Caring for Infants and Toddlers in Early Care and Education

Applicable Standards from:

Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd Edition

A Joint Collaborative Project of

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Support for this project was provided by the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services (Cooperative Agreement #U46MC09810)
# TABLE OF CONTENTS

**Introduction** .................................................................................................................................................. vii

**I. Enrollment and Admission** ........................................................................................................................... 1

1.1.2.1 Minimum Age to Enter Child Care .............................................................................................................. 1

9.2.1.3 Enrollment Information to Parents/Guardians and Caregivers/Teachers .................................................. 1

9.4.2.3 Contents of Admission Agreement Between Child Care Program and Parent/Guardian .......................... 2

**II. Staffing, Consultants, and Supervision** ...................................................................................................... 3

A. **Staff Qualifications and Training** .................................................................................................................. 3

1.2.0.2 Background Screening .................................................................................................................................. 3

1.3.1.1* General Qualifications for Directors ........................................................................................................... 3

1.3.2.2* Qualifications of Lead Teachers and Teachers ............................................................................................. 4

1.3.2.3 Qualifications for Assistant Teachers, Teacher Aides, and Volunteers ......................................................... 4

1.3.2.4 Additional Qualifications for Caregivers/Teachers Serving Children Three to Thirty-Five Months of Age ...... 4

1.3.2.7 Qualifications and Responsibilities of Health Advocates ............................................................................ 5

1.3.3.1* General Qualifications of Family Child Care Caregivers/Teachers to Operate a Family Child Care Home ...... 6

1.4.1.1* Pre-service Training .................................................................................................................................... 6

1.4.2.2* Orientation for Care of Children with Special Health Care Needs ............................................................ 7

1.4.2.3* Orientation Topics ....................................................................................................................................... 8

1.4.3.1* First Aid and CPR Training for Staff ............................................................................................................ 8

1.4.5.2* Child Abuse and Neglect Education ........................................................................................................... 8

1.5.0.2* Orientation of Substitutes .......................................................................................................................... 9

7.4.0.2 Staff Education and Policies on Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections ......................... 9

7.7.1.1 Staff Education and Policies on Cytomegalovirus (CMV) ........................................................................ 10

B. **Consultants** .................................................................................................................................................. 10

1.6.0.1* Child Care Health Consultants ................................................................................................................ 10

1.6.0.2 Frequency of Child Care Health Consultation Visits ..................................................................................... 11

1.6.0.3 Early Childhood Mental Health Consultants .............................................................................................. 12

1.6.0.4 Early Childhood Education Consultants .................................................................................................... 12

C. **Supervision** .................................................................................................................................................. 13

1.1.1.1* Ratios for Small Family Child Care Homes ................................................................................................. 13

1.1.1.2* Ratios for Large Family Child Care Homes and Centers ............................................................................. 13

1.1.1.3* Ratios for Facilities Serving Children with Special Health Care Needs and Disabilities ........................ 14

1.1.1.4* Ratios and Supervision During Transportation .......................................................................................... 14

1.1.1.5* Ratios and Supervision for Swimming, Wading, and Water Play ................................................................ 15

2.2.0.1* Methods of Supervision of Children ........................................................................................................ 15

2.2.0.4* Supervision Near Bodies of Water ............................................................................................................ 15

4.5.0.6* Adult Supervision of Children Who Are Learning to Feed Themselves ...................................................... 16

**III. Environment and Equipment** .................................................................................................................. 17

A. **Building and Environment: Inside and Outside** ............................................................................................ 17

5.1.1.5* Environmental Audit of Site Location ......................................................................................................... 17

5.1.1.7 Use of Basements and Below Grade Areas .................................................................................................. 17

5.1.1.12 Multiple Use of Rooms ............................................................................................................................... 17

5.1.2.1* Space Required Per Child .......................................................................................................................... 17

5.1.3.2* Possibility of Exit From Windows ............................................................................................................... 17

5.2.1.1* Fresh Air ..................................................................................................................................................... 18

5.2.1.2 Indoor Temperature ...................................................................................................................................... 18

5.2.1.6 Ventilation to Control Odors ........................................................................................................................ 18

---

*Caring for Infants and Toddlers in Child Care and Early Education

*Standard included in Stepping Stones, 3rd Ed.
### Table of Contents

5.2.1.11* Portable Electric Space Heater ................................................................. 18
5.2.6.2 Testing of Drinking Water Not From Public System ........................................ 18
5.2.6.3* Testing for Lead and Copper Levels in Drinking Water .................................. 18
5.2.8.1* Integrated Pest Management .......................................................................... 18
5.2.9.4* Radon Concentrations .................................................................................. 19
5.2.9.10 Prohibition of Poisonous Plants ...................................................................... 19
5.2.9.13* Testing for Lead .......................................................................................... 19
5.2.9.14 Shoes in Infant Play Areas .............................................................................. 20
5.4.1.1 General Requirements for Toilet and Handwashing Areas .............................. 20
5.4.1.4 Preventing Entry to Toilet Rooms by Infants and Toddlers .............................. 20
6.1.0.1 Size and Location of Outdoor Play Area .......................................................... 20
6.1.0.2 Size and Requirements of Indoor Play Area ...................................................... 20
6.1.0.4 Elevated Play Areas .......................................................................................... 21
6.3.1.1* Enclosures of Bodies of Water ...................................................................... 21

### B. Equipment, Materials, and Toys ......................................................................... 21

#### Facility ......................................................................................................................... 21

3.4.6.1* Strangulation Hazards ..................................................................................... 21
5.1.5.4* Guards at Stairway Access Openings ............................................................... 22
5.1.6.6* Guardrails and Protective Barriers .................................................................. 22
5.2.4.2* Safety Covers and Shock Protection Devices for Electrical Outlets .............. 22
5.2.5.1* Smoke Detection Systems and Smoke Alarms ............................................... 22
5.2.9.1* Use and Storage of Toxic Substances ............................................................. 23
5.2.9.5* Carbon Monoxide Detectors .......................................................................... 23
5.2.9.6 Preventing Exposure to Asbestos or Other Friable Materials ......................... 23
5.3.1.1* Safety of Equipment, Materials, and Furnishings .......................................... 24
5.3.1.3 Size of Furniture .............................................................................................. 24
5.3.1.4 Surfaces of Equipment, Furniture, Toys, and Play Materials .......................... 24
5.3.1.7 Facility Arrangements to Minimize Back Injuries .............................................. 24
5.4.1.6 Ratios of Toilets, Urinals, and Hand Sinks to Children .................................... 24
5.4.1.7 Toilet Learning/Training Equipment ................................................................. 25
5.4.2.1 Diaper Changing Tables .................................................................................. 25
5.4.2.4 Use, Location, and Setup of Diaper Changing Areas ...................................... 25
5.4.2.5 Changing Table Requirements ......................................................................... 26
5.4.1.10 Handwashing Sinks ....................................................................................... 26
5.4.1.11 Prohibited Uses of Handwashing Sinks ......................................................... 26
5.4.2.2 Handwashing Sinks for Diaper Changing Areas in Centers ........................... 26
5.4.2.3 Handwashing Sinks for Diaper Changing Areas in Homes ................................ 26
5.4.5.1 Sleeping Equipment and Supplies .................................................................. 26
5.4.5.2* Cribs ............................................................................................................... 27
5.4.5.3 Stackable Cribs ............................................................................................... 28
5.4.5.4 Futons .............................................................................................................. 28
5.5.0.7* Storage of Plastic Bags .................................................................................. 28
5.5.0.8* Firearms ......................................................................................................... 28
6.3.3.4 Pool Water Temperature .................................................................................. 28
6.3.5.1* Hot Tubs, Spas, and Saunas ........................................................................... 28
6.3.5.2* Water in Containers ...................................................................................... 28
6.4.1.5* Balloons ........................................................................................................ 29
6.5.2.2* Child Passenger Safety ................................................................................ 29
6.5.2.4* Interior Temperature of Vehicles .................................................................. 29

**Appendix X** Adaptive Equipment for Children with Special Health Care Needs .......................... 30

*Standard included in Stepping Stones, 3rd Ed*  
Caring for Infants and Toddlers in Child Care and Early Education
### Food Preparation and Feeding Area

- 4.5.0.2 Tableware and Feeding Utensils ................................................................................................. 30
- 4.8.0.1* Food Preparation Area .................................................................................................................. 30
- 4.8.0.8 Microwave Ovens .......................................................................................................................... 30
- 5.3.1.8 High Chair Requirements .............................................................................................................. 31

### Play Areas

- 5.2.9.7 Proper Use of Art and Craft Materials.......................................................................................... 31
- 5.3.1.9 Carriage, Stroller, Gate Enclosure, and Play Yard Requirements ...................................................... 31
- 6.2.1.1 Play Equipment Requirements ....................................................................................................... 31
- 6.2.1.7 Enclosure of Moving Parts on Play Equipment ................................................................................ 32
- 6.2.1.9* Entrapment Hazards on Play Equipment ...................................................................................... 32
- 6.2.4.3 Sensory Table Materials ................................................................................................................ 32
- 6.4.1.2* Inaccessibility of Toys or Objects to Children Under Three Years of Age .................................... 32
- 6.4.1.3 Crib Toys .......................................................................................................................................... 33
- 6.4.2.1 Riding Toys with Wheels and Wheeled Equipment ...................................................................... 33
- 6.4.2.2* Helmets .......................................................................................................................................... 33

### Appendix II

- Bike Helmets: Quick Fit-Check .................................................................................................................. 33

### IV. Program Activities for Healthy Development

#### A. Developmentally Appropriate Practice

- 2.1.1.4* Monitoring Children’s Development/Obtaining Consent for Screening ....................................... 34
- 2.1.1.5 Helping Families Cope with Separation ......................................................................................... 34
- 2.1.1.6 Transitions within Programs and Indoor and Outdoor Learning/Play Environments ................. 35
- 2.1.1.7 Communication in Native Language Other Than English ......................................................... 36
- 2.1.1.9 Verbal Interaction .......................................................................................................................... 36
- 2.1.2.1* Personal Caregiver/Teacher Relationships for Infants and Toddlers ........................................ 36
- 2.1.2.2 Interactions with Infants and Toddlers .......................................................................................... 36
- 2.1.2.3 Space and Activity to Support Learning of Infants and Toddlers .................................................. 36
- 2.1.2.4 Separation of Infants and Toddlers from Older Children ............................................................ 37
- 2.1.2.5 Toilet Learning/Training ................................................................................................................ 37
- 2.2.0.2 Limiting Infant/Toddler time in Crib, High Chair, Care Seat, Etc.................................................. 38
- 2.2.0.3 Limiting Screen Time – Media, Computer Time ............................................................................ 38
- 2.2.0.5 Behavior Around a Pool ................................................................................................................ 38
- 2.3.1.1 Mutual Responsibility of Parents/Guardians and Staff .................................................................. 38
- 3.1.4.4 Scheduled Rest Periods and Sleep Arrangements ....................................................................... 39
- 5.3.1.10 Restrictive Infant Equipment Requirements .............................................................................. 39
- 9.2.1.1 Content of Policies ....................................................................................................................... 39
- 9.2.2.1 Planning for the Child’s Transition to New Services .................................................................. 40

#### B. Positive Behavior Management

- 2.2.0.6* Discipline Measures .................................................................................................................... 40
- 2.2.0.7 Handling Physical Aggression, Biting and Hitting ...................................................................... 41
- 2.2.0.8* Preventing Expulsions, Suspensions, and Other Limitations in Services ............................... 42
- 2.2.0.9* Prohibited Caregiver/Teacher Behaviors .................................................................................. 43
- 2.2.0.10* Using Physical Restraint ........................................................................................................ 43
- 4.5.0.11 Prohibited Uses of Food ............................................................................................................. 44
- 9.2.1.6 Written Discipline Policies ......................................................................................................... 44
## V. Healthy Weight Promotion

### A. Physical Activity

- **3.1.3.1** Active Opportunities for Physical Activity ................................................................. 45
- **3.1.3.2** Playing Outdoors ............................................................................................................ 45
- **9.2.3.1** Policies and Practices that Promote Physical Activity ............................................... 46

### B. Nutrition

- **4.2.0.2** Assessment and Planning of Nutrition for Individual Children .................................... 46
- **4.2.0.3** Use of USDA – CACFP Guidelines ............................................................................... 47
- **4.2.0.4** Categories of Foods ....................................................................................................... 48
- **4.2.0.5** Meal and Snack Patterns ................................................................................................ 49
- **4.2.0.6** Availability of Drinking Water ......................................................................................... 49
- **4.2.0.7** 100% Fruit Juice ............................................................................................................... 49
- **4.2.0.8** Feeding Plans and Dietary Modifications ........................................................................ 49
- **4.2.0.9** Written Menus and Introduction of New Foods ................................................................. 50
- **4.2.0.12** Vegetarian/Vegan Diets ............................................................................................... 50
- **4.3.1.1** General Plan for Feeding Infants ..................................................................................... 51
- **4.3.1.2** Feeding Infants on Cue by A Consistent Caregiver/Teacher ............................................ 51
- **4.3.1.3** Use of Soy-Based Formula and Soy Milk ....................................................................... 51
- **4.3.1.4** Feeding Cow’s Milk ........................................................................................................ 51
- **4.3.1.5** Technique for Bottle Feeding .......................................................................................... 51
- **4.3.1.11** Introduction of Age-Appropriate Solid Foods to Infants ............................................... 52
- **4.3.1.12** Feeding Age-Appropriate Solid Foods to Toddlers ....................................................... 52
- **4.3.2.1** Meal and Snack Patterns for Toddlers and Preschoolers ............................................... 52
- **4.3.2.2** Serving Size for Toddlers and Preschoolers .................................................................... 52
- **4.3.2.3** Encouraging Self-Feeding by Older Infants and Toddlers ............................................ 52
- **4.5.0.1** Developmentally Appropriate Seating and Utensils for Meals ...................................... 53
- **4.5.0.4** Socialization During Meals ............................................................................................. 53
- **4.5.0.5** Experience with Familiar and New Foods ...................................................................... 53
- **4.7.0.1** Nutritional Learning Experiences for Children ................................................................. 53
- **9.2.3.11** Food and Nutrition Service Policies and Plans ............................................................... 53
- **9.2.3.12** Infant Feeding Policy ................................................................................................... 54

### Appendix JJ

- Our Child Care Center Supports Breastfeeding ........................................................................... 54

## VI. Safe and Healthy Practices and Procedures

### A. Safe Food Practices

- **4.3.1.3** Preparing, Feeding and Storing Human Milk ................................................................. 55
- **4.3.1.4** Feeding Human Milk to Another Mother’s Child ............................................................ 56
- **4.3.1.5** Preparing, Feeding and Storing Infant Formula ............................................................. 57
- **4.3.1.6** Warming Bottles and Infant Foods .................................................................................. 58
- **4.5.0.3** Activities that Are Incompatible with Eating ................................................................. 58
- **4.5.0.5** Numbers of Children Fed Simultaneously by One Adult ................................................ 58
- **4.5.0.9** Hot Liquids and Foods ................................................................................................... 58
- **4.5.0.10** Foods that Are Choking Hazards .................................................................................. 58
- **4.8.0.4** Food Preparation Sinks ................................................................................................. 59
- **4.9.0.2** Staff Restricted from Food Preparation and Handling ................................................... 59
- **4.9.0.3** Precautions for a Safe Food Supply ................................................................................ 59
- **5.2.9.9** Plastic Containers and Toys ............................................................................................ 60

### B. Health Promotion and Protection

- **3.1.2.1** Routine Health Supervision and Growth Monitoring .................................................. 60
- **3.1.4.1** Safe Sleep Practices and SIDS/Suffocation Risk Reduction ........................................ 60
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.4.2 Swaddling</td>
<td>61</td>
</tr>
<tr>
<td>3.1.4.3 Pacifier Use</td>
<td>61</td>
</tr>
<tr>
<td>3.1.5.1* Routine Oral Hygiene Activities</td>
<td>62</td>
</tr>
<tr>
<td>3.1.5.2 Toothbrushes and Toothpaste</td>
<td>62</td>
</tr>
<tr>
<td>3.2.1.1 Type of Diapers Worn</td>
<td>63</td>
</tr>
<tr>
<td>3.2.1.2 Handling Cloth Diapers</td>
<td>63</td>
</tr>
<tr>
<td>3.2.1.3 Checking for the Need to Change Diapers</td>
<td>63</td>
</tr>
<tr>
<td>3.2.1.4* Diaper Changing Procedure</td>
<td>63</td>
</tr>
<tr>
<td>3.2.1.5 Procedure for Changing Children's Soiled Underwear/Pull-Ups and Clothing</td>
<td>64</td>
</tr>
<tr>
<td>3.2.2.1* Situations that Require Hand Hygiene</td>
<td>66</td>
</tr>
<tr>
<td>3.2.2.2* Handwashing Procedure</td>
<td>66</td>
</tr>
<tr>
<td>3.2.2.3* Assisting Children with Hand Hygiene</td>
<td>67</td>
</tr>
<tr>
<td>3.2.2.5 Hand Sanitizers</td>
<td>67</td>
</tr>
<tr>
<td>3.4.1.1* Use of Tobacco, Alcohol, and Illegal Drugs</td>
<td>67</td>
</tr>
<tr>
<td>3.4.5.1* Sun Safety Including Sunscreen</td>
<td>67</td>
</tr>
<tr>
<td>3.4.5.2 Insect Repellent and Protection from Vector-Borne Diseases</td>
<td>68</td>
</tr>
<tr>
<td>3.5.0.1* Care Plan for children with Special Health Care Needs</td>
<td>69</td>
</tr>
<tr>
<td>3.5.0.2* Caring for Children Who Require Medical Procedures</td>
<td>69</td>
</tr>
<tr>
<td>4.2.0.10* Care for Children with Food Allergies</td>
<td>69</td>
</tr>
<tr>
<td>9.4.1.9 Records of Injury</td>
<td>70</td>
</tr>
<tr>
<td>Appendix O* Care Plan for Children with Special Health Care Needs</td>
<td>71</td>
</tr>
<tr>
<td>C. Cleaning/Sanitizing/Disinfecting Practices</td>
<td>71</td>
</tr>
<tr>
<td>3.2.3.1 Procedures for Nasal Secretions and Use of Nasal Bulb Syringes</td>
<td>71</td>
</tr>
<tr>
<td>3.3.0.1* Routine Cleaning, Sanitizing, and Disinfecting</td>
<td>71</td>
</tr>
<tr>
<td>3.3.0.2 Cleaning and Sanitizing Toys</td>
<td>71</td>
</tr>
<tr>
<td>3.3.0.3 Cleaning and Sanitizing Objects Intended for the Mouth</td>
<td>71</td>
</tr>
<tr>
<td>3.3.0.4 Cleaning Individual Bedding</td>
<td>71</td>
</tr>
<tr>
<td>3.3.0.5 Cleaning Crib Surfaces</td>
<td>72</td>
</tr>
<tr>
<td>4.3.1.10 Cleaning and Sanitizing Equipment Used for Bottle Feeding</td>
<td>72</td>
</tr>
<tr>
<td>5.4.2.6 Maintenance of Changing Tables</td>
<td>72</td>
</tr>
<tr>
<td>9.2.3.10 Sanitation Policies and Procedures</td>
<td>72</td>
</tr>
<tr>
<td>Appendix J* Selecting an Appropriate Sanitizer or Disinfectant</td>
<td>72</td>
</tr>
<tr>
<td>Appendix K* Routine Schedule for Cleaning, Sanitizing and Disinfecting</td>
<td>72</td>
</tr>
<tr>
<td>D. Infection Control/Disease Prevention and Management</td>
<td>72</td>
</tr>
<tr>
<td>3.1.1.1 Conduct of Daily Health Check</td>
<td>72</td>
</tr>
<tr>
<td>3.2.3.4* Prevention of Exposure to Blood and Body Fluids</td>
<td>73</td>
</tr>
<tr>
<td>3.6.1.1* Inclusion/Exclusion/Dismissal of Children</td>
<td>73</td>
</tr>
<tr>
<td>3.6.1.2* Staff Exclusion for Illness</td>
<td>76</td>
</tr>
<tr>
<td>3.6.1.3 Thermometers for Taking Human Temperatures</td>
<td>77</td>
</tr>
<tr>
<td>3.6.1.4 Procedure for Parent/Guardian Notification About Exposure of Children to Infectious Disease</td>
<td>77</td>
</tr>
<tr>
<td>3.6.2 Infectious Diseases that Require Parent/Guardian Notification</td>
<td>77</td>
</tr>
<tr>
<td>3.6.4.4 List of Excludable and Reportable Conditions for Parents</td>
<td>78</td>
</tr>
<tr>
<td>5.2.7.4 Containment of Soiled Diapers</td>
<td>78</td>
</tr>
<tr>
<td>5.2.7.5 Labeling, Cleaning, and Disposal of Waste and Diaper Containers</td>
<td>78</td>
</tr>
<tr>
<td>5.5.0.1 Storage and Labeling of Personal Articles</td>
<td>78</td>
</tr>
<tr>
<td>7.2.0.1 Immunization Documentation</td>
<td>79</td>
</tr>
<tr>
<td>7.2.0.2* Unimmunized Children</td>
<td>79</td>
</tr>
<tr>
<td>7.2.0.3* Immunization of Caregivers/Teachers</td>
<td>79</td>
</tr>
<tr>
<td>7.3.2.1 Immunization for Haemophilus Influenzae Type B (HIB)</td>
<td>80</td>
</tr>
<tr>
<td>7.3.3.1* Influenza Immunizations for Children and Caregivers/Teachers</td>
<td>80</td>
</tr>
</tbody>
</table>

Appendix O* Care Plan for Children with Special Health Care Needs

Caring for Infants and Toddlers in Child Care and Early Education

*Standard included in Stepping Stones, 3rd Ed.
Table of Contents

7.3.5.1 Recommended Control Measures for Invasive Meningococcal Infection in Child Care ......................... 80
7.3.7.3 Exclusion for Pertussis ......................................................................................................................... 80
7.3.8.1 Attendance of Children with Respiratory Syncytial virus (RSV) Respiratory Tract Infection .................. 81
7.3.11.1 Attendance of Children with Unspecified Respiratory Tract Infection ............................................. 81
7.4.0.1 Control of Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections ................................................. 81
7.5.1.1 Conjunctivitis ....................................................................................................................................... 82
7.5.10.1 Staphylococcus Aureus Skin Infections Including MRSA ................................................................. 82
7.7.1.2.3 Thrush ............................................................................................................................................... 83
7.7.2.1 Disease Recognition and Control of Herpes Simplex Virus ............................................................... 83
Appendix G Recommended Immunization Schedule for Persons Aged 0-6 Years (only 1st and 3rd page of Appendix) ... 83
Appendix H* Recommended Adult Immunization Schedule ................................................................................ 83

E. Medication Administration ........................................................................................................................... 83
3.6.3.1 Medication Administration .................................................................................................................. 83
3.6.3.2 Labeling, Storage, and Disposal of Medications .................................................................................. 84
3.6.3.3 Training of Caregivers/Teachers to Administer Medications ............................................................... 84
9.4.2.6 Contents of Medication Record ........................................................................................................... 84
Appendix AA: Medication Administration Packet ............................................................................................. 85

F. Abuse/Neglect .............................................................................................................................................. 85
3.4.4.1 Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation ................................. 85
3.4.4.3 Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma ........................................ 85
3.4.4.4 Facility Layout to Reduce Risk of Child Abuse and Neglect ............................................................. 86
Appendix M Recognizing Child Abuse and Neglect: Signs and Symptoms .................................................... 86

G. Emergency and Disaster Preparedness ......................................................................................................... 86
3.6.4.1 Death .................................................................................................................................................... 86
5.6.0.1 First Aid and Emergency Supplies ........................................................................................................ 86
9.2.4.3 Disaster Planning, Training, and Communication .................................................................................... 87
9.2.4.4 Written Plan for Seasonal and Pandemic Influenza ........................................................................... 89
9.2.4.5 Emergency and Evacuation Drills/Exercises Policy ............................................................................. 90
Appendix P Situations that Require Medical Attention Right Away ................................................................. 91

Quick Reference: Safe Sleep, Handwashing, Diaper Changing and Toileting .............................................. 92

Appendices
Appendix G Recommended Immunization Schedule for Persons Aged 0-6 Years (only 1st and 3rd page of Appendix) ... 93
Appendix H* Recommended Adult Immunization Schedule ................................................................................ 96
Appendix J* Selecting an Appropriate Sanitizer or Disinfectant ....................................................................... 101
Appendix K* Routine Schedule for Cleaning, Sanitizing and Disinfecting ......................................................... 108
Appendix M Recognizing Child Abuse and Neglect: Signs and Symptoms .................................................... 110
Appendix O* Care Plan for Children with Special Health Care Needs ............................................................ 114
Appendix P Situations that Require Medical Attention Right Away ................................................................. 121
Appendix X Adaptive Equipment for Children with Special Health Care Needs ............................................. 122
Appendix AA Medication Administration Packet ............................................................................................ 124
Appendix II Bike Helmets: Quick Fit-Check ....................................................................................................... 129
Appendix JJ Our Child Care Center Supports Breastfeeding ........................................................................... 131

*Standard included in Stepping Stones, 3rd Ed
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(Editor’s Note: All other appendices are located in Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition. http://www.cfoc.nackids.org/)
INTRODUCTION

Caring for Infants and Toddlers in Early Care and Education (I/T) is a collection of 232 nationally recognized health and safety standards applicable to the infant and toddler population in early care and education settings. These materials and the associated 11 Appendices are a subset of materials available in Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd Edition (CFOC3). These materials have been selected for inclusion because they are of particular relevance to the care of the youngest children.

Another important subset of CFOC3 is Stepping Stones, 3rd Edition, which presents the 138 essential CFOC3 standards that, when put into practice, are most likely to prevent various adverse outcomes in early care and education settings. The SS3 standards included in this (I/T) collection are designated with an asterisk (*). These noted standards represent the most critical standards for ensuring a healthy and safe environment for infants and toddlers.

The purpose of this collection is to serve as a goal for programs that care for infants and toddlers. In some cases, additional resources may be needed in order to meet the standard.

The Importance of Health and Safety in the Early Years

Every day millions of children attend early care and education programs, and an increasing number of children are spending longer hours in these programs. It is critical that they have the opportunity to grow and learn in healthy and safe environments with caring and professional caregivers/teachers. Following health and safety best practices is an important way to provide quality early care and education for young children. It is critical that they have the opportunity to grow and learn in healthy and safe environments with caring and professional caregivers/teachers. Following health and safety best practices is an important way to provide quality early care and education for young children (1). Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd Edition (CFOC3)† is a collection of nationally recognized best practice health and safety standards for the early care and education environment.

The first three years of life are a period of rapid growth in all areas of a child’s development (2). These years are the optimal time to provide a foundation for healthy habits as well as identify developmental disabilities or early mental health problems. Early childhood mental health, which can be promoted in child care settings, underlies much of what constitutes school readiness. Establishing healthy eating and exercise habits before kindergarten entry reduces the likelihood of obesity later in life (3). Finally, we know that, infants and toddlers are more vulnerable to a host of environmental hazards, infectious diseases, and injuries when compared to preschool-age children.

Keeping children of all ages healthy and safe in every environment is vital, yet our youngest children are especially vulnerable when being cared for in early care and education settings. Early care and education caregivers/teachers are in a unique position to support, identify possible intervention needs, and nurture the most favorable growth and development of an infant and toddler during this critical time. The developmental effects of child care depend both on the safety of the setting and on the opportunities the setting provides for nurturing and stable relationships (4).

Overview and Organization of Content

Caring for Infants and Toddlers in Early Care and Education (I/T) is a collection of 232 nationally recognized health and safety standards and 11 Appendices from CFOC3 that are applicable to the infant/toddler population in early care and education settings.

- The I/T collection presents the CFOC3 Standard and Type of Facility only, whereas CFOC3 also includes the Rationale for why the standard is important to implement, Comments relevant to implementing the standard, Related Standards, and References. It is essential to review and understand the rationale and comments that support these standards.
- Users can click directly on the hyperlinked standard number and title in this collection to review these additional sections in the CFOC3 database. Users can also find these additional sections in the CFOC3 book and the PDF version of CFOC3. PLEASE NOTE: Since CFOC3 publication (2011), several standards have been updated. The standards in this collection reflect the most current standard language.
- Standards and appendices are organized according to topic areas. For this reason, the 232 standards and 11 Appendices are not necessarily in numerical or alphabetical order as they are presented in CFOC3. However, they are in numerical order within their heading and subheading.
- Most of the standards included in this collection are infant-/toddler-specific. However, some standards (and appendices) that are applicable to all age groups are included because they can have a significant impact on infants and toddlers. For example, Standard 5.2.9.4 Radon Concentrations is included in this collection. This population may be especially vulnerable to the effects of radon gas when left unchecked in an early care and education setting because of their smaller lungs (therefore faster breathing rate), proximity to the floor, and amount of time spent indoors (3).
- Standards related to safe sleep, handwashing, and diaper changing and toileting are issues identified as especially critical for the health and safety of the infant and toddler population due to the frequency these activities occur within the child care and early education environment. While standards relating to these topics appear throughout this collection, they are also grouped together in the Quick Reference section for your convenience.
- Standards that are relevant to children with special health care needs are integrated throughout this collection so as to emphasize the need to promote an inclusionary approach.
The intended audiences for this document are:

- **Early care and education caregivers/teachers** who can implement these strategies to provide a safe and healthy environments for infants and toddlers in early care and education settings, while simultaneously supporting and partnering with families during this critical stage of development;
- **State regulators and policy makers** who can promote the adoption of these standards in this collection in their state licensing standards in an effort to promote best practices within programs that serve the infant/toddler population;
- **Health, mental health and education consultants, infant/toddler specialists, trainers and other health professionals** who can promote these standards to early care and education caregivers/teachers;
- **Parents/guardians** who can access and petition the use of these standards in their child’s early care and education setting; and
- **Early care and education academic degree program administrators** who can enhance their infant/toddler curriculum.

**Standard Determination**

There were numerous steps that determined the standards to be included in I/T.

1. The NRC staff searched the CFOC3 database (http://cfoc.nrckids.org/) for standards that included the terms “infants” and “toddlers”.
2. A subsequent database search using other key terms usually associated with infant/toddler care (e.g. safe sleep, diapers, breast feeding) revealed additional standards.
3. Once these standards were collected the staff did a standard by standard review of CFOC3 to determine which standards while not specific to infants and toddlers should be included in the collection.
4. The staff then reviewed Stepping Stones, 3rd Edition (SS3) to determine if any of those standards not already included should be a part of I/T.
5. This feedback was incorporated into a draft document that was shared with a group of reviewers, which included parents/guardians, early care and education providers, health care professionals, early childhood researchers, licensors and regulators, national organizations, and the NRC’s Federal project officer.
6. The feedback received was then compiled by the NRC staff into a draft document sent to the CFOC3 Steering Committee, which conducted a review and provided final approval.

**References**


† The full edition is available on the National Resource Center for Health and Safety in Child Care and Early Education (NRC) website at http://cfoc.nrckids.org/. Since publication (2011), several standards have been updated. Please consult the NRC website for the most current standard language. Print copies can be purchased from the American Academy of Pediatrics (http://www.aap.org) and the American Public Health Association (http://www.apha.org/publications/bookstore/).

**Resources**

As with all areas in health, new research comes forth and we recommend that users continue to visit the following web sites for the most up-to-date information on the health and safety of infants and toddlers:

- **American Academy of Pediatrics:**
  Healthy Child Care America (HCCA) Child Care Health Partnership:
  Managing Chronic Health Needs in Child Care and Schools: A Quick Reference Guide
  Editor: Elaine A. Donoghue, MD, FAAP
  Managing Infectious Diseases in Child Care and Schools, 3rd Edition
  A Quick Reference Guide
  Editors: Susan S. Aronson, MD, FAAP and Timothy R. Shope, MD, MPH, FAAP
  https://www.nfaap.org/eWeb/DynamicPage.aspx?webcode=aapbks_productdetail&key=e2eeb3fb-1cb2-4df7-8be2-de364fd59ee6
Introduction

Acknowledgements

The American Academy of Pediatrics (AAP), the American Public Health Association (APHA), and the National Resource Center for Health and Safety in Child Care and Early Education (NRC) would like to acknowledge the outstanding contributions of all persons and organizations involved in the creation of: Caring for Infants and Toddlers in Child Care and Early Education (I/T). It is a collection of those CFOC3 Standards that are applicable to the Infant/Toddler population. Forty-one individuals, representing thirty-four organizations, reviewed and validated the chosen standards. This broad collaboration and review from the best minds in the field has lead to a comprehensive and useful tool. We would like to acknowledge those individuals and those whose names may have been omitted. Our sincere appreciation goes to all of our colleagues who willingly gave their time and expertise to the development of this resource.

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*Standard included in Stepping Stones, 3rd Ed.*
I. Enrollment and Admission

STANDARD 1.1.2.1: Minimum Age to Enter Child Care

Reader’s Note: This standard reflects a desirable goal when sufficient resources are available; it is understood that for some families, waiting until three months of age to enter their infant in child care may not be possible.

Healthy full-term infants can be enrolled in child care settings as early as three months of age. Premature infants or those with chronic health conditions should be evaluated by their primary care providers and developmental specialists to make an individual determination concerning the appropriate age for child care enrollment.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 9.2.1.3: Enrollment Information to Parents/Guardians and Caregivers/Teachers

At enrollment, and before assumption of supervision of children by caregivers/teachers at the facility, the facility should provide parents/guardians and caregivers/teachers with a statement of services, policies, and procedures, including, but not limited to, the following:

a. The licensed capacity, child:staff ratios, ages and number of children in care. If names of children and parents/guardians are made available, parental/guardian permission for any release to others should be obtained;

b. Services offered to children including a written daily activity plan, sleep positioning policies and arrangements, napping routines, guidance and discipline policies, diaper changing and toilet learning/training methods, child handwashing, medication administration policies, oral health, physical activity, health education, and willingness for special health or therapy services delivered at the program (special requirements for a child should be clearly defined in writing before enrollment);

c. Hours and days of operation;

d. Admissions criteria, enrollment procedures, and daily sign-in/sign-out policies, including authorized individuals for pick-up and allowing parent/guardian access whenever their child is in care;

e. Payment of fees, deposits, and refunds;

f. Methods and schedules for conferences or other methods of communication between parents/guardians and staff.

Policies on:

a. Staffing, including caregivers/teachers, the use of volunteers, helpers, or substitute caregivers/teachers, and deployment of staff for different activities;

b. Inclusion of children with special health care needs;

c. Nondiscrimination;

d. Termination and parent/guardian notification of termination;

e. Supervision;

f. Discipline;

g. Care of children and caregivers/teachers who are ill;

h. Temporary exclusion and alternative care for children who are ill;

i. Health assessments and immunizations;

j. Handling urgent medical care or threatening incidents;

k. Medication administration;

l. Use of child care health consultants, education and mental health consultants;

m. Plan for health promotion and prevention (tracking routine child health care, health consultation, health education for children/staff/families, oral health, sun safety, safety surveillance, etc.);

n. Disasters, emergency plan and drills, evacuation plan, and alternative shelter arrangements;

o. Security;

p. Confidentiality of records;

q. Transportation and field trips;

r. Physical activity (both outdoors and when children are kept indoors), play areas, screen time, and outdoor play policy;

s. Sleeping, safe sleep policy, areas used for sleeping/napping, sleep equipment, and bed linen;

t. Sanitation and hygiene;

u. Presence and care of any animals on the premises;

v. Food and nutrition including food handling, human milk, feeding and food brought from home, as well as a daily schedule of meals and snacks;

w. Evening and night care plan;

x. Smoking, tobacco use, alcohol, prohibited substances, and firearms;

y. Preventing and reporting child abuse and neglect;

z. Use of pesticides and other potentially toxic substances in or around the facility.

Parents/guardians and caregivers/teachers should sign that they have reviewed and accepted this statement of services, policies, and procedures. Policies, plans and procedures should generally be reviewed annually or when any changes are made.
I. Enrollment and Admission

To view the Rationale and Comments for this standard, click here.

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

STANDARD 9.4.2.3: Contents of Admission Agreement Between Child Care Program and Parent/Guardian

The file for each child should include an admission agreement signed by the parent/guardian at enrollment. The admission agreement should contain the following topics and documentation of consent:

a. General topics:
   1. Operating days and hours;
   2. Holiday closure dates;
   3. Payment for services;
   4. Drop-off and pick-up procedures;
   5. Family access (visiting site at any time when their child is there and admitted immediately under normal circumstances) and involvement in child care activities;
   6. Name and contact information of any primary staff person designation, especially primary caregivers/teachers designated for infants and toddlers, to make parent/guardian contact of a caregiver/teacher more comfortable.

b. Health topics:
   1. Immunization record;
   2. Breast feeding policy;
   3. For infants, statement that parent/guardian(s) has received and discussed a copy of the program’s infant safe sleep policy;
   4. Documentation of written consent signed and dated by the parent/guardian for:
   5. Any health service obtained for the child by the facility on behalf of the parent/guardian. Such consent should be specific for the type of care provided to meet the tests for “informed consent” to cover on-site screenings or other services provided;
   6. Administration of medication for prescriptions and non-prescription medications (over-the-counter [OTC]) including records and special care plans (if needed).

c. Safety topics:
   1. Prohibition of corporal punishment in the child care facility;
   2. Statement that parent/guardian has received and discussed a copy of the state child abuse and neglect reporting requirements;
   3. Documentation of written consent signed and dated by the parent/guardian for:
      i. Emergency transportation;
      ii. All other transportation provided by the facility;
      iii. Planned or unplanned activities off-premises (such consent should give specific information about where, when, and how such activities should take place, including specific information about walking to and from activities away from the facility);
      iv. Swimming, if the child will be participating;
      v. Release of any information to agencies, schools, or providers of services;
      vi. Written authorization to release the child to designated individuals other than the parent/guardian.

To view the Rationale and Comments for this standard, click here.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home
II. Staffing, Consultants, and Supervision

A. Staff Qualifications and Training

*STANDARD 1.2.0.2: Background Screening

Directors of centers and caregivers/teachers in large and small family child care homes should conduct a complete background screening before employing any staff member (including substitutes, cooks, clerical staff, transportation staff, bus drivers, or custodians who will be on the premises or in vehicles when children are present). The background screening should include:

a. Name and address verification;
b. Social Security number verification;
c. Education verification;
d. Employment history;
e. Alias search;
f. Driving history through state Department of Motor Vehicles records;
g. Background screening of:
   1. State and national criminal history records;
   2. Child abuse and neglect registries;
   3. Licensing history with any other state agencies (i.e., foster care, mental health, nursing homes, etc.);
   4. Fingerprints; and
   5. Sex offender registries;
h. Court records;
i. References.

All family members over age ten living in large and small family child care homes should also have background screenings.

Drug tests may also be incorporated into the background screening. Written permission to obtain the background screening (with or without a drug screen) should be obtained from the prospective employee. Consent to the background investigation should be required for employment consideration.

When checking references and when conducting employee or volunteer interviews, prospective employers should specifically ask about previous convictions and arrests, investigation findings, or court cases with child abuse/neglect or child sexual abuse. Failure of the prospective employee to disclose previous history of child abuse/neglect or child sexual abuse is grounds for immediate dismissal.

Persons should not be hired or allowed to work or volunteer in the child care facility if they acknowledge being sexually attracted to children or having physically or sexually abused children, or are known to have committed such acts.

Background screenings should be repeated periodically taking into consideration state laws and/or requirements.

Screenings should be repeated more frequently if there are additional concerns.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 1.3.1.1: General Qualifications for Directors

The director of a center enrolling fewer than sixty children should be at least twenty-one-years-old and should have all the following qualifications:

a. Have a minimum of a Baccalaureate degree with at least nine credit-bearing hours of specialized college-level course work in administration, leadership, or management, and at least twenty-four credit-bearing hours of specialized college-level course work in early childhood education, child development, elementary education, or early childhood special education that addresses child development, learning from birth through kindergarten, health and safety, and collaboration with consultants OR documents meeting an appropriate combination of relevant education and work experiences (6);
b. A valid certificate of successful completion of pediatric first aid that includes CPR;
c. Knowledge of health and safety resources and access to education, health, and mental health consultants;
d. Knowledge of community resources available to children with special health care needs and the ability to use these resources to make referrals or achieve interagency coordination;
e. Administrative and management skills in facility operations;
f. Capability in curriculum design and implementation, ensuring that an effective curriculum is in place;
g. Oral and written communication skills;
h. Certificate of satisfactory completion of instruction in medication administration;
i. Demonstrated life experience skills in working with children in more than one setting;
j. Interpersonal skills;
k. Clean background screening.

Knowledge about parenting training/counseling and ability to communicate effectively with parents/guardians about developmental-behavioral issues, child progress, and in creating an intervention plan beginning with how the center will address challenges and how it will help if those efforts are not effective.

The director of a center enrolling more than sixty children should have the above and at least three years experience as a teacher of children in the age group(s) enrolled in the center where the individual will act as the director, plus at least six months experience in administration.
II. Staffing, Consultants, and Supervision

*Standard included in Stepping Stones, 3rd Ed                   Caring for Infants and Toddlers in Child Care and Early Education

To view the Rationale and Comments for this standard, click here.

TYPE OF FACILITY: Center

*STANDARD 1.3.2.2: Qualifications of Lead Teachers and Teachers

Lead teachers and teachers should be at least twenty-one years of age and should have at least the following education, experience, and skills:

a. A Bachelor’s degree in early childhood education, school-age care, child development, social work, nursing, or other child-related field, or an associate’s degree in early childhood education and currently working towards a bachelor’s degree;

b. A minimum of one year on-the-job training in providing a nurturing indoor and outdoor environment and meeting the child’s out-of-home needs;

c. One or more years of experience, under qualified supervision, working as a teacher serving the ages and developmental abilities of the children in care;

d. A valid certificate in pediatric first aid, including CPR;

e. Thorough knowledge of normal child development and early childhood education, as well as knowledge of indicators that a child is not developing typically;

f. The ability to respond appropriately to children’s needs;

g. The ability to recognize signs of illness and safety/injury hazards and respond with prevention interventions;

h. Oral and written communication skills;

i. Medication administration training (8).

Every center, regardless of setting, should have at least one licensed/certified lead teacher (or mentor teacher) who meets the above requirements working in the child care facility at all times when children are in care.

Additionally, facilities serving children with special health care needs associated with developmental delay should employ an individual who has had a minimum of eight hours of training in inclusion of children with special health care needs.

To view the Rationale and Comments for this standard, click here.

TYPE OF FACILITY: Center; Large Family Child Care Home

STANDARD 1.3.2.4: Additional Qualifications for Caregivers/Teachers Serving Children Three to Thirty-Five Months of Age

Caregivers/teachers should be prepared to work with infants and toddlers and, when asked, should be knowledgeable and demonstrate competency in tasks associated with caring for infants and toddlers:

a. Diapering and toileting;

b. Bathing;

c. Feeding, including support for continuation of breastfeeding;

d. Holding;

e. Comforting;

f. Practicing safe sleep practices to reduce the risk of Sudden Infant Death Syndrome (SIDS) (3);

g. Providing warm, consistent, responsive caregiving and opportunities for child-initiated activities;

h. Stimulating communication and language development and pre-literacy skills through play, shared reading, song, rhyme, and lots of talking;

i. Promoting cognitive, physical, and social emotional development;

j. Preventing shaken baby syndrome/abusive head trauma;

k. Promoting infant mental health;

l. Promoting positive behaviors;

All assistant teachers, teacher aides, and volunteers should possess:

a. The ability to carry out assigned tasks competently under the supervision of another staff member;

b. An understanding of and the ability to respond appropriately to children’s needs;

c. Sound judgment;

d. Emotional maturity; and

e. Clearly discernible affection for and commitment to the well-being of children.

To view the Rationale and Comments for this standard, click here.

*Standard included in Stepping Stones, 3rd Ed                   Caring for Infants and Toddlers in Child Care and Early Education
m. Setting age-appropriate limits with respect to safety, health, and mutual respect;

n. Using routines to teach children what to expect from caregivers/teachers and what caregivers/teachers expect from them.

Caregivers/teachers should demonstrate knowledge of development of infants and toddlers as well as knowledge of indicators that a child is not developing typically; knowledge of the importance of attachment for infants and toddlers, the importance of communication and language development, and the importance of nurturing consistent relationships on fostering positive self-efficacy development.

To help manage atypical or undesirable behaviors of children, caregivers/teachers, in collaboration with parents/guardians, should seek professional consultation from the child’s primary care provider, an early childhood mental health professional, or an early childhood mental health consultant.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 1.3.2.7: Qualifications and Responsibilities of Health Advocates

Each facility should designate at least one administrator or staff person as the health advocate to be responsible for policies and day-to-day issues related to health, development, and safety of individual children, children as a group, staff, and parents/guardians. In large centers it may be important to designate health advocates at both the center and classroom level. The health advocate should be the primary contact for parents/guardians when they have health concerns, including health-related parent/guardian/staff observations, health-related information, and the provision of resources. The health advocate ensures that health and safety is addressed, even when this person does not directly perform all necessary health and safety tasks.

The health advocate should also identify children who have no regular source of health care, health insurance, or positive screening tests with no referral documented in the child’s health record. The health advocate should assist the child’s parent/guardian in locating a Medical Home by referring them to a primary care provider who offers routine child health services.

For centers, the health advocate should be licensed/certified/credentialed as a director or lead teacher or should be a health professional, health educator, or social worker who works at the facility on a regular basis (at least weekly).

The health advocate should have documented training in the following:

a. Control of infectious diseases, including Standard Precautions, hand hygiene, cough and sneeze etiquette, and reporting requirements;

b. Childhood immunization requirements, record-keeping, and at least quarterly review and follow-up for children who need to have updated immunizations;

c. Child health assessment form review and follow-up of children who need further medical assessment or updating of their information;

d. How to plan for, recognize, and handle an emergency;

e. Poison awareness and poison safety;

f. Recognition of safety, hazards, and injury prevention interventions;

g. Safe sleep practices and the reduction of the risk of Sudden Infant Death Syndrome (SIDS);

h. How to help parents/guardians, caregivers/teachers, and children cope with death, severe injury, and natural or man-made catastrophes;

i. Recognition of child abuse, neglect/child maltreatment, shaken baby syndrome/abusive head trauma (for facilities caring for infants), and knowledge of when to report and to whom suspected abuse/neglect;

j. Facilitate collaboration with families, primary care providers, and other health service providers to create a health, developmental, or behavioral care plan;

k. Implementing care plans;

l. Recognition and handling of acute health related situations such as seizures, respiratory distress, allergic reactions, as well as other conditions as dictated by the special health care needs of children;

m. Medication administration;

n. Recognizing and understanding the needs of children with serious behavior and mental health problems;

o. Maintaining confidentiality;

p. Healthy nutritional choices;

q. The promotion of developmentally appropriate types and amounts of physical activity;

r. How to work collaboratively with parents/guardians and family members;

s. How to effectively seek, consult, utilize, and collaborate with child care health consultants, and in partnership with a child care health consultant, how to obtain information and support from other education, mental health, nutrition, physical activity, oral health, and social service consultants and resources;

t. Knowledge of community resources to refer children and families who need health services including access to State Children’s Health Insurance (SCHIP), importance of a primary care provider and medical home, and provision of immunizations and Early Periodic Screening, Diagnosis, and Treatment (EPSDT).
To view the Rationale and Comments for this standard, click here.

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

**STANDARD 1.3.3.1: General Qualifications of Family Child Care Caregivers/Teachers to Operate a Family Child Care Home**

All caregivers/teachers in large and small family child care homes should be at least twenty-one years of age, hold an official credential as granted by the authorized state agency, meet the general requirements specified in Standard 1.3.2.4 through Standard 1.3.2.6, based on ages of the children served, and those in Section 1.3.3, and should have the following education, experience, and skills:

a. Current accreditation by the National Association for Family Child Care (NAFCC) (including entry-level qualifications and participation in required training) and a college certificate representing a minimum of three credit hours of early childhood education leadership or master caregiver/teacher training or hold an Associate’s degree in early childhood education or child development;

b. A provider who has been in the field less than twelve months should be in the self-study phase of NAFCC accreditation;

c. A valid certificate in pediatric first aid, including CPR;

d. Pre-service training in health management in child care, including the ability to recognize signs of illness, knowledge of infectious disease prevention and safety injury hazards;

e. If caring for infants, knowledge on safe sleep practices including reducing the risk of sudden infant death syndrome (SIDS) and prevention of shaken baby syndrome/abusive head trauma (including how to cope with a crying infant);

f. Knowledge of normal child development, as well as knowledge of indicators that a child is not developing typically;

g. The ability to respond appropriately to children’s needs;

h. Good oral and written communication skills;

i. Willingness to receive ongoing mentoring from other teachers;

j. Pre-service training in business practices;

k. Knowledge of the importance of nurturing adult-child relationships on self-efficacy development;

l. Medication administration training (6).

Additionally, large family child care home caregivers/teachers should have at least one year of experience serving the ages and developmental abilities of the children in their large family child care home.

Assistants, aides, and volunteers employed by a large family child care home should meet the qualifications specified in Standard 1.3.2.3.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 1.4.1.1: Pre-service Training**

In addition to the credentials listed in Standard 1.3.1.1, upon employment, a director or administrator of a center or the lead caregiver/teacher in a family child care home should provide documentation of at least thirty clock-hours of pre-service training. This training should cover health, psychosocial, and safety issues for out-of-home child care facilities. Small family child care home caregivers/teachers may have up to ninety days to secure training after opening except for training on basic health and safety procedures and regulatory requirements.

All directors or program administrators and caregivers/teachers should document receipt of pre-service training prior to working with children that includes the following content on basic program operations:

a. Typical and atypical child development and appropriate best practice for a range of developmental and mental health needs including knowledge about the developmental stages for the ages of children enrolled in the facility;

b. Positive ways to support language, cognitive, social, and emotional development including appropriate guidance and discipline;

c. Developing and maintaining relationships with families of children enrolled, including the resources to obtain supportive services for children’s unique developmental needs;

d. Procedures for preventing the spread of infectious disease, including hand hygiene, cough and sneeze etiquette, cleaning and disinfection of toys and equipment, diaper changing, food handling, health department notification of reportable diseases, and health issues related to having animals in the facility;

e. Teaching child care staff and children about infection control and injury prevention through role modeling;

f. Safe sleep practices including reducing the risk of Sudden Infant Death Syndrome (SIDS) (infant sleep position and crib safety);

g. Shaken baby syndrome/abusive head trauma prevention and identification, including how to cope with a crying/fussy infant;

h. Poison prevention and poison safety;

i. Immunization requirements for children and staff;

j. Common childhood illnesses and their management, including child care exclusion policies and recognizing signs and symptoms of serious illness;

k. Reduction of injury and illness through environmental design and maintenance;

l. Knowledge of U.S. Consumer Product Safety Commission (CPSC) product recall reports;
m. Staff occupational health and safety practices, such as proper procedures, in accordance with Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations;

n. Emergency procedures and preparedness for disasters, emergencies, other threatening situations (including weather-related, natural disasters), and injury to infants and children in care;

o. Promotion of health and safety in the child care setting, including staff health and pregnant workers;

p. First aid including CPR for infants and children;

q. Recognition and reporting of child abuse and neglect in compliance with state laws and knowledge of protective factors to prevent child maltreatment;

r. Nutrition and age-appropriate child-feeding including food preparation, choking prevention, menu planning, and breastfeeding supportive practices;

s. Physical activity, including age-appropriate activities and limiting sedentary behaviors;

t. Prevention of childhood obesity and related chronic diseases;

u. Knowledge of environmental health issues for both children and staff;

v. Knowledge of medication administration policies and practices;

w. Caring for children with special health care needs, mental health needs, and developmental disabilities in compliance with the Americans with Disabilities Act (ADA);

x. Strategies for implementing care plans for children with special health care needs and inclusion of all children in activities;

y. Positive approaches to support diversity;

z. Positive ways to promote physical and intellectual development.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 1.4.2.2: Orientation for Care of Children with Special Health Care Needs*

When a child care facility enrolls a child with special health care needs, the facility should ensure that all staff members have been oriented in understanding that child’s special health care needs and have the skills to work with that child in a group setting.

Caregivers/teachers in small family child care homes, who care for a child with special health care needs, should meet with the parents/guardians and meet or speak with the child’s primary care provider (if the parent/guardian has provided prior, informed, written consent) or a child care health consultant to ensure that the child’s special health care needs will be met in child care and to learn how these needs may affect his/her developmental progression or play with other children.

In addition to Orientation Training, Standard 1.4.2.1, the orientation provided to staff in child care facilities should be based on the special health care needs of children who will be assigned to their care. All staff oriented for care of children with special health needs should be knowledgeable about the care plans created by the child’s primary care provider in their medical home as well as any care plans created by other health professionals and therapists involved in the child’s care. A template for a care plan for children with special health care needs can be found in Appendix O. Child care health consultants can be an excellent resource for providing health and safety orientation or referrals to resources for such training. This training may include, but is not limited to, the following topics:

a. Positioning for feeding and handling, and risks for injury for children with physical/mental disabilities;

b. Tolleting techniques;

c. Knowledge of special treatments or therapies (e.g., PT, OT, speech, nutrition/diet therapies, emotional support and behavioral therapies, medication administration, etc.) the child may need/ receive in the child care setting;

d. Proper use and care of the individual child’s adaptive equipment, including how to recognize defective equipment and to notify parents/guardians that repairs are needed;

e. How different disabilities affect the child’s ability to participate in group activities;

f. Methods of helping the child with special health care needs or behavior problems to participate in the facility’s programs, including physical activity programs;

g. Role modeling, peer socialization, and interaction;

h. Behavior modification techniques, positive behavioral supports for children, promotion of self-esteem, and other techniques for managing behavior;

i. Grouping of children by skill levels, taking into account the child’s age and developmental level;

j. Health services or medical intervention for children with special health care problems;

k. Communication methods and needs of the child;

l. Dietary specifications for children who need to avoid specific foods or for children who have their diet modified to maintain their health, including support for continuation of breastfeeding;

m. Medication administration (for emergencies or on an ongoing basis);

n. Recognizing signs and symptoms of impending illness or change in health status;

o. Recognizing signs and symptoms of injury;

p. Understanding temperament and how individual behavioral differences affect a child’s adaptive skills, motivation, and energy;

*Standard included in Stepping Stones, 3rd Ed.*
q. Potential hazards of which staff should be aware;
r. Collaborating with families and outside service providers to create a health, developmental, and behavioral care plan for children with special needs;
s. Awareness of when to ask for medical advice and recommendations for non-emergent issues that arise in school (e.g., head lice, worms, diarrhea);
t. Knowledge of professionals with skills in various conditions, e.g., total communication for children with deafness, beginning orientation and mobility training for children with blindness (including arranging the physical environment effectively for such children), language promotion for children with hearing-impairment and language delay/disorder, etc.;
u. How to work with parents/guardians and other professionals when assistive devices or medications are not consistently brought to the child care program or school;
v. How to safely transport a child with special health care needs.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 1.4.2.3: Orientation Topics**

During the first three months of employment, the director of a center or the caregiver/teacher in a large family home should 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 should include the ability to perform a daily health check of children to determine whether any children are ill or injured and, if so, whether a child who is ill should be excluded from the facility;
b. Exclusion and readmission procedures and policies;
c. Cleaning, sanitation, and disinfection procedures and policies;
d. Procedures for administering medication to children and for documenting medication administered to children;
e. Procedures for notifying parents/guardians of an infectious 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;
g. Emergency procedures and policies related to unintentional injury, medical emergency, and natural disasters;
h. Procedure for accessing the child care health consultant for assistance;
i. Injury prevention strategies and hazard identification procedures specific to the facility, equipment, etc.;
j. Proper hand hygiene.

Before being assigned to tasks that involve identifying and responding to illness, staff members should receive orientation training on these topics. Small family child care home caregivers/teachers should not commence operation before receiving orientation on these topics in pre-service training (1).

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 1.4.3.1: First Aid and CPR Training for Staff**

The director of a center or a large family child care home and the caregiver/teacher in a small family child care home should ensure all staff members involved in providing direct care have documentation of satisfactory completion of training in pediatric first aid and pediatric CPR skills. Pediatric CPR skills should be taught by demonstration, practice, and return demonstration to ensure the technique can be performed in an emergency. These skills should be current according to the requirement specified for retraining by the organization that provided the training.

At least one staff person who has successfully completed training in pediatric first aid that includes CPR should be in attendance at all times with a child whose special care plan indicates an increased risk of needing respiratory or cardiac resuscitation.

Records of successful completion of training in pediatric first aid should be maintained in the personnel files of the facility.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 1.4.5.2: Child Abuse and Neglect Education**

Caregivers/teachers should use child abuse and neglect prevention education to educate and establish child abuse and neglect prevention and recognition measures for the children, caregivers/teachers, and parents/guardians. The education should address physical, sexual, and psychological or emotional abuse and neglect. The dangers of shaking infants and toddlers and repeated exposure to domestic violence should be included in the education and prevention materials. Caregivers/teachers should also receive education on promoting protective factors to prevent child maltreatment. Caregivers/teachers should be able to identify signs of stress in families and assist families by providing support and linkages to resources when needed. Children with disabilities are at a higher risk of being abused. Special training in child abuse

*Standard included in Stepping Stones, 3rd Ed* Caring for Infants and Toddlers in Child Care and Early Education
and neglect and children with disabilities should be provided (2).

Caregivers/teachers are mandatory reporters of child abuse or neglect. Caregivers/teachers should be trained in compliance with their state’s child abuse reporting laws. Child abuse reporting requirements are known and available from the child care regulation department in each state.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 1.5.0.2: Orientation of Substitutes**

The director of any center or large family child care home and the small family child care home caregiver/teacher should provide orientation training to newly hired substitutes to include a review of ALL the program’s policies and procedures (listed below is a sample). This training should include the opportunity for an evaluation and a repeat demonstration of the training lesson. In all child care settings the orientation should be documented. Substitutes should have background screenings.

All substitutes should be oriented to, and demonstrate competence in, the tasks for which they will be responsible. On the first day a substitute caregiver/teacher should be oriented on the following topics:

a. Safe infant sleep practices if an infant is enrolled in the program;

b. Any emergency medical procedure/medication needs of the children;

c. Any nutrition needs of the children.

All substitute caregivers/teachers, during the first week of employment, should be oriented to, and should demonstrate competence in at least the following items:

a. The names of the children for whom the caregiver/teacher will be responsible, and their specific developmental needs;

b. The planned program of activities at the facility;

c. Routines and transitions;

d. Acceptable methods of discipline;

e. Meal patterns and safe food handling policies of the facility (special attention should be given to life-threatening food allergies);

f. Emergency health and safety procedures;

g. General health policies and procedures as appropriate for the ages of the children cared for, including but not limited to the following:
   1. Hand hygiene techniques, including indications for hand hygiene;
   2. Diapering technique, if care is provided to children in diapers, including appropriate diaper disposal and diaper changing techniques, use and wearing of gloves;

h. Emergency plans and practices;

i. Access to list of authorized individuals for releasing children.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 7.4.0.2: Staff Education and Policies on Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections**

Facilities should adhere to the following staff educational policies to prevent and control infections of the gastrointestinal tract (mainly diarrhea) and hepatitis A:

a. The facility should conduct ongoing continuing education for staff members, to include the following:
   1. Methods of transmission of pathogens that cause diarrhea and hepatitis A;
   2. Recognition and prevention of diarrhea and disease associated with hepatitis A virus (HAV) infection.

b. All caregivers/teachers, food handlers, and maintenance staff should receive ongoing education and monitoring concerning hand hygiene and cleaning of environmental surfaces as specified in the facility’s plan.

c. At least annually, the director should review all procedures related to preventing diarrhea and HAV infections. Each caregiver/teacher, food handler, and maintenance person should review a written copy of these procedures or view a video, which should include age-specific criteria for inclusion and exclusion of children who have a diarrheal illness or HAV infection and infection control procedures.
d. Guidelines for administration of immunization against HAV should be enforced to prevent infection in contacts of children and adults with hepatitis A disease (f).

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 7.7.1.1 Staff Education and Policies on Cytomegalovirus (CMV)**

Facilities that employ women of childbearing age should provide information to employees providing care to infants and children with regard to the following:

a. The increased probability of exposure to cytomegalovirus (CMV) in the child care setting;

b. The potential for fetal damage when CMV is acquired during pregnancy;

c. Hygiene measures (especially handwashing and avoiding contact with urine, saliva, and nasal secretions) aimed at reducing acquisition of CMV;

d. The availability of counseling and testing for serum antibody to CMV to determine the caregiver/teacher’s immune status.

Female employees of childbearing age should be referred to their primary care provider or to the health department authority for counseling about their risk of CMV infection. This counseling may include testing for serum antibodies to CMV to determine the employee’s immunity against CMV infection.

Staff should be advised not to kiss children on the lips or allow children to put their fingers or hands in another person’s mouth. Additionally, since saliva can transmit CMV, cups or eating utensils should not be shared.

To view the Rationale and Comments for this standard, click here.

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

**B. Consultants**

**STANDARD 1.6.0.1: Child Care Health Consultants**

A facility should identify and engage/partner with a child care health consultant (CCHC) who is a licensed health professional with education and experience in child and community health and child care and preferably specialized training in child care health consultation.

CCHCs have knowledge of resources and regulations and are comfortable linking health resources with child care facilities.

The child care health consultant should be knowledgeable in the following areas:

a. Consultation skills both as a child care health consultant as well as a member of an interdisciplinary team of consultants;

b. National health and safety standards for out-of-home child care;

c. Indicators of quality early care and education;

d. Day-to-day operations of child care facilities;

e. State child care licensing and public health requirements;

f. State health laws, Federal and State education laws (e.g., ADA, IDEA), and state professional practice acts for licensed professionals (e.g., State Nurse Practice Acts);

g. Infancy and early childhood development, social and emotional health, and developmentally appropriate practice;

h. Recognition and reporting requirements for infectious diseases;

i. American Academy of Pediatrics (AAP) and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screening recommendations and immunizations schedules for children;

j. Importance of medical home and local and state resources to facilitate access to a medical home as well as child health insurance programs including Medicaid and State Children’s Health Insurance Program (SCHIP);

k. Injury prevention for children;

l. Oral health for children;

m. Nutrition and age-appropriate physical activity recommendations for children including feeding of infants and children, the importance of breastfeeding and the prevention of obesity;

n. Inclusion of children with special health care needs, and developmental disabilities in child care;

o. Safe medication administration practices;

p. Health education of children;

q. Recognition and reporting requirements for child abuse and neglect/child maltreatment;

r. Safe sleep practices and policies (including reducing the risk of SIDS);

s. Development and implementation of health and safety policies and practices including poison awareness and poison prevention;

t. Staff health, including adult health screening, occupational health risks, and immunizations;

u. Disaster planning resources and collaborations within child care community;

v. Community health and mental health resources for child, parent/guardian and staff health;

w. Importance of serving as a healthy role model for children and staff.

The child care health consultant should be able to perform or arrange for performance of the following activities:

a. Assessing caregivers/teachers’ knowledge of health, development, and safety and offering training as indicated;

b. Developing, updating, and implementing policies and procedures related to health and safety;

c. Identifying, collaborating with, and referring children to medical homes;

d. Supporting the development of the baby’s health and growth;

The child care health consultant should have a working knowledge of the following:

1. Roles and responsibilities of health professionals;

2. Standards, guidelines, and practices of health professionals;

3. Availability and accessibility of health services;

4. Referral processes for health services.

The child care health consultant should be knowledgeable of the following:

1. Infectious disease transmission source and prevention;

2. Effective communication with families and children;

3. Disease prevention measures.

The child care health consultant should be able to perform the following activities:

1. Safe medication administration practices;

2. Safe sleep practices and policies (including reducing the risk of SIDS);

3. Development and implementation of health and safety policies and practices including poison awareness and poison prevention.

The child care health consultant should have knowledge of the following:

1. Developmental milestones and normal developmental processes;

2. Normal growth and development.

The child care health consultant should be able to perform the following activities:

1. Providing information about health issues to parents, staff, and children;

2. Identifying health resources and referring families to these resources.

The child care health consultant should have knowledge of the following:

1. Early childhood development and learning;
II. Staffing, Consultants, and Supervision

b. Assessing parents'/guardians' health, development, and safety knowledge, and offering training as indicated;
c. Assessing children's knowledge about health and safety and offering training as indicated;
d. Conducting a comprehensive indoor and outdoor health and safety assessment and on-going observations of the child care facility;
e. Consulting collaboratively on-site and/or by telephone or electronic media;
f. Providing community resources and referral for health, mental health and social needs, including accessing medical homes, children’s health insurance programs (e.g., CHIP), and services for special health care needs;
g. Developing or updating policies and procedures for child care facilities (see comment section below);
h. Reviewing health records of children;
i. Reviewing health records of caregivers/teachers;
j. Assisting caregivers/teachers and parents/guardians in the management of children with behavioral, social and emotional problems and those with special health care needs;
k. Consulting a child's primary care provider about the child’s individualized health care plan and coordinating services in collaboration with parents/guardians, the primary care provider, and other health care professionals (the CCHC shows commitment to communicating with and helping coordinate the child’s care with the child’s medical home, and may assist with the coordination of skilled nursing care services at the child care facility);
l. Consulting with a child’s primary care provider about medications as needed, in collaboration with parents/guardians;
m. Teaching staff safe medication administration practices;
n. Monitoring safe medication administration practices;
o. Observing children’s behavior, development and health status and making recommendations if needed to staff and parents/guardians for further assessment by a child’s primary care provider;
p. Interpreting standards, regulations and accreditation requirements related to health and safety, as well as providing technical advice, separate and apart from an enforcement role of a regulation inspector or determining the status of the facility for recognition;
q. Understanding and observing confidentiality requirements;
r. Assisting in the development of disaster/emergency medical plans (especially for those children with special health care needs) in collaboration with community resources;
s. Developing an obesity prevention program in consultation with a nutritionist/registered dietitian (RD) and physical education specialist;
t. Working with other consultants such as nutritionists/RDs, kinesiologists (physical activity specialists), oral health consultants, social service workers, early childhood mental health consultants, and education consultants.

The role of the CCHC is to promote the health and development of children, families, and staff and to ensure a healthy and safe child care environment (11).

The CCHC is not acting as a primary care provider at the facility but offers critical services to the program and families by sharing health and developmental expertise, assessments of child, staff, and family health needs and community resources. The CCHC assists families in care coordination with the medical home and other health and developmental specialists. In addition, the CCHC should collaborate with an interdisciplinary team of early childhood consultants, such as, early childhood education, mental health, and nutrition consultants.

In order to provide effective consultation and support to programs, the CCHC should avoid conflict of interest related to other roles such as serving as a caregiver/teacher or regulator or a parent/guardian at the site to which child care health consultation is being provided.

The CCHC should have regular contact with the facility’s administrative authority, the staff, and the parents/guardians in the facility. The administrative authority should review, and collaborate with the CCHC in implementing recommended changes in policies and practices. In the case of consulting about children with special health care needs, the CCHC should have contact with the child’s medical home with permission from the child’s parent/guardian.

Programs with a significant number of non-English-speaking families should seek a CCHC who is culturally sensitive and knowledgeable about community health resources for the parents'/guardians’ native culture and languages.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 1.6.0.2: Frequency of Child Care Health Consultation Visits

The child care health consultant (CCHC) should visit each facility as needed to review and give advice on the facility’s health component and review the overall health status of the children and staff (1-4). Early childhood programs that serve any child younger than three years of age should be visited at least once monthly by a health professional with general knowledge and skills in child health and safety and health consultation. Child care programs that serve children three to five years of age should be visited at least quarterly and programs serving school-age children should
be visited at least twice annually. In all cases, the frequency of visits should meet the needs of the composite group of children and be based on the needs of the program for training, support, and monitoring of child health and safety needs, including (but not limited to) infectious disease, injury prevention, safe sleep, nutrition, oral health, physical activity and outdoor learning, emergency preparation, medication administration, and the care of children with special health care needs. Written documentation of CCHC visits should be maintained at the facility.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 1.6.0.3: Early Childhood Mental Health Consultants**

A facility should engage a qualified early childhood mental health consultant who will assist the program with a range of early childhood social-emotional and behavioral issues and who will visit the program at minimum quarterly and more often as needed.

The knowledge base of an early childhood mental health consultant should include:

a. Training, expertise and/or professional credentials in mental health (e.g., psychiatry, psychology, clinical social work, nursing, developmental-behavioral medicine, etc.);

b. Early childhood development (typical and atypical) of infants, toddlers, and preschool age children;

c. Early care and education settings and practices;

d. Consultation skills and approaches to working as a team with early childhood consultants from other disciplines, especially health and education consultants, to effectively support directors and caregivers/teachers.

The role of the early childhood mental health consultant should be focused on building staff capacity and be both proactive in decreasing the incidence of challenging classroom behaviors and reactive in formulating appropriate responses to challenging classroom behaviors and should include:

a. Developing and implementing classroom curricula regarding conflict resolution, emotional regulation, and social skills development;

b. Developing and implementing appropriate screening and referral mechanisms for behavioral and mental health needs;

c. Forming relationships with mental health providers and special education systems in the community;

d. Providing mental health services, resources and/or referral systems for families and staff;

e. Helping staff facilitate and maintain mentally healthy environments within the classroom and overall system;

f. Helping address mental health needs and reduce job stress within the staff;

g. Improving management of children with challenging behaviors;

h. Preventing the development of problem behaviors;

i. Providing a classroom climate that promotes positive social-emotional development;

j. Recognizing and appropriately responding to the needs of children with internalizing behaviors, such as persistent sadness, anxiety, and social withdrawal;

k. Actively teaching developmentally appropriate social skills, conflict resolution, and emotional regulation;

l. Addressing the mental health needs and daily stresses of those who care for young children, such as families and caregivers/teachers;

m. Helping the staff to address and handle unforeseen crises or bereavements that may threaten the mental health of staff or children and families, such as the death of a caregiver/teacher or the serious illness of a child.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 1.6.0.4: Early Childhood Education Consultants**

A facility should engage an early childhood education consultant who will visit the program at minimum semi-annually and more often as needed. The consultant must have a minimum of a Baccalaureate degree and preferably a Master’s degree from an accredited institution in early childhood education, administration and supervision, and a minimum of three years in teaching and administration of an early care/education program. The facility should develop a written plan for this consultation which must be signed annually by the consultant. This plan should outline the responsibilities of the consultant and the services the consultant will provide to the program.

The knowledge base of an early childhood education consultant should include:

a. Working knowledge of theories of child development and learning for children from birth through eight years across domains, including socio-emotional development and family development;

b. Principles of health and wellness across the domains, including social and emotional wellness and approaches in the promotion of healthy development and resilience;

c. Current practices and materials available related to screening, assessment, curriculum, and measurement of child outcomes across the domains, including practices that aid in early identification and individualizing for a wide range of needs;

d. Resources that aid programs to support inclusion of children with diverse health and learning needs
and families representing linguistic, cultural, and economic diversity of communities;

e. Methods of coaching, mentoring, and consulting that meet the unique learning styles of adults;

f. Familiarity with local, state, and national regulations, standards, and best practices related to early education and care;

g. Community resources and services to identify and serve families and children at risk, including those related to child abuse and neglect and parent education;

h. Consultation skills as well as approaches to working as a team with early childhood consultants from other disciplines, especially child care health consultants, to effectively support program directors and their staff.

The role of the early childhood education consultant should include:

a. Review of the curriculum and written policies, plans and procedures of the program;

b. Observations of the program and meetings with the director, caregivers/teachers, and parents/guardians;

c. Review of the professional needs of staff and program and provision of recommendations of current resources;

d. Reviewing and assisting directors in implementing and monitoring evidence based approaches to classroom management;

e. Maintaining confidences and following all Family Educational Rights and Privacy Act (FERPA) regulations regarding disclosures;

f. Keeping records of all meetings, consultations, recommendations and action plans and offering/providing summary reports to all parties involved;

g. Seeking and supporting a multidisciplinary approach to services for the program, children and families;

h. Following the National Association for the Education of Young Children (NAEYC) Code of Ethics;

i. Availability by telecommunication to advise regarding practices and problems;

j. Availability for on-site visit to consult to the program;

k. Familiarity with tools to evaluate program quality, such as the Early Childhood Environment Rating Scale–Revised (ECERS–R), Infant/Toddler Environment Rating Scale–Revised (ITERS–R), Family Child Care Environment Rating Scale–Revised (FCCERS–R), School-Age Care Environment Rating Scale (SACERS), Classroom Assessment Scoring System (CLASS), as well as tools used to support various curricular approaches.

**C. Supervision**

**STANDARD 1.1.1.1: Ratios for Small Family Child Care Homes**

The small family child care home caregiver/teacher child:staff ratios should conform to the following table:

<table>
<thead>
<tr>
<th>Child:staff ratio</th>
<th>Special Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the small family child care home caregiver/teacher has one to six children</td>
<td>then the small family child care home caregiver/teacher may have one to six children over two years of age in care</td>
</tr>
<tr>
<td>over two years of age in care</td>
<td></td>
</tr>
<tr>
<td>If the small family child care home caregiver/teacher has one child under two</td>
<td>then the small family child care home caregiver/teacher may have one to three children over two years of age in care</td>
</tr>
<tr>
<td>years of age in care</td>
<td></td>
</tr>
<tr>
<td>If the small family child care home caregiver/teacher has two children under</td>
<td>then the small family child care home caregiver/teacher may have no children over</td>
</tr>
<tr>
<td>two years of age in care</td>
<td>two years of age in care</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The small family child care home caregiver’s/teacher’s own children as well as any other children in the home temporarily requiring supervision should be included in the child:staff ratio. During nap time, at least one adult should be physically present in the same room as the children.

To view the Rationale and Comments for this standard, click here.

**TYPE OF FACILITY: Small Family Child Care Home**

**STANDARD 1.1.1.2: Ratios for Large Family Child Care homes and Centers**

Child:staff ratios in large family child care homes and centers should be maintained as follows during all hours of operation, including in vehicles during transport.
### II. Staffing, Consultants, and Supervision

**Large Family Child Care Homes**

<table>
<thead>
<tr>
<th>Age</th>
<th>Maximum Child:Staff Ratio</th>
<th>Maximum Group Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 12 months</td>
<td>2:1</td>
<td>6</td>
</tr>
<tr>
<td>13-23 months</td>
<td>2:1</td>
<td>8</td>
</tr>
<tr>
<td>24-35 months</td>
<td>3:1</td>
<td>12</td>
</tr>
<tr>
<td>3-year-olds</td>
<td>7:1</td>
<td>12</td>
</tr>
<tr>
<td>4- to 5-year-olds</td>
<td>8:1</td>
<td>12</td>
</tr>
<tr>
<td>6- to 8-year-olds</td>
<td>10:1</td>
<td>12</td>
</tr>
<tr>
<td>9- to 12-year-olds</td>
<td>12:1</td>
<td>12</td>
</tr>
</tbody>
</table>

During nap time for children birth through thirty months of age, the child:staff ratio must be maintained at all times regardless of how many infants are sleeping. They must also be maintained even during the adult’s break time so that ratios are not relaxed.

<table>
<thead>
<tr>
<th>Age</th>
<th>Maximum Child:Staff Ratio</th>
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<tr>
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<td>13-35 months</td>
<td>4:1</td>
<td>8</td>
</tr>
<tr>
<td>3-year-olds</td>
<td>7:1</td>
<td>14</td>
</tr>
<tr>
<td>4-year-olds</td>
<td>8:1</td>
<td>16</td>
</tr>
<tr>
<td>5-year-olds</td>
<td>8:1</td>
<td>16</td>
</tr>
<tr>
<td>6- to 8-year-olds</td>
<td>10:1</td>
<td>20</td>
</tr>
<tr>
<td>9- to 12-year-olds</td>
<td>12:1</td>
<td>24</td>
</tr>
</tbody>
</table>

During nap time for children ages thirty-one months and older, at least one adult should be physically present in the same room as the children and maximum group size must be maintained. Children over thirty-one months of age can usually be organized to nap on a schedule, but infants and toddlers as individuals are more likely to nap on different schedules. In the event even one child is not sleeping the child should be moved to another activity where appropriate supervision is provided.

If there is an emergency during nap time other adults should be on the same floor and should immediately assist the staff supervising sleeping children. The caregiver/teacher who is in the same room with the children should 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 should be consistent with the age of most of the children. When infants or toddlers are in the mixed age group, the child:staff ratio and group size for infants and toddlers should be maintained. In large family child care homes with two or more caregivers/teachers caring for no more than twelve children, no more than three children younger than two years of age should be in care.

Children with special health care needs or who require more attention due to certain disabilities may require additional staff on-site, depending on their special needs and the extent of their disabilities (1). See Standard 1.1.1.3.

At least one adult who has satisfactorily completed a course in pediatric first aid, including CPR skills within the past three years, should be part of the ratio at all times.

To view the Rationale and Comments for this standard, click [here](#).
II. Staffing, Consultants, and Supervision

*STANDARD 1.1.1.5: Ratios and Supervision for Swimming, Wading, and Water Play

The following child:staff ratios should apply while children are swimming, wading, or engaged in water play:

<table>
<thead>
<tr>
<th>Developmental Levels</th>
<th>Child:Staff Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants</td>
<td>1:1</td>
</tr>
<tr>
<td>Toddlers</td>
<td>1:1</td>
</tr>
<tr>
<td>Preschoolers</td>
<td>4:1</td>
</tr>
<tr>
<td>School-age Children</td>
<td>6:1</td>
</tr>
</tbody>
</table>

Constant and active supervision should be maintained when any child is in or around water (4). During any swimming/wading/water play activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. The required ratio of adults to older children should be met without including the adults who are required for supervision of infants and/or toddlers. An adult should remain in direct physical contact with an infant at all times during swimming or water play (4).

Whenever children thirteen months and up to five years of age are in or around water, the supervising adult should be within an arm’s length providing “touch supervision” (6). The attention of an adult who is supervising children of any age should be focused on the child, and the adult should never be engaged in other distracting activities (4), such as talking on the telephone, socializing, or tending to chores.

A lifeguard should not be counted in the child:staff ratio.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 2.2.0.4: Supervision Near Bodies of Water

Constant and active supervision should be maintained when any child is in or around water (1). During any swimming/wading/water play activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. Children ages thirteen months to five years of age should not be permitted to play in areas where there is any body of water, including swimming pools, ponds and irrigation ditches, built-in wading pools, tubs, pails, sinks, or toilets unless the supervising adult is within an arm’s length providing “touch supervision”.

Caregivers/teachers should ensure that all pools meet the Virginia Graeme Baker Pool and Spa Safety Act, requiring the retrofitting of safe suction-type devices for pools and spas to prevent underwater entrapment of children in such locations with strong suction devices that have led to deaths of children of varying ages (2).

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 2.2.0.1: Methods of Supervision of Children

Caregivers/teachers should directly supervise infants, toddlers, and preschoolers by sight and hearing at all times, even when the children are going to sleep, napping or sleeping, are beginning to wake up, or are indoors or outdoors. School-age children should be within sight or hearing at all times. Caregivers/teachers should not be on one floor level of the building, while children are on another floor or room. Ratios should remain the same whether inside or outside.

School-age children should be permitted to participate in activities off the premises with appropriate adult supervision and with written approval by a parent/guardian and by the caregiver. If parents/guardians give written permission for the school-age child to participate in off-premises activities, the facility would no longer be responsible for the child during the off-premises activity and not need to provide staff for the off-premises activity.

Caregivers/teachers should regularly count children (name to face on a scheduled basis, at every transition, and whenever leaving one area and arriving at another), going indoors or outdoors, to confirm the safe whereabouts of every child at all times. Additionally, they must be able to state how many children are in their care at all times.

Developmentally appropriate child:staff ratios should be met during all hours of operation, including indoor and outdoor play and field trips, and safety precautions for specific areas and equipment should be followed. No center-based facility or large family child care home should operate with fewer than two staff members if more than six children are in care, even if the group otherwise meets the child:staff ratio. Although centers often downsize the number of staff for the early arrival and late departure times, another adult must be present to help in the event of an emergency. The supervision policies of centers and large family child care homes should be written policies.

*Standard included in Stepping Stones, 3rd Ed.
STANDARD 4.5.0.6: Adult Supervision of Children Who Are Learning to Feed Themselves

Children in mid-infancy who are learning to feed themselves should be supervised by an adult seated within arm’s reach of them at all times while they are being fed. Children over twelve months of age who can feed themselves should be supervised by an adult who is seated at the same table or within arm’s reach of the child’s highchair or feeding table. When eating, children should be within sight of an adult at all times.

To view the Rationale and Comments for this standard, click here.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home
III. ENVIRONMENT AND EQUIPMENT

A. Building/Environment: Inside and Outside

*STANDARD 5.1.1.5: Environmental Audit of Site Location

An environmental audit should be conducted before construction of a new building; renovation or occupation of an older building; or after a natural disaster, to properly evaluate and, where necessary, remediate or avoid sites where children's health could be compromised (1,3).

The environmental audit should include assessments of:

a. Potential air, soil, and water contamination on child care facility sites and outdoor play spaces;

b. Potential toxic or hazardous materials in building construction; and

c. Potential safety hazards in the community surrounding the site.

A written environmental audit report that includes any remedial action taken should be kept on file.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 5.1.1.7: Use of Basements and Below Grade Areas

Finished basements or areas that are partially below grade may be used for children who independently ambulate and who are two years of age or older, if the space is in compliance with applicable building and fire codes. Environmental health factors may be reviewed with county or city public health departments.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 5.1.1.12: Multiple Use of Rooms

Playing, eating, and napping may occur in the same area (exclusive of diaper changing areas, toilet rooms, kitchens, hallways, and closets), provided that:

a. The room is of sufficient size to have a defined area for each of the activities allowed there at the time the activity is under way;

b. The room meets other building requirements;

c. Programming is such that use of the room for one purpose does not interfere with use of the room for other purposes.

To view the Rationale and Comments for this standard, click here.
**STANDARD 5.2.1.1: Fresh Air**

As much fresh outdoor air as possible should be provided in rooms occupied by children. Windows should be opened whenever weather and the outdoor air quality permits or when children are out of the room (1). When windows are not kept open, rooms should be ventilated, as specified in Standards 5.2.1.1-5.2.1.6. The specified rates at which outdoor air must be supplied to each room within the facility range from fifteen to sixty cubic feet per minute per person (cfm/p). The rate depends on the activities that normally occur in that room.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.2.1.2: Indoor Temperature**

A draft-free temperature of 68°F to 75°F should be maintained at thirty to fifty percent relative humidity during the winter months. A draft-free temperature of 74°F to 82°F should be maintained at thirty to fifty percent relative humidity during the summer months (1,3). All rooms that children use should be heated and cooled to maintain the required temperatures and humidity.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.2.1.6: Ventilation to Control Odors**

Odors in toilets, bathrooms, diaper changing, and other inhabited areas of the facility should be controlled by ventilation and appropriate cleaning and disinfecting. Toilets and bathrooms, janitorial closets, and rooms with utility sinks or where wet mops and chemicals are stored should be mechanically ventilated to the outdoors with local exhaust mechanical ventilation to control and remove odors in accordance with local building codes. Chemical air fresheners or air sanitizers should not be used. Adequate ventilation should be maintained during any cleaning, sanitizing or disinfecting procedure to prevent children and caregivers/teachers from inhaling potentially toxic fumes.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.2.1.11: Portable Electric Space Heaters**

Portable electric space heaters should:

- Be attended while in use and be off when unattended;
- Be inaccessible to children;
- Have protective covering to keep hands and objects away from the electric heating element;
- Bear the safety certification mark of a nationally recognized testing laboratory;
- Be placed on the floor only and at least three feet from curtains, papers, furniture, and any flammable object;
- Be properly vented, as required for proper functioning;
- Be used in accordance with the manufacturer’s instructions;
- Not be used with an extension cord.

The heater cord should be inaccessible to children as well.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.2.6.2: Testing of Drinking Water Not From Public System**

If the facility’s drinking water does not come from a public water system, or the facility gets the drinking water from a household well, programs should test the water every year or as required by the local health department, for bacteriological quality, nitrates, total dissolved solids, pH levels, and other water quality indicators as required by the local health department. Testing for nitrate is especially important if there are infants under six months of age in care.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.2.6.3: Testing for Lead and Copper Levels in Drinking Water**

Drinking water, including water in drinking fountains, should be tested and evaluated in accordance with the assistance of the local health authority or state drinking water program to determine whether lead and copper levels are safe.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.2.8.1: Integrated Pest Management**

Facilities should adopt an integrated pest management program (IPM) to ensure long-term, environmentally sound pest suppression through a range of practices including pest exclusion, sanitation and clutter control, and elimination of conditions that are conducive to pest infestations. IPM is a simple, common-sense approach to pest management that eliminates the root causes of pest problems, providing safe and effective control of insects, weeds, rodents, and other pests while minimizing risks to human health and the environment (2,4).

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"Standard included in Stepping Stones, 3rd Ed"  
Caring for Infants and Toddlers in Child Care and Early Education
Pest Prevention: Facilities should prevent pest infestations by ensuring sanitary conditions. This can be done by eliminating pest breeding areas, filling in cracks and crevices; holes in walls, floors, ceilings and water leads; repairing water damage; and removing clutter and rubbish on the premises (5).

Pest Monitoring: Facilities should establish a program for regular pest population monitoring and should keep records of pest sightings and sightings of indicators of the presence of pests (e.g., gnaw marks, frass, rub marks).

Pesticide Use: If physical intervention fails to prevent pest infestations, facility managers should ensure that targeted, rather than broadcast applications of pesticides are made, beginning with the products that pose least exposure hazard first, and always using a pesticide applicator who has the licenses or certifications required by state and local laws.

Facility managers should follow all instructions on pesticide product labels and should not apply any pesticide in a manner inconsistent with label instructions. Material Safety Data Sheets (MSDS) are available from the product manufacturer or a licensed exterminator and should be on file at the facility. Facilities should ensure that pesticides are never applied when children are present and that re-entry periods are adhered to.

Records of all pesticides applications (including type and amount of pesticide used), timing and location of treatment, and results should be maintained either on-line or in a manner that permits access by facility managers and staff, state inspectors and regulatory personnel, parents/guardians, and others who may inquire about pesticide usage at the facility.

Facilities should avoid the use of sprays and other volatilizing pesticide formulations. Pesticides should be applied in a manner that prevents skin contact and any other exposure to children or staff members and minimizes odors in occupied areas. Care should be taken to ensure that pesticide applications do not result in pesticide residues accumulating on tables, toys, and items mouthed or handled by children, or on soft surfaces such as carpets, upholstered furniture, or stuffed animals with which children may come in direct contact (3).

Following the use of pesticides, herbicides, fungicides, or other potentially toxic chemicals, the treated area should be ventilated for the period recommended on the product label.

Notification: Notification should be given to parents/guardians and staff before using pesticides, to determine if any child or staff member is sensitive to the product. A member of the child care staff should directly observe the application to be sure that toxic chemicals are not applied on surfaces with which children or staff may come in contact.

Registry: Child care facilities should provide the opportunity for interested staff and parents/guardians to register with the facility if they want to be notified about individual pesticide applications before they occur.

Warning Signs: Child care facilities must post warning signs at each area where pesticides will be applied. These signs must be posted forty-eight hours before and seventy-two hours after applications and should be sufficient to restrict uninformed access to treated areas.

Record Keeping: Child care facilities should keep records of pesticide use at the facility and make the records available to anyone who asks. Record retention requirements vary by state, but federal law requires records to be kept for two years (7). It is a good idea to retain records for a minimum of three years.

Pesticide Storage: Pesticides should be stored in their original containers and in a locked room or cabinet accessible only to authorized staff. No restricted-use pesticides should be stored or used on the premises except by properly licensed persons. Banned, illegal, and unregistered pesticides should not be used.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 5.2.9.4: Radon Concentrations*

Radon concentrations inside a home or building used for child care must be less than four picocuries per liter of air. All facilities must be tested for the presence of radon, according to U.S. Environmental Protection Agency (EPA) testing protocols for long-term testing (i.e., greater than ninety days in duration using alpha-track or electret test devices).

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.2.9.10: Prohibition of Poisonous Plants**

Poisonous or potentially harmful plants are prohibited in any part of a child care facility that is accessible to children. All plants not known to be nontoxic should be identified and checked by name with the local poison center (1-800-222-1222) to determine safe use.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 5.2.9.13: Testing for Lead*

In all centers, both exterior and interior surfaces covered by paint with lead levels of 0.06% and above, or equal to or greater than 1.0 milligram per square centimeter and accessible to children, should be removed by a safe chemical or physical means or made inaccessible to children, regardless of the condition of the surface. In large and small family child care homes, flaking or deteriorating lead-based paint on any surface accessible to...
children should be removed or abated according to health department regulations. Where lead paint is removed, the surface should be refinished with lead-free paint or nontoxic material. Sanding, scraping, or burning of lead-based paint surfaces should be prohibited. Children and pregnant women should not be present during lead renovation or lead abatement activities.

Any surface and the grounds around and under surfaces that children use at a child care facility, including dirt and grassy areas should be tested for excessive lead in a location designated by the health department. Caregivers/teachers should check the U.S. Consumer Product Safety Commission’s Website, http://www.cpsc.gov, for warnings of potential lead exposure to children and recalls of play equipment, toys, jewelry used for play, imported vinyl mini-blinds and food contact products. If they are found to have toxic levels, corrective action should be taken to prevent exposure to lead at the facility. Only nontoxic paints should be used.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.2.9.14: Shoes in Infant Play Areas**

Adults and children should remove or cover shoes before entering a play area used by a specific group of infants. These individuals, as well as the infants playing in that area, may wear shoes, shoe covers, or socks that are used only in the play area for that group of infants.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.4.1.1: General Requirements for Toilet and Handwashing Areas**

Clean toilet and handwashing facilities should be located in the best place to meet the developmental needs of children.

For infant areas, toilets and handwashing facilities are for adult rather than child use. They should be located within the infant area to reduce staff absence.

For toddler areas, toilet and handwashing facilities should be located in or adjacent to the toddler rooms.

For preschool and school-age children, toilet and handwashing facilities should be located near the entrance to the group room and near the entrance to the playground. If both entrances are close to each other, then only one set of toilet and handwashing facilities is needed.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.4.1.4: Preventing Entry to Toilet Rooms by Infants and Toddlers**

Toilet rooms should have barriers that prevent entry by infants and toddlers who are unattended. Infants and toddlers should be supervised by sight and sound at all times.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 6.1.0.1: Size and Location of Outdoor Play Area**

The facility or home should be equipped with an outdoor play area that directly adjoins the indoor facilities or that can be reached by a route that is free of hazards and is no farther than one-eighth mile from the facility. The playground should comprise a minimum of seventy-five square feet for each child using the playground at any one time.

The following exceptions to the space requirements should apply:

- A minimum of thirty-three square feet of accessible outdoor play space is required for each infant;
- A minimum of fifty square feet of accessible outdoor play space is required for each child from eighteen to twenty-four months of age.

There should be separated areas for play for the following ages of children:

- Ages six through twenty-three months
- Ages two to five years*
- Ages five to twelve years**

*These areas may be further sub-divided into ages two to three years and four to five years.

** These areas may be further sub-divided into grades K-1, 2-3, and 4-6.

The outdoor playground should include an open space for running that is free of other equipment (4).

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 6.1.0.2: Size and Requirements of Indoor Play Area**

If a facility has less than seventy-five square feet of accessible outdoor space per child or provides active play space indoors for other reasons, a large indoor activity room that meets the requirement for seventy-five square feet per child may be used if it meets the following requirements:

- It provides for types of activities equivalent to those performed in an outdoor play space;

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*Standard included in Stepping Stones, 3rd Ed*
b. The area is ventilated with fresh, temperate air at a minimum of five cubic feet per minute per occupant when open windows are not possible;

c. The surfaces and finishes are shock-absorbing, as required for outdoor installations in Standard 6.2.3.1;

d. The play equipment meets the requirements for outdoor installation as stated in Standards 6.2.1.3-6.2.1.6 and Standards 6.2.2.3-6.2.2.4.

There should be separated areas for play for the following ages of children:

a. Ages six through twenty-three months
b. Ages two to five years*
c. Ages five to twelve years**

*These areas may be further sub-divided into ages two to three years and four to five years.

** These areas may be further sub-divided into grades K-1, 2-3, and 4-6.

To view the Rationale and Comments for this standard, click here.

**TYPE OF FACILITY:** Center

**STANDARD 6.1.0.4: Elevated Play Areas**

Elevated play areas that have been created using a retaining wall should have a guardrail, protective barrier, or fence running along the top of the retaining wall.

If the exposed side of the retaining wall is higher than two feet, a fence not less than six feet high should be installed. The bottom edge of the fence should be less than three and one-half inches from the base and should be designed to prevent children from climbing it. Fences should be designed so all spaces are less than three and one-half inches from the ground. If the fence is made of horizontal and vertical members, the distance between the bottoms of the horizontal parts of the fence is less than forty-five inches, the horizontal parts should be on the swimming pool side of the fence. The spacing of the vertical members should not exceed one and three-quarters inches.

For a chain link fence, the mesh size should not exceed one and one-quarter square inches.

Exit and entrance points should have self-closing, positive latching gates with locking devices a minimum of fifty-five inches from the ground.

A wall of the child care facility should not constitute one side of the fence unless the wall has no openings capable of providing direct access to the pool (such as doors, windows, or other openings).

If the facility has a water play area, the following requirements should be met:

a. Water play areas should conform to all state and local health regulations;

b. Water play areas should not include hidden or enclosed spaces;

c. Spray areas and water-collecting areas should have a non-slip surface, such as asphalt;

d. Water play areas, particularly those that have standing water, should not have sudden changes in depth of water;

e. Drains, streams, water spouts, and hydrants should not create strong suction effects or water-jet forces;

f. All toys and other equipment used in and around the water play area should be made of sturdy plastic or metal (no glass should be permitted);

g. Water play areas in which standing water is maintained for more than twenty-four hours should be treated according to Standard 6.3.4.1, and inspected for glass, trash, animal excrement, and other foreign material.

To view the Rationale and Comments for this standard, click here.

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

**B. Equipment, Materials, and Toys**

**Facility**

**STANDARD 3.4.6.1: Strangulation Hazards**

Strings and cords (such as those that are parts of toys and those found on window coverings) long enough to encircle a child’s neck should not be accessible to children in child care. Miniblinds and venetian blinds should not have looped cords. Vertical blinds, continuous looped blinds, and drapery cords should have tension or tie-down devices to hold the cords tight. Inner cord stops should be

*Standard included in Stepping Stones, 3rd Ed.*
III. Environment and Equipment

installed. Shoulder straps on guitars and chin straps on hats should be removed (1).

Straps/handles on purses/bags used for dramatic play should be removed or shortened. Ties, scarves, necklaces, and boas used for dramatic play should not be used for children under three years. If used by children three years and over, children should be supervised.

Pacifiers attached to strings or ribbons should not be placed around infants’ necks or attached to infants’ clothing.

Hood and neck strings from all children’s outerwear, including jackets and sweatshirts, should be removed. Drawstrings on the waist or bottom of garments should not extend more than three inches outside the garment when it is fully expanded. These strings should have no knots or toggles on the free ends. The drawstring should be sewn to the garment at its midpoint so the string cannot be pulled out through one side.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 5.1.5.4: Guards at Stairway Access Openings

Securely installed, effective guards (such as gates) should be provided at the top and bottom of each open stairway in facilities where infants and toddlers are in care. Gates should have latching devices that adults (but not children) can open easily in an emergency. “Pressure gates” or accordion gates should not be used. Gate design should not aid in climbing. Gates at the top of stairways should be hardware mounted (e.g., to the wall) for stability. Basement stairways should be shut off from the main floor level by a full door. This door should be self-closing and should be kept locked to entry when the basement is not in use. No door should be locked to prohibit exit at any time.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 5.1.6.6: Guardrails and Protective Barriers

Guardrails, a minimum of thirty-six inches in height, should be provided at open sides of stairs, ramps, and other walking surfaces (e.g., landings, balconies, porches) from which there is more than a thirty-inch vertical distance to fall. Spaces below the thirty-six inches height guardrail should be further divided with intermediate rails or balusters as detailed in the next paragraph.

For preschoolers, bottom guardrails greater than nine inches but less or equal to twenty-three inches above the floor should be provided for all porches, landings, balconies, and similar structures. For school age children, bottom guardrails should be greater than nine inches but less or equal to twenty inches above the floor, as specified above.

For infants and toddlers, protective barriers should be less than three and one-half inches above the floor, as specified above. All spaces in guardrails should be less than three and a half inches. All spaces in protective barriers should be less than three and one-half inches. If spaces do not meet the specifications as listed above, a protective material sufficient to prevent the passing of a three and one-half inch diameter sphere should be provided.

Where practical or otherwise required by applicable codes, guardrails should be a minimum of forty-two inches in height to help prevent falls over the open side by staff and other adults in the child care facility.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 5.2.4.2: Safety Covers and Shock Protection Devices for Electrical Outlets

All electrical outlets accessible to children who are not yet developmentally at a kindergarten grade level of learning should be a type called “tamper-resistant electrical outlets.” These types of outlets look like standard wall outlets but contain an internal shutter mechanism that prevents children from sticking objects like hairpins, keys, and paperclips into the receptacle. This spring-loaded shutter mechanism only opens when equal pressure is applied to both shutters such as when an electrical plug is inserted (2.3).

In existing child care facilities that do not have “tamper-resistant electrical outlets,” outlets should have “safety covers” that are attached to the electrical outlet by a screw or other means to prevent easy removal by a child. “Safety plugs” should not be used since they can be removed from an electrical outlet by children (2.3).

All newly installed or replaced electrical outlets that are accessible to children should use “tamper-resistant electrical outlets.”

In areas where electrical products might come into contact with water, a special type of outlet called Ground Fault Circuit Interrupters (GFCIs) should be installed (2). A GFCI is designed to trip before a deadly electrical shock can occur (1). To ensure that GFCIs are functioning correctly, they should be tested at least monthly (2). GFCIs are also available in a tamper-resistant design.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 5.2.5.1: Smoke Detection Systems and Smoke Alarms

In centers with new installations, a smoke detection system (such as hard-wired system detectors with battery back-up system and control panel) or monitored wireless battery operated detectors that automatically signal an alarm

*Standard included in Stepping Stones, 3rd Ed
through a central control panel when the battery is low or when the detector is triggered by a hazardous condition should be installed with placement of the smoke detectors in the following areas:

- Each story in front of doors to the stairway;
- Corridors of all floors;
- Lounges and recreation areas;
- Sleeping rooms.

In large and small family child care homes, smoke alarms that receive their operating power from the building electrical system or are of the wireless signal-monitored-alarm system type should be installed. Battery-operated smoke alarms should be permitted provided that the facility demonstrates to the fire inspector that testing, maintenance, and battery replacement programs ensure reliability of power to the smoke alarms and signaling of a monitored alarm when the battery is low and that retrofitting the facility to connect the smoke alarms to the electrical system would be costly and difficult to achieve.

Facilities with smoke alarms that operate using power from the building electrical system should keep a supply of batteries and battery-operated detectors for use during power outages.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.2.9.1: Use and Storage of Toxic Substances**

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

- Cleaning materials;
- Detergents;
- Automatic dishwasher detergents;
- Aerosol cans;
- Pesticides;
- Health and beauty aids;
- Medications;
- Lawn care chemicals;
- Other toxic materials.

Material Safety Data Sheets (MSDS) must be available onsite for each hazardous chemical that is on the premises.

These substances should 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 or staff. When not in active use, all chemicals used inside or outside should be stored in a safe and secure manner in a locked room or cabinet, fitted with a child-resistant opening device, inaccessible to children, and separate from stored medications and food.

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

Medications can be toxic if taken by the wrong person or in the wrong dose. Medications should be stored safely (see Standard 3.6.3.1) and disposed of properly (see Standard 3.6.3.2).

The telephone number for the poison center should be posted in a location where it is readily available in emergency situations (e.g., next to the telephone). Poison centers are open twenty-four hours a day, seven days a week, and can be reached at 1-800-222-1222.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.2.9.5: Carbon Monoxide Detectors**

Carbon monoxide detector(s) should be installed in child care settings if one of the following guidelines is met:

- The child care program uses any sources of coal, wood, charcoal, oil, kerosene, propane, natural gas, or any other product that can produce carbon monoxide indoors or in an attached garage;
- If detectors are required by state/local law or state licensing agency.

Facilities must meet state or local laws regarding carbon monoxide detectors. Detectors should be tested monthly. Batteries should be changed at least yearly. Detectors should be replaced at least every five years.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.2.9.6: Preventing Exposure to Asbestos or Other Friable Materials**

Any asbestos, fiberglass, or other friable material or any material that is in a dangerous condition found within a facility or on the grounds of the facility should be repaired or removed. Repair usually involves either sealing (encapsulating) or covering asbestos material. Any repair or removal of asbestos should be done by a contractor certified to do in accordance with existing regulations of the U.S. Environmental Protection Agency (EPA). No children or staff should be present until the removal and cleanup of the hazardous condition have been completed.

Pipe and boiler insulation should be sampled and examined in an accredited laboratory for the presence of asbestos in a friable or potentially dangerous condition.

Non-friable asbestos should be identified to prevent disturbance and/or exposure during remodeling or future activities.
III. Environment and Equipment

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 5.3.1.1: Safety of Equipment, Materials, and Furnishings*

Equipment, materials, furnishings, and play areas should be sturdy, safe, and in good repair and should meet the recommendations of the U.S. Consumer Product Safety Commission (CPSC) for control of the following safety hazards:

a. Openings that could entrap a child’s head or limbs;
b. Elevated surfaces that are inadequately guarded;c. Lack of specified surfacing and fall zones under and around climbable equipment;d. Mismatched size and design of equipment for the intended users;e. Insufficient spacing between equipment;f. Tripping hazards;g. Components that can pinch, shear, or crush body tissues;h. Equipment that is known to be of a hazardous type;i. Sharp points or corners;j. Splinters;k. Protruding nails, bolts, or other components that could entangle clothing or snag skin;l. Loose, rusty parts;m. Hazardous small parts that may become detached during normal use or reasonably foreseeable abuse of the equipment and that present a choking, aspiration, or ingestion hazard to a child;n. Strangulation hazards (e.g., straps, strings, etc.);o. Flaking paint;p. Paint that contains lead or other hazardous materials;q. Tip-over hazards, such as chests, bookshelves, and televisions.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.3.1.3: Size of Furniture**

Furniture should be durable and child-sized or adapted for children’s use. Tables should be between waist and mid-chest level of the intended child-user and allow the child’s feet to rest on a firm surface while seated for eating.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.3.1.4: Surfaces of Equipment, Furniture, Toys, and Play Materials**

Equipment, furnishings, toys, and play materials should have smooth, nonporous surfaces or washable fabric surfaces that are easy to clean and sanitize, or be disposable.

Walls, ceilings, floors, furnishings, equipment, and other surfaces should be suitable to the location and the users. They should be maintained in good repair, free from visible soil and in a clean condition. Programs should choose materials with the least probability of containing materials that off-gas toxic elements such as volatile organic compounds (VOCs), formaldehyde, or toxic flame retardants (polybrominated diphenylethers [PBDE]). Carpets, porous fabrics, and other surfaces that trap soil and potentially contaminated materials should not be used in toilet rooms, diaper change areas, and areas where food handling occurs (1).

Areas used by staff or children who have allergies to dust mites or components of furnishings or supplies should be maintained according to the recommendations of primary care providers.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.3.1.7: Facility Arrangements to Minimize Back Injuries**

The child care setting should be organized to reduce the risk of back injuries for adults provided that such measures do not pose hazards for children or affect the implementation of developmentally appropriate practice. Furnishings and equipment should enable caregivers/teachers to hold and comfort children and enable their activities while minimizing the need for bending and for lifting and carrying heavy children and objects. Caregivers/teachers should not routinely be required to use child-sized chairs, tables, or desks.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.4.1.6: Ratios of Toilets, Urinals, and Hand Sinks to Children**

Toilets and hand sinks should be easily accessible to children and facilitate adult supervision. The number of toilets and hand sinks should be subject to the following minimums:

a. Toddlers:
   1. If each group size is less than ten children, provide one sink and one toilet per group.

b. Preschool-age children:
   1. If each group size is less than ten children, provide one sink and one toilet per group;
2. If each group size is between ten to sixteen children, provide two sinks and two flush toilets for each group.

c. School-age children:
   1. If each group size is less than ten children, provide one sink and one toilet per group;
   2. If each group size is between ten to twenty children, provide two sinks and two toilets per group. Provide separation of male and female toilets.

For toddlers and preschoolers, the maximum toilet height should be eleven inches, and maximum height for hand sinks should be twenty-two inches. Urinals should not exceed 30% of the total required toilet fixtures and should be used by one child at a time. For school-age children, standard height toilet, urinal, and hand sink fixtures are appropriate.

Non-flushing equipment in toilet learning/training should not be counted as toilets in the toilet:child ratio.

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Diaper Changing and Toiletting for a list of the diapering- and toileting-related standards included in this collection.

**STANDARD 5.4.1.7: Toilet Learning/Training Equipment**

Equipment used for toilet learning/training should be provided for children who are learning to use the toilet. Child-sized toilets or safe and cleanable step aids and modified toilet seats (where adult-sized toilets are present) should be used in facilities. Non-flushing toilets (i.e., potty chairs) should be strongly discouraged.

If child-sized toilets, step aids, or modified toilet seats cannot be used, non-flushing toilets (potty chairs) meeting the following criteria should be provided for toddlers, preschoolers, and children with disabilities who require them. Potty chairs should be:

   a. Easily cleaned and disinfected;
   b. Used only in a bathroom area;
   c. Used over a surface that is impervious to moisture;
   d. Out of reach of toilets or other potty chairs;
   e. Cleaned and disinfected after each use in a sink used only for cleaning and disinfecting potty chairs.

Equipment used for toilet learning/training should be accessible to children only under direct supervision.

The sink used to clean and disinfect the potty chair should also be cleaned and disinfected after each use.

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Diaper Changing and Toiletting for a list of the diapering- and toileting-related standards included in this collection.

**STANDARD 5.4.2.1: Diaper Changing Tables**

The facility should have at least one diaper changing table per infant group or toddler group to allow sufficient time for changing diapers and for cleaning and sanitizing between children. Diaper changing tables and sinks should be used only by the children in the group whose routine care is provided together throughout their time in child care. The facility should not permit shared use of diaper changing tables and sinks by more than one group.

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Diaper Changing and Toiletting for a list of the diapering- and toileting-related standards included in this collection.

**STANDARD 5.4.2.4: Use, Location, and Setup of Diaper Changing Areas**

Infants and toddlers should be diapered only in the diaper changing area. Children should be discouraged from remaining in or entering the diaper changing area. The contaminated surfaces of waste containers should not be accessible to children.

Diaper changing areas and food preparation areas should be physically separated. Diaper changing should not be conducted in food preparation areas or on surfaces used for other purposes. Food and drinking utensils should not be washed in sinks located in diaper changing areas.

The diaper changing area should be set up so that no other surface or supply container is contaminated during diaper changing. Bulk supplies should not be stored on or brought to the diaper changing surface. Instead, the diapers, wipes, gloves, a thick layer of diaper cream on a piece of disposable paper, a plastic bag for soiled clothes, and disposable paper to cover the table in the amount needed for a specific diaper change will be removed from the bulk container or storage location and placed on or near the diaper changing surface before bringing the child to the diaper changing area.

Conveniently located, washable, plastic-lined, tightly covered, hands-free receptacles, should be provided for soiled cloths and linen containing body fluids.

Where only one staff member is available to supervise a group of children, the diaper changing table should be positioned to allow the staff member to maintain constant sight and sound supervision of children.

To view the Rationale and Comments for this standard, click here.

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

*Standard included in Stepping Stones, 3rd Ed.*
See Quick Reference: Diaper Changing and Toileting for a list of the diapering- and toileting-related standards included in this collection.

**STANDARD 5.4.2.5: Changing Table Requirements**

Changing tables should meet the following requirements:

a. Have impervious, nonabsorbent, smooth surfaces that do not trap soil and are easily disinfected;

b. Be sturdy and stable to prevent tipping over;

c. Be at a convenient height for use by caregivers/teachers (between twenty-eight and thirty-two inches high);

d. Be equipped with railings or barriers that extend at least six inches above the change surface.

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Diaper Changing and Toileting for a list of the diapering- and toileting-related standards included in this collection.

**STANDARD 5.4.1.10: Handwashing Sinks**

A handwashing sink should be accessible without barriers (such as doors) to each child care area. In areas for infants, toddlers, and preschoolers, the sink should be located so the caregiver/teacher may visually supervise the group of children while carrying out routine handwashing or having children wash their hands. Sinks should be placed at the child’s height or be equipped with a stable step platform to make the sink available to children. If a platform is used, it should have slip-proof steps and platform surface. Also, each sink should be equipped so that the user has access to:

a. Water, at a temperature at least 60°F and no hotter than 120°F;

b. A foot-pedal operated, electric-eye operated, open, self-closing, slow-closing, or metering faucet that provides a flow of water for at least thirty seconds without the need to reactivate the faucet;

c. A supply of hand-cleansing non-antibacterial, unscented liquid soap;

d. Disposable single-use cloth or paper towels or a heated-air hand-drying device with heat guards to prevent contact with surfaces that get hotter than 120°F.

A steam tap or a water tap that provides hot water that is hotter than 120°F may not be used at a handwashing sink.

To view the Rationale and Comments for this standard, click here.

**TYPE OF FACILITY:** Center

See Quick Reference: Handwashing for a list of the handwashing-related standards included in this collection.

**STANDARD 5.4.1.11: Prohibited Uses of Handwashing Sinks**

Handwashing sinks should not be used for rinsing soiled clothing, for cleaning equipment that is used for toileting, or for the disposal of any waste water used in cleaning the facility.

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Handwashing for a list of the handwashing-related standards included in this collection.

**STANDARD 5.4.2.2: Handwashing Sinks for Diaper Changing Areas in Centers**

Handwashing sinks in centers should be provided within arm’s reach of the caregiver/teacher to diaper changing tables and toilets. A minimum of one handwashing sink should be available for every two changing tables. Where infants and toddlers are in care, sinks and diaper changing tables should be assigned for use to a specific group of children and used only by children and adults who are in the assigned group as defined by Standard 5.4.2.1. Handwashing sinks should not be used for bathing or removing smeared fecal material.

To view the Rationale and Comments for this standard, click here.

**TYPE OF FACILITY:** Center

See Quick Reference: Handwashing for a list of the handwashing-related standards included in this collection.

**STANDARD 5.4.2.3: Handwashing Sinks for Diaper Changing Areas in Homes**

Handwashing sinks in large and small family child care homes should be supplied for diaper changing, as specified in Standard 5.4.2.2, except that they should be within ten feet of the changing table if the diapering area cannot be set up so the sink is adjacent to the changing table. If diapered toddlers and preschool-age children are in care, a stepstool should be available at the handwashing sink, as specified in Standard 5.4.1.10, so smaller children can stand at the sink to wash their hands. Handwashing sinks should not be used for bathing or removing smeared fecal material.

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Handwashing for a list of the handwashing-related standards included in this collection.

**STANDARD 5.4.5.1: Sleeping Equipment and Supplies**

Facilities should have an individual crib, cot, sleeping bag, bed, mat, or pad that has not been recalled for each child who spends more than four hours a day at the facility. No
child should simultaneously share a crib, bed, or bedding with another child. Facilities should ensure that toddler beds are in compliance with the current U.S. Consumer Product Safety Commission (CPSC) and ASTM safety standards (1). Clean linens should be provided for each child. Beds and bedding should be washed between uses if used by different children. Regardless of age group, bed linens should not be used as rest equipment in place of cots, beds, pads, or similar approved equipment. Bed linens used under children on cots, cribs, futons, and playpens should be tight-fitting. Sheets for an adult bed should not be used on a crib mattress. See Standard 5.4.5.2 for crib specifications.

When pads are used, they should be enclosed in washable covers and should be long enough so the child’s head or feet do not rest off the pad. Mats and cots should be made with a waterproof material that can be easily washed and sanitized. Plastic bags or loose plastic material should never be used as a covering.

No child should sleep on a bare, uncovered surface. Seasonally appropriate covering, such as sheets, sleep garments, or blankets that are sufficient to maintain adequate warmth, should be available and should be used by each child below school-age. Pillows, blankets, and sleep positioners should not be used with infants. If pillows are used by toddlers and older children, pillows should have removable cases that can be laundered, be assigned to a child, and used by that child only while s/he is enrolled in the facility. Each child’s pillow, blanket, sheet, and any special sleep item should be stored separately from those of other children.

Pads and sleeping bags should not be placed directly on any floor that is cooler than 65°F when children are resting. Cribs, cots, sleeping bags, beds, mats, or pads in/on which children are sleeping should be placed at least three feet apart. If the room used for sleeping cannot accommodate three feet of spacing between children, it is recommended for caregivers/teachers to space children as far as possible from one another and/or alternate children head to feet. Screens used to separate sleeping children are not recommended because screens can affect supervision, interfere with immediate access to a child, and could potentially injure a child if pushed over on a child. If unoccupied sleep equipment is used to separate sleeping children, the arrangement of such equipment should permit the staff to observe and have immediate access to each child. The ends of cribs do not suffice as screens to separate sleeping children.

The sleeping surfaces of one child’s rest equipment should not come in contact with the sleeping surfaces of another child’s rest equipment during storage.

Caregivers/teachers should never use strings to hang any object, such as a mobile, or a toy or a diaper bag, on or near the crib where a child could become caught in it and strangle.

Infant monitors and their cords and other electrical cords should never be placed in the crib or sleeping equipment.

Crib mattresses should fit snugly and be made specifically for the size crib in which they are placed. Infants should not be placed on an inflatable mattress due to potential of entrapment or suffocation.

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Safe Sleep for a list of the safe sleep-related standards included in this collection.

*STANDARD 5.4.5.2: Cribs

Facilities should check each crib before its purchase and use to ensure that it is in compliance with the current U.S. Consumer Product Safety Commission (CPSC) and ASTM safety standards.

Recalled or “second-hand” cribs should not be used or stored in the facility. When it is determined that a crib is no longer safe for use in the facility, it should be dismantled and disposed of appropriately.

Staff should only use cribs for sleep purposes and should ensure that each crib is a safe sleep environment. No child of any age should be placed in a crib for a time-out or for disciplinary reasons. When an infant becomes large enough or mobile enough to reach crib latches or potentially climb out of a crib, they should be transitioned to a different sleeping environment (such as a cot or sleeping mat).

Each crib should be identified by brand, type, and/or product number and relevant product information should be kept on file (with the same identification information) as long as the crib is used or stored in the facility.

Staff should inspect each crib before each use to ensure that hardware is tightened and that there are not any safety hazards. If a screw or bolt cannot be tightened securely, or there are missing or broken screws, bolts, or mattress support hangers, the crib should not be used.

Safety standards document that cribs used in facilities should be made of wood, metal, or plastic. Crib slats should be spaced no more than two and three-eighths inches apart, with a firm mattress that is fitted so that no more than two fingers can fit between the mattress and the crib side in the lowest position. The minimum height from the top of the mattress to the top of the crib rail should be twenty inches in the highest position. Crib with drop sides should not be used. The crib should not have corner post extensions (over one-sixteenth inch). The crib should have no cutout openings in the head board or footboard structure in which a child’s head could become entrapped. The mattress support system should not be easily dislodged from any point of the crib by an upward force from underneath the crib. All cribs should meet the ASTM F1169-10a Standard Consumer Safety Specification for Full-Size Baby Cribs, F406-10b Standard Consumer Safety Specification for Non-Full-Size Baby Cribs/Play Yards, or the CPSC 16 CFR 1219, 1220, and 1500 – Safety Standards for Full-Size Baby Cribs and Non-Full-Size Baby Cribs; Final Rule.

Cribs should be placed away from window blinds or draperies.

*Standard included in Stepping Stones, 3rd Ed.
III. Environment and Equipment

As soon as a child can stand up, the mattress should be adjusted to its lowest position. Once a child can climb out of his/her crib, the child should be moved to a bed. Children should never be kept in their crib by placing, tying, or wedging various fabric, mesh, or other strong coverings over the top of the crib.

Crib intended for evacuation purpose should be of a design and have wheels that are suitable for carrying up to five non-ambulatory children less than two years of age to a designated evacuation area. This crib should be used for evacuation in the event of fire or other emergency. The crib should be easily moveable and should be able to fit through the designated fire exit.

To view the **Rationale and Comments** for this standard, click here.

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

See **Quick Reference: Safe Sleep** for a list of the safe sleep-related standards included in this collection.

**STANDARD 5.4.5.3: Stackable Cribs**

Use of stackable cribs (i.e., cribs that are built in a manner that there are two or three cribs above each other that do not touch the ground floor) in facilities is not advised. In older facilities, where these cribs are already built into the structure of the facility, staff should develop a plan for phasing out the use of these cribs.

If stackable cribs are used, they must meet the current Consumer Product Safety Commission’s (CPSC) federal standard for non-full-size cribs, 16 CFR 1220. In addition they should be three feet apart and staff placing or removing a child from a crib that cannot reach from standing on the floor, should use a stable climbing device such as a permanent ladder rather than climbing on a stool or chair. Infants who are able to sit, pull themselves up, etc. should not be placed in stackable cribs.

To view the **Rationale and Comments** for this standard, click here.

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

See **Quick Reference: Safe Sleep** for a list of the safe sleep-related standards included in this collection.

**STANDARD 5.4.5.4: Futons**

Child-sized futons should be used only if they meet the following requirements:

a. Not on a frame;

b. Easily cleanable;

c. Encased in a tight-fitting waterproof cover;

d. Meet all other standards on sleep and rest areas (Section 5.4.5).

To view the **Rationale and Comments** for this standard, click here.

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

See **Quick Reference: Safe Sleep** for a list of the safe sleep-related standards included in this collection.

**STANDARD 5.5.0.7: Storage of Plastic Bags**

Plastic bags, whether intended for storage, trash, diaper disposal, or any other purpose, should be stored out of reach of children.

To view the **Rationale and Comments** for this standard, click here.

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

**STANDARD 5.5.0.8: Firearms**

Centers should not have any firearms, pellet or BB guns (loaded or unloaded), darts, bows and arrows, cap pistols, stun guns, paint ball guns, or objects manufactured for play as toy guns within the premises at any time. If present in a small or large family child care home, these items must be unloaded, equipped with child protective devices, and kept under lock and key with the ammunition locked separately in areas inaccessible to the children. Parents/guardians should be informed about this policy.

To view the **Rationale and Comments** for this standard, click here.

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

**STANDARD 6.3.3.4: Pool Water Temperature**

Water temperatures should be maintained at no less than 82°F and no more than 88°F while the pool is in use.

To view the **Rationale and Comments** for this standard, click here.

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

**STANDARD 6.3.5.1: Hot Tubs, Spas, and Saunas**

Children should not be permitted in hot tubs, spas, or saunas in child care. Areas should be secured to prevent any access by children.

To view the **Rationale and Comments** for this standard, click here.

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

**STANDARD 6.3.5.2: Water in Containers**

Bathtubs, buckets, diaper pails, and other open containers of water should be emptied immediately after use.

To view the **Rationale and Comments** for this standard, click here.

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

*Standard included in Stepping Stones, 3rd Ed*
**STANDARD 6.4.1.5: Balloons**

Infants, toddlers, and preschool children should not be permitted to inflate balloons, suck on or put balloons in their mouths nor have access to uninflated or underinflated balloons. Children under eight should not have access to latex balloons or inflated latex objects that are treated as balloons. Children under eight should not have access to balloons and these objects should not be permitted in the child care facility.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 6.5.2.2: Child Passenger Safety**

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

a. A child should be transported only if the child is restrained in developmentally appropriate car safety seat, booster seat, seat belt, or harness that is suited to the child’s weight, age, and/or psychological development in accordance with state and federal laws and regulations and the child is securely fastened, according to the manufacturer’s instructions, in a developmentally appropriate child restraint system.

b. Age and size-appropriate vehicle child restraint systems should be used for children under eighty pounds and under four-feet-nine-inches tall and for all children considered too small, in accordance with state and federal laws and regulations, to fit properly in a vehicle safety belt. The child passenger restraint system must meet the federal motor vehicle safety standards contained in the Code of Federal Regulations, Title 49, Section 571.213 (especially Federal Motor Vehicle Safety Standard 213), and carry notice of such compliance.

c. For children who are obese or overweight, it is important to find a car safety seat that fits the child properly. Caregivers/teachers should not use a car safety seat if the child weighs more than the seat’s weight limit or is taller than the height limit. Caregivers/teachers should check the labels on the seat or manufacturer’s instructions if they are unsure of the limits. Manufacturer’s instructions that include these specifications can also be found on the manufacturer’s Website.

d. Child passenger restraint systems should be installed and used in accordance with the manufacturer’s instructions and should be secured in back seats only.

e. All children under the age of thirteen should be transported in the back seat of a car and each child not riding in an appropriate child restraint system (i.e., a child seat, vest, or booster seat) should have an individual lap-and-shoulder seat belt.

f. For maximum safety, infants and toddlers should ride in a rear-facing orientation (i.e., facing the back of the car) until they are two years of age or until they have reached the upper limits for weight or height for the rear-facing seat, according to the manufacturer’s instructions (1). Once their seat is adjusted to face forward, the child passenger must ride in a forward-facing child safety seat (either a convertible seat or a combination seat) until reaching the upper height or weight limit of the seat, in accordance with the manufacturer’s instructions (10). Plans should include limiting transportation times for young infants to minimize the time that infants are sedentary in one place.

g. A booster seat should be used when, according to the manufacturer’s instructions, the child has outgrown a forward-facing child safety seat, but is still too small to safely use the vehicle seat belts (for most children this will be between four feet nine inches tall and between eight and twelve years of age) (1).

h. Car safety seats, whether provided by the child’s parents/guardians or the child care program, should be labeled with the child passenger’s name and emergency contact information.

i. Car safety seats should be replaced if they have been recalled, are past the manufacturer’s “date of use” expiration date, or have been involved in a crash that meets the U.S. Department of Transportation crash severity criteria or the manufacturer’s criteria for replacement of seats after a crash (3,11).

j. The temperature of all metal parts of vehicle child restraint systems should be checked before use to prevent burns to child passengers.

If the child care program uses a vehicle that meets the definition of a school bus and the school bus has safety restraints, the following should apply:

a. The school bus should accommodate the placement of wheelchairs with four tie-downs affixed according to the manufactures' instructions in a forward-facing direction;

b. The wheelchair occupant should be secured by a three-point tie restraint during transport;

c. At all times, school buses should be ready to transport children who must ride in wheelchairs;

d. Manufacturers' specifications should be followed to assure that safety requirements are met.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 6.5.2.4: Interior Temperature of Vehicles**

The interior of vehicles used to transport children should be maintained at a temperature comfortable to children. When the vehicle's interior temperature exceeds 82°F and
III. Environment and Equipment

providing fresh air through open windows cannot reduce the temperature, the vehicle should be air-conditioned. When the interior temperature drops below 65°F and when children are feeling uncomfortably cold, the interior should be heated. To prevent hyperthermia, all vehicles should be locked when not in use, head counts of children should be taken after transporting to prevent a child from being left unintentionally in a vehicle, and children should never be intentionally left in a vehicle unattended.

To view the Rationale and Comments for this standard, click here.

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

Appendix X: Adaptive Equipment for Children with Special Health Care Needs (PDF Link)

Food Preparation and Feeding Area

STANDARD 4.5.0.2: Tableware and Feeding Utensils

Tableware and feeding utensils should meet the following requirements:

a. Dishes should have smooth, hard, glazed surfaces and should be free from cracks or chips. Sharp-edged plastic utensils (intended for use in the mouth) or dishes that have sharp or jagged edges should not be used;

b. Imported dishes and imported ceramic dishware or pottery should be certified by the regulatory health authority to meet U.S. standards and to be safe from lead or other heavy metals before they can be used;

c. Disposable tableware (such as plates, cups, utensils made of heavy weight paper, food-grade medium-weight or BPA- or phthalates-free plastic) should be permitted for single service if they are discarded after use. The facility should not use foam tableware for children under four years of age;

d. Single-service articles (such as napkins, paper placemats, paper tablecloths, and paper towels) should be discarded after one use;

e. Washable bibs, placemats, napkins, and tablecloths, if used, should be laundered or washed, rinsed, and sanitized after each meal. Fabric articles should be sanitized by being machine-washed and dried after each use;

f. Highchair trays, plates, and all items used in food service that are not disposable should be washed, rinsed, and sanitized. Highchair trays that are used for eating should be washed, rinsed, and sanitized just before and immediately after they are used for eating. Children who eat at tables should have disposable or washed and sanitized plates for their food;

g. All surfaces in contact with food should be lead-free;

h. Tableware and feeding utensils should be child-sized and developmentally appropriate.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 4.8.0.1: Food Preparation Area

The food preparation area of the kitchen should be separate from eating, play, laundry, toilet, and bathroom areas and from areas where animals are permitted. The food preparation area should not be used as a passageway while food is being prepared. Food preparation areas should be separated by a door, gate, counter, or room divider from areas the children use for activities unrelated to food, except in small family child care homes when separation may limit supervision of children.

Infants and toddlers should not have access to the kitchen in child care centers. Access by older children to the kitchen of centers should be permitted only when supervised by staff members who have been certified by the nutritionist/registered dietitian or the center director as qualified to follow the facility’s sanitation and safety procedures.

In all types of child care facilities, children should never be in the kitchen unless they are directly supervised by a caregiver/teacher. Children of preschool-age and older should be restricted from access to areas where hot food is being prepared. School-age children may engage in food preparation activities with adult supervision in the kitchen or the classroom. Parents/guardians and other adults should be permitted to use the kitchen only if they know and follow the food safety rules of the facility. The facility should check with local health authorities about any additional regulations that apply.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 4.8.0.8: Microwave Ovens

Microwave ovens should be inaccessible to all children, with the exception of school-age children under close adult supervision. Any microwave oven in use in a child care facility should be manufactured after October 1971 and should be in good condition. While the microwave is being used, it should not be left unattended.

If foods need to be heated in a microwave:

a. Avoid heating foods in plastic containers;

b. Avoid transferring hot foods/drinks into plastic containers;

c. Do not use plastic wrap or aluminum foil in the microwave;

d. Avoid plastics for food and beverages labeled “3” (PVC), “6” (PS), and “7” (polycarbonate);

e. Stir food before serving to prevent burns from hot spots.
III. Environment and Equipment

To view the Rationale and Comments for this standard, click here.

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

STANDARD 5.3.1.8: High Chair Requirements

High chairs, if used, should have a wide base and a securely locking tray, along with a crotch bar/guard to prevent a child from slipping down and becoming entrapped between the tray and the seat. High chairs should also be equipped with a safety strap to prevent a child from climbing out of the chair. The safety strap should be fastened with every use. Caps or plugs on tubing should be firmly attached. Folding high chairs should have a locking device that prevents the high chair from collapsing. High chairs should be labeled or warranted by the manufacturer in documents provided at the time of purchase or verified thereafter by the manufacturer as meeting the ASTM International current Standard F404-08 Consumer Safety Specification for High Chairs. High chairs should be used in accordance with manufacturer’s instructions including following restrictions based on age and minimum/maximum weight of children.

High chairs should be kept far enough away from a table, counter, wall or other surface so that the child can’t use them to push off or to grab potentially dangerous cords or objects.

To view the Rationale and Comments for this standard, click here.

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

Play Areas

STANDARD 5.2.9.7: Proper Use of Art and Craft Materials

Only art and craft materials that are approved by the Art and Creative Materials Institute (ACMI) should be used in the child care facility. Art and craft materials should conform to all applicable ACMI safety standards. Materials should be labeled in accordance with the chronic hazard labeling standard, ASTM D4236.

The facility should prohibit use of unlabeled, improperly labeled old, or donated materials with potentially harmful ingredients.

Caregivers/teachers should closely supervise all children using art and craft materials and should make sure art and craft materials are properly used, cleaned up, and stored in original containers that are fully labeled. Materials should be age-appropriate. Children should not eat or drink while using art and craft materials.

Caregivers/teachers should have emergency protocols in place in the event of an injury, poisoning, or allergic reaction. If caregivers/teachers suspect a poisoning may have occurred they should call their poison center at 1-800-222-1222. Rooms should be well ventilated while using art and craft materials.

Only ACMI-approved unscented water-based markers should be used for children’s art projects and work.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 5.3.1.9: Carriage, Stroller, Gate Enclosure, and Play Yard Requirements

Each carriage, stroller, gate, enclosure, and play yard used should meet the corresponding ASTM International standard and should be so labeled on the equipment.


To view the Rationale and Comments for this standard, click here.

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

STANDARD 6.2.1.1: Play Equipment Requirements

Play equipment and materials in the facility should meet the recommendations of the U.S. Consumer Product Safety Commission (CPSC) and the ASTM International (ASTM) for public playground equipment. Equipment and materials intended for gross-motor (active) play should conform to the recommendations in the CPSC Public Playground Safety Handbook and the provisions in the ASTM “Standard F1487-07ae1: Consumer Safety Performance Specifications for Playground Equipment for Public Use.”

All play equipment should be constructed, installed, and made available to the intended users in such a manner that meets CPSC guidelines and ASTM standards, as warranted by the manufacturers’ recommendations. A Certified Playground Safety Inspector (CPSI) who has been certified by the National Recreation and Park Association (NRPA) should conduct an inspection of playground plans for new installations. Previously installed playgrounds should be inspected at least once each year, by a CPSI or local regulatory agency, and whenever changes are made to the equipment or intended users.

Inspectors should specifically test wooden play equipment structures for chromated copper arsenate (CCA). The wood in many playground sets can contain potentially hazardous levels of arsenic due to the use of CCA as a wood preservative.

Play equipment and materials should be deemed appropriate to the developmental needs, individual interests, abilities, and ages of the children, by a person...
III. Environment and Equipment

with at least a master’s degree in early childhood education or psychology, or identified as age-appropriate by a manufacturer’s label on the product package. Enough play equipment and materials should be available to avoid excessive competition and long waits.

The facility should offer a wide variety of age-appropriate portable play equipment (e.g., balls, jump ropes, hoops, ribbons, scarves, push/pull toys, riding toys, rocking and twisting toys, sand and water play toys) in sufficient quantities that multiple children can play at the same time (1-5).

Children should always be supervised when playing on playground equipment.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 6.2.1.7: Enclosure of Moving Parts on Play Equipment**

All pieces of play equipment should be designed so moving parts (swing components, teeter-totter mechanism, spring-ride springs, and so forth) will be shielded or enclosed. Teeter-totters should not be used by preschool-age children unless they are equipped with a spring centering device and have an appropriate shock-absorbing material underneath the seats. Use of teeter totters is prohibited for infants and toddlers (1-3).

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 6.2.1.9: Entrapment Hazards on Play Equipment**

All openings in pieces of play equipment should be designed too large for a child’s head to get stuck in or too small for a child’s body to fit into, in order to prevent entrapment and strangulation. Openings in exercise rings (overhead hanging rings such as those used in a ring trek or ring ladder) should be smaller than three and one-half inches or larger than nine inches in diameter. Rings on long chains are prohibited. A play structure should have no openings with a dimension between three and one-half inches and nine inches. In particular, side railings, stairs, and other locations where a child might slip or try to climb through should be checked for appropriate dimensions.

Protrusions such as pipes, wood ends, or long bolts that may catch a child’s clothing are prohibited. Distances between two vertical objects that are positioned near each other should be less than three and one-half inches to prevent entrapment of a child’s head. No opening should have a vertical angle of less than fifty-five degrees. To prevent entrapment of fingers, openings should not be larger than three-eighths inch or smaller than one inch. A Certified Playground Safety Inspector (CPSI) is specially trained to find and measure various play equipment hazards.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 6.2.4.3: Sensory Table Materials**

All materials used in a sensory table should be nontoxic and should not be of a size or material that could cause choking. Sensory table activities should not be used with children under eighteen months of age. For toddlers, materials should be limited to water, sand and fixed plastic objects. All sensory table activities should be supervised for toddlers and preschool children. When water is used in a sensory table, the requirements of Standard 6.2.4.2, Water Play Tables should be met.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 6.4.1.2: Inaccessibility of Toys or Objects to Children Under Three Years of Age**

Small objects, toys, and toy parts available to children under the age of three years should meet the federal small parts standards for toys. The following toys or objects should not be accessible to children under three years of age:

a. Toys or objects with removable parts with a diameter less than one and one-quarter inches and a length between one inch and two and one-quarter inches;
b. Balls and toys with spherical, ovoid (egg shaped), or elliptical parts that are smaller than one and three-quarters inches in diameter;
c. Toys with sharp points and edges;
d. Plastic bags;
e. Styrofoam objects;
f. Coins;
g. Rubber or latex balloons;
h. Safety pins;
i. Marbles;
j. Magnets;
k. Foam blocks, books, or objects;
l. Other small objects;
m. Latex gloves;
n. Bulletin board tacks;
o. Glitter.

To view the Rationale and Comments for this standard, click here.

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

*Standard included in Stepping Stones, 3rd Ed*
III. Environment and Equipment

**STANDARD 6.4.1.3: Crib Toys**

Crib gyms, crib toys, mobiles, mirrors, and all objects/toys are prohibited in or attached to an infant’s crib. Items or toys should not be hung from the ceiling over an infant’s crib.

*To view the Rationale and Comments for this standard, click here.*

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

See Quick Reference: Safe Sleep for a list of the safe sleep-related standards included in this collection.

**STANDARD 6.4.2.1: Riding Toys with Wheels and Wheeled Equipment**

Riding toys (such as tricycles) and wheeled equipment (such as scooters) used in the child care setting should:

a. Be spokeless;

b. Be capable of being steered;

c. Be of a size appropriate for the child;

d. Have a low center of gravity;

e. Be in good condition, work properly, and free of sharp edges or protrusions that may injure the children;

Be non-motorized (excluding wheelchairs).

All riders should wear properly fitting helmets. See Standard 6.4.2.2 Helmets, regarding proper usage and type of helmet. Helmets should be removed once children are no longer using wheeled riding toys or wheeled equipment. Children should wear knee and elbow pads in addition to helmets when using wheeled equipment such as scooters, skateboards, rollerblades, etc.

Children should be closely supervised when using riding toys or wheeled equipment.

When not in use, riding toys with wheels and wheeled equipment should be stored in a location where they will not present a physical obstacle to the children and caregivers/teachers. The staff should inspect riding toys and wheeled equipment at least monthly for loose or missing hardware/parts, protrusions, cracks, or rough edges that can lead to injury.

*To view the Rationale and Comments for this standard, click here.*

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

**STANDARD 6.4.2.2: Helmets**

All children one year of age and over should wear properly fitted and approved helmets while riding toys with wheels (tricycles, bicycles, etc.) or using any wheeled equipment (rollerblades, skateboards, etc.). Helmets should be removed as soon as children stop riding the wheeled toys or using wheeled equipment. Approved helmets should meet the standards of the U.S. Consumer Product Safety Commission (CPSC) (5). The standards sticker should be located on the bike helmet. Bike helmets should be replaced if they have been involved in a crash, the helmet is cracked, when straps are broken, the helmet can no longer be worn properly, or according to recommendations by the manufacturer (usually after three years).

*To view the Rationale and Comments for this standard, click here.*

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

**Appendix II Bike Helmets: Quick Fit-Check (PDF Link)**
IV. Program Activities for Healthy Development

A. Developmentally Appropriate Practice

*STANDARD 2.1.1.4: Monitoring Children’s Development/Obtaining Consent for Screening

Child care settings provide daily indoor and outdoor opportunities for promoting and monitoring children’s development. Caregivers/teachers should monitor the children’s development, share observations with parents/guardians, and provide resource information as needed for screenings, evaluations, and early intervention and treatment. Caregivers/teachers should work in collaboration to monitor a child’s development with parents/guardians and in conjunction with the child’s primary care provider and health, education, mental health, and early intervention consultants. Caregivers/teachers should utilize the services of health and safety, education, mental health, and early intervention consultants to strengthen their observation skills, collaborate with families, and be knowledgeable of community resources.

Programs should have a formalized system of developmental screening with all children that can be used near the beginning of a child’s placement in the program, at least yearly thereafter, and as developmental concerns become apparent to staff and/or parents/guardians. The use of authentic assessment and curricular-based assessments should be an ongoing part of the services provided to all children (5-9). The facility’s formalized system should include a process for determining when a health or developmental screening or evaluation for a child is necessary. This process should include parental/guardian consent and participation.

Parents/guardians should be explicitly invited to:

a. Discuss reasons for a health or developmental assessment;

b. Participate in discussions of the results of their child’s evaluations and the relationship of their child’s needs to the caregivers/teachers’ ability to serve that child appropriately;

c. Give alternative perspectives;

d. Share their expectations and goals for their child and have these expectations and goals integrated with any plan for their child;

e. Explore community resources and supports that might assist in meeting any identified needs that child care centers and family child care homes can provide;

f. Give written permission to share health information with primary health care professionals (medical home), child care health consultants and other professionals as appropriate;

The facility should document parents’/guardians’ presence at these meetings and invitations to attend.

If the parents/guardians do not attend the screening, the caregiver/teacher should inform the parents/guardians of the results, and offer an opportunity for discussion. Efforts should be made to provide notification of meetings in the primary language of the parents/guardians. Formal evaluations of a child’s health or development should also be shared with the child’s medical home with parent/guardian consent.

Programs are encouraged to utilize validated screening tools to monitor children’s development, as well as various measures that may inform their work facilitating children’s development and providing an enriching indoor and outdoor environment, such as authentic-based assessment, work sampling methods, observational assessments, and assessments intended to support curricular implementation (5,9). Programs should have clear policies for using reliable and valid methods of developmental screening with all children and for making referrals for diagnostic assessment and possible intervention for children who screen positive. All programs should use methods of ongoing developmental assessment that inform the curricular approaches used by the staff. Care must be taken in communicating the results. Screening is a way to identify a child at risk of a developmental delay or disorder. It is not a diagnosis.

If the screening or any observation of the child results in any concern about the child’s development, after consultation with the parents/guardians, the child should be referred to his or her primary care provider (medical home), or to an appropriate specialist or clinic for further evaluation. In some situations, a direct referral to the Early Intervention System in the respective state may also be required.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 2.1.1.5: Helping Families Cope with Separation

The staff of the facility should engage strategies to help a child and parents/guardians cope with the experience of separation and reunion, such as death of family members, divorce, or placement in foster care.

For the child, this should be accomplished by:

a. Encouraging parents/guardians to spend time in the facility with the child and supporting the separation transition;

b. Providing a comfortable setting both indoors and outdoors for parents/guardians to be with their children to transition or to have conversation with staff;

c. Having established routines for drop-off and pick-up times to assist with transition;
d. Enabling the child to bring to child care tangible reminders of home/family (such as a favorite toy or a picture of self and parent/guardian);

e. Encouraging parents/guardians to reassure the child of their return and to calmly say “goodbye”;

f. Helping the child play out themes of separation and reunion;

g. Frequently exchanging information between the child’s parents/guardians and caregivers/teachers, including activities and routine care information particularly during greeting and departing;

h. Reassuring the child about the parent’s/guardian’s return;

i. Ensuring the caregivers/teachers are consistent both within the parts of a day and across days;

j. Requesting assistance from early childhood mental health consultants, mental health professionals, developmental-behavioral pediatricians, parent/guardian counselors, etc. when a child’s adjustment continues to be problematic over time;

k. When a family is experiencing separation due to a military deployment, explore changes in children’s behavior that may be related to feelings of anger, fear, sadness, or uncertainty related to changes in family structure as a result of deployment. Work with the parent/guardian at home to help the child adjust to these changes, including providing activities that help the child remain connected to the deployed parent/guardian and manage their emotions throughout the deployment cycle.

For the parents/guardians, this should be accomplished by:

   a. Validating their feelings as a universal human experience;
   b. Providing parents/guardians with information about the positive effects for children of high quality facilities with strong parent/guardian participation;
   c. Encouraging parents/guardians to discuss their feelings;
   d. Providing parents/guardians with evidence, such as photographs, that their child is being cared for and is enjoying the activities of the facility;
   e. Ask parents/guardians to bring pictures from home that may be placed in the room or cubby and displayed throughout the indoor and outdoor learning/play environment at the child’s eye level;
   f. Where a family is experiencing separation due to a military deployment, collaborate with the parent/guardian at home to address changes in children’s behavior that may be related to the deployment, providing parents/guardians with information about activities in care and at home may help promote their child’s positive adjustment throughout the deployment cycle (connect parents/guardians with services/resources in the community that can help to support them);
   g. Requesting assistance from early childhood mental health consultants, mental health professionals, developmental-behavioral pediatricians, parent/guardian counselors, etc. when a child’s adjustment continues to be problematic over time.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 2.1.1.6: Transitions within Programs and Indoor and Outdoor Learning/Play Environments**

Caregivers/teachers should take into consideration the individual needs of children when transitioning them to a new indoor and outdoor learning/play environment. The transitioning child/children should be offered the opportunity to visit the new space with a familiar caregiver/teacher with enough time to allow them to display comfort in the new space. The program should allow time for communication with the families regarding the process and for each child to follow through a comfortable time line of adaptation to the new indoor and outdoor learning/play environment, caregiver/teachers, and peers.

Children need time to manipulate, explore and familiarize themselves with the new space and caregivers/teachers. This should be done before they are part of a new group to allow them time to explore to their personal satisfaction. Eating is a primary reinforcer and need. The opportunity to share food within the new space will help reassures a child and help adults assess how the transition is going.

Toiletting involves another level of trust. Diapering/toiletting should be introduced in the new space with a familiar teacher.

New routines should be introduced by the new staff with a familiar caregiver/teacher present to support the child/children. Transitions to the indoor and outdoor learning/play environment, especially if the space is different than the one from which they are familiar, should follow similar procedures as moving to another indoor space. Parents/guardians should be part of the transition as they too are in the process of learning to trust a new indoor and outdoor learning/play environment for their child. Primary needs need to be met to support a smooth transition.

Transitions should be planned in advance, based on the child’s readiness. A written plan should be developed and shared with parents/guardians, describing how and when the transition will occur. Children should not be moved to a new indoor and outdoor learning/play environment for the sole purpose of maintaining child: staff ratios.

To view the Rationale and Comments for this standard, click here.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home
STANDARD 2.1.1.7: Communication in Native Language Other Than English

At least one member of the staff should be able to communicate with the parents/guardians and children in the family’s native language (sign or spoken), or the facility should work with parents/guardians to arrange for a translator to communicate with parents/guardians and children. Efforts should be made to support a child’s and family’s native language while providing resources and opportunities for learning English (2). Children should not be used as translators. They are not developmentally able to understand the meaning of all words as used by adults, nor should they participate in all conversations that may be regarding the child.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 2.1.1.9: Verbal Interaction

The child care facility should assure that a rich environment of spoken language by caregivers/teachers surrounds and includes all children with opportunities to expand their language communication skills. Each child should have at least one speaking adult person who engages the child in language communication skills. Each child should have at least one speaking adult person who engages the child in language communication skills. Each child should have at least one speaking adult person who engages the child in language communication skills. Each child should have at least one speaking adult person who engages the child in language communication skills. Each child should have at least one speaking adult person who engages the child in language communication skills.

a. For infants, these interactions should include responses to, and encouragement of, soft infant sounds, as well as identifying objects, feelings, and desires by the caregiver/teacher.

b. For toddlers, the interactions should include naming of objects, feelings, listening to the child and responding, along with actions and supporting, but not forcing, the child to do the same.

c. For preschool and school-age children, interactions should include respectful listening and responses to what the child has to say, amplifying and clarifying the child’s intent, and not reinforcing mispronunciations (e.g., Wambulance instead of Ambulance).

d. Frequent interchange of questions, comments, and responses to children, including extending children’s utterances with a longer statement, by teaching staff.

e. For children with special needs, alternative methods of communication should be available, including but not limited to: sign language, assistive technology, picture boards, picture exchange communication systems (PECS), FM systems for hearing aids, etc. Communication through methods other than verbal communication can result in the same desired outcomes.

f. Profanity should not be used at any time.

Opportunities should be provided for each child to develop a personal and affectionate relationship with, and attachment to, that child’s parents/guardians and one or a small number of caregivers/teachers whose care for and responsiveness to the child ensure relief of distress, experiences of comfort and stimulation, and satisfaction of the need for a personal relationship.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 2.1.2.1: Personal Caregiver/Teacher Relationships for Infants and Toddlers

The facility should practice a relationship-based philosophy that promotes consistency and continuity of caregivers/teachers for infants and toddlers. The facility should limit the number of caregivers/teachers who interact with any one infant (1,2) to no more than five caregivers/teachers across the period that the child is an infant in child care. The caregiver/teacher should:

a. Hold and comfort children who are upset;

b. Engage in frequent, multiple, and rich social interchanges such as smiling, talking, touching, singing, and eating;

c. Be play partners as well as protectors;

d. Be attuned to children’s feelings and reflect them back;

e. Communicate consistently with parents/guardians;

f. Interact with children and develop a relationship in the context of everyday routines (diapering, feeding, etc.)

Opportunities should be provided for each child to develop a personal and affectionate relationship with, and attachment to, that child’s parents/guardians and one or a small number of caregivers/teachers whose care for and responsiveness to the child ensure relief of distress, experiences of comfort and stimulation, and satisfaction of the need for a personal relationship.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 2.1.2.2: Interactions with Infants and Toddlers

Caregivers/teachers should provide consistent, continuous and inviting opportunities to talk, listen to, and otherwise interact with young infants throughout the day (indoors and outdoors) including feeding, changing, playing with, and cuddling them.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 2.1.2.3: Space and Activity to Support Learning of Infants and Toddlers

The facility should provide a safe and clean learning environment, both indoors and outdoors, colorful materials and equipment arranged to support learning. The indoor and outdoor learning/play environment should encourage and be comfortable with staff on the floor level when interacting with active infant crawlers and toddlers. The indoor and outdoor play and learning settings should
provide opportunities for the child to act upon the environment by experiencing age-appropriate obstacles, frustrations, and risks in order to learn to negotiate environmental challenges. The facility should provide opportunities for play that:

- Lessen the child’s anxiety and help the child adapt to reality and resolve conflicts;
- Enable the child to explore and experience the natural world;
- Help the child practice resolving conflicts;
- Use symbols (words, numbers, etc.);
- Manipulate objects;
- Exercise physical skills;
- Encourage language development;
- Foster self-expression;
- Strengthen the child’s identity as a member of a family and a cultural community;
- Promote sensory exploration.

For infants and toddlers the curriculum should be based on the child’s development at the time and connected to a sound understanding as to where they are in their developmental course.

To view the Rationale and Comments for this standard, click here.

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

### STANDARD 2.1.2.4: Separation of Infants and Toddlers from Older Children

Infants and toddlers younger than three years of age should be cared for in a closed room(s) that separates them from other groups of toddlers and older children.

In facilities caring for three or more children younger than three years of age, activities that bring children younger than three years of age into contact with older children should be prohibited, unless the younger children already have regular contact with the older children as part of a group.

Pooling, as a practice in larger settings where the infants/toddlers are not part of the group all day – as in home care – should be avoided for the following reasons:

- Unfamiliarity with caregivers/teachers if not the primary one during the day;
- Concerns of noise levels, space ratios, social-emotional well-being, etc.);
- Occurs at times when children are least able to handle transitions;
- Increases the number of transitions for children,
- Increases the number of adults caring for infants and toddlers, a practice to be avoided if possible.

Caregivers/teachers of infants should not be responsible for the care of older children who are not a part of the infants’ closed child care group.

Groups of younger infants should receive care in closed room(s) that separates them from other groups of toddlers and older children.

When partitions are used, they must control interaction between groups, provide separated ventilation of the spaces and control sound transmission. The acoustic controls should limit significant transmission of sound from one group’s activity into other group environments.

To view the Rationale and Comments for this standard, click here.

### TYPE OF FACILITY: Center

#### STANDARD 2.1.2.5: Toilet Learning/Training

The facility should develop and implement a plan that teaches each child how and when to use the toilet. Toilet learning/training, when initiated, should follow a prescribed, sequential plan that is developed and coordinated with the parent’s/guardian’s plan for implementation in the home environment. Toilet learning/training should be based on the child’s developmental level rather than chronological age.

To help children achieve bowel and bladder control, caregivers/teachers should enable children to take an active role in using the toilet when they are physically able to do so and when parents/guardians support their children’s learning to use the toilet.

Diapering/toilet training should not be used as rationale for not spending time outdoors. Practices and policies should be offered to address diapering/toileting needs outdoors such as providing staff who can address children’s needs, or provide outdoor diapering and toileting that meets all sanitation requirements.

Caregivers/teachers should take into account the preferences and customs of the child’s family.

For children who have not yet learned to use the toilet, the facility should defer toilet learning/training until the child’s family is ready to support this learning and the child demonstrates:

- An understanding of the concept of cause and effect;
- An ability to communicate, including sign language;
- The physical ability to remain dry for up to two hours;
- An ability to sit on the toilet, to feel/understand the sense of elimination;
- A demonstrated interest in autonomous behavior.

For preschool and school-age children, an emphasis should be placed on appropriate handwashing after using the toilet and they should be provided frequent and unrestricted opportunities to use the toilet.

Children with special health care needs may require specific instructions, training techniques, adapted toilets, and/or supports or precautions. Some children will need to be taught special techniques like catheterization or care of ostomies. This can be provided by trained staff or older

*Caring for Infants and Toddlers in Child Care and Early Education

*Standard included in Stepping Stones, 3rd Ed.*
children can sometimes learn self-care techniques. Any special techniques should be documented in a written care plan. The child care health consultant can provide training or coordinate resources necessary to accommodate special toileting techniques while in child care.

Cultural expectations of toilet learning/training need to be recognized and respected.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 2.2.0.2: Limiting Infant/Toddler time in Crib, High Chair, Care Seat, Etc.**

A child should not sit in a high chair or other equipment that constrains his/her movement (1,2) indoors or outdoors for longer than fifteen minutes, other than at meals or snack time. Children should never be left out of the view and attention of adult caregivers/teachers while in these types of equipment/furniture. A least restrictive environment should be encouraged at all times. Children should not be left to sleep in equipment, such as car seats, swings, or infant seats that does not meet ASTM International (ASTM) product safety standards for sleep equipment.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 2.2.0.3: Limiting Screen Time – Media, Computer Time**

In early care and education settings, media (television [TV], video, and DVD) viewing and computer use should not be permitted for children younger than two years. For children two years and older in early care and early education settings, total screen time should be limited to not more than thirty minutes once a week, and for educational or physical activity use only. During meal or snack time, TV, video, or DVD viewing should not be allowed (1). Computer use should be limited to no more than fifteen-minute increments except for school-age children completing homework assignments (2) and children with special health care needs who require and consistently use assistive and adaptive computer technology.

Parents/guardians should be informed if screen media are used in the early care and education program. Any screen media used should be free of advertising and brand placement. TV programs, DVD, and computer games should be reviewed and evaluated before participation of the children to ensure that advertising and brand placement are not present.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 2.2.0.5: Behavior Around a Pool**

When children are in or around a pool, caregivers/teachers should teach age-appropriate behavior and safety skills including not pushing each other, holding each other under water, or running at the poolside. Children should be shown the depth of the water at different part of the pool. They should be taught that when going into a body of water, they should go in feet first the first time to check the depth. Children should be instructed what an emergency would be and to only call for help only in a real/genuine emergency. They should be taught to never dive in shallow water.

To view the Rationale and Comments for this standard, click here.

**STANDARD 2.3.1.1: Mutual Responsibility of Parents/Guardians and Staff**

The quality of the relationship between parents/guardians and caregivers/teachers has an influence on the child. There should be a reciprocal responsibility of the family and caregivers/teachers to observe, participate, and be trained in the care that each child requires, and they should be encouraged to work together as partners in providing care.

During the enrollment process, caregivers/teachers should clarify who is/are the legal guardian(s) of the child. All relevant legal documents, court orders, etc., should also be collected and filed during the enrollment process (1). Caregivers/teachers should comply with court orders and written consent from the parent/guardian with legal authority, and not try to make the determination themselves regarding the best interests of the child.

All aspects of child care programs should be designed to facilitate parent/guardian input and involvement. Non-custodial parents should have access to the same developmental and behavioral information given to the custodial parent/guardian, if they have joint legal custody, permission by court order, or written consent from the custodial parent/guardian.

Caregivers/teachers should also clarify with whom the child spends significant time and with whom the child has primary relationships as they will be key informants for the caregivers/teachers about the child and his/her needs.

Parent/guardian involvement is needed at all levels of the program, including program planning for indoors and outdoors, provision of quality care, screening for children who are ill, and support for other parents/guardians. Communication between the administrator, caregiver/teacher and parent/guardian are essential to facilitate the involvement and commitment of parents/guardians. Parents/guardians should be invited to participate on the program board or planning meetings for the program. Parents/guardians should meet with their child’s caregiver/teacher or the director annually to discuss how their child is doing in the program. On a daily basis, parents/guardians and caregivers/teachers should share information about the child’s health, changes in drop-off or

*Standard included in Stepping Stones, 3rd Ed*
IV. Program Activities for Healthy Development

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

STANDARD 9.2.1.1: Content of Policies

The facility should have policies to specify how the caregiver/teacher addresses the developmental functioning and individual or special health care needs of children of different ages and abilities who can be served by the facility, as well as other services and procedures. These policies should include, but not be limited to, the following:

a. Admissions criteria, enrollment procedures, and daily sign-in/sign-out policies, including authorized individuals for pick-up and allowing parent/guardian access whenever their child is in care;
b. Inclusion of children with special health care needs;
c. Nondiscrimination;
d. Payment of fees, deposits, and refunds;
e. Termination of enrollment and parent/guardian notification of termination;
f. Supervision;
g. Staffing, including caregivers/teachers, the use of volunteers, helpers, or substitute caregivers/teachers, and deployment of staff for different activities;
h. A written comprehensive and coordinated planned program based on a statement of principles;
i. Discipline;
j. Methods and schedules for conferences or other methods of communication between parents/guardians and staff;
k. Care of children and staff who are ill;
l. Temporary exclusion for children and staff who are ill and alternative care for children who are ill;
m. Health assessments and immunizations;
n. Handling urgent medical care or threatening incidents;
o. Medication administration;
p. Use of child care health consultants and education and mental health consultants;
q. Plan for health promotion and prevention (e.g., tracking routine child health care, health consultation, health education for children/staff/families, oral health, sun safety, safety surveillance, preventing obesity, etc.);
r. Disasters, emergency plan and drills, evacuation plan, and alternative shelter arrangements;
s. Security;
t. Confidentiality of records;
u. Transportation and field trips;
v. Physical activity (both outdoors and when children are kept indoors), play areas, screen time, and outdoor play policy;
w. Sleeping, safe sleep policy, areas used for sleeping/napping, sleep equipment, and bed linen;

Caring for Infants and Toddlers in Child Care and Early Education

*Standard included in Stepping Stones, 3rd Ed.*
The facility should have specific strategies for implementing each policy. For centers, all of these items should be written. Facility policies should vary according to the ages and abilities of the children enrolled to accommodate individual or special health care needs. Program planning should precede, not follow the enrollment and care of children at different developmental levels and abilities and with different health care needs. Policies, plans, and procedures should generally be reviewed annually or when any changes are made. A child care health consultant can be very helpful in developing and implementing model policies.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 9.2.2.1: Planning for the Child’s Transition to New Services

If a parent/guardian requests assistance with the transition process from the facility to a public school or another program, the designated care or service coordinator at the facility should review the child’s records, including needs, learning style, supports, progress, and recommendations. The designated care or service coordinator should obtain written informed consent from the parent/guardian prior to sharing information at a transition meeting, in a written summary, or in some other verbal or written format.

The process for the child’s departure should also involve sharing and the exchange of progress reports with other care providers for the child and the parents/guardians of the child within the realm of confidentiality guidelines.

Any special health care need of the child and successful strategies that have been employed while at child care should be shared. For children who are receiving services under Part C of IDEA, a transition plan is required, usually at least ninety days prior to the time that the child will leave the facility or program.

In the case of a child who may be eligible for preschool services, with approval of the family of the child, a conference should be convened among the lead agency, the family, and the local educational agency not less than ninety days (and at the discretion of all such parties, not more than nine months) before the child is eligible for the preschool services, to discuss any such services that the child may receive. In the case of a child who may not be eligible for such preschool services, with the approval of the family, reasonable efforts should be made to convene a conference among the lead agency, the family, and providers of other appropriate services, to discuss the appropriate services that the child may receive; to review the child’s program options; for the period from the child’s third birthday through the remainder of the school year; and to establish a transition plan, including as appropriate, steps to exit from the program. A plan also requires description of efforts to promote collaboration among Early Head Start programs under section 645A of the Head Start Act, early education and child care programs.

The facility should determine in what form and for how long archival records of transitioned children should be maintained by the facility.

To view the Rationale and Comments for this standard, click here.

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

B. Positive Behavior Management

*STANDARD 2.2.0.6: Discipline Measures

Reader’s Note: The word discipline means to teach and guide. Discipline is not punishment. The discipline standard therefore reflects an approach that focuses on preventing behavior problems by supporting children in learning appropriate social skills and emotional responses.

Caregivers/teachers should guide children to develop self-control and appropriate behaviors in the context of relationships with peers and adults. Caregivers/teachers should care for children without ever resorting to physical punishment or abusive language. When a child needs assistance to resolve a conflict, manage a transition, engage in a challenging situation, or express feelings, needs, and wants, the adult should help the child learn strategies for dealing with the situation. Discipline should be an ongoing process to help children learn to manage their own behavior in a socially acceptable manner, and should not just occur in response to a problem behavior. Rather, the adult’s guidance helps children respond to difficult situations using socially appropriate strategies. To develop self-control, children should receive adult support that is individual to the child and adapts as the child develops internal controls. This process should include:

a. Forming a positive relationship with the child. When children have a positive relationship with the adult, they are more likely to follow that person’s directions. This positive relationship occurs when the adult spends time talking to the child, listening to the child, following the child’s lead, playing with the child, and responding to the child’s needs;

b. Basing expectations on children’s developmental level;
c. Establishing simple rules children can understand (e.g., you can't hurt others, our things, or yourself) and being proactive in teaching and supporting children in learning the rules;

d. Adapting the physical indoor and outdoor learning/play environment or family child care home to encourage positive behavior and self regulation by providing engaging materials based on children's interests and ensuring that the learning environment promotes active participation of each child. Well-designed child care environments are ones that are supportive of appropriate behavior in children, and are designed to help children learn about what to expect in that environment and to promote positive interactions and engagement with others;

e. Modifying the learning/play environment (e.g., schedule, routine, activities, transitions) to support the child's appropriate behavior;

f. Creating a predictable daily routine and schedule. When a routine is predictable, children are more likely to know what to do and what is expected of them. This may decrease anxiety in the child. When there is less anxiety, there may be less acting out. Reminders need to be given to the children so they can anticipate and prepare themselves for transitions within the schedule. Reminders should be individualized such that each child understands and anticipates the transition;

g. Using encouragement and descriptive praise. When clear encouragement and descriptive praise are used to give attention to appropriate behaviors, those behaviors are likely to be repeated. Encouragement and praise should be stated positively and descriptively. Encouragement and praise should provide information that the behavior the child engaged in was appropriate. Examples: “I can tell you are ready for circle time because you are sitting on your name and looking at me.” “Your friend looked so happy when you helped him clean up his toys.” “You must be so proud of yourself for putting on your coat all by yourself.” Encouragement and praise should label the behaviors, not the child (e.g., good listening, good eating, instead of good boy);

h. Using clear, direct, and simple commands. When clear commands are used with children, they are more likely to follow them. The caregiver/teacher should tell the child what to do rather than what NOT to do. The caregiver/teacher should limit the number of commands. The caregiver/teacher should use if/then and when/then statements with logical and natural consequences. These practices help children understand they can make choices and that choices have consequences;

i. Showing children positive alternatives rather than just telling children “no”;

j. Modeling desired behavior;

k. Using planned ignoring and redirection. Certain behaviors can be ignored while at the same time the adult is able to redirect the children to another activity. If the behavior cannot be ignored, the adult should prompt the child to use a more appropriate behavior and provide positive feedback when the child engages in the behavior;

l. Individualizing discipline based on the individual needs of children. For example, if a child has a hard time transitioning, the caregiver/teacher can identify strategies to help the child with the transition (individualized warning, job during transition, individual schedule, peer buddy to help, etc.) If a child has a difficult time during a large group activity, the child might be taught to ask for a break;

m. Using time-out for behaviors that are persistent and unacceptable. Time-out should only be used in combination with instructional approaches that teach children what to do in place of the behavior problem. (See guidance for time-outs below.)

Expectations for children’s behavior and the facility’s policies regarding their response to behaviors should be written and shared with families and children of appropriate age. Further, the policies should address proactive as well as reactive strategies. Programs should work with families to support their children’s appropriate behaviors before it becomes a problem.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 2.2.0.7: Handling Physical Aggression, Biting and Hitting

Caregivers/teachers should intervene immediately when a child’s behavior is aggressive and endangers the safety of others. It is important that the child be clearly told verbally, “no hitting” or “no biting.” The caregiver/teacher should use age–appropriate interventions. For example, a toddler can be picked up and moved to another location in the room if s/he bites other children or adults. A preschool child can be invited to walk with you first but, if not compliant, taken by the hand and walked to another location in the room. The caregiver/teacher should remain calm and make eye contact with the child telling him/her the behavior is unacceptable. If the behavior persists, parents/guardians, caregivers/teachers, the child care health consultant and the early childhood mental health consultant should be involved to create a plan targeting this behavior. For example, a plan may be developed to teach children what to do in place of the behavior themselves and the reason for and antecedents of the behavior must be considered when developing a plan for addressing the behavior.

To view the Rationale and Comments for this standard, click here.

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

*Standard included in Stepping Stones, 3rd Ed.*
**STANDARD 2.2.0.8: Preventing Expulsions, Suspensions, and Other Limitations in Services**

Child care programs should not expel, suspend, or otherwise limit the amount of services (including denying outdoor time, withholding food, or using food as a reward/punishment) provided to a child or family on the basis of challenging behaviors or a health/safety condition or situation unless the condition or situation meets one of the two exceptions listed in this standard.

Expulsion refers to terminating the enrollment of a child or family in the regular group setting because of a challenging behavior or a health condition. Suspension and other limitations in services include all other reductions in the amount of time a child may be in attendance of the regular group setting, either by requiring the child to cease attendance for a particular period of time or reducing the number of days or amount of time that a child may attend. Requiring a child to attend the program in a special place away from the other children in the regular group setting is included in this definition.

Child care programs should have a comprehensive discipline policy that includes an explicit description of alternatives to expulsion for children exhibiting extreme levels of challenging behaviors, and should include the program’s protocol for preventing challenging behaviors. These policies should be in writing and clearly articulated and communicated to parents/guardians, staff and others. These policies should also explicitly state how the program plans to use any available internal mental health and other support staff during behavioral crises to eliminate to the degree possible any need for external supports (e.g., local police departments) during crises.

Staff should have access to in-service training on both a proactive and as-needed basis on how to reduce the likelihood of problem behaviors escalating to the level of risk for expulsion and how to more effectively manage behaviors throughout the entire class/group. Staff should also have access to in-service training, resources, and child care health consultation to manage children’s health conditions in collaboration with parents/guardians and the child’s primary care provider. Programs should attempt to obtain access to behavioral or mental health consultation to help establish and maintain environments that will support children’s mental well-being and social-emotional health, and have access to such a consultant when more targeted child-specific interventions are needed. Mental health consultation may be obtained from a variety of sources, as described in Standard 1.6.0.3.

When children exhibit or engage in challenging behaviors that cannot be resolved easily, as above, staff should:

a. Assess the health of the child and the adequacy of the curriculum in meeting the developmental and educational needs of the child;

b. Immediately engage the parents/guardians/family in a spirit of collaboration regarding how the child’s behaviors may be best handled, including appropriate solutions that have worked at home or in other settings;

c. Access an early childhood mental health consultant to assist in developing an effective plan to address the child’s challenging behaviors and to assist the child in developing age-appropriate, pro-social skills;

d. Facilitate, with the family’s assistance, a referral for an evaluation for either Part C (early intervention) or Part B (preschool special education), as well as any other appropriate community-based services (e.g., child mental health clinic);

e. Facilitate with the family communication with the child’s primary care provider (e.g., pediatrician, family medicine provider, etc.), so that the primary care provider can assess for any related health concerns and help facilitate appropriate referrals.

The only possible reasons for considering expelling, suspending or otherwise limiting services to a child on the basis of challenging behaviors are:

a. Continued placement in the class and/or program clearly jeopardizes the physical safety of the child and/or his/her classmates as assessed by a qualified early childhood mental health consultant AND all possible interventions and supports recommended by a qualified early childhood mental health consultant aimed at providing a physically safe environment have been exhausted; or

b. The family is unwilling to participate in mental health consultation that has been provided through the child care program or independently obtain and participate in child mental health assistance available in the community; or

c. Continued placement in this class and/or program clearly fails to meet the mental health and/or social-emotional needs of the child as agreed by both the staff and the family AND a different program that is better able to meet these needs has been identified and can immediately provide services to the child.

In either of the above three cases, a qualified early childhood mental health consultant, qualified special education staff, and/or qualified community-based mental health care provider should be consulted, referrals for special education services and other community-based services should be facilitated, and a detailed transition plan from this program to a more appropriate setting should be developed with the family and followed. This transition could include a different private or public-funded child care or early education program in the community that is better equipped to address the behavioral concerns (e.g., therapeutic preschool programs, Head Start or Early Head Start, prekindergarten programs in the public schools that have access to additional support staff, etc.), or public-funded special education services for infants and toddlers (i.e., Part C early intervention) or preschoolers (i.e., Part B preschool special education).

To the degree that safety can be maintained, the child should be transitioned directly to the receiving program. The program should assist parents/guardians in securing
the more appropriate placement, perhaps using the services of a local child care resource and referral agency. With parent/guardian permission, the child’s primary care provider should be consulted and a referral for a comprehensive assessment by qualified mental health provider and the appropriate special education system should be initiated. If abuse or neglect is suspected, then appropriate child protection services should be informed. Finally, no child should ever be expelled or suspended from care without first conducting an assessment of the safety of alternative arrangements (e.g., Who will care for the child? Will the child be adequately and safely supervised at all times?) (1).

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 2.2.0.9: Prohibited Caregiver/Teacher Behaviors**

The following behaviors should be prohibited in all child care settings and by all caregivers/teachers:

a. The use of corporal punishment. Corporal punishment means punishment inflicted directly on the body including, but not limited to:
   1. Hitting, spanking (refers to striking a child with an open hand on the buttocks or extremities with the intention of modifying behavior without causing physical injury), slapping, twisting, pulling, squeezing, or biting;

b. Isolating a child in an adjacent room, hallway, closet, darkened area, play area, or any other area where a child cannot be seen or supervised;

b. Binding or tying to restrict movement, such as in a car seat (except when travelling) or taping the mouth;

c. Using or withholding food as a punishment or reward;

d. Toilet learning/training methods that punish, demean, or humiliate a child;

e. Any form of emotional abuse, including rejecting, terrorizing, extended ignoring, isolating, or corrupting a child;

f. Any abuse or maltreatment of a child, either as an incident of discipline or otherwise. Any child care program must not tolerate, or in any manner condone, an act of abuse or neglect of a child by an older child, employee, volunteer, or any person employed by the facility or child’s family;

g. Abusive, profane, or sarcastic language or verbal abuse, threats, or derogatory remarks about the child or child’s family;

h. Any form of public or private humiliation, including threats of physical punishment (1);

i. Physical activity/outdoor time should not be taken away as punishment.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 2.2.0.10: Using Physical Restraint**

Reader’s Note: It should never be necessary to physically restrain a typically developing child unless his/her safety and/or that of others are at risk.

When a child with special behavioral or mental health issues is enrolled who may frequently need the cautious use of restraint in the event of behavior that endangers his or her safety or the safety of others, a behavioral care plan should be developed with input from the child’s primary care provider, mental health provider, parents/guardians, center director/family child care home caregiver/teacher, child care health consultant, and possibly early childhood mental health consultant in order to address underlying issues and reduce the need for physical restraint.

That behavioral care plan should include:

a. An indication and documentation of the use of other behavioral strategies before the use of restraint and a precise definition of when the child could be restrained;

b. That the restraint be limited to holding the child as gently as possible to accomplish the restraint;

c. That such child restraint techniques do not violate the state’s mental health code;

d. That the amount of time the child is physically restrained should be the minimum necessary to control the situation and be age-appropriate; reevaluation and change of strategy should be used every few minutes;

e. That no bonds, ties, blankets, straps, car seats, heavy weights (such as adult body sitting on child), or abusive words should be used;

f. That a designated and trained staff person, who should be on the premises whenever

To view the Rationale and Comments for this standard, click here.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home
IV. Program Activities for Healthy Development

**STANDARD 4.5.0.11: Prohibited Uses of Food**

Caregivers/teachers should not force or bribe children to eat nor use food as a reward or punishment.

To view the Rationale and Comments for this standard, click [here](#).

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

**STANDARD 9.2.1.6: Written Discipline Policies**

Each facility should have a written discipline policy reflective of the positive methods of guidance appropriate to the ages of the children enrolled outlined in Standard 2.2.0.6 and prohibited caregiver behaviors as outlined in Standard 2.2.0.9.

The facility should have policies for dealing with biting, hitting, and other undesired behavior by children and written protocol reflective guidance outlined in Standard 2.2.0.7.

Policies should explicitly prohibit corporal punishment, psychological abuse, humiliation, abusive language, binding or tying to restrict movement, restriction of access to large motor physical activities, and the withdrawal or forcing of food and other basic needs.

All caregivers/teachers should sign an agreement to implement the facility’s discipline policies. A policy explicitly stating the consequence for staff who do not follow the discipline policies should be reviewed and signed by each staff member prior to hiring.

To view the Rationale and Comments for this standard, click [here](#).

**TYPE OF FACILITY**: Center; Large Family Child Care Home; Small Family Child Care Home
V. Healthy Weight Promotion

A. Physical Activity

*STANDARD 3.1.3.1: Active Opportunities for Physical Activity

The facility should promote children's active play every day. Children should have ample opportunity to do moderate to vigorous activities such as running, climbing, dancing, skipping, and jumping. All children, birth to six years, should participate daily in:

- a. Two to three occasions of active play outdoors, weather permitting (see Standard 3.1.3.2: Playing Outdoors for appropriate weather conditions);
- b. Two or more structured or caregiver/teacher/adult-led activities or games that promote movement over the course of the day—indoor or outdoor;
- c. Continuous opportunities to develop and practice age-appropriate gross motor and movement skills.

The total time allotted for outdoor play and moderate to vigorous indoor or outdoor physical activity can be adjusted for the age group and weather conditions.

- Outdoor play:
  1. Infants (birth to twelve months of age) should be taken outside two to three times per day, as tolerated. There is no recommended duration of infants’ outdoor play;
  2. Toddlers (twelve months to three years) and preschoolers (three to six years) should be allowed sixty to ninety total minutes of outdoor play. These outdoor times can be curtailed somewhat during adverse weather conditions in which children may still play safely outdoors for shorter periods, but should increase the time of indoor activity, so the total amount of exercise should remain the same;

- Total time allotted for moderate to vigorous activities:
  1. Toddlers should be allowed sixty to ninety minutes per eight-hour day for moderate to vigorous physical activity, including running;
  2. Preschoolers should be allowed ninety to one hundred and twenty minutes per eight-hour day (4).

Infants should have supervised tummy time every day when they are awake. Beginning on the first day at the early care and education program, caregivers/teachers should interact with an awake infant on their tummy for short periods of time (three to five minutes), increasing the amount of time as the infant shows s/he enjoys the activity (27).

Time spent outdoors has been found to be a strong, consistent predictor of children’s physical activity (1-3). Children can accumulate opportunities for activity over the course of several shorter segments of at least ten minutes each. Because structured activities have been shown to produce higher levels of physical activity in young children, it is recommended that caregivers/teachers incorporate two or more short structured activities (five to ten minutes) or games daily that promote physical activity.

Opportunities to be actively enjoying physical activity should be incorporated into part-time programs by prorating these recommendations accordingly, i.e., twenty minutes of outdoor play for every three hours in the facility.

Active play should never be withheld from children who misbehave (e.g., child is kept indoors to help another caregiver/teacher while the rest of the children go outside) (5). However, children with out-of-control behavior may need five minutes or less to calm themselves or settle down before resuming cooperative play or activities.

Infants should not be seated for more than fifteen minutes at a time, except during meals or naps. Infant equipment such as swings, stationary activity centers (ex. exersaucers), infant seats (ex. bouncers), molded seats, etc. if used should only be used for short periods of time. A least restrictive environment should be encouraged at all times (5,6,26).

Children should have adequate space for both inside and outside play.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 3.1.3.2: Playing Outdoors

Children should play outdoors when the conditions do not pose a safety risk, individual child health risk, or significant health risk of frostbite or of heat related illness. Caregivers/teachers must protect children from harm caused by adverse weather, ensuring that children wear appropriate clothing and/or appropriate shelter is provided for the weather conditions. Outdoor play for infants may include riding in a carriage or stroller; however, infants should be offered opportunities for gross motor play outdoors, as well.

Weather that poses a significant health risk should include wind chill factor at or below minus 15°F and heat index at or above 90°F, as identified by the National Weather Service (NWS).

Sunny weather:

- a. Children should be protected from the sun by using shade, sun-protective clothing, and sunscreen with UVB-ray and UVA-ray protection of SPF 15 or higher, with permission from parents/guardians;
- b. Children should wear sun-protective clothing, such as hats, when playing outdoors between the hours of 10 AM and 4 PM.

Warm weather:

- a. Children should be well hydrated before engaging in prolonged periods of physical activity and encouraged to drink water during periods of prolonged physical activity;
Cold weather:

a. Children should wear layers of loose-fitting, lightweight clothing. Outer garments such as coats should be tightly woven, and be at least water repellent when precipitation is present, such as rain or snow;

b. Children should wear a hat, coat, and gloves/mittens kept snug at the wrist;

c. Caregivers/teachers should check children’s extremities for maintenance of normal color and warmth at least every fifteen minutes.

Caregivers/teachers should also be aware of environmental hazards such as contaminated water, loud noises, and lead in soil when selecting an area to play outdoors. Children should be observed closely when playing in dirt/soil, so that no soil is ingested. Play areas should be secure and away from heavy traffic areas.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 9.2.3.1: Policies and Practices that Promote Physical Activity

The facility should have written policies on the promotion of physical activity and the removal of potential barriers to physical activity participation. Policies should cover the following:

a. Benefits: benefits of physical activity and outdoor play;

b. Duration: children will spend sixty to one hundred and twenty minutes each day outdoors depending on their age, weather permitting. Policies will describe what will be done to ensure physical activity and provisions for gross motor activities indoors on days with more extreme conditions (i.e., very wet, very hot, or very cold);

c. Setting: provision of covered areas for shade and shelter on playgrounds, if feasible (2);

d. Clothing: clothing should permit easy movement (not too loose and not too tight) that enables children to participate fully in active play; footwear should provide support for running and climbing.

Examples of appropriate clothing/footwear include:

a. Gym shoes or sturdy gym-shoe-equivalent;

b. Clothes for the weather, including heavy coat, hat, and mittens in the winter/snow; raincoat and boots for the rain; and layered clothes for climates in which the temperature can vary dramatically on a daily basis.

Examples of inappropriate clothing/footwear include:

a. Footwear that can come off while running or that provide insufficient support for climbing (3);

b. Clothing that can catch on playground equipment (e.g., those with drawstrings or loops).

If children wear “dress clothes” or special outfits that cannot be easily laundered, caregivers/teachers should talk with the children’s parents/guardians about the program’s goals in providing physical activity during the program day and encourage them to provide a set of clothes that can be used during physical activities.

Facilities should discuss the importance of this policy with parents/guardians upon enrollment and periodically thereafter.

In addition to outdoor play, the facility is encouraged to incorporate movement activities or games into the standard indoor curriculum.

To view the Rationale and Comments for this standard, click here.

B. Nutrition

STANDARD 4.2.0.2: Assessment and Planning of Nutrition for Individual Children

As a part of routine health supervision by the child’s primary care provider, children should be evaluated for nutrition-related medical problems such as failure to thrive, overweight, obesity, food allergy, reflux disease, and iron-deficiency anemia. The nutritional standards throughout this document are general recommendations that may not always be appropriate for some children with medically-identified special nutrition needs. Caregivers/teachers should communicate with the child’s parent/guardian and primary care provider to adapt nutritional offerings to individual children as indicated and medically-appropriate. Caregivers/teachers should work with the parent/guardian to implement individualized feeding plans developed by the child’s primary care provider to meet a child’s unique nutritional needs. These plans could include, for instance, additional iron-rich foods to a child who has been diagnosed as having iron-deficiency anemia. For a child diagnosed as overweight, the plan would focus on controlling portion sizes. Also, calorie dense foods like sugar sweetened juices, nectars, and beverages should not be served. Denying a child food that others are eating is difficult to explain and difficult for some children to understand and accept. Attention should be paid to teaching about proper portion sizes and the average daily caloric intake of the child.

Some children require special feeding techniques such as thickened foods or special positioning during meals. Other children will require dietary modifications based on food

*Standard included in Stepping Stones, 3rd Ed
intolerances such as lactose or wheat (gluten) intolerance. Some children will need dietary modifications based on cultural or religious preferences such as vegetarian or kosher diets.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 4.2.0.3: Use of USDA – CACFP Guidelines*

All meals and snacks and their preparation, service, and storage should meet the requirements for meals of the child care component of the U.S. Department of Agriculture (USDA), Child and Adult Care Food Program (CACFP), and the 7 Code of Federal Regulations (CFR) Part 226.20 (1,5).

To view the Rationale and Comments for this standard, click here.

**TYPE OF FACILITY**: Center; Large Family Child Care Home; Small Family Child Care Home
## STANDARD 4.2.0.4: Categories of Foods

Children in care should be offered items of food from the following categories:

<table>
<thead>
<tr>
<th>Food Groups</th>
<th>USDA†</th>
<th>CFOC Guidelines for Young Children</th>
</tr>
</thead>
</table>
| Fruits            | All fresh, frozen, canned, dried fruits, and fruit juices | Eat a variety, especially whole fruits  
Whole fruit, mashed or pureed, for infants seven months up to one year of age  
No juice before twelve months of age  
4 to 6 oz juice/day for one- to six-year-olds  
8 to 12 oz juice/day for seven- to twelve-year-olds |
| Vegetables        | Dark green, red, and orange; beans and peas (legumes); starchy vegetables; other vegetables | Dark green, red, orange, deep yellow vegetables  
Other vegetables, including starchy ones like potatoes  
Other root vegetables, such as viandas  
Dried peas and beans (legumes) |
| Grains            | Whole grains and enriched grains | Whole and enriched grains, breads, cereals, crackers, pasta, and rice |
| Protein Foods     | Seafood, meat, poultry, eggs, nuts, seeds, and soy products | Fish, chicken, lean meat, eggs  
Nuts and seeds (if appropriate)  
Avoid fried fish, meat, and chicken |
| Dairy             | Milk | Human milk, infant formula for infants at least up to one year of age  
Whole milk for children ages on up to two years of age  
or reduced fat (2%) milk for those at risk for obesity or hypercholesterolemia  
1% or skim milk for children two years of age and older  
Other milks such as soy when recommended  
Other milk equivalent products such as yogurt and cottage cheese (low-fat for children two years of age and older) |
| Oils              | Oils, soft margarines, includes vegetable, nut, and fish oils and soft vegetable oil table spreads that have no trans fats | Choose monounsaturated and polyunsaturated fats (olive oil, safflower oil)  
Soft margarines  
Avoid trans fats, saturated fats and fried foods |
| Solid Fats and Added Sugar | Limit calories (% of calories) of these food groups | Avoid concentrated sweets such as candy, sodas, sweetened drinks, fruit nectars, and flavored milk  
Limit salty foods such as chips and pretzels |

*All foods are assumed to be in nutrient-dense forms, lean or low-fat and prepared without added fats, sugars, or salt. Solid fats and added sugars may be included up to the daily maximum limit identified in the Dietary Guidelines for Americans, 2010.
†Recommends: Find your balance between food and physical activity.

To view the Rationale and Comments for this standard, click [here](#).

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

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*Standard included in Stepping Stones, 3rd Ed*  
Caring for Infants and Toddlers in Child Care and Early Education
STANDARD 4.2.0.5: Meal and Snack Patterns

The facility should ensure that the following meal and snack pattern occurs:

- Children in care for eight and fewer hours in one day should be offered at least one meal and two snacks or two meals and one snack.
- Children in care more than eight hours in one day should be offered at least two meals and two snacks or three snacks and one meal.
- A nutritious snack should be offered to all children in midmorning (if they are not offered a breakfast on-site that is provided within three hours of lunch) and in the middle of the afternoon.
- Children should be offered food at intervals at least two hours apart and not more than three hours apart unless the child is asleep. Some very young infants may need to be fed at shorter intervals than every two hours to meet their nutritional needs, especially breastfed infants being fed expressed human milk. Lunch service may need to be served to toddlers earlier than the preschool-aged children due to their need for an earlier nap schedule. Children must be awake prior to being offered a meal/snack.
- Children should be allowed time to eat their food and not be rushed during the meal or snack service. They should not be allowed to play during these times.
- Caregivers/teachers should discuss the breastfed infant’s feeding patterns with the parents/guardians because the frequency of breastfeeding at home can vary. For example, some infants may still be feeding frequently at night, while others may do the bulk of their feeding during the day. Knowledge about the infant’s feeding patterns over twenty-four hours will help caregivers/teachers assess the infant’s feeding during his/her time with the caregiver/teacher.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 4.2.0.7: 100% Fruit Juice

The facility should serve only full-strength (100%) pasteurized fruit juice or full-strength fruit juice diluted with water from a cup to children twelve months of age or older. Juice should have no added sweeteners. The facility should offer juice at specific meals and snacks instead of continuously throughout the day. Juice consumption should be no more than a total of four to six ounces a day for children aged one to six years. This amount includes juice served at home. Children ages seven through twelve years of age should consume no more than a total of eight to twelve ounces of fruit juice per day. Caregivers/teachers should ask parents/guardians if they provide juice at home and how much. This information is important to know if and when to serve juice. Infants should not be given any fruit juice before twelve months of age. Whole fruit, mashed or pureed, is recommended for infants seven months up to one year of age.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 4.2.0.8: Feeding Plans and Dietary Modifications

Before a child enters an early care and education facility, the facility should obtain a written history that contains any special nutrition or feeding needs for the child, including use of human milk or any special feeding utensils. The staff should review this history with the child’s parents/guardians, clarifying and discussing how parental/guardian home feeding routines may differ from the facility’s planned routine. The child’s primary care provider should provide written information about any dietary modifications or special feeding techniques that are required at the early care and education program and these plans should be shared with the child’s parents/guardians upon request.

If dietary modifications are indicated, based on a child’s medical or special dietary needs, the caregiver/teacher should modify or supplement the child’s diet to meet the individual child’s specific needs. Dietary modifications should be made in consultation with the parents/guardians and the child’s primary care provider. Caregivers/teachers can consult with a nutritionist/registered dietitian.

Caring for Infants and Toddlers in Child Care and Early Education

*Standard included in Stepping Stones, 3rd Ed.
Reasons for modification of a child’s diet may be related to food sensitivity. Food sensitivity includes a range of conditions in which a child exhibits an adverse reaction to a food that, in some instances, can be life threatening. Modification of a child’s diet may be related to a food allergy, inability to digest or to tolerate certain foods, need for extra calories, need for special positioning while eating, diabetes and the need to match food with insulin, food idiosyncrasies, and other identified feeding issues. Examples include celiac disease, phenylketonuria, diabetes, severe food allergy (anaphylaxis), and others. In some cases, a child may become ill if the child is unable to eat, so missing a meal could have a negative consequence, especially for diabetics.

For a child identified with special health care needs for dietary modification or special feeding techniques, written instructions from the child’s parent/guardian and the child’s primary care provider should be provided in the child’s record and carried out accordingly. Dietary modifications should be recorded. These written instructions must identify:

a. The child’s full name and date of instructions;
b. The child’s special needs;
c. Any dietary restrictions based on the special needs;
d. Any special feeding or eating utensils;
e. Any foods to be omitted from the diet and any foods to be substituted;
f. Limitations of life activities;
g. Any other pertinent special needs information;
h. What, if anything, needs to be done if the child is exposed to restricted foods.

The written history of special nutrition or feeding needs should be used to develop individual feeding plans and, collectively, to develop facility menus. Disciplines related to special nutrition needs, including nutrition, nursing, speech, occupational therapy, and physical therapy, should participate when needed and/or when they are available to the facility. The nutritionist/registered dietitian should approve menus that accommodate needed dietary modifications.

The feeding plan should include steps to take when a situation arises that requires rapid response by the staff, such as a child’s choking during mealt ime or a child with a known history of food allergies demonstrating signs and symptoms of anaphylaxis (severe allergic reaction, e.g., difficulty breathing or severe redness and swelling of the face or mouth). The completed plan should be on file and accessible to the staff and available to parents/guardians upon request.

To view the Rationale and Comments for this standard, click here.

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

### STANDARD 4.2.0.9: WrittenMenus and Introduction of New Foods

Facilities should develop, at least one month in advance, written menus showing all foods to be served during that month and should make the menus available to parents/guardians. The facility should date and retain these menus for six months, unless the state regulatory agency requires a longer retention time. The menus should be amended to reflect any and all changes in the food actually served. Any substitutions should be of equal nutrient value.

To avoid problems of food sensitivity in very young children under eighteen months of age, caregivers/teachers should obtain from the child’s parents/guardians a list of foods that have already been introduced (without any reaction), and then serve some of these foods to the child. As new foods are considered for serving, caregivers/teachers should share and discuss these foods with the parents/guardians prior to their introduction.

To view the Rationale and Comments for this standard, click here.

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

### STANDARD 4.2.0.12: Vegetarian/Vegan Diets

Infants and children, including school-age children from families practicing any level of vegetarian diet, can be accommodated in an early care and education environment when there is:

- Written documentation from parents/guardians on the detailed and accurate dietary history about food choices - foods eaten, levels of limitations/restrictions to foods, and frequency of foods offered;
- An up-to-date health record of the child available to the caregivers/teachers, including information about linear growth and rate of weight gain, or consistent poor appetite (these indicators can be warning signs of growth deficiencies);
- Collaboration among early care and education staff, especially the sharing of updated information on the child’s health with the parents/guardians by the child care health consultant and the nutritionist/registered dietitian;
- Sound health and nutrition information that is culturally relevant to the family to ensure that the child receives adequate calories and essential nutrients which promote adequate growth and development of the child.

To view the Rationale and Comments for this standard, click here.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home
STANDARD 4.3.1.1: General Plan for Feeding Infants

At a minimum, meals and snacks the facility provides for infants should contain the food in the meal and snack patterns of the Child and Adult Care Food Program (CACFP). Food should be appropriate for the infant’s individual nutrition requirements and developmental stages as determined by written instructions obtained from the child’s parent/guardian or primary care provider.

The facility should encourage, provide arrangements for, and support breastfeeding. The facility staff, with appropriate training, should be the mother’s cheerleader and enthusiastic supporter for the mother’s plan to provide her milk. Facilities should have a designated place set aside for breastfeeding mothers who want to come during work to breastfeed, as well as a private area with an outlet (not a bathroom) for mothers to pump their breast milk (2–8). A place that mothers feel they are welcome to breastfeed, pump, or bottle feed can create a positive environment when offered in a supportive way.

Infants may need a variety of special formulas such as soy-based formula or elemental formulas which are easier to digest and less allergenic. Elemental or special non-allergic formulas should be specified in the infant’s care plan.

Age-appropriate solid foods (complementary foods) may be introduced no sooner than when the child has reached the age of four months, but preferably six months and as indicated by the individual child’s nutritional and developmental needs. For breastfed infants, gradual introduction of iron-fortified foods may occur no sooner than around four months, but preferably six months to complement the human milk.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 4.3.1.2: Feeding Infants on Cue by A Consistent Caregiver/Teacher

Caregivers/teachers should feed infants on the infant’s cue unless the parent/guardian and the child’s primary care provider give written instructions otherwise (6). Whenever possible, the same caregiver/teacher should feed a specific infant for most of that infant’s feedings. Cues such as opening the mouth, making suckling sounds, and moving the hands at random all send information from an infant to a caregiver/teacher that the infant is ready to feed. Caregivers/teachers should not feed infants beyond satiety, just as hunger cues are important in initiating feedings, observing satiety cues can limit overfeeding.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 4.3.1.6: Use of Soy-Based Formula and Soy Milk

Soy-based formula or soy milk should be provided to a child whose parents/guardians present a written request because of family dietary restrictions on foods produced from animals (i.e., cow’s milk and other dairy products). Both soy-based formula and soy milk should be labeled with the infant’s or child’s full name and date and stored properly.

The caregiver/teacher should collaborate with parents/guardians in exploring community resources to secure soy-based formula. Soy milk should be available for the children of parents/guardians participating in the Women, Infants, and Children (WIC) Supplemental Food Program, Child and Adult Care Food Program (CACFP), or Food Stamp Program.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 4.3.1.7: Feeding Cow’s Milk

The facility should not serve cow’s milk to infants from birth to twelve months of age, unless provided with a written exception and direction from the child’s primary care provider and parents/guardians. Children between twelve and twenty-four months of age, who are not on human milk or prescribed formula, can be served whole pasteurized milk, or reduced fat (2%) pasteurized milk for those children who are at risk for hypercholesterolemia or obesity (1). Children two years of age and older should be served skim or 1% pasteurized milk.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 4.3.1.8: Technique for Bottle Feeding

Infants should always be held for bottle feeding. Caregivers/teachers should hold infants in the caregiver’s/teacher’s arms or sitting up on the caregiver’s/teacher’s lap. Bottles should never be propped. The facility should not permit infants to have bottles in the crib. The facility should not permit an infant to carry a bottle while standing, walking, or running around.

Bottle feeding techniques should mimic approaches to breastfeeding:

a. Initiate feeding when infant provides cues (rooting, sucking, etc.);

b. Hold the infant during feedings and respond to vocalizations with eye contact and vocalizations;

c. Alternate sides of caregiver’s/teacher’s lap;

d. Allow breaks during the feeding for burping;

e. Allow infant to stop the feeding.
A caregiver/teacher should not bottle feed more than one infant at a time.

Bottles should be checked to ensure they are given to the appropriate child, have human milk, infant formula, or water in them.

When using a bottle for a breastfed infant, a nipple with a cylindrical teat and a wider base is usually preferable. A shorter or softer nipple may be helpful for infants with a hypersensitive gag reflex, or those who cannot get their lips well back on the wide base of the teat.

The use of a bottle or cup to modify or pacify a child’s behavior should not be allowed.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 4.3.1.11: Introduction of Age-Appropriate Solid Foods to Infants

A plan to introduce age-appropriate solid foods (complementary foods) to infants should be made in consultation with the child’s parent/guardian and primary care provider. Age-appropriate solid foods may be introduced no sooner than when the child has reached the age of four months, but preferably six months and as indicated by the individual child’s nutritional and developmental needs.

For breastfed infants, gradual introduction of iron-fortified foods may occur no sooner than around four months, but preferably six months and to complement the human milk. Modification of basic food patterns should be provided in writing by the child’s primary care provider.

Evidence for introducing complementary foods in a specific order or rate is not available. The current best practice is that the first solid foods should be single-ingredient foods and should be introduced one at a time at two- to seven-day intervals.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 4.3.1.12: Feeding Age-Appropriate Solid Foods to Infants

Staff members should serve commercially packaged baby food from a dish, not directly from a factory-sealed container. They should serve age-appropriate solid food (complementary food) by spoon only. Age-appropriate solid food should not be fed in a bottle or an infant feeder unless written in the child’s care plan by the child’s primary care provider. Caregivers/teachers should discard uneaten food left in dishes from which they have fed a child. The facility should wash off all jars of baby food with soap and warm water before opening the jars, and examine the food carefully when removing it from the jar to make sure there are not glass pieces or foreign objects in the food.

Food should not be shared among children using the same dish or spoon. Unused portions in opened factory-sealed baby food containers or food brought in containers prepared at home should be stored in the refrigerator and discarded if not consumed after twenty-four hours of storage.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 4.3.2.1: Meal and Snack Patterns for Toddlers and Preschoolers

Meals and snacks should contain at least the minimum amount of foods shown in the meal and snack patterns for toddlers and preschoolers described in the Child and Adult Care Food Program (CACFP) guidelines at http://www.fns.usda.gov/sites/default/files/Child_Meals.pdf

To view the Rationale and Comments for this standard, click here.

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

STANDARD 4.3.2.2: Serving Size for Toddlers and Preschoolers

The facility should serve toddlers and preschoolers small-sized, age-appropriate portions and should permit children to have one or more additional servings of the nutritious foods that are low in fat, sugar, and sodium as needed to meet the caloric needs of the individual child. Serving sizes should contain the appropriate amount of food based on serving sizes or portions recommended for each child and adult as described in the Child and Adult Care Food Program (CACFP) guidelines at http://www.fns.usda.gov/sites/default/files/Child_Meals.pdf

Young children should learn what appropriate portion size is by being served in plates, bowls, and cups that are developmentally appropriate to their nutritional needs.

Food service staff and/or a caregiver/teacher is responsible for preparing the amount of food based on the recommended age-appropriate amount of food per serving for each child to be fed. Usually a reasonable amount of additional food is prepared to respond to a child or children requesting a second serving of the nutritious foods that are low in fat, sugar, and sodium.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 4.3.2.3: Encouraging Self-Feeding by Older Infants and Toddlers

Caregivers/teachers should encourage older infants and toddlers to hold and drink from an appropriate child-sized cup, to use a child-sized spoon (short handle with a shallow bowl like a soup spoon), a child-sized fork (short, blunt tines and broad handle similar to a salad fork), all of which are developmentally appropriate for young children.

*Standard included in Stepping Stones, 3rd Ed
to feed themselves, and to use their fingers for self-feeding.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 4.5.0.1: Developmentally Appropriate Seating and Utensils for Meals**

The child care staff should ensure that children who do not require highchairs are comfortably seated at tables that are between waist and mid-chest level and allow the seated child’s feet to rest on a firm surface.

All furniture and eating utensils that a child care facility uses should make it possible for children to eat at their best skill level and to increase their eating skill.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 4.5.0.4: Socialization During Meals**

Caregivers/teachers and children should sit at the table and eat the meal or snack together. Family style meal service, with the serving platters, bowls, and pitchers on the table so all present can serve themselves, should be encouraged, except for infants and very young children who require an adult to feed them. A separate utensil should be used for serving. Children should not handle foods that they will not be consuming. The adults should encourage, but not force, the children to help themselves to all food components offered at the meal. When eating meals with children, the adult(s) should eat items that meet nutrition standards. The adult(s) should encourage social interaction and conversation, using vocabulary related to the concepts of color, shape, size, quantity, number, temperature of food, and events of the day. Extra assistance and time should be provided for slow eaters. Eating should be an enjoyable experience at the facility and at home.

Special accommodations should be made for children who cannot have the food that is being served. Children who need limited portion sizes should be taught and monitored.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 4.5.0.8: Experience with Familiar and New Foods**

In consultation with the family and the nutritionist/registered dietitian, caregivers/teachers should offer children familiar foods that are typical of the child’s culture and religious preferences and should also introduce a variety of healthful foods that may not be familiar, but meet a child’s nutritional needs. Experiences with new foods can include tasting and swallowing but also include engagement of all senses (seeing, smelling, speaking, etc.) to facilitate the introduction of these new foods.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 4.7.0.1: Nutritional Learning Experiences for Children**

The facility should have a nutrition plan that integrates the introduction of food and feeding experiences with facility activities and home feeding. The plan should include opportunities for children to develop the knowledge and skills necessary to make appropriate food choices.

For centers, this plan should be a written plan and should be the shared responsibility of the entire staff, including directors and food service personnel, together with parents/guardians. The nutrition plan should be developed with guidance from, and should be approved by, the nutritionist/registered dietitian or child care health consultant.

Caregivers/teachers should teach children about the taste, smell, texture of foods, and vocabulary and language skills related to food and eating. The children should have the opportunity to feel the textures and learn the different colors, sizes, and shapes of foods and the nutritional benefits of eating healthy foods. Children should also be taught about appropriate portion sizes. The teaching should be evident at mealtimes and during curricular activities, and emphasize the pleasure of eating. Caregivers/teachers need to be aware that children between the ages of two- and five-years-old are often resistant to trying new foods and that food acceptance may take eight to fifteen times of offering a food before it is eaten (14).

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 9.2.3.11: Food and Nutrition Service Policies and Plans**

The facility should have food handling, feeding, and nutrition policies and plans under the direction of the administration that address the following items and assigns responsibility for each:

- Kitchen layout;
- Food budget;
- Food procurement and storage;
- Menu and meal planning;
- Food preparation and service;
- Kitchen and meal service staffing;
- Nutrition education for children, staff, and parents/guardians;

*Standard included in Stepping Stones, 3rd Ed.*
A nutritionist/registered dietitian and a food service expert should provide input for and facilitate the development and implementation of a written nutrition plan for the early care and education facility.  

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 9.2.3.12: Infant Feeding Policy**

A policy about infant feeding should be developed with the input and approval from the nutritionist/registered dietitian and should include the following:

- a. Storage and handling of expressed human milk;
- b. Determination of the kind and amount of commercially prepared formula to be prepared for infants as appropriate;
- c. Preparation, storage, and handling of infant formula;
- d. Proper handwashing of the caregiver/teacher and the children;
- e. Use and proper sanitizing of feeding chairs and of mechanical food preparation and feeding devices, including blenders, feeding bottles, and food warmers;
- f. Whether expressed human milk, formula, or infant food should be provided from home, and if so, how much food preparation and use of feeding devices, including blenders, feeding bottles, and food warmers, should be the responsibility of the caregiver/teacher;
- g. Holding infants during bottle-feeding or feeding them sitting up;
- h. Prohibiting bottle propping during feeding or prolonging feeding;
- i. Responding to infants’ need for food in a flexible fashion to allow cue feedings in a manner that is consistent with the developmental abilities of the child (policy acknowledges that feeding infants on cue rather than on a schedule may help prevent obesity) (1,2);
- j. Introduction and feeding of age-appropriate solid foods (complementary foods);
- k. Specification of the number of children who can be fed by one adult at one time;
- l. Handling of food intolerance or allergies (e.g., cow’s milk, peanuts, orange juice, eggs, wheat).

Individual written infant feeding plans regarding feeding needs and feeding schedule should be developed for each infant in consultation with the infant’s primary care provider and parents/guardians.  

To view the Rationale and Comments for this standard, click here.

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

**Appendix JJ: Our Child Care Center Supports Breastfeeding (PDF Link)**
VI. Safe and Healthy Practices and Procedures

A. Safe Food Practices

*STANDARD 4.3.1.3: Preparing, Feeding and Storing Human Milk

Expressed human milk should be placed in a clean and sanitary bottle with a nipple that fits tightly or into an equivalent clean and sanitary sealed container to prevent spilling during transport to home or to the facility. Only cleaned and sanitized bottles, or their equivalent, and nipples should be used in feeding. The bottle or container should be properly labeled with the infant’s full name and the date and time the milk was expressed. The bottle or container should immediately be stored in the refrigerator on arrival.

The mother’s own expressed milk should only be used for her own infant. Likewise, infant formula should not be used for a breastfed infant without the mother’s written permission.

Bottles made of plastics containing BPA or phthalates should be avoided (labeled with #3, #6, or #7). Glass bottles or plastic bottles labeled BPA-free or with #1, #2, #4, or #5 are acceptable.

Non-frozen human milk should be transported and stored in the containers to be used to feed the infant, identified with a label which will not come off in water or handling, bearing the date of collection and child’s full name. The filled, labeled containers of human milk should be kept refrigerated. Human milk containers with significant amount of contents remaining (greater than one ounce) may be returned to the mother at the end of the day as long as the child has not fed directly from the bottle.

Frozen human milk may be transported and stored in single use plastic bags and placed in a freezer (not a compartment within a refrigerator but either a freezer with a separate door or a standalone freezer). Human milk should be defrosted in the refrigerator if frozen, and then heated briefly in bottle warmers or under warm running water so that the temperature does not exceed 98.6°F. If there is insufficient time to defrost the milk in the refrigerator before warming it, then it may be defrosted in a container of running cool tap water, very gently swirling the bottle periodically to evenly distribute the temperature in the milk. Some infants will not take their mother’s milk unless it is warmed to body temperature, around 98.6°F. The caregiver/teacher should check for the infant’s full name and the date on the bottle so that the oldest milk is used first. After warming, bottles should be mixed gently (not shaken) and the temperature of the milk tested before feeding.

Expressed human milk that presents a threat to an infant, such as human milk that is in an unsanitary bottle, is curdled, smells rotten, and/or has not been stored following the storage guidelines of the Academy of Breastfeeding Medicine as shown later in this standard, should be returned to the mother.

Some children around six months to a year of age may be developmentally ready to feed themselves and may want to drink from a cup. The transition from bottle to cup can come at a time when a child’s fine motor skills allow use of a cup. The caregiver/teacher should use a clean small cup without cracks or chips and should help the child to lift and tilt the cup to avoid spillage and leftover fluid. The caregiver/teacher and mother should work together on cup feeding of human milk to ensure the child is receiving adequate nourishment and to avoid having a large amount of human milk remaining at the end of feeding. Two to three ounces of human milk can be placed in a clean cup and additional milk can be offered as needed. Small amounts of human milk (about an ounce) can be discarded.
Human milk can be stored using the following guidelines from the Academy of Breastfeeding Medicine:

<table>
<thead>
<tr>
<th>Location</th>
<th>Temperature</th>
<th>Duration</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Countertop, table</td>
<td>Room temperature (up to 77°F or 25°C)</td>
<td>6-8 hours</td>
<td>Containers should be covered and kept as cool as possible; covering the container with a cool towel may keep milk cooler.</td>
</tr>
<tr>
<td>Insulated cooler bag</td>
<td>5°F – 39°F or -15°C – 4°C</td>
<td>24 hours</td>
<td>Keep ice packs in contact with milk containers at all times, limit opening cooler bag.</td>
</tr>
<tr>
<td>Refrigerator</td>
<td>39°F or 4°C</td>
<td>5 days</td>
<td>Store milk in the back of the main body of the refrigerator.</td>
</tr>
<tr>
<td>Freezer compartment of a fridge</td>
<td>5°F or -15°C</td>
<td>2 weeks</td>
<td>Store milk toward the back of the freezer, where temperature is most constant. Milk stored for longer durations in the ranges listed is safe, but some of the lipids in the milk undergo degradation resulting in lower quality.</td>
</tr>
<tr>
<td>Freezer compartment of fridge</td>
<td>0°F or -18°C</td>
<td>3-6 months</td>
<td></td>
</tr>
<tr>
<td>Chest or upright deep freezer</td>
<td>-4°F or -20°C</td>
<td>6-12 months</td>
<td></td>
</tr>
</tbody>
</table>

From the Centers for Disease Control and Prevention Website: Proper handling and storage of human milk – Storage duration of fresh human milk for use with healthy full term infants. [http://www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.htm]

To view the **Rationale** and **Comments** for this standard, click [here](http://www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.htm).

**TYPE OF FACILITY:** Center; Large Family Child Care
Home; Small Family Child Care Home
STANDARD 4.3.1.4: Feeding Human Milk to Another Mother’s Child

If a child has been mistakenly fed another child’s bottle of expressed human milk, the possible exposure to hepatitis B, hepatitis C, or HIV should be treated as if an exposure to other body fluids had occurred. For possible exposure to hepatitis B, hepatitis C, or HIV, the caregiver/teacher should:

a. Inform the mother who expressed the human milk about the mistake and when the bottle switch occurred, and ask:
   1. When the human milk was expressed and how it was handled prior to being delivered to the caregiver/teacher or facility;
   2. Whether she has ever had a hepatitis B, hepatitis C, or HIV blood test and, if so, the date of the test and would she be willing to share the results with the parents/guardians of the child who was fed the incorrect milk;
   3. If she does not know whether she has ever been tested for hepatitis B, hepatitis C, or HIV, would she be willing to contact her primary care provider and find out if she has been tested;
   4. If she has never been tested for hepatitis B, hepatitis C, or HIV, would she be willing to be tested and share the results with the parents/guardians of the other child;

b. Discuss the mistake of giving the wrong milk with the parents/guardians of the child who was fed the wrong bottle:
   1. Inform them that their child was given another child’s bottle of expressed human milk and the date it was given;
   2. Inform them that the risk of transmission of hepatitis B, hepatitis C, or HIV and other infectious diseases is low;
   3. Encourage the parents/guardians to notify the child’s primary care provider of the exposure;
   4. Provide the family with information including the time at which the milk was expressed and how the milk was handled prior to its being delivered to the caregiver/teacher so that the parents/guardians may inform the child’s primary care provider;
   5. Inform the parents/guardians that, depending upon the results from the mother whose milk was given mistakenly (1), their child may soon need to undergo a baseline blood test for hepatitis B (also see below), hepatitis C, or HIV;

c. Assess why the wrong milk was given and develop a prevention plan to be shared with the parents/guardians as well as the staff in the facility.

If the human milk given mistakenly to a child is from a woman who does not know her hepatitis B status, the caregiver/teacher should determine if the child has received the complete hepatitis B vaccine series. If the child has not been vaccinated or is incompletely vaccinated, then the parent/guardian of the child who received the milk should seek vaccination of the child. The child should complete the recommended childhood hepatitis B vaccine series as soon as possible. If human milk from a hepatitis B-positive woman is given mistakenly to an unimmunized child, the child may receive HBIG (Hepatitis B Immune Globulin) as soon as possible within seven days, but it is not necessary because of the low risk of transmission (3). The hepatitis B vaccine series should be initiated and completed as soon as possible.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 4.3.1.5: Preparing, Feeding and Storing Infant Formula

Formula provided by parents/guardians or by the facility should come in a factory-sealed container. The formula should be of the same brand that is served at home and should be of ready-to-feed strength or liquid concentrate to be diluted using water from a source approved by the health department. Powdered infant formula, though it is the least expensive formula, requires special handling in mixing because it cannot be sterilized. The primary source for proper and safe handling and mixing is the manufacturer’s instructions that appear on the can of powdered formula. Before opening the can, hands should be washed. The can and plastic lid should be thoroughly rinsed and dried. Caregivers/teachers should read and follow the manufacturer’s directions. If instructions are not readily available, caregivers/teachers should obtain information from the World Health Organization’s Safe Preparation, Storage and Handling of Powdered Infant Formula Guidelines at http://www.who.int/foodsafety/publications/micro/pif2007/en/index.html (8). The local WIC program can also provide instructions.

Formula mixed with cereal, fruit juice, or any other foods should not be served unless the child’s primary care provider provides written documentation that the child has a medical reason for this type of feeding.

Iron-fortified formula should be refrigerated until immediately before feeding. For bottles containing formula, any contents remaining after a feeding should be discarded.

Bottles of formula prepared from powder or concentrate or ready-to-feed formula should be labeled with the child’s full name and time and date of preparation. Any prepared formula must be discarded within one hour after serving to an infant. Prepared powdered formula that has not been given to an infant should be covered, labeled with date and time of preparation and child’s full name, and may be stored in the refrigerator for up to twenty-four hours. An open container of ready-to-feed, concentrated formula, or formula prepared from concentrated formula, should be covered, refrigerated, labeled with date of opening and

Caring for Infants and Toddlers in Child Care and Early Education
child’s full name, and discarded at forty-eight hours if not used (7,9). The caregiver/teacher should always follow manufacturer’s instructions for mixing and storing of any formula preparation.

Bottles made of plastics containing BPA or phthalates should be avoided (labeled with #3, #6, or #7). Glass bottles or plastic bottles labeled BPA-free or with #1, #2, #4, or #5 are acceptable.

Some infants will require specialized formula because of allergy, inability to digest certain formulas, or need for extra calories. The appropriate formula should always be available and should be fed as directed. For those infants getting supplemental calories, the formula may be prepared in a different way from the directions on the container. In those circumstances, either the family should provide the prepared formula or the caregiver/teacher should receive special training, as noted in the infant’s care plan, on how to prepare the formula.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 4.3.1.9: Warming Bottles and Infant Foods*

Bottles and infant foods can be served cold from the refrigerator and do not have to be warmed. If a caregiver/teacher chooses to warm them, bottles should be warmed under running, warm tap water or by placing them in a container of water that is no warmer than 120°F. Bottles should not be left in a pot of water to warm for more than five minutes. Bottles and infant foods should never be warmed in a microwave oven.

Infant foods should be stirred carefully to distribute the heat evenly. A caregiver/teacher should not hold an infant while removing a bottle or infant food from the container of warm water or while preparing a bottle or stirring infant food that has been warmed in some other way. Only BPA-free plastic, plastic labeled #1, #2, #4 or #5, or glass bottles should be used.

If a slow-cooking device, such as a crock pot, is used for warming infant formula, human milk, or infant food, this slow-cooking device should be out of children’s reach, should contain water at a temperature that does not exceed 120°F, and should be emptied, cleaned, sanitized, and refilled with fresh water daily.

If a bottle warmer is used for warming infant formula, human milk, or infant food, it should be out of children’s reach and used according to manufacturer’s instructions.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 4.5.0.3: Activities that Are Incompatible with Eating*

Children should be seated when eating. Caregivers/teachers should ensure that children do not eat when standing, walking, running, playing, lying down, watching TV, playing on the computer, or riding in vehicles.

Children should not be allowed to continue to feed themselves or continue to be assisted with feeding themselves if they begin to fall asleep while eating. Caregivers/teachers should check that no food is left in a child’s mouth before laying a child down to sleep.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 4.5.0.5: Numbers of Children Fed Simultaneously by One Adult*

One adult should not feed more than one infant or three children who need adult assistance with feeding at the same time.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 4.5.0.9: Hot Liquids and Foods*

Adults should not consume hot liquids above 120°F in child care areas (3). Hot liquids and hot foods should be kept out of the reach of infants, toddlers, and preschoolers. Hot liquids and foods should not be placed on a surface at a child’s level, at the edge of a table or counter, or on a tablecloth that could be yanked down. Appliances containing hot liquids, such as coffee pots and crock pots, should be kept out of the reach of children. Electrical cords from any appliance, including coffee pots, should not be allowed to hang within the reach of children. Food preparers should position pot handles toward the back of the stove and use only back burners when possible.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 4.5.0.10: Foods that Are Choking Hazards*

Caregivers/teachers should not offer to children under four years of age foods that are associated with young children’s choking incidents (round, hard, small, thick and sticky, smooth, compressible or dense, or slippery). Examples of these foods are hot dogs and other meat sticks (whole or sliced into rounds), raw carrot rounds, whole grapes, hard candy, nuts, seeds, raw peas, hard pretzels, chips, peanuts, popcorn, rice cakes, marshmallows, spoonfuls of peanut butter, and chunks of meat larger than can be swallowed whole. Food for infants should be cut into pieces one-quarter inch or smaller, food...
for toddlers should be cut into pieces one-half inch or smaller to prevent choking. In addition to the food monitoring, children should always be seated when eating to reduce choking hazards. Children should be supervised while eating, to monitor the size of food and that they are eating appropriately (for example, not stuffing their mouths full).

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 4.8.0.4: Food Preparation Sinks**

The sink used for food preparation should not be used for handwashing or any other purpose. Handwashing sinks and sinks involved in diaper changing should not be used for food preparation. All food service sinks should be supplied with hot and cold running water under pressure.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 4.9.0.2: Staff Restricted from Food Preparation and Handling**

Anyone who has signs or symptoms of illness, including vomiting, diarrhea, and infectious skin sores that cannot be covered, or who potentially or actually is infected with bacteria, viruses or parasites that can be carried in food, should be excluded from food preparation and handling. Staff members may not contact exposed, ready-to-eat food with their bare hands and should use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. No one with open or infected skin should work in the food preparation area unless the injuries are covered with nonporous (such as latex or vinyl), single use gloves.

In centers and large family child care homes, staff members who are involved in the process of preparing or handling food should not change diapers. Staff members who work with diapered children should not prepare or serve food for older groups of children. When staff members who are caring for infants and toddlers are responsible for changing diapers, they should handle food only for the infants and toddlers in their groups and only after thoroughly washing their hands. Caregivers/teachers who prepare food should wash their hands carefully before handling any food, regardless of whether they change diapers. When caregivers/teachers must handle food, staffing assignments should be made to foster completion of the food handling activities by caregivers/teachers of older children, or by caregivers/teachers of infants and toddlers before the caregiver/teacher assumes other caregiving duties for that day. Aprons worn in the food service area must be clean and should be removed when diaper changing or when using the toilet.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 4.9.0.3: Precautions for a Safe Food Supply**

All foods stored, prepared, or served should be safe for human consumption by observation and smell (1-2). The following precautions should be observed for a safe food supply:

a. Home-canned food; food from dented, rusted, bulging, or leaking cans, and food from cans without labels should not be used;

b. Foods should be inspected daily for spoilage or signs of mold, and foods that are spoiled or moldy should be promptly and appropriately discarded;

c. Meat should be from government-inspected sources or otherwise approved by the governing health authority (3);

d. All dairy products should be pasteurized and Grade A where applicable;

e. Raw, unpasteurized milk, milk products; unpasteurized fruit juices; and raw or undercooked eggs should not be used. Freshly squeezed fruit or vegetable juice prepared just prior to serving in the child care facility is permissible;

f. Unless a child’s health care professional documents a different milk product, children from twelve months to two years of age should be served only human milk, formula, whole milk or 2% milk (6). Note: For children between twelve months and two years of age for whom overweight or obesity is a concern or who have a family history of obesity, dyslipidemia, or CVD, the use of reduced-fat milk is appropriate only with written documentation from the child’s primary health care professional (4). Children two years of age and older should be served skim or 1% milk. If cost-saving is required to accommodate a tight budget, dry milk and milk products may be reconstituted in the facility for cooking purposes only, provided that they are prepared, refrigerated, and stored in a sanitary manner, labeled with the date of preparation, and used or discarded within twenty-four hours of preparation;

g. Meat, fish, poultry, milk, and egg products should be refrigerated or frozen until immediately before use (5);

h. Frozen foods should be defrosted in one of four ways: In the refrigerator; under cold running water; as part of the cooking process, or by removing food from packaging and using the defrost setting of a microwave oven (5). Note: Frozen human milk should not be defrosted in the microwave;

i. Frozen foods should never be defrosted by leaving them at room temperature or standing in water that is not kept at refrigerator temperature (5);

j. All fruits and vegetables should be washed thoroughly with water prior to use (5);
VI. Safe and Healthy Practices and Procedures

k. Food should be served promptly after preparation or cooking or should be maintained at temperatures of not less than 135°F for hot foods and not more than 41°F for cold foods (12);

l. All opened moist foods that have not been served should be covered, dated, and maintained at a temperature of 41°F or lower in the refrigerator or frozen in the freezer, verified by a working thermometer kept in the refrigerator or freezer (12);

m. Fully cooked and ready-to-serve hot foods should be held for no longer than thirty minutes before being served, or promptly covered and refrigerated;

n. Pasteurized eggs or egg products should be substituted for raw eggs in the preparation of foods such as Caesar salad, mayonnaise, meringue, eggnog, and ice cream. Pasteurized eggs or egg products should be substituted for recipes in which more than one egg is broken and the eggs are combined, unless the eggs are cooked for an individual child at a single meal and served immediately, such as in omelets or scrambled eggs; or the raw eggs are combined as an ingredient immediately before baking and the eggs are fully cooked to a ready-to-eat form, such as a cake, muffin or bread;

o. Raw animal foods should be fully cooked to heat all parts of the food to a temperature and for a time of; 145°F or above for fifteen seconds for fish and meat; 160°F for fifteen seconds for chopped or ground fish, chopped or ground meat or raw eggs; or 165°F or above for fifteen seconds for poultry or stuffed fish, stuffed meat, stuffed pasta, stuffed poultry or stuffing containing fish, meat or poultry.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 5.2.9.9: Plastic Containers and Toys

The facility should use infant bottles, plastic containers, and toys that do not contain Polyvinyl chloride (PVC), Bisphenol A (BPA), or phthalates. When possible, caregivers/teachers should substitute materials such as paper, ceramic, glass, and stainless steel for plastics.

To view the Rationale and Comments for this standard, click here.

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

B. Health Promotion and Protection

*STANDARD 3.1.2.1: Routine Health Supervision and Growth Monitoring

The facility should require that each child has routine health supervision by the child’s primary care provider, according to the standards of the American Academy of Pediatrics (AAP) (3). For all children, health supervision includes routine screening tests, immunizations, and chronic or acute illness monitoring. For children younger than twenty-four months of age, health supervision includes documentation and plotting of sex-specific charts on child growth standards from the World Health Organization (WHO), available at http://www.who.int/childgrowth/standards/en/, and assessing diet and activity. For children twenty-four months of age and older, sex-specific height and weight graphs should be plotted by the primary care provider in addition to body mass index (BMI), according to the Centers for Disease Control and Prevention (CDC). BMI is classified as underweight (BMI less than 5%), healthy weight (BMI 5%-84%), overweight (BMI 85%-94%), and obese (BMI equal to or greater than 95%). Follow-up visits with the child’s primary care provider that include a full assessment and laboratory evaluations should be scheduled for children with weight for length greater than 95% and BMI greater than 85% (5).

School health services can meet this standard for school-age children in care if they meet the AAP’s standards for school-age children and if the results of each child’s examinations are shared with the caregiver/teacher as well as with the school health system. With parental/guardian consent, pertinent health information should be exchanged among the child’s routine source of health care and all participants in the child’s care, including any school health program involved in the care of the child.

To view the Rationale and Comments for this standard, click here.

*STANDARD 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction

Facilities should develop a written policy that describes the practices to be used to promote safe sleep when infants are napping or sleeping. The policy should explain that these practices aim to reduce the risk of sudden infant death syndrome (SIDS) or suffocation death and other infant deaths that could occur when an infant is in a crib or asleep.

All staff, parents/guardians, volunteers and others approved to enter rooms where infants are cared for should receive a copy of the Safe Sleep Policy and additional educational information and training on the importance of consistent use of safe sleep policies and practices before they are allowed to care for infants (i.e., first day of employment/volunteering/subbing). Documentation that training has occurred and that these individuals have received and reviewed the written policy should be kept on file.

All staff, parents/guardians, volunteers and others who care for infants in the child care setting should follow these required safe sleep practices as recommended by the American Academy of Pediatrics (AAP) (1):

a. Infants up to twelve months of age should be placed for sleep in a supine position (wholly on their back) for every nap or sleep time unless the
b. Infants should be placed for sleep in safe sleep environments; which includes: a firm crib mattress covered by a tight-fitting sheet in a safety-approved crib (the crib should meet the standards and guidelines reviewed/approved by the U.S. Consumer Product Safety Commission [CPSC] and ASTM International [ASTM]), no monitors or positioning devices should be used unless required by the child’s primary care provider, and no other items should be in a crib occupied by an infant except for a pacifier;

c. Infants should not nap or sleep in a car safety seat, bean bag chair, bouncy seat, infant seat, swing, jumping chair, play pen or play yard, highchair, chair, futon, or any other type of furniture/equipment that is not a safety-approved crib (that is in compliance with the CPSC and ASTM safety standards) (4);

d. If an infant arrives at the facility asleep in a car safety seat, the parent/guardian or caregiver/teacher should immediately remove the sleeping infant from this seat and place them in the supine position in a safe sleep environment (i.e., the infant’s assigned crib);

e. If an infant falls asleep in any place that is not a safe sleep environment, staff should immediately move the infant and place them in the supine position in their crib;

f. Only one infant should be placed in each crib (stackable cribs are not recommended);

g. Soft or loose bedding should be kept away from sleeping infants and out of safe sleep environments. These include, but are not limited to: bumper pads, pillows, quilts, comforters, sleep positioning devices, sheepskins, blankets, flat sheets, cloth diapers, bibs, etc. Also, blankets/items should not be hung on the sides of cribs. Swaddling infants when they are in a crib is not necessary or recommended, but rather one-piece sleepers should be used (see Standard 3.1.4.2 for more detail information on swaddling);

h. Toys, including mobiles and other types of play equipment that are designed to be attached to any part of the crib should be kept away from sleeping infants and out of safe sleep environments;

i. When caregivers/teachers place infants in their crib for sleep, they should check to ensure that the temperature in the room is comfortable for a lightly clothed adult, check the infants to ensure that they are comfortably clothed (not overheated or sweaty), and that bibs, necklaces, and garments with ties or hoods are removed (clothing sacks or other clothing designed for sleep can be used in lieu of blankets);

j. Infants should be directly observed by sight and sound at all times, including when they are going to sleep, are sleeping, or are in the process of waking up;

k. Bedding should be changed between children, and if mats are used, they should be cleaned between uses.

The lighting in the room must allow the caregiver/teacher to see each infant’s face, to view the color of the infant’s skin, and to check on the infant’s breathing and placement of the pacifier (if used).

A caregiver/teacher trained in safe sleep practices and approved to care for infants should be present in each room at all times where there is an infant. This caregiver/teacher should remain alert and should actively supervise sleeping infants in an ongoing manner. Also, the caregiver/teacher should check to ensure that the infant’s head remains uncovered and re-adjust clothing as needed.

The construction and use of sleeping rooms for infants separate from the infant group room is not recommended due to the need for direct supervision. In situations where there are existing facilities with separate sleeping rooms, facilities should develop a plan to modify room assignments and/or practices to eliminate placing infants to sleep in separate rooms.

Facilities should be aware of the current recommendation of the AAP about pacifier use (1). If pacifiers are allowed, facilities should have a written policy that describes relevant procedures and guidelines. Pacifier use outside of the crib in rooms and programs where there are mobile infants or toddlers is not recommended.

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Safe Sleep for a list of the safe sleep-related standards included in this collection.

**STANDARD 3.1.4.2: Swaddling**

In child care settings, swaddling is not necessary or recommended.

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Safe Sleep for a list of the safe sleep-related standards included in this collection.

**STANDARD 3.1.4.3: Pacifier Use**

Facilities should be informed and follow current recommendations of the American Academy of Pediatrics (AAP) about pacifier use (1-3). If pacifiers are allowed, facilities should have a written policy that indicates:

a. Rationale and protocols for use of pacifiers;

b. Written permission and any instructions or preferences from the child’s parent/guardian;
c. If desired, parent/guardian should provide at least two new pacifiers (labeled with their child’s name using a waterproof label or non-toxic permanent marker) on a regular basis for their child to use. The extra pacifier should be available in case a replacement is needed;

d. Staff should inspect each pacifier for tears or cracks (and to see if there is unknown fluid in the nipple) before each use;

e. Staff should clean each pacifier with soap and water before each use;

f. Pacifiers with attachments should not be allowed; pacifiers should not be clipped, pinned, or tied to an infant’s clothing, and they should not be tied around an infant’s neck, wrist, or other body part;

g. If an infant refuses the pacifier, s/he should not be forced to take it;

h. If the pacifier falls out of the infant’s mouth, it does not need to be reinserted;

i. Pacifiers should not be coated in any sweet solution;

j. Pacifiers should be cleaned and stored open to air; separate from the diapering area, diapering items, or other children’s personal items.

Infants should be directly observed by sight and sound at all times, including when they are going to sleep, are sleeping, or are in the process of waking up. The lighting in the room must allow the caregiver/teacher to see each infant’s face, to view the color of the infant’s skin, and to check on the infant’s breathing and placement of the pacifier.

Pacifier use outside of a crib in rooms and programs where there are mobile infants or toddlers is not recommended.

Caregivers/teachers should work with parents/guardians to wean infants from pacifiers as the suck reflex diminishes between three and twelve months of age. Objects which provide comfort should be substituted for pacifiers (6).

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 3.1.5.2: Toothbrushes and Toothpaste**

In facilities where tooth brushing is an activity, each child should have a personally labeled, age-appropriate toothbrush. No sharing or borrowing should be allowed. After use, toothbrushes should be stored on a clean surface with the bristle end of the toothbrush up to air dry in such a way that the toothbrushes cannot contact or drip on each other and the bristles are not in contact with any surface (6). Racks and devices used to hold toothbrushes for storage should be labeled and disinfected as needed. The toothbrushes should be replaced at least every three to four months, or sooner if the bristles become frayed (2-4.6). When a toothbrush becomes contaminated through contact with another brush or use by more than one child, it should be discarded and replaced with a new one.

If toothpaste is used, each child should have his/her own labeled toothpaste tube. If toothpaste from a single tube is shared among the children, it should be dispensed onto a clean piece of paper or paper cup for each child rather than directly on the toothbrush (1,6). Children under two years of age should have only a smear of fluoride toothpaste (rice grain) on the brush when brushing. Those over two years of age should use a pea-sized amount of fluoride toothpaste. Toothpaste should be stored out of children’s reach.

When children require assistance with brushing, caregivers/teachers should wash their hands thoroughly between brushings for each child. Caregivers/teachers should wear gloves when assisting such children with brushing their teeth.

To view the Rationale and Comments for this standard, click here.

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

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*Standard included in Stepping Stones, 3rd Ed*  
Caring for Infants and Toddlers in Child Care and Early Education
STANDARD 3.2.1.1: Type of Diapers Worn

Diapers worn by children should be able to contain urine and stool and minimize fecal contamination of children, caregivers/teachers, environmental surfaces, and objects in the child care setting. Only disposable diapers with absorbent material (e.g., polymers) may be used unless the child has a medical reason that does not permit the use of disposable diapers (such as allergic reactions). When children cannot use disposable diapers for a medical reason, the reason should be documented by the child's primary care provider. Children of all ages who are incontinent of urine or stool should wear a barrier method to prevent contamination of their environment.

If cloth diapers are used, the diaper should have an absorbent inner lining completely contained within an outer covering made of waterproof material that prevents the escape of feces and urine. An alternative is the use of cloth diapers that contain a waterproof cover that is adherent to the cloth material. If a cloth diaper with a separate lining is used, the outer covering and inner lining should be changed together at the same time as a unit and should not be reused in the child care facility. No rinsing or dumping of the contents of cloth diapers should be performed at the child care facility. Soiled cloth diapers should be completely wrapped in a non-permeable material, stored in a location inaccessible to children, and given directly to the parent/guardian upon discharge of the child.

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Diaper Changing and Toileting for a list of the diapering- and toileting-related standards included in this collection.

STANDARD 3.2.1.2: Handling Cloth Diapers

If cloth diapers are used, soiled cloth diapers and/or soiled training pants should never be rinsed or carried through the child care area to place the fecal contents in a toilet. Reusable diapers should be laundered by a commercial diaper service. Soiled cloth diapers should be stored in a labeled container with a tight-fitting lid provided by an accredited commercial diaper service, or in a sealed plastic bag for removal from the facility by an individual child's family. The sealed plastic bag should be sent home with the child at the end of the day. The containers or sealed diaper bags of soiled cloth diapers should not be accessible to any child (1).

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Diaper Changing and Toileting for a list of the diapering- and toileting-related standards included in this collection.

STANDARD 3.2.1.3: Checking for the Need to Change Diapers

Diapers should be checked for wetness and feces at least hourly, visually inspected at least every two hours, and whenever the child indicates discomfort or exhibits behavior that suggests a soiled or wet diaper. Diapers should be changed when they are found to be wet or soiled.

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Diaper Changing and Toileting for a list of the diapering- and toileting-related standards included in this collection.

*STANDARD 3.2.1.4: Diaper Changing Procedure

The following diaper changing procedure should be posted in the changing area, should be followed for all diaper changes, and should be used as part of staff evaluation of caregivers/teachers who diaper. The signage should be simple and should be in multiple languages if caregivers/teachers who speak multiple languages are involved in diapering. All employees who will diaper should undergo training and periodic assessment of diapering practices. Caregivers/teachers should never leave a child unattended on a table or countertop, even for an instant. A safety strap or harness should not be used on the diaper changing table. If an emergency arises, caregivers/teachers should bring any child on an elevated surface to the floor or take the child with them.

An EPA-registered disinfectant suitable for the surface material that is being disinfected should be used. If an EPA-registered product is not available, then household bleach diluted with water is a practical alternative. All cleaning and disinfecting solutions should be stored to be accessible to the caregiver/teacher but out of reach of any child. Please refer to Appendix J, Selecting an Appropriate Sanitizer or Disinfectant.

Step 1: Get organized. Before bringing the child to the diaper changing area, perform hand hygiene, gather and bring supplies to the diaper changing area:

a. Non-absorbent paper liner large enough to cover the changing surface from the child’s shoulders to beyond the child’s feet;
b. Unused diaper, clean clothes (if you need them);
c. Wipes, dampened cloths or wet paper towels for cleaning the child’s genitalia and buttocks readily available;
d. A plastic bag for any soiled clothes or cloth diapers;
e. Disposable gloves, if you plan to use them (put gloves on before handling soiled clothing or diapers) and remove them before handling clean diapers and clothing;

f. A thick application of any diaper cream (e.g., zinc oxide ointment), when appropriate, removed from the container to a piece of disposable material such as facial or toilet tissue.

Step 2: Carry the child to the changing table, keeping soiled clothing away from you and any surfaces you cannot easily clean and sanitize after the change.

a. Always keep a hand on the child;
b. If the child’s feet cannot be kept out of the diaper or from contact with soiled skin during the changing process, remove the child’s shoes and socks so the child does not contaminate these surfaces with stool or urine during the diaper changing.

c. Lift the child’s legs as needed to use disposable wipes, or a dampened cloth or wet paper towel to clean the skin on the child’s genitalia and buttocks and prevent recontamination from a soiled diaper. Remove stool and urine from front to back and use a fresh wipe, or a dampened cloth or wet paper towel each time you swipe. Put the soiled wipes or paper towels into the soiled diaper or directly into a plastic-lined, hands-free covered can. Reusable cloths should be stored in a washable, plastic-lined, tightly covered receptacle (within arm’s reach of diaper changing tables) until they can be laundered. The cover should not require touching with contaminated hands or objects.

Step 3: Clean the child’s diaper area.

a. Place the child on the diaper change surface and unfasten the diaper, but leave the soiled diaper under the child;
b. If safety pins are used, close each pin immediately once it is removed and keep pins out of the child’s reach (never hold pins in your mouth);
c. Lift the child’s legs as needed to use disposable wipes, or a dampened cloth or wet paper towel to clean the skin on the child’s genitalia and buttocks and prevent recontamination from a soiled diaper. Remove stool and urine from front to back and use a fresh wipe, or a dampened cloth or wet paper towel each time you swipe. Put the soiled wipes or paper towels into the soiled diaper or directly into a plastic-lined, hands-free covered can. Reusable cloths should be stored in a washable, plastic-lined, tightly covered receptacle (within arm’s reach of diaper changing tables) until they can be laundered. The cover should not require touching with contaminated hands or objects.

Step 4: Remove the soiled diaper and clothing without contaminating any surface not already in contact with stool or urine.

a. Fold the soiled surface of the diaper inward;
b. Put soiled disposable diapers in a covered, plastic-lined, hands-free covered can. If reusable cloth diapers are used, put the soiled cloth diaper and its contents (without emptying or rinsing) in a plastic bag or into a plastic-lined, hands-free covered can to give to parents/guardians or laundry service;
c. Put soiled clothes in a plastic-lined, hands-free plastic bag;
d. Check for spills under the child. If there are any, use the corner of the paper to fold the paper that extends under the child’s feet over the soiled area so a fresh, unsoiled paper surface is now under the child’s buttocks;
e. If gloves were used, remove them using the proper technique (see Appendix D) and put them into a plastic-lined, hands-free covered can;
f. Whether or not gloves were used, use a fresh wipe to wipe the hands of the caregiver/teacher and another fresh wipe to wipe the child’s hands. Put the wipes into the plastic-lined, hands-free covered can.

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

a. Slide a fresh diaper under the child;
b. Use a facial or toilet tissue or wear clean disposable glove to apply any necessary diaper creams, discarding the tissue or glove in a covered, plastic-lined, hands-free covered can;
c. Note and plan to report any skin problems such as redness, skin cracks, or bleeding;
d. Fasten the diaper; if pins are used, place your hand between the child and the diaper when inserting the pin.

Step 6: Wash the child’s hands and return the child to a supervised area.

a. Use soap and warm water, between 60°F and 120°F, at a sink to wash the child’s hands, if you can.

Step 7: Clean and disinfect the diaper-changing surface.

a. Dispose of the disposable paper liner used on the diaper changing surface in a plastic-lined, hands-free covered can;
b. If clothing was soiled, securely tie the plastic bag used to store the clothing and send home;
c. Remove any visible soil from the changing surface with a disposable paper towel saturated with water and detergent, rinse;
d. Wet the entire changing surface with a disinfectant that is appropriate for the surface material you are treating. Follow the manufacturer’s instructions for use;
e. Put away the disinfectant. Some types of disinfectants may require rinsing the change table surface with fresh water afterwards.

Step 8: Perform hand hygiene according to the procedure in Standard 3.2.2.2 and record the diaper change in the child’s daily log.

a. In the daily log, record what was in the diaper and any problems (such as a loose stool, an unusual odor, blood in the stool, or any skin irritation), and report as necessary (2).

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Diaper Changing and Toileting for a list of the diapering- and toileting-related standards included in this collection.

STANDARD 3.2.1.5: Procedure for Changing Children’s Soiled Underwear/Pull-Ups and Clothing

The following changing procedure for soiled pull-ups or underwear and clothing should be posted in the changing area, should be followed for all changes, and should be
Step 2: Avoid contact with soiled items.

- If the child is standing, it may cause the clothing, shoes and socks to become soiled. The caregiver/teacher must remove these items before the change begins;
- To avoid contaminating the child’s clothes, have the child hold their shirt, sweater, etc. up above their waist during the change. This keeps the child's hands busy and the caregiver/teacher knows where the child's hands are during the changing process. Caregivers/teachers can also use plastic clothes pins that can be washed and sanitized to keep the clothing out of the way;
- If disposable pull-ups were used, pull the sides apart, rather than sliding the garment down the child’s legs. If underwear is being changed, remove the soiled underwear and any soiled clothing, doing your best to avoid contamination of surfaces;
- To avoid contamination of the environment and/or the increased risk of spreading germs to the other children in the room, do not rinse the soiled clothing in the toilet or elsewhere. Place all soiled garments in a plastic-lined, hands-free plastic bag to be cleaned at the child’s home;
- If the child’s shoes are soiled, the caregiver/teacher must wash and sanitize them before putting them back on the child. It is a good idea for the child care facility to request a few extra pairs of socks and shoes from the parent/caregiver to be kept at the facility in case these items become soiled (1).

Step 3: Clean the child’s skin and check for spills.

- Lift the child’s legs as needed to use disposable wipes, or a dampened cloth or wet paper towel to clean the skin on the child’s genitalia and buttocks. Remove stool and urine from front to back and use a fresh wipe, dampened cloth or wet paper towel each time you swipe. Put the soiled wipes or paper towels into the soiled pull-up or directly into a plastic-lined, hands-free covered can. Reusable cloths should be stored in a washable, plastic-lined, tightly covered receptacle (within arm’s reach of diaper changing tables) until they can be laundered. The cover should not require touching with contaminated hands or objects;
- Check for spills under the child. If there are any, use the paper that extends beyond or under the child’s feet to fold over the soiled area so a fresh, unsoiled paper surface is now under the child;
- If gloves were used, remove them using the proper technique (see Appendix D) and put them into a plastic-lined, hands-free covered can;
- Whether or not gloves were used, use a fresh wipe to wipe the hands of the caregiver/teacher and another fresh wipe to wipe the child’s hands. Put the wipes into the plastic-lined, hands-free covered can;

Step 4: Put on a clean pull-up or underwear and clothing, if necessary.

- Assist the child, as needed, in putting on a clean disposable pull-up or underwear, then in redressing (1);
- Note and plan to report any skin problems such as redness, skin cracks, or bleeding;
- Put the child’s socks and shoes back on if they were removed during the changing procedure (1).
Step 5: Wash the child’s hands and return the child to a supervised area.
   a. Use soap and warm water, between 60°F and 120°F, at a sink to wash the child’s hands, if you can.

Step 6: Clean and disinfect the changing surface.
   a. Dispose of the disposable paper liner used on the changing surface in a plastic-lined, hands-free covered can;
   b. If clothing was soiled, securely tie the plastic bag used to store the clothing and send home;
   c. Remove any visible soil from the changing surface with a disposable paper towel saturated with water and detergent, rinse;
   d. Wet the entire changing surface with a disinfectant that is appropriate for the surface material you are treating. Follow the manufacturer’s instructions for use;
   e. Put away the disinfectant. Some types of disinfectants may require rinsing the change table surface with fresh water afterwards.

Step 7: Perform hand hygiene according to the procedure in Standard 3.2.2.2 and record the change in the child’s daily log.
   a. In the daily log, record what was in the pull-up or underwear and any problems (such as a loose stool, an unusual odor, blood in the stool, or any skin irritation), and report as necessary (3).

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Handwashing for a list of the handwashing-related standards included in this collection.

*STANDARD 3.2.2.2: Handwashing Procedure

Children and staff members should wash their hands using the following method:
   a. Check to be sure a clean, disposable paper (or single-use cloth) towel is available;
   b. Turn on warm water, between 60°F and 120°F, to a comfortable temperature;
   c. Moisten hands with water and apply soap (not antibacterial) to hands;
   d. Rub hands together vigorously until a soapy lather appears, hands are out of the water stream, and continue for at least twenty seconds (sing Happy Birthday silently twice) (2), Rub areas between fingers, around nail beds, under fingernails, jewelry, and back of hands. Nails should be kept short; acrylic nails should not worn (3);
   e. Rinse hands under running water, between 60°F and 120°F, until they are free of soap and dirt. Leave the water running while drying hands;
   f. Dry hands with the clean, disposable paper or single use cloth towel;
   g. If taps do not shut off automatically, turn taps off with a disposable paper or single use cloth towel;
   h. Throw the disposable paper towel into a lined trash container; or place single-use cloth towels in the laundry hamper; or hang individually labeled cloth towels to dry. Use hand lotion to prevent chapping of hands, if desired.

The use of alcohol based hand sanitizers is an alternative to traditional handwashing with soap and water by children over twenty-four months of age and adults on hands that are not visibly soiled. A single pump of an alcohol-based sanitizer should be dispensed. Hands should be rubbed together, distributing sanitizer to all hand and finger surfaces and hands should be permitted to air dry.

Situations/times that children and staff should wash their hands should be posted in all handwashing areas.
Use of antimicrobial soap is not recommended in child care settings. There are no data to support use of antibacterial soaps over other liquid soaps.

Children and staff who need to open a door to leave a bathroom or diaper changing area should open the door with a disposable towel to avoid possibly re-contaminating clean hands. If a child can not open the door or turn off the faucet, they should be assisted by an adult.

To view the Rationale and Comments for this standard, click here.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home
See Quick Reference: Handwashing for a list of the handwashing-related standards included in this collection.

**STANDARD 3.2.2.3: Assisting Children with Hand Hygiene**

Caregivers/teachers should provide assistance with handwashing at a sink for infants who can be safely cradled in one arm and for children who can stand but not wash their hands independently. A child who can stand should either use a child-height sink or stand on a safety step at a height at which the child’s hands can hang freely under the running water. After assisting the child with handwashing, the staff member should wash his or her own hands. Hand hygiene with an alcohol-based sanitizer is an alternative to handwashing with soap and water by children over twenty-four months of age and adults when there is no visible soiling of hands (1).

To view the Rationale and Comments for this standard, click here.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home
See Quick Reference: Handwashing for a list of the handwashing-related standards included in this collection.

**STANDARD 3.2.2.5: Hand Sanitizers**

The use of hand sanitizers by children over twenty-four months of age and adults in child care programs is an appropriate alternative to the use of traditional handwashing with soap and water. For visibly dirty hands, rinsing under running water or wiping with a water-saturated towel should be used to remove as much dirt as possible before using a hand sanitizer.

Hand sanitizers using an alcohol-based active ingredient must contain 60% to 95% alcohol in order to be effective to kill germs, including multi-drug resistant pathogens. Child care programs should follow the manufacturer’s instructions for use, check instructions to determine how long the hand sanitizer needs to remain on the skin surface to be effective.

Supervision of children is required to monitor effective use and to avoid potential ingestion or inadvertent contact of hand sanitizers with eyes and mucous membranes.

When alcohol-based hand sanitizers are offered in a child care facility, the facility should encourage parents/guardians to teach their children about their use at home.

Where alcohol-based hand sanitizer dispensers are used:

a. The maximum individual dispenser fluid capacity should be as follows:
   b. 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors;
   c. 0.53 gal (2.0 L) for dispensers in suites of rooms;
   d. Where aerosol containers are used, the maximum capacity of the aerosol dispenser should be 18 oz. (0.51 kg) and should be limited to Level 1 aerosols as defined in NFPA 30B: Code for the Manufacture and Storage of Aerosol Products;
   e. Wall mounted dispensers should be separated from each other by horizontal spacing of not less than 48 in. (1,220 mm);
   f. Wall mounted dispensers should not be installed above or adjacent to ignition sources such as electrical outlets;
   g. Wall mounted dispensers installed directly over carpeted floors should be permitted only in child care facilities protected by automatic sprinklers (1).

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 3.4.1.1 Use of Tobacco, Alcohol, and Illegal Drugs**

Tobacco use, alcohol, and illegal drugs should be prohibited on the premises of the program (both indoor and outdoor environments) and in any vehicles used by the program at all times. Caregivers/teachers should not use tobacco, alcohol, or illegal drugs off the premises during the child care program’s paid time including break time.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 3.4.5.1: Sun Safety Including Sunscreen**

Caregivers/teachers should implement the following procedures to ensure sun safety for themselves and the children under their supervision:

a. Keep infants younger than six months out of direct sunlight. Find shade under a tree, umbrella, or the stroller canopy;
   b. Wear a hat or cap with a brim that faces forward to shield the face;
   c. Limit sun exposure between 10 AM and 4 PM, when UV rays are strongest;
   d. Wear child safe shatter resistant sunglasses with at least 99% UV protection;
e. Apply sunscreen (1).

Over-the-counter ointments and creams, such as sunscreen that are used for preventive purposes do not require a written authorization from a primary care provider with prescriptive authority. However, parent/guardian written permission is required, and all label instructions must be followed. If the skin is broken or an allergic reaction is observed, caregivers/teachers should discontinue use and notify the parent/guardian.

If parents/guardians give permission, sunscreen should be applied on all exposed areas, especially the face (avoiding the eye area), nose, ears, feet, and hands and rubbed in well especially from May through September. Sunscreen is needed on cloudy days and in the winter at high altitudes. Sun reflects off water, snow, sand, and concrete. “Broad spectrum” sunscreen will screen out both UVB and UVA rays. Use sunscreen with an SPF of 15 or higher, the higher the SPF the more UVB protection offered. UVA protection is designated by a star rating system, with four stars the highest allowed in an over-the-counter product.

Sunscreen should be applied thirty minutes before going outdoors as it needs time to absorb into the skin. If the children will be out for more than one hour, sunscreen will need to be reapplied every two hours as it can wear off. If children are playing in water, reapplication will be needed more frequently. Children should also be protected from the sun by using shade and sun protective clothing. Sun exposure should be limited between the hours of 10 AM and 4 PM when the sun’s rays are the strongest.

Sunscreen should be applied to the child at least once by the parents/guardians and the child observed for a reaction to the sunscreen prior to its use in child care.

*To view the Rationale and Comments for this standard, click here.*

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

**STANDARD 3.4.5.2: Insect Repellent and Protection from Vector-Borne Diseases**

Insect repellents offer varying levels of protection from insect bites. Most insects do not carry human disease and most bites only cause mild irritation. Insect repellents may be used with children in child care in areas of the country due to specific disease outbreaks and alerts. Parents/guardians and caregivers/teachers should decide about the use of repellents depending upon the likelihood that local insects are carrying diseases (e.g., local cases of meningitis from mosquito bites). Caregivers/teachers should consult with a child care health consultant, the primary care provider, or the local health department about the appropriateness of use.

Insect repellent used for preventive purposes does not require a written authorization from a primary care provider. Parent/guardian written permission is required, and all label instructions must be followed. If the skin is broken or an allergic reaction is observed, discontinue use and notify the parent/guardian.

Repellents with 10%-30% DEET offer the broadest protection against mosquitoes, ticks, flies, chiggers, and fleas. The concentration of DEET that is used should be dependent upon how much time the child will be exposed. Products with 10% DEET are effective for approximately two hours whereas products with 24% DEET offers protection for approximately five hours.

Caregivers/teachers should read the product label and confirm that the product is safe for children and contains a concentration of 30% DEET or less. Some repellents may contain up to 100% DEET and could be very dangerous if applied to a child. DEET is not approved for infants less than two months of age.

Application of this product for children older than two months is acceptable using the following guidelines:

a. Apply insect repellent to the caregiver/teacher’s hands first and then put it on the child;

b. Use just enough repellent to cover exposed skin;

c. Do not apply under clothing;

d. Do not use DEET on the hands of young children;

e. Avoid applying to areas around the eyes and mouth;

f. Do not use over cuts or irritated skin;

g. Do not use near food;

h. Do not use products that combine insect repellent and sunscreen. If sunscreen is used, apply sunscreen first;

i. Do not apply a second application to the skin (1);

j. DEET concentration should not exceed 30% for use with children (1);

k. After returning indoors, wash treated skin immediately with soap and water;

l. If the child gets a rash or other bad reaction from an insect repellent, stop using the repellent, wash the repellent off with mild soap and water, and call a local poison center (1-800-222-1222) for further guidance. (1,3,4)

Oil of lemon and eucalyptus products should NOT be used on CHILDREN UNDER THREE YEARS OF AGE (1). Most product labels for registrations containing DEET recommend consultation with a physician if applying to a child less than six months of age.

Picaridin and IR3535 are other products registered at the Environmental Protection Agency (EPA) identified as providing repellent activity sufficient to help people avoid the bites of disease carrying mosquitoes (3).

Caregivers/teachers should practice hand hygiene after applying insect repellent to the children in the group.

Written parent/guardian permission is required before applying any insect repellent to children.

In places where ticks are likely to be found, caregivers/teachers should take the following steps to protect children in their care from ticks:

a. Wear light colored clothing, long sleeves and pants, tuck pants into socks;

b. Conduct tick checks when returning indoors (2).
c. Caregivers/teachers should also take the following protective measures against ticks and mosquitoes with children’s play areas:
d. Remove stagnant water sources to prevent breeding grounds for mosquito larvae;
e. Remove leaf litter and clear tall grasses and brush around homes and buildings and at the edges of lawns;
f. Place wood chips or gravel between lawns and wooded areas to restrict tick migration to recreational areas;
g. Mow the lawn and clear brush and leaf litter frequently;
h. Keep playground equipment, decks, and patios away from yard edges and trees.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 3.5.0.1 Care Plan for Children with Special Health Care Needs

Reader’s Note: Children with special health care needs are defined as “...those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally” (1).

Any child who meets these criteria should have a Routine and Emergent Care Plan completed by their primary care provider in their medical home. In addition to the information specified in Standard 9.4.2.4 for the Health Report, there should be:

a. A list of the child’s diagnosis/diagnoses;
b. Contact information for the primary care provider and any relevant sub-specialists (i.e., endocrinologists, oncologists, etc.);
c. Medications to be administered on a scheduled basis;
d. Medications to be administered on an emergent basis with clearly stated parameters, signs, and symptoms that warrant giving the medication written in lay language;
e. Procedures to be performed;
f. Allergies;
g. Dietary modifications required for the health of the child;
h. Activity modifications;
i. Environmental modifications;
j. Stimulus that initiates or precipitates a reaction or series of reactions (triggers) to avoid;
k. Symptoms for caregiver/teachers to observe;
l. Behavioral modifications;
m. Emergency response plans – both if the child has a medical emergency and special factors to consider in programmatic emergency, like a fire;

n. Suggested special skills training and education for staff.

A template for a Care Plan for children with special health care needs is provided in Appendix O.

The Care Plan should be updated after every hospitalization or significant change in health status of the child. The Care Plan is completed by the primary care provider in the medical home with input from parents/guardians, and it is implemented in the child care setting. The child care health consultant should be involved to assure adequate information, training, and monitoring is available for child care staff.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 3.5.0.2: Caring for Children Who Require Medical Procedures

A facility that enrolls children who require the following medical procedures: tube feedings, endotracheal suctioning, supplemental oxygen, postural drainage, or catheterization daily (unless the child requiring catheterization can perform this function on his/her own), checking blood sugars or any other special medical procedures performed routinely, or who might require special procedures on an urgent basis, should receive a written plan of care from the primary care provider who prescribed the special treatment (such as a urologist for catheterization). Often, the child’s primary care provider may be able to provide this information. This plan of care should address any special preparation to perform routine and/or urgent procedures (other than those that might be required in an emergency for any typical child, such as cardiopulmonary resuscitation [CPR]). This plan of care should include instructions for how to receive training in performing the procedure, performing the procedure, a description of common and uncommon complications of the procedure, and what to do and who to notify if complications occur. Specific/relevant training for the child care staff should be provided by a qualified health care professional in accordance with state practice acts. Facilities should follow state laws where such laws require RN’s or LPN’s under RN supervision to perform certain medical procedures. Updated, written medical orders are required for nursing procedures.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 4.2.0.10: Care for Children with Food Allergies

When children with food allergies attend the early care and education facility, the following should occur:

a. Each child with a food allergy should have a care plan prepared for the facility by the child’s primary care provider, to include:

   *Standard included in Stepping Stones, 3rd Ed.*
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 should include specific symptoms that would indicate the need to administer one or more medications;

b. Based on the child’s care plan, the child’s caregivers/teachers should 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/guardians and staff should 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 early care and education facility;

d. Caregivers/teachers should promptly and properly administer prescribed medications in the event of an allergic reaction according to the instructions in the care plan;

e. The facility should notify the parents/guardians immediately 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 should recommend to the family that the child’s primary care provider be notified if the child has required treatment by the facility for a food allergic reaction;

g. The facility should contact the emergency medical services system immediately whenever epinephrine has been administered;

h. Parents/guardians of all children in the child’s class should be advised to avoid any known allergens in class treats or special foods brought into the early care and education setting;

i. Individual child’s food allergies should be posted prominently in the classroom where staff can view and/or wherever food is served;

j. The written child care plan, a mobile phone, and the proper medications for appropriate treatment if the child develops an acute allergic reaction should be routinely carried on field trips or transport out of the early care and education setting.

To view the Rationale and Comments for this standard, click here.

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

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**STANDARD 9.4.1.9 Records of Injury**

When an injury occurs in the facility that results in first aid or medical attention for a child or adult, the facility should complete a report form that provides the following information:

a. Name, sex, and age of the injured person;

b. Date and time of injury;

c. Location where injury took place;

d. Description of how the injury occurred, including who (name, address, and phone number) saw the incident and what they reported, as well as what was reported by the child;

e. Body part(s) involved;

f. Description of any consumer product involved;

g. Name and location of the staff member responsible for supervising the child at the time of the injury;

h. Actions taken by staff members on behalf of the injured following the injury as well as specifically whether emergency medical services and/or professional dental/medical care was required;

i. Recommendations of preventive strategies that could be taken to avoid future occurrences of this type of injury;

j. Name of person who completed the report;

k. Name, address, and phone number of the facility;

l. Signature of the parent/guardian of the child injured or signature of the adult injured and the date signature obtained (recommended that the signature be obtained the same day as the injury);

m. If parent/guardian of child was notified at time of injury;

n. Documentation that written report was sent home the day of the injury, regardless of parental signature.

Examples of injuries that should be documented include:

a. Child maltreatment (physical, sexual, emotional, and neglect abuse);

b. Bites that are continuous in nature, break the skin, left a mark, and cause significant pain;

c. Falls, burns, broken limbs, tooth loss, other injury;

d. Motor vehicle injury;

e. Aggressive/unusual behavior;

f. Ingestion of non-food substances;

g. Medication error;

h. Blows to the head;

i. Death.

Three copies of the injury report form should be completed. One copy should be given to the child’s parent/guardian (or to the injured adult). The second copy should be kept in the child’s (or adult’s) folder at the facility. A third copy should be kept in a chronologically filed injury log that is analyzed periodically to determine any patterns regarding time of day, equipment, location or supervision issues. This last copy should be kept in the
facility for the period required by the state’s statute of limitations. If required by state regulations, a copy of an injury report for each injury that required medical attention should be sent to the state licensing agency. Based on the logs, the facility should plan to take corrective action. Examples of corrective action include: adjusting schedules, removing or limiting the use of equipment, relocating equipment or furnishings, and/or increasing supervision.

To view the Rationale and Comments for this standard, click here.

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

*Appendix O: Care Plan for Children with Special Health Care Needs (PDF Link)

C. Cleaning/Sanitizing/Disinfecting Practices

STANDARD 3.2.3.1: Procedures for Nasal Secretions and Use of Nasal Bulb Syringes

Staff members and children should blow or wipe their noses with disposable, single use tissues and then discard them in a plastic-lined, covered, hands-free trash container. After blowing the nose, they should practice hand hygiene, as specified in Standards 3.2.2.1 and 3.2.2.2.

Use of nasal bulb syringes is permitted. Nasal bulb syringes should be provided by the parents/guardians for individual use and should be labeled with the child’s name. If nasal bulb syringes are used, facilities should have a written policy that indicates:

a. Rationale and protocols for use of nasal bulb syringes;

b. Written permission and any instructions or preferences from the child’s parent/guardian;

c. Staff should inspect each nasal bulb syringe for tears or cracks (and to see if there is unknown fluid in the nasal bulb syringe) before each use;

d. Nasal bulb syringes should be cleaned with warm soapy water and stored open to air.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 3.3.0.1: Routine Cleaning, Sanitizing, and Disinfecting

Keeping objects and surfaces in a child care setting as clean and free of pathogens as possible requires a combination of:

a. Frequent cleaning; and

b. When necessary, an application of a sanitizer or disinfectant.

Facilities should follow a routine schedule of cleaning, sanitizing, and disinfecting as outlined in Appendix K: Routine Schedule for Cleaning, Sanitizing, and Disinfecting. Cleaning, sanitizing and disinfecting products should not be used in close proximity to children, and adequate ventilation should be maintained during any cleaning, sanitizing or disinfecting procedure to prevent children and caregivers/teachers from inhaling potentially toxic fumes.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 3.3.0.2: Cleaning and Sanitizing Toys

Toys that cannot be cleaned and sanitized should not be used. Toys that children have placed in their mouths or that are otherwise contaminated by body secretion or excretion should be set aside until they are cleaned by hand with water and detergent, rinsed, sanitized, and air-dried or in a mechanical dishwasher that meets the requirements of Standard 4.9.0.11 through Standard 4.9.0.13. Play with plastic or play foods, play dishes and utensils, should be closely supervised to prevent shared mouthing of these toys.

Machine washable cloth toys should be used by one individual at a time. These toys should be laundered before being used by another child.

Indoor toys should not be shared between groups of infants or toddlers unless they are washed and sanitized before being moved from one group to the other.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 3.3.0.3: Cleaning and Sanitizing Objects Intended for the Mouth

Thermometers, pacifiers, teething toys, and similar objects should be cleaned, and reusable parts should be sanitized between uses. Pacifiers should not be shared.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 3.3.0.4: Cleaning Individual Bedding

Bedding (sheets, pillows, blankets, sleeping bags) should be of a type that can be washed. Each child’s bedding should be kept separate from other children’s bedding, on the bed or stored in individually labeled bins, cubbies, or bags. Bedding that touches a child’s skin should be cleaned weekly or before use by another child.
To view the Rationale and Comments for this standard, click here.

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

**STANDARD 3.3.0.5: Cleaning Crib Surfaces**

Cribs and crib mattresses should have a nonporous, easy-to-wipe surface. All surfaces should be cleaned as recommended in Appendix K, Routine Schedule for Cleaning, Sanitizing, and Disinfecting.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 4.3.1.10: Cleaning and Sanitizing Equipment Used for Bottle Feeding**

Bottles, bottle caps, nipples and other equipment used for bottle feeding should not be reused without first being cleaned and sanitized by washing in a dishwasher or by washing, rinsing, and boiling them for one minute.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.4.2.6: Maintenance of Changing Tables**

Changing tables should be nonporous, kept in good repair, and cleaned and disinfected after each use to remove visible soil and germs.

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Diaper Changing and Toileting for a list of the diapering- and toileting-related standards included in this collection.

**STANDARD 9.2.3.10: Sanitation Policies and Procedures**

The child care facility should have written sanitation policies and procedures for the following items:

- Maintaining equipment used for hand hygiene, toilet use, and toilet learning/training in a sanitary condition;
- Maintaining diaper changing areas and equipment in a sanitary condition;
- Maintaining toys in a sanitary condition;
- Managing animals in a safe and sanitary manner;
- Practicing proper handwashing and diapering procedures (the facility should display proper handwashing instruction signs conspicuously);
- Practicing proper personal hygiene of caregivers/teachers and children;
- Practicing environmental sanitation policies and procedures, such as sanitary disposal of soiled diapers;
- Maintaining sanitation for food preparation and food service.

To view the Rationale and Comments for this standard, click here.

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

*Appendix J: Selecting an Appropriate Sanitizer or Disinfectant (PDF Link)*

*Appendix K: Routine Schedule for Cleaning, Sanitizing and Disinfecting (PDF Link)*

**D. Infection Control/Disease Prevention and Management**

**STANDARD 3.1.1.1: Conduct of Daily Health Check**

Every day, a trained staff member should conduct a health check of each child. This health check should be conducted as soon as possible after the child enters the child care facility and whenever a change in the child’s behavior or appearance is noted while that child is in care. The health check should address:

- Reported or observed illness or injury affecting the child or family members since the last date of attendance;
- Reported or observed changes in behavior of the child (such as lethargy or irritability) or in the appearance (e.g., sad) of the child from the previous day at home or the previous day’s attendance at child care;
- Skin rashes, impetigo, itching or scratching of the skin, itching or scratching of the scalp, or the presence of one or more live crawling lice;
- A temperature check if the child appears ill (a daily screening temperature check is not recommended);
- Other signs or symptoms of illness and injury (such as drainage from eyes, vomiting, diarrhea, cuts/lacerations, pain, or feeling ill).

The caregiver/teacher should gain information necessary to complete the daily health check by direct observation of the child, by querying the parent/guardian, and, where applicable, by conversation with the child.

To view the Rationale and Comments for this standard, click here.

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

*Standard included in Stepping Stones, 3rd Ed*  
Caring for Infants and Toddlers in Child Care and Early Education
*STANDARD 3.2.3.4: Prevention of Exposure to Blood and Body Fluids

Child care facilities should adopt the use of Standard Precautions developed for use in hospitals by the Centers for Disease Control and Prevention (CDC). Standard Precautions should be used to handle potential exposure to blood, including blood-containing body fluids and tissue discharges, and to handle other potentially infectious fluids.

In child care settings:

a. Use of disposable gloves is optional unless blood or blood containing body fluids may contact hands. Gloves are not required for feeding human milk, cleaning up of spills of human milk, or for diapering;
b. Barriers to prevent contact with body fluids include moisture-resistant disposable diaper table paper, disposable gloves, and eye protection.

c. Barriers to prevent contact with body fluids include moisture-resistant disposable diaper table paper, disposable gloves, and eye protection.

Caregivers/teachers are required to be educated regarding Standard Precautions to prevent transmission of bloodborne pathogens before beginning to work in the facility and at least annually thereafter. Training must comply with requirements of the Occupational Safety and Health Administration (OSHA).

Procedures for Standard Precautions should include:

a. Surfaces that may come in contact with potentially infectious body fluids must be disposable or of a material that can be disinfected. Use of materials that can be sterilized is not required.
b. The staff should use barriers and techniques that:
   1. Minimize potential contact of mucous membranes or openings in skin to blood or other potentially infectious body fluids and tissue discharges; and
   2. Reduce the spread of infectious material within the child care facility. Such techniques include avoiding touching surfaces with potentially contaminated materials unless those surfaces are disinfected before further contact occurs with them by other objects or individuals.
c. When spills of body fluids, urine, feces, blood, saliva, nasal discharge, eye discharge, injury or tissue discharges occur, these spills should be cleaned up immediately, and further managed as follows:
   1. For spills of vomit, urine, and feces, all floors, walls, bathrooms, tabletops, toys, furnishings and play equipment, kitchen counter tops, and diaper-changing tables in contact should be cleaned and disinfected as for the procedure for diaper changing tables in Standard 3.2.1.4, Step 7;
   2. For spills of blood or other potentially infectious body fluids, including injury and tissue discharges, the area should be cleaned and disinfected. Care should be taken and eye protection used to avoid splashing any contaminated materials onto any mucus membrane (eyes, nose, mouth);
3. Blood-contaminated material and diapers should be disposed of in a plastic bag with a secure tie;
4. Floors, rugs, and carpeting that have been contaminated by body fluids should be cleaned by blotting to remove the fluid as quickly as possible, then disinfected by spot-cleaning with a detergent-disinfectant. Additional cleaning by shampooing or steam cleaning the contaminated surface may be necessary. Caregivers/teachers should consult with local health departments for additional guidance on cleaning contaminated floors, rugs, and carpeting.

Prior to using a disinfectant, clean the surface with a detergent and rinse well with water. Facilities should follow the manufacturer’s instruction for preparation and use of disinfectant (3, 4). For guidance on disinfectants, refer to Appendix J, Selecting an Appropriate Sanitizer or Disinfectant.

If blood or bodily fluids enter a mucous membrane (eyes, nose, mouth) the following procedure should occur. Flush the exposed area thoroughly with water. The goal of washing or flushing is to reduce the amount of the pathogen to which an exposed individual has contact. The optimal length of time for washing or flushing an exposed area is not known. Standard practice for managing mucous membrane(s) exposures to toxic substances is to flush the affected area for at least fifteen to twenty minutes. In the absence of data to support the effectiveness of shorter periods of flushing it seems prudent to use the same fifteen to twenty minute standard following exposure to bloodborne pathogens (5).

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 3.6.1.1: Inclusion/Exclusion/Dismissal of Children


Preparing for managing illness:

Caregivers/teachers should:

a. Encourage all families to have a backup plan for child care in the event of short or long term exclusion;
b. Review with families the inclusion/exclusion criteria and clarify that the program staff (not the families) will make the final decision about whether children who are ill may stay based on the program’s inclusion/exclusion criteria and their
ability to care for the child who is ill without compromising the care of other children in the program;

c. Develop, with a child care health consultant, protocols and procedures for handling children's illnesses, including care plans and an inclusion/exclusion policy;

d. Request the primary care provider's note to readmit a child if the primary care provider's advice is needed to determine whether the child is a health risk to others, or if the primary care provider's guidance is needed about any special care the child requires (1);

e. Rely on the family's description of the child's behavior to determine whether the child is well enough to return, unless the child's status is unclear from the family's report.

Daily health checks as described in Standard 3.1.1.1 should be performed upon arrival of each child each day. Staff should objectively determine if the child is ill or well. Staff should determine which children with mild illnesses can remain in care and which need to be excluded. Staff should notify the parent/guardian when a child develops new signs or symptoms of illness. Parent/guardian notification should be immediate for emergency or urgent issues. Staff should notify parents/guardians of children who have symptoms that require exclusion and parents/guardians should remove the child from the child care setting as soon as possible. For children whose symptoms do not require exclusion, verbal or written notification of the parent/guardian at the end of the day is acceptable. Most conditions that require exclusion do not require a primary care provider visit before reentering care.

Conditions/symptoms that do not require exclusion:

a. Common colds, runny noses (regardless of color or consistency of nasal discharge);

b. A cough not associated with a infectious disease (such as pertussis) or a fever;

c. Watery, yellow or white discharge or crusting eye discharge without fever, eye pain, or eyelid redness;

d. Yellow or white eye drainage that is not associated with pink or red conjunctiva (i.e., the whites of the eyes);

e. Pink eye (bacterial conjunctivitis) indicated by pink or red conjunctiva with white or yellow eye mucus drainage and matted eyelids after sleep. Parents/guardians should discuss care of this condition with their child's primary care provider, and follow the primary care provider's advice. Some primary care providers do not think it is necessary to examine the child if the discussion with the parents/guardians suggests that the condition is likely to be self-limited. If two unrelated children in the same program have conjunctivitis, the organism causing the conjunctivitis may have a higher risk for transmission and a child health care professional should be consulted;

f. Fever without any signs or symptoms of illness in children who are older than six months regardless of whether acetaminophen or ibuprofen was given. Fever (temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) is an indication of the body's response to something, but is neither a disease nor a serious problem by itself. Body temperature can be elevated by overheating caused by overdressing or a hot environment, reactions to medications, and response to infection. If the child is behaving normally but has a fever of below 102°F per rectum or the equivalent, the child should be monitored, but does not need to be excluded for fever alone;

g. Rash without fever and behavioral changes;

h. Lice or nits (exclusion for treatment of an active lice infestation may be delayed until the end of the day);

i. Ringworm (exclusion for treatment may be delayed until the end of the day);

j. Molluscum contagiosum (do not require exclusion or covering of lesions);

k. Thrush (i.e., white spots or patches in the mouth or on the cheeks or gums);

l. Fifth disease (slapped cheek disease, parvovirus B19) once the rash has appeared;

m. Methicillin-resistant Staphylococcus aureus, or MRSA, without an infection or illness that would otherwise require exclusion. Known MRSA carriers and/or chronic illnesses should not be excluded;

n. Cytomegalovirus infection;

o. Chronic hepatitis B infection;

p. Human immunodeficiency virus (HIV) infection;

q. Asymptomatic children who have been previously evaluated and found to be shedding potentially infectious organisms in the stool. Children who are continent of stool or who are diapered with formed stools that can be contained in the diaper may return to care. For some infectious organisms, exclusion is required until certain guidelines have been met. Note: These agents are not common and caregivers/teachers will usually not know the cause of most cases of diarrhea;

r. Children with chronic infectious conditions that can be accommodated in the program according to the legal requirement of federal law in the Americans with Disabilities Act. The act requires that child care programs make reasonable accommodations for children with disabilities and/or chronic illnesses, considering each child individually.

Key criteria for exclusion of children who are ill:

When a child becomes ill but does not require immediate medical help, a determination must be made regarding whether the child should be sent home (i.e., should be temporarily “excluded” from child care). Most illnesses do
not require exclusion. The caregiver/teacher should determine if the illness:

a. Prevents the child from participating comfortably in activities;

b. Results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;

c. Poses a risk of spread of harmful diseases to others.

If any of the above criteria are met, the child should be excluded, regardless of the type of illness. The child should be removed from direct contact with other children and should be monitored and supervised by a single staff member known to the child until dismissed from care to the care of a parent/guardian or a primary care provider. The area should be where the toys, equipment, and surfaces will not be used by other children or adults until after the ill child leaves and after the surfaces and toys have been cleaned and disinfected.

Temporary exclusion is recommended when the child has any of the following conditions:

a. The illness prevents the child from participating comfortably in activities;

b. The illness results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;

c. An acute change in behavior - this could include lethargy/lack of responsiveness, irritability, persistent crying, difficult breathing, or having a quickly spreading rash;

d. Fever (temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea). An unexplained temperature above 102°F [38.9°C] axillary (armpit) or 101°F (38.3°C) rectally in a child younger than six months should be medically evaluated. Any infant younger than two months of age with any fever should get urgent medical attention. See COMMENTS Below for important information about taking temperatures;

e. Diarrhea is defined by watery stools or decreased form of stool that is not associated with changes of diet. Exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing soiled pants or clothing. In addition, diapered children with diarrhea should be excluded if the stool frequency exceeds two or more stools above normal for that child, because this may cause too much work for the caregivers/teachers. Readmission after diarrhea can occur when diapered children have their stool contained by the diaper (even if the stools remain loose) and when toilet-trained children are continent. Special circumstances that require specific exclusion criteria include the following (2):

1. Toxin-producing E. coli or Shigella infection, until stools are formed and the test results of two stool cultures obtained from stools produced twenty-four hours apart do not detect these organisms;

2. Salmonella serotype Typhi infection, until diarrhea resolves. In children younger than five years with Salmonella serotype Typhi, three negative stool cultures obtained with twenty-four-hour intervals are required; people five years of age or older may return after a twenty-four-hour period without a diarrheal stool. Stool cultures should be collected from other attendees and staff members, and all infected people should be excluded;

f. Blood or mucus in the stools not explained by dietary change, medication, or hard stools;

g. Vomiting more than two times in the previous twenty-four hours, unless the vomiting is determined to be caused by a non-infectious condition and the child remains adequately hydrated;

h. Abdominal pain that continues for more than two hours or intermittent pain associated with fever or other signs or symptoms of illness;

i. Mouth sores with drooling unless the child’s primary care provider or local health department authority states that the child is noninfectious;

j. Rash with fever or behavioral changes, until the primary care provider has determined that the illness is not a infectious disease;

k. Active tuberculosis, until the child’s primary care provider or local health department states child is on appropriate treatment and can return;

l. Impetigo, until treatment has been started;

m. Streptococcal pharyngitis (i.e., strep throat or other streptococcal infection), until twenty-four hours after treatment has been started;

n. Head lice until after the first treatment (note: exclusion is not necessary before the end of the program day);

o. Scabies, until after treatment has been given;

p. Chickenpox (varicella), until all lesions have dried or crusted (usually six days after onset of rash);

q. Rubella, until six days after the rash appears;

r. Pertussis, until five days of appropriate antibiotic treatment;

s. Mumps, until five days after onset of parotid gland swelling;

t. Measles, until four days after onset of rash;

u. Hepatitis A virus infection, until one week after onset of illness or jaundice if the child’s symptoms are mild or as directed by the health department. (Note: immunization status of child care contacts should be confirmed; within a fourteen-day period of exposure, incompletely immunized or unimmunized contacts from one through forty years of age should receive the hepatitis A vaccine...
as post exposure prophylaxis, unless contraindicated.) Other individuals may receive immune globulin. Consult with a primary care provider for dosage and recommendations;

v. Any child determined by the local health department to be contributing to the transmission of illness during an outbreak.

Procedures for a child who requires exclusion:

The caregiver/teacher will:

a. Provide care for the child in a place where the child will be comfortable and supervised by someone who knows the child well and who will continue to observe the child for new or worsening symptoms. A potentially contagious child should be separated from other children by at least three feet. Each facility should have a predetermined physical location(s) where an ill child(ren) could be placed until care can be transferred to a parent/guardian or primary care provider;

b. Ask the family to pick up the child as soon as possible;

c. Discuss the signs and symptoms of illness with the parent/guardian who is assuming care. Review guidelines for return to child care. If necessary, provide the family with a written communication that may be given to the primary care provider. The communication should include onset time of symptoms, observations about the child, vital signs and times (e.g., temperature 101.5°F at 10:30 AM) and any actions taken and the time actions were taken (e.g., one child’s acetaminophen given at 11:00 AM). The nature and severity of symptoms and or requirements of the local or state health department will determine the necessity of medical consultation. Telephone advice, electronic transmissions of instructions are acceptable without an office visit;

d. Follow the advice of the child’s primary care provider;

e. Contact the local health department if there is a question of a reportable (harmful) infectious disease in a child or staff member in the facility. If there are conflicting opinions from different primary care providers about the management of a child with a reportable infectious disease, the health department has the legal authority to make a final determination;

f. Document actions in the child’s file with date, time, symptoms, and actions taken (and by whom); sign and date the document;

g. In collaboration with the local health department, notify the parents of contacts to the child or staff member with presumed or confirmed reportable infectious infection.

The caregiver/teacher should make the decision about whether a child meets or does not meet the exclusion criteria for participation and the child’s need for care relative to the staff’s ability to provide care. If parents/guardians and the child care staff disagree, and the reason for exclusion relates to the child’s ability to participate or the caregiver’s/teacher’s ability to provide care for the other children, the caregiver/teacher should not be required to accept responsibility for the care of the child.

Reportable conditions:

The current list of infectious diseases designated as notifiable in the United States at the national level by the Centers for Disease Control and Prevention (CDC) are listed at http://www.cdc.gov/osels/ph_surveillance/.

The caregiver/teacher should contact the local health department:

a. When a child or staff member who is in contact with others has a reportable disease;

b. If a reportable illness occurs among the staff, children, or families involved with the program;

c. For assistance in managing a suspected outbreak. Generally, an outbreak can be considered to be two or more unrelated (e.g., not siblings) children with the same diagnosis or symptoms in the same group within one week. Clusters of mild respiratory illness, ear infections, and certain dermatological conditions are common and generally do not need to be reported.

Caregivers/teachers should work with their child care health consultants to develop policies and procedures for alerting staff and families about their responsibility to report illnesses to the program and for the program to report diseases to the local health authorities.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 3.6.1.2: Staff Exclusion for Illness**

Please note that if a staff member has no contact with the children, or with anything with which the children come into contact, this standard may not apply to that staff member.

A facility should not deny admission to or send home a staff member or substitute with illness unless one or more of the following conditions exists. The staff member should be excluded as follows:

a. Chickenpox, until all lesions have dried and crusted, which usually occurs by six days;

b. Shingles, only if the lesions cannot be covered by clothing or a dressing until the lesions have crusted;

c. Rash with fever or joint pain, until diagnosed not to be measles or rubella;

d. Measles, until four days after onset of the rash (if the staff member or substitute is immunocompetent);

e. Rubella, until six days after onset of rash;

f. Diarrheal illness, stool frequency exceeds two or more stools above normal for that individual or blood in stools, until diarrhea resolves; if E. coli

*Standard included in Stepping Stones, 3rd Ed Caring for Infants and Toddlers in Child Care and Early Education*
Rectal temperatures should be taken only by persons with specific health training in performing this procedure. Oral (under the tongue) temperatures can be used for children over age four. Individual plastic covers should be used on oral or rectal thermometers with each use or thermometers should be cleaned and sanitized after each use according to the manufacturer’s instructions. Axillary (under the arm) temperatures are less accurate, but are a good option for infants and young children when the caregiver/teacher has not been trained to take a rectal temperature.

To view the Rationale and Comments for this standard, click [here](#).

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

**STANDARD 3.6.4.1: Procedure for Parent/Guardian Notification About Exposure of Children to Infectious Disease**

Caregivers/teachers should work collaboratively with local and state health authorities to notify parents/guardians about potential or confirmed exposures of their child to a infectious disease. Notification should include the following information:

a. The names, both the common and the medical name, of the diagnosed disease to which the child was exposed, whether there is one case or an outbreak, and the nature of the exposure (such as a child or staff member in a shared room or facility);

b. Signs and symptoms of the disease for which the parent/guardian should observe;

c. Mode of transmission of the disease;

d. Period of communicability and how long to watch for signs and symptoms of the disease;

e. Disease-prevention measures recommended by the health department (if appropriate);

f. Control measures implemented at the facility;

g. Pictures of skin lesions or skin condition may be helpful to parents/guardians (i.e., chicken pox, spots on tonsils, etc.)

The notice should not identify the child who has the infectious disease.

To view the Rationale and Comments for this standard, click [here](#).

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

**STANDARD 3.6.4.2: Infectious Diseases that Require Parent/Guardian Notification**

In cooperation with the child care regulatory authority and health department, the facility or the health department should inform parents/guardians if their child may have been exposed to the following diseases or conditions while attending the child care program, while retaining the confidentiality of the child who has the infectious disease:

a. Neisseria meningitidis (meningitis);
b. Pertussis;

c. Invasive infections;

d. Varicella-zoster (Chickenpox) virus;

e. Skin infections or infestations (head lice, scabies, and ringworm);

f. Infections of the gastrointestinal tract (often with diarrhea) and hepatitis A virus (HAV);

g. Haemophilus influenzae type B (Hib);

h. Parvovirus B19 (fifth disease);

i. Measles;

j. Tuberculosis;

k. Two or more affected unrelated persons affiliated with the facility with a vaccine-preventable or infectious disease.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 3.6.4.4: List of Excludable and Reportable Conditions for Parents**

The facility should give to each parent/guardian a written list of conditions for which exclusion and dismissal may be indicated (2).

For the following symptoms, the caregiver/teacher should ask parents to have the child evaluated by a primary care provider. The advice of the primary care provider should be documented for the caregiver/teacher in the following situations:

a. The child has any of the following conditions: fever, lethargy, irritability, persistent crying, difficult breathing, or other manifestations of possible severe illness;

b. The child has a rash with fever and behavioral change;

c. The child has tuberculosis that has not been evaluated;

d. The child has scabies;

e. The child has a persistent cough with inability to practice respiratory etiquette.

The facility should have a list of reportable diseases provided by the health department and should provide a copy to each parent/guardian.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.2.7.4: Containment of Soiled Diapers**

Soiled diapers should be stored inside the facility in containers separate from other waste. Washable, plastic-lined, tightly covered receptacles, with a firmly fitting cover that does not require touching with contaminated hands or objects, should be provided, within arm’s reach of diaper changing tables, to store soiled diapers. The container for soiled diapers should be designed to prevent the user from contaminating any exterior surfaces of the container or the user when inserting the soiled diaper. Soiled diapers do not have to be individually bagged before placing them in the container for soiled diapers. Soiled cloth diapers and soiled clothing that are to be sent home with a parent/guardian, however, should be individually bagged.

The following types of diaper containers should not be used:

a. Those that require the user’s hand to push the diaper through a narrow opening;

b. Those with exterior surfaces that must be touched with the hand;

c. Those with exterior surfaces that are likely to be touched with the soiled diaper while the user is discarding the soiled diaper;

d. Those that have lids with handles.

Separate containers should be used for disposable diapers, cloth diapers (if used), and soiled clothes and linens. All containers should be inaccessible to children and should be tall enough to prevent children reaching into the receptacle or from falling headfirst into containers. The containers should be placed in an area that children cannot enter without close adult supervision.

To view the Rationale and Comments for this standard, click here.

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

See Quick Reference: Diaper Changing and Toileting for a list of the diapering- and toileting-related standards included in this collection.

**STANDARD 5.2.7.5: Labeling, Cleaning, and Disposal of Waste and Diaper Containers**

Each waste and diaper container should be labeled to show its intended contents. These containers should be cleaned daily to keep them free from build-up of soil and odor. Wastewater from these cleaning operations should be disposed of by pouring it down a toilet or floor drain. Wastewater should not be poured onto the ground, into basins, bathtubs.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.5.0.1: Storage and Labeling of Personal Articles**

The facility should provide separate storage areas for each child’s and staff member’s personal articles and clothing. Personal effects and clothing should be labeled with the child’s name. Bedding should be labeled with the child’s full name, stored separately for each child, and not touching other children’s personal items.
If children use the following items at the child care facility, those items should be stored in separate, clean containers and should be labeled with the child’s full name:

a. Individual cloth towels for bathing purposes;
b. Toothbrushes;
c. Washcloths;
d. Combs and brushes.

Toothbrushes, towels, and washcloths should be allowed to dry when they are stored and not touching.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 7.2.0.1: Immunization Documentation**

Child care facilities should require that all parents/guardians of children enrolled in child care provide written documentation of receipt of immunizations appropriate for each child’s age. Infants, children, and adolescents should be immunized as specified in the “Recommended Immunization Schedules for Persons Aged 0 Through 18 Years – United States, 2011” developed by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). Children whose immunizations are not up-to-date or have not been administered according to the recommended schedule should receive the required immunizations, unless contraindicated or for legal exemptions (1,2).

An updated immunization schedule is published annually in the AAP’s Pediatrics and in the CDC’s MMWR and should be consulted for current information. In addition to print versions of the recommended immunization schedules, the current child, adolescent, and catch-up schedules are posted on the Websites of the CDC at [http://www.cdc.gov/vaccines/](http://www.cdc.gov/vaccines/) and the AAP at [http://www.aap.org/immunization/](http://www.aap.org/immunization/).

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 7.2.0.2: Unimmunized Children**

If immunizations have not been or are not to be administered because of a medical condition (contraindication), a statement from the child’s primary care provider documenting the reason why the child is temporarily or permanently medically exempt from the immunization requirements should be on file. If immunizations are not to be administered because of the parents/guardians’ religious or philosophical beliefs, a legal exemption with notarization, waiver or other state-specific required documentation signed by the parent/guardian should be on file (1,2).

The parent/guardian of a child who has not received the age-appropriate immunizations prior to enrollment and who does not have documented medical, religious, or philosophical exemptions from routine childhood immunizations should provide documentation of a scheduled appointment or arrangement to receive immunizations. This could be a scheduled appointment with the primary care provider or an upcoming immunization clinic sponsored by a local health department or health care organization. An immunization plan and catch-up immunizations should be initiated upon enrollment and completed as soon as possible according to the “Recommended Immunization Schedules for Persons Aged 0 Through 18 Years – United States” from the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). Parents/guardians of children who attend an unlicensed child care facility should be encouraged to comply with the “Recommended Immunization Schedules” (6).

If a vaccine-preventable disease to which children are susceptible occurs in the facility and potentially exposes the unimmunized children who are susceptible to that disease, the health department should be consulted to determine whether these children should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 7.2.0.3: Immunization of Caregivers/Teachers**

Caregivers/teachers should be current with all immunizations routinely recommended for adults by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) as shown in the “Recommended Adult Immunization Schedule” at [http://www.cdc.gov/vaccines/recs/schedules/default.htm#adult/](http://www.cdc.gov/vaccines/recs/schedules/default.htm#adult/). This schedule is updated annually at the beginning of the calendar year and can be found in Appendix H.

Caregivers/teachers should have received the recommended vaccines in the following categories: (1,2)

1. Tdap/Td;
2. Varicella-zoster;
3. MMR (measles, mumps, and rubella);
4. Seasonal influenza;
5. Human papillomaviruses (HPV) (eleven through twenty-six years of age);
6. Others as determined by the ACIP and state and local public health authorities.

b. Recommended if a specific risk factor is present:
   1. Pneumococcal;
   2. Hepatitis A;
   3. Hepatitis B;
   4. Meningococcal;
   5. Others as determined by the ACIP and state and local public health authorities.

c. If a staff member is not appropriately immunized for medical, religious or philosophical reasons, the child care facility should require written documentation of the reason.

d. If a vaccine-preventable disease to which adults are susceptible occurs in the facility and potentially exposes the unimmunized adults who are susceptible to that disease, the health department should be consulted to determine whether these adults should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 7.3.2.1: Immunization for Haemophilus Influenzae Type B (HIB)**

All children in a child care facility should have received age-appropriate immunizations with a Haemophilus influenzae type b (Hib) conjugate containing vaccine (1). Children in child care who are not immunized or not age-appropriately immunized against invasive Hib disease should be excluded from care immediately if the child care facility has been notified of a documented case of an invasive Hib infection. These children should be allowed to return when the risk of infection is no longer present, as determined by the health department.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 7.3.3.1: Influenza Immunizations for Children and Caregivers/Teachers**

The parent/guardian of each child six months of age and older should provide written documentation of current annual vaccination against influenza unless there is a medical contraindication or philosophical or religious objection. Children who are too young to receive influenza vaccine before the start of influenza season should be immunized annually beginning when they reach six months of age.

Staff caring for all children should receive annual vaccination against influenza. Ideally people should be vaccinated before the start of the influenza season (as early as August or September) and immunization should continue through March or April.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 7.3.5.1: Recommended Control Measures for Invasive Meningococcal Infection in Child Care**

Identification of an individual with invasive meningococcal infection in the child care setting should result in the following:

a. Immediate notification of the local or state health department;

b. Notification of parents/guardians about child care contacts to the person with invasive meningococcal infection;

c. Assistance with provision of antibiotic prophylaxis and vaccine receipt, as advised by the local or state health department, to child care contacts;

d. Frequent updates and communication with parents/guardians, health care professionals, and local health authorities.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 7.3.7.3: Exclusion for Pertussis**

Children and staff members with characteristic symptoms of pertussis (whooping cough) should be excluded from child care pending evaluation by a primary care provider. A symptomatic child or staff member with pertussis or suspected pertussis may not return to the facility until:

a. Five days after initiation of a course of any of the following antibiotics: azithromycin (full course of treatment is five days), erythromycin (full course of treatment is fourteen days), or clarithromycin (full course of treatment is seven days) antimicrobial therapy;

b. The medical condition allows;

c. The child’s need for care does not compromise the caregiver’s/teacher’s ability to provide for the health and safety of the other children in the group.

Untreated adults should be excluded until twenty-one days after onset of cough.

To view the Rationale and Comments for this standard, click here.

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

*Standard included in Stepping Stones, 3rd Ed*
STANDARD 7.3.8.1: Attendance of Children with Respiratory Syncytial virus (RSV) Respiratory Tract Infection

Respiratory syncytial virus (RSV) is a common cause of respiratory tract infection in infants and young children, although infection in all ages may occur. Children with known RSV infection may return to child care once symptoms have resolved, temperature has returned to normal, the child can participate in child care activities and the child’s care does not result in more care than the staff can provide without compromising the health and safety of other children.

Parents/guardians and staff need to be aware that the period of RSV shedding is usually three to eight days but shedding may last longer, especially in young infants from whom virus can be shed in nasal secretions and saliva for three to four weeks following infection.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 7.3.11.1: Attendance of Children with Unspecified Respiratory Tract Infection

Children without fever who have mild symptoms associated with the common cold, sore throat, croup, bronchitis, rhinitis, rhinorrhea (runny nose), or otitis media (ear infection) should not be denied admission to child care, sent home from child care, or separated from other children in the facility unless their illness is characterized by one or more of the following conditions:

a. The illness has a specified cause that requires exclusion, as determined by other specific performance standards in Child and Staff Inclusion/Exclusion/Dismissal, Standards 3.6.1.1-3.6.1.4;

b. The illness limits the child’s comfortable participation in child care activities;

c. The illness results in a need for more care than the staff can provide without compromising the health and safety of other children.

Treatment with antimicrobial agents should not be required or otherwise encouraged as a condition for attendance of children with mild respiratory tract infections unless directed by local health officials.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 7.4.0.1: Control of Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections

Facilities should employ the following procedures, in addition to those stated in Child and Staff Inclusion/Exclusion/Dismissal, Standards 3.6.1.1-3.6.1.4, to prevent and control infections of the gastrointestinal tract (including diarrhea) or hepatitis A (1-3):

a. Toilet trained children who cannot use a toilet for all bowel movements while attending the facility and who develop diarrhea, as defined in Standard 3.6.1.1, should be removed from the facility by their parent/guardian. Exclude diapered children if stool is not contained in the diaper, stool frequency exceeds two or more stools above normal for that child, blood or mucus in the stool, abnormal color of stool, no urine output in eight hours, jaundice, fever with behavior change, or looks or acts ill. Pending arrival of the parent/guardian, the child should not be permitted to have contact with other children or be placed in areas used by adults who have contact with children in the facility. This should be accomplished by removing the child who is ill to a separate area of the child care program or, if not possible, to a separate area of the child’s room. The area should be one where the child is supervised by an adult known to the child, and where the toys, equipment, and surfaces will not be used by other children or adults until after the child who is ill leaves and after the surfaces and toys have been disinfected. When moving a child to a separate area of the facility creates problems with supervision of the other children, as occurs in small family child care homes, the child who is ill should be kept as comfortable as possible, with minimal contact between children who are ill and well children, until the parent/guardian arrives. Caregivers/teachers with diarrhea as defined in Standard 3.6.1.2 should be excluded. Separation and exclusion of children or caregivers/teachers should not be deferred pending health assessment or laboratory testing to identify an enteric pathogen.

b. A child who develops jaundice (when skin and white parts of the eye are yellow) while attending child care should be separated from other children and the child’s parent/guardian should be contacted to remove the child. The child should remain separated from other children as described above until the parent/guardian arrives and removes the child from the facility.

c. Exclusion for diarrhea should continue until either the diarrhea stops or the continued loose stools are deemed not to be infectious by a licensed health care professional. Exclusion for hepatitis A virus (HAV) should continue for one week after onset of jaundice.

d. Alternate care for children with diarrhea or hepatitis A in special facilities for children who are
ill should be provided in facilities that can provide separate care for children with infections of the gastrointestinal tract (including diarrhea) or hepatitis A.

e. Children and caregivers/teachers who excrete intestinal pathogens but no longer have diarrhea generally may be allowed to return to child care once the diarrhea resolves, except for the case of infections with Shigella, Shiga toxin-producing E. coli (STEC), or Salmonella enterica serotype Typhi. For Shigella and STEC, resolution of symptoms and two negative stool cultures are required for readmission, unless state requirements differ. For Salmonella serotype Typhi, resolution of symptoms and three negative stool cultures are required for return to child care. For Salmonella species other than serotype Typhi, documentation of negative stool cultures are not required from asymptomatic people for readmission to child care.

f. The local health department should be informed immediately of the occurrence of HAV infection or an increased frequency of diarrheal illness in children or staff in a child care facility.

g. Recommended post-exposure prophylaxis for hepatitis A includes administration of hepatitis A vaccine or immune globulin to all previously unimmunized staff members and attendees of a child care facility in which a person with hepatitis A is identified.

h. If there has been an exposure to a person with hepatitis A or diarrhea in the child care facility, caregivers/teachers should inform parents/guardians, in cooperation with the health department, that their children may have been exposed to children with HAV infection or to another person with a diarrheal illness.

To view the Rationale and Comments for this standard, click here.

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

STANDARD 7.5.1.1: Conjunctivitis

Children and staff with conjunctivitis should not be excluded from child care unless:

a. They are unable to participate in activities;

b. Care for other children would be compromised because of the care that the child with conjunctivitis requires;

c. The person with conjunctivitis has fever or a change in behavior;

d. A health care professional or health department recommends exclusion of the person with conjunctivitis.

Note: Recommendations for the approach to children with conjunctivitis have changed since publication of the last edition of Caring for Our Children.

Children and staff in close contact with a person with conjunctivitis should be observed for symptoms and referred for evaluation, if indicated. If two or more children in a group care setting develop conjunctivitis in the same period, advice from the program’s child care health consultant or public health authority should be obtained.

 Conjunctivitis, defined as redness and swelling of the covering of the white part of the eye, may result from a number of causes. Bacteria, viruses, allergies, chemical reactions, and immunological conditions may manifest as redness and discharge from one or both eyes. Management of conjunctivitis should involve frequent hand hygiene to prevent spread and evaluation by the primary care provider of children who have severe or prolonged symptoms.

To view the Rationale and Comments for this standard, click here.

STANDARD 7.5.10.1: Staphylococcus Aureus Skin Infections Including MRSA

The following should be implemented when children or staff with lesions suspicious for Staphylococcus aureus infections are identified:

a. Lesions should be covered with a dressing;

b. Report the lesions to the parent/guardian with a recommendation for evaluation by a primary care provider;

c. Exclusion is not warranted unless the individual meets any of the following criteria:

1. Care for other children would be compromised by care required for the person with the S. aureus infection;

2. The individual with the S. aureus infection has fever or a change in behavior;

3. The lesion(s) cannot be adequately covered by a bandage or the bandage needs frequent changing;

4. A health care professional or health department official recommends exclusion of the person with S. aureus infection.

Meticulous hand hygiene following contact with lesions should be practiced. Careful hand hygiene and sanitization of surfaces and objects potentially exposed to infectious material are the best ways to prevent spread. Children and staff in close contact with an infected person should be observed for symptoms of S. aureus infection and referred for evaluation, if indicated.

A child may return to group child care when staff members are able to care for the child without compromising their ability to care for others, the child is able to participate in activities, appropriate therapy is being given, and the lesions can be covered.

S. aureus skin infections initially may appear as red raised areas that may become pus-filled abscesses or “boils,” surrounded by areas of redness and tenderness. Fever and other symptoms including decreased activity, bone and joint pain, and difficulty breathing may occur when the infection occurs in other body systems. If any of these

*Standard included in Stepping Stones, 3rd Ed
signs or symptoms occur, the child should be evaluated by his/her primary care provider.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 7.5.12.1: Thrush**

Children with thrush do not need to be excluded from group settings. Careful hand hygiene and sanitization of surfaces and objects potentially exposed to oral secretions including pacifiers and toothbrushes is the best way to prevent spread. Toothbrushes and pacifiers should be labeled individually so that children do not share toothbrushes or pacifiers, as specified in Standard 3.1.5.2. The presence of children with thrush should be noted by caregivers/teachers, and parents/guardians of the children should be notified to seek care, if indicated.

Treatment of thrush may consist of a topical or an oral medication. Most people are able to control thrush without treatment. Evaluation by a primary care provider of people with severe or prolonged symptoms may be indicated.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 7.7.2.1: Disease Recognition and Control of Herpes Simplex Virus**

Children with herpetic gingivostomatitis, an infection of the mouth caused by the herpes simplex virus, who do not have control of oral secretions, should be excluded from child care. In selected situations, children with mild disease who are in control of their oral secretions may not need to be excluded. The facility’s child care health consultant or health department officials should be consulted.

Caregivers/teachers with herpetic gingivostomatitis, cold sores, or herpes labialis should do the following:

a. Refrain from kissing and nuzzling children;

b. Refrain from sharing food and drinks with children and other caregivers;

c. Avoid touching the lesions;

d. Wash their hands frequently;

e. Cover any skin lesion with a bandage, clothing, or an appropriate dressing if practical.

Caregivers/teachers should be instructed in the importance of and technique for hand hygiene and other measures aimed at limiting transfer of infected material, such as saliva, tissue fluid, or fluid from a skin sore.

Caregivers/teachers who work in a child care program with young infants should avoid caring for infants including neonates when the caregiver has an active “fever blister” on their lips.

To view the Rationale and Comments for this standard, click here.

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

**Appendix G: Recommended Immunization Schedule for Persons Aged 0-6 Years (only 1st and 3rd page of Appendix) (PDF Link)**

**E. Medication Administration**

*STANDARD 3.6.3.1: Medication Administration*

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

a. Prescription or non-prescription medication (over-the-counter [OTC]) ordered by the prescribing health professional for a specific child with written permission of the parent/guardian. Written orders from the prescribing health professional should specify medical need, medication, dosage, and length of time to give medication;

b. Labeled medications brought to the child care facility by the parent/guardian in the original container (with a label that includes the child’s name, date filled, prescribing clinician’s name, pharmacy name and phone number, dosage/instructions, and relevant warnings).

Facilities should not administer folk or homemade remedy medications or treatment. Facilities should not administer a medication that is prescribed for one child in the family to another child in the family.

No prescription or non-prescription medication (OTC) should be given to any child without written orders from a prescribing health professional and written permission from a parent/guardian. Exception: Non-prescription sunscreen and insect repellent always require parental consent but do not require instructions from each child’s prescribing health professional.

Documentation that the medicine/agent is administered to the child as prescribed is required.

“Standing orders” guidance should include directions for facilities to be equipped, staffed, and monitored by the primary care provider capable of having the special health care plan modified as needed. Standing orders for medication should only be allowed for individual children with a documented medical need if a special care plan is provided by the child’s primary care provider in conjunction with the standing order or for OTC medications for which a primary care provider has provided specific instructions that define the children, conditions and methods for administration of the medication. Signatures from the primary care provider and one of the child’s parents/guardians must be obtained on the special care
plan. Care plans should be updated as needed, but at least yearly.  

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 3.6.3.2: Labeling, Storage, and Disposal of Medications*

Any prescription medication should be dated and kept in the original container. The container should be labeled by a pharmacist with:

- The child’s first and last names;
- The date the prescription was filled;
- The name of the prescribing health professional who wrote the prescription, the medication’s expiration date;
- The manufacturer’s instructions or prescription label with specific, legible instructions for administration, storage, and disposal;
- The name and strength of the medication.

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

All medications, refrigerated or unrefrigerated, should:

- Have child-resistant caps;
- Be kept in an organized fashion;
- Be stored away from food;
- Be stored at the proper temperature;
- Be completely inaccessible to children.

Medication should not be used beyond the date of expiration. Unused medications should be returned to the parent/guardian for disposal. In the event medication cannot be returned to the parent or guardian, it should be disposed of according to the recommendations of the US Food and Drug Administration (FDA) (1). Documentation should be kept with the child care facility of all disposed medications. The current guidelines are as follows:

- If a medication lists any specific instructions on how to dispose of it, follow those directions.
- If there are community drug take back programs, participate in those.
- Remove medications from their original containers and put them in a sealable bag. Mix medications with an undesirable substance such as used coffee grounds or kitty litter. Throw the mixture into the regular trash. Make sure children do not have access to the trash (1).

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 3.6.3.3: Training of Caregivers/Teachers to Administer Medications*

Any caregiver/teacher who administers medication should complete a standardized training course that includes skill and competency assessment in medication administration. The trainer in medication administration should be a licensed health professional. The course should be repeated according to state and/or local regulation. At a minimum, skill and competency should be monitored annually or whenever medication administration error occurs. In facilities with large numbers of children with special health care needs involving daily medication, best practice would indicate strong consideration to the hiring of a licensed health care professional. Lacking that, caregivers/teachers should be trained to:

a. Check that the name of the child on the medication and the child receiving the medication are the same;

b. Check that the name of the medication is the same as the name of the medication on the instructions to give the medication if the instructions are not on the medication container that is labeled with the child’s name;

c. Read and understand the label/prescription directions or the separate written instructions in relation to the measured dose, frequency, route of administration (ex. by mouth, ear canal, eye, etc.) and other special instructions relative to the medication;

d. Observe and report any side effects from medications;

e. Document the administration of each dose by the time and the amount given;

f. Document the person giving the administration and any side effects noted;

g. Handle and store all medications according to label instructions and regulations.

The trainer in medication administration should be a licensed health professional: Registered Nurse, Advanced Practice Registered Nurse (APRN), MD, Physician’s Assistant, or Pharmacist.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 9.4.2.6: Contents of Medication Record*

The file for each child should include a medication record for prescription and non-prescription (over-the-counter [OTC]) medications. State requirements should be checked and followed. The medication record for prescription and non-prescription medications should include the following:

a. A separate consent signed by the parent/guardian for each medication the caregiver/teacher has permission to administer to the child; each
c. Administration log which includes the child’s name, the medication that was given, the dose, the route of administration, the time and date, and the signature or initials of the person administering the medication. For medications given “as needed,” record the reason the medication was given. Space should be available for notations of any side-effects noted after the medication was given or if the dose was not retained because of the child vomiting or spitting out the medication. Documentation should also be made of attempts to give medications that were refused by the child;

d. Information about prescription medication brought to the facility by the parents/guardians in the original, labeled container with a label that includes the child’s name, date filled, prescribing clinician’s name, pharmacy name and phone number, dosage/instructions, and relevant warnings. Potential side effects and other warnings about the medication should be listed on the authorization form;

e. Non prescription medications should be brought to the facility in the original container, labeled with the child’s complete name and administered according to the authorization completed by the person with prescriptive authority;

f. For medications that are to be given or available to be given for the entire year, a Care Plan should also be in place (for instance, inhalers for asthma or epinephrine for possible allergy);

g. Side effects.

To view the Rationale and Comments for this standard, click here.

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

Appendix AA: Medication Administration Packet (PDF Link)

F. Abuse/Neglect

*STANDARD 3.4.4.3: Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma

All child care facilities should have a policy and procedure to identify and prevent shaken baby syndrome/abusive head trauma. All caregivers/teachers who are in direct contact with children including substitute caregivers/teachers and volunteers, should receive training on preventing shaken baby syndrome/abusive head trauma, recognition of potential signs and symptoms of shaken baby syndrome/abusive head trauma, strategies for coping with a crying, fussing or distraught child, and the development and vulnerabilities of the brain in infancy and early childhood.

To view the Rationale and Comments for this standard, click here.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home
**STANDARD 3.4.4.5: Facility Layout to Reduce Risk of Child Abuse and Neglect**

The physical layout of facilities should be arranged so that there is a high level of visibility in the inside and outside areas as well as diaper changing areas and toileting areas used by children. All areas should be viewed by at least one other adult in addition to the caregiver/teacher at all times when children are in care. For center-based programs, rooms should be designed so that there are windows to the hallways to keep classroom activities from being too private. Ideally each area of the facility should have two adults at all times. Such an arrangement reduces the risk of child abuse and neglect and the likelihood of extended periods of time in isolation for individual caregivers/teachers with children, especially in areas where children may be partially undressed or in the nude.

Caregivers/teachers should have increased awareness regarding risk of abuse and neglect when a caregiver/teacher is alone with a child. Other caregivers/teachers should periodically walk into a room with one caregiver/teacher to ensure there is no abuse and neglect.

To view the Rationale and Comments for this standard, click here.

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

**Appendix M: Recognizing Child Abuse and Neglect: Signs and Symptoms (PDF Link)**

### G. Emergency Preparedness

**STANDARD 3.6.4.5: Death**

Each facility should have a plan in place for responding to any death relevant to children enrolled in the facility and their families. The plan should describe protocols the program will follow and resources available for children, families, and staff.

If a facility experiences the death of a child or adult, the following should be done:

1. If a child or adult dies while at the facility:
   - The caregiver/teacher(s) responsible for any children who observed or were in the same room where the death occurred, should take the children to a different room, while other staff tend to appropriate response/follow-up. Minimal explanations should be provided until direction is received from the proper authorities. Supportive and reassuring comments should be provided to children directly affected;
   - Designated staff should:
     - Immediately notify emergency medical personnel;
     - Immediately notify the child’s parents/guardians or adult’s emergency contact;
   - If a child or adult known to the children enrolled in the facility dies while not at the facility:
     - The caregiver/teacher(s) responsible for any children who observed or were in the same room where the death occurred, should take the children to a different room, while other staff tend to appropriate response/follow-up. Minimal explanations should be provided until direction is received from the proper authorities. Supportive and reassuring comments should be provided to children directly affected;
   - Designated staff should:
     - Immediately notify emergency medical personnel;
     - Immediately notify the child’s parents/guardians or adult’s emergency contact;
   - The caregiver/teacher(s) responsible for any children who observed or were in the same room where the death occurred, should take the children to a different room, while other staff tend to appropriate response/follow-up. Minimal explanations should be provided until direction is received from the proper authorities. Supportive and reassuring comments should be provided to children directly affected;
   - Designated staff should:
     - Immediately notify emergency medical personnel;
     - Immediately notify the child’s parents/guardians or adult’s emergency contact;

2. If a child or adult known to the children enrolled in the facility dies while not at the facility:
   - The caregiver/teacher(s) responsible for any children who observed or were in the same room where the death occurred, should take the children to a different room, while other staff tend to appropriate response/follow-up. Minimal explanations should be provided until direction is received from the proper authorities. Supportive and reassuring comments should be provided to children directly affected;
   - Designated staff should:
     - Immediately notify emergency medical personnel;
     - Immediately notify the child’s parents/guardians or adult’s emergency contact;

   - Do not disturb the scene;
   - Do not show the scene to others;
   - Reserve conversation about the event until having completed all interviews with law enforcement.

   - Provide age-appropriate information for children, parents/guardians and staff;
   - Make resources for support available to staff, parents and children;

   - If a suspected Sudden Infant Death Syndrome (SIDS) death or other unexplained deaths:
     - Seek support and information from local, state, or national SIDS resources;
     - Provide SIDS information to the parents/guardians of the other children in the facility;
     - Provide age-appropriate information to the other children in the facility;
     - Provide appropriate information for staff at the facility;

   - If a child or adult known to the children enrolled in the facility dies while not at the facility:
     - Provide age-appropriate information for children, parents/guardians and staff;
     - Make resources for support available to staff, parents and children.

Facilities may release specific information about the circumstances of the child or adult’s death that the authorities and the deceased member’s family agrees the facility may share.

If the death is due to suspected child maltreatment, the caregiver/teacher is mandated to report this to child protective services.

Depending on the cause of death (SIDS, suffocation or other infant death, injury, maltreatment etc.), there may be a need for updated education on the subject for caregivers/teachers and/or children as well as implementation of improved health and safety practices.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 5.6.0.1: First Aid and Emergency Supplies**

The facility should maintain first aid and emergency supplies in each location where children are cared for. The first aid kit or supplies should be kept in a closed container, cabinet, or drawer that is labeled and stored in a location known to all staff, accessible to staff at all times, but locked or otherwise inaccessible to children. When
children leave the facility for a walk or to be transported, a designated staff member should bring a transportable first aid kit. In addition, a transportable first aid kit should be in each vehicle that is used to transport children to and from a child care facility.

First aid kits or supplies should be restocked after use. An inventory of first aid supplies should be conducted at least monthly. A log should be kept that lists the date that each inventory was conducted, verification that expiration dates of supplies were checked, location of supplies (i.e., in the facility supply, transportable first aid kit(s), etc.,) and the legal name/signature of the staff member who completed the inventory.

The first aid kit should contain at least the following items:

a. Disposable nonporous, latex-free or non-powdered latex gloves (latex-free recommended);
b. Scissors;
c. Tweezers;
d. Non-glass, non-mercury 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 patch or dressing;
k. Pen/pencil and note pad;
l. Cold pack;
m. Current American Academy of Pediatrics (AAP) standard first aid chart or equivalent first aid guide such as the AAP Pediatric First Aid For Caregivers and Teachers (PedFACTS) Manual;

n. Coins for use in a pay phone and cell phone;
o. Water (two liters of sterile water for cleaning wounds or eyes);
p. Liquid soap to wash injury and hand sanitizer, used with supervision, if hands are not visibly soiled or if no water is present;
q. Tissues;
r. Wipes;
s. Individually wrapped sanitary pads to contain bleeding of injuries;
t. Adhesive strip bandages, plastic bags for cloths, gauze, and other materials used in handling blood;
u. Flashlight;
v. Whistle;
w. Battery-powered radio (1).

When children walk or are transported to another location, the transportable first aid kit should include ALL items listed above AND the following emergency information/items:

a. List of children in attendance (organized by caregiver/teacher they are assigned to) and their emergency contact information (i.e., parents/guardian/emergency contact home, work, and cell phone numbers);
b. Special care plans for children who have them;
c. Emergency medications or supplies as specified in the special care plans;
d. List of emergency contacts (i.e., location information and phone numbers for the Poison Center, nearby hospitals or other emergency care clinics, and other community resource agencies);
e. Maps;
f. Written transportation policy and contingency plans.

To view the Rationale and Comments for this standard, click here.

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

*STANDARD 9.2.4.3: Disaster Planning, Training, and Communication

Facilities should consider how to prepare for and respond to emergency or natural disaster situations and develop written plans accordingly. All programs should have procedures in place to address natural disasters that are relevant to their location (such as earthquakes, tornados, tsunamis or flash floods, storms, and volcanoes) and all hazards/disasters that could occur in any location including acts of violence, bioterrorism/terrorism, exposure to hazardous agents, facility damage, fire, missing child, power outage, and other situations that may require evacuation, lock-down, or shelter-in-place.

Written Emergency/Disaster Plan:

Facilities should develop and implement a written plan that describes the practices and procedures they use to prepare for and respond to emergency or disaster situations. This Emergency/Disaster Plan should include:

a. Information on disasters likely to occur in or near the facility, county, state, or region that require advance preparation and/or contingency planning;
b. Plans (and a schedule) to conduct regularly scheduled practice drills within the facility and in collaboration with community or other exercises;
c. Mechanisms for notifying and communicating with parents/guardians in various situations (e.g., Website postings; email notification; central telephone number, answering machine, or answering service messaging; telephone calls, use of telephone tree, or cellular phone texts; and/or posting of flyers at the facility and other community locations);
d. Mechanisms for notifying and communicating with emergency management public officials;
e. Information on crisis management (decision-making and practices) related to sheltering in place, relocating to another facility, evacuation procedures including how non-mobile children and adults will be evacuated, safe transportation of children including children with special health care
needs, transporting necessary medical equipment obtaining emergency medical care, responding to an intruder, etc.;

f. Identification of primary and secondary meeting places and plans for reunification of parents/guardians with their children;

g. Details on collaborative planning with other groups and representatives (such as emergency management agencies, other child care facilities, schools, emergency personnel and first responders, pediatricians/health professionals, public health agencies, clinics, hospitals, and volunteer agencies including Red Cross and other known groups likely to provide shelter and related services);

h. Continuity of operations planning, including backing up or retrieving health and other key records/files and managing financial issues such as paying employees and bills during the aftermath of the disaster;

i. Contingency plans for various situations that address:
   1. Emergency contact information and procedures;
   2. How the facility will care for children and account for them, until the parent/guardian has accepted responsibility for their care;
   3. Acquiring, stockpiling, storing, and cycling to keep updated emergency food/water and supplies that might be needed to care for children and staff for up to one week if shelter-in-place is required and when removal to an alternate location is required;
   4. Administering medicine and implementing other instructions as described in individual special care plans;
   5. Procedures that might be implemented in the event of an outbreak, epidemic, or other infectious disease emergency (e.g., reviewing relevant immunization records, keeping symptom records, implementing tracking procedures and corrective actions, modifying exclusion and isolation guidelines, coordinating with schools, reporting or responding to notices about public health emergencies);
   6. Procedures for staff to follow in the event that they are on a field trip or are in the midst of transporting children when an emergency or disaster situation arises;
   7. Staff responsibilities and assignment of tasks (facilities should recognize that staff can and should be utilized to assist in facility preparedness and response efforts, however, they should not be hindered in addressing their own personal or family preparedness efforts, including evacuation).

Details in the Emergency/Disaster Plan should be reviewed and updated bi-annually and immediately after any relevant event to incorporate any best practices or lessons learned into the document.

Facilities should identify in advance which agency or agencies would be the primary contact for them regarding child care regulations, evacuation instructions, and other directives that might be communicated in various emergency or disaster situations.

Training:

Staff should receive training on emergency/disaster planning and response. Training should be provided by emergency management agencies, educators, child care health consultants, health professionals, or emergency personnel qualified and experienced in disaster preparedness and response. The training should address:

   a. Why it is important for child care facilities to prepare for disasters and to have an Emergency/Disaster Plan;
   b. Different types of emergency and disaster situations and when and how they may occur;
      1. Natural Disasters;
      2. Terrorism (i.e., biological, chemical, radiological, nuclear);
      3. Outbreaks, epidemics, or other infectious disease emergencies;
   c. The special and unique needs of children, appropriate response to children’s physical and emotional needs during and after the disaster, including information on consulting with pediatric disaster experts;
   d. Providing first aid, medications, and accessing emergency health care in situations where there are not enough available resources;
   e. Contingency planning including the ability to be flexible, to improvise, and to adapt to ever-changing situations;
   f. Developing personal and family preparedness plans;
   g. Supporting and communicating with families;
   h. Floor plan safety and layout;
   i. Location of emergency documents, supplies, medications, and equipment needed by children and staff with special health care needs;
   j. Typical community, county, and state emergency procedures (including information on state disaster and pandemic influenza plans, emergency operation centers, and incident command structure);
   k. Community resources for post-event support such as mental health consultants, safety consultants;
   l. Which individuals or agency representatives have the authority to close child care programs and schools and when and why this might occur;
   m. Insurance and liability issues;
   n. New advances in technology, communication efforts, and disaster preparedness strategies customized to meet children’s needs.

Communicating with Parents/Guardians:
Facilities should share detailed information about facility disaster planning and preparedness with parents/guardians when they enroll their children in the program, including:

a. Portions of the Emergency/Disaster Plan relevant to parents/guardians or the public;
b. Procedures and instructions for what parents/guardians can expect if something happens at the facility;
c. Description of how parents/guardians will receive information and updates during or after a potential emergency or disaster situation;
d. Situations that might require parents/guardians to have a contingency plan regarding how their children will be cared for in the unlikely event of a facility closure.

Facilities should conduct an annual drill, test, or “practice use” of the communication options/mechanisms that are selected.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 9.2.4.4: Written Plan for Seasonal and Pandemic Influenza**

The facility should have a written plan for seasonal and pandemic influenza (flu) to limit and contain influenza-related health hazards to the staff, children, their families and the general public. The plan should include information on:

a. Planning and coordination:
   1. Forming a committee of staff members, parents/guardians, and the child care health consultant to produce/review a plan for dealing with the flu each year including specific plans if there is a flu pandemic;
   2. Reviewing the seasonal flu plan during and after flu season so that key staff could discuss how the program would plan for a more serious outbreak or pandemic;
   3. Assigning one person to identify reliable sources of information regarding the seasonal flu strain or pandemic flu outbreak considering local, state and national resources, monitor public health department announcements and other guidance, and forward key information to staff and parents/guardians as needed (the child care health consultant can be especially helpful with this);
   4. Including the infection control policy and procedure (see below) and a communication plan (see below) in the seasonal flu plan;
   5. Including a communication plan (see below), the infection control policy and procedure (see below), and the child learning and program operations plan (see below) in the pandemic flu plan. In addition the pandemic flu plan should include:
      i. Identification of who in the program’s community has legal authority to close child care programs if there is a public health emergency or pandemic;
      ii. A list of key contacts such as representatives at the local/state health departments and agencies that regulate child care and their plans to combat or address seasonal or pandemic influenza (programs can extend an invitation for consultation from these departments when formulating the plan);
      iii. Development of a plan of action for addressing key business continuity and programmatic issues relevant to pandemic flu;
      iv. Communication to parents/guardians encouraging them to have a back-up plan for care for their children if the program must be closed;
      v. Collaboration with those in charge of the community’s planning to find other sources of meals for low-income children who receive subsidized meals in child care in case of a closure;
      vi. Knowledge of services in the community that can help staff, children, and their families deal with stress and other problems caused by a flu pandemic;
      vii. Communicate with other child care programs in the area to share information and possibly share expertise and resources.

b. Communications plan:
   1. Developing a plan for keeping in touch during the flu and/or pandemic with staff members and children’s families;
   2. Ensuring staff and families have read and understand the flu and/or pandemic plan and understand why it’s needed;
   3. Communicating reliable information to staff and children’s families on the issues listed below in their languages and at their reading levels:
      i. How to help control the spread of flu by handwashing/cleansing and covering the mouth when coughing or sneezing (see http://www.cdc.gov/flu/school/);
      ii. How to recognize a person that may have the flu, and what to do if they think they have the flu (see http://www.pandemicflu.gov);
VI. Safe and Healthy Practices and Procedures

- How to care for family members who are ill (see http://www.hhs.gov/pandemicflu/plan/sup5.html#box4/);
- How to develop a family plan for dealing with a flu pandemic (see http://pandemicflu.gov/individualfamily/).

c. Infection control policy and procedures:

1. Developing a plan for keeping children who become ill at the child care facility away from other children until the family arrives, such as a fixed place for holding children who are ill in an area of their usual caregiving room or in a separate room where interactions with unexposed children and staff will be limited;
2. Establishing and enforcing guidelines for excluding children with infectious diseases from attending the child care facility (1);
3. Teaching staff, children, and their parents/guardians how to limit the spread of infection (see http://www.cdc.gov/flu/school/ and http://www.healthykids.us/cleanliness.htm);
4. Maintaining adequate supplies of items to control the spread of infection;
5. Educating families about the influenza vaccine, including that experts recommend yearly influenza vaccine (and an influenza-specific vaccine, for example H1N1, if necessary) for everyone, however, if there is a vaccine shortage, priority should be given to children and adolescents six months through eighteen years of age, caregivers/teachers of all children younger than five years of age, and health care professionals (see http://www.cdc.gov/flu/);
6. Staff caring for all children should receive annual vaccination against influenza (and an influenza-specific vaccine such as what was used during the 2009 H1N1 pandemic, if necessary) each year, preferably before the start of the influenza season (as early as August or September) and as long as influenza is circulating in the community, immunization should continue through March or April;
7. Maintaining accurate records when children or staff are ill with details regarding their symptoms and/or the kind of illness (especially when influenza was verified through testing);
8. Practicing daily health checks of children and adults each day for illness;
9. Determining guidelines to support staff members to remain home if they think they might be ill and a mechanism to provide paid sick leave so they can stay home until completely well without losing wages.

d. Child learning and program operations:

1. Plan how to deal with program closings and staff absences;
2. Support families in continuing their child’s learning if the child care program or preschool is closed;
3. Plan ways to continue basic functions (meeting payroll, maintaining communication with staff, children, and families) if modifications to program planning are necessary or the program is closed.

The facility should also include procedures for staff and parent/guardian training on this plan.

Some of the above plan components may be beyond the scope of ability in a small family child care home. In this case, the caregiver/teacher should work closely with a child care health consultant to determine what specific procedures can be implemented and/or adapted to best meet the needs of the caregiver/teacher and the families s/he serves.

To view the Rationale and Comments for this standard, click here.

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

**STANDARD 9.2.4.5: Emergency and Evacuation Drills/Exercises Policy**

The facility should have a policy documenting that emergency drills/exercises should be regularly practiced for geographically appropriate natural disasters and human generated events such as:

- Fire, monthly;
- Tornadoes, on a monthly basis in tornado season;
- Floods, before the flood season;
- Earthquakes, every six months;
- Hurricanes, annually;
- Threatening person outside or inside the facility;
- Rabid animal;
- Toxic chemical spill;
- Nuclear event.

All drills/exercises should be recorded. Please see Standard 9.4.1.16: Evacuation and Shelter-in-Place Drill Record for more information.

A fire evacuation procedure should be approved and certified in writing by a fire inspector for centers, and by a local fire department representative for large and small family child care homes, during an annual on-site visit when an evacuation drill is observed and the facility is inspected for fire safety hazards.

Depending on the type of disaster, the emergency drill may be within the existing facility such as in the case of earthquakes or tornadoes where the drill might be moving to a certain location within the building (basements, away from windows, etc.) Evacuation drills/exercises should be practiced at various times of the day, including nap time, during varied activities and from all exits. Children should be accounted for during the practice.
The facility should time evacuation procedures. They should aim to evacuate all persons in the specific number of minutes recommended by the local fire department for the fire evacuation, or recommended by emergency response personnel.

Cribs designed to be used as evacuation cribs, can be used to evacuate infants, if rolling is possible on the evacuation route(s).

To view the Rationale and Comments for this standard, click here.

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

Appendix P: Situations that Require Medical Attention Right Away (PDF Link)
Quick Reference: Safe Sleep, Handwashing, Diaper Changing and Toileting

Please Note: Infants and toddlers are at a greater risk for mortality and infectious diseases. These three issues were identified as especially critical issues for the health and safety of the infant and toddler population due to the frequency with which these activities occur within the child care/early education program. While standards relating to these topics appear throughout this collection, they are also grouped together here for your convenience.

A. Safe Sleep

**Equipment and Materials**
- 5.4.5.1 Sleeping Equipment and Supplies
- 5.4.5.2* Cribs
- 5.4.5.3 Stackable Cribs
- 5.4.5.4 Futons
- 6.4.1.3 Crib Toys

**Safe and Healthy Practices**
- 3.1.4.1* Safe Sleep Practices and SIDS/Suffocation Risk Reduction
- 3.1.4.2 Swaddling
- 3.1.4.3 Pacifier Use

B. Handwashing

**Equipment and Materials**
- 5.4.1.10 Handwashing Sinks
- 5.4.1.11 Prohibited Uses of Handwashing Sinks
- 5.4.2.2 Handwashing Sinks for Diaper Changing Areas in Centers
- 5.4.2.3 Handwashing Sinks for Diaper Changing Areas in Homes

**Safe and Healthy Practices**
- 3.2.2.1* Situations that Require Hand Hygiene
- 3.2.2.2* Handwashing Procedure
- 3.2.2.3* Assisting Children with Hand Hygiene

C. Diaper Changing and Toileting

**Equipment and Material**
- 5.4.1.6 Ratios of Toilets, Urinals, and Hand Sinks to Children
- 5.4.1.7 Toilet Learning/Training Equipment
- 5.4.2.1 Diaper Changing Tables
- 5.4.2.4 Use, Location, and Setup of Diaper Changing Areas
- 5.4.2.5 Changing Table Requirements
- 5.4.2.6 Maintenance of Changing Tables

**Safe and Healthy Practices**
- 3.2.1.1 Type of Diapers Worn
- 3.2.1.2 Handling Cloth Diapers
- 3.2.1.3 Checking for the Need to Change Diapers
- 3.2.1.4* Diaper Changing Procedure
- 3.2.1.6 Procedure for Changing Children’s Soiled Underwear/Pull-Ups and Clothing
- 5.2.7.4 Containment of Soiled Diapers
This schedule was current at the time of *Caring for Our Children* Appendix G update in 2015. To check for the latest edition, go to http://www.cdc.gov/vaccines/schedules/index.html.

**Recommended Immunization Schedules for Persons Aged 0 Through 18 Years**

**UNITED STATES, 2015**

This schedule includes recommendations in effect as of January 1, 2015. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the

- **Advisory Committee on Immunization Practices** (http://www.cdc.gov/vaccines/acip)
- **American Academy of Pediatrics** (http://www.aap.org)
- **American Academy of Family Physicians** (http://www.aafp.org)
- **American College of Obstetricians and Gynecologists** (http://www.acog.org)
This schedule was current at the time of Caring for Our Children Appendix G update in 2015. To check for the latest edition, go to http://www.cdc.gov/vaccines/schedules/index.html.

**Figure 1. Recommended immunization schedule for persons aged 0 through 18 years - United States, 2015.**

*(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).*

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded.

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<thead>
<tr>
<th>Vaccine</th>
<th>Birth</th>
<th>1 mo</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>9 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>19–23 mos</th>
<th>2–3 yrs</th>
<th>4–6 yrs</th>
<th>7–10 yrs</th>
<th>11–12 yrs</th>
<th>13–15 yrs</th>
<th>16–18 yrs</th>
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<tr>
<td>Hepatitis B (HepB)</td>
<td>1 dose</td>
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<td>Rotavirus (RV) (1st dose)</td>
<td>1 dose</td>
<td>2nd</td>
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<td>Rotavirus (RV) (2nd dose)</td>
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<td>Diphtheria, tetanus, &amp; pertussis (DTaP)</td>
<td>1 dose</td>
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<td>Haemophilus influenzae type b (Hib)</td>
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<td>Pneumococcal conjugate vaccine (PCV13)</td>
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<td>Pneumococcal polysaccharide vaccine (PPSV23)</td>
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<td>Inactivated poliovirus (IPV)</td>
<td>1 dose</td>
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<td>Influenza (IV, IAV) (2 doses for some)</td>
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<td>Measles, mumps, rubella (MMR)</td>
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<td>Varicella (VAR)</td>
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</table>

This schedule includes recommendations in effect as of January 1, 2015. Any dose not administered at the recommended age should be administered at subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm) or by telephone (800-232-4636).

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/acip), the American Academy of Pediatrics (http://www.aap.org), the American Academy of Family Physicians (http://www.aafp.org), and the American College of Obstetricians and Gynecologists (http://www.acog.org).

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.
This schedule was current at the time of *Caring for Our Children* Appendix G update in 2015.

### FIGURE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind —United States, 2015.

*The figures below provide catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child’s age. Always use this table in conjunction with Figure 1 and the footnotes that follow.*

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for First Dose</th>
<th>Children age 4 months through 6 years</th>
<th>Children and adolescents age 7 through 18 years</th>
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<tr>
<td></td>
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<td>Dose 1 to Dose 2</td>
<td>Minimum Interval Between Doses</td>
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<td>Hepatitis B</td>
<td>Birth</td>
<td>4 weeks</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Rota virus</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Diphtheria, tetanus, acellular pertussis</td>
<td>5 weeks</td>
<td>4 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Haemophilus influenzae type B</td>
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<td>4 weeks</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Inactivated poliovirus</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>8 weeks</td>
</tr>
<tr>
<td>MenACWY</td>
<td>6 weeks</td>
<td>8 weeks</td>
<td>6 weeks</td>
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<tr>
<td>Measles, mumps, rubella</td>
<td>12 months</td>
<td>4 weeks</td>
<td>6 months</td>
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<td>Varicella</td>
<td>12 months</td>
<td>3 months</td>
<td>3 months</td>
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<tr>
<td>Hepatitis A</td>
<td>12 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
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**NOTE:** The above recommendations must be used along with the footnotes of this schedule.

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Standard included in Stepping Stones, 3rd Ed.
Appendix G

Footing — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2015

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.

Additional information:
- For contraindications and precautions to use of a vaccine and for additional information regarding that vaccine, vaccine providers should consult the relevant ACIP statement available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For purposes of calculating intervals between doses, 4 weeks = 28 days. Intervals of 4 months or greater are determined by calendar months.
- Vaccine doses administered 4 days or less before the minimum interval are considered valid. Doses of any vaccine administered ≤5 days earlier than the minimum interval or minimum age should not be counted as valid doses and should be recorded as separate age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see MMWR, General Recommendations on Immunization and Reports / Vol. 60 / No. 2; Table 1. Recommended and minimum ages and intervals between vaccine doses available online at http://www.cdc.gov/mmwr/pdf/rr6002.pdf.
- Information on travel vaccine requirements and recommendations is available at http://wwwnc.cdc.gov/travel/destination/list.

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)

Routine vaccination:
- At birth:
  - Administer monovalent HepB vaccine to all newborns before hospital discharge.
  - For infants born to hepatitis B surface antigen (HBsAg) positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBS) 1 to 2 months after completion of the HepB series at age 9 through 18 months (preferably at the next well child visit).
  - If mother’s HBsAg status is unknown, within 12 hours of birth administer HepB vaccine regardless of birth weight. For infants weighing less than 2000 grams, administer HBIG in addition to HepB vaccine within 12 hours of birth. Determine mother’s HBsAg status as soon as possible and, if mother is HBsAg-positive, also administer HBIG for infants weighing 2000 grams or more as soon as possible, but no later than age 7 days.

Doses following the birth dose:
- The second dose should be administered at age 1 to 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
- Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine on a schedule of 0, 1 to 2 months, and 5 months starting as soon as feasible. See Figure 2.
- Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks), administer the third dose at least 8 weeks after the second dose AND at least 16 weeks after the first dose. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks.
- Administration of a total of 4 doses of HepB vaccine is permitted when a combination vaccine containing HepB is administered after the birth dose.

Catch-up vaccination:
- Unvaccinated persons should complete a 3-dose series.
- A 2-dose series (doses separated by at least 4 months) of adult formulation recombinant HB is licensed for use in children aged 11 through 15 years.
- For other catch-up guidance, see Figure 2.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV1 [Rotarix] and RVV [Rotavirus])

Routine vaccination:
- Administer a series of RV vaccine to all infants as follows:
  1. If Rotarix is used, administer a 2-dose series at 2 and 4 months of age.
  2. If Rotarix is used, administer a 3-dose series at ages 2, 4, and 6 months.
  3. If any dose in the series was Rotarix-vaccine product is unknown for any dose in the series, a total of 3 doses of RV vaccine should be administered.

Catch-up vaccination:
- The maximum age for the first dose in the series is 14 weeks. 5 days, vaccination should not be initiated for infants aged 15 weeks. 6 days of age.
- The maximum age for the final dose in the series is 8 months. 6 days.
- For other catch-up guidance, see Figure 2.


Routine vaccination:
- A 4-dose series of DTaP vaccine at ages 2, 4, 6, and 18 through 24 months, and 4 through 6 years. The fourth dose may be administered as early as age 12 months, provided at least 6 months has elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at

Catch-up vaccination:
- The fifth dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4 years or older.

4. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years for both Boostrix and Adacel)

Routine vaccination:
- Administer 1 dose of Tdap vaccine to all adolescents aged 11 through 12 years.
- Tdap may be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Administer 1 dose of Tdap vaccine to pregnant adolescents during each pregnancy preferably during 22 through 26 weeks gestation regardless of time since prior Td or Tdap vaccination.

Catch-up vaccination:
- Persons aged 7 years and older who are not fully immunized with DTaP vaccine should receive Tdap vaccine at 1 dose (preferably the first) in the catch-up series. If additional doses are needed, use Td vaccine. For children through 18 years who receive a dose of Tdap as part of the catch-up series, an adolescent Tdap vaccine dose at age 11 through 12 years should be administered instead. All Td vaccine doses should be administered 12 months apart and no earlier than age 24 months.
- Administration of a total of 4 doses of Tdap vaccine is permitted when a combination vaccine containing Tdap is administered after the birth dose.

5. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 5 weeks for PRP-T [ACTHIB, DTaP-IPV/Hib (Pentacel) and Hib-MenCY (MenHibrix), PRP-OPE [PedavaxHb or COMMvax], 12 months for PRP-T [Hibrix])

Routine vaccination:
- Administer 2- or 3-dose Hib vaccine primary series and a booster dose (dose 3 or 4 depending on vaccine used in primary series) at age 6 through 12 months to complete a 3-dose Hib vaccine series.
- The primary series with ACTHIB, MenHibrix, or Pentacel consists of 3 doses and should be administered at 2, 4, and 6 months of age. The primary series with PedavaxHb or COMMvax consists of 2 doses and should be administered at 2 and 4 months of age; a dose at age 6 months is not indicated.
- One booster dose (dose 3 or 4 depending on vaccine used in primary series) of any Hib vaccine should be administered at age 12 through 15 months. An exception is Hibrix vaccine. Hibrix should only be used for the booster (final dose in children aged 12 months through 4 years who have received at least 1 prior dose of Hib-containing vaccine).
- For recommendations on the use of Hib vaccines in patients at increased risk for meningococcal disease, please refer to the meningococcal vaccine footnotes and also to MMWR February 28, 2014 / 63(RR01):1-13, available at http://www.cdc.gov/mmwr/PDF/rr6301.pdf.
For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

5. Haemophilus influenzae type b (Hib) conjugate vaccine (cont'd)

Catching up with Hib:
- If dose 1 was administered at ages 12 through 15 months, administer a second (final) dose at least 8 weeks after dose 1, regardless of Hib vaccine used in the primary series.
- If dose 1 was Hib and dose 2 was PRP-OMP (PedvaxHib or Convarix), and both were administered before the first birthday, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose, whichever is later.
- If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a third (and final) dose at age 12 through 15 months or 8 weeks after second dose, whichever is later.
- If the first dose is administered before the first birthday and second dose administered at younger than 15 months, a third (and final) dose should be given 8 weeks later.
- If unvaccinated children aged 15 months or older, administer dose 1 only.
- For other catch-up guidance, see Figure 2. For catch-up guidance related to MenACWY, see the meningococcal vaccine footnotes and also MMWR February 28, 2014 / 63(08):1-13, available at http://www.cdc.gov/mmwr/PDF/rr/rr6301.pdf.

Vaccination for infants with high-risk conditions:
- Children aged 12 through 23 months at increased risk for Hib disease, including chemotherapy recipients and those with atonic or functional asplenia (including sickle cell disease), human immunodeficiency virus (HIV) infection, immunodeficiency, or other component deficiency, should receive 2 doses of Hib vaccine before 12 months of age; should receive 2 additional doses of Hib vaccine 6 through 12 months; and should receive 2 additional doses of Hib vaccine 12 through 15 months.
- For patients younger than 5 years of age undergoing chemotherapy or radiation treatment who received a Hib vaccine dose(s) within 14 days of starting therapy or during therapy, repeat the dose(s) at least 3 months following therapy completion.
- Recipients of hematopoietic stem cell transplant (HSCT) should be revaccinated with a 3-dose regimen of Hib vaccine starting 6 to 12 months after successful transplant, regardless of vaccination history; doses should be administered at least 4 weeks apart.
- A single dose of any Hib-containing vaccine should be administered to unimmunized* children aged 5 years or older who have atonic or functional asplenia (including sickle cell disease) and unvaccinated persons 5 through 18 years of age with impaired immunity (HIV) infection.

*Patients who have not received a primary series and booster dose at least 3 months after dose 2 of Hib vaccine 12 through 15 months are considered unimmunized.

6. Pneumococcal vaccines. (Minimum age: 6 weeks for PCV13; 2 years for PSV23)

Routine vaccination with PCV13:
- Administer a 4-dose series of PCV13 vaccine at ages 2, 4, and 6 months and at ages 12 through 15 months.
- For children aged 14 through 59 months who have received a 2-dose series of PCV7 vaccine (PedvaxHib), administer a single supplemental dose of 15-valent PCV13.
- For children aged 2 through 11 years, administer 1 dose of PCV13 to all healthy children aged 6 through 15 months who are not completely vaccinated for their age.
- For other catch-up guidance, see Figure 2.

Vaccination of persons with high-risk conditions with PCV13 and PSV23:
- All recommended PCV13 doses should be administered prior to PSV23 vaccination if possible.
- For children aged 2 through 5 years of age with any of the following conditions: chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma if treated with high dose oral corticosteroid therapy); diabetes mellitus; cerebral spinal fluid leak; history of skin infections due to Haemophilus influenzae type b; sickle cell disease; and other hemorrhagic disorders; anatomic or functional asplenia.
- For children 6 through 15 years of age with any of the following conditions: chronic heart disease; chronic lung disease (including asthma if treated with high dose oral corticosteroid therapy); diabetes mellitus; cerebral spinal fluid leak; history of skin infections due to Haemophilus influenzae type b; sickle cell disease; and other hemorrhagic disorders; anatomic or functional asplenia.

- Administer 1 dose of PCV13 if any incomplete schedule of 1 dose of PCV(PCV and/or PCV107) were received previously.
- Administer 2 doses of PCV13 at least 8 weeks apart if unvaccinated or any incomplete schedule of fewer than 3 doses of PCV13 and/or PCV107 were received previously.
- Administer 1 supplemental dose of PCV13 if 4 doses of PCV7 or other age-appropriate complete PCV7 schedule was previously received.
- The minimum interval between doses of PCV13 is 4 weeks.
- For children with a history of PSV23 vaccine, administer PSV23 at least 8 weeks after the most recent dose of PCV13.

7. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

Routine vaccination:
- Administer a 3-dose series of IPV at ages 2, 4, and 6 through 15 months. The final dose in the series should be administered after the fourth birthday and at least 6 months after the previous dose.

Catch-up vaccination:
- In the first 6 months of life, minimum age and minimum intervals are only recommended if the infant is at risk of imminent exposure to circulating polioviruses (i.e., travel to a polio-free region or during an outbreak).
- If more than 8 months of age and unvaccinated before age 5 years, an additional dose should be administered at age 4 through 6 years and at least 6 months after the previous dose.
- If a fourth dose is not given, the third dose was administered at age 4 years or older and at least 6 months after the previous dose.
- If both OPV and IPV were administered apart of a series, a total of 4 doses should be administered regardless of the child’s current age. IPV is not routinely recommended for US residents aged 18 years or older.
- For other catch-up guidance, see Figure 2.

8. Influenza vaccine. (Minimum age: 6 months for inactivated influenza vaccine [IIV]; 2 years for live, attenuated influenza vaccine [LAIV])

Routine vaccination:
- Administer influenza vaccine annually to all children beginning at age 6 months. For healthy, nonpregnant persons aged 2 through 49 years, either LAIV or IIV may be used. However, LAIV should not be administered to some persons, including 1) persons who have experienced severe allergic reactions to influenza vaccine, any of its components, or to a previous dose of any other influenza vaccine; 2) children 2 through 17 years receiving aspirin or aspirin-containing products; 3) persons who are allergic to eggs; 4) pregnant women; 5) immunocompromised persons; 6) children 2 through 4 years of age with chronic respiratory illness; 7) persons who have had wheezing in the past 2 months; 8) children who have received influenza antiviral medications in the past 48 hours; 9) for other contraindications and precautions to use of LAIV, see MMWR August 15, 2014, 63(03):61-67 and page 168; http://www.cdc.gov/mmwr/pdf/rr/rr6332.pdf.

For children aged 6 months through 8 years:
- For the 2015-16 season, administer 2 doses (separated by at least 4 weeks) to children who are receiving influenza vaccine for the first time. Some children in this age group who have been vaccinated previously will also need 2 doses, for additional guidance, follow dosing guidelines in the 2014-15 ACIP Influenza vaccine recommendation. MMWR August 15, 2014 / 63(33):661-662 [H40 pages] available at http://www.cdc.gov/mmwr/pdf/rr/rr6332.pdf.

For the 2015-16 season, follow the dosing guidelines for the 2014-15 ACIP influenza vaccine recommendation. For persons aged 9 years and older:
- Administer 1 dose.
For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

9. **Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)**

   **Routine vaccination:**
   - Administer a 2-dose series of MMR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
   - Administer 1 dose of MMR vaccine to infants aged 6 through 11 months before departure from the United States for international travel. These children should be revaccinated with 2 doses of MMR vaccine, the first at age 12 through 15 months (12 months if the child remains in an area where disease risk is high), and the second dose at least 4 weeks later.
   - Administer 2 doses of MMR vaccine to children aged 12 months and older before departure from the United States for international travel. The first dose should be administered on or after age 12 months and the second dose at least 4 weeks later.

   **Catch-up vaccination:**
   - Ensure that all school-aged children and adolescents have had 2 doses of MMR vaccine; the minimum interval between the 2 doses is 4 weeks.

10. **Varicella (VAR) vaccine. (Minimum age: 12 months)**

   **Routine vaccination:**
   - Administer a 2-dose series of VAR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose. If the second dose was administered before age 4 years, it can be accepted as valid.

   **Catch-up vaccination:**
   - Ensure that all persons aged 7 through 18 years without evidence of immunity (see MMR 2007/56 [Itu. MMG, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/MMR4606a1.htm]) have 2 doses of varicella vaccine. For children aged 7 through 12 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid for persons aged 13 years and older, the minimum interval between doses is 4 weeks).

11. **Hepatitis A (HepA) vaccine. (Minimum age: 12 months)**

   **Routine vaccination:**
   - Initiate the 2-dose HepA vaccine series at 12 through 23 months; separate the 2 doses by 6 to 18 months.
   - Children who have received 1 dose of HepA vaccine before age 24 months should receive a second dose 6 to 18 months after the first dose.
   - For any person aged 2 years or older who has not already received the HepA vaccine series, 2 doses of HepA vaccine separated by 6 to 18 months may be administered if immunity against hepatitis A virus infection is desired.

   **Catch-up vaccination:**
   - The minimum interval between the two doses is 6 months. Special populations:
   - Adults aged 2 doses of HepA vaccine at least 6 months apart to previously unvaccinated persons who live in areas where vaccination programs target older children, or who are at increased risk for infection. This includes persons traveling to or working in countries that have high or intermediate endemicity of infection; men having sex with men; users of injection and non-injection drug; persons who work with HAV-infected primates or with HAV in a research laboratory; persons with clotting factor disorders; persons with chronic liver disease; and persons who anticipate close personal contact (e.g., household or regular baby-sitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. The first dose should be administered as soon as possible after the child is planned, ideally 2 or more weeks before the arrival of the adoptee.

12. **Human papillomavirus (HPV) vaccines. (Minimum age: 9 years for HPV2 [Cervarix] and HPV4 [Gardasil])**

   **Routine vaccination:**
   - Administer a 3-dose series of HPV vaccine on a schedule of 0, 1, and 6 months to all adolescents aged 11 through 12 years. Either HPV4 or HPV2 may be used for females, and only HPV4 may be used for males.
   - This 3-dose series may be started at age 9 years.
   - Administer the second dose 2 months after the first dose (minimum interval of 3 weeks) and the third dose 6 months after the first dose and 12 weeks after the second dose (or minimum of 4 weeks).

   **Catch-up vaccination:**
   - Administer the vaccine series to females (either HPV2 or HPV4) and males (HPV4) at age 13 through 18 years if not previously vaccinated.
   - Use recommended routine dosing intervals (see Routine vaccination above) for vaccine series catch-up.
This schedule was current at the time of *Caring for Our Children* Appendix G update in 2015. To check for the latest edition, go to [http://www.cdc.gov/vaccines/schedules/index.html](http://www.cdc.gov/vaccines/schedules/index.html).

### 2015 Recommended Immunizations for Adults: By Age

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<tr>
<th>Age</th>
<th>Flu Influenza</th>
<th>Tet/Tox Tdap*</th>
<th>Shingles Zoster</th>
<th>Pneumococcal</th>
<th>Meningococcal</th>
<th>HPV Human papillomavirus</th>
<th>Chickenpox Varicella</th>
<th>Hepatitis A</th>
<th>Hepatitis B</th>
<th>Hib Hemophilus influenzae type b</th>
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### More Information:
- *Recommended For You*: This vaccine is recommended for you unless your healthcare professional tells you that you cannot safely receive it or that you do not need it.
- *May Be Recommended For You*: This vaccine is recommended for you if you have certain risk factors due to your health, job, or lifestyle that are not listed here. Talk to your healthcare professional to see if you need this vaccine.

If you are traveling outside the United States, you may need additional vaccines. Ask your healthcare professional about which vaccines you may need at least 6 weeks prior to your travel.

For more information, call 1-800-CDC-INFO (1-800-232-4636) or visit [www.cdc.gov/vaccines](http://www.cdc.gov/vaccines).

*Standard included in Stepping Stones, 3rd Ed.*
This schedule was current at the time of *Caring for Our Children* Appendix G update in 2015. To check for the latest edition, go to http://www.cdc.gov/vaccines/schedules/index.html.

![2015 Recommended Immunizations for Adults: By Health Condition](image)

If you have this health condition, talk to your healthcare professional about these vaccines:

- **Flu (Influenza)**
- **Td/Tdap (Tetanus, diphtheria, pertussis)**
- **Shingles (Zoster)**
- **Pneumococcal**
- **Meningococcal**
- **MMR (Measles, mumps, rubella)**
- **HPV (Human papillomavirus)**
- **Chickenpox (Varicella)**
- **Hepatitis A**
- **Hepatitis B**
- **Hib (Haemophilus influenzae type b)**

### Pregnancy

- **Flu vaccine** every year
- **Td/Tdap** 1 dose of Tdap followed by Td every 10 years
- **Shingles** 1 or more doses for those 60 years or older

### Weakened Immune System

- **Flu vaccine** every year
- **Ebola** 1 dose of Tdap followed by Td every 10 years
- **Shingles** 1 or more doses for those 60 years or older

### HIV: CD4 count less than 200

- **Flu vaccine** every year
- **Tuberculosis** 1 dose of Tdap followed by Td every 10 years
- **Shingles** 1 or more doses for those 60 years or older

### HIV: CD4 count 200 or greater

- **Flu vaccine** every year
- **Tuberculosis** 1 dose of Tdap followed by Td every 10 years
- **Shingles** 1 or more doses for those 60 years or older

### Kidney disease or poor kidney function

- **Flu vaccine** every year
- **Tuberculosis** 1 dose of Tdap followed by Td every 10 years
- **Shingles** 1 or more doses for those 60 years or older

### Asplenia (if you do not have a spleen or it does not work well)

- **Flu vaccine** every year
- **Tuberculosis** 1 dose of Tdap followed by Td every 10 years
- **Shingles** 1 or more doses for those 60 years or older

### Heart disease

- **Flu vaccine** every year
- **Tuberculosis** 1 dose of Tdap followed by Td every 10 years
- **Shingles** 1 or more doses for those 60 years or older

### Chronic liver disease

- **Flu vaccine** every year
- **Tuberculosis** 1 dose of Tdap followed by Td every 10 years
- **Shingles** 1 or more doses for those 60 years or older

### Chronic alcoholism

- **Flu vaccine** every year
- **Tuberculosis** 1 dose of Tdap followed by Td every 10 years
- **Shingles** 1 or more doses for those 60 years or older

### Diabetes (Type 1 or Type 2)

- **Flu vaccine** every year
- **Tuberculosis** 1 dose of Tdap followed by Td every 10 years
- **Shingles** 1 or more doses for those 60 years or older

### More Information:

- There are several flu vaccines available. Talk to your healthcare professional about which flu vaccine is right for you.
- If you are pregnant, you should get a flu vaccine during the 3rd trimester of pregnancy to help protect your babies from pertussis (whooping cough).
- You should get a tetanus vaccine even if you had them before.
- There are two different types of pneumococcal vaccine: PCV13 (conjugate) and PPV23 (polysaccharide). Talk with your healthcare professional to find out if one or both pneumococcal vaccines are recommended for you.

**Recommended for You:** This vaccine is recommended for you unless your healthcare professional tells you that you cannot safely receive it or that you do not need it.

**May Be Recommended for You:** This vaccine is recommended for you if you have certain other risk factors, due to your age, health, job, or lifestyle that are not listed here. Talk to your healthcare professional to see if you need this vaccine.

**You Should Not Get This Vaccine:**

- **For more information, call 1-800-CDC-INFO (1-800-232-4636) or visit www.cdc.gov/vaccines

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
One of the most important steps in reducing the spread of infectious diseases in child care settings is cleaning, sanitizing or disinfecting surfaces that could possibly pose a risk to children or staff. Routine cleaning with detergent and water is the most common method for removing some germs from surfaces in the child care setting. However, most items and surfaces in a child care setting require sanitizing or disinfecting after cleaning to further reduce the number of germs on a surface to a level that is unlikely to transmit disease.

What is the difference between sanitizing and disinfecting?

Sometimes these terms are used as if they mean the same thing, but they are not the same.

**Sanitizer** is a product that reduces but does not eliminate germs on inanimate surfaces to levels considered safe by public health codes or regulations. A sanitizer may be appropriate to use on food contact surfaces (dishes, utensils, cutting boards, high chair trays), toys that children may place in their mouths, and pacifiers. See Appendix K, Routine Schedule for Cleaning, Sanitizing and Disinfecting for guidance on use of sanitizer vs. disinfectant.

**Disinfectant** is a product that destroys or inactivates germs (but not spores) on an inanimate object. A disinfectant may be appropriate to use on hard, non-porous surfaces such as diaper change tables, counter tops, door & cabinet handles, and toilets and other bathroom surfaces. See Appendix K, Routine Schedule for Cleaning, Sanitizing and Disinfecting for guidance on use of sanitizer vs. disinfectant.

The U.S. Environmental Protection Agency (EPA) recommends that only EPA-registered products be used. Only a sanitizer or disinfectant product with an EPA registration number on the label can make public health claims that they are effective in reducing or inactivating germs. Many bleach and hydrogen peroxide products are EPA-registered and can be used to sanitize or disinfect. Please see the “How to Find EPA Registration Information” section below to learn more specific information on the products.

Always follow the manufacturers’ instructions when using EPA-registered products described as sanitizers or disinfectants. This includes pre-cleaning, how long the product needs to remain wet on the surface or item, whether or not the product should be diluted or used as is, and if rinsing is needed. Also check to see if that product can be used on a food contact surface or is safe for use on items that may go into a child’s mouth. Please note that the label instructions on most sanitizers and disinfectants indicate that the surface must be pre-cleaned before applying the sanitizer or disinfectant.

Are there alternatives to chlorine bleach?

A product that is not chlorine bleach can be used in child care settings IF:

- it is registered with the EPA;
- it is also described as a sanitizer or as a disinfectant;
- it is used according to the manufacturer’s instructions.

Check the label to see how long you need to leave the sanitizer or disinfectant in contact with the surface you are treating, whether you need to rinse it off before contact by children, for any precautions when handling, and whether it can be used on a surface that may come in contact with child’s mouth.

Some child care settings are using products with hydrogen peroxide as the active ingredient instead of chlorine bleach. Check to see if the product has an EPA registration number and follow the manufacturer’s instructions for use and safe handling. (Please see the “How to Find EPA Registration Information” section
below for more information.) Remember that EPA-registered products will also have available a Material Safety Data Sheet (MSDS) that will provide instructions for the safe use of the product and guidance for first aid response to an accidental exposure to the chemical.

In addition, some manufacturers of sanitizer and disinfectant products have developed “green cleaning products” that have EPA registration. As new environmentally-friendly cleaning products appear in the market, check to see if they are EPA-registered.

**Household Bleach & Water**

Many household bleach products are now EPA-registered. When purchasing EPA-registered chlorine bleach, make sure that the bleach concentration is for household use, and not for industrial applications. Household chlorine bleach is typically sold in retail stores as an 8.25% sodium hypochlorite solution.

EPA-registered bleach products are described as sanitizers and disinfectants. Check the label to see if the product has an EPA registration number and follow the manufacturer's safety and use instructions. (Please see the “How to Find EPA Registration Information” section below for more information.) Pay particular attention to the mixing “recipe” and the required contact time (i.e., the time the solution must remain on a surface to be effective) for each use. Remember, the recipe and contact time are most likely different for sanitizing and disinfecting.

If you are not using an EPA-registered product for sanitizing and disinfecting, please be sure you are following state or local recommendations and/or manufacturer's instructions for creating safe dilutions necessary to sanitize and/or disinfect surfaces in your early care and education environment. Using too little (a weak concentration) bleach may make the mixture ineffective; however, using too much (a strong concentration) bleach may create a potential health hazard.

**To safely prepare bleach solutions:**

- Dilute bleach with cool water and do not use more than the recommended amount of bleach.
- Select a bottle made of opaque material.
- Make a fresh bleach dilution daily; label the bottle with contents and the date mixed.
- Wear gloves and eye protection when diluting bleach.
- Use a funnel.
- Add bleach to the water rather than the water to bleach to reduce fumes.
- Make sure the room is well ventilated.
- Never mix or store ammonia with bleach or products that contain bleach.

**To safely use bleach solutions:**

- Apply the bleach dilution after cleaning the surface with soap or detergent and rinsing with water if visible soil is present.
- If using a spray bottle, adjust the setting to produce a heavy spray instead of a fine mist.
- Allow for the contact time specified on the label of the bleach product.
- Apply when children are not present in the area.
- Ventilate the area by allowing fresh air to circulate and allow the surfaces to completely air dry or wipe dry after the required contact time before allowing children back into the area.
• Store all chemicals securely, out of reach of children and in a way that they will not tip and spill.

_**Adapted**_ from: California Childcare Health Program. 2013. Safe and Effective Cleaning sanitizing and Disinfecting. _Health and Safety Notes_ (March).

**To Review:**

• Determine if the surface requires sanitizing or disinfecting;
• Check the labels of all products to see if they are EPA-registered; there are alternatives to chlorine bleach;
• Many chlorine bleach products (8.25% sodium, hypochlorite) are now EPA-registered
  
  o If EPA-registered, you must follow the label instructions for “recipes” and contact times;
• If using non-EPA-registered products, follow state or local recommendations for “recipes” and contact times;
• Prepare and use the solutions safely;
• Use products that are safe for oral contact when used on food contact surfaces or on items that may mouthed by children.

**How to Find EPA Registration Information**

_The following information is intended to serve as a visual guide to locating EPA registration numbers and product label information. Any products featured in the examples below are used for illustrative purpose only, and do not represent an endorsement by the National Resource Center for Health and Safety in Child Care and Early Education (NRC). The NRC does not endorse specific products._

1. Locate the EPA Registration number on the product label:

2. Go to [http://iaspub.epa.gov/apex/pesticides/f?p=PPLS:1](http://iaspub.epa.gov/apex/pesticides/f?p=PPLS:1). Enter this number into the box titled “EPA Registration Number” and click the Search button:
You should see the details about the product, and beneath that, a portable document file (PDF) bearing the date that this product was registered by the EPA (if there is a list, the PDF at the top of the list should show the most recent approval). Click on that most recently-approved PDF. You will need a PDF file reader to access this file. There are a variety of readers available and most are free.
4. The PDF should come up on your screen. Scroll down to the section that shows the directions for using the product as a sanitizer or disinfectant. Follow the directions listed for your intended use.
### For Sanitizing - or To Sanitize

<table>
<thead>
<tr>
<th>Surface</th>
<th>Solution</th>
<th>1 Gallon</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work Surfaces</td>
<td>2 tsp [1/3 oz]</td>
<td>1 Gallon</td>
<td>Wash, rinse, wipe surface area with bleach solution for [at least] 2 minutes, let air dry.</td>
</tr>
<tr>
<td>Dishes, Glassware, Utensils</td>
<td>2 tsp [1/3 oz]</td>
<td>1 Gallon</td>
<td>Wash and rinse. After washing, soak for [at least] 2 minutes in bleach solution, then drain and let air dry. To sanitize dishes, glassware, and utensils, wash and rinse. After washing, soak for [at least] 2 minutes in a solution of 2 teaspoons of bleach per 1 gallon of water. Drain and air dry.</td>
</tr>
<tr>
<td>Refrigerators, Freezers</td>
<td>2 tsp [1/3 oz]</td>
<td>1 Gallon</td>
<td>Remove food from refrigerator and freezer. Wash, rinse, wipe surface area with bleach solution for [at least] 2 minutes. Let air dry.</td>
</tr>
<tr>
<td>Wooden Cutting Boards</td>
<td>2 Tbsp [1 oz]</td>
<td>1 Gallon</td>
<td>Wash, wipe, or rinse with detergent and water, then apply sanitizing - or bleach solution. Let stand 2 minutes. Rinse with a solution of 2 teaspoons of this product per gallon of water. Do not rinse or soak equipment overnight.</td>
</tr>
<tr>
<td>Baby Bottles</td>
<td>2 tsp [1/3 oz]</td>
<td>1 Gallon</td>
<td>Wash and rinse. After washing, soak for [at least] 2 minutes in bleach solution, let air dry.</td>
</tr>
<tr>
<td>Garbage Cans</td>
<td>1/2 cup [4 oz]</td>
<td>1 Gallon</td>
<td>After washing and rinsing, brush inside with bleach solution. Let stand for 5 minutes before rinsing.</td>
</tr>
<tr>
<td>Pet (Food - and/or- Water) Bowls</td>
<td>2 tsp [1/3 oz]</td>
<td>1 Gallon</td>
<td>Wash and rinse. After washing, soak for [at least] 2 minutes in bleach solution, let air dry.</td>
</tr>
<tr>
<td>Kitchen [Dish]cloths &amp; Rags</td>
<td>1/2 cup [4 oz]</td>
<td>1 Gallon</td>
<td>Pre-wash items, then soak in solution for [at least] 5 minutes. Rinse and let air dry.</td>
</tr>
</tbody>
</table>

### For Disinfecting - or To Disinfect

<table>
<thead>
<tr>
<th>Surface</th>
<th>Solution</th>
<th>1 Gallon</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floors, Walls, Vinyl, Glazed Tile - and/or [insert relevant use site(s)]</td>
<td>1/2 cup [4 oz]</td>
<td>1 Gallon</td>
<td>Pre-wash surface, then [mop] wipe with bleach solution. Allow solution to contact surface for [at least] 5 minutes. Rinse well and air dry.</td>
</tr>
<tr>
<td>Nonporous Baby Toys [&amp; Furniture]</td>
<td>1/2 cup [4 oz]</td>
<td>1 Gallon</td>
<td>Pre-wash surface, soak or wipe with bleach solution. Allow solution to contact surface for [at least] 5 minutes. Rinse well and air dry.</td>
</tr>
<tr>
<td>Nonporous pet toys and/or accessories - or pet areas</td>
<td>1/2 cup [4 oz]</td>
<td>1 Gallon</td>
<td>Pre-wash surface, then [mop] wipe with bleach solution. Allow solution to contact surface for [at least] 5 minutes. Rinse well and air dry.</td>
</tr>
</tbody>
</table>
| Toilet Bowl                    | 3/4 cup [Toilet] | 1 Gallon | Flush toilet. Pour this product into bowl, brush bowl, making sure to
A Final Note

Remember that any cleaning, sanitizing or disinfecting product must always be safely stored out of reach of children. Always follow the manufacturer’s instruction for safe handling to protect yourselves and those in your care.

References:
**Routine Schedule** for Cleaning, Sanitizing, and Disinfecting

<table>
<thead>
<tr>
<th>Areas</th>
<th>Before Each Use</th>
<th>After Each Use</th>
<th>Daily (At the End of the Day)</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food Areas</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Food preparation surfaces</td>
<td>Clean, Sanitize</td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Eating utensils &amp; dishes</td>
<td></td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td>If washing the dishes and utensils by hand, use a sanitizer safe for food contact as the final step in the process; Use of an automated dishwasher will sanitize</td>
</tr>
<tr>
<td>• Tables &amp; highchair trays</td>
<td>Clean, Sanitize</td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Countertops</td>
<td>Clean</td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Food preparation appliances</td>
<td>Clean</td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mixed use tables</td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Refrigerator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Clean</td>
<td></td>
</tr>
<tr>
<td><strong>Child Care Areas</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Plastic mouthed toys</td>
<td>Clean</td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td>Reserve for use by only one child; Use dishwasher or boil for one minute</td>
</tr>
<tr>
<td>• Pacifiers</td>
<td>Clean</td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hats</td>
<td>Clean</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Clean after each use if head lice present</td>
</tr>
<tr>
<td>• Door &amp; cabinet handles</td>
<td></td>
<td>Clean, Disinfect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Corrected to “Routine Schedule” from “Guide” in second printing, August 2011.

*Standard included in Stepping Stones, 3rd Ed.*  
*Caring for Infants and Toddlers in Child Care and Early Education*
<table>
<thead>
<tr>
<th><strong>Floors</strong></th>
<th>Clean</th>
<th>Sweep or vacuum, then damp mop, (consider microfiber damp mop to pick up most particles)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Machine</strong></td>
<td>Clean</td>
<td>Launder</td>
</tr>
<tr>
<td><strong>washable</strong></td>
<td>Clean</td>
<td></td>
</tr>
<tr>
<td><strong>cloth toys</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dress-up</strong></td>
<td>Clean</td>
<td></td>
</tr>
<tr>
<td><strong>clothes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Play activity</strong></td>
<td>Clean</td>
<td></td>
</tr>
<tr>
<td><strong>centers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Drinking</strong></td>
<td>Clean</td>
<td></td>
</tr>
<tr>
<td><strong>Fountains</strong></td>
<td>Clean, Disinfect</td>
<td></td>
</tr>
<tr>
<td><strong>Computer</strong></td>
<td>Clean, Sanitize</td>
<td>Use sanitizing wipes, do not use spray</td>
</tr>
<tr>
<td><strong>keyboards</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Phone</strong></td>
<td>Clean</td>
<td></td>
</tr>
<tr>
<td><strong>receivers</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Toilet & Diapering Areas**

<table>
<thead>
<tr>
<th><strong>Changing</strong></th>
<th>Clean, Disinfect</th>
<th>Clean with detergent, rinse, disinfect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>tables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Potty</strong></td>
<td>Clean, Disinfect</td>
<td></td>
</tr>
<tr>
<td><strong>chairs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Handwashing</strong></td>
<td>Clean, Disinfect</td>
<td></td>
</tr>
<tr>
<td><strong>sinks &amp; faucets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Countertops</strong></td>
<td>Clean, Disinfect</td>
<td></td>
</tr>
<tr>
<td><strong>Toilets</strong></td>
<td>Clean, Disinfect</td>
<td></td>
</tr>
<tr>
<td><strong>Diaper pails</strong></td>
<td>Clean, Disinfect</td>
<td></td>
</tr>
<tr>
<td><strong>Floors</strong></td>
<td>Clean, Disinfect</td>
<td></td>
</tr>
</tbody>
</table>

**Sleeping Areas**

<table>
<thead>
<tr>
<th><strong>Bed sheets &amp; pillow cases</strong></th>
<th>Clean</th>
<th>Clean before use by another child</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cribs, cots, &amp; mats</strong></td>
<td>Clean</td>
<td>Clean before use by another child</td>
</tr>
<tr>
<td><strong>Blankets</strong></td>
<td>Clean</td>
<td></td>
</tr>
</tbody>
</table>
Recognizing Child Abuse and Neglect: Signs and Symptoms

The first step in helping abused or neglected children is learning to recognize the signs of child abuse and neglect. The presence of a single sign does not prove child abuse is occurring in a family, but a closer look at the situation may be warranted when these signs appear repeatedly or in combination.

If you do suspect a child is being harmed, reporting your suspicions may protect the child and get

What’s Inside:
- Recognizing child abuse
- Types of abuse
- Signs of physical abuse
- Signs of neglect
- Signs of sexual abuse
- Signs of emotional maltreatment
Recognizing Child Abuse and Neglect: Signs and Symptoms

www.childwelfare.gov

help for the family. Any concerned person can report suspicions of child abuse and neglect. Some people (typically certain types of professionals) are required by law to make a report of child maltreatment under specific circumstances—these are called mandatory reporters. For more information, see the Child Welfare Information Gateway publication, Mandatory Reporters of Child Abuse and Neglect: www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm

For more information about where and how to file a report, contact your local child protective services agency or police department. An additional resource for information and referral is the Childhelp® National Child Abuse Hotline (800.4.A.CHILD).

Recognizing Child Abuse

The following signs may signal the presence of child abuse or neglect.

The Child:

• Shows sudden changes in behavior or school performance
• Has not received help for physical or medical problems brought to the parents’ attention
• Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes
• Is always watchful, as though preparing for something bad to happen

• Lacks adult supervision
• Is overly compliant, passive, or withdrawn
• Comes to school or other activities early, stays late, and does not want to go home

The Parent:

• Shows little concern for the child
• Denies the existence of—or blames the child for—the child’s problems in school or at home
• Asks teachers or other caregivers to use harsh physical discipline if the child misbehaves
• Sees the child as entirely bad, worthless, or burdensome
• Demands a level of physical or academic performance the child cannot achieve
• Looks primarily to the child for care, attention, and satisfaction of emotional needs

The Parent and Child:

• Rarely touch or look at each other
• Consider their relationship entirely negative
• State that they do not like each other

Types of Abuse

The following are some signs often associated with particular types of child abuse and neglect: physical abuse, neglect, sexual abuse, and emotional abuse. It is important to note, however, that these
types of abuse are more typically found in combination than alone. A physically abused child, for example, is often emotionally abused as well, and a sexually abused child also may be neglected.

**Signs of Physical Abuse**

Consider the possibility of physical abuse when the **child:**

- Has unexplained burns, bites, bruises, broken bones, or black eyes
- Has fading bruises or other marks noticeable after an absence from school
- Seems frightened of the parents and protests or cries when it is time to go home
- Shrinks at the approach of adults
- Reports injury by a parent or another adult caregiver

Consider the possibility of physical abuse when the **parent or other adult caregiver:**

- Offers conflicting, unconvincing, or no explanation for the child’s injury
- Describes the child as “evil,” or in some other very negative way
- Uses harsh physical discipline with the child
- Has a history of abuse as a child

**Signs of Neglect**

Consider the possibility of neglect when the **child:**

- Is frequently absent from school
- Begs or steals food or money
- Lacks needed medical or dental care, immunizations, or glasses
- Is consistently dirty and has severe body odor
- Lacks sufficient clothing for the weather
- Abuses alcohol or other drugs
- States that there is no one at home to provide care

Consider the possibility of neglect when the **parent or other adult caregiver:**

- Appears to be indifferent to the child
- Seems apathetic or depressed
- Behaves irrationally or in a bizarre manner
- Is abusing alcohol or other drugs

**Signs of Sexual Abuse**

Consider the possibility of sexual abuse when the **child:**

- Has difficulty walking or sitting
- Suddenly refuses to change for gym or to participate in physical activities
- Reports nightmares or bedwetting
• Experiences a sudden change in appetite
• Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
• Becomes pregnant or contracts a venereal disease, particularly if under age 14
• Runs away
• Reports sexual abuse by a parent or another adult caregiver

Consider the possibility of sexual abuse when the parent or other adult caregiver:
• Is unduly protective of the child or severely limits the child’s contact with other children, especially of the opposite sex
• Is secretive and isolated
• Is jealous or controlling with family members

Signs of Emotional Maltreatment

Consider the possibility of emotional maltreatment when the child:

• Shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity, or aggression
• Is either inappropriately adult (parenting other children, for example) or inappropriately infantile (frequently rocking or head-banging, for example)
• Is delayed in physical or emotional development

• Has attempted suicide
• Reports a lack of suicide

Consider the possibility of attachment to the parent when the parent or other adult caregiver:

• Constantly blames, belittles, or berates the child
• Is unconcerned about the child and refuses to consider offers of help for the child’s problems
• Overtly rejects the child

RESOURCES ON THE CHILD WELFARE INFORMATION GATEWAY WEBSITE

Child Abuse and Neglect
www.childwelfare.gov/can/index.cfm

Defining Child Abuse and Neglect
www.childwelfare.gov/can/defining/

Preventing Child Abuse and Neglect
www.childwelfare.gov/preventing/

Reporting Child Abuse and Neglect
www.childwelfare.gov/responding/reporting.cfm

This factsheet was adapted, with permission, from Recognizing Child Abuse: What Parents Should Know. Prevent Child Abuse America. © 2003.
CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS
- To be completed by a Health Care Provider -

<table>
<thead>
<tr>
<th>Child’s Full Name</th>
<th>Date of Birth</th>
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<thead>
<tr>
<th>Parent’s/Guardian’s Name</th>
<th>Telephone No.</th>
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<thead>
<tr>
<th>Primary Health Care Provider</th>
<th>Telephone No.</th>
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<th>Specialty Provider</th>
<th>Telephone No.</th>
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<th>Specialty Provider</th>
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<table>
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<tr>
<th>Diagnosis(es)</th>
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Allergies

<table>
<thead>
<tr>
<th>ROUTINE CARE</th>
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<table>
<thead>
<tr>
<th>Medication To Be Given at Child Care</th>
<th>Schedule/Dose (When and How Much?)</th>
<th>Route (How?)</th>
<th>Reason Prescribed</th>
<th>Possible Side Effects</th>
</tr>
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List medications given at home:

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<tr>
<th>NEEDED ACCOMMODATION(S)</th>
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Describe any needed accommodation(s) the child needs in daily activities and why:

Diet or Feeding: __________________________

Classroom Activities: __________________________

Naptime/Sleeping: __________________________

Toleting: __________________________

Outdoor or Field Trips: __________________________

Transportation: __________________________

Other: __________________________

Additional comments: __________________________
CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS

Continued

<table>
<thead>
<tr>
<th>SPECIAL EQUIPMENT / MEDICAL SUPPLIES</th>
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<tbody>
<tr>
<td>1.</td>
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<td>3.</td>
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<table>
<thead>
<tr>
<th>EMERGENCY CARE</th>
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<tbody>
<tr>
<td>CALL PARENTS/GUARDIANS if the following symptoms are present:</td>
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<tr>
<td>CALL 911 (EMERGENCY MEDICAL SERVICES) if the following symptoms are present, as well as contacting the parents/guardians:</td>
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<table>
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<tr>
<th>TAKE THESE MEASURES while waiting for parents or medical help to arrive:</th>
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<tr>
<th>SUGGESTED SPECIAL TRAINING FOR STAFF</th>
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<table>
<thead>
<tr>
<th>Health Care Provider Signature</th>
<th>Date</th>
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<table>
<thead>
<tr>
<th>PARENT NOTES (OPTIONAL)</th>
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<p>| I hereby give consent for my child’s health care provider or specialist to communicate with my child’s child care provider or school nurse to discuss any of the information contained in this care plan. |
|                                                                                           |</p>
<table>
<thead>
<tr>
<th>Parent/Guardian Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
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Important: In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of your child’s special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child’s special health needs.
Special Health Care Plan

The special health care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on appropriately accommodating the special health concerns and needs of this child while in child care.

Name of Child: __________________________________________ Date: ____________________

Facility Name: __________________________________________

Description of condition(s): (include description of difficulties associated with each condition) __________________________________________

Team Member Names and Titles (parents of the child are to be included)

Care Coordinator (responsible for developing and administering the Special Health Care Plan): ____________________________

Outside Professionals Involved

Health Care Provider (MD, NP, etc.): ____________________________ Telephone: ____________________________

Speech & Language Therapist: ____________________________ Telephone: ____________________________

Occupational Therapist: ____________________________ Telephone: ____________________________

Physical Therapist: ____________________________ Telephone: ____________________________

Psychologist/Mental Health Consultant: ____________________________ Telephone: ____________________________

Social Worker: ____________________________ Telephone: ____________________________

Family-Child Advocate: ____________________________ Telephone: ____________________________

Other: ____________________________ Telephone: ____________________________

Communication

How the team will communicate (notes, communication log, phone calls, meetings, etc.):

________________________________________________________________________

How often will team communication occur: ☐ Daily ☐ Weekly ☐ Monthly ☐ Bi-monthly ☐ Other ____________________________

Date and time specifics: ____________________________
Specific Medical Information
* Medical documentation provided and attached: ☐ Yes ☐ No
☐ Information Exchange Form completed by health care provider is in child’s file on site.
* Medication to be administered: ☐ Yes ☐ No
☐ Medication Administration Form completed by health care provider and parents are in child’s file on site (including type of medications, method, amount, time schedule, potential side effects, etc.)

Any known allergies to foods and/or medications: ____________________________________________
Specific health-related needs: ____________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Planned strategies to support the child’s needs and any safety issues while in child care: (diapering/toileting, outdoor play, circle time, nap/sleeping, etc.) ____________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

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

Other (i.e., transportation, field trips, etc.): ________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Special Staff Training Needs
Training monitored by: ________________________________________________
1) Type (be specific): __________________________________________________________________
   Training done by: __________________________ Date of Training: ____________________________
2) Type (be specific): __________________________________________________________________
   Training done by: __________________________ Date of Training: ____________________________
3) Type (be specific): __________________________________________________________________
   Training done by: __________________________ Date of Training: ____________________________

Equipment/Positioning
* Physical Therapist (PT) and/or Occupational Therapist (OT) consult provided: ☐ Yes ☐ No ☐ Not Needed
Special equipment needed/to be used: ______________________________________________________
___________________________________________________________________________________
Positioning requirements (attach additional documentation as necessary): ______________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Equipment care/maintenance notes: ______________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
**Nutrition and Feeding Needs**

☐ Nutrition and Feeding Care Plan Form completed by team is in child’s file on-site. (See for detailed requirements/needs.)

**Behavior Changes** (be specific when listing changes in behavior that arise as a result of the health-related condition/concerns)

__________________________________________________________________________

__________________________________________________________________________

**Additional Information** (include any unusual episodes that might arise while in care and how the situation should be handled)

__________________________________________________________________________

__________________________________________________________________________

**Support Programs the Child Is Involved with Outside of Child Care**

1. Name of program: ___________________________ Contact person: ___________________________
   Address and telephone: ___________________________
   Frequency of attendance: ___________________________

2. Name of program: ___________________________ Contact person: ___________________________
   Address and telephone: ___________________________
   Frequency of attendance: ___________________________

3. Name of program: ___________________________ Contact person: ___________________________
   Address and telephone: ___________________________
   Frequency of attendance: ___________________________

**Emergency Procedures**

☐ Special emergency and/or medical procedure required (additional documentation attached)

Emergency instructions: __________________________________________________________

__________________________________________________________________________

Emergency contact: ___________________________ Telephone: ___________________________

**Follow-up: Updates/Revisions**

This Special Health Care Plan is to be updated/revised whenever child’s health status changes or at least every ________ months as a result of the collective input from team members.

Due date for revision and team meeting: ___________________________
Nutrition and Feeding Care Plan

The nutrition and feeding care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on a child’s diet and feeding needs for this child while in child care.

Name of Child: _______________________________ Date: ___________________

Facility Name: ____________________________________________

Team Member Names and Titles (parents of the child are to be included)

Care Coordinator (responsible for developing and administering Nutrition and Feeding Care Plan): ________________________________

If training is necessary, then all team members will be trained.

☐ Individualized Family Service Plan (IFSP) attached ☐ Individualized Education Plan (IEP) attached

Communication

What is the team’s communication goal and how will it be achieved (notes, communication log, phone calls, meetings, etc.):

How often will team communication occur: ☐ Daily ☐ Weekly ☐ Monthly ☐ Bi-monthly ☐ Other ___________________________

Date and time specifics:

Specific Diet Information

* Medical documentation provided and attached: ☐ Yes ☐ No ☐ Not Needed

Specific nutrition/feeding-related needs and any safety issues: ________________________________

* Foods to avoid (allergies and/or intolerances): ________________________________

Planned strategies to support the child’s needs: ________________________________

Plan for absences of personnel trained and responsible for nutrition/feeding-related procedure(s): ________________________________

* Food texture/consistency needs: ________________________________

* Special dietary needs: ________________________________

* Other: ________________________________

Eating Equipment/Positioning

* Physical Therapist (PT) and/or Occupational Therapist (OT) consult provided ☐ Yes ☐ No ☐ Not Needed

Special equipment needed: ________________________________

Specific body positioning for feeding (attach additional documentation as necessary): ________________________________
Behavior Changes (be specific when listing changes in behavior that arise before, during, or after feeding/eating)

Medical Information

☐ Information Exchange Form completed by Health Care Provider is in child’s file onsite.

* Medication to be administered as part of feeding routine:  ☐ Yes  ☐ No

☐ Medication Administration Form completed by health care provider and parents is in child’s file on-site (including type of medication, who administers, when administered, potential side effects, etc.)

Tube Feeding Information

Primary person responsible for daily feeding: _____________________________________________

Additional person to support feeding: __________________________________________________

☐ Breast Milk  ☐ Formula (list brand information): ______________________________________

Time(s) of day:

Volume (how much to feed): __________ Rate of flow: __________ Length of feeding: __________

Position of child:

☐ Oral feeding and/or stimulation (attach detailed instructions as necessary): ____________________

Special Training Needed by Staff

Training monitored by: _____________________________________________

1) Type (be specific): _____________________________________________

Training done by: _____________________________________________ Date of Training: __________

2) Type (be specific): _____________________________________________

Training done by: _____________________________________________ Date of Training: __________

Additional Information (include any unusual episodes that might arise while in care and how the situation should be handled)

______________________________________________________________________________

Emergency Procedures

☐ Special emergency and/or medical procedure required (additional documentation attached)

Emergency instructions: ___________________________________________________________

Emergency contact: __________________________________ Telephone: ____________________

Follow-up: Updates/Revisions

This Nutrition and Feeding Care Plan is to be updated/revised whenever child’s health status changes or at least every ___ months as a result of the collective input from team members.

Due date for revision and team meeting: ____________
Appendix P
Caring for Infants and Toddlers in Child Care and Early Education *Standard included in Stepping Stones, 3rd Ed.

In the two boxes below, you will find lists of common medical emergencies or urgent situations you may encounter as a child care provider. To prepare for such situations:

1) Know how to access Emergency Medical Services (EMS) in your area. See Glossary for definition of EMS.
2) Know how to reach your Poison Center right away, nationally call 1-800-222-1222.
3) Educate staff on the recognition of an emergency, and when in doubt, call EMS.
4) Know how to contact each child’s guardian and primary health care provider. Obtain permission from parents/guardians to speak directly to each child’s health care professional.
5) Develop plans for children with special medical needs together with their family and primary care provider.
6) Compile information on when and how to contact public health authorities.

At any time you believe the child’s life may be at risk, or you believe there is a risk of permanent injury, seek immediate medical treatment. Do not hesitate, when in doubt, call EMS.

Determine contingency plans for times when there may be power outages, transportation issues etc.

Document what happened and what actions were taken; share verbally and in writing with parents/guardians.

Some children may have urgent situations that do not necessarily require ambulance transport but still need medical attention. The box below lists some of these more common situations. The legal guardian should be informed of the following conditions. If you or the guardian cannot reach the physician within one hour, the child should be brought to a hospital.

Get medical attention within one hour for:

• Fever* in any age child who looks more than mildly ill.
• Fever* in a child less than two months (eight weeks) of age.
• A quickly spreading purple or red rash.
• A large volume of blood in the stools.
• A cut that may require stitches.
• Any medical condition specifically outlined in a child’s care plan requiring parental notification.

*Fever is defined as a temperature above 101°F (38.3°C) orally, above 102°F (38.9°C) rectally, or 100°F (37.8°C) or higher taken axillary (armpit) or measured by an equivalent method.

References:

Caring for Infants and Toddlers in Child Care and Early Education

Call Emergency Medical Services (EMS) immediately if:

• You believe the child’s life is at risk or there is a risk of permanent injury.
• The child is acting strangely, much less alert, or much more withdrawn than usual.
• The child has difficulty breathing, is having an asthma exacerbation, or is unable to speak.
• The child's skin or lips look blue, purple, or gray.
• The child has rhythmic jerking of arms and legs and a loss of consciousness (seizure).
• The child is unconscious.
• The child is less and less responsive.
• The child has any of the following after a head injury: decrease in level of alertness, confusion, headache, vomiting, irritability, or difficulty walking.
• The child has increasing or severe pain anywhere.
• The child has a cut or burn that is large, deep, and/or won’t stop bleeding.
• The child is vomiting blood.
• The child has a severe stiff neck, headache, and fever.
• The child is significantly dehydrated: sunken eyes, lethargic, not making tears, not urinating.
• Multiple children affected by injury or serious illness at the same time.
• When in doubt, call EMS.
• After you have called EMS, remember to contact the child’s legal guardian.
Adaptive Equipment for Children with Special Health Care Needs

Children on a gluten-free diet and those with latex allergies must be protected from ingesting or coming in contact with equipment/materials that may contain these substances. Check manufacturer's specifications and/or labels of all equipment, feeding materials, and toys including art supplies.

Physical Therapy/Occupational Therapy Equipment

Infants, Ages Birth to Two

**Equipment**
- Floor mats, 2 to 3 inches of varying firmness
- Therapy balls of varying sizes
- Wedges: 4, 6, 8, and 12 inch
- Inflatable mattress
- Air compressor (for inflatables)
- Therapy rolls and half rolls of varying sizes
- Nesting benches, varying heights
- Wooden weighted pushcart
- Toddler swing
- Floor mirror
- Dycem non-slip matting

**Feeding**
- Bottle straws
- Cut-out cups
- Bottle holders
- Built-up handled utensils
- Scoop bowls
- Coated spoons

**Toys**
- Books
- Mirror
- Ring stack
- Container toys
- Pegboard
- Rattles
- Squeeze toys
- Tracking toys
- Toys for pushing, swiping, cause and effect
- Adapted switches
- Form boards
- Large beads
- Large crayons

Pre-K, Ages Two to Five

**Equipment**
- Floor mats, 2 to 3 inches of varying firmness
- Therapy balls: 16, 20, 24, and 37 inch diameter
- Nesting benches
- Therapy rolls: 8, 10, and 12 inch diameter
- Steps

**Toys**
- Dolls (soft with large features and feeding bathing and daily living equipment)
- Rattles (noisemakers and easy to grasp)
- Manipulative toys (for pulling, pushing, shaking, cause and effect)
- Assorted picture books (large pictures, one-a-page, photographs, simple plot)
- Building blocks
- Balls/belts
- Telephone
- Stacking rings
- Shape sorters
- Xylophone, Drum

Assessments and Books
- Small Wonder Activity Kit

Floor mirrors
- Climbing equipment
- Small chair and table
- Scooter board
- Dycem non-slip matting
- Suspended equipment (see also Adaptive Physical Education Equipment, Balance/Gross Motor Coordination)
- Walkers, sidelyers, proneboards, adapted chairs
- Adapted tricycles

Easel
- Tricycles
- Ride-on scooters
- Wagon
- Wooden push cart
- Manipulative toys (puzzles, beads, pegs and pegboard, nesting toys, etc.)
- Fastening boards (zippers, snaps, laces, etc.)
- Paper, crayons, chalk, markers
- Sand/water table
- Playdough or clay (consider gluten free and latex free alternatives)
- Target activities (beanbags, ring toss)
- Playground balls (see under Adaptive Physical Education Equipment, Eye-Hand Coordination)

Speech and Language Development

Infants, Ages Birth to Two

**Equipment**
- Mirrors, wall and hand-held
- Assorted spoons, cups, bowls, plates
- Mats and sheets
- Preston feeding chairs
- High chair

**Toys**
- Assorted picture books (large pictures, one-a-page, photographs, simple plot)
- Building blocks
- Balls/belts
- Telephone
- Stacking rings
- Shape sorters
- Xylophone, Drum

Assessments and Books
- Small Wonder Activity Kit

*Standard included in Stepping Stones, 3rd Ed.*
Pre-Feeding Skills by Suzanne Morris
Parent-Infant Communication
Bayley Scales of Infant Development
Communication and Symbolic Behavior Scale
Movement Assessment in Infants by S. Harris and L. Chandler
RIDES
HAWAII HELP
Early Learning Accomplishments
Profile and Kit (Kaplan)
Receptive Expressive Emergent Language Test 3
Rossetti Infant/Toddler Language Scale

**Pre-K, Ages Two to Five**

**Equipment**
- Mirrors, wall and hand-held
- Tongue depressors
- Penlight
- Stopwatch
- Tape recorder and tapes
- Toothettes
- Horns and Whistles

**Toys**
- Dolls (with movable parts and removable clothing)
- Manipulative toys (cars and toys for pushing, stacking, cause and effect)
- Building blocks
- Dollhouse
- Pretend play items (dress-up clothes, dishes, sink, food, telephone)
- Playdough or clay (consider gluten free and latex free alternatives)
- Puzzles (individual pieces or minimal interlocking parts)
- Picture cards (nouns, actions, etc.)
- Puppets
- Animals
- Storybooks with simple plot lines (large pictures and few, if any, words)

**Assessments and books**
- Clinical evaluation of Language Fundamentals - Pre-School
- Sequested Inventory of Communication
- Test of Auditory Comprehension of Language
- Goldman Fristore Test of Articulation
- Pre-School Language Assessment Inventory
- Assessment of Phonological Processes
- Expressive Vocabulary Test-2
- Peabody Picture Vocabulary Test-4

**Adaptive Physical Education Equipment**

**Pre-K, Ages Two to Five**

**Balance/Gross Motor Coordination**
- Incline mat
- Balance beams, 4 and 12 inch wide
- Floor mats, 2 inch
- Bolsters
- Rocking platforms
- Scooters (sit-on type)
- Tunnel (accordion style)
- Training stairs
- Hurdles, adjustable height
- Pediatric climbing wall

**Eye-Hand Coordination**
- Balls (to hit, throw, and catch)
- Beanbags and Target
- Hula hoops
- Lightweight paddles/rackets
- Lightweight bats
- Traffic cones
- Batting tees
- Beachballs

**Eye-Foot Coordination**
- Balls for kicking
- Foot placement ladder
- Footprints or “stepping stones”
- Horizontal ladder
### Medication Administration Packet

#### Authorization to Give Medicine

**PAGE 1—TO BE COMPLETED BY PARENT/GUARDIAN**

<table>
<thead>
<tr>
<th>CHILD’S INFORMATION</th>
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<tbody>
<tr>
<td>Name of Facility/School</td>
<td><strong>/</strong>/___</td>
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<tr>
<td>Name of Child (First and Last)</td>
<td><strong>/</strong>/___</td>
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<tr>
<td>Name of Medicine</td>
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<tr>
<td>Reason medicine is needed during school hours</td>
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<tr>
<td>Dose</td>
<td>Route</td>
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<td>Time to give medicine</td>
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<tr>
<td>Additional instructions</td>
<td></td>
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<tr>
<td>Date to start medicine</td>
<td>Stop date</td>
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<tr>
<td>Known side effects of medicine</td>
<td></td>
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<tr>
<td>Plan of management of side effects</td>
<td></td>
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<tr>
<td>Child allergies</td>
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<table>
<thead>
<tr>
<th>PRESCRIBER’S INFORMATION</th>
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<tbody>
<tr>
<td>Prescribing Health Professional’s Name</td>
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<tr>
<td>Phone Number</td>
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<tr>
<th>PERMISSION TO GIVE MEDICINE</th>
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<tr>
<td>I hereby give permission for the facility/school to administer medicine as prescribed above. I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.</td>
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<tr>
<td>Parent or Guardian Name (Print)</td>
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<tr>
<td>Parent or Guardian Signature</td>
<td></td>
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<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Home Phone Number</td>
<td>Work Phone Number</td>
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</table>
Receiving Medication

PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child ___________________________________________________________________________________________

Name of medicine ________________________________________________________________________________________

Date medicine was received _____/_____/_____

Safety Check


□ 2. Original prescription or manufacturer’s label with the name and strength of the medicine.

□ 3. Name of child on container is correct (first and last names).

□ 4. Current date on prescription/expiration label covers period when medicine is to be given.

□ 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.

□ 6. Copy of Child Health Record is on file.

□ 7. Instructions are clear for dose, route, and time to give medicine.

□ 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.

□ 9. Child has had a previous trial dose.

Y □ N □ 10. Is this a controlled substance? If yes, special storage and log may be needed.

________________________________________________________________________________________________________

Caregiver/Teacher Name (Print)

________________________________________________________________________________________________________

Caregiver/Teacher Signature
### Medication Log

**PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER**

Name of child: ____________________________________________________________  Weight of child: ______________________

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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<tbody>
<tr>
<td>Medicine</td>
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<tr>
<td>Date</td>
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<tr>
<td>Actual time given</td>
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<td>PM _______</td>
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<tr>
<td>Dosage/amount</td>
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<tr>
<td>Route</td>
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<tr>
<td>Staff signature</td>
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</tr>
</tbody>
</table>

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

<table>
<thead>
<tr>
<th>Date/time</th>
<th>Error/problem/reaction to medication</th>
<th>Action taken</th>
<th>Name of parent/guardian notified and time/date</th>
<th>Caregiver/teacher signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Returned to parent/guardian

<table>
<thead>
<tr>
<th>Date</th>
<th>Parent/guardian signature</th>
<th>Caregiver/teacher signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ /</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Disposed of medicine

<table>
<thead>
<tr>
<th>Date</th>
<th>Caregiver/teacher signature</th>
<th>Witness signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ /</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of treatment. Child care providers, taking into account individual circumstances, may be appropriate.
Medication Incident Report

Date of report ___________________________ School/center __________________

Name of person completing this report _________________________________________

Signature of person completing this report _________________________________________

Child’s name _________________________________________________________________

Date of birth ___________________________ Classroom/grade __________________________

Date incident occurred __________________ Time noted _____________________________

Person administering medication _________________________________________________

Prescribing health care provider _________________________________________________

Name of medication ____________________________________________________________

Dose ___________________________ Scheduled time _________________________________

Describe the incident and how it occurred (wrong child, medication, dose, time, or route?)

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Action taken/intervention _________________________________________________________

Parent/guardian notified? Yes ___________ No ___________ Date ___________ Time ___________

Name of the parent/guardian that was notified _______________________________________

Follow-up and outcome __________________________________________________________

Administrator’s signature _________________________________________________________

Adapted with permission from Healthy Child Care Colorado.
## Preparing to Give Medication

This is a checklist to use at your child care facility/school to make sure that your program is ready to give medication.

<table>
<thead>
<tr>
<th>1. Paperwork</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Parent authorization to give medications is signed.</td>
</tr>
<tr>
<td>□ Health care professional authorization or instructions are on file.</td>
</tr>
<tr>
<td>□ Child Health Record is on file.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Medication checked when received</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Properly labeled.</td>
</tr>
<tr>
<td>□ Proper container.</td>
</tr>
<tr>
<td>□ Stored correctly.</td>
</tr>
<tr>
<td>□ Instructions are clear.</td>
</tr>
<tr>
<td>□ Disposal plan is developed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Administering medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Area is clean and quiet.</td>
</tr>
<tr>
<td>□ Staff is trained.</td>
</tr>
<tr>
<td>□ Hands are washed.</td>
</tr>
<tr>
<td>□ The 5 rights are followed—right child, medication, dose, time, and route.</td>
</tr>
<tr>
<td>□ Child is observed for side effects.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Medication log is completed fully and in ink.</td>
</tr>
</tbody>
</table>

Documents in Appendix AA adopted with permission from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill, American Academy of Pediatrics, Connecticut Department of Public, Healthy Child Care Pennsylvania and Healthy Child Care Colorado, 2011.
Bike Helmets: Quick-Fit Check

Use this easy, three-point check to test for a proper helmet fit

1. Eyes
   Helmet sits level on your child's head and rests low on the forehead, one to two finger widths above the eyebrows. Your child should be able to see the very edge of their helmet by looking up with their eyes only, while keeping their head still. A helmet pushed up too high will not protect the face or head well in a fall or crash.

2. Ears
   The straps are even and form a “Y” under each earlobe. The straps are snug against the head.

3. Mouth
   The buckled chin strap is loose enough so that your child can breathe. There should be enough room so you can insert a finger between the buckle and chin, but it should be tight enough that if your child opens their mouth, you can feel the helmet pull down on top.

Why are bike helmets needed?
Helmets provide the best protection against injury, whether your child is riding a bike, scooter or on skates. Wearing a helmet can prevent about 85 percent of head injuries from bike crashes. However, a helmet will only protect when it fits well.

Help your child get in the habit of wearing a helmet by starting when they’re young. Be a good role model and wear a helmet yourself.

The “Eyes, Ears, Mouth Test” is courtesy of the Bicycle Coalition of Maine.

Used with Permission of the Seattle Children’s Hospital, 2010.
How do I choose a helmet?

- Choose a helmet that meets safety standards. Look for a CPSC (U.S. Consumer Product Safety Commission) or Snell sticker inside the helmet.
- Helmet costs vary. Expensive helmets are not always better. Choose one that your child likes and will wear. Let your child help choose a helmet that fits well and looks good.
- Check used or hand-me-down helmets with care, and never wear a helmet that is cracked, broken or has been in a crash. Used helmets may have cracks you cannot see. Older helmets may not meet current safety standards.

What are the pads for?

Helmets come with fit pads to help ensure a proper fit. Use the pads where there is space at the front, back and/or sides of the helmet to get a snug fit. Move pads around to touch your child’s head evenly all the way around. Replace thick pads with thinner ones as your child grows.

How do I check the fit?

With one hand, gently lift the front of the helmet up and back. The helmet should not move up and back to reveal the forehead. If it does, tighten the strap in front of the ear. Now lift the back of the helmet up and forward from the back. Can you move the helmet more than an inch? If so, tighten the back strap. If you can move the helmet from side to side, add thicker pads at the side.

When done, the helmet should feel level, fit solidly on your child’s head and be comfortable. If it doesn’t fit, keep working with the fit pads and straps or try another helmet.

Safety tips

- Teach your child to take their helmet off before playing at the playground or climbing on equipment or trees. The straps can get caught on poles or branches and prevent your child from breathing.
- Leave hair loose or tie it back at the base of the neck.
- Bike helmets can be worn with inline roller skates or scooters. For skateboarding or snowboarding, you will need another type of helmet.
- If your child does aggressive, trick or extreme skating or skateboarding, look for a true multi-impact helmet that has a sticker inside saying it meets ASTM F1492.
- Helmets are good for only one crash. Replace the helmet after a crash.

To Learn More

- www.bhsi.org, Bicycle Helmet Safety Institute
- www.cbcef.org, Cascade Bicycle Club Education Foundation
- www.seattlechildrens.org
- Seattle Children’s Resource Line
  206-987-2500 or 866-987-2500
toll-free Washington, Alaska, Montana, Idaho
- Your child’s healthcare provider

Seattle Children’s will make this information available in alternate formats upon request. Call Marketing Communications at 206-987-5205 or 206-987-2280 (TTY).

This handout has been reviewed by the clinical staff at Seattle Children’s. However, your child’s needs are unique. Before you act or rely upon this information, please talk with your child’s healthcare provider.

Our Child Care Center Supports Breastfeeding

Because we are committed to healthy mothers and children,

Our Child Care Center Supports Breastfeeding

In order to support families who are breastfeeding or who are considering breastfeeding, we strive to do the following:

• Make a commitment to the importance of breastfeeding, especially exclusive breastfeeding, and proudly share this commitment with our staff and clients.

• Train all staff in supporting the best infant and young child feeding.

• Inform families about the importance of breastfeeding.

• Develop a breastfeeding-friendly feeding plan with each family.

• Train all staff to handle, store, and feed mother’s milk properly.

• Teach our clients to properly store and label their milk for child care center use.

• Provide a breastfeeding-friendly environment, welcoming mothers to nurse their babies at our center.

• Display posters and brochures that support breastfeeding and show best practices.

• Contact and coordinate with local skilled breastfeeding support and actively refer.

• Continually update our information and learning about breastfeeding support.

Breastfeeding Families Welcome Here!