC is located in Appendix BB.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### **STANDARD 8.053 PARENTAL INFORMED CONSENT BEFORE SHARING CHILD'S HEALTH RECORDS**

With prior written informed consent of the parent, child care facilities may share the child's health records including conference reports, service plans, and follow-up reports, as needed, with other service providers, including child care **health consultants** and specialized agencies providing services, as confidentiality guidelines or

state laws permit. Effort shall be made to inform parents prior to any such communication.

The facility shall have policies and procedures that cover the exchange of information among parents, the facility, and other professionals or agencies that are involved with the child and family before the child enters the facility, during the time the child is cared for in the facility, and after the child leaves the facility. For centers, these shall be written policies and procedures.

If other children are mentioned in a child's record that is authorized for release, the confidentiality of those children shall be maintained. The record shall be edited to remove any information that could identify another child.

RATIONALE: The exchange of information about the child and family among providers of service can greatly enhance the effectiveness of child and family support and should be accomplished with sensitivity to issues of confidentiality and the need to know. This information is confidential, and parental consent for release is required if the child care facility is to gain access to it. Prior informed, written consent of the parent/guardian is required for the release of records/information (verbal and written) to other service providers, including process for secondary release of records. Consent forms should be in the native language of the parents, whenever possible, and communicated to them in their normal mode of communication. Foreign language interpreters should be used whenever possible to inform parents about their confidentiality rights. At the time when facilities obtain prior, informed consent from parents for release of records, caregivers should inform parents who may be looking at the records, e.g., child care health consultants, licensing agencies.

Procedures should be developed and a method established to ensure accountability and to ensure that the exchange is being carried out. The child's record shall be available to the parents for inspection at all times.

COMMENTS: The responsibility for a child's health is shared by all those responsible for the child: parents, health professionals, and caregivers. Three-way alliances among the pediatric primary care clinician, the child care provider, and the parents should be encouraged to promote the optimal health and safety of the child. Caregivers should expect parents to transfer to them health information about the child given to and by health professionals. Such transfer of

information is often facilitated by the use of forms, but telephone communication, with parental consent, is also appropriate to clarify concerns about a specific child. If a parent does not give permission, caregivers can use state override procedures when it is in the child's best interest to do so. Caregivers should also expect health professionals to provide their expertise for the formulation and implementation of facility policies and procedures.

If records are shared electronically, providers should ensure that the records are encrypted for security and confidentiality.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### **STANDARD 8.064 ACCESSIBILITY OF INJURY AND ILLNESS REPORTS**

The completed injury and illness report forms shall be made available to **health consultants** and other appropriate health agencies for review and analysis. In addition to maintaining a record for documentation of liability, forms shall be used to identify patterns of injury and illness occurring in child care that are amenable to prevention. The injury and illness log shall be reviewed by caregivers at least semi-annually and inspected by licensing staff and health consultants at least annually.

**RATIONALE:** Injury patterns and child abuse can be detected from such records and can be used to prevent future problems (30). A report form is also necessary for providing information to the child's parents and health care provider and other appropriate health agencies.

**COMMENTS:** Surveillance for symptoms can be accomplished easily by using a combined attendance and symptom record. Any symptoms can be noted when the child is signed in, with added notations made during the day when additional symptoms appear. Simple forms, for a weekly or monthly period, that record data for the entire group help caregivers spot patterns of illness for an individual child or among the children in the group or center.

For a sample enrollment/attendance/symptom record, see Appendix F. For a sample *Incident Report Form*, see Appendix Y. Multicopy forms can be used to make copies of an injury report simultaneously for the child's record, for the parent, for the folder that logs all injuries at the facility, and for the regulatory agency. Facilities should secure the parent's signature on the form at the time it is presented to the parent. For additional information, see *Model Child Care Health Policies*, 3rd edition, from the American Academy of Pediatrics (AAP). Contact information for the AAP is located in Appendix BB.

See Inspections, RECOMMENDATION 9.017 through RECOMMENDATION 9.019. See also Health Consultants, STANDARD I.040 through STANDARD I.044.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### **STANDARD 8.073 DOCUMENTATION OF HEALTH CONSULTATION/TRAINING VISITS**

Documentation of health consultation/training visits shall be maintained in the facility's files. Documentation of the health consultation/training experiences shall also be provided to caregivers.

**RATIONALE:** Health consultants, licensing agents, health departments, and fellow caregivers should reinforce the importance of appropriate health behavior. Documentation of consultation by a health consultant or other health professional provides the opportunity to evaluate the use of recommendations and training provided by the consultant.

**COMMENTS:** Documentation can take the form of a list of recommendations and training topics addressed. Documentation can include:

- a) Who the consultant was;
- b) The topic discussed;
- c) Availability of certification for caregivers' training;
- d) When, where, and how the consultation took place;
- e) Any recommended follow-up.

See Health Consultants, STANDARD 1.040 through STANDARD 1.044, on health consultant responsibilities and qualifications.

TYPE OF FACILITY: *Center; Large Family Child Care Home; Small Family Child Care Home*

### **RECOMMENDATION 9.033 SUPPORT FOR CONSULTANTS TO PROVIDE TECHNICAL ASSISTANCE TO FACILITIES**

State agencies should encourage the arrangement of and the fiscal support for consultants from the local community to provide technical assistance for program development and maintenance. Consultants should have training and experience in early childhood education, issues of health and safety in child care settings, ability to establish collegial relationships with child care providers, adult learning techniques, and ability to help establish links between facilities and community resources.

The state regulatory agency should provide or arrange for other public agencies, private organizations or technical assistance agencies (such as a resource and referral agency) to make the following consultants available to the community of child care providers of all types:

- 1) Program Consultant, to provide technical assistance for program development and maintenance. Consultants should be chosen on the basis of training and experience in early childhood education and ability to help establish links between the facility and community resources;
- 2) Child Health Consultant, who has expertise in child health and child development, is knowledgeable about the special needs of children in out-of-home care settings, and knows the child care licensing requirements and available health resources. A regional plan to make consultants accessible to facilities should be developed;
- 3) Nutrition Specialist, to be responsible for the development of policies and procedures and for the implementation of nutrition standards to provide high quality meals, nutrition education programs, and appropriately trained personnel, and to provide consultation to

agency personnel, including licensing inspectors;

- 4) Mental Health Consultant, to assist centers, large family child care homes, and networks of small family child care homes in meeting the emotional needs of children and families. The state mental health agency should promote funding through community mental health agencies and child guidance clinics for these services. At the least, such consultants should be available when caregivers identify children whose behaviors are more difficult to manage than typically developing children.

DISCUSSION: Securing expertise is acceptable by whatever method is most workable at the state or local level (for example, consultation could be provided from a resource and referral agency). Providers, not the regulatory agency, are responsible for securing the type of consultation that is required by their individual facilities.

The mental health consultant for children younger than school-age is the most difficult of the health consultants to locate. Pediatricians who specialize in developmental pediatrics are most likely to be helpful for this type of consultation. Some, but not all, pediatric psychiatrists and psychologists have the necessary skills to work with behavior problems of this youngest age group. To find such specialists, contact the Department of Pediatrics at academic centers. The faculty at such centers can usually refer child care facilities to individuals with the necessary skills in their area.

The administrative practice of developing systems for technical assistance is designed to enhance the overall quality of child care that meets the social and developmental needs of children. The chief sources of technical assistance are:

- a) Licensing agencies (on ways to meet the regulations);
- b) Health departments (on health related matters);
- c) Resource and referral agencies (on ways to achieve quality, how to start a new facility, supply and demand data, how to get licensed, and what parents want).

Providing centers and networks of small or large family child care homes with guidelines and information on establishing a program of care is intended to promote appropriate programs of activities. Child care staff are rarely trained health professionals. Since staff and time are often limited, caregivers should have access to consultation on available resources in a variety of fields (such as physical and mental health care; nutrition; safety,

including fire safety; oral health care; developmental disabilities, and cultural sensitivity) (31).

The public agencies can facilitate access to children and their families by providing useful materials to child care providers.

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### American Academy of Pediatrics (AAP)

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### American Association for Health Education (AAHE)

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### American Nurses Association (ANA)

600 Maryland Ave., SW  
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Washington, DC 20024  
Phone: 1-800-274-4262 or 202-651-7000  
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### American Public Health Association (APHA)

800 I Street N.W.,  
Washington, DC 20001-3710  
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### Early Childhood Education Linkage System (ECLS)

Healthy Child Care America Pennsylvania  
Pennsylvania Chapter, American Academy of Pediatrics  
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### Emergency Medical Services for Children National Resource Center

111 Michigan Avenue, N.W.  
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### The Healthy Child Care America Campaign

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141 N.W. Point Blvd.  
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Please note contact information may change. Check <http://nrc.uchsc.edu> for updates.

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States - IA, KS, MO, NE

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### MCHB Region IX

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States - AZ, CA, HI, NV, AS, FM, GU, MH, MP, PW

### MCHB Region X

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States - AK, ID, OR, WA

### National Association for the Education of Young Children (NAEYC)

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### National Association for Family Child Care (NAFCC)

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### National Resource Center for Health and Safety in Child Care

University of Colorado School of Nursing  
Campus Mail Stop F541, P.O. Box 6508  
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### **Visiting Nurse Associations of America**

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