

TRANSPORTING CHILDREN IN CHILD CARE

Applicable Standards from:

CARING FOR OUR CHILDREN

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

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INTRODUCTION

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

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

INTENDED AUDIENCES

The intended audiences for this document are:

- child care providers who want to know what are the recommended practices in transporting children safely while in their care;
- state policy makers who are looking for guidance in setting state rules on this issue; and
- parents who need to understand the importance of appropriate practices in transporting their child while they are attending a child care program.

Throughout this document there will be references to other standards contained in the full edition of *Caring for Our Children, 2nd Ed.* For example, Standard 2.029 (which is located in this document) is about the competence and training of transportation staff. Standard 2.029 refers to Standard 1.026 First Aid Training (which is not included in this document but is located in the larger, comprehensive *Caring for Our Children, 2nd Edition*). The reader would need to go to *Caring for Our Children, 2nd Edition* in order to find the description of Standard 1.026. In the web version, the user can click on the link to this standard to get to the full edition.

We would like to give special thanks to Phyllis Stubbs-Wynn, MD, Chief, Infant and Child Health Branch; R. Lorraine Brown, Public Health Analyst with the Maternal and Child Health Bureau, Health Resources and Services Administration and Nancy Netherland with the Academy for Educational Development for reviewing this compilation of standards on transporting children. We would also like to thank all those individuals who contributed to *Caring for Our Children, 2nd Ed.* A listing can be viewed at: <http://nrc.uchsc.edu/CFOC/PDFVersion/Acknowledgments.pdf>

As with all areas in safety, new research comes forth on such topics as school bus and van safety issues. Readers who have Head Start children should also consult the Head Start Performance Standard, 45 CFR 1310, Head Start Transportation (<http://www.acf.hhs.gov/programs/hsb/performance/1310.htm>). We recommend that users continue to visit the following web sites for the most up-to-date information on transporting children safely, related to health and safety concerns including but not limited to purchasing and proper installation of age-appropriate safety seats in automobiles and/or on school buses:

American Academy of Pediatrics

<http://www.aap.org>

Head Start Transportation Toolkit

http://www.headstartinfo.org/infocenter/tran_tkit.htm

Moving Kids Safely in Child Care

<http://www.healthychildcare.org/cps.cfm>

National Highway and Transportation Safety Administration

<http://www.nhtsa.dot.gov/>

U.S. Consumer Product Safety Commission

<http://www.cpsc.gov>

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

natl.child.res.ctr@UCHSC.edu

CHILD:STAFF RATIOS

**STANDARD 1.004
RATIOS DURING TRANSPORTATION**

Child:staff ratios established for out-of-home child care shall be maintained on all transportation the facility provides or arranges. The driver shall not be included in the ratio. No child of any age shall be left unattended in a vehicle.

RATIONALE: Children must continue to receive adequate supervision during transport. Placement of a child in a vehicle does not eliminate the need for supervision.

Drivers must not be distracted from safe driving practices by being simultaneously responsible for the supervision of children.

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

**STANDARD 1.001
RATIOS FOR SMALL FAMILY CHILD CARE HOMES**

The small family child care home provider child:staff ratios shall conform to the following table:

If the small family child care home provider has no children under two years of age in care,	then the small family child care home provider may have 1-6 children over two years of age in care
If the small family child care home provider has 1 child under two years of age in care,	then the small family child care home provider may have 1-3 children over two years of age in care
If the small family child care home provider has 2 children under two years of age in care,	then the small family child care home provider may have no children over two years of age in care

The small family child care home provider's own children shall be included in the child:staff ratio.

RATIONALE: Although child:staff ratios alone do not predict the quality of care, direct warm social interaction between adults and children is more common and more likely with lower child:staff ratios. Care - givers must be recognized as performing a job for groups of children that parents of twins, triplets, or quadruplets would rarely be left to handle alone. In child care, these children do not come from the same family and must learn a set of common rules that may differ from expectations in their own homes.

Low child:staff ratios are most critical for infants and young toddlers (0 to 24 months) (1). Infant development and caregiving quality improves when group size and child:staff ratios are smaller (2.). Improved verbal interactions are correlated with lower child:staff ratios (3.). For 3- and 4-year old children, the size of the group is even more important than ratios. The recommended group size and child:staff ratio allow 3- to 5- year old children to have continuing adult support and guidance while encouraging independent, self-initiated play and other activities (4.).

The National Fire Protection Association (NFPA) requires in the *NFPA-101 Life Safety Code* that small family child care homes serve no more than 2 clients incapable of self-preservation (5.).

COMMENTS: Some states are setting limits on the number of school-age children that are allowed to be cared for in small family child care homes, e.g., two school-age children in addition to the maximum number allowed for infants/preschool children. No data are available to support using a different ratio where school-age children are in family child care homes. Since school-age children require focused caregiver time and attention for supervision and adult-child interaction, this standard applies the same ratio to all children over two years of age. The family child care provider must be able to have a positive relationship and provide guidance for each child in care.

Unscheduled inspections encourage compliance with this standard.

For more information regarding brain development in children in child care, see STANDARD 1.010.

TYPE OF FACILITY: *Small Family Child Care Home*

**STANDARD 1.002
RATIOS FOR LARGE FAMILY CHILD
CARE HOMES AND CENTERS**

Child:staff ratios in centers and large family child care homes shall be maintained as follows during all hours of operation, **including transport** and nap times:

Age	Maximum Child:Staff Ratio	Maximum Group Size
Birth - 12 mos.	3:1	6
13 - 30 mos.	4:1	8
31 - 35 mos.	5:1	10
3-year-olds	7:1	14
4-year-olds	8:1	16
5-year-olds	8:1	16
6 - 8-year-olds	10:1	20
9 - 12-year-olds	12:1	24

During nap time, at least one adult shall be physically present in the same space as the children.

Other adults who are included in the child:staff ratio need not be in the same space with the children when all the children are napping. However, in case of emergency, these adults shall be on the same floor and shall have no barrier to their coming to help immediately. The caregiver who is in the same space with the children shall be able to summon these adults without leaving the children.

When there are mixed age groups in the same room, the child:staff ratio and group size shall be consistent with the age of most of the children when no infants or toddlers are in the mixed age

group. When infants or toddlers are in the mixed age group, the child:staff ratio and group size for infants and toddlers shall be maintained. In large family child care homes with two or more caregivers caring for no more than 12 children, no more than three children younger than 2 years of age shall be in care.

RATIONALE: These child:staff ratios are within the range of recommendations for each age group that the National Association for the Education of Young Children (NAEYC) uses in its accreditation program (6.). The NAEYC recommends a range that assumes the director and staff are highly trained and, by virtue of the accreditation process, has determined a staffing pattern that enables effective staff function. The standard for child:staff ratios in this document uses a single desired ratio, rather than a range, for each age group. In some cases, these child:staff ratios and group sizes are the more stringent ratios and group sizes recommended in the National Research Council's report, *Who Cares for America's Children? Child Care Policy for the 1990s* (1). According to the National Research Council, child:staff ratios and group size are two of the four most important areas to be addressed in national standards.

Children with special health care needs may require additional staff on-site, depending on their special need and extent of disability (1).

Low child:staff ratios for non-ambulatory children are essential for fire safety. The National Fire Protection Association, in its *NFPA-101 Life Safety Code*, recommends that no more than three children younger than 2 years of age be cared for in large family child care homes where two staff members are caring for up to 12 children (5.).

Children benefit from social interactions with peers. However, larger groups are generally associated with less positive interactions and developmental outcomes. Group size and ratio of children to adults are limited to allow for one to one interaction, intimate knowledge of individual children, and consistent caregiving (7.).

Although child:staff ratios alone do not predict the quality of care, direct warm social interaction

between adults and children is more common and more likely with lower child:staff ratios. Caregivers must be recognized as performing a job for groups of children that parents of twins, triplets, or quadruplets would rarely be left to handle alone. In child care, these children do not come from the same family and must learn a set of common rules that may differ from expectations in their own homes.

Low child:staff ratios are most critical for infants and young toddlers (0 to 24 months) (1). Infant development and caregiving quality improves when group size and child:staff ratios are smaller (2.). Improved verbal interactions are correlated with lower ratios (3.). For 3- and 4-year old children, the size of the group is even more important than ratios. The recommended group size and child:staff ratio allow 3- to 5- year old children to have continuing adult support and guidance while encouraging independent, self-initiated play and other activities (4.).

In addition, the children's physical safety and sanitation routines require a staff that is not fragmented by excessive demands. Child:staff ratios in child care settings should be sufficiently low to keep staff stress below levels that might result in anger with children. Caring for too many young children, in particular, increases the possibility of stress to the caregiver, and may result in loss of self-control.

Although observation of sleeping children does not require the physical presence of more than one caregiver, the staff needed for an emergency response or evacuation of the children must remain available for this purpose. Nap time may be the best option for regular staff conferences and staff training, but these activities should take place in an area next to the room where the children are sleeping so no barrier will prevent the staff from assisting if emergency evacuation becomes necessary.

COMMENTS: The child:staff ratio indicates the maximum number of children permitted per caregiver (8.). These ratios assume that caregivers do not have time-consuming bookkeeping and housekeeping duties, so they are free to provide direct care for children. The ratios do not include other personnel (such as bus drivers) necessary for specialized functions (such as driving a vehicle).

Group size is the number of children assigned to a caregiver or team of caregivers occupying an individual classroom or well-defined space within a larger room (8.).The "group" in child care represents the "homeroom" for school-age children. It is the psychological base with which the child identifies and from which the child gains continual guidance and support in various activities. This standard does not prohibit larger numbers of children from joining in collective activities as long as child:staff ratios and the concept of "home room" are maintained.

Unscheduled inspections encourage compliance with this standard.

These standards are based on what children need for quality nurturing care. Those who question whether these ratios are affordable must consider that our efforts to limit costs have resulted in overlooking the basic needs of children and creating a highly stressful work environment for caregivers. Community resources other than parent fees and a greater public investment in child care are critical to achieving the child:staff ratios and group sizes specified in this standard.

For more information regarding brain development in children in child care, see STANDARD I.010.

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

STANDARD I.003 RATIOS FOR FACILITIES SERVING CHILDREN WITH SPECIAL HEALTH NEEDS

Facilities enrolling children with special needs shall determine, by an individual assessment of each child's needs, whether the facility requires a lower child:staff ratio.

RATIONALE: The child:staff ratio must allow the needs of the children enrolled to be met. The facility should have sufficient direct care professional staff to provide the required programs and services. Integrated facilities with fewer resources may be able

to serve children who need fewer services, and the staffing levels may vary accordingly. Adjustment of the ratio allows for the flexibility needed to meet the child's type and degree of special need. The facility should seek consultation with parents and other professionals regarding the appropriate child:staff ratio and may wish to increase the number of staff members if the child requires significant special assistance.

COMMENTS: These ratios do not include personnel who have other duties that might preclude their involvement in needed supervision while they are performing those duties, such as cooks, maintenance workers, or bus drivers.

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

QUALIFICATIONS AND TRAINING OF TRANSPORTATION STAFF

STANDARD 1.018 QUALIFICATIONS FOR ASSOCIATE TEACHERS, ASSISTANT TEACHERS, AIDES, AND VOLUNTEERS

Associate teachers shall be at least 18 years of age and shall have an Associate's degree in early childhood education or child development, and 6 or more months' of experience in child care.

Assistant teachers shall be at least 18 years of age, have a high school diploma or GED, and participate in on-the-job training, including a structured orientation to the developmental needs of young children and access to consultation, with periodic review, by a supervisory staff member.

Aides and volunteers shall be at least 16 years of age and shall participate in on-the-job training, including a structured orientation to the developmental needs of young children. Aides and volunteers shall not be counted in the child:staff ratio and shall work only under the continual supervision of qualified staff.

Any driver who transports children for a child care program shall be at least 21 years of age.

All associate teachers, assistant teachers, aides, **drivers**, and volunteers shall possess:

- The ability to carry out assigned tasks competently under the supervision of another staff member;
- An understanding of and the ability to respond appropriately to children's needs;
- Sound judgement;
- Emotional maturity.

RATIONALE: While volunteers and students can be as young as 16, age 18 is the earliest age of legal consent. Mature leadership is clearly preferable. Age 21 allows for the maturity necessary to meet the responsibilities of managing a center or independently caring for a group of children who are not one's own.

Child care that promotes healthy development is based on the developmental needs of infants, toddlers, and preschool children. Caregivers are chosen for their knowledge of, and ability to respond appropriately to, the general needs of children of this age and the unique characteristics of individual children (2., 7., 9., 10.).

Staff training in child development and/or early childhood education is related to positive outcomes for children (11.). This training enables the staff to provide children with a variety of learning and social experiences appropriate to the age of the child. Everyone providing service to, or interacting with, children in a center contributes to the child's total experience.

Adequate compensation for skilled workers will not be given priority until the skills required are recognized and valued. Caregiving requires skills to promote development and learning by children whose needs and abilities change at a rapid rate.

COMMENTS: Experience and qualifications used by the Child Development Associate (CDA) program and the National Child Care Association credentialing program (NCCA) and included in degree programs with field placement are valued above didactic teaching alone. Early childhood professional

knowledge must be required whether programs are in private centers, public schools, or other settings.

The National Association for the Education of Young Children's (NAEYC) National Academy of Early Childhood Programs has established a table of qualifications for accredited programs (6.).

Caregivers who lack educational qualifications may be employed as continuously supervised personnel while they acquire the necessary educational qualifications if they have personal characteristics, experience, and skills in working with parents and children, and the potential for development on the job or in a training program.

TYPE OF FACILITY: *Center; Large 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 (12.).

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 2.030 QUALIFICATIONS FOR DRIVERS

Any driver who transports children for a child care program shall be at least 21 years of age and shall have:

- a) A valid driver's license that authorizes the driver to operate the vehicle being driven;
- b) Evidence of a safe driving record for more than five years, with no crashes where a citation was issued;
- c) No record of substance abuse or conviction for crimes of violence or child abuse;
- d) No alcohol or other drugs associated with impaired ability to drive within 12 hours prior to transporting children. Drivers shall ensure that any prescription drugs taken will not impair their ability to drive;
- e) No criminal record of crimes against or involving children, child neglect or abuse, or any crime of violence.

The driver's license number, vehicle insurance information, and verification of current state vehicle inspection shall be on file in the facility.

The center director shall require drug testing when noncompliance with the restriction on the use of alcohol or other drugs is suspected.

RATIONALE: Driving children is a significant responsibility. Child care programs must assure that anyone who drives the children is competent to drive the vehicle being driven.

COMMENTS: The driver should advise the health care provider of his/her job and question whether it is safe to drive children while on medication(s) prescribed. Compliance can be measured by testing blood or urine levels for drugs. Refusal to permit such testing should preclude continued employment.

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

VEHICLE SAFETY RESTRAINTS

STANDARD 2.033 VEHICLE SAFETY RESTRAINTS

When children are driven in a motor vehicle other than a bus, school bus, or a bus operated by a common carrier, the following shall apply:

- A child shall be transported only if the child is fastened in an approved developmentally appropriate safety seat, seat belt, or harness appropriate to the child's weight, and the restraint is installed and used in accordance with the manufacturers' instructions for the car seat and the motor vehicle. Each child must have an individual seat belt and be positioned in the vehicle in accordance with the requirements for the safe use of air bags in the back seat;
- A child under the age of 4 shall be transported only if the child is securely fastened in a developmentally appropriate child passenger restraint system that meets the federal motor vehicle safety standards contained in the Code of Federal Regulations, Title 49, Section 571.213, and this compliance is so indicated on the safety restraint device;
- If small buses or vans have safety restraints installed, children weighing over 40 pounds shall have access to belt-positioning booster seats with lap and shoulder belts. Children weighing under 40 pounds shall use car safety seats;
- Vehicles shall accommodate the placement of wheelchairs with four tie-downs affixed according to the manufactures' instructions in a forward-facing direction. The wheelchair occupant shall be secured by a three-point tie restraint during transport.

RATIONALE: Safety restraints are effective in reducing death and injury when they are used properly. The best car safety seat is one that fits in the vehicle being used, fits the child being transported, has never been in a crash, and is used correctly every time. The use of restraint devices while riding in a vehicle reduces the likelihood of a passenger's suffering serious injury or death if the vehicle is involved in a crash. The use of child safety seats reduces risk of

death by 71% for children less than 1 year of age and by 54% for children ages 1-4 (13.).

It is reasonable to require that the license holder ensure that the child be placed in restraint devices that conform to state and federal laws. The standard does not apply when children are being transported in vehicles not routinely or commonly equipped with restraints. The standard, however, does clarify that it is the responsibility of the caregiver to ensure that children are fastened in a restraint system. Federal law applies only to vehicles equipped with factory-installed seat belts after 1967.

The provision of mandatory restraints, regardless of the driver or age of the vehicle, is necessary to ensure children's health and safety. The use of safety restraints and choice of positioning in the vehicle is determined by close inspection of the manufacturer's instructions for seat restraints and for the vehicle.

At all times, vehicles should be ready to transport children who must ride in wheelchairs (14., 15.). Manufacturers' specifications should be followed to assure that safety requirements are met.

COMMENTS: When school buses meet current standards for the transport of school-age children, containment design features help protect children from injury, although the use of seat belts would provide additional protection. To obtain the Code of Federal Regulations, contact the Superintendent of Documents. Contact information is located in Appendix BB.

Many issues are involved in fitting the wide variety of safety restraints into the many different types of motor vehicles. Positioning children in relation to air bags in the vehicle adds a further complication. If the instructions for the safety restraint and for the motor vehicle do not make clear what should be done, contact the National Highway and Transportation Safety Administration (NHTSA) Auto Safety Hotline for more information. Contact information is located in Appendix BB.

Parents and others who transport young children should be aware that incompatibility problems between the design of the car safety seat, vehicle seat,

and the seat belt system can be life-threatening and can be avoided by:

- Reading the vehicle owner's manual and child restraint device instructions carefully;
- Testing the car safety seat for a safe snug fit in the vehicle;
- Having the car seat installation checked by a certified car seat technician at an approved car seat check station in the community;
- Remembering that the rear vehicle seat is the safest place for a child of any age to ride.

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

STANDARD 5.236 VEHICLE CHILD RESTRAINT SYSTEMS

Age and size appropriate vehicle child restraint systems shall be used for children under 80 pounds and 4 feet 9 inches. Vehicle child restraint systems shall be secured in back seats only. Infants shall ride facing the back of the car until they have reached one year of age and weigh at least 20 pounds. A booster child safety seat shall be used when the child has outgrown a convertible child safety seat but is too small to fit properly in a vehicle safety belt.

All children, who weigh at least 80 pounds and are at least 4 feet 9 inches in height, shall wear seatbelts.

RATIONALE: Motor vehicle crashes are the leading cause of death of children in the United States (16). Children who are not buckled are 11 times more likely to die in a motor vehicle crash than children who are buckled (17).

The safest place for all infants and children under 12 years of age to ride is in the back seat. Head-on crashes cause the greatest number of serious injuries. A child sitting in the back seat is farthest away from the impact and less likely to be injured or killed. Additionally, many newer cars have air bags in the front seats. Air bags inflate at speeds up to 200 mph and can injure small children who may be sitting too

close to the air bag or who are positioned incorrectly in the seat. A rapidly inflating air bag can hit the back of an infant seat behind a baby's head and cause severe injury or death.

Infants under 1 year of age have less rigid bones in the neck. If placed in a child safety seat facing forward, a collision could snap the infant's head forward, causing neck and spinal cord injuries. If placed in a child safety seat facing to the rear of the car, the force of a collision is spread across the infant's entire body. The rigidity of the bones in the neck, in combination with the connecting ligaments determine whether the spinal cord will remain intact in the vertebral column. Based on physiologic measures, immature and incompletely ossified bones will separate more easily than more mature vertebrae, leaving the spinal cord as the last link between the head and the torso (18). At 12 months of age, more moderate consequences seem to occur than before 12 months of age (19). Rearward positioning that spreads deceleration forces over the largest possible area is an advantage at any age.

The National Highway Transportation Safety Administration (NHTSA) recommends that children should be in booster child safety seats until they weigh at least 80 pounds and have reached the height of 4 feet 9 inches (20). When the vehicle safety belt fits properly, the lap belt lies low and tight across the child's hips (not the abdomen) and the shoulder belt lies flat across the shoulder, away from the neck and face.

COMMENTS: Seat restraint systems are often installed in cars incorrectly (21). Some police departments and car dealerships offer free inspections to ensure that child safety seats are installed correctly. For more information on vehicle child restraint systems, see STANDARD 2.033.

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

EMERGENCY TRANSPORTATION

STANDARD 2.03 I ROUTE TO EMERGENCY MEDICAL FACILITY

Any driver who transports children for a child care program shall keep instructions for the quickest route to the nearest hospital from any point on the route in the vehicle.

RATIONALE: Driving children is a significant responsibility. Child care programs must assure that anyone who transports children can obtain emergency care promptly.

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

STANDARD 3.048 EMERGENCY PROCEDURES

When an immediate response is required, the following emergency procedures shall be utilized:

- a) First aid shall be employed, and the emergency medical response team shall be called, as indicated;
- b) The facility shall implement a plan for emergency transportation to a local hospital or health care facility;
- c) The parent or parent's emergency contact person shall be called as soon as practical;
- d) A staff member shall accompany the child to the hospital and will stay with the child until the parent or emergency contact person arrives.

RATIONALE: The staff must know the plan for dealing with emergency situations when a child requires immediate care and a parent is not available.

COMMENTS: First aid instructions are provided by the American Academy of Pediatrics (AAP). 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 3.049 WRITTEN PLAN FOR MEDICAL EMERGENCY

Facilities shall have a written plan for immediate management and rapid access to medical care as appropriate to the situation. This plan shall:

- a) Describe for each child any special emergency procedures that will be used, if required, by the caregiver or by a physician or registered nurse available to the caregiver;
- b) Note any special medical procedures, if required by the child's condition, that will be used or might be required for the child while he/she is in the facility's care, including the possibility of a need for cardiac resuscitation;
- c) Include in a separate format, any information to be given to an emergency responder in the event that one must be called to the facility for the child. This information shall include:
 - 1) Any special information needed by the emergency responder to respond appropriately to the child's condition;
 - 2) A listing of the child's health care providers in the event of an emergency.

RATIONALE: The medical aspect of caring for children is likely to be the facet of care that caregivers are most poorly equipped to carry out, as their training is usually in early childhood education. The preparation of a written plan (a brief one would suffice) provides an opportunity for caregivers to work out how to deal with routine, urgent, and emergency medical needs.

Children with special needs may need an emergency responder whether it is for an asthma emergency, a cardiac emergency, or any of a number of conditions that put children at risk for emergency response and transport. An individual child's written plan for the first responders will save time and may be critical in the provision of appropriate care of a child in crisis.

COMMENTS: Training and other technical assistance for developing emergency plans can be obtained from the following:

- a) American Academy of Pediatrics (AAP);
- b) American Nurses' Association (ANA);
- c) State and community nursing associations;
- d) National therapy associations;
- e) Local resource and referral agencies;
- f) Federally funded, University Centers for Excellence in Developmental Disabilities Education, Research, and Service, programs for individuals with developmental disabilities;
- g) Other colleges and universities with expertise in training others to work with children who have special needs;
- h) Community-based organizations serving people with disabilities (Easter Seals, American Diabetes Association, American Lung Association, etc.);
- i) Community sources of training in infant/child CPR (American Heart Association, American Red Cross, Emergency Medical Services for Children National Resource Center).

The State-designated lead agency responsible for implementing IDEA may provide additional help.

For additional information regarding emergency plans, see STANDARD 8.022 and STANDARD 8.023. For additional discussion about first aid and CPR, see STANDARD 1.026.

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*

TRANSPORTATION PROCEDURES

STANDARD 2.031 ROUTE TO EMERGENCY MEDICAL FACILITY

Any driver who transports children for a child care program shall keep instructions for the quickest route to the nearest hospital from any point on the route in the vehicle.

RATIONALE: Driving children is a significant responsibility. Child care programs must assure that anyone who transports children can obtain emergency care promptly.

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

STANDARD 2.032 DROP-OFF AND PICK-UP POINTS

The facility shall have, and communicate to staff and parents, a plan for safe, supervised drop-off and pick-up points and pedestrian crosswalks in the vicinity of the facility. The plan shall require drop-off and pick-up only at the curb or at an off-street location protected from traffic. The facility shall assure that any adult who supervises drop-off and loading can see and assure that children are clear of the perimeter of all vehicles before any vehicle moves.

RATIONALE: Injuries and fatalities have occurred during the loading and unloading process, especially in situations where vans or school buses are used to transport children.

COMMENTS: The child care provider should examine the parking area and determine the safest way to drop off and pick up children. Plans for loading and unloading should be discussed with the children, families, caregivers, and drivers.

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

STANDARD 2.034 TRAVEL TIME

Children shall not be transported for more than 1 hour per one-way trip on a routine basis.

RATIONALE: It is unreasonable to expect young children to remain confined and seated in a transportation device for a period exceeding 1 hour. Commuting is tiring in general, and particularly difficult if the child spends many hours in child care. The time period may need to be lessened for infants or children with special health needs.

Exceptions for a special field trip may be allowed, but these exceptions should occur infrequently and allow for rest and stretch stops during the trip.

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

STANDARD 2.035 NO SMOKING IN VEHICLES

There shall be no smoking in the vehicles used by the facility at any time.

In each vehicle from a center, a "NO SMOKING" sign shall be posted.

RATIONALE: Children in confined spaces, e.g., closed vehicles, should not be exposed to secondhand

smoke, particularly children with respiratory problems. Exposure to smoke and smoke fumes could trigger increased respiratory difficulties.

COMMENTS: Compliance can be measured by interviewing drivers and inspecting vehicles for evidence of smoking.

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

STANDARD 2.036 DISTRACTIONS WHILE DRIVING

The driver shall not play the radio or CD player loudly or use ear phones to listen to music or other distracting sounds while children are in the vehicles operated by the facility. Cellular phones shall be used only when the vehicle is stopped and in emergency situations only.

In each vehicle from a center, a sign shall be posted stating "NO LOUD RADIOS, TAPES, OR CDS".

RATIONALE: Loud noise interferes with normal conversation and may be especially disturbing to children with central nervous system abnormalities. It is also distracting to the driver and the passenger monitor or assistant attending the children in the vehicle.

COMMENTS: A driver's use of a portable radio, tape, or CD player with earphones is unacceptable.

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

STANDARD 2.037 CHILD BEHAVIOR DURING TRANSPORTATION

Children, as both passengers and pedestrians, shall be instructed in safe transportation behavior with terms and concepts appropriate for their age and stage of development.

RATIONALE: Teaching passenger safety to children reduces injury from motor vehicle crashes to young children (22.). Young children need to develop skills that will aid them in assuming responsibility for their own health and safety, and these skills can be developed through health education implemented during the early years (23., 24.).

COMMENTS: Curricula and materials can be obtained from state departments of transportation, the American Automobile Association (AAA), the American Academy of Pediatrics (AAP), the American Red Cross, and the National Association for the Education of Young Children (NAEYC). Contact information is located in Appendix BB.

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

STANDARD 2.038 EMERGENCY SUPPLIES FOR FIELD TRIPS

First aid kits shall be taken on field trips, as specified in STANDARD 5.093. Cellular phones shall be taken on field trips for use in emergency situations.

RATIONALE: The ability to communicate for help in an emergency situation while traveling is critical to the safety of children in a vehicle.

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 (29). 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 5.235 VEHICLE LICENSE

A caregiver who provides transportation for children or contracts to provide transportation, shall license the vehicle according to the laws of the state.

RATIONALE: For the children's safety, caregivers must comply with minimum requirements governing the transportation of children in their care, in the absence of a parent.

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

STANDARD 5.238 INTERIOR TEMPERATURE OF VEHICLES

The interior of vehicles used to transport children shall be maintained at a comfortable temperature to children. When the vehicle's interior temperature exceeds 82 degrees F and providing fresh air through open windows cannot reduce the temperature, the vehicle shall be air-conditioned. When the interior temperature drops below 65 degrees F and when children are feeling uncomfortably cold, the interior shall be heated.

RATIONALE: Some children have problems with temperature variations. Whenever possible, open windows to provide fresh air to cool a hot interior is preferable before using air conditioning. Over-use of air conditioning can increase problems with respiratory infections and allergies. Excessively high temperatures in vehicles can cause neurological damage in children (25).

COMMENTS: In geographical areas that are prone to very cold or very hot weather, a small thermometer should be kept inside the vehicle. In areas that are very cold, adults tend to wear very warm clothing and children tend to wear less clothing than might actually

be required. Adults in a vehicle, then, may be comfortable while the children are not. When air conditioning is used, adults might find the cool air comfortable, but the children may find that the cool air is uncomfortably cold. To determine whether the interior of the vehicle is providing a comfortable temperature to children, a thermometer should be used and children in the vehicle should be asked if they are comfortable.

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

STANDARD 5.239 BACKUP VEHICLES

When vehicles are transporting children, a backup vehicle shall always be available and shall be dispatched immediately in case of emergency. Documentation of these arrangements shall be included in the facility's written transportation plan.

RATIONALE: Children cannot be left sitting in a disabled vehicle. A backup vehicle must be dispatched and the children transferred immediately.

COMMENTS: Transportation contracts are best arranged with this provision. See also STANDARD 8.031, for information on a written plan. See STANDARD 2.029, for procedures to assure that children are counted when transported.

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

STANDARD 5.240 PREVENTIVE MAINTENANCE OF VEHICLES

A caregiver shall assure that preventive maintenance of the vehicle is carried out according to the manufacturer's specifications. Vehicles the facility operates shall be cleaned and inspected inside and out at least weekly.

RATIONALE: Weekly cleaning and inspection help to ensure that the vehicle will be kept free of visible accumulation of soil and litter inside and that signs, lights, tires, and other safety features of the vehicle, such as coolant, brake fluid, oil are checked and operating effectively.

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

TRANSPORTATION 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 8.031 TRANSPORTATION POLICY FOR CENTERS

Written policies shall address the safe transport of children by vehicle to or from the facility, including on field trips, home pick-ups and deliveries, and special outings. The transportation policy shall include:

- a) Licensing of vehicles and drivers
- b) Operation and maintenance of vehicles. See Vehicles, STANDARD 5.235 through STANDARD 5.240;
- c) Driver selection, training, and supervision. See Qualifications of Drivers, STANDARD 2.030;
- d) Child:staff ratio during transport. See STANDARD 1.004;
- e) Permitted and prohibited activities during transport;
- f) Backup arrangements for emergencies;
- g) Seat belt and car seat use. STANDARD 2.033;
- h) Drop-off and pick-up plans. See STANDARD 2.032.

RATIONALE: Motor vehicle crashes are the leading cause of death in the United States (26). Therefore, it is necessary for the safety of children to require that the caregiver comply with requirements governing the transportation of children in care, in the absence of the parent.

COMMENTS: Maintenance should include an inspection checklist for every trip. Vehicle maintenance service should be performed according to the manufacturer's recommendations or at least every 3 months.

TYPE OF FACILITY: *Center*

STANDARD 8.032 TRANSPORTATION POLICY FOR HOMES

Written policies shall address the safe transport of children by vehicle to and from the small or large family child care home for any reason, including field trips or special outings. The following shall be provided for:

- a) Child:staff ratio during transport;
- b) Backup arrangements for emergencies;
- c) Seat belt and car seat use;
- d) Licensing of vehicles and drivers;
- e) Maintenance of the vehicles;
- f) Safe use of air bags.

RATIONALE: Motor vehicle crashes are the leading cause of death in the United States (26). Therefore, it is necessary for the safety of children to require that the caregiver comply with minimum requirements governing the transportation of children in care, in the absence of the parent.

COMMENTS: For information on child:staff ratio during transport, see STANDARD 1.004. For information on seat belt and car seat use, see STANDARD 2.033.

TYPE OF FACILITY: *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*

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 (27). 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 (28).

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*

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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 Automobile Association (AAA)

1000 AAA Dr.
Heathrow, FL 32746
Phone: 407-444-4240
Fax: 407-444-4247
<http://www.aaa.com>

American Public Health Association (APHA)

800 I Street N.W.,
Washington, DC 20001-3710
Phone: 202-777-APHA(2742)
Fax: 202-777-2534
<http://www.apha.org>
E-mail: comments@apha.org

American Red Cross (ARC)

4333 Arlington Blvd.
Arlington, VA 22203-2904
Phone: 703-527-3010
Fax: 703-527-2705
<http://www.redcross.org>

Early Childhood Education Linkage System (ECELS)

Healthy Child Care America Pennsylvania
Pennsylvania Chapter, American Academy of Pediatrics
Rosemont Business Campus
Building 2, Suite 307
919 Conestoga Road
Rosemont, PA 19010
Phone: 610-520-3662
<http://www.paaap.org>

Emergency Medical Services for Children National Resource Center

111 Michigan Avenue, N.W.
Washington, DC 20010-2970
Phone: 202-884-4927
Fax: 202-884-6845
<http://www.ems-c.org>

Head Start Bureau

Head Start Information and Publication Center
1133 15th Street, NW, S
Suite 450
Washington, DC 20005
Phone: 1-866-763-6481
Fax: 202-737-1151
<http://www.headstartinfo.org>

The Healthy Child Care America Campaign

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

Maternal and Child Health Bureau (MCHB)

MCHB Region I

Room 1826
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Boston MA 02203
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Fax: 617-565-3044
States - CT, ME, MA, NH, RI, VT

MCHB Region II

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States - NJ, NY, PR, VI

MCHB Region III

Health Resources, Northeast Cluster
Public Ledger Building
150 S. Independence Mall West
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States - DE, DC, MD, PA, VA, WV

MCHB Region IV

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MCHB Region V

105 W. Adams Street, 17th Floor
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States - IL, IN, MI, MN, OH, WI

Please note contact information may change. Check <http://nrc.uchsc.edu> for updates.

Contact Information

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1301 Young Street, 10th Floor, HRSA-4
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MCHB Region VII

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States - IA, KS, MO, NE

MCHB Region VIII

Federal Office Building, Room 409
1961 Stout Street
Denver, CO 80294
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States - CO, MT, ND, SD, UT, WY

MCHB Region IX

Federal Office Building, Room 317
50 United Nations Plaza
San Francisco, CA 94102
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Fax: 415-437-8105
States - AZ, CA, HI, NV, AS, FM, GU, MH, MP, PW

MCHB Region X

Mail Stop RX-23
2201 Sixth Avenue, Room 700,
Seattle, WA 98121
Phone: 206-615-2518
Fax: 206-615-2500
<http://www.mchb.hrsa.gov>
States - AK, ID, OR, WA

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 Family Child Care

5202 Pinemont Drive
Salt Lake City, Utah 84123
Phone: 801-269-9338
Fax: 801-268-9507
Email: nafcc@nafcc.org
<http://www.nafcc.org>

National Child Care Association (NCCA)

1016 Rosser Street
Conyers, GA 30012
Phone: 1-800-543-7161
Fax: 770-388-7772
<http://www.nccanet.org>

National Highway and Transportation Safety Administration (NHTSA)

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States - CT, ME, MA, NH, RI, VT

NHTSA Region II

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