

EMERGENCY/ DISASTER PREPAREDNESS FOR CHILD CARE PROGRAMS

Applicable Standards from:

CARING FOR OUR CHILDREN

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

A Joint Collaborative Project of

American Academy of Pediatrics
141 Northwest Point Blvd.
Elk Grove Village, IL 60007-1098

American Public Health Association
8001 I Street, N.W.
Washington, DC 20001-3710

National Resource Center for Health and Safety in Child Care
University of Colorado Health Sciences Center at Fitzsimons
Campus Mail Stop F541, PO Box 6508
Aurora, CO 80045-0508

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INTRODUCTION

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

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

Parents and society expect their children to be in a safe environment while in the care of child care programs. However emergencies and disasters do occur in these settings and child care providers need to plan and be prepared when such events happen. A variety of emergencies can take place. Medical emergencies can vary from an injury on the playground to choking on a piece of food. Natural disasters can occur without warning such as an earth quake or can quickly become dangerous such as a flood. And there is the human- or faulty equipment-initiated emergency such as a fire or a missing child. Emergencies can also happen while in route to a field trip or play activity and appropriate measures and procedures need to be in place.

Child care providers need to be trained on appropriate procedures depending on the emergency and children and staff need to regularly participate in evacuation drills. This guide is to help the following audiences in developing appropriate plans, procedures, policies and drills:

INTENDED AUDIENCES

The intended audiences for this document are:

- child care providers who need to have appropriate emergency/disaster procedures and plans in place and practiced regularly;
- state regulators and policy makers who are formulating or changing state regulations in the area of emergency plans for child care programs;
- health consultants and trainers who can promote and teach appropriate emergency/disaster procedures and policies;
- parents who need to understand and participate in the emergency plan and policies of their child's early care and education program.

Throughout this document there will be references to other standards contained in the full edition of *Caring for Our Children, 2nd Ed.* that are not present in this document. For example, comments in Standard 3.061 regarding the training for staff to handle seizures refers to other standards which are not in this document but ARE found in the full edition of *Caring for Our Children, 2nd Ed.* The full edition of *CFOC* can be found at <http://nrc.uchsc.edu/CFOC/index.html>. Also, standards in this compilation are not necessarily in numerical order because similar topics were brought together from different sections in the larger *Caring for Our Children*.

Since the publication of *Caring for Our Children, 2nd Ed.* in January 2002, many new issues have surfaced in preparing for emergencies that were not included in the standards. Examples of these emerging points for providers, parents and regulators to consider as they work on emergency preparedness issues are:

- the need for children and the programs they spend time in to be included in the state emergency response plans from how first responders best work with children to minimize the trauma and stress, to being listed as a vulnerable population that central agencies are designated to find and assist during a disaster;
- the need for multiple, compatible communication systems accessible in a disaster (e.g. land lines, cell phones, battery operated radios);
- the need for alternative contacts if standard communication systems are inoperable; and
- the need for programs to be aware of the procedure for access to the Strategic National Stockpile (SNS) of emergency drugs and vaccines.

We would like to give special thanks to R. Lorraine Brown, RN, BS, Steven B. Eng, MPH, and Anne B. Keith, DrPH, RN, C-PNP for reviewing this compilation of standards on emergency preparedness. We would also like to thank all those individuals who contributed to *CFOC, 2nd Ed.* A listing can be viewed at: <http://nrc.uchsc.edu/CFOC/PDFVersion/Acknowledgments.pdf>

The following organizations/web sites provide additional resources on emergency planning/preparedness and/or helping children cope with disasters:

American Academy of Pediatrics
<http://www.aap.org/terrorism/index.html/>

American Public Health Association
<http://www.apha.org/>

Federal Emergency Management Agency
<http://www.fema.gov/>
State Offices and Agencies on Emergency Management
<http://www.fema.gov/fema/statedr.shtm>

Healthy Child Care Magazine
Emergency Preparation Special Issue 2004
<http://www.healthychild.net/>

Head Start Disaster Preparedness Workbook
<http://www.cphd.ucla.edu/headstart/Final%20Workbook/Complete%20Workbook.pdf>

National Association of Child Care Resource and Referral Agencies
<http://www.nrex.org/>

National Child Care Information Center
<http://nccic.org/cctopics/cope.html>

National Resource Center for Health and Safety in Child Care
<http://nrc.uchsc.edu/RESOURCES/list.htm#E>

Protecting Our Kids from Disaster
Institute for Business and Home Safety
<http://www.ibhs.org/docs/childcare.pdf>

US Department of Homeland Security
<http://www.dhs.gov/dhspublic/>

For questions or assistance on these standards or *Caring for Our Children, 2nd Edition*, please contact: National Resource Center for Health and Safety in Child Care
1-800-598-5437
<http://nrc.uchsc.edu>
natl.child.res.ctr@UCHSC.edu

PLAN

Emergencies and disasters can affect your child care setting quickly and without warning and can threaten the health, safety or welfare of the children and staff. Knowing what to do is your best protection. Developing a written plan provides the opportunity to be prepared and to prevent poor judgments made under the stress of an emergency.

Applicable standards from *Caring for Our Children: National Health and Safety Performance Standards, 2nd Edition* include:

**STANDARD 8.004
CONTENT OF POLICIES**

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

- a) Admission and Enrollment;
- b) Supervision;
- c) Discipline;
- d) Care of Acutely Ill Children;
- e) Child Health Services;
- f) Use of Health Consultants
- g) Health Education
- h) Medications;
- i) Emergency Plan;**
- j) Evacuation Plan, Drills, and Closings;**
- k) Authorized Caregivers;
- l) Safety Surveillance;
- m) Transportation and Field Trips;
- n) Sanitation and Hygiene;
- o) Food Handling, Feeding, and Nutrition;
- p) Sleeping
- q) Evening and Night Care Plan;
- r) Smoking, Prohibited Substances, and Firearms;
- s) Staff Health, Training, Benefits, and Evaluation;
- t) Maintenance of the Facility and Equipment;
- u) Review and Revision of Policies, Plans, and Procedures, STANDARD 8.040 and STANDARD 8.041.

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

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

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

**STANDARD 8.022
WRITTEN PLAN AND TRAINING
FOR HANDLING URGENT MEDICAL
CARE OR THREATENING
INCIDENTS**

The facility shall have a written plan for reporting and managing any incident or unusual occurrence that is threatening to the health, safety, or welfare of the children, staff, or volunteers. The facility shall also include procedures of staff training on this plan.

The following incidents, at a minimum, shall be addressed in the plan:

- a) Lost or missing child;
- b) Suspected sexual, physical, or emotional abuse or neglect of a child (as mandated by state law);
- c) Injuries requiring medical or dental care;
- d) Serious illness requiring hospitalization, or the death of a child or caregiver, including deaths that occur outside of child care hours.

The following procedures, at a minimum, shall be addressed in the plan:

- a) Provision for a caregiver to accompany a child to the source of urgent care and remain with the child until the parent or legal guardian assumes responsibility for the child;
- b) Provision for a backup caregiver or substitute (see Substitutes, STANDARD 1.037 through STANDARD 1.039) for large and small family child care homes to make this feasible.

- Child:staff ratios must be maintained at the facility during the emergency;
- c) The source of urgent medical and dental care (such as a hospital emergency room, medical or dental clinic, or other constantly staffed facility known to caregivers and acceptable to parents);
 - d) Assurance that the first aid kits are resupplied following each first aid incident, and that required contents are maintained in a serviceable condition, by a periodic review of the contents;
 - e) Policy for scheduled reviews of staff members' ability to perform first aid for averting the need for emergency medical services.

RATIONALE: Emergency situations are not conducive to calm and composed thinking. Drafting a written plan provides the opportunity to prepare and to prevent poor judgements made under the stress of an emergency.

An organized, comprehensive approach to injury prevention and control is necessary to ensure that a safe environment is provided to children in child care. Such an approach requires written plans, policies, procedures, and record-keeping so that there is consistency over time and across staff and an understanding between parents and caregivers about concerns for, and attention to, the safety of children.

Routine restocking of first aid kits is necessary to ensure supplies are available at the time of an emergency.

Management within the first hour or so following a dental injury may save a tooth.

COMMENTS: Parents may also have on file their preferred dentists in case of emergency. Parents should be notified, if at all possible, before dental services are rendered, but emergency care should not be delayed because the child's own dentist is not immediately available.

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

STANDARD 8.023 REVIEW OF WRITTEN PLAN FOR URGENT CARE

The facility's written plan for urgent medical care and threatening incidents shall be reviewed with each employee upon employment and yearly thereafter in the facility to ensure that policies and procedures are understood and followed in the event of such an occurrence.

RATIONALE: Emergency situations are not conducive to calm and composed thinking. Drafting a written plan and reviewing it in preservice meetings with new employees and annually thereafter, provides the opportunity to prepare and to prevent poor judgements made under the stress of an emergency.

An organized, comprehensive approach to injury prevention and control is necessary to ensure that a safe environment is provided to children in child care. Such an approach requires written plans, policies, procedures, and record-keeping so that there is consistency over time and across staff and an understanding between parents and caregivers about concerns for, and attention to, the safety of children.

For additional information on emergency plans, see also Evacuation Plan, Drills, and Closings, STANDARD 8.024 through STANDARD 8.027; and Emergency Procedures, STANDARD 3.048 through STANDARD 3.052. See Appendix Y, for a sample *Incident Report Form*.

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

STANDARD 8.024 WRITTEN EVACUATION PLAN

The facility shall have a written plan for reporting and evacuating in case of fire, flood, tornado, earthquake, hurricane, blizzard, power failure, bomb threat, or other disaster that could create structural damages to the facility or pose health and safety hazards to the children and staff. The facility shall also include procedures for staff training on this emergency plan.

RATIONALE: Emergency situations are not conducive to calm and composed thinking. Drafting a written plan provides the opportunity to prepare and to prevent poor judgments made under the stress of an emergency. An organized, comprehensive approach to injury prevention and control is necessary to

ensure that a safe environment is provided children in child care. Such an approach requires written plans, policies, procedures, rehearsals, and record-keeping so that there is consistency over time and across staff and an understanding between parents and caregivers about concerns for, and attention to, the safety of the children and staff.

COMMENTS: Diagrammed evacuation procedures are easiest to follow in an emergency. Floor plan layouts that show two alternate exit routes are best. Plans should be clear enough that a visitor to the facility could easily follow the instructions. A sample emergency evacuation plan is provided in *Healthy Young Children* from the National Association for the Education of Young Children (NAEYC). Contact information for the NAEYC is located in Appendix BB. See Appendix Y, for a sample *Incident Report Form*.

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

RECOMMENDATION 9.025 STATE AND LOCAL HEALTH DEPARTMENT ROLE

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

1. Assisting in the planning of a comprehensive health and safety program for children and child care providers.
2. Monitoring the occurrence of serious injury events and outbreaks involving children or providers.
3. Alerting the responsible child care administrators about identified or potential injury hazards and infectious disease risks in the child care setting.
4. Controlling outbreaks, identifying and reporting communicable diseases in child care settings including:
 - a) Methods for notifying parents, caregivers, and health care providers of the problem.
 - b) Providing appropriate actions for the child care provider to take;

- c) Providing policies for exclusion or isolation of infected children;
 - d) Arranging a source and method for the administration of needed medication.
 - e) Providing a list of reportable diseases, including descriptions of these diseases. The list should specify where diseases are to be reported and what information is to be provided by the child care provider to the health department and to parents;
 - f) Requiring that all facilities, regardless of licensure status, and all health care providers report certain communicable diseases to the responsible local or state public health authority. The child care licensing authority should require such reporting under its regulatory jurisdiction and should collaborate fully with the health department when the latter is engaged in an enforcement action with a licensed facility;
 - g) Determining whether a disease represents a potential health risk to children in out-of-home child care;
 - h) Conducting the epidemiological investigation necessary to initiate public health interventions;
 - i) Recommending a disease prevention or control strategy that is based on sound public health and clinical practices (such as the use of vaccine, immunoglobulin, or antibiotics taken to prevent an infection).
 - j) Verifying reports of communicable diseases received from facilities with the assessment and diagnosis of the disease made by a health care provider and, or the local or state health department.
5. Designing systems and forms for use by facilities for the care of ill children to document the surveillance of cared for illnesses and problems that arise in the care of children in such child care settings.
 6. Assisting in the development of orientation and annual training programs for caregivers. Such training shall include specialized education for staff of facilities that include ill children, as well as those in special facilities that serve only ill children. Specialized training for staff who care for ill children should focus on the recognition and management of childhood illnesses, as well as the care of children with communicable diseases.

7. Assisting the licensing authority in the periodic review of facility performance related to caring for ill children by:
 - a) Reviewing written policies developed by facilities regarding inclusion, exclusion, dismissal criteria and plans for health care, **urgent and emergency care**, and reporting and managing children with communicable disease;
 - b) Assisting with periodic compliance reviews for those rules relating to inclusion, exclusion, dismissal, daily health care, **urgent and emergency care**, and reporting and management of children with communicable disease.
9. Collaborating in the planning and implementation of appropriate training and educational programs related to health and safety in child care facilities. Such training should include education of parents, physicians, public health workers, licensing inspectors, and employers about how to prevent injury and disease as well as promote health of children and their caregivers.
10. Ensuring that health care personnel, such as qualified public health nurses, pediatric and family nurse practitioners, and pediatricians serve as child care health consultants as required in STANDARD 1.040 through STANDARD 1.044 and as members of advisory boards for facilities serving ill children.

DISCUSSION: A number of studies have described the incidence of injuries in the child care settings (23-26). Although the injuries described have not been serious, these occur frequently, and may require medical or emergency attention. Child care programs need the assistance of local and state health agencies in planning of the safety program that will minimize the risk for serious injury(21). This would include planning for such significant emergencies as fire, flood, tornado, or earthquake (26). A community health agency can collect information that can promptly identify an injury risk or hazard and provide an early notice about the risk or hazard (27). An example is the recent identification of un-powered scooters as a significant injury risk for preschool children (28). Once the injury risk is identified, appropriate channels of communication are required to alert the child care administrators and to provide training and educational activities.

Effective control and prevention of infectious diseases in child care settings depends on affirmative relationships among parents, caregivers, public health authorities, regulatory agencies, and primary health care providers. The major barriers to productive working relationships between caregivers and health care providers are inadequate channels of communication and uncertainty of role definition. Public health authorities can play a major role in improving the relationship between caregivers and health care providers by disseminating information regarding disease reporting laws, prescribed measures for control and prevention of diseases and injuries, and resources that are available for these activities (20).

State and local health departments are legally required to control certain communicable diseases within their jurisdictions. All states have laws that grant extraordinary powers to public health departments during outbreaks of communicable diseases (16). Since communicable disease is likely to occur in child care settings, a plan for the control of communicable diseases in these settings is essential and often legally required. Early recognition and prompt intervention will reduce the spread of infection. Outbreaks of communicable disease in child care settings can have great implications for the general community (17). Programs administered by local health departments have been more successful in controlling outbreaks of hepatitis A than those that rely primarily on private physicians. Programs coordinated by the local health department also provide reassurance to caregivers, staff, and parents, and thereby promote cooperation with other disease control policies (18). Communicable diseases in child care settings pose new epidemiological considerations. Only in recent decades has it been so common for very young children to spend most of their days together in groups. Public health authorities should expand their role in studying this situation and designing new preventive health measures (19).

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

Health departments generally have or should develop the expertise to provide leadership and technical assistance to licensing authorities, caregivers, parents, and health professionals in the development of licensing requirements and guidelines for the management of ill children. The heavy reliance on the

expertise of local and state health departments in the establishment of facilities to care for ill children has fostered a partnership in many states among health departments, licensing authorities, caregivers, and parents for the adequate care of ill children in child care settings. In addition, the business community has a vested interest in assuring that parents have facilities that provide quality care for ill children so parents can be productive in the workplace.

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

See also Reporting Illness, STANDARD 3.086 and STANDARD 3.087.

STANDARD 8.005 INITIAL PROVISION OF WRITTEN INFORMATION TO PARENTS AND CAREGIVERS

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

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

- e) Policies for termination and notice by the parent or the facility;
- f) Policies regarding payments of fees, deposits, and refunds;
- g) Planned methods and schedules for conferences or other methods of communication between parents and staff;
- h) **Plan for Urgent and Emergency Medical Care or Threatening Incidents.** See Emergency Procedures, STANDARD 3.048 through STANDARD 3.052; and Plan for Urgent Medical Care or Threatening Incidents, STANDARD 8.022 and STANDARD 8.023.
- i) **Evacuation procedures and alternate shelter arrangements for fire, natural disasters, and building emergencies.** See **Evacuation Plan, Drills, and Closings, STANDARD 8.024 through STANDARD 8.027;**
- j) Nutrition. Schedule of meals and snacks. See General Requirements, STANDARD 4.001 through STANDARD 4.010; Requirements for Special Groups or Ages of Children, STANDARD 4.011 through STANDARD 4.025 and Plans and Policies for Food Handling, Feeding, and Nutrition, STANDARD 8.035 and STANDARD 8.036;
- k) Policy for food brought from home. See Food Brought from Home, STANDARD 4.040 and STANDARD 4.041;
- l) Policy on infant feeding. See Nutrition for Infants, STANDARD 4.011 through STANDARD 4.021 and Plans and Policies for Food Handling, Feeding, and Nutrition, STANDARD 8.035 and STANDARD 8.036;
- m) Policies for staffing including the use of volunteers, helpers, or substitute caregivers, child:staff ratios, deployment of staff for different activities, authorized caregivers, methods used to ensure continuous supervision of children. See Child:Staff Ratio and Group Size, STANDARD 1.001 through STANDARD 1.005;
- n) Policies for sanitation and hygiene. See Hygiene and Sanitation, Disinfection, and Maintenance, STANDARD 3.012 through STANDARD 3.040;
- o) Non-emergency transportation policies. See Transportation, STANDARD 2.029 through STANDARD 2.038;
- p) Presence and care of any pets or any other animals on the premises. See Animals,

- STANDARD 3.042 through STANDARD 3.044;
- q) Policy on health assessments and immunizations. See Daily Health Assessment, STANDARD 3.001 and STANDARD 3.002; Preventive Health Services, STANDARD 3.003 through STANDARD 3.004; and Immunizations, STANDARD 3.005 through STANDARD 3.007;
 - r) Policy regarding care of acutely ill children, including exclusion or dismissal from the facility. See Child Inclusion/Exclusion/Dismissal, STANDARD 3.065 through STANDARD 3.068; Caring for Ill Children, STANDARD 3.070 through STANDARD 3.080; and Plan for the Care of Acutely Ill Children, STANDARD 8.011 and STANDARD 8.012;
 - s) Policy on administration of medications. See Medications, STANDARD 3.081 through STANDARD 3.083; and Medication Policy, STANDARD 8.021;
 - t) Policy on use of child care health consultants. See STANDARD 1.040 through STANDARD 1.044;
 - u) Policy on health education. See STANDARD 2.060 through STANDARD 2.067.
 - v) Policy on smoking, tobacco use, and prohibited substances. See Smoking and Prohibited Substances, STANDARD 3.041 and Policy on Smoking, Tobacco Use, Prohibited Substances, and Firearms, STANDARD 8.038 and STANDARD 8.039;
 - w) Policy on confidentiality of records. See STANDARD 8.054.

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

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

COMMENTS: Parents are encouraged to interact with their own children and other children at drop-off and pick-up times and during visits at the center. Parents and caregivers, including volunteers, may have different approaches to routines than those followed

by the facility. Review of written policies and procedures by all adults prior to contact with the children in care helps ensure consistent implementation of carefully considered decisions about how care should be provided at the facility.

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

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

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

STANDARD 8.028 AUTHORIZED PERSONS TO PICK UP CHILD

Names, addresses, and telephone numbers of persons authorized to take a child under care out of the facility shall be maintained. The facility shall establish a mechanism for identifying a person for whom the parents have given the facility prior written authorization to pick up their child. Also, policies shall address how the facility will handle the situation if a parent arrives who is intoxicated or otherwise incapable of bringing the child home safely, or if a non-custodial parent attempts to claim the child without the consent of the custodial parent.

RATIONALE: Caregivers must not be unwitting accomplices in schemes to gain custody of children by accepting a telephone authorization provided falsely by a person claiming to be the child's custodial parent or claiming to be authorized by the parent to pick up the child.

COMMENTS: When a parent wants to authorize additional persons to pick up their child, documentation of this request should be kept in the child's file. The facility can use photo identification, photographs supplied by the parents or taken with a camera by the facility, as a mechanism for verifying the identification of a new person to whom the parents have given written authorization to pick up their child.

Child care providers should not attempt to handle on their own an unstable (for example, intoxicated) parent who wants to be admitted but whose behavior poses a risk to the children. Child care providers should consult local police or the local child protection agency about their recommendations for how staff can obtain support from law enforcement authorities to avoid incurring increased liability by releasing a child into an unsafe situation or by improperly refusing to release a child.

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

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

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

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

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

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

STANDARD 8.030 DOCUMENTATION OF DROP OFF AND PICK UP OF CHILD

Caregiving adults (parents and staff) who bring the child to or remove the child from the facility shall sign a roster with the names of the children noting the time of arrival and departure, and use an established mechanism to ensure that the caregiver accepting or relinquishing the care of the child is aware that the child is being dropped off or picked up.

RATIONALE: The keeping of accurate records of admission and release is of utmost importance to the caregiver in relation to establishing who is in the care of the facility at any one time. Accurate record keeping also aids in tracking the amount (and date) of service for reimbursement and for allows for documentation in the event of legal action involving the facility.

COMMENTS: Time clocks and cards can serve as verification, but they should be signed by the adult who drops off and picks up the child each day. Some notification system must be used to alert the caregiver whenever the responsibility for the care of the child is being transferred to or from the caregiver to another person.

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

STANDARD 8.077 PUBLIC POSTING OF DOCUMENTS

In a conspicuous place, centers and large family child care homes shall post the following items:

- a) The facility's license or registration (which also includes the telephone number for filing complaints with the regulatory agency), as specified in Licensing and Legal Records, STANDARD 8.065 through STANDARD 8.067;
- b) A statement informing parents/legal guardians about how they may obtain a copy of the

- licensing or registration requirements from the regulatory agency;
- c) Information on procedures for filing complaints with the regulatory authority. See Procedures for Complaints and Reporting, RECOMMENDATION 9.020 through RECOMMENDATION 9.022;
- d) Inspection and any accreditation certificates, as specified in Licensing and Legal Records, STANDARD 8.065 and STANDARD 8.066;
- e) Reports of any legal sanctions, as specified in Licensing and Legal Records, STANDARD 8.067;
- f) A notice that inspection reports, legal actions, and compliance letters are available for inspection in the facility;
- g) **Evacuation plan**, as specified in STANDARD 8.024 through STANDARD 8.027
- h) **Fire evacuation procedures**, to be posted in each room of the center;
- i) Procedures for the reporting of child abuse consistent with state law and local law enforcement and child protective service contacts;
- j) Notice announcing the "open-door policy" (that parents may visit at any time and will be admitted without delay) and the action the facility will take to handle a visitor's request for access if the caregiver is concerned about the safety of the children. See Written Statement of Services, STANDARD 8.045;
- k) A roster of the children in each facility room in child care centers, or a list of children in the facility in family child care homes that lists the names of all children who receive care in that room in the center or in the family child care home, the name of the caregiver primarily responsible for each child, and the names of children presently in attendance;
- l) A current weekly menu of any food or beverage served in the facility for parents and caregivers. The facility shall provide copies to parents, if requested. Copies of menus served shall be kept on file for 1 year. See also Food Service Records, STANDARD 8.074;
- m) A statement of nondiscrimination for programs participating in the United States Department of Agriculture (USDA) Child and Adult Care Food Program;
- n) A copy of the policy and procedures for discipline, including the prohibition of corporal punishment. This requirement also applies to school-age child care facilities. See also Discipline Policy, STANDARD 8.008 through STANDARD 8.010;
- o) Legible safety rules for the use of swimming and built-in wading pools if the facility has such pools. Safety rules shall be posted conspicuously on the pool enclosure. See also Safety Rules, STANDARD 5.215, and Water Safety, STANDARD 3.045 through STANDARD 3.047;
- p) **Phone numbers and instructions for contacting the fire department, police, emergency medical services, physicians, dentists, rescue and ambulance services, and the poison control center; the address of the facility; and directions to the facility from major routes north, south, east, and west.** This information shall be conspicuously posted adjacent to the telephone;
- q) A list of reportable communicable diseases as required by the state and local health authorities. See Reporting Illness, STANDARD 3.086 and STANDARD 3.087;
- r) Employee rights and safety standards as required by the Occupational Safety and Health Administration (OSHA) and/or state agencies.

RATIONALE: Each local and/or state regulatory agency gives official permission to certain persons to operate child care programs by virtue of their compliance with standards. Therefore, documents relating to investigations, inspections, and approval to operate should be made available to consumers, caregivers, concerned persons, and the community. Posting other documents listed in this standard increases access to parents over having the policies filed in a less accessible location.

Awareness of the child abuse reporting requirements and procedures is essential to the prevention of child abuse. State requirements may differ, but those for whom the reporting of child abuse is mandatory usually include child care personnel. Information on how to call and how to report should be readily available to parents and caregivers. Therefore, posting these instructions is necessary.

The open-door policy may be the single most important method for preventing the abuse of children in child care(15). When access is restricted, areas observable by the parents may not reflect the care the children actually receive.

Identification of primary caregiver responsibility helps identify responsibility for supervision and monitoring

of developmental progress of the child over time. In addition, primary caregiver assignments foster and channel meaningful communication between parents and caregivers. A posted roster also helps parents see how facility responsibility is assigned and know which children receive care in their child's group.

To ensure that children receive the minimum daily requirements of nutrients, parents need to know the daily menu provided by the facility.

Parents and caregivers must have a common basis of understanding about what disciplinary measures are to be used to avoid conflict and promote consistency in approach between caregivers and parents. Corporal punishment may be physical abuse or become very abusive easily.

Parents have a right to see any reports and notices of any legal actions taken against the facility that have been sustained by the court. Since unfounded suits may be filed, knowledge of which could undermine parent confidence, only actions that result in corrections or judgment needs to be made accessible.

The caregiver and parents need to know how an unstable (such as intoxicated) parent who wants admittance but whose behavior presents a risk to children will be handled.

Parents need to know what food and beverages their children receive while in child care. Menus filed should reflect last-minute changes so that parents and any nutrition consultant who reviews these documents can get an accurate picture of what was actually served.

Pool safety requires reminders to users of pool rules (5).

In an emergency, phone numbers must be immediately accessible.

COMMENTS: Compliance can be measured by looking for posted documents.

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

When it is possible to translate documents into the native language of the parents of children in care, it increases the level of communication between facility and parents.

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

PREPARE

Develop specific policies and procedures, train staff, and assemble supplies that you think you might need.

Applicable standards include:

EMERGENCY PROCEDURES

STANDARD 3.048 EMERGENCY PROCEDURES

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

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

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

COMMENTS: First aid instructions are provided by the American Academy of Pediatrics (AAP). Contact information for the AAP is located in Appendix BB.

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

STANDARD 3.049 WRITTEN PLAN FOR MEDICAL EMERGENCY

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

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

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

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

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

- a) American Academy of Pediatrics (AAP);
- b) American Nurses' Association (ANA);
- c) State and community nursing associations;
- d) National therapy associations;
- e) Local resource and referral agencies;
- f) Federally funded, University Centers for Excellence in Developmental Disabilities Education, Research, and Service, programs for individuals with developmental disabilities;

- g) Other colleges and universities with expertise in training others to work with children who have special needs;
- h) Community-based organizations serving people with disabilities (Easter Seals, American Diabetes Association, American Lung Association, etc.);
- i) Community sources of training in infant/child CPR (American Heart Association, American Red Cross, Emergency Medical Services for Children National Resource Center).

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

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

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

SUPERVISION

STANDARD 2.028 METHODS OF SUPERVISION

Caregivers shall directly supervise infants, toddlers, and preschool children by sight and hearing at all times, even when the children are in sleeping areas. Caregivers shall not be on one floor level of the building, while children are on another floor.

School-age children shall be permitted to participate in activities off the premises with written approval by a parent and by the caregiver.

Caregivers shall regularly count children on a scheduled basis, at every transition, and whenever leaving one area and arriving at another, to confirm the safe whereabouts of every child at all times.

Developmentally appropriate child:staff ratios shall be met during all hours of operation, including indoor and outdoor play and field trips, following precautions for specific areas and equipment. No center-based facility shall 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 shall be written policies.

RATIONALE: Supervision is basic to the prevention of harm. Parents have a contract with caregivers to supervise their children. To be available for supervision or rescue in an emergency, an adult must be able to hear and see the children. In case of fire, a supervising adult should not need to climb stairs or use a ramp or an elevator. These changes in elevation usually become unusable because they are the pathways for smoke.

Children who are presumed to be sleeping might be awake and in need of adult attention. Risk-taking behavior must be detected; and illness, fear, or other stressful behavior must be managed.

Children like to test their skills and abilities. This is particularly noticeable around playground equipment. Even if the highest safety standards for playground layout, design and surfacing are met, serious injuries can happen if children are left unsupervised. Adults who are involved, aware, and appreciative of young children's behaviors are in the best position to safeguard their well-being. Active and positive supervision involves:

- a) Knowing each child's abilities;
- b) Establishing clear and simple safety rules;
- c) Being aware of potential safety hazards;
- d) Standing in a strategic position;
- e) Scanning play activities and circulating;
- f) Focusing on the positive rather than the negative to teach a child what is safe for the child and other children.

Children should be protected against sexual abuse by limiting situations in which a caregiver, other adult, or an older child is left alone with a child in care without another adult present. See STANDARD 3.059, for additional information regarding safe physical layouts for child care facilities.

Many instances have been reported where a child has hidden when the group was moving to another location, or where the child wandered off when a door was opened for another purpose. Regular counting of children will alert the staff to begin a search before the child gets too far or into trouble. Counting children routinely is without substitute in assuring that a child has not slipped into an unobserved location.

COMMENTS: Caregivers should record the count on an attendance sheet or on a pocket card, along with notations of any children joining or leaving the group. Caregivers should do the counts before the group leaves an area and when the group enters a new area. The facility should assign and reassign counting responsibility as needed to maintain a counting routine. Facilities might consider counting systems such as using a reminder tone on a watch or musical clock that sounds at timed intervals (about every 15 minutes) to help the staff remember to count.

Older preschool children and school-age children may use toilet facilities without direct visual observation.

The staff should assess the setting to ascertain how the ability to see and hear child activities might be improved. The use of devices such as convex mirrors to assure visibility around corners, and baby monitors for older preschool and school-age children, who use the toilet by themselves, may be considered. Facilities might also consider the use of surveillance devices or systems placed strategically in areas where they might contribute further to child safety. In addition, these systems are beneficial because they can allow parents to observe the facility; and caregivers can use them as support in the event of an accusation of abuse.

Planning must include advance assignments to maintain appropriate staffing. Sufficient staff must be maintained to evacuate the children safely in case of emergency. Compliance with proper child:staff ratios should be measured by structured observation, by counting caregivers and children in each group at varied times of the day, and by reviewing written policies.

For additional information on supervision, see STANDARD 5.117, on children using toilet learning/training equipment.

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

STANDARD 3.045 SUPERVISION NEAR BODIES OF WATER

Children shall not be permitted to play without constant supervision in areas where there is any body of water, including swimming pools, built-in wading pools, tubs, pails, sinks, or toilets, ponds and irrigation ditches.

Children who need assistance with toileting shall not be allowed in toilet or bathroom facilities without direct visual supervision. Children less than 5 years of age shall not be left unattended in a bathtub or shower.

RATIONALE: Small children can drown within 30 seconds, in as little as 2 inches of liquid (30).

In a comprehensive study of drowning and submersion incidents involving children under 5 years of age in Arizona, California, and Florida, the U.S. Consumer Product Safety Commission found that:

- a) Submersion incidents involving children usually happen in familiar surroundings;
- b) Pool submersions involving children happen quickly. Seventy-seven percent of the victims had been missing from sight for 5 minutes or less;
- c) Child drowning is a silent death. Splashing may not occur to alert someone that the child is in trouble.

Each year, approximately 1,500 children under age 20 drown. A national study that examines where drowning most commonly take place concluded that infants are most likely to drown in bathtubs, toddlers are most likely to drown in swimming pools, and older children and adolescents are most likely to drown in freshwater (rivers, lakes, ponds). Researchers from the National Institute of Child Health and Human Development, Johns Hopkins University School of Public Health, the U.S. Consumer Product Safety Commission and the

Maternal and Child Health Bureau reviewed more than 1,400 death certificates from 1995. All of the death certificates were for children under 20 years of age who drowned.

While swimming pools pose the greatest risk for toddlers, about one-quarter of drowning among toddlers are in other freshwater sites, such as ponds or lakes. Researchers found that after the age of 10, the risk of drowning in a swimming pool was up to 15 times greater among black males as compared with white males. The reason for this increased risk is unknown. One explanation offered by the study's authors was that the public pools in which black teens swim might be less safe, with fewer lifeguards and more crowded conditions. Or the increased risk could be attributed to a difference in swimming ability, resulting from fewer opportunities for black males to participate in swimming lessons. The study authors conclude that there is a need for multifaceted approach to drowning prevention.

The American Academy of Pediatrics recommends:

- Swimming lessons for all children over the age of 5;
- Constant supervision of infants and young children when they are in the bathtub or around other bodies of water;
- Installation of fencing that separates homes from residential pools;
- Use of personal flotation devices when riding on a boat or playing near a river, lake or ocean;
- Teaching children never to swim alone or without adult supervision;
- Teaching children the dangers of drug and alcohol consumption during aquatic activities;
- Stressing the need for parents and teens to learn cardiopulmonary resuscitation (74).

Deaths and nonfatal injuries have been associated with baby bathtub "supporting ring" devices that are supposed to keep a baby safe in the tub. These rings usually contain three or four legs with suction cups that attach to the bottom of the tub. The suction cups, however, may release suddenly, allowing the bath ring and baby to tip over. A baby also may slip between the legs of the bath ring and become trapped under it. Caregivers must not rely on these devices to keep a baby safe in the bath and must never leave a baby alone in these bath support rings (33, 34).

An estimated 50 infants and toddlers drown each year in buckets containing liquid used for mopping floors and other household chores. Of all buckets, the 5-gallon size presents the greatest hazard to young children because of its tall straight sides and its weight with even just a small amount of liquid. It is nearly impossible for top-heavy infants and toddlers to free themselves when they fall into a 5-gallon bucket head first (31).

The Centers for Disease Control (CDC)-National Center for Injury Prevention and Control recommends that whenever young children are swimming, playing, or bathing in water, an adult should be watching them constantly. The supervising adult should not read, play cards, talk on the telephone, mow the lawn, or do any other distracting activity while watching children (32).

COMMENTS: Flotation devices should never be used as a substitute for supervision. Knowing how to swim does not make a child drown-proof.

The need for constant supervision is of particular concern in dealing with very young children and children with significant motor dysfunction or mental retardation.

See STANDARD 1.005, for information regarding supervision and child:staff ratios during wading and swimming activities. See also Safety Rules for Swimming/Wading Pools, STANDARD 5.215. For fencing water hazards, see STANDARD 5.198.

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

EQUIPMENT AND SUPPLIES

STANDARD 5.084 AVAILABILITY OF A TELEPHONE

The facility shall provide at least one working non-pay telephone for general and emergency use.

RATIONALE: A telephone must be available to all caregivers in an emergency.

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

STANDARD 5.093 FIRST AID KITS

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

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

RATIONALE: Facilities must place emphasis on safeguarding each child and ensuring that the staff members are able to handle emergencies. In a study that reviewed 423 injuries, first aid was sufficient treatment for 84.4% of the injuries (22). The supplies needed for pediatric first aid, including rescue breathing and management of a blocked airway must be available for use where the injury occurs.

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

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

STANDARD 2.038 EMERGENCY SUPPLIES FOR FIELD TRIPS

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

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

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

STANDARD 5.237 EMERGENCY EQUIPMENT AND INFORMATION DURING TRANSPORT

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

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

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

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

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

STANDARD 8.047 PRE-ADMISSION ENROLLMENT INFORMATION FOR EACH CHILD

The file for each child shall include the following pre-admission enrollment information:

- a) The child's name, address, sex, and date of birth;
- b) The full names of the child's parents or legal guardians, and their home and work addresses and telephone numbers. Telephone contact numbers shall be confirmed by a call placed to the contact number during the facility's hours of operation. Names, addresses, and telephone numbers shall be updated at least quarterly;
- c) The names, addresses, and telephone numbers of at least two additional persons to be notified in the event that the parents or legal guardians cannot be located. Telephone information shall be confirmed and updated as specified in item b above;
- d) The names and telephone numbers of the child's primary sources of medical care, emergency medical care, and dental care;
- e) The child's health payment resource;
- f) Written instructions of the parent, legal guardian, and the child's health care provider for any special dietary needs or special needs

- due to a health condition; or any other special instructions from the parent;
- g) Scheduled days and hours of attendance;
 - h) In the event that one parent is the sole legal guardian of the child, legal documentation evidencing his/her authority;
 - i) Enrollment date, reason for entry in child care, and fee arrangements;
 - j) Signed permission to act on parent's behalf for emergency treatment and for use of syrup of ipecac, if medically indicated. See STANDARD 3.050;
 - k) Authorization to release child to anyone other than the custodial parent. See Authorized Caregivers, STANDARD 8.028 through STANDARD 8.030.

The emergency information in items a through e above shall be obtained in duplicate with original parent/legal guardian signatures on both copies. One copy shall be in the child's confidential record and one copy shall be easily accessible at all times. This information shall be updated quarterly and as necessary. A copy of the emergency information must accompany the child to all offsite excursions.

RATIONALE: These records and reports are necessary to protect the health and safety of children in care. An organized, comprehensive approach to injury prevention and control is necessary to ensure that a safe environment is provided for children in child care. Such an approach requires written plans, policies, procedures, and record-keeping so that there is consistency over time and across staff and an understanding between parents and caregivers about concerns for, and attention to, the safety of children.

Emergency information is the key to obtaining needed care in emergency situations (37). Caregivers must have written parental permission to allow them access to information they and Emergency Medical Services personnel may need to care for the child in an emergency (37). Contact information must be verified for accuracy. See Appendix X, for the *Emergency Information Form for Children with Special Needs*, developed by the American Academy of Pediatrics (AAP), the American College of Emergency Physicians (ACEP) and the Emergency Medical Services for Children National Resource Center (EMSC). Contact information for the AAP, ACEP and EMSC is located in Appendix BB.

Health payment resource information is usually required before any non-life-threatening emergency care is provided.

COMMENTS: Duplicate records are easily made using multiple-copy forms, carbon paper, or photocopying.

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

STANDARD 8.058 MAINTENANCE AND CONTENT OF STAFF RECORDS

Individual files for all staff members and volunteers, shall be maintained in a central location within the facility and shall contain the following:

- a) The individual's name, birth date, address, and telephone number;
- b) The position application, which includes a record of work experience and work references; verification of reference information, education, and training; and records of any checking for driving records, criminal records and/or listing in child abuse registry. See Individual Licensure/Certification, STANDARD 1.006, and Training, STANDARD 1.023 through STANDARD 1.039;
- c) The health assessment record, a copy of which, having been dated and signed by the employee's health care provider, shall be kept in a confidential file in the facility. This record shall be updated by another health appraisal when recommended by the staff member's health care provider or supervisory or regulatory/certifying personnel (36). See Staff Health Appraisals, STANDARD 1.045 and STANDARD 1.046;
- d) The name and telephone number of the person, physician, or health facility to be notified in case of emergency;**
- e) The job description or the job expectations for staff and substitutes. See General Qualifications for All Caregivers, STANDARD 1.007 through STANDARD 1.013;
- f) Required licenses, certificates, and transcripts. See Individual Licensure/Certification, STANDARD 1.006;
- g) The date of employment or volunteer assignment;

- h) A signed statement of agreement that the employee understands and will abide by the following:
- 1) Regulations and statutes governing child care;
 - 2) Personnel policies and procedures. See Personnel Policies, STANDARD 8.044;
 - 3) Health Policies and Procedures. See Management and Health Policies and Statement of Services, STANDARD 8.004 and STANDARD 8.005;
 - 4) Discipline policy. See Discipline Policy, STANDARD 8.008 through STANDARD 8.010; and Discipline, STANDARD 2.039 through STANDARD 2.043;
 - 5) Guidelines for reporting suspected child abuse, neglect, and sexual abuse;
 - 6) Confidentiality policy. See STANDARD 8.054.
- i) The date and content of staff and volunteer orientation(s);
- j) A daily record of hours worked, including paid planning time and parent conference time;
- k) A record of continuing education for each staff member and volunteer. See Continuing Education, STANDARD 1.029 through STANDARD 1.033;
- l) Written performance evaluations. See Performance Evaluation, STANDARD 1.051 through STANDARD 1.057.

RATIONALE: Complete identification of staff, paid or volunteer, is an essential step in safeguarding children in child care. Maintaining complete records on each staff person employed at the facility is a sound administrative practice. Employment history, a daily record of days worked, performance evaluations, a record of benefits, and whom to notify in case of emergency provide important information for the employer. Licensors will check the records to assure that applicable licensing requirements are met (such as identifying information, educational qualifications, health assessment on file, record of continuing education, signed statement of agreement to observe the discipline policy, and guidelines for reporting suspected child abuse, neglect, and sexual abuse).

Emergency contact information for staff, paid or volunteer, is needed in child care in the event that an adult becomes ill or injured at the facility.

The signature of the employee confirms the employee's notification of responsibilities that might otherwise be overlooked by the employee.

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

STANDARD 5.053 SMOKE DETECTION SYSTEMS

In centers with new installations, a smoke detection system (such as hard-wired system detectors with control panel) shall be installed with placement of the smoke detectors in the following areas:

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

In large and small family child care homes, smoke alarms that receive their operating power from the building electrical system shall be installed. Battery-operated smoke alarms shall 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 that retrofitting the facility to connect the smoke alarms to the electrical system would be costly and difficult to achieve.

RATIONALE: Because of the large number of children at risk in a center, up-to-date smoke detection system technology is needed. In large and small family child care homes, single-station smoke alarms are acceptable. However, for all new building installations where access to enable necessary wiring is available, smoke alarms should be used that receive their power from the building's electrical system. The hard-wired smoke detectors should be interconnected so that occupants receive instantaneous alarms throughout the facility, not just in the room of origin. Batteries are not reliable enough; battery-operated smoke alarms should be accepted only where connecting smoke detectors to existing wiring would be too difficult and expensive as a retrofitted arrangement.

COMMENTS: Some state and local building codes specify the installation and maintenance of smoke detectors and fire alarm systems. For specific information, see the *NFPA-101 Life Safety Code* and the

NFPA 72 National Fire Alarm Code from the National Fire Protection Association and from the Building Officials and Code Administrators International (BOCA). Contact information is located in Appendix BB.

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

STANDARD 5.054 FIRE EXTINGUISHERS

Fire extinguisher(s) shall be installed and maintained. The fire extinguisher shall be of the A-B-C type. Size and number of fire extinguishers shall be determined after a survey by the fire marshal or by an insurance company fire loss prevention representative. Instructions for the use of the fire extinguisher shall be posted on or near the fire extinguisher.

RATIONALE: All fire extinguishers are labeled, using standard symbols, for the classes of fires on which they can be used. A red slash through any of the symbols tells you the extinguisher cannot be used on that class of fire. Class A designates ordinary combustibles such as wood, cloth, and paper. Class B designates flammable liquids such as gasoline, oil, and oil-based paint. Class C designates energized electrical equipment, including wiring, fuse boxes, circuit breakers, machinery and appliances

COMMENTS: Staff should be trained that the first priority is to remove the children from the facility safely and quickly. Fighting a fire is secondary to the safe exit of the children and staff.

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

STANDARD 3.051 USE OF FIRE EXTINGUISHERS

The staff shall demonstrate the ability to locate and operate the Fire extinguishers.

RATIONALE: A fire extinguisher may be used to put out a small fire or to clear an escape path. (3).

COMMENTS: Staff should be trained that the first priority is to remove the children from the facility safely and quickly. Fighting a fire is secondary to the safe exit of the children and staff.

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

STANDARD 4.058 SUPPLY OF FOOD AND WATER FOR DISASTERS

In areas where natural disasters (such as earthquakes) occur, a 48 hour supply of food and water shall be kept in stock for each child and staff member (8).

RATIONALE: It may take as long as 48 hours for help to arrive in some areas after a natural disaster of great magnitude.

COMMENTS: A child care facility should consult with their local health authority or local emergency preparedness agency for more information on disaster preparedness.

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

STANDARD 5.063 EMERGENCY SAFE DRINKING WATER AND BOTTLED WATER

Emergency safe drinking water shall be supplied during interruption of the regular approved water supply. Bottled water shall be certified as chemically and bacteriologically potable by the health department or its designee.

RATIONALE: Children must have constant access to fresh, potable water if the regular approved supply of drinking water is temporarily interrupted.

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

FIRST AID/EMERGENCY TRAINING

STANDARD 1.026 FIRST AID TRAINING FOR STAFF

The director of a center and a large family child care home and the caregiver in a small family child care home shall ensure that all staff members involved in providing direct care have training in pediatric first aid, including management of a blocked airway and rescue breathing, as specified in STANDARD 1.027.

At least one staff person who has successfully completed training in pediatric first aid, as specified in STANDARD 1.027, shall be in attendance at all times and in all places where children are in care. Instances in which at least one staff member shall be certified in CPR include when children are involved in swimming and wading and when at least one child is known to have a specific special health need as determined by that child's physician (such as cardiac arrhythmia) that makes the child more likely than a typical child to require cardiac resuscitation. In each case of a child with a special health need, the child care provider shall ask the child's physician whether caregivers with skills in the management of a blocked airway and rescue breathing will suffice, or whether caregivers require skills in cardiac resuscitation to meet the particular health needs of the child. Records of successful completion of training in pediatric first aid, as specified in STANDARD 1.027, shall be maintained in the files of the facility.

RATIONALE: To ensure the health and safety of children in a child care setting, someone who is qualified to respond to common life-threatening emergencies must be in attendance at all times. A staff trained in pediatric first aid, including management of a blocked airway and rescue breathing, coupled with a facility that has been designed or modified to ensure the safety of children, can mitigate the consequences of injury and reduce the potential for death from life-threatening conditions. Knowledge of pediatric first

aid, including management of a blocked airway and rescue breathing, and the confidence to use these skills, are critically important to the outcome of an emergency situation.

The need for cardiac resuscitation is rare. Children who have specific cardiac problems, such as cardiac arrhythmia, or children who are drowning in cold water, require cardiac resuscitation. Except in these two instances, cessation of cardiac function does not occur until respiratory failure causes irreversible and devastating brain damage. Therefore, except in these two instances, caregivers require respiratory resuscitation skills, not CPR skills.

Small family child care home providers often work alone and are solely responsible for the health and safety of children in care. They must have the necessary skills to manage any emergency while caring for all the children in the group.

In a study of incidence of injuries in centers, first aid was sufficient treatment for the majority of incidents (24.). In a survey of over 2,000 child care programs in North Carolina, 16% had used first aid for choking, 2.3% had used rescue breathing, and only 1% had used CPR during the preceding 36 months of the survey. The authors of this report felt that maintaining CPR training and certification was difficult and probably not cost-effective (29). Minor injuries are common. For emergency situations that require attention from a health professional, first aid procedures can be taken to control the situation until a medical professional can provide definitive care.

Documentation of current certification in the facility assists in implementing and in monitoring for proof of compliance.

COMMENTS: Preparation of the first edition of this document included an extensive discussion of whether the staff should have cardiac resuscitation skills for children.

Many people use the term "CPR" as shorthand for resuscitation and rescue skills. In discussions with the American Academy of Pediatrics' liaison to the American Heart Association pediatric resuscitation committee, this issue was discussed again during the

preparation of this edition of the Standards, with the same conclusion related to limited circumstances where CPR training should be required. Ongoing education about the difference between training in pediatric first aid that includes management of a blocked airway and rescue breathing and training in CPR will be necessary because of the public's familiarity with and use of the term "CPR."

CPR training for cardiac resuscitation involves specific courses focused on pulmonary and cardiac resuscitation, not first aid for other, more common injuries. Evaluations of retention of the techniques taught in CPR courses reportedly reveals poor recall within months after completion. The time and other resources required to provide pediatric CPR training could be better spent on learning first aid, including management of a blocked airway and rescue breathing, and other types of training. CPR training for management of adult cardiac emergencies is valuable and appropriate as a staff and community health goal, but as described above, such training is not a standard of practice for routine child care.

For each child with a special health need, the child care health form should have a check-off box or a request for notification about whether caregivers with skills in management of a blocked airway and rescue breathing will suffice, or does the child have a greater risk than a typical child to require cardiac resuscitation. This proactive approach will alert the child's clinician to consider the need for caregivers to acquire cardiac resuscitation skills on a case-by-case basis. If the child's clinician indicates that the child's condition might require that caregivers provide cardiac resuscitation, CPR training should be required for staff who care for the child. Instead of CPR training for all staff in child care, this focused approach is more likely to insure the safety of the few children for whom CPR might be required.

For additional information on first aid and CPR, see STANDARD 2.027, on pediatric first aid training requirements; STANDARD 1.028, which requires staff to have CPR training for activities involving swimming or wading; and RECOMMENDATION 9.038 through RECOMMENDATION 9.040, on state and local training and technical assistance.

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

STANDARD 1.027 TOPICS COVERED IN FIRST AID TRAINING

Management of a blocked airway and rescue breathing comprise two of the core elements of pediatric first aid training. In addition, the course must present an overview of the Emergency Medical Services (EMS), accessing EMS, safety at the scene, and isolation of body substances, and the first aid instruction that is offered shall include, but not be limited to, recognition and first response of pediatric emergency management in a child care setting of the following situations:

- a) Abrasions and lacerations;
- b) Bleeding, including nosebleeds;
- c) Burns;
- d) Fainting;
- e) Poisoning, including swallowed, contact, and inhaled;
- f) Puncture wounds, including splinters;
- g) Injuries, including insect, animal, and human bites;
- h) Shock;
- i) Convulsions or nonconvulsive seizures;
- j) Musculoskeletal injury (such as sprains, fractures);
- k) Dental and mouth injuries;
- l) Head injuries;
- m) Allergic reactions, including information about when auto-injected epinephrine might be required;
- n) Eye injuries;
- o) Loss of consciousness;
- p) Electric shock;
- q) Drowning;
- r) Heat-related injuries, including heat exhaustion/heat stroke;
- s) Cold injuries;
- t) Moving and positioning injured/ill persons;
- u) Management of a blocked airway and rescue breathing for infants and children with return demonstration by the learner;
- v) Illness-related emergencies (such as stiff neck, inexplicable confusion, sudden onset of blood-red or purple rash, severe pain, temperature of 105 degrees F or higher, or looking/acting severely ill);

- w) Standard Precautions;
- x) Organizing and implementing a plan to meet an emergency for any child with a special health care need;
- y) Addressing the needs of the other children in the group while managing emergencies in a child care setting.

RATIONALE: First aid for children in the child care setting requires a more child-specific approach than standard adult-oriented first aid offers. To ensure the health and safety of children in a child care setting, someone who is qualified to respond to common injuries and life-threatening emergencies must be in attendance at all times. A staff trained in pediatric first aid, including management of a blocked airway and rescue breathing, coupled with a facility that has been designed or modified to ensure the safety of children, can reduce the potential for death and disability. Knowledge of pediatric first aid, including management of a blocked airway and rescue breathing, and the confidence to use these skills, are critically important to the outcome of an emergency situation.

Small family child care home providers often work alone and are solely responsible for the health and safety of children in care. Such providers must have pediatric first aid competence.

COMMENTS: Usually, other children will have to be supervised while the injury is managed. Parental notification and communication with emergency medical services must be carefully planned. First aid information can be obtained from the American Academy of Pediatrics (AAP) and the American Heart Association (AHA). Contact information for the AAP and the AHA is located in Appendix BB.

For discussion of the need for training in CPR, see STANDARD I.026.

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

STANDARD I.028 CPR TRAINING FOR SWIMMING AND WADING

Facilities that have a swimming pool or use a water-filled wading pool shall require that at least one staff member with current documentation of successful completion of training in infant and child (pediatric) CPR (Cardiopulmonary Resuscitation) shall be on duty at all times during business hours.

At least one of the caregivers, volunteers, or other adults who is counted in the child:staff ratio for wading and swimming shall have documentation of successful completion of training in basic water safety and infant and child CPR according to the criteria of the American Red Cross or the American Heart Association.

For small family child care homes, the person trained in water safety and CPR shall be the caregiver. Written verification of successful completion of CPR and lifesaving training, water safety instructions, and emergency procedures shall be kept on file.

RATIONALE: Drowning involves cessation of breathing and rarely requires cardiac resuscitation of salvageable victims. Nevertheless, because of the increased risk for cardiopulmonary arrest related to wading and swimming, the facility should have personnel trained to provide CPR and to deal promptly with a life-threatening drowning emergency. During drowning, cold exposure provides the possibility of protection of the brain from irreversible damage associated with respiratory and cardiac arrest. Children drown in as little as 2 inches of water. The difference between a life and death situation is the submersion time. Thirty seconds can make a difference. The timely administration of resuscitation efforts by a care-giver trained in water safety and CPR is critical. Studies have shown that prompt rescue and the presence of a trained resuscitator at the site can save about 30% of the victims without significant neurological consequences.

COMMENTS: See also Safety Rules for Swimming/Wading Pools, STANDARD 5.215; and Water Safety, STANDARD 3.045 through STANDARD 3.047. For information on the child:staff ratio for wading and swimming, see STANDARD I.005.

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

STANDARD 1.009 PRESERVICE AND ONGOING STAFF TRAINING

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

Small family child care home providers shall provide documentation of at least 12 hours of training in child development and health management for out-of-home child care facilities prior to initiating operation.

All directors and caregivers shall document receipt of training that revisits the following topics every 3 years:

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

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

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

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

Training in infectious disease control and injury prevention is strongly recommended. This type of training may be obtained from qualified personnel of children's and community hospitals, managed care companies, health agencies, public health departments, pediatric emergency room physicians, or other health professionals in the community.

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

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

EVACUATION/EXITS

STANDARD 5.014 POSSIBILITY OF EXIT FROM WINDOWS

All windows in areas used by children under 5 years of age shall be constructed, adapted, or adjusted to limit the exit opening accessible to children to less than 3.5 inches, or be otherwise protected with guards that prevent exit by a child, but that do not block outdoor light. Where such windows are required by building or fire codes to provide for emergency rescue and escape, the windows and guards, if provided, shall be equipped to enable staff to release the guard and open the window fully when escape or rescue is required. Such release shall not require the use of tools or keys.

RATIONALE: This standard is needed to prevent children from falling out of windows. Standards from the U.S. Consumer Product Safety Commission (CPSC) and the American Society for Testing and Materials (ASTM) require the opening size to be 3.5 inches to prevent the child from getting through or the head from being entrapped. Some children may be able to pass their body through a slightly larger opening but then get stuck and hang from the window

opening with their head trapped inside. Caregivers must not depend on screens to keep children from falling out of windows. Windows to be used as fire exits must be immediately accessible.

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

STANDARD 5.020 ALTERNATE EXITS AND EMERGENCY SHELTER

Each building or structure, new or old, shall be provided with a minimum of two exits, at different sides of the building or home, leading to an open space at ground level. If the basement in a small family child care home is being used, one exit must lead directly to the outside. Exits shall be unobstructed, allowing occupants to escape to an outside door or exit stair enclosure in case of fire or other emergency. Each floor above or below ground level used for child care shall have at least two unobstructed exits that lead to an open area at ground level and thereafter to an area that meets safety requirements for a child care indoor or outdoor area where children may remain until their parents can pick them up, if reentry into the facility is not possible.

Entrance and exit routes shall be reviewed and approved by the applicable fire inspector. Exiting shall meet all the requirements of the current edition of the *NFPA-101 Life Safety Code* from the National Fire Protection Association (NFPA).

RATIONALE: Unobstructed exit routes are essential for prompt evacuation. The purpose of having two ways to exit when child care is provided on a floor above or below ground level is to ensure an alternative exit if fire blocks one exit.

COMMENTS: Using an outdoor playground as a safe place to exit to may not always be possible. Some child care facilities do not have a playground located adjacent to the child care building and use local parks as the playground site. Access to these parks may require crossing a street at an intersection with a crosswalk. This would normally be considered safe, especially in areas of low traffic; however, when sirens

go off, a route that otherwise may be considered safe becomes chaotic and dangerous. During evacuation or an emergency, children, as well as staff, become excited and may run into the street when the playground is not fenced and immediately adjacent to the center.

In the event of a fire, staff members and children should be able to get at least 50 feet away from the building or structure. If the children cannot return to their usual building, a suitable shelter containing all items necessary for child care must be available where the children can safely remain until their parents come for them. An evacuation plan should take into consideration all available open areas to which staff and children can safely retreat in an emergency.

For information about the *NFPA-101 Life Safety Code*, contact the National Fire Protection Association. Contact information is located in Appendix BB.

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

STANDARD 5.021 EVACUATION OF CHILDREN WITH DISABILITIES

In facilities that include children who have physical disabilities, all exits and steps necessary for evacuation shall have ramps approved by the local building inspector. Children who have ambulatory difficulty, use wheelchairs or other equipment that must be transported with the child (such as an oxygen ventilator) shall be located on the ground floor of the facility or provisions shall be made for efficient emergency evacuation to a safe sheltered area.

RATIONALE: The facility must meet building code standards for the community and also the requirements under the Americans with Disabilities Act (ADA) and their access guidelines. All children must be able to exit the building quickly in case of emergency. Locating children in wheelchairs or those with special equipment on the ground floor may eliminate the need for transporting these children down the stairs during an emergency exit. In buildings

where the ground floor cannot be used for such children, arrangements must be made to remove them to a safe location, such as a fire tower stairwell, during an emergency exit.

COMMENTS: Assuring physical access to a facility also requires that a means of evacuation meeting safety standards for exit accommodates any special needs of the children in care.

For additional information on additional access requirements, see STANDARD 5.004 and STANDARD 5.008.

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

STANDARD 5.023 LOCKS

The facility shall have no lock or fastening device that prevents free escape from the interior. All door hardware in areas that school-age children use shall be within the reach of the children. In centers, only panic hardware (hardware that can be opened by pressure in the direction of travel) or single-action hardware (hardware that allows a door to open either way but keeps it from swinging back past the center point) shall be permitted on exterior doors.

A double-cylinder deadbolt lock which requires a key to unlock from the inside shall not be permitted on any door along the path of egress from any child care area of a large or small family child care home except the exterior door, and then only if the lock is of a key-capturing type and the key is kept hanging near the door.

If emergency exits lead to potentially unsafe areas for children (such as a busy street), alarms or other signaling devices shall be installed on these exit doors to alert the staff in case a child attempts to leave.

RATIONALE: Children, as well as staff members, must be able to evacuate a building in the event of a fire or other emergency. Nevertheless, the child care

provider must assure security from intruders and from unsupervised use of the exit by children.

COMMENTS: Double cylinder deadbolt locks that require a key to unlock the door from the inside are often installed in private homes for added security. In such situations, these dead bolt locks should be present only on exterior doors and should be left in the unlocked position during the hours of child care operation. Locks that prevent opening from the outside, but can be opened without a key from the inside should be used for security during hours of child care operation. Double cylinder deadbolt locks should not be used on interior doors, such as closets, bathrooms, storage rooms, and bedrooms.

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

STANDARD 5.024 LABELED EMERGENCY EXITS

Emergency exits shall be clearly identified and visible at all times during operation of the child care facility. The exits for escape shall be arranged or marked so the path to safety outside is unmistakable.

RATIONALE: As soon as children can learn to recognize exit signs and pathway markings, they will benefit from having these paths of escape clearly marked. Adults who come into the building as visitors need these markings to direct them as well.

TYPE OF FACILITY: *Center*

STANDARD 5.025 ACCESS TO EXITS

An exit to the outside or a common hallway leading to the outside shall be directly accessible from any room. If it is necessary to pass through another room for direct access to the outside, the other room shall not have a barrier or door that can be latched to prevent access through it.

No obstructions shall be placed in the corridors or passageways leading to the exits.

RATIONALE: A room that requires exit through another room to get to an exit path can entrap its occupants when there is a fire or emergency condition if passage can be impeded by a barrier or door that is latched.

An obstruction in the path of exit can lead to entrapment, especially in an emergency situation where groups of people may be exiting together.

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

STANDARD 2.031 ROUTE TO EMERGENCY MEDICAL FACILITY

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

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

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

SPECIAL MEDICAL CONDITIONS

STANDARD 3.060 SEIZURE CARE PLAN

The child care facility shall have a seizure care plan and ensure that all caregivers receive training to successfully implement the plan. If a child in care has epilepsy or a history of febrile seizures that are not considered a form of epilepsy, the child's seizure care plan shall include the following:

- a) Types of seizures the child has (such as partial, generalized, or unclassified), as well as a

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

RATIONALE: A child that has a seizure may not have epilepsy or even a history of seizures. Child care providers should be trained to care for any child who has a seizure. For children with epilepsy, the child care staff should have detailed information and skills to understand the child's health needs and how to meet these needs in the child care setting. Seizures are usually self-limited events. Prolonged seizures, sequential seizures without recovery to a normal status, or remaining unresponsive for 20 minutes after a seizure suggests that the child is in status epilepticus and requires emergency care. The staff must respond

appropriately to self-limited seizures and situations that require emergency help.

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

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

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

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

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

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

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

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

STANDARD 3.061 TRAINING FOR STAFF TO HANDLE SEIZURES

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

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

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

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

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

Changes in health and behavior that may result from medication should be reported to the parent in the parent's native language and with sensitivity to the parent's ethnic and cultural practices. With written parental consent, the caregiver may also share this information with the child's primary health care provider. Useful references concerning seizures and side effects of medications used to control seizures, particularly if a child begins a new medicine while attending the facility, include the following:

a) The child's parent;

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

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

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

STANDARD 3.062 MANAGEMENT OF CHILDREN WITH ASTHMA

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

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

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

RATIONALE: Asthma is common, occurring in 7%-10% of all preschool and school-aged children. Asthma is a major cause of morbidity in childhood, resulting in sleep disturbance, limitations in exercise, absenteeism from child care and school, and hospitalization. Despite increased awareness and knowledge of the problem, asthma remains underdiagnosed and undertreated. Proper diagnosis, treatment, and prevention of exposure to environmental triggers can lessen complications and improve long term outcome. (4)

Respiratory infections are the primary trigger of asthma (especially of severe episodes) in the young child. Because respiratory infections and asthma are common in early childhood, child care providers should expect to serve children with asthma.

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

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

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

COMMENTS: Asthma is a chronic lung disease caused by an oversensitivity of the bronchial tubes to various stimuli or "triggers." In asthma, the lining of the tubes becomes inflamed and swollen and extra mucus is produced. Muscles surrounding the airways tighten so that the air passages become narrower. Typical symptoms of asthma include coughing,

wheezing, tightness in chest, and shortness of breath. The symptoms of asthma can occur together or alone. Often, the only symptom of asthma is chronic or recurrent cough, particularly while sleeping, during activity, or with colds. Asthma is not the only condition that can cause these symptoms but is certainly the most common.

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

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

Notify parents if any one of the following is present (1):

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

Notify physician/emergency services if any one of the following occurs (1):

- a) Child is struggling to breathe, hunches over, or sucks in chest and neck muscles in an attempt to breathe;
- b) Child is having difficulty walking or talking because of shortness of breath;

- c) Peak flow is less than 50% of normal;
- d) Lips or fingernails turn gray or blue.

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

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

STANDARD 4.010 CARE FOR CHILDREN WITH FOOD ALLERGIES

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

- a) Each child with a food allergy shall have a special care plan prepared for the facility by the child's source of health care, to include:
 - 1) Written instructions regarding the food(s) to which the child is allergic and steps that need to be taken to avoid that food;
 - 2) A detailed treatment plan to be implemented in the event of an allergic reaction, including the names, doses, and methods of administration of any medications that the child should receive in the event of a reaction. The plan shall include specific symptoms that would indicate the need to administer one or more medications;
- b) Based on the child's special care plan, the child's caregivers shall receive training, demonstrate competence in, and implement measures for:
 - 1) Preventing exposure to the specific food(s) to which the child is allergic;
 - 2) Recognizing the symptoms of an allergic reaction;
 - 3) Treating allergic reactions;
- c) Parents and staff shall arrange for the facility to have necessary medications, proper storage of such medications, and the equipment and training to manage the child's food allergy while the child is at the child care facility;

- d) Caregivers shall promptly and properly administer prescribed medications in the event of an allergic reaction according to the instructions in the special care plan;
- e) The facility shall notify the parents of any suspected allergic reactions, the ingestion of the problem food, or contact with the problem food, even if a reaction did not occur;
- f) The facility shall notify the child's physician if the child has required treatment by the facility for a food allergic reaction;
- g) The facility shall contact the emergency medical services system immediately whenever epinephrine has been administered;
- h) Parents of all children in the child's class shall be advised to avoid any known allergies in class treats or special foods brought into the child care setting.
- i) Individual child's food allergies shall be posted prominently in the classroom and/or wherever food is served.
- j) On field trips or transport out of the child care setting, the written child care plan for the child with allergies shall be routinely carried.

RATIONALE: Food allergy is common, occurring in between two and eight percent of infants and children (6). Food allergic reactions can range from mild skin or gastrointestinal symptoms to severe, life-threatening reactions with respiratory and/or cardiovascular compromise. Deaths from food allergy are being reported in increasing numbers. A major factor in these deaths has been a delay in the administration of life-saving emergency medication, particularly epinephrine. Intensive efforts to avoid exposure to the offending food(s) are therefore warranted. Detailed care plans and the ability to implement such plans for the treatment of reactions is essential for all food-allergic children (10, 11, 13).

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

able to provide safe foods as long as they have been fully educated about effective food avoidance.

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

Some children with food allergy will have mild reactions and will only need to avoid the problem food(s). Others will need to have an antihistamine or epinephrine available to be used in the event of a reaction. For all children with a history of anaphylaxis, or for those with peanut and/or tree nut allergy (whether or not they have had anaphylaxis), epinephrine should be readily available. This will usually be provided as a pre-measured dose in an auto-injector, such as the Epi-Pen or Epi-Pen Junior. Specific indications for administration of epinephrine should be provided in the detailed care plan. In virtually all cases, Emergency Medical Services (EMS) should be called immediately and children should be transported to the emergency room by ambulance after the administration of epinephrine (11). A single dose of epinephrine wears off in 15 to 20 minutes.

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

PRACTICE

The routine practice of emergency evacuation plans fosters calm, competent use of the plan in the event of an emergency or disaster.

Applicable standards include:

**STANDARD 8.025
IMPLEMENTING EVACUATION
DRILLS**

Evacuation drills for natural disasters shall be practiced in areas where they occur:

- a) Tornadoes, on a monthly basis in tornado season;
- b) Floods, before the flood season;
- c) Earthquakes, every 6 months;
- d) Hurricanes, annually.

RATIONALE: Regular evacuation drills constitute an important safety practice in areas where these natural disasters occur.

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

**STANDARD 8.026
USE OF DAILY ROSTER DURING
DRILLS**

The center director or his/her designee shall use a daily class roster in checking the evacuation and return to a safe space for ongoing care of all children and staff members in attendance during an evacuation drill. Small and large family home child caregivers shall count to be sure that all children are safely evacuated and returned to a safe space for ongoing care during an evacuation drill.

RATIONALE: Use of a roster ensures that all children are accounted for. Evacuation of the usual child care facility is only the first step. Children and staff must have a safe and appropriately supplied place of refuge where children can receive care until parents can arrive to provide care for their children. Parents should be informed in advance of the location of this alternate site so that in an emergency, they can go

directly there instead of needing to search for their children during a crisis.

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

**STANDARD 8.027
APPROVAL AND
IMPLEMENTATION OF FIRE
EVACUATION PROCEDURE**

A fire evacuation procedure shall be approved 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. The procedure shall be practiced at least monthly from all exit locations at varied times of the day and during varied activities, including nap time.

RATIONALE: The extensive turnover of both staff and children, in addition to the changing developmental ability of children to participate in evacuation procedures in child care, necessitates frequent practice of the evacuation drill. Practicing fire evacuation procedures on a monthly basis helps make these procedures routine for everyone.

Fires are responsible for the great majority of burn deaths (14). The routine practice of emergency evacuation plans fosters calm, competent use of the plans in an emergency.

COMMENTS: Fire prevention programs for planning exit routes in the home are readily available. One such program is called "EDITH" ("Exit Drill In The Home"), which applies to one's own family. This, or a similar program, is available from some local fire departments.

The facility should time the procedure and aim to evacuate all persons in a specific number of minutes recommended by the local fire department for that facility. See STANDARD 8.069, for information on evacuation drill records. See also Posting Documents, STANDARD 8.077.

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

**STANDARD 8.069
EVACUATION DRILL RECORD**

A record of evacuation drills shall be kept on file. Each date and time shall be recorded.

RATIONALE: Routine practice of emergency evacuation plans fosters calm, competent use of the plans in an emergency.

COMMENTS: For information on evacuation plans, drills, and closings, see STANDARD 8.024 through STANDARD 8.027. For additional information on evacuation drill records, see also STANDARD 8.077, on posting fire evacuation procedures.

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

**STANDARD 3.052
RESPONSE TO FIRE AND BURNS**

Children shall be instructed to STOP, DROP, and ROLL when garments catch fire. Children shall be instructed to crawl on the floor under the smoke. Cool water shall be applied to burns immediately. The injury shall be covered with a loose bandage or clean cloth.

RATIONALE: Running when garments have been ignited will fan the fire. Removing heat from the affected area will prevent continued burning and aggravation of tissue damage. Asphyxiation causes more deaths in house fires than does thermal injury (3).

COMMENTS: For additional information on emergency procedures, see Emergency Plan, STANDARD 8.022 and STANDARD 8.023; and Evacuation Plan and Drills, STANDARD 8.024 through STANDARD 8.027.

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

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Special Care Plan for a Child with Asthma

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

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

Emergency phone numbers: Mother: _____ Father: _____

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

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

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

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

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

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

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

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

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

reading to get medical help: _____

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

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

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

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

Reminders:

1. Notify parents immediately if emergency medication is required.

2. Get emergency medical help if.

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

- after receiving a treatment for wheezing, the child:

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

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

Special Care Plan for a Child with Asthma (Continued)

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

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

Situations that Require Medical Attention Right Away

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.
- 2) Educate Staff on the recognition of an emergency.
- 3) Know the phone number for each child's guardian and primary health care provider.
- 4) Develop plans for children with special medical needs with their family and physician.

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.

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 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.

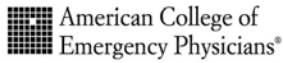
After you have called EMS, remember to call the child's legal guardian.

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 2 months (8 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.

Emergency Information Form for Children With Special Needs



American Academy of Pediatrics



Date form completed	Revised	Initials
By Whom	Revised	Initials

Last Name: _____

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

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

*Consent for release of this form to health care providers

Last Name: _____

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

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

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

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

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

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

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

Incident Report Form

Fill in all blanks and boxes that apply.

Name of Program: _____ Phone: _____

Address of Facility: _____

Child's Name: _____ Sex: M F Birthdate: ___/___/___ Incident Date: ___/___/___

Time of Incident: ___:___ am/pm Witnesses: _____

Name of Legal Guardian/Parent Notified: _____ Notified by: _____ Time Notified: ___:___ am/pm

EMS (911) or other medical professional Not notified Notified Time Notified: ___:___ am/pm

Location where incident occurred: Playground Classroom Bathroom Hall Kitchen Doorway
 Gym Office Dining Room Stairway Unknown Other (specify) _____

Equipment / Product involved: Climber Slide Swing Playground Surface Sandbox
 Trike/Bike Handtoy (specify): _____
 Other Equipment (specify): _____

Cause of Injury (describe): _____

- Fall to surface; Estimated height of fall ___ feet; Type of surface: _____
 Fall from running or tripping Bitten by child Motor vehicle Hit or pushed by child
 Injured by object Eating or choking Insect sting/bite Animal bite Exposure to cold
 Other (specify): _____

Parts of body injured: Eye Ear Nose Mouth Tooth Part of face Part of head
 Neck Arm/Wrist/Hand Leg/Ankle/Foot Trunk Other (specify): _____

First aid given at the facility (e.g. comfort, pressure, elevation, cold pack, washing, bandage): _____

Treatment provided by: _____

- No doctor's or dentist's treatment required
 Treated as an outpatient (e.g. office or emergency room)
 Hospitalized (overnight) # of days: _____

Number of days of limited activity from this incident: _____ Follow-up plan for care of the child: _____

Corrective action needed to prevent reoccurrence: _____

Name of Official/Agency notified: _____

Signature of Staff Member: _____ Date: _____

Signature of Legal Guardian/Parent: _____ Date: _____

Reference: Pennsylvania Chapter; American Academy of Pediatrics. *Model Child Care Health Policies*. 3rd ed. Washington D.C.: National Association for the Education of Young Children, 1997.

This form was developed for *Model Child Care Health Policies*, June 1997, by the Early Childhood Education Linkage System (ECELS), a program funded by the Pennsylvania Depts. of Health & Public Welfare and contractually administered by the PA Chapter, American Academy of Pediatrics.

Contact Information

American Academy of Pediatrics (AAP)

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

American Diabetes Association

1701 North Beauregard Street
Alexandria, VA 22311
Phone: 800-342-2383
Fax: 703-549-6995
E-mail: customerservice@diabetes.org
<http://www.diabetes.org>

American Dietetic Association (ADA)

216 West Jackson Boulevard
Chicago, Illinois 60606-6995
Phone: 312-899-0040
Fax: 312-899-1979
<http://www.eatright.org>

American Heart Association (AHA)

7272 Greenville Avenue
Dallas, Texas 75231
Phone: 214-373-6300
<http://www.amhrt.org>

American Lung Association

432 Park Ave. South
New York, NY 10016
Phone: 212-889-3370
Fax: 212-889-3375
<http://www.alany.org>

American Nurses Association (ANA)

600 Maryland Ave., SW
Suite 100 West
Washington, DC 20024
Phone: 1-800-274-4262 or 202-651-7000
Fax: 202-651-7001
<http://www.nursingworld.org>

American Public Health Association (APHA)

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

American Red Cross (ARC)

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

Early Childhood Education Linkage System (ECELS)

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

Easter Seals

230 West Monroe St.
Suite 1800
Chicago, IL 60606
Phone: 312-726-6200 or 1-800-221-6827
Fax: 312-726-1494
<http://www.easter-seals.org>

Emergency Medical Services for Children National Resource Center

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

Maternal and Child Health Bureau (MCHB)

MCHB Region I

Room 1826
John F. Kennedy Federal Building
Boston MA 02203
Phone: 617-565-1433
Fax: 617-565-3044
States - CT, ME, MA, NH, RI, VT

MCHB Region II

26 Federal Plaza
Federal Building, Room 3835
New York, N.Y. 10278
Phone: 212-264-2571
Fax: 212-264-2673
States - NJ, NY, PR, VI

MCHB Region III

Health Resources, Northeast Cluster
Public Ledger Building
150 S. Independence Mall West
Suite 1172
Philadelphia, PA 19106-3499
Phone: 215-861-4422
Fax: 215-861-4385
States - DE, DC, MD, PA, VA, WV

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

Contact Information

MCHB Region IV

HRSA Field Coordinator, Southeast Cluster
Atlanta Federal Center
61 Forsyth Street, S.W., Suite 3M60
Atlanta, GA 30303-8909
Phone: 404-562-7980
Fax: 404-562-7974
States - AL, FL, GA, KY, MS, NC, SC, TN

MCHB Region V

105 W. Adams Street, 17th Floor
Chicago, IL 60603
Phone: 312-353-4042
Fax: 312-886-3770
States - IL, IN, MI, MN, OH, WI

MCHB Region VI

1301 Young Street, 10th Floor, HRSA-4
Dallas, TX 75202
Phone: 214-767-3003
Fax: 214-767-3038
States - AR, LA, NM, OK, TX

MCHB Region VII

Federal Building, Room 501
601 E. 12th Street
Kansas City, MO 64106-2808
Phone: 816-426-5292
Fax: 816-426-3633
States - IA, KS, MO, NE

MCHB Region VIII

Federal Office Building, Room 409
1961 Stout Street
Denver, CO 80294
Phone: 303-844-7862
Fax: 303-844-0002
States - CO, MT, ND, SD, UT, WY

MCHB Region IX

Federal Office Building, Room 317
50 United Nations Plaza
San Francisco, CA 94102
Phone: 415-437-8101
Fax: 415-437-8105
States - AZ, CA, HI, NV, AS, FM, GU, MH, MP, PW

MCHB Region X

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

National Association for the Education of Young Children (NAEYC)

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

National Fire Protection Association (NFPA)

1 Battery March Park
Quincy, MA 02269-9101
Phone: 617-770-3000
Fax: 617-770-0700
<http://www.nfpa.org>

National Resource Center for Health and Safety in Child Care

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

Occupational Health & Safety Administration (OSHA)

200 Constitution Avenue, N.W.
Washington, D.C. 20210
Phone: 202-693-1999
<http://www.osha.gov>
(Web site of OSHA Regional Office Contacts)

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