

MEDICATION ADMINISTRATION

Applicable Standards from:

CARING FOR OUR CHILDREN

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

A Joint Collaborative Project of

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INTRODUCTION

Caring for Our Children: National Health and Safety Performance Standards for Out-of-Home Child Care Programs, 2nd Edition (CFOC, 2nd Ed.) was released by the American Academy of Pediatrics (AAP), American Public Health Association (APHA), the Maternal and Child Health Bureau (MCHB), and the National Resource Center for Health and Safety in Child Care (NRC) in January 2002. The full edition of *CFOC, 2nd Ed.* contains 707 standards and recommendations on all aspects regarding 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 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) and the American Public Health Association (www.apha.org).

In an effort to make select subject areas more accessible to intended users, the National Resource Center for Health and Safety in Child Care (NRC) is developing smaller documents on specific subject areas. This document is a compilation of the standards on medication administration in child care settings.

The inclusion of children with chronic illnesses and the need for medications during their time at a child care facility has continued to increase. For example, the cases of asthma in children under 5 years old increased more than 160% between 1980 and 1994 (1). It is critical for the health and safety of these children to have child care providers who are

properly trained on medication administration. The standards included were developed to provide guidelines to states on “best practice” regarding medication administration. In some cases, states surpass the recommended guidelines, such as in the case of Connecticut which has more explicit training requirements and requires more frequent medication administration training. In other states, the topic is not covered in detail and we hope these standards will provide guidance to all who work with children on medication. Also users should consult their state agencies responsible for child care regulations and their State Health Professional Boards (e.g. State Board of Nursing) regarding the state rules on medication administration and specifically who may administer medications, who may train child care providers, and the qualifications of the trainer.

States are beginning to develop medication administration training through 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>)

The intended audiences for this document are:

- child care providers who will need to administer medications to children in their care;
- state regulators and policy makers who are formulating or changing state regulations regarding medication administration in their state;
- health consultants and trainers who can promote and teach appropriate medication administration policies to child care providers; and

- parents who need to understand the importance of appropriate training and knowledge needed for their child care provider to administer medications to their child.

Throughout this document there will be references to other standards contained in the full edition of *Caring for Our Children, 2nd Ed.* that are not present in this document. For example, comments in Standard 8.046 regarding the contents of children's records, refer to Standard 8.053 for more information on confidentiality of records (which is not in this document but is in the full edition of *Caring for Our Children, 2nd Ed.*). 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 thanks to Phyllis Stubbs-Wynn, MD, MPH, Angela A. Crowley, PhD, APRN, BC, PNP, and R. Lorraine Brown, RN, BS for reviewing this compilation of standards on the various aspects of medication administration. We would also like to thank all those individuals who contributed to *CFOC, 2nd Ed.* A listing can be viewed at: <http://nrc.uchsc.edu/CFOC/PDFVersion/Acknowledgments.pdf>

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
<http://nrc.uchsc.edu>
natl.child.res.ctr@UCHSC.edu

(1) Mannino DM, Homa DM, Peertowski CA, Ashizawa A, et al. Surveillance for Asthma-United States, 1960-1995. Morbidity and

Mortality Weekly Report (MMWR), CDC Surveillance Summaries 1998; 47 (1):1-28. See <http://www.cdc.gov/mmwr/preview/mmwrhtml/00052262.htm>.

STAFF TRAINING**STANDARD 1.009
PRESERVICE AND ONGOING STAFF
TRAINING**

In addition to the credentials listed in STANDARD 1.014, prior to employment, a director of a center or a small family child care home network enrolling 30 or more children shall provide documentation of at least 26 clock hours of training in health, psychosocial, and safety issues for out-of-home child care facilities.

Small family child care home providers shall provide documentation of at least 12 hours of training in child development and health management for out-of-home child care facilities prior to initiating operation. All directors and caregivers shall document receipt of training that revisits the following topics every 3 years:

- a) Child development knowledge and best practice, including knowledge about the developmental stages of each child in care;
- b) Child care as a support to parents;
- c) Parent relations;
- d) Ways that communicable diseases are spread;
- e) Procedures for preventing the spread of communicable disease, including handwashing, sanitation, diaper changing, food handling, health department notification of reportable diseases, equipment, toy selection and proper washing, sanitizing to reduce the risk for disease and injury, and health issues related to having pets in the facility;
- f) Immunization requirements for children and staff, as defined in STANDARD 1.045;
- g) Common childhood illnesses and their management, including child care exclusion policies;
- h) Organization of the facility to reduce the risks for illness and injury;
- i) Teaching child care staff and children about infection control and injury prevention;
- j) Staff occupational health and safety practices, such as proper procedures, in accordance with Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations;

- k) Emergency procedures, as defined in STANDARD 3.048 through STANDARD 3.052;
- l) Promotion of health in the child care setting, through compliance with STANDARD 3.001 through STANDARD 3.089;
- m) Management of a blocked airway, rescue breathing, and other first aid procedures, as required in STANDARD 1.026;
- n) Recognition and reporting of child abuse in compliance with state laws;
- o) Nutrition;
- p) Knowledge of medication administration policies and practices;**
- q) Caring for children with special needs in compliance with the Americans with Disabilities Act (ADA);
- r) Behavior management.

RATIONALE: The director of a center or large family child care home or the small family child care home provider is the person accountable for all policies. Basic entry-level knowledge of health and safety is essential to administer the facility. Caregivers must be knowledgeable about infectious disease because properly implemented health policies can reduce the spread of disease, not only among the children but also among staff members, family members, and in the greater community. Knowledge of injury prevention measures in child care is essential to control known risks. Pediatric first aid training is important because the director or small family child care home provider is fully responsible for all aspects of the health of the children in care.

COMMENTS: The American Academy of Pediatrics (AAP) and the National Association for the Education of Young Children (NAEYC) published a set of videos, based on the first edition of *Caring for Our Children*, that illustrates how to meet the standards in centers and family child care homes. This six-part video series is accompanied by a set of reproducible handouts for training. Other training materials, including videos, workshop curricula, and print materials suitable for training of caregivers, are also available from the AAP and NAEYC. Contact information for the AAP and the NAEYC is located in Appendix BB.

Training in infectious disease control and injury prevention is strongly recommended. This type of

training may be obtained from qualified personnel of children's and community hospitals, managed care companies, health agencies, public health departments, pediatric emergency room physicians, or other health professionals in the community.

For more information about training opportunities, contact the AAP, Healthy Child Care America Project, the National Resource Center for Health and Safety in Child Care, or the National Training Institute for Child Care Health Consultants (at the University of North Carolina). Contact information is located in Appendix BB.

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

STANDARD I.023 INITIAL ORIENTATION OF ALL STAFF

All new full-time and part-time staff shall be oriented to, and demonstrate knowledge of, the items listed below. The director of any center or large family child care home shall provide this training to all newly hired caregivers before they begin to care for children. For centers, the director shall document, for each new staff member, the topics covered and the dates of orientation training. Staff members shall not be expected to take responsibility for any aspect of care for which their orientation and training have not prepared them.

Small family child care home providers shall avail themselves of orientation training offered by the licensing agency, a resource and referral agency, or other such agency. This training shall include evaluation that involves demonstration of the knowledge and skills covered in the training lesson.

The orientation shall address, at a minimum:

- a) Regulatory requirements;
- b) The goals and philosophy of the facility;
- c) The names and ages of the children for whom the caregiver will be responsible, and their specific developmental needs;

- d) Any special adaptation(s) of the facility required for a child with special needs for whom the staff member might be responsible at any time;
- e) Any special health or nutrition need(s) of the children assigned to the caregiver;
- f) The planned program of activities at the facility. See Program of Developmental Activities, STANDARD 2.001 through STANDARD 2.027;
- g) Routines and transitions;
- h) Acceptable methods of discipline. See Discipline, STANDARD 2.039 through STANDARD 2.043; and Discipline Policy, STANDARD 8.008 through STANDARD 8.010;
- i) Policies and practices of the facility about relating to parents. See Parent Relationships, STANDARD 2.044 through STANDARD 2.057;
- j) Meal patterns and food handling policies and practices of the facility. See Plans and Policies for Food Handling, Feeding, and Nutrition, STANDARD 8.035 and STANDARD 8.036; Food Service Records, STANDARD 8.074; Nutrition and Food Service, STANDARD 4.001 through STANDARD 4.070;
- k) Occupational health hazards for caregivers, including attention to the physical health and emotional demands of the job and special considerations for pregnant caregivers. See Occupational Hazards, STANDARD 1.048; and *Major Occupational Health Hazards*, Appendix B;
- l) Emergency health and safety procedures. See Plan for Urgent Medical Care or Threatening Incidents, STANDARD 8.022 and STANDARD 8.023; and Emergency Procedures, STANDARD 3.048 through STANDARD 3.052;
- m) General health and safety policies and procedures, including but not limited to the following:
 - 1) Handwashing techniques and indications for handwashing. See Handwashing, STANDARD 3.020 through STANDARD 3.024;
 - 2) Diapering technique and toilet use, if care is provided to children in diapers and/or children needing help with toilet use, including appropriate diaper disposal and diaper-changing techniques. See Toilet, Diapering, and Bath Areas, STANDARD

- 5.116 through STANDARD 5.125; Toilet Use, Diapering, and Toilet Learning/ Training, STANDARD 3.012 through STANDARD 3.019; Toilet Learning/ Training Equipment, Toilets, and Bathrooms, STANDARD 3.029 through STANDARD 3.033;
- 3) Identifying hazards and injury prevention;
 - 4) Correct food preparation, serving, and storage techniques if employee prepares food. See Food Safety, STANDARD 4.042 through STANDARD 4.060;
 - 5) Knowledge of when to exclude children due to illness and the means of illness transmission;
 - 6) Formula preparation, if formula is handled. See Plans and Policies for Food Handling, Feeding, and Nutrition, STANDARD 8.035 and STANDARD 8.036; and Nutrition for Infants, STANDARD 4.011 through STANDARD 4.021;
 - 7) Standard precautions and other measures to prevent exposure to blood and other body fluids, as well as program policies and procedures in the event of exposure to blood/body fluid. See Prevention of Exposure to Body Fluids, STANDARD 3.026;
- n) Recognizing symptoms of illness. See Daily Health Assessment, STANDARD 3.001 and STANDARD 3.002;
 - o) Teaching health promotion concepts to children and parents as part of the daily care provided to children. See Health Education for Children, STANDARD 2.060 through STANDARD 2.063;
 - p) Child abuse detection, prevention, and reporting. See Child Abuse and Neglect, STANDARD 3.053 through STANDARD 3.059;
 - q) Medication administration policies and practices;**
 - r) Putting infants down to sleep positioned on their backs and on a firm surface to reduce the risk of Sudden Infant Death Syndrome (SIDS).

Caregivers shall also receive continuing education each year, as specified in Continuing Education, STANDARD 1.029 through STANDARD 1.036.

RATIONALE: Upon employment, staff members should be able to perform basic sanitizing and

emergency procedures. Orientation ensures that all staff members receive specific and basic training for the work they will be doing and become acquainted with their new responsibilities. Orientation programs for new employees should be specific to an individual facility since facilities and the children enrolled vary(1).

Because of frequent staff turnover, directors are obligated to institute orientation programs that protect the health and safety of children and new staff members.

Orientation and ongoing training are especially important for aides and assistant teachers, for whom preservice educational requirements are limited. Entry into the field at the level of aide or assistant teacher should be attractive and easy for members of the families and cultural groups of the children in care to enter the field. Training ensures that staff members are challenged and stimulated, have access to current knowledge, and have access to education that will qualify them for new roles. Offering a career ladder will attract individuals into the child care field, where labor is in short supply. Ongoing training in one role can become preservice training to qualify for another role.

Health training for child care staff not only protects the children in care, infectious disease control in child care helps to prevent spread of infectious disease in the community. Young children in child care have been shown to be associated with community outbreaks.

COMMENTS: Many states have preservice education and experience qualifications for caregivers by role and function. States are including ongoing health training in their licensing requirements; the broader skills have proved important and necessary to teachers in part-day and full-day programs alike. Both full-day and part-day programs require competence in all facets of child development, not just the learning components.

Child care staff members are important figures in the lives of the young children in their care and in the wellbeing of families and the community. In the future, all training for child care staff should include more attention to health issues.

Training in conflict resolution is encouraged. Child abuse includes also children's abuse of their peers. Staff should learn how to handle conflict resolution among the children and among themselves, as well as modeling examples of conflict resolution from which children can learn.

Colleges and accrediting bodies should examine teacher preparation guidelines and substantially increase the health content of early childhood professional preparation.

For definitions of Standard precautions, Transmission-based precautions, Universal precautions, see Glossary.

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

STANDARD 1.025 ORIENTATION DURING INITIAL EMPLOYMENT

During the first 3 months of employment, the director of a center or the caregiver in a large family home shall document, for all full-time and part-time staff members, additional orientation in, and the employees' satisfactory knowledge of, the following topics:

- a) Recognition of symptoms of illness and correct documentation procedures for recording symptoms of illness. This shall include the ability to perform a daily health assessment of children to determine whether any are ill and, if so, whether a child who is ill should be excluded from the facility;
- b) Exclusion and readmission procedures and policies;
- c) Cleaning and sanitation procedures and policies;
- d) **Procedures for administering medication to children and for documenting medication administered to children;**
- e) Procedures for notifying parents or legal guardians of a communicable disease occurring in children or staff within the facility;

- f) Procedures and policies for notifying public health officials about an outbreak of disease or the occurrence of a reportable disease.

Before being assigned to tasks that involve identifying and responding to illness, staff members shall receive orientation training on these topics. Small family child care home providers shall not commence operation before receiving orientation on these topics.

RATIONALE: Children are ill frequently. Staff members responsible for child care must be able to recognize illness, carry out the measures required to prevent the spread of communicable diseases, and handle ill children appropriately.

COMMENTS: See also Daily Health Assessment, STANDARD 3.001 and STANDARD 3.002.

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

STANDARD 3.083 TRAINING OF CAREGIVERS TO ADMINISTER MEDICATION

Any caregiver who administers medication shall be trained to:

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

RATIONALE: Caregivers need to be aware of what medication the child is receiving, who prescribed the medicine and when, and what the known reactions or side effects may be if a child has a negative reaction to the medicine (2). A child's reaction to medication occasionally is extreme enough to initiate the protocol developed for emergencies. The medication

record is especially important if medications are frequently prescribed or if long-term medications are being used. See *Model Child Care Health Policies* from the American Academy of Pediatrics (AAP) and the National Association for the Education of Young Children (NAEYC). Contact information for the AAP and the NAEYC is located in Appendix BB.

COMMENTS: For additional information on medications, see STANDARD 8.021 and STANDARD 8.051.

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 (1).

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 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 2.029 COMPETENCE AND TRAINING OF TRANSPORTATION STAFF

At least one adult who accompanies or drives children for field trips and out-of-facility activities shall receive training by a professional knowledgeable about child development and procedures to ensure the safety of all children. The caregiver shall hold a valid pediatric first aid certificate, including rescue breathing and management of blocked airways, as specified in First Aid and CPR, STANDARD 1.026 through STANDARD 1.028.

All drivers, passenger monitors, chaperones, and assistants shall receive instructions in safety precautions. If transportation is provided, these instructions shall include:

- a) Use of developmentally appropriate safety restraints;
- b) Proper placement of the child in the motor vehicle;
- c) Handling of emergency situations. If a child has a chronic medical condition that could result in an emergency (such as asthma, diabetes, seizures), the driver or chaperone shall have written instructions including parent emergency contacts, child summary health information, special needs, and treatment plans, and shall be trained to:
 - 1) Recognize the signs of a medical emergency;
 - 2) Know emergency procedures to follow;
 - 3) **Have on-hand, any emergency supplies or medications necessary;**
- d) Map and appropriate route to emergency facility;
- e) Defensive driving;
- f) Child supervision during transport, including never leaving a child unattended in a vehicle.

The receipt of such instructions shall be documented in a personnel record for any paid staff or volunteer who participates in field trips or transportation activities. Child:staff ratios shall be maintained on field trips and during transport, as specified in STANDARD 1.001 through STANDARD 1.005.

RATIONALE: Injuries are more likely to occur when a child's surroundings or routine changes. Activities outside the facility may pose increased risk for injury. When children are excited or busy playing in unfamiliar areas, they are more likely to forget safety measures unless they are closely supervised at all times.

Children have died from heat stress from being left unattended in closed vehicles. Temperatures in hot cars can reach dangerous levels within 15 minutes (4).

Adults cannot be assumed to be knowledgeable about the various developmental levels or special needs of children. Training by someone with appropriate knowledge and experience is needed to appropriately address these issues.

COMMENTS: When field trips are planned, it is recommended that the sites should be visited by child care staff in advance of the actual field trip to ensure that the site is accessible for the children with special needs. This standard also applies when caregivers are walking with children to and from a destination.

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

STANDARD 3.073 CAREGIVER QUALIFICATIONS FOR FACILITIES THAT CARE FOR ILL CHILDREN

Each caregiver in a facility that cares for ill children with level 2 or level 3 illness (as defined in STANDARD 3.064) shall have at least 2 years of successful work experience as a caregiver in a regular well-child facility prior to employment in the special facility. In addition, the Level 1 or Level 2 facility shall document, for each caregiver, 20 hours of pre-service orientation training on care

of ill children beyond the orientation training specified in Training, STANDARD 1.023 through STANDARD 1.033. This training shall include the following subjects:

- a) Pediatric first aid, including management of a blocked airway, rescue breathing, and first aid for choking. See STANDARD 1.026 through STANDARD 1.028;
- b) General infection-control procedures, including:
 - 1) Handwashing;
 - 2) Handling of contaminated items;
 - 3) Use of sanitizing chemicals;
 - 4) Food handling;
 - 5) Washing and sanitizing of toys;
 - 6) Education about methods of disease transmission.
- c) Care of children with common mild childhood illnesses, including:
 - 1) Recognition and documentation of signs and symptoms of illness;
 - 2) **Administration and recording of medications;**
 - 3) Temperature taking;
 - 4) Nutrition of ill children;
 - 5) Communication with parents of ill children;
 - 6) Knowledge of immunization requirements;
 - 7) When and how to call for medical assistance or notify the health department of communicable diseases;
 - 8) Emergency procedures. See STANDARD 3.048 through STANDARD 3.052;
- d) Child development activities for children who are ill;
- e) Orientation to the facility and its policies.

This training shall be documented in the staff personnel files, and compliance with the content of training routinely evaluated. Based on these evaluations, the training on care of ill children shall be updated with a minimum of 6 hours of annual training for individuals who continue to provide care to ill children.

RATIONALE: Because meeting the physical and psychological needs of ill children requires a higher level of skill and understanding than caring for well children, a commitment to children and an understanding of their general needs is essential. Work experience will help the caregiver develop these skills. States that have developed rules

regulating facilities have recognized the need for training in illness prevention and control and management of medical emergencies. First and foremost, people working with children should have an understanding of children and should create an environment for children that is developmentally appropriate, healthful, and safe at all times. Therefore, staff members caring for ill children in special facilities or in a get well room in a regular center should meet the staff qualifications that are applied to child care facilities generally.

Child care providers have to be prepared for handling illness and must understand their scope of work. Special training is required of teachers who work in special facilities for ill children because the director and the caregivers are dealing with communicable diseases and need to know how to prevent the spread of infection. Each caregiver should have training to decrease the risk of transmitting disease. The potential for medical emergencies as a result of illness is greater in facilities for ill children than in regular well-child facilities, so these facilities have to be prepared.

COMMENTS: States that have developed rules regulating facilities have recognized the need for training in illness prevention and control, aseptic technique, and management of medical emergencies.

See RECOMMENDATION 9.025, on health department assistance in developing this training.

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

STANDARD 2.06 I HEALTH EDUCATION TOPICS

Health education for children and staff shall include physical, oral, mental/emotional, nutritional, and social health and shall be integrated daily in the program of activities, to include such topics as:

- a) Body awareness;
- b) Families (including cultural heritage);
- c) Personal/social skills;
- d) Expression of feelings;

- e) Self-esteem;
- f) Nutrition;
- g) Personal hygiene;
- h) Safety (such as home, vehicular care seats and belts, playground, bicycle, fire, and firearms);
- i) Conflict management and violence prevention;
- j) First aid;
- k) Physical health;
- l) Handwashing;
- m) Awareness of special needs;
- n) Importance of rest and sleep;
- o) Fitness;
- p) Oral health;
- q) Health risks of secondhand smoke;
- r) Taking medications;**
- s) Dialing 911 for emergencies.

RATIONALE: For young children, health and education are inseparable. Children learn about health and safety by experiencing risk taking and risk control, fostered by adults who are involved with them. Whenever opportunities for learning arise; facilities should integrate education to promote healthy behaviors. Health education should be seen not as a structured curriculum, but as a daily component of the planned program that is part of child development. Certified health education specialists are a good resource for this instruction. The American Association for Health Education (AAHE), the National Commission for Health Education Credentialing, Inc. (NCCHEC), and the State and Territorial Injury Prevention Directors' Association (STIPDA) provide information on this specialty. Contact information for the AAHE, NCCHEC, and STIPDA is located in Appendix BB.

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

SITUATIONS REQUIRING THE ADMINISTRATION OF MEDICATIONS

STANDARD 3.060 SEIZURE CARE PLAN

The child care facility shall have a seizure care plan and ensure that all caregivers receive training to

successfully implement the plan. If a child in care has epilepsy or a history of febrile seizures that are not considered a form of epilepsy, the child's seizure care plan shall include the following:

- a) Types of seizures the child has (such as partial, generalized, or unclassified), as well as a description of the manifestation of these types of seizures in this child;
- b) The current treatment regimen for this child, including medications, doses, schedule of administration, guidelines, route of administration, and potential side effects for routine and as-needed medications;**
- c) Restrictions from activities that:
 - 1) Could be dangerous if the child were to have a seizure during the activity;
 - 2) Could precipitate a seizure (examples include swimming and falling from a height);
- d) Recognizing and providing first aid for a seizure;
- e) Guidelines on when emergency medical help should be sought for the child who has epilepsy, such as:
 - 1) A major convulsive seizure lasting more than 5 minutes;
 - 2) One seizure after another without waking up between seizures;
 - 3) The child is completely unresponsive for 20 minutes after the seizure;
- f) Documentation in the child's health report that indicates:
 - 1) Whether the child has had a history of any type of seizures;
 - 2) Whether the child is currently taking medication to control the seizures;
 - 3) What observations caregivers should make to help the child's clinician adjust the medication;
 - 4) The type and frequency of reported seizures as well as seizures observed in the facility;
- g) Plans for support of the child with epilepsy and the child's family.

RATIONALE: A child that has a seizure may not have epilepsy or even a history of seizures. Child care providers should be trained to care for any child who has a seizure. For children with epilepsy, the child care staff should have detailed information and skills to understand the child's health needs and how to meet

these needs in the child care setting. Seizures are usually self-limited events. Prolonged seizures, sequential seizures without recovery to a normal status, or remaining unresponsive for 20 minutes after a seizure suggests that the child is in status epilepticus and requires emergency care. The staff must respond appropriately to self-limited seizures and situations that require emergency help.

Epilepsy can be overwhelming for the child and family. The child care staff must offer support in understanding the condition and contribute positively to management of the child.

The child's physician needs reliable information on the number and type of seizures as well as the symptoms that might be side effects of the child's medication so the physician can make appropriate adjustments in the child's therapy.

COMMENTS: This information should be provided by the child's physician. Although children may be sleepy for a period after having a generalized seizure, sending children home after they have recovered from a seizure is unnecessary and should be discouraged, unless specified in the health plan.

The classification system currently used for seizures replaces earlier terminology as follows:

- Grand Mal is now referred to as Generalized Seizure.
- Petit Mal is now referred to as Partial Seizure.

Children with febrile seizures (who are not diagnosed with any form of epilepsy) do not receive anticonvulsant medication. These children usually outgrow this condition.

If the child's parents consent, child care providers should establish a close and continuing liaison with the child's health care provider, especially if the seizures are not well controlled. Sometimes the child's clinicians will monitor the medication prescribed to control seizures by measuring blood samples and sometimes through observations by caregivers and parents. In either case, dosage may have to be adjusted to reduce side effects or provide better control.

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

STANDARD 3.06 I TRAINING FOR STAFF TO HANDLE SEIZURES

Staff members shall be trained in, and shall be prepared to follow, the prescribed procedure when a child has a seizure. These procedures include proper positioning, keeping the airway open, and knowing when and whom to call for medical assistance. All staff members shall be instructed about the relevant side effects of any **anti-convulsant medications** that children in the facility take and how to observe and report them.

Telephone numbers for emergency care shall be posted, as specified in Posting Documents, **STANDARD 8.077.**

RATIONALE: Without training, a staff member may panic when a child has a seizure. Without specific procedures, well-intended staff members may not take the steps required to avoid preventable injury during a seizure.

Anti-convulsant medication may affect a child's health and behavior. Observing and reporting these side effects contributes significantly to a health care provider's ability to recommend appropriate modifications in medication.

COMMENTS: The general guidelines for managing seizures apply to children with special needs. Staff members can be trained through initial and ongoing inservice efforts in specific procedures to follow with a child who has a seizure as well as appropriate supervision and movement of the other children present. See Continuing Education, **STANDARD 1.029** through **STANDARD 1.033.**

Changes in health and behavior that may result from medication should be reported to the parent in the parent's native language and with sensitivity to the parent's ethnic and cultural practices. With written parental consent, the caregiver may also share this information with the child's primary health care

provider. Useful references concerning seizures and side effects of medications used to control seizures, particularly if a child begins a new medicine while attending the facility, include the following:

- a) The child's parent;
- b) The child's primary health care provider (if the parents consent to contact between the provider and the child care facility);
- c) A pharmacist;
- d) A health textbook.

See also Medications, STANDARD 3.081 through STANDARD 3.083; and Medication Policy, STANDARD 8.021.

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

STANDARD 3.062 MANAGEMENT OF CHILDREN WITH ASTHMA

When a child who has had a diagnosis of asthma by a health professional attends the child care facility, the following actions shall occur:

- a) Each child with asthma shall have a special care plan prepared for the facility by the child's source of health care, to include:
 - 1) Written instructions regarding how to avoid the conditions that are known to trigger asthma symptoms for the child;
 - 2) Indications for treatment of the child's asthma in the child care facility;
 - 3) **Names, doses, and method of administration of any medications, e.g., inhalers, the child should receive for an acute episode and for ongoing prevention;**
 - 4) When the next update of the special care plan is due;
- b) Based on the child's special care plan, the child's caregivers shall receive training, demonstrate competence in, and implement measures for:
 - 1) Preventing exposure of the asthmatic child to conditions likely to trigger the child's asthma;
 - 2) Recognizing the symptoms of asthma;
 - 3) Treating acute episodes;

- c) Parents and staff shall arrange for the facility to have necessary medications and equipment to manage the child's asthma while the child is at the child care facility;
- d) Properly trained caregivers shall promptly and properly administer prescribed medications according to the training provided and in accordance with the special care plan;
- e) The facility shall notify parents of any change in asthma symptoms when that change occurs. See the *Special Care Plan for a Child with Asthma*, Appendix M;
- f) The facility shall try to reduce these common asthma triggers by:
 - 1) Encouraging the use of allergen impermeable nap mats or crib/mattress covers;
 - 2) Prohibiting pets (particularly furred or feathered pets);
 - 3) Prohibiting smoking inside the facility or on the playground;
 - 4) Discouraging the use of perfumes, scented cleaning products, and other fumes;
 - 5) Quickly fixing leaky plumbing or other sources of excess water;
 - 6) Ensuring frequent vacuuming of carpet and upholstered furniture at times when the children are not present;
 - 7) Storing all food in airtight containers, cleaning up all food crumbs or spilled liquids, and properly disposing of garbage and trash;
 - 8) Using integrated pest management techniques to get rid of pests (using the least hazardous treatments first and progressing to more toxic treatments only as necessary);
 - 9) Keeping children indoors when local weather forecasts predict unhealthy ozone levels or high pollen counts.

RATIONALE: Asthma is common, occurring in 7%-10% of all preschool and school-aged children. Asthma is a major cause of morbidity in childhood, resulting in sleep disturbance, limitations in exercise, absenteeism from child care and school, and hospitalization. Despite increased awareness and knowledge of the problem, asthma remains underdiagnosed and undertreated. Proper diagnosis, treatment, and prevention of exposure to environmental triggers can lessen complications and improve long term outcome. (5)

Respiratory infections are the primary trigger of asthma (especially of severe episodes) in the young child. Because respiratory infections and asthma are common in early childhood, child care providers should expect to serve children with asthma. Respiratory irritants such as secondhand cigarette smoke, fumes, odors, chemicals, excess humidity, and very hot or cold air may also trigger asthma, so children with asthma should be protected from these irritants. In older preschoolers and school-age children, allergens (pets, mold, cockroaches, dust mites) in the child care setting or school may contribute as well. Reducing exposure to potential triggers is important to control symptoms and prevent attacks and also to improve the long-term prognosis.

Prompt and appropriate intervention during an acute episode of asthma is essential to prevent severe or prolonged effects. Many hospitalizations and most deaths from asthma are the result of delayed recognition of the symptoms or delayed and inadequate treatment. In general, when a child with known asthma has symptoms suggesting an acute asthma episode, treatment should begin promptly, according to instructions. In most instances, a delay in treatment is likely to have more negative effects than occasional overtreatment. Children should not have to wait to begin treatment until a parent can arrive to give it.

The physical assessment of some children with asthma can be augmented by use of a peak flow meter. Peak flow meters can only be used with children who are old enough to understand directions for use and able to cooperate. Peak flow readings can help to determine when treatment should be started, even for a child with no signs of distress, when treatment is helping, and when additional treatment or advice is needed. Staff members must receive training about the purpose, expected response, and possible side effects of medications they are expected to administer. They also must be trained in the proper use of equipment such as inhalers or nebulizers according to the guidelines for medication administration in that state's licensure regulations.

COMMENTS: Asthma is a chronic lung disease caused by an oversensitivity of the bronchial tubes to various stimuli or "triggers." In asthma, the lining of the tubes becomes inflamed and swollen and extra mucus is produced. Muscles surrounding the airways tighten so that the air passages become narrower. Typical symptoms of asthma include coughing, wheezing, tightness in chest, and shortness of breath. The symptoms of asthma can occur together or alone. Often, the only symptom of asthma is chronic or recurrent cough, particularly while sleeping, during activity, or with colds. Asthma is not the only condition that can cause these symptoms but is certainly the most common.

Symptoms can vary from very mild to severe and life threatening. They can be only occasional or continuous. Specific symptoms and warning signs can vary from child to child. Likewise, specific recommendations for treatment are likely to vary. Appropriate treatment depends on the frequency and severity of the symptoms. Accurate assessment by caregivers will aid in establishing the diagnosis and determining long-term management needs.

All of the symptoms of asthma need not be present at one time in any child. Asthma episodes can range from very mild to severe and life threatening. Not all children with asthma have allergies. Sensitivity to triggers may fluctuate over time, so exposure to one or more triggers may not always precipitate an attack. Also, triggers tend to be cumulative; the more a child is exposed to at one time, the more likely is an attack. Indications for notification of parents and physician will vary.

Notify parents if any one of the following is present (6):

- a) Symptoms persist despite one dose of prescribed "rescue" medication (especially if symptoms are bad enough to interfere with sleep, eating, or activity);
- b) Two or more doses of "rescue" medication have been needed during the course of a single day for recurrent symptoms;
- c) Peak flow remains 50%-80% of normal despite one dose of the prescribed "rescue" medication;
- d) Symptoms are severe (see below).

Notify physician/emergency services if any one of the following occurs (6):

- a) Child is struggling to breathe, hunches over, or sucks in chest and neck muscles in an attempt to breathe;
- b) Child is having difficulty walking or talking because of shortness of breath;
- c) Peak flow is less than 50% of normal;
- d) Lips or fingernails turn gray or blue.

Additional resources on caring for children with asthma such as the *How Asthma-Friendly is Your Child-Care Setting? Checklist* can be obtained from the National Heart, Lung, and Blood Institute and other useful materials from the Asthma and Allergy Foundation of America. Contact information for these organizations is located in Appendix BB.

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

STANDARD 3.063 CARING FOR CHILDREN WHO REQUIRE MEDICAL PROCEDURES

A facility that enrolls children who require tube feedings, endotracheal suctioning, oxygen, postural drainage, or catheterization daily (unless the child requiring catheterization can perform this function on his/her own) or any other special medical procedures performed routinely, or who might require special procedures on an urgent basis, shall receive a written report from the health care provider who prescribed the special treatment (such as a urologist for catheterization). A facility shall receive a written report from the child's clinician about any special preparation to perform urgent procedures other than those that might be required for a typical child, such as cardiac resuscitation. This report shall include instructions for performing the procedure, how to receive training in performing the procedure, and what to do and who to notify if complications occur. Training for the child care staff shall be provided by a qualified health care professional in accordance with state practice acts.

RATIONALE: The specialized skills required to implement these procedures are not traditionally

taught to educators or educational assistants as part of their academic or practical experience.

COMMENTS: Parents are responsible for supplying the required equipment. The facility should offer staff training and allow sufficient staff time to carry out the necessary procedures. Caring for children who require intermittent catheterization or maintaining supplemental oxygen is not as demanding as it first sounds, but the implication of this standard is that facilities serving children who have complex medical problems need special training and consultation. Without these supports, facilities should not be expected to serve these children.

Before enrolling a child who will need this type of care, child care providers can request and review fact sheets and instructions, and training that includes a return demonstration of competence of caregivers for handling specific procedures. Often, the child's parents or clinicians have these materials and know where training is available. When the specifics are known, caregivers can make a more responsible decision about what would be required to serve the child.

See STANDARD 7.001, regarding facilities serving children with disabilities and other special needs. For additional discussion about first aid and CPR, see STANDARD 1.026.

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

STANDARD 4.010 CARE FOR CHILDREN WITH FOOD ALLERGIES

When children with food allergies attend the child care facility, the following shall occur:

- a) Each child with a food allergy shall have a special care plan prepared for the facility by the child's source of health care, to include:
 - 1) Written instructions regarding the food(s) to which the child is allergic and steps that need to be taken to avoid that food;
 - 2) A detailed treatment plan to be implemented in the event of an allergic reaction, including the names, doses, and

methods of administration of any medications that the child should receive in the event of a reaction. The plan shall include specific symptoms that would indicate the need to administer one or more medications;

- b) Based on the child's special care plan, the child's caregivers shall receive training, demonstrate competence in, and implement measures for:
 - 1) Preventing exposure to the specific food(s) to which the child is allergic;
 - 2) Recognizing the symptoms of an allergic reaction;
 - 3) Treating allergic reactions;
- c) Parents and staff shall arrange for the facility to have necessary medications, proper storage of such medications, and the equipment and training to manage the child's food allergy while the child is at the child care facility;
- d) Caregivers shall promptly and properly administer prescribed medications in the event of an allergic reaction according to the instructions in the special care plan;
- e) The facility shall notify the parents of any suspected allergic reactions, the ingestion of the problem food, or contact with the problem food, even if a reaction did not occur;
- f) The facility shall notify the child's physician if the child has required treatment by the facility for a food allergic reaction;
- g) The facility shall contact the emergency medical services system immediately whenever epinephrine has been administered;
- h) Parents of all children in the child's class shall be advised to avoid any known allergies in class treats or special foods brought into the child care setting.
- i) Individual child's food allergies shall be posted prominently in the classroom and/or wherever food is served.
- j) On field trips or transport out of the child care setting, the written child care plan for the child with allergies shall be routinely carried.

RATIONALE: Food allergy is common, occurring in between two and eight percent of infants and children (7). Food allergic reactions can range from mild skin or gastrointestinal symptoms to severe, life-threatening reactions with respiratory and/or cardiovascular compromise. Deaths from food allergy

are being reported in increasing numbers. A major factor in these deaths has been a delay in the administration of life-saving emergency medication, particularly epinephrine. Intensive efforts to avoid exposure to the offending food(s) are therefore warranted. Detailed care plans and the ability to implement such plans for the treatment of reactions is essential for all food-allergic children (8, 9, 10).

Successful food avoidance requires a cooperative effort that must include the parents, the child, the child's health care provider, and the child care staff. The parents, with the help of the child's health care provider, must provide detailed information on the specific foods to be avoided. In some cases, especially for children with multiple food allergies, the parents may need to take responsibility for providing all the child's food. In other cases, the child care staff may be able to provide safe foods as long as they have been fully educated about effective food avoidance.

Effective food avoidance has several facets. Foods can be listed on an ingredient list under a variety of names, such as milk being listed as casein, caseinate, whey, and lactoglobulin. Food sharing between children must be prevented by careful supervision and repeated instruction to the child about this issue. Accidental exposure may also occur through contact between children or by contact with contaminated surfaces, such as a table on which the food allergen remains after eating. Some children may have an allergic reaction just from being in proximity to the offending food, without actually ingesting it. Such contact should be minimized by washing children's hands and faces and all surfaces that were in contact with food. In addition, reactions may occur when a food is used as part of an art or craft project, such as the use of peanut butter to make a bird feeder or wheat to make play dough.

Some children with food allergy will have mild reactions and will only need to avoid the problem food(s). Others will need to have an antihistamine or epinephrine available to be used in the event of a reaction. For all children with a history of anaphylaxis, or for those with peanut and/or tree nut allergy (whether or not they have had anaphylaxis), epinephrine should be readily available. This will usually be provided as a pre-measured dose in an

auto-injector, such as the Epi-Pen or Epi-Pen Junior. Specific indications for administration of epinephrine should be provided in the detailed care plan. In virtually all cases, Emergency Medical Services (EMS) should be called immediately and children should be transported to the emergency room by ambulance after the administration of epinephrine (9). A single dose of epinephrine wears off in 15 to 20 minutes.

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 (11, 12). 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 (13):

- 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 (14). 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 (13, 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 3.077 INFORMATION REQUIRED FOR ILL CHILDREN

For each day of care in a special facility that provides care for ill children, the caregiver shall have the following information on each child:

- a) The child's specific diagnosis and the individual providing the diagnosis (physician, parent or legal guardian);
- b) Current status of the illness, including potential for contagion, diet, activity level, and duration of illness;
- c) Health care, diet, allergies (particularly to foods or medication), and medication plan, including appropriate release forms to obtain emergency health care and administer medication;
- d) Communication with the parent on the child's progress;
- e) Name, address, and telephone number of the child's source of primary health care;
- f) Communication with the child's primary health care provider.

RATIONALE: The caregiver must have child-specific information to provide optimum care for each ill child and to make appropriate decisions regarding whether to include or exclude a given child. The caregiver must have contact information for the child's source of primary health care to assist with the management of any situation that arises.

COMMENTS: Too often, parents who are not with the child contact the child's source of health care to seek advice. The parent is relaying secondhand information and cannot answer questions that must be addressed by the caregiver who is with the child at the time. These three-way conversations are frustrating and can lead to inappropriate advice.

For school-age children, documentation of the care of the child during the illness should be provided to the parent to deliver to the school health program upon the child's return to school. Coordination with the child's source of health care and school health program facilitates the overall care of the child.

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

STANDARD 3.081 PERMISSIBLE ADMINISTRATION OF MEDICATION

The administration of medicines at the facility shall be limited to:

- a) Prescribed medications ordered by a health care provider for a specific child, with written permission of the parent or legal guardian;
- b) Nonprescription (over-the-counter) medications recommended by a health care provider for a specific child or for a specific circumstance for any child in the facility, with written permission of the parent or legal guardian.

RATIONALE: Before assuming responsibility for administration of medicine, facilities must have clear, accurate instruction and medical confirmation of the child's need for medication while in the facility. Caregivers should not be involved in inappropriate use of drugs based solely on a parent's desire to give the child medication. Parents are victims of their own desire to do something for self-limited illnesses and the vigorous advertisement for many over-the-counter medications, including acetaminophen and combinations of antihistamines and decongestants as cold remedies.

Overuse of medications has been confirmed by results of the National Center for Health Statistics' survey of the incidence of medicated respiratory tract infection, which showed that 29.5% of children under 5 years of age in the survey were reported by their parents to have received a medication for a respiratory tract illness in the 2 weeks before the interview (16).

Decongestants and antihistamines have been shown to prolong the retention of secretions in the middle ear rather than helping children get well. No existing evidence reports that decongestants or antihistamines, alone or in combination, prevent middle ear infections; therefore, the use of such medications for common colds is not recommended (17).

COMMENTS: A health care provider can write a standing order for a commonly used nonprescription

medication (such as acetaminophen or sunscreen) that defines when the medication should be used for any child in the facility. For example: "With parental consent, children who are older than 4 months of age may receive acetaminophen when their body temperature exceeds 101 degrees F, according to the dose schedule and instructions provided by the manufacturer of the acetaminophen," or "With parental consent, children may have sunscreen applied to exposed skin, except eyelids, 30 minutes before exposure to the sun and every 2 hours while in the sun. Sunscreen preparations shall be applied according to the instructions provided by the manufacturer."

Parents should always be notified in every instance when medication is used. Telephone instructions from a health care provider are acceptable if the caregiver fully documents them and if the parent initiates the request for health care provider instruction. Advance notification of the parent (before medication is given) is ideal but may not be appropriate if a child needs medication urgently (such as to stop an allergic reaction) or when contacting the parent will unreasonably delay appropriate care.

Safeguards against liability for accepting telephone instructions for medication administration should be checked with an attorney. Nonprescription medications should be given according to the manufacturers' instructions unless a health care provider provides written instructions otherwise. A sample form for parental consent to administer medication is in *Healthy Young Children*, 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*

PROHIBITED USE OF MEDICATIONS

STANDARD 2.043 USING PHYSICAL RESTRAINT

When a child's behavior makes it necessary, for his own or others' protection, to restrain the child, the most desirable method of restraint is holding

the child by another person as gently as possible to accomplish the restraint. Children shall not be physically restrained longer than necessary to control the situation. No bonds, ties, or straps shall be employed to restrain young children.

Children shall not be given medicines, drugs, or herbal or folk remedies that will affect their behavior except as prescribed by their health care provider and with specific written instructions from their health care provider for use of the medicine.

The decision to restrain the child shall be made by the staff person with the most experience in child care and shall only be made for extreme circumstances. Training in the use of any form of physical restraint shall be provided by persons with extensive child care experience including experience with children who have required restraint.

RATIONALE: Undue physical restraint, especially with bonds, ties, or straps can be abusive, as can the use of medications or drugs to control children's behavior.

COMMENTS: For Medication Policy, see STANDARD 8.021 and STANDARD 3.081 through STANDARD 3.083.

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

STANDARD 8.038 POLICIES PROHIBITING SMOKING, TOBACCO, ALCOHOL, ILLEGAL DRUGS, AND TOXIC SUBSTANCES

Facilities shall have written policies specifying that smoking, use of chewing tobacco, use of alcohol, use or possession of illegal drugs, over-use or inappropriate use of prescribed drugs, or unauthorized potentially toxic substances are prohibited in the facility at all times (including outdoor play areas) and during all times when caregivers are responsible for the supervision of children, including times when children are transported and during field trips. The facility shall provide information to employees about available

drug, alcohol, and tobacco counseling and rehabilitation and employee assistance programs.

RATIONALE: The age, defenselessness, and lack of discretion of the child under care make this prohibition an absolute requirement. The hazards of second-hand smoke warrant the prohibition of smoking in proximity of child care areas at any time. Residual toxins from smoking at times when the children are not using the space can trigger asthma and allergies when the children do use the space.

Smoking in outdoor areas when children are not present is acceptable. The use of alcoholic beverages in family homes while children are not in care is also permissible.

COMMENTS: The policies related to smoking and use of prohibited substances should be discussed via handouts or pamphlets that are given to parents, especially those who have children in small family child care homes or school-age child care facilities, and staff, to inform them of the dangers of these prohibited substances and of services to prevent their use. For family child care home providers who smoke, provisions will need to be made to assure that children are not left unsupervised while the caregiver smokes. In addition, it is strongly urged that, whenever possible, the caregivers be non-tobacco users because of the role model effect of tobacco users on children.

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

LABELING AND STORAGE OF MEDICATIONS

STANDARD 3.082 LABELING AND STORAGE OF MEDICATIONS

Any prescribed medication brought into the facility by the parent, legal guardian, or responsible relative of a child shall be dated, and shall be kept in the original container. The container shall be labeled by a pharmacist with:

- a) The child's first and last names;
- b) The date the prescription was filled;

- c) The name of the health care provider who wrote the prescription, the medication's expiration date;
- d) The manufacturer's instructions or prescription label with specific, legible instructions for administration, storage, and disposal;
- e) The name and strength of the medication.

Over-the-counter medications shall be kept in the original container as sold by the manufacturer, labeled by the parent, with the child's name and specific instructions given by the child's health professional for administration.

All medications, refrigerated or unrefrigerated, shall have child-resistant caps, shall be kept in an organized fashion, shall be stored away from food at the proper temperature, and shall be inaccessible to children. Medication shall not be used beyond the date of expiration.

RATIONALE: Before assuming responsibility for administration of medicine, facilities must have clear, accurate instruction and medical confirmation of the child's need for medication while in the facility.

Child-resistant safety packaging was shown to decrease among children aged 0-4 years, while poisonings from unregulated products increased for this age group (18).

COMMENTS: A small lock box can be kept in the refrigerator to hold medications.

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

STANDARD 5.093 FIRST AID KITS

The facility shall maintain at least one readily available first aid kit wherever children are in care, including one for field trips and outings away from the facility and one to remain at the facility if all the children do not attend the field trip. In addition, a first aid kit shall be in each vehicle that is used to transport children to and from a child care center. Each kit shall be a closed container for storing first aid supplies, accessible to child care staff members at all times but out of reach of

children. First aid kits shall be restocked after use, and an inventory shall be conducted at least monthly. The first aid kit shall contain at least the following items:

- a) Disposable nonporous gloves;
- b) Scissors;
- c) Tweezers;
- d) A non-glass thermometer to measure a child's temperature;
- e) Bandage tape;
- f) Sterile gauze pads;
- g) Flexible roller gauze;
- h) Triangular bandages;
- i) Safety pins;
- j) Eye dressing;
- k) Pen/pencil and note pad;
- l) Syrup of ipecac (use only if recommended by the Poison Control Center);
- m) Cold pack;
- n) Current American Academy of Pediatrics (AAP) standard first aid chart or equivalent first aid guide;
- o) Coins for use in a pay phone;
- p) Water;
- q) Small plastic or metal splints;
- r) Liquid soap;
- s) Adhesive strip bandages, plastic bags for cloths, gauze, and other materials used in handling blood;
- t) Any emergency medication needed for child with special needs;**
- u) List of emergency phone numbers, parents' home and work phone numbers, and the Poison Control Center phone number.

RATIONALE: Facilities must place emphasis on safeguarding each child and ensuring that the staff members are able to handle emergencies. In a study that reviewed 423 injuries, first aid was sufficient treatment for 84.4% of the injuries (19). The supplies needed for pediatric first aid, including rescue breathing and management of a blocked airway must be available for use where the injury occurs.

COMMENTS: Many centers simply leave a first aid kit in all vehicles used to transport children, regardless of whether the vehicle is used to take a child to or from a center, or for outings. Contact information for the AAP is located in Appendix BB.

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

STANDARD 5.100 USE AND STORAGE OF TOXIC SUBSTANCES

The following items shall be used as recommended by the manufacturer and shall be stored in the original labeled containers:

- a) Cleaning materials;
- b) Detergents;
- c) Automatic dishwasher detergents;
- d) Aerosol cans;
- e) Pesticides;
- f) Health and beauty aids;
- g) Medications;
- h) Lawn care chemicals
- i) Other toxic materials.

They shall be used only in a manner that will not contaminate play surfaces, food, or food preparation areas, and that will not constitute a hazard to the children. All chemicals used inside or outside shall be stored in their original containers in a safe and secure manner, well away from food. These chemicals shall be used according to manufacturers' instructions, and in a manner that will not contaminate play surfaces or articles.

When not in actual use, toxic materials shall be kept in a locked room or cabinet, fitted with a child-resistive opening device, inaccessible to children, separate from stored medications and food.

Chemicals used in lawn care treatments shall be limited to those listed for use in areas that can be occupied by children.

RATIONALE: There were 2,475,010 human poison exposures reported in 1997 by 73 poison control centers nationwide, representing an estimated 6% of the U.S. population (20). Children under 6 years of age accounted for the following number of exposures:

- Industrial and Home Personal Care Products:
92,560 exposures
- Insecticides:
22,136 exposures
- Chemicals:
16,215 exposures

- Deodorizers:
9,557 exposures
- Rodenticides:
9,406 exposures
- Insecticides with Repellents:
4,475 exposures

Automatic dishwasher detergent is a common household substance that is extremely corrosive and potentially fatal if ingested. Young children have been known to take automatic dishwasher detergent from the dispenser on the internal surface of the door, and have taken detergent directly from the packet (21, 22).

COMMENTS: Many child-resistant types of closing devices can be installed on doors to prevent young children from accessing poisonous substances. Many of these devices are self-engaging when the door is closed and require an adult hand size or skill to open the door. A locked cabinet or room where children cannot gain access is best if such a barrier is used consistently. If a lock requires conscious action on the user's part, however, the lock may not be used consistently.

Lawn care chemicals may have an impact on children's health. Even when using lawn care chemicals that have EPA approval for use in child care environments, operators of child care facilities must take into consideration the quantity and frequency of lawn care chemicals used, whether the lawn is being used by infants or other children who play near the ground and may contaminate their skin or actually ingest grass with lawn care chemical residue, and whether older children have direct skin contact with the lawn when playing. Preferably, no lawn care chemicals should be used on lawns that are used by children. If lawn care chemicals are used, their use should be kept to a minimum.

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

STANDARD 5.237 EMERGENCY EQUIPMENT AND INFORMATION DURING TRANSPORT

Each vehicle shall be equipped with a first aid kit, emergency identification and contact information for all children being transported, and a means of immediate communication to summon help (such as a cell phone).

When transporting children with chronic medical conditions (such as asthma, diabetes, or seizures), their emergency care plans and supplies or medications shall be available. The responsible adult shall be trained to recognize and respond appropriately to the emergency.

RATIONALE: Caregivers must be able to respond to the needs of children in case of injury or emergency. Because no environment is totally injury-proof, adequate supplies and emergency information must be available. The staff must be knowledgeable in their use.

COMMENTS: For information on contents of first aid kits, see STANDARD 5.093.

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

POLICIES

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 (23).

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 8.021 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 (24). 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 8.049 CONTENTS OF ADMISSION AGREEMENT

The file for each child shall include an admission agreement signed by the parent at enrollment. The agreement shall include the following:

- a) Admission agreement or contract stating the rule prohibiting corporal punishment and verbal abuse. See Discipline Policy, STANDARD 8.008 through STANDARD 8.010;
- b) Admission agreement or contract stating that all parents may visit the site at any time when their child is there, and that they will be admitted immediately. See STANDARD 2.046;
- c) Documentation of written consent signed and dated by the parent or legal guardian for:
 - 1) Emergency transportation;
 - 2) All other transportation provided by the facility. See STANDARD 1.004; and Transportation, STANDARD 2.029 through STANDARD 2.038;
 - 3) Planned or unplanned activities off-premises. Such consent shall give specific information about where, when, and how such activities shall take place, including specific information about walking to and from activities away from the facility;
 - 4) Telephone authorizations for release of the child. See Authorized Caregivers, STANDARD 8.028 through STANDARD 8.030;
 - 5) Swimming/wading, if the child will be participating. See STANDARD 1.005, on child:staff ratio; Water Safety, STANDARD 3.045 through STANDARD 3.047; and Swimming, Wading, and Water, STANDARD 5.198 through STANDARD 5.218;
 - 6) Any health service obtained for the child by the facility on behalf of the parent. Such consent shall be specific for the type of care provided to meet the tests for "informed consent" to cover on-site screenings or other services provided;
 - 7) Release of any information to agencies, schools, or providers of services. See Confidentiality and Access to Records, STANDARD 8.053 through STANDARD 8.057;
 - 8) Authorization to release the child to anyone other than the custodial parent;

9) Emergency treatment;

10) Administration of medications (standing orders and short-term). See Medication Policy, STANDARD 8.021;

- k) Statement that parent has received and discussed a copy of the state child abuse reporting requirements.

RATIONALE: Positive guidance and discipline is more effective than corporal punishment, which may become abusive very easily.

The open-door policy may be the single most important method of preventing the abuse of children in child care (25). When access is restricted, areas observable by the parent may not reflect the care the children actually receive.

These records and reports are necessary to protect the health and safety of children in care.

These consents are needed by the person delivering the medical care. Advance consent for emergency medical or surgical service is not legally valid, since the nature and extent of injury, proposed medical treatment, risks, and benefits cannot be known until after the injury occurs.

The parent/child care partnership is vital. Participation of parents in decisions concerning children is a primary goal of Head Start (26).

COMMENTS: 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*

RECORDS

STANDARD 8.046 CONTENTS OF CHILD RECORDS

The facility shall maintain a file for each child in one central location within the facility. This file shall be kept in a confidential manner (see Confidentiality and Access to Records, STANDARD 8.053 through STANDARD 8.057) but shall be immediately available to the child's caregivers (who shall have parental consent for

access to records), parents or legal guardian, and the licensing authority upon request.

The file for each child shall include the following:

- a) Pre-admission enrollment information;
- b) Health report and immunization record, completed and signed by the child's health care provider, preferably prior to enrollment or no later than 6 weeks after admission. This record shall document the most recent assessment based on the standard age-related schedule of the American Academy of Pediatrics (AAP);
- c) Admission agreement signed by the parent at enrollment;
- d) Health history, completed by the parent at admission, preferably with staff involvement;
- e) **Medication record, maintained on an ongoing basis by designated staff.**

RATIONALE: The health and safety of individual children requires that information regarding each child in care be kept and made available on a need-to-know basis. 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.

COMMENTS: See STANDARD 8.053 for information on confidentiality and access to records.

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

STANDARD 8.048 CONTENTS OF CHILD'S HEALTH REPORT

The file for each child shall include a health report of an age-appropriate health assessment completed and signed by the child's health care provider. Preferably, this report shall be submitted prior to enrollment, but it shall be submitted no later than 6 weeks after admission. The health report shall include the following medical and developmental information:

- a) Records of the child's immunizations;
- b) A description of any disability, sensory impairment, developmental variation, seizure disorder, or emotional or behavioral disturbance that may affect adaptation to child care (including previous surgery, serious illness, history of prematurity, if relevant);
- c) An assessment of the child's growth based on the percentile for height, weight, and, if the child is younger than 24 months, head circumference;
- d) A description of health problems or findings from an examination or screening that needs follow-up;
- e) Results of screenings—vision, hearing, dental, nutrition, developmental, tuberculosis, hematocrit or hemoglobin, urine, lead, blood pressure and so forth;
- f) Dates of significant communicable diseases (such as chickenpox);
- g) **Prescribed medication(s), including information on recognizing, documenting, reporting, and responding to potential side effects;**
- h) A description of current acute or chronic health problems and a special care plan that defines routine and emergency management that might be required by the child while in child care. The care plan for the child with acute or chronic health problems shall include specific instructions for caregiver observations, program activities or services that differ from those required by typically developing children. Such instructions shall include specific teaching and return demonstration of the ability of caregivers to provide medications, procedures, or implement modifications required by children with asthma, severe allergic reactions, diabetes, medically-indicated special feedings, seizures, hearing impairments, vision problems or any other condition that requires accommodation in child care;
- i) A description of serious injuries sustained by the child in the past that required medical attention or hospitalization;
- j) Other special instructions for the caregiver.

The health report shall include space for additional comments about the management of health problems and for additional health-related data offered by the health care provider or required from the facility.

The health report shall be updated at each age-appropriate health assessment by supplemental notes dated and signed by the child's health provider on a copy of the previous health report or by submission of a new report and whenever the child's health status changes.

RATIONALE: The requirement of a health report for each child reflecting completion of health assessments and immunizations is a valid way to ensure timely preventive care for children who might not otherwise receive it and can be used in decision-making at the time of admission and during ongoing care (25). This requirement encourages families to have a primary health care provider (medical home) for each child where timely and periodic well-child evaluations are done. The objective of timely and periodic evaluations is to permit detection and counseling for improved oral, physical, mental, and emotional/social health (27). The reports of such evaluations provide a conduit for communication of information that helps the health professional and the child care provider determine appropriate services for the child. When the parent carries the request for the report to the health professional, concerns of the child care provider can be delivered by the parent to the child's health professional and consent for communication is thereby given. The parent can give written consent for direct communication between the health care provider and the caregiver so that the forms can be faxed or mailed.

Quality child care requires information about the child's health status and need for accommodations in child care (25).

COMMENTS: The purpose of a health report is to:

- a) Give information about a child's health history, special needs, and current health status to allow the caregiver to provide a safe setting and healthful experience for each child;
- b) Promote individual and collective health by fostering compliance with approved standards for health care assessments and immunizations;
- c) Document compliance with licensing standards;
- d) Serve as a means to ensure early detection of health problems and a guide to steps for remediation;
- e) Serve as a means to facilitate and encourage communication and learning about the child's needs among caregivers, health care providers, and parents.

If the child's medical record is not available at the time the child is enrolled in a program, child care providers can offer a 6-week grace period when the parent can arrange to obtain the medical record, but written permission should be obtained from the child's parent or guardian to contact the child's primary health care provider in case of an emergency. The child care provider should also ask whether or not there are any health problems (such as allergies, asthma, or developmental irregularities) that might affect the child's participation in the program.

The requirement for updated health reports does not mean that the child should have a special examination for entry into child care or at intervals related to duration of participation in child care. The evaluations by the child's health professional should occur according to the national schedule for routine preventive care. The medical reports should confirm that the child has received all the age appropriate services outlined in the guidelines for assessments of the American Academy of Pediatrics (AAP), Bright Futures, or Medicaid's Early Periodic Screening and Diagnostic Treatment (EPSDT) program (28, 29, 30).

The report submitted upon enrollment can document a previous age-appropriate examination if the child is not due for the next check-up visit. Updates of the report should address new immunizations, contagious diseases, new or changed medications, and new or changed special concerns. Busy clinicians appreciate having the parent and child care provider complete as much information on the medical report as possible, so that they know what information the child care provider already has on hand and what information needs to be added. Filling in the child's and child care provider's identifying information, and previously provided immunization dates are evidence to the clinician of an interest in sharing information and the paperwork burden.

Health data should be presented in a form usable by caregivers to identify any special needs for care. Local Early Periodic Screening and Diagnostic Treatment (EPSDT) program contractor, if available, should be called upon to help with liaison and education activities. In some situations, screenings may be performed at the facilities. When clinicians do not fill out forms completely enough to assist the caregiver

in understanding the significance of health assessment findings or the unique characteristics of a child, the caregiver should obtain parental consent to contact the child's clinician to explain why the information is needed and to request clarification.

Samples of a health care provider's exam form and special care plans for children with chronic illness are provided in *Model Child Care Health Policies* from the National Association for the Education of Young Children (NAEYC) or the American Academy of Pediatrics (AAP). Contact information for the NAEYC and the AAP is located in Appendix BB.

The AAP recommends vision and hearing screenings at every health supervision visit, with objective vision screening and measurement of visual acuity by 4 years of age, and objective hearing screening (audiometry) by 5 years of age. The AAP recommends that all children have their first dental exam, by an oral health professional, at 3 years of age. A primary health care provider could examine the mouth of a child up to 3 years of age. After 3 years, the child should visit a dentist for examinations at intervals prescribed by the dentist. Children with suspected oral problems should see a dentist immediately, regardless of age or interval. These guidelines are described in "A Guide to Children's Dental Health," a brochure published by the AAP. Bright Futures recommends the first dental exam, by an oral health professional, at 12 months of age. Contact information for the AAP is located in Appendix BB.

See Appendix H, for *Recommendations for Preventive Pediatric Health Care*.

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

STANDARD 8.050 CONTENTS OF CHILD CARE PROGRAM'S HEALTH HISTORY

The file for each child shall include a health history completed by the parent at admission, preferably with staff involvement. This history shall include the following:

- a) Identification of the child's pediatric primary care clinician or designated "medical home";

- b) Developmental variations, sensory impairment, or disabilities that may need consideration in the child care setting;
- c) Description of current physical, social, and language developmental levels;
- d) **Current medications. See Medication Policy, STANDARD 8.021; and Medications, STANDARD 3.081 through STANDARD 3.083;**
- e) Special concerns (such as allergies, chronic illness, pediatric first aid information needs);
- f) Specific diet restrictions, if the child is on a special diet;
- g) Individual characteristics or personality factors relevant to child care;
- h) Special family considerations;
- i) Dates of communicable diseases.

RATIONALE: A health history is the basis for meeting the child's needs in health, mental and social areas in the child care setting and should be thoroughly understood by the significant child care provider at the time of registration or upon its receipt.

COMMENTS: A sample developmental health history is provided in *Healthy Young Children* from the National Association for the Education of Young Children (NAEYC). Contact information for the NAEYC is located in Appendix BB.

For a sample *Child Health Assessment*, see Appendix Z.

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

STANDARD 8.051 CONTENTS OF MEDICATION RECORD

The file for each child shall include a medication record maintained on an ongoing basis by designated staff. The medication record shall include the following:

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

RATIONALE: Caregivers should not administer medication based solely on a parent's request. Before assuming responsibility for administration of medicine, facilities must have written confirmation of a physician or nurse practitioner's orders to include clear, accurate instruction and medical confirmation of the child's need for medication while in the facility.

COMMENTS: The medication record contents and format, as well as policies on handling of medications, are provided in *Model Child Care Health Policies*, 3rd edition, from the American Academy of Pediatrics (AAP). Contact information for the AAP is located in Appendix BB.

A sample medication administration log is provided in *Healthy Young Children* from the National Association for the Education of Young Children (NAEYC). Contact information for the NAEYC is located in Appendix BB.

For additional information, see Medications, STANDARD 3.081 through STANDARD 3.083; and Medication Policy, STANDARD 8.021. 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*
 rms 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.

COMMENTS: See STANDARD 8.053 for information on confidentiality and access to records.

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

LIABILITY INSURANCE

STANDARD 8.070 INSURANCE COVERAGE

Facilities shall carry the following insurance:

- a) Accident insurance on children;
- b) Liability insurance;

- c) Vehicle insurance on any vehicle owned or leased by the facility and used to transport children.

Small and large family child care home providers shall carry this insurance if available.

RATIONALE: With the current increase in litigation, reasonable protection against liability action through proper insurance is essential for reasons of economic security, peace of mind, and public relations. Requiring insurance reduces risks because insurance companies stipulate compliance with health and safety regulations before issuing or continuing a policy. Property insurance would also be desirable since the costs of adverse events occurring at a facility can easily cause a financial disaster that can disrupt children's care. Protection, via insurance, must be secured to provide stability and protection for both the individuals and the facility. Liability insurance carried by the facility provides recourse for parents of children enrolled in the event of negligence.

COMMENTS: The liability insurance should include **coverage for administration of medications**, as well as for unintentional injuries and illnesses. Individual health injury coverage may be documented by evidence of personal health insurance coverage as a dependent. Workers' compensation covers adult injuries in the case of an accident.

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

HEALTH DEPARTMENT ROLE

RECOMMENDATION 9.025 STATE AND LOCAL HEALTH DEPARTMENT ROLE

State and local health departments should play an important role in the identification, prevention and control of injuries, injury risk, and infectious disease in child care settings as well as in using the child care setting to promote health. This role includes the following activities to be conducted in collaboration with the child care licensing agency:

1. Assisting in the planning of a comprehensive health and safety program for children and child care providers.

2. Monitoring the occurrence of serious injury events and outbreaks involving children or providers.
3. Alerting the responsible child care administrators about identified or potential injury hazards and infectious disease risks in the child care setting.
4. Controlling outbreaks, identifying and reporting communicable diseases in child care settings including:
 - a) Methods for notifying parents, caregivers, and health care providers of the problem.
 - b) Providing appropriate actions for the child care provider to take;
 - c) Providing policies for exclusion or isolation of infected children;
 - d) Arranging a source and method for the administration of needed medication.**
 - e) Providing a list of reportable diseases, including descriptions of these diseases. The list should specify where diseases are to be reported and what information is to be provided by the child care provider to the health department and to parents;
 - f) Requiring that all facilities, regardless of licensure status, and all health care providers report certain communicable diseases to the responsible local or state public health authority. The child care licensing authority should require such reporting under its regulatory jurisdiction and should collaborate fully with the health department when the latter is engaged in an enforcement action with a licensed facility;
 - g) Determining whether a disease represents a potential health risk to children in out-of-home child care;
 - h) Conducting the epidemiological investigation necessary to initiate public health interventions;
 - i) Recommending a disease prevention or control strategy that is based on sound public health and clinical practices (such as the use of vaccine, immunoglobulin, or antibiotics taken to prevent an infection).
 - j) Verifying reports of communicable diseases received from facilities with the assessment and diagnosis of the disease made by a health care provider and, or the local or state health department.
5. Designing systems and forms for use by facilities for the care of ill children to document the surveillance of cared for illnesses and problems that arise in the care of children in such child care settings.
6. Assisting in the development of orientation and annual training programs for caregivers. Such training shall include specialized education for staff of facilities that include ill children, as well as those in special facilities that serve only ill children. Specialized training for staff who care for ill children should focus on the recognition and management of childhood illnesses, as well as the care of children with communicable diseases.
7. Assisting the licensing authority in the periodic review of facility performance related to caring for ill children by:
 - a) Reviewing written policies developed by facilities regarding inclusion, exclusion, dismissal criteria and plans for health care, urgent and emergency care, and reporting and managing children with communicable disease;
 - b) Assisting with periodic compliance reviews for those rules relating to inclusion, exclusion, dismissal, daily health care, urgent and emergency care, and reporting and management of children with communicable disease.
9. Collaborating in the planning and implementation of appropriate training and educational programs related to health and safety in child care facilities. Such training should include education of parents, physicians, public health workers, licensing inspectors, and employers about how to prevent injury and disease as well as promote health of children and their caregivers.
10. Ensuring that health care personnel, such as qualified public health nurses, pediatric and family nurse practitioners, and pediatricians serve as child care health consultants as required in STANDARD I.040 through STANDARD I.044 and as members of advisory boards for facilities serving ill children.

DISCUSSION: A number of studies have described the incidence of injuries in the child care settings (31-34). Although the injuries described have not been serious, these occur frequently, and may require medical or emergency attention. Child care programs

need the assistance of local and state health agencies in planning of the safety program that will minimize the risk for serious injury(35). This would include planning for such significant emergencies as fire, flood, tornado, or earthquake (36). A community health agency can collect information that can promptly identify an injury risk or hazard and provide an early notice about the risk or hazard (37). An example is the recent identification of un-powered scooters as a significant injury risk for preschool children (38). Once the injury risk is identified, appropriate channels of communication are required to alert the child care administrators and to provide training and educational activities.

Effective control and prevention of infectious diseases in child care settings depends on affirmative relationships among parents, caregivers, public health authorities, regulatory agencies, and primary health care providers. The major barriers to productive working relationships between caregivers and health care providers are inadequate channels of communication and uncertainty of role definition. Public health authorities can play a major role in improving the relationship between caregivers and health care providers by disseminating information regarding disease reporting laws, prescribed measures for control and prevention of diseases and injuries, and resources that are available for these activities (39).

State and local health departments are legally required to control certain communicable diseases within their jurisdictions. All states have laws that grant extraordinary powers to public health departments during outbreaks of communicable diseases (40). Since communicable disease is likely to occur in child care settings, a plan for the control of communicable diseases in these settings is essential and often legally required. Early recognition and prompt intervention will reduce the spread of infection. Outbreaks of communicable disease in child care settings can have great implications for the general community (41). Programs administered by local health departments have been more successful in controlling outbreaks of hepatitis A than those that rely primarily on private physicians. Programs coordinated by the local health department also provide reassurance to caregivers, staff, and parents, and thereby promote cooperation with other disease control policies (42). Communicable diseases in child care settings pose new epidemiological considerations. Only in recent decades has it been so common for very young children to spend most of their days together in groups. Public health authorities should expand their role in studying this situation and designing new preventive health measures (43).

Collaboration is necessary to use limited resources most effectively. In small states, a state level task force that includes the Department of Health, might be sufficient. In larger or more populous states, local task forces may be needed. The collaboration should focus on establishing the role of each agency in ensuring that necessary services and systems exist to prevent and control injuries and communicable diseases in facilities.

Health departments generally have or should develop the expertise to provide leadership and technical assistance to licensing authorities, caregivers, parents, and health professionals in the development of licensing requirements and guidelines for the management of ill children. The heavy reliance on the expertise of local and state health departments in the establishment of facilities to care for ill children has fostered a partnership in many states among health departments, licensing authorities, caregivers, and parents for the adequate care of ill children in child care settings. In addition, the business community has a vested interest in assuring that parents have facilities that provide quality care for ill children so parents can be productive in the workplace.

This vested interest is likely to produce meaningful contributions from the business community to creative solutions and innovative ideas about how to approach the regulation of facilities for ill children. All stakeholders in the care of ill children should be involved for the solutions that are developed in regulations to be most successful. For additional information on the training for staff in facilities serving ill children, see STANDARD 3.073; for information regarding health consultants in facilities serving ill children, see STANDARD 3.075.

See also Reporting Illness, STANDARD 3.086 and STANDARD 3.087.

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Special Care Plan for a Child with Asthma

Child's Name: _____ **Date of Birth:** _____

Parent(s) or Guardian(s) Name: _____

Emergency phone numbers: Mother: _____ Father: _____

(see emergency contact information for alternate contacts if parents are unavailable)

Primary health provider's name: _____ **Emergency Phone:** _____

Asthma specialist's name (if any): _____ **Emergency Phone:** _____

Known triggers for this child's asthma (circle all that apply):

colds	mold	exercise	tree pollens
house	dust	strong odors	grass flowers
excitement	weather changes	animals	smoke
foods (specify): _____			room deodorizers
other (specify): _____			

Activities for which this child has needed special attention in the past (circle all that apply)

<i>outdoors</i>	<i>indoors</i>
field trip to see animals	kerosene/wood stove heated rooms
running hard	art projects with chalk, glues, fumes
gardening	sitting on carpets
jumping in leaves	pet care
outdoors on cold or windy days	recent pesticides application in facility
playing in freshly cut grass	painting or renovation in facility
other (specify): _____	

Can this child use a **flowmeter** to monitor need for medication in child care? NO YES

personal best reading: _____ reading to give extra dose of medicine: _____

reading to get medical help: _____

How often has this child needed urgent care from a doctor for an attack of asthma:

in the past 12 months? _____ in the past 3 months? _____

Typical signs and symptoms of the child's asthma episodes (circle all that apply):

fatigue	face red, pale or swollen	grunting
breathing faster	wheezing	sucking in chest/neck
restlessness, agitation	dark circles under eyes	persistent coughing
complaints of chest pain/tightness	gray or blue lips or fingernails	
flaring nostrils, mouth open (panting)	difficulty playing, eating, drinking, talking	

Reminders:

1. Notify parents immediately if emergency medication is required.

2. Get emergency medical help if.

- the child does not improve 15 minutes after treatment and family cannot be reached

- after receiving a treatment for wheezing, the child:

- | | |
|---------------------------------------------------------|----------------------------------------|
| • is working hard to breathe or grunting | • won't play |
| • is breathing fast at rest (>50/min) | • has gray or blue lips or fingernails |
| • has trouble walking or talking | • cries more softly and briefly |
| • has nostrils open wider than usual | • is hunched over to breathe |
| • has sucking in of skin (chest or neck) with breathing | • is extremely agitated or sleepy |

3. Child's doctor & child care facility should keep a current copy of this form in child's record.

Special Care Plan for a Child with Asthma (Continued)

Medications for routine and emergency treatment of asthma for:			
_____		_____	
Child's name		Date of Birth	
Name of medication			
When to use (e.g., symptoms, time of day, frequency, etc.)	<i>routine or emergency</i>	<i>routine or emergency</i>	<i>routine or emergency</i>
How to use (e.g., by mouth, by inhaler, with or without spacing device, in nebulizer, with or without dilution, diluting fluid, etc.)			
Amount (dose) of medication			
How soon treatment should start to work			
Expected benefit for the child			
Possible side effects, if any			
Date instructions were last updated by child's doctor	Date: _____ Name of Doctor (print): _____ Doctor's signature: _____		
Parent's permission to follow this medication plan	Date: _____ Parent's signature: _____		

If more columns are needed for medication or equipment instruction, copy this page

Permission for Medical Condition Treatment

Parent or Guardian signature indicates permission for child care provider to follow these instructions:

(Parent Signature)

TO: Facility name _____ Phone: _____
Address: _____ Fax: _____

Child's name: _____ Date of Birth: _____
Address: _____
Medical condition(s) of concern: _____

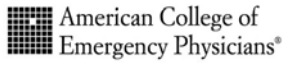
Signs and/or symptom(s) to watch for: _____
Medications: _____ Dose: _____
How given: _____ When given? _____
Possible side effects: _____
Temporary program adaptations: _____

When to call parent/health provider regarding symptoms or failure to respond to treatment: _____

When to consider that the condition requires urgent care or reassessment: _____

FROM: Health care provider: _____ Phone: _____
Address: _____
Date of exam: _____

Emergency Information Form for Children With Special Needs



American Academy of Pediatrics



Date form completed	Revised	Initials
By Whom	Revised	Initials

Last Name: _____

Name:		Birth date:	Nickname:
Home Address:		Home/Work Phone:	
Parent/Guardian:	Emergency Contact Names & Relationship:		
Signature/Consent*:			
Primary Language:	Phone Number(s):		
Physicians:			
Primary care physician:	Emergency Phone:		
	Fax:		
Current Specialty physician:	Emergency Phone:		
	Specialty:		
Current Specialty physician:	Emergency Phone:		
	Specialty:		
Anticipated Primary ED:	Pharmacy:		
Anticipated Tertiary Care Center:			

Diagnoses/Past Procedures/Physical Exam:	
1. _____	Baseline physical findings:
_____	_____
2. _____	_____
_____	_____
3. _____	Baseline vital signs:
_____	_____
4. _____	_____
_____	_____
Synopsis:	Baseline neurological status:
_____	_____
_____	_____
_____	_____

*Consent for release of this form to health care providers

Last Name: _____

Diagnoses/Past Procedures/Physical Exam continued:	
Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	Prostheses/Appliances/Advanced Technology Devices:
5. _____	_____
6. _____	_____

Management Data:	
Allergies: Medications/Foods to be avoided	and why:
1. _____	_____
2. _____	_____
3. _____	_____
Procedures to be avoided	and why:
1. _____	_____
2. _____	_____
3. _____	_____

Immunizations (mm/yy)									
Dates						Dates			
DPT						Hep B			
OPV						Varicella			
MMR						TB status			
HIB						Other			

Antibiotic prophylaxis: _____ Indication: _____ Medication and dose: _____

Common Presenting Problems/Findings With Specific Suggested Managements		
Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:	
Physician/Provider Signature:	Print Name:

Reference: American College of Emergency Physicians & American Academy of Pediatrics. *Emergency Information Form for Children with Special Needs* Available at: <http://www.acep.org/library/index.cfm/id/1256.pdf>. Accessed 2001. Used with permission of the American College of Emergency Physicians and American Academy of Pediatrics, 2001.

CHILD HEALTH ASSESSMENT

Parents & Child Care Providers fill-in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

To Parents: Submission of this form to the child care provider implies consent for the child care provider to discuss the child's health with the child's clinician.

PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007. The schedule is available at www.aap.org or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

Health history and medical information pertinent to routine child care and emergencies (describe, if any): <input type="checkbox"/> NONE	Date of most recent well-child exam: _____
Allergies to food or medicine (describe, if any): <input type="checkbox"/> NONE	Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.

Parents may write immunization dates, health professionals should verify and complete all data.

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE			
IN/CM % ILE	LB/KG % ILE	IN/CM % ILE	(BEGINNING AT AGE 3) /			
PHYSICAL EXAMINATION	✓ = NORMAL	IF ABNORMAL - COMMENTS				
HEAD/EARS/EYES/NOSE/THROAT						
TEETH						
CARDIORESPIRATORY						
ABDOMEN/GI						
GENITALIA/BREASTS						
EXTREMITIES/JOINTS/BACK/CHEST						
SKIN/LYMPH NODES						
NEUROLOGIC & DEVELOPMENTAL						
IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTaP/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
OTHER						
SCREENING TESTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL				
LEAD						
ANEMIA (HGB/HCT)						
URINALYSIS (UA) (at age 5)						
HEARING (subjective until age 4)						
VISION (subjective until age 3)						
PROFESSIONAL DENTAL EXAM						
HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE						(ATTACH ADDITIONAL SHEETS IF NECESSARY)
<input type="checkbox"/> NONE						NEXT APPOINTMENT - MONTH/YEAR:
MEDICAL CARE PROVIDER: SIGNATURE OF PHYSICIAN OR CPNP:				SIGNATURE OF PHYSICIAN OR CPNP:		
ADDRESS:						
			PHONE	LICENSE NUMBER:	DATE FORM SIGNED:	

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Contact Information

American Academy of Pediatrics (AAP)

141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1098
Phone: 847-434-4000
Fax: 847-228-5097
<http://www.aap.org>

American Association for Health Education (AAHE)

1900 Association Drive
Reston, VA 20191-1599
Phone: 1-800-213-7193 or 703-476-3437
Fax: 703-476-6638
E-mail: aahe@ahhperd.org
<http://www.aahperd.org/aahe>

Asthma and Allergy Foundation of America

1233 20th St., N.W.
Suite 402
Washington, DC 20036
Phone: 1-800-727-8462
Fax: 202-466-8940
<http://www.aafa.org>

The Healthy Child Care America Campaign

American Academy of Pediatrics
141 N.W. Point Blvd.
Elk Grove Village, IL 60007
Phone: 888-227-5409
Fax: 847-228-6432
E-mail: childcare@aap.org

National Association for the Education of Young Children (NAEYC)

1509 16th Street, NW
Washington DC 20036
1-800-424-2460
<http://www.naeyc.org>

National Association for Sick Child Daycare (NASCD)

1716 5th. Ave. N.
Birmingham, AL 35203
Phone: 202-324-8447
Fax: 202-324-8050
E-mail: gwj@nascd.com
<http://www.nascd.com>

National Commission for Health Education Credentialing, Inc. (NCHEC)

944 Marcon BLVD., Suite 310
Allentown, PA 18103
Phone: 1-888-624-3248
Fax: 1-800-813-0727
E-mail: nchectce@fast.net
<http://www.nchec.org>

National Heart, Lung, and Blood Institute

Health Information Center
P.O. Box 30105
Bethesda, MD
Phone: 301-592-8573
Fax: 301-592-8563
E-mail: NHLBInfo@rover.nhlbi.nih.gov
<http://www.nhlbi.nih.gov/health/infoctr/index.htm>

National Resource Center for Health and Safety in Child Care

University of Colorado School of Nursing
Campus Mail Stop F541, P.O. Box 6508
Aurora, CO 80045-0508
Phone: 1-800-598-5437
Fax: 303-724-0960
<http://nrc.uchsc.edu>

National Training Institute for Child Care Health Consultants

Department of Maternal and Child Health
University of North Carolina at Chapel Hill
116A S. Merritt Mill Rd. Box 8126
Chapel Hill, NC 27599-8126
Phone: 919-966-3780
Fax: 919-843-4752
E-mail: nticchc@sph.unc.edu

State and Territorial Injury Prevention Directors' Association

2141 Kingston Court, Suite 110-B
Marietta, GA 30067
Phone: 770-690-9000
Fax: 770-690-8996
E-mail:
<http://www.stipda.org/>

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