

EXCLUSION AND INCLUSION OF ILL CHILDREN IN CHILD CARE FACILITIES AND CARE OF ILL CHILDREN IN CHILD CARE

Applicable Standards from:

CARING FOR OUR CHILDREN

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

A Joint Collaborative Project of

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INTRODUCTION

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

In an effort to make select subject areas more accessible to intended users, the NRC is developing smaller documents on specific subject areas. This document is a compilation of the standards related to exclusion and inclusion criteria for ill children in child care settings and those standards related to the caring of ill children.

INTENDED AUDIENCES

The intended audiences for this document are:

- child care providers faced with the daily decisions on when is a child too sick to be in their care and those providers who provide care for ill children,
- health consultants and trainers who can promote and teach these criteria to child care providers

- parents who want to be informed on when it is appropriate for their ill child to be in child care and when it is not, and
- state policy makers who are looking for guidance in setting state rules on these issues.

SPECIAL NOTE

Since the publication of *Caring for Our Children, 2nd Ed.*, the Centers for Disease Control and Prevention (CDC) has addressed the issue of hand hygiene in health care facilities with an extensive review of the literature and a set of recommendations for health care settings. See *Hand Hygiene Guidelines Fact Sheet* (<http://www.cdc.gov/od/oc/media/pressrel/fs021025.htm>). A clarification of the application of this information to the child care setting is detailed in the article *2002 Update on Hand Hygiene in Child (Day) Care* found on the ChildCare Information Exchange website (<http://mail.ccie.com/library/5015058.pdf>).

We would like to give special thanks to Susan Aronson, MD, FAAP and Phyllis Stubbs-Wynn, MD, MPH for reviewing this compilation of exclusion/inclusion standards. We would also like to thank all those individuals who contributed to *Caring For Our Children, 2nd Ed.* A listing can be viewed at: <http://nrc.uchsc.edu/CFOC/PDFVersion/Acknowledgments.pdf>

For questions or assistance on these standards or *Caring for Our Children, 2nd Ed.*, please contact:
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EXCLUSION AND INCLUSION OF ILL CHILDREN

GENERAL EXCLUSION/ INCLUSION CRITERIA

STANDARD 3.065 INCLUSION/EXCLUSION/DISMISSAL OF CHILDREN

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

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

- a) The illness prevents the child from participating comfortably in activities as determined by the child care provider;
- b) The illness results in a greater need for care than the child care staff can provide without compromising the health and safety of the other children as determined by the child care provider;
- c) The child has any of the following conditions:
 - 1) Fever, accompanied by behavior changes or other signs or symptoms of illness until medical professional evaluation finds the child able to be included at the facility;
 - 2) Symptoms and signs of possible severe illness until medical professional evaluation finds the child able to be included at the facility. Symptoms and signs of possible severe illness shall include

- lethargy that is more than expected tiredness,
 - uncontrolled coughing,
 - inexplicable irritability or persistent crying,
 - difficult breathing,
 - wheezing, or
 - other unusual signs for the child;
- 3) Diarrhea, defined by more watery stools, decreased form of stool that is not associated with changes of diet, and increased frequency of passing stool, that is not contained by the child's ability to use the toilet. Children with diarrheal illness of infectious origin generally may be allowed to return to child care once the diarrhea resolves, except for children with diarrhea caused by *Salmonella typhi*, *Shigella* or *E. coli 0157:H7*. For *Salmonella typhi*, 3 negative stool cultures are required. For *Shigella* or *E. coli 0157:H7*, two negative stool cultures are required. Children whose stools remain loose but who, otherwise, seem well and whose stool cultures are negative, need not be excluded. See also Child-Specific Procedures for Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections, STANDARD 6.023, for additional separation and exclusion information for children with diarrhea; STANDARD 3.066, on separate care for these children; and STANDARD 3.084 and STANDARD 3.087, on notifying parents;
 - 4) Blood in stools not explainable by dietary change, medication, or hard stools;
 - 5) Vomiting illness (two or more episodes of vomiting in the previous 24 hours) until vomiting resolves or until a health care provider determines that the cause of the vomiting is not contagious and the child is not in danger of dehydration. See also STANDARD 3.066, on separate care for these children;
 - 6) Persistent abdominal pain (continues more than 2 hours) or intermittent pain associated with fever or other signs or symptoms;
 - 7) Mouth sores with drooling, unless a health care provider or health department official determines that the child is noninfectious;

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

23) Herpes simplex, see STANDARD 6.018.

Some states have regulations governing isolation of persons with communicable diseases including some of those listed here. Providers shall contact their health consultant or health department for information regarding isolation of children with diseases such as chickenpox, pertussis, mumps, hepatitis A, measles, rubella, and tuberculosis (1). If different health care professionals give conflicting opinions about the need to exclude an ill child on the basis of the risk of transmission of infection to other children, the health department shall make the determination.

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

RATIONALE: Short term exclusion of children with many mild infectious diseases is likely to have only a minor impact on the incidence of infection among other children in the group. Thus, when formulating exclusion policies, it is reasonable to focus on the needs and behavior of the ill child and the ability of the staff in the out-of-home child care setting to meet those needs without compromising the care of other children in the group (4).

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

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

Because very young infants may have serious illnesses without much change in behavior in the early stages of illness, rectal temperatures above 101 degrees F or axillary (armpit) temperatures above 100 degrees F without behavioral change is considered to be significant in infants 8 weeks of age and younger and a reason to seek immediate medical professional care for these young infants. Although health care professionals worry most about children under 8 weeks of age who have fever, concern for fever in infants under 4 months of age provides a wide margin of safety. No age standard for fever is included, but prudent practice would be to seek medical evaluation for infants under 4 months of age who have an unexplained fever. An infant under 4 months of age with a fever on the day following an immunization would not be considered to have an unexplained temperature elevation and need not be excluded as long as the child is acting normally. The presence of fever alone has little relevance to the spread of disease and should not disallow a child's participation in child care. A small proportion of childhood illness with fever is caused by life-threatening diseases, such as meningitis. Except for very young infants, serious illnesses with fever are associated with recognizable behavior change. Facilities should inform parents promptly when their child is found to have a fever or behavior change in child care.

The presence of diarrhea, particularly in diapered children and the presence of vomiting increase the likelihood of exposing other children to the infectious agents that cause these illnesses. It may not be reasonable to routinely culture children who have fever and diarrhea. In some outbreak settings,

however, identifying infected children and excluding or treating them may be necessary. Because these infections are easily transmitted and can be severe, exclusion of children with diarrhea because of *Shigella* and *E. coli O157:H7* is recommended until two stool cultures are negative and exclusion of children with diarrhea because of *Salmonella typhi* is recommended until three stool cultures are negative. For *Salmonella* species other than *S.typhi* stool cultures are not required from asymptomatic individuals (1).

Vomiting with symptoms such as lethargy and/or dry skin or mucous membranes, or reduced urine output, may indicate dehydration. A child with these symptoms should be evaluated medically (6). A child who vomits should be observed carefully for other signs of illness and for dehydration. If dehydration is not present, the child may continue to attend the facility.

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

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

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

contributing to transmission of the infection within or outside the facility.

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

Lice and scabies are highly contagious, and all parents should be notified to watch for signs of infestation (1, 7). However, children discovered with lice need not be removed until the end of the day and may return after the first treatment.

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

A child may be included in the regular facility and his or her activities may be modified if the child is comfortable and the facility has enough caregivers to accommodate the adaptation. No child should be forced to participate in activities when in ill health. Exclusion/dismissal should be for the comfort and safety of both the ill child and the rest of the children in the group, if the facility cannot meet the ill child's needs (5).

Parents and the child care staff may disagree about whether a child meets or does not meet the exclusion criteria. If the reason for exclusion relates to the child's ability to participate or the caregiver's ability to provide care for the other children, the child care provider is entitled to make this decision and cannot be forced by a parent to accept responsibility for the care of an ill child. The parent is neither in a position to assess the factors involved in care of the group, nor legally able to transfer responsibility for the care of the child to an unwilling caregiver. If the

reason for exclusion relates to a decision about whether the child has a communicable disease that poses a risk to the other children in the group, different health care professionals in the community might give conflicting opinions. In these cases, the health department has the legal authority to make a determination.

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

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

Diarrhea is considered resolved when the child seems well and has resumed a pre-illness stool pattern, or when the child seems well and has developed a new, but regular pattern of non-watery bowel movements for more than a week, even if this new pattern is more frequent and loose bowel movements than was usual for the child before the diarrhea episode.

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

provided in the *Child Care Health Handbook*, available from the Seattle King County Department of Public Health. Contact information for the organizations listed is located in Appendix BB.

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

STANDARD 3.066 SEPARATION OF EXCLUDED CHILDREN FROM THE GROUP

A child with uncontrolled vomiting or diarrhea or any other illness that requires that the child be sent home from the facility shall be provided care separate from the other children, with extra attention to hygiene and sanitation, until the child's parent arrives to remove the child.

RATIONALE: Uncontrolled vomiting and acute diarrhea often are caused by bacteria, viruses or parasites that can be found in vomit or stool. Until the cause of the episode is known and because organisms can be spread from infected persons to susceptible contacts, children with uncontrolled vomiting or diarrhea should not be in contact with other children in the child care facility. To minimize the spread of infection to others, the child shall be provided care separate from other children until the child leaves the facility. In addition, these children often are too ill to participate comfortably in program activities.

COMMENTS: For additional information on the inclusion, exclusion, and dismissal of children from child care, see STANDARD 3.065.

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

STANDARD 3.067 OUTBREAK CONTROL

During the course of an identified outbreak of any communicable illness at the facility, a child shall be excluded if the health department official or health care provider suspects that the child is contribut-

ing to transmission of the illness at the facility. The child shall be readmitted when the health department official or health care provider who made the initial determination decides that the risk of transmission is no longer present.

RATIONALE: Secondary spread of infectious disease has been proven to occur in child care. Control of outbreaks of infectious diseases in child care may include age appropriate immunization, antibiotic prophylaxis, observing well children for signs and symptoms of disease and ensuring that children do not spread organisms which may sustain an outbreak. Removal of children known or suspected of contributing to an outbreak will help to limit transmission of the disease by preventing the development of new cases of the disease.

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

STANDARD 3.068 CONDITIONS THAT DO NOT REQUIRE EXCLUSION

Certain conditions do not constitute a reason for automatically denying admission to, or sending a child home from child care, unless the child would be excluded by the criteria in STANDARD 3.068 or the child is suspected by a health department authority to contribute to transmission of the illness at the facility. These conditions that do not require exclusion include:

- a) Presence of bacteria or viruses in urine or feces in the absence of illness symptoms, like diarrhea. Exceptions include children infected with highly contagious organisms capable of causing serious illness such as *E. coli 0157:H7*, *Shigella*, or *Salmonella typhi*. Children with *E. coli 0157:H7* or *Shigella* shall be excluded from child care until two stool cultures are negative and they are cleared to return by local health department officials. Children with *Salmonella typhi* shall be excluded from child care until three stool cultures are negative and they are cleared to return by local health department officials;
- b) Nonpurulent conjunctivitis, defined as pink conjunctiva with a clear, watery eye discharge and without fever, eye pain, or eyelid redness;

- c) Rash without fever and without behavior changes;
- d) CMV infection, as described in STANDARD 6.021 and STANDARD 6.022;
- e) Hepatitis B virus carrier state, provided that children who carry HBV chronically have no behavioral or medical risk factors, such as unusually aggressive behavior (biting, frequent scratching), generalized dermatitis, or bleeding problems;
- f) HIV infection, provided that the health, neurologic development, behavior, and immune status of an HIV-infected child are appropriate as determined on a case-by-case basis by qualified health professionals, including the child's health care provider, who are able to evaluate whether the child will receive optimal care in the specific facility being considered and whether that child poses a potential threat to others;
- g) Parvovirus B19 infection in a person with a normal immune system.

RATIONALE: Excluding children with many mild infectious diseases is likely to have only a minor impact on the incidence of infection among other children in the group and the staff (4). Thus, when formulating exclusion policies, it is reasonable to focus on the needs and behavior of the ill child and the ability of staff in the out-of-home child care setting to meet those needs without compromising the care of other children in the group (4).

COMMENTS: The lay term pink eye is used interchangeably to describe purulent and nonpurulent conjunctivitis. The infectious characteristics of purulent and nonpurulent conjunctivitis, however, are quite different. For more information on the difference between purulent and nonpurulent conjunctivitis, see STANDARD 3.068, on conjunctivitis.

For additional information on child inclusion, exclusion, and dismissal, see STANDARD 6.003 on exclusion during antibiotic treatment of *Haemophilus influenzae* type b (Hib); STANDARD 6.008, on exclusion during antibiotic treatment of meningococcal infection; STANDARD 6.011, on exclusion during antibiotic treatment of pertussis; STANDARD 6.034 on excluding children with an immune system that does not function properly to prevent infection.

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

STANDARD 3.069 STAFF EXCLUSION FOR ILLNESS

Please note that if a staff member has no contact with the children, or with anything with which the children come into contact, this standard does not apply to that staff member.

A facility shall not deny admission to or send home a staff member or substitute with illness unless one or more of the following conditions exists (8). The staff member shall be excluded as follows:

- a) Chickenpox, until all lesions have dried and crusted, which usually occurs by 6 days;
- b) Shingles, only if the lesions cannot be covered by clothing or a dressing until the lesions have crusted;
- c) Rash with fever or joint pain, until diagnosed not to be measles or rubella;
- d) Measles, until 4 days after onset of the rash (if the staff member or substitute is immunocompetent);
- e) Rubella, until 6 days after onset of rash;
- f) Diarrheal illness, three or more episodes of diarrhea during the previous 24 hours or blood in stools, until diarrhea resolves; if *E.coli* O157:H7 or *Shigella* is isolated, until diarrhea resolves and two stool cultures are negative;
- g) Vomiting illness, two or more episodes of vomiting during the previous 24 hours, until vomiting resolves or is determined to result from noncommunicable conditions such as pregnancy or a digestive disorder;
- h) Hepatitis A virus, until 1 week after onset or as directed by the health department when immunoglobulin has been given to appropriate children and staff in the facility;
- i) Pertussis, until after 5 days of appropriate antibiotic therapy (which is to be given for a total of 14 days) and until disease preventive measures, including preventive antibiotics and vaccines for children and staff who have been in contact with children infected with pertussis, have been implemented;
- j) Skin infection (such as impetigo), until 24 hours after treatment has been initiated;

- k) Tuberculosis, until noninfectious and cleared by a health department official;
- l) Strep throat or other streptococcal infection, until 24 hours after initial antibiotic treatment and end of fever;
- m) Head lice, from the end of the day of discovery until after the first treatment;
- n) Scabies, until after treatment has been completed;
- o) Purulent conjunctivitis, defined as pink or red conjunctiva with white or yellow eye discharge, often with matted eyelids after sleep, and including eye pain or redness of the eyelids or skin surrounding the eye, until 24 hours after treatment has been initiated;
- p) *Haemophilus influenzae* type b (Hib), prophylaxis, until antibiotic treatment has been initiated;
- q) Meningococcal infection, until all staff members, for whom antibiotic prophylaxis has been recommended, have been treated. See STANDARD 6.006 through STANDARD 6.008;
- r) Respiratory illness, if the illness limits the staff member's ability to provide an acceptable level of child care and compromises the health and safety of the children.

Child care providers who have herpes cold sores shall not be excluded from the child care facility, but shall:

- 1) Cover and not touch their lesions;
- 2) Carefully observe handwashing policies;
- 3) Refrain from kissing or nuzzling infants or children, especially children with dermatitis.

RATIONALE: Adults are as capable of spreading infectious disease as children are. See also the Rationale for Child Inclusion/Exclusion/Dismissal, STANDARD 3.065.

COMMENTS: Other management procedures should be followed as stated in Child Inclusion/Exclusion/Dismissal, STANDARD 3.065. For additional information on infectious disease, see STANDARD 6.001 through STANDARD 6.039.

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

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

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

- a) Fever and a stiff neck, lethargy, irritability, or persistent crying;
- b) Diarrhea (three or more loose stools in an 8-hour period or more stools compared to the child's normal pattern, with more stool water or less form) and one or more of the following:
 - 1) Signs of dehydration;
 - 2) Blood or mucus in the stool, unless at least one stool culture demonstrates absence of *Shigella*, *Salmonella*, *Campylobacter*, and *E. coli* 0157:H7. See STANDARD 3.065 and STANDARD 6.023;
 - 3) Diarrhea attributable to *Salmonella*, *Campylobacter*, or *Giardia* except that a child with diarrhea attributable to *Campylobacter* or *Giardia* may be readmitted 24 hours after treatment has been initiated if cleared by the child's physician;
- c) Diarrhea attributable to *Shigella* and *E. coli* 0157:H7, until diarrhea resolves and two stool cultures taken 48 hours apart are negative (3);
- d) Vomiting three or more times, or signs of dehydration;
- e) Contagious stages of pertussis, measles, mumps, chickenpox, rubella, or diphtheria, unless the child is appropriately isolated from children with other illnesses and cared for only with children having the same illness;
- f) Untreated infestation of scabies or head lice;
- g) Untreated tuberculosis;
- h) Undiagnosed rash;

- i) Abdominal pain that is intermittent or persistent;
- j) Difficulty in breathing;
- k) Lethargy such that the child does not play;
- l) Undiagnosed jaundice (yellow skin and whites of eyes);
- m) Other conditions as may be determined by the director or health consultant.

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

Antibiotic therapy of *Campylobacter* may not alter symptoms, but it does decrease shedding of the organism and, therefore, lowers the infectivity of these children. Antibiotic therapy for salmonella gastroenteritis is generally not recommended unless diarrhea is severe, sepsis is present, or the child has a specific underlying medical condition that makes this illness problematic. Therefore, most children with *Salmonella* gastroenteritis will not be treated with antibiotics and should not be included in regular or special child care until the diarrheal illness has resolved. *Shigella* and *E. coli 0157:H7* both can produce severe illness and, therefore, exclusion recommendations are more stringent.

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

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

SPECIFIC DISEASE INCLUSION/ EXCLUSION CRITERIA

STANDARD 6.008 PROTECTIVE MEASURES FOR MENINGOCOCCAL INFECTION

When an antibiotic to prevent an infection with *Neisseria meningitidis* (meningococcal infection) is indicated for child care contacts, all children and staff members, for whom prophylaxis has been recommended, shall be excluded from attending the facility until these measures have begun. Any exposed individual who develops a febrile illness (one accompanied by a fever) shall receive prompt medical evaluation.

New entry children shall not be enrolled in a child care facility in which a case of invasive *N. meningitidis* has been documented until 2 months has elapsed since the diagnosis was made.

RATIONALE: Children and staff exposed, by close contact for an extended period to the child first infected with meningococcal disease, are at risk for contracting invasive meningococcal disease (12). The attack rate of meningococcal disease for this population is more than 300 times higher than rates in the general population (13).

Because outbreaks may occur in child care settings, chemoprophylaxis with rifampin or ceftriaxone is indicated for exposed child care contacts. Children in child care who are exposed to a child or an adult with meningococcal infection should receive rifampin or ceftriaxone as soon as possible to prevent an infection, preferably within 24 hours of diagnosis of the primary case (13, 14). In contacts over 18 years of age, ciprofloxacin is effective. Rifampin and ciprofloxacin are not recommended for pregnant women.

COMMENTS: For additional information regarding meningococcal disease, consult the *Red Book* from 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 6.010 PROPHYLACTIC TREATMENT FOR PERTUSSIS

When there is a known or suspected occurrence of pertussis in a child care facility, all staff members and children in care shall initiate the appropriate prophylactic treatment (usually administration of erythromycin or another appropriate antibiotic) and any additional treatment deemed medically necessary by a health care provider before they are allowed to return to the facility.

Adults and children who have been in contact with a person infected with pertussis shall be monitored closely for respiratory tract symptoms for 20 days after the last contact with the infected person.

RATIONALE: Even if outbreaks of pertussis in child care facilities have not been reported, children and staff who attend out-of-home child care occasionally contract pertussis. The spread of infection to contacts who are incompletely immunized can be reduced by treating the primary case and susceptible contacts with prophylactic antibiotics, usually erythromycin (15, 16).

COMMENTS: For additional information regarding pertussis, consult the *Red Book* from 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 6.012 EXCLUSION FOR GROUP A STREPTOCOCCAL INFECTIONS

Children with group A streptococcal (GAS) respiratory tract, skin, or ear infections shall be excluded from child care until 24 hours after antibiotic treatment has been initiated and until the child has no fever for 24 hours.

RATIONALE: Streptococcal respiratory tract infections and scarlet fever resulting from GAS have been reported in children in child care, but are not a major problem (17, 18). Group A streptococcal respiratory tract infections may resolve without treatment; how-

ever, GAS respiratory tract infections can be complicated by pneumonia, arthritis, rheumatic fever, and glomerulonephritis (19).

Early identification and treatment of GAS infection in children and adults are important in reducing transmission and subsequent occurrence of disease. Consultation with the health department is advised when high rates of streptococcal infection occur in child care facilities. Parents of children exposed to a child with documented GAS infection should be notified of the exposure.

COMMENTS: For additional information regarding group A streptococcal respiratory tract infection, consult the *Red Book* from 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 6.015 ATTENDANCE OF CHILDREN WITH TUBERCULOSIS INFECTION

Children with tuberculosis infection or disease can attend child care if they are receiving appropriate therapy.

RATIONALE: Children can return to regular activities as soon as effective therapy has been instituted, adherence to therapy has been documented, and clinical symptoms have disappeared. If approved by local health officials, children may attend out-of-home child care once they are considered non-infectious to others.

COMMENTS: For additional information regarding tuberculosis, consult the *Red Book* from 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 6.016

ATTENDANCE OF CHILDREN WITH ERYTHEMA INFECTIONOSUM (EI)

Children who develop erythema infectiosum (EI), also known as fifth disease, following infection with parvovirus B19, shall be allowed to attend child care because they are no longer contagious when signs and symptoms appear.

RATIONALE: EI is caused by parvovirus B19. EI begins with a fever, headache, and muscle aches, and is followed by a rash, which is intensely red with a “slapped cheek” appearance. A lace-like rash appears on the rest of the body. Isolation or exclusion of an immunocompetent person with parvovirus B19 infection in the child care setting is not necessary because little to no virus is present in the respiratory tract secretions at the time of occurrence of the rash (20).

COMMENTS: For additional information regarding parvovirus B19, consult the *Red Book* from 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 6.017

ATTENDANCE OF CHILDREN WITH UNSPECIFIED RESPIRATORY TRACT INFECTION

Children without fever who have mild symptoms associated with the common cold, sore throat, croup, bronchitis, rhinitis (runny nose), or otitis media (ear infection) shall not be denied admission to child care, sent home from child care, or separated from other children in the facility unless their illness is characterized by one or more of the following conditions:

- a) The illness has a specified cause that requires exclusion, as determined by other specific performance standards in Child Inclusion/Exclusion/Dismissal, STANDARD 3.065 through STANDARD 3.068;
- b) The illness limits the child's comfortable participation in child care activities;

- c) The illness results in a need for more care than the staff can provide without compromising the health and safety of other children.

Treatment with antibiotics shall not be required or otherwise encouraged as a condition for attendance of children with mild respiratory tract infections unless directed by local health authorities.

RATIONALE: The incidence of acute diseases of the respiratory tract, including the common cold, croup, bronchitis, pneumonia, and otitis media, is high in infants and young children, whether they are cared for at home or attend out-of-home facilities (21). Studies suggest that children who attend child care facilities have a significantly higher risk of upper and lower respiratory tract infections compared to children who are cared for at home and that infants and young children in child care have a higher incidence of these infections when they first begin to attend child care (22, 23, 24).

Children, 3 years of age and younger, experience an average of 5 to 10 respiratory tract infections each year, most of which are not severe and are caused by viruses that infect the respiratory tract (25). There is no evidence that the incidence of most acute diseases of the respiratory tract can be reduced among children in child care by any specific intervention other than routine sanitation and personal hygiene.

Exclusion of ill children from the facility has not been found of value in preventing common respiratory infections.

When compliance with environmental infection control practices is high in child care settings, a reduction in episodes of colds is possible (26). Most children with viral respiratory tract infections remain infectious for at least 5 to 8 days. Frequently, infected children are shedding viruses before they are obviously ill, and some infected children never become overtly ill. Therefore, excluding children with respiratory tract disease from child care is not likely to limit transmission of respiratory tract infections in the child care setting.

The inappropriate use of antibiotics is a serious public health problem leading to development of antibiotic resistance (27, 28). Inappropriate antibiotic use in child care for mild respiratory tract infections is common even though these infections are often caused by viruses. Parents may attempt to pressure physicians into prescribing antibiotics for infections because they falsely believe that antibiotics will shorten the time when their children are excluded from child care.

COMMENTS: Uncontrolled coughing, difficult or rapid breathing, and wheezing (if associated with difficult breathing or if the child has no history of asthma) may represent severe illness or even a life-threatening condition. Exclusion in these cases is for the child's safety. The child should receive medical care before being allowed to return to the facility.

For additional information regarding unspecified respiratory tract infections, consult the *Red Book* from 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 6.020 EXCLUSION OF CHILDREN WITH VARICELLA-ZOSTER (CHICKENPOX) VIRUS

Children who develop chickenpox shall be excluded until all sores have dried and crusted (usually 6 days).

Staff members or children with shingles (herpes zoster) shall keep sores covered by clothing or a dressing until sores have crusted. The need for excluding an infected person shall be decided based on the recommendations of the person's health care provider. If a conflict or question about return to the child care facility arises, the facility shall consult personnel at the health department. Until the conflict is resolved, readmission shall be delayed.

RATIONALE: Exclusion of children infected with varicella-zoster virus may not control illness in child care, but exclusion may help control disease caused by this virus in some individuals (such as adults, children and adults who have a compromised immune system, and newborn infants).

The chickenpox virus seems to be present in respiratory tract secretions and to be shed from the mouth and throat as well as from skin lesions. Spread from oral or respiratory tract secretions to susceptible contacts is likely.

With shingles, the virus is present in small, fluid-filled blisters, and is spread by direct contact. Sores that are

covered seem to pose little risk to susceptible persons. Older children and staff members with herpes zoster should be instructed to wash their hands if they touch potentially infectious lesions.

About 5 to 10 percent of adults will be susceptible to varicella-zoster virus. Susceptible child care staff members who are pregnant and are exposed to children with chickenpox should be referred to physicians or other health care professionals who are knowledgeable in the area of varicella infection during pregnancy within 24 hours after the exposure is recognized.

COMMENTS: Initial viral infection with varicella-zoster virus produces an acute fever and the appearance of chickenpox blisters; reactivation of the virus results in shingles (herpes zoster). See STANDARD 6.023, for more information on shingles. Routine use of varicella vaccine as recommended by the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC) will reduce the likelihood of transmission of wild type strains of varicella virus (29, 30, 31).

In mild cases with only a few sores and rapid recovery, an otherwise healthy child may be able to return to child care sooner once the lesions are crusted. Children whose immune system does not function properly and children with more severe cases of chickenpox shall be excluded from child care until lesions are crusted.

For additional information regarding varicella, consult the *Red Book* from the AAP. Contact information for the AAP is located in Appendix BB. For information about health education for children, staff, and parents, see STANDARD 2.060 through STANDARD 2.067.

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

STANDARD 6.022 ATTENDANCE AND TESTING OF CHILDREN WITH CMV

Testing children to detect CMV excretion or excluding children known to be CMV infected is not recommended. All infants and toddlers shall be assumed to be infected with CMV.

RATIONALE: Testing of urine and saliva for CMV excretion in children is expensive and is likely to be misleading, since excretion of CMV by children in child care is intermittent and common (32, 33).

COMMENTS: For additional information regarding CMV, consult the *Red Book* from 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 6.023 CONTROL OF ENTERIC (DIARRHEAL) AND HEPATITIS A VIRUS INFECTIONS

Facilities shall employ the following procedures, in addition to those stated in Inclusion/Exclusion/Dismissal, STANDARD 3.065 through STANDARD 3.068, to prevent and control infections of the gastrointestinal tract (including diarrhea) or liver:

- a) Children who cannot use a toilet for all bowel movements while attending the facility and who develop diarrhea shall be removed from the facility by their parent or legal guardian. Pending arrival of the parent or legal guardian, the child shall not be permitted to have contact with other children or be placed in areas used by adults who have contact with children in the facility. This shall be accomplished by removing the ill child to a separate area of the child care center or, if not possible, to a separate area of the child's room. The area shall be one where the child is supervised by an adult known to the child, and where the toys, equipment, and surfaces will not be used by other children or adults until after the ill child leaves and after the surfaces have been disinfected. When moving a child to a separate area of the facility creates problems with supervision of the other children, as in small family child care homes, the ill child shall be kept as comfortable as possible, with minimal contact between ill and well children, until the parent or legal guardian arrives. The child who requires separation because of diarrhea shall be separated from the group upon the onset of the diarrhea. Caregivers with diarrhea as defined in

STANDARD 3.069 shall be excluded. Separation and exclusion of children or caregivers shall not be deferred pending health assessment or laboratory testing to identify an enteric pathogen.

- b) A child who develops jaundice (when skin and white parts of the eye are yellow) while attending child care shall be separated from other children and the child's parent or legal guardian shall be called to remove the child. The child shall remain separated from the other children as described above until the parent or legal guardian arrives and removes the child from the facility.
- c) Exclusion for acute diarrhea shall continue until either the diarrhea stops or the continued loose stools are deemed not to be infectious by a licensed health care professional. Exclusion for hepatitis A virus (HAV) as specified in item b) above shall continue for one week after onset of illness or until immune globulin has been administered to appropriate children and staff at the facility. See also STANDARD 3.065, on inclusion/exclusion/dismissal of children with diarrhea.
- d) Alternate care for children with diarrhea or hepatitis A in special facilities for ill children shall be provided only in facilities that can provide separate care for children with infections of the gastrointestinal tract (including diarrhea) or liver. See also STANDARD 3.070 through STANDARD 3.080, on caring for ill children.
- e) Children and caregivers who excrete intestinal pathogens but no longer have diarrhea generally may be allowed to return to child care once the diarrhea resolves, except for the case of infections with *Shigella*, *E. coli* 0157:H7 or *Salmonella typhi*. For *Shigella* and *E. coli* 0157:H7 two negative stool cultures are required for readmission, unless state requirements differ. For *Salmonella typhi*, three negative cultures are required. For *Salmonella* species other than *S. typhi* stool cultures are not required from asymptomatic individuals.
- f) The local health department shall be informed within 24 hours of the occurrence of hepatitis A virus infection or an increased frequency of diarrheal illness in children or staff in a child care facility.
- g) In addition to the recommended postexposure prophylaxis, hepatitis A immunization shall be considered in child care settings with

ongoing or recurrent outbreaks, especially in communities where routine immunization of children for hepatitis A is recommended (34). In the absence of ongoing outbreaks, immunization in child care centers shall be used to implement routine hepatitis A immunization, particularly in communities where cases in the child care facility contribute substantially to the total number of hepatitis A cases and seem play a role in sustaining community-wide outbreaks.

- h) If there has been an exposure to a case of hepatitis A or diarrhea in the child care facility, caregivers shall inform parents of other children in the facility, in cooperation with the health department, that their children may have been exposed to children with hepatitis A virus (HAV) infection or diarrheal illness.
- i) These procedures shall be implemented in addition to those stated in STANDARD 3.065 through STANDARD 3.068.

RATIONALE: Intestinal organisms, including hepatitis A virus, cause disease in children, child care providers, and close family members (35, 36, 37, 38). The primary age groups involved are children younger than 3 years of age who wear diapers. Disease has occurred in outbreaks within centers and as sporadic episodes. Although many intestinal agents can cause diarrhea in children in child care, rotavirus, other enteric viruses, *Giardia lamblia*, *Shigella*, and *Cryptosporidium* have been the main organisms implicated in outbreaks. In addition, excretion of intestinal agents, particularly *Giardia lamblia* and rotavirus, has been shown to occur in children who show no symptoms (39, 40). The significance of this phenomenon in transmission is unknown. Child care providers should observe children for signs of disease to permit early detection and implementation of control measures. Facilities should consult the local health department to determine whether the increased frequency of diarrheal illness requires public health intervention.

The most important characteristic of child care facilities associated with increased frequencies of diarrhea or hepatitis A is the presence of young children who are not toilet-trained (37, 41). Contamination of hands, communal toys, and other classroom objects is common and plays a role in the transmission of enteric pathogens in child care facilities.

Studies commonly find that fecal contamination of the environment is frequent in centers and is highest in infant and toddler areas where diarrhea or hepatitis A are known to occur most often (42, 43). Studies indicate that the risk of diarrhea is significantly higher for

children in centers than in age-matched children cared for at home or in small family child care homes (11). The spread of infection from children who are not toilet-trained to other children in child care facilities or to their families is common, particularly when *Shigella*, rotavirus and other enteric viruses, *Giardia lamblia*, *Cryptosporidium*, or hepatitis A virus (HAV) is the causal agent (35).

To decrease diarrheal disease in child care, the staff and parents must be educated about modes of transmission as well as practical methods of prevention and control. Staff training in handwashing and hygiene, combined with close monitoring of staff compliance, is associated with a significant decrease in infant and toddler diarrhea (44, 45). Staff training on a single occasion, without close staff monitoring, however, does not result in a decrease in diarrhea rates; this finding emphasizes the importance of monitoring as well as education (44,45). Therefore, appropriate hygienic practices, hygiene monitoring, and education are important in limiting infections of the intestines or liver in child care.

The Centers for Disease Control and Prevention (CDC) recommends excluding children with diarrhea (for any reason) from child care until diarrhea has resolved. This standard is more lenient than the CDC recommendation by allowing children whose feces are contained by use of a toilet to remain in care. Because outbreaks are rare in groups of toilet-trained children, a more lenient approach may be taken in this age group.

COMMENTS: See also the environmental and personal hygiene standards given in the following standards to prevent and control infections of the gastrointestinal tract (including diarrhea) or liver:

- 1) STANDARD 3.070 through STANDARD 3.080, on caring for ill children;
- 2) STANDARD 3.012 through STANDARD 3.019, on toileting and diapering,
- 3) STANDARD 3.020 through STANDARD 3.024, on handwashing;
- 4) STANDARD 3.028 through STANDARD 3.040, on sanitation, disinfection, and maintenance;
- 5) STANDARD 4.050 through STANDARD 4.060, on food safety;
- 6) STANDARD 3.042 through STANDARD 3.044, on animals;
- 7) STANDARD 8.046 through STANDARD 8.052, on child records;

- 8) STANDARD 5.219 through STANDARD 5.225, on interior maintenance;
- 9) STANDARD 8.035 and STANDARD 8.036, on food handling, feeding, and nutrition policies.

Sample letters of notification to parents that their child may have been exposed to an infectious disease are contained in the (National Academy for the Education of Young Children (NAEYC) publication, *Healthy Young Children*. Contact information is located in Appendix BB.

For information about health education for children, staff, and parents, see STANDARD 2.060 through STANDARD 2.067.

For additional information regarding enteric (diarrheal) and hepatitis A virus (HAV) infections, consult the *Red Book* from 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 6.027 DISEASE RECOGNITION AND CONTROL OF HBV INFECTION

Facilities shall have written policies for inclusion and exclusion of children known to be infected with hepatitis B virus (HBV) and immunization of children with hepatitis B vaccine as part of their routine immunization schedule. When a child who is an HBV carrier is admitted to a facility, the facility director or the caregiver usually responsible for the child shall be informed.

Children who carry HBV chronically and who have no behavioral or medical risk factors, such as aggressive behavior (biting and frequent scratching), generalized dermatitis (weeping skin lesions), or bleeding problems shall be admitted to the facility without restrictions.

Testing of children for HBV shall not be a prerequisite for admission to facilities.

With regard to infection control measures, every person shall be assumed to be an HBV carrier.

Child care personnel shall adopt standard precautions, as outlined in Prevention of Exposure to Blood, STANDARD 3.026 and STANDARD 3.027.

Toys and objects that young children (infants and toddlers) mouth shall be cleaned and sanitized, as stated in STANDARD 3.036 through STANDARD 3.038.

Toothbrushes shall be individually labeled so that the children do not share toothbrushes, as specified in STANDARD 5.095.

RATIONALE: Transmission of HBV in the child care setting is of concern to public health authorities. Children who are HBV carriers (particularly children born in countries highly endemic for HBV) can be expected to require child care (47, 48, 49, 50, 51). The risk of transmitting the disease in child care is theoretically small, though, because blood or infected body fluid must get inside another body for it to transmit HBV infection and because immunization of infants as part of the routine childhood immunization schedule has decreased the number of susceptible children. Immunization not only will reduce the potential for transmission but also will allay anxiety about transmission from children and staff in the child care setting who may be carriers of hepatitis B.

The risk of disease transmission from an HBV-carrier child or staff member with no behavioral risk factors and without generalized dermatitis or bleeding problems is considered very low. This extremely low risk does not justify exclusion of an HBV-carrier child from out-of-home care, nor does it justify the routine screening of children as possible HBV carriers prior to admission to child care.

HBV transmission in a child care setting is most likely to occur through direct exposure via bites or scratches that break the skin and introduce blood or body secretions from the HBV carrier into the victim. Indirect transmission via blood or saliva through environmental contamination may be possible but has not been documented. Saliva contains much less virus (1/1000) than blood; therefore, the potential infection from saliva is lower. In gibbons and chimpanzees, saliva has been shown to be infectious only when inoculated through the skin; it has not caused infection when administered by aerosol through the nose or mouth, by ingestion through the mouth, or by toothbrush on the gums (47).

No data are available to indicate the risk of transmission if a susceptible person bites an HBV carrier. When the HBV statuses of both the biting child and

the victim are unknown, the risk of HBV transmission would be extremely low because of the expected low incidence of HBV carriage by children of preschool-age and the low efficiency of disease transmission by bite exposure. Because a bite in this situation is extremely unlikely to involve an HBV-carrier child, screening is not warranted, particularly in children who are immunized appropriately against HBV (47).

COMMENTS: Parents are not required to share information about their child's HBV status, but they should be encouraged to do so.

For additional information regarding HBV, consult the *Red Book* from 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 6.033 ATTENDANCE OF CHILDREN WITH HIV

Children infected with human immunodeficiency virus (HIV) shall be admitted to child care provided that their health, neurological development, behavior, and immune status are acceptable, as determined on a case-by-case basis by persons knowledgeable in the area of HIV infection, including the child's health care provider. These individuals must be able to evaluate whether the child will receive optimal care in the specific facility being considered and whether an HIV-infected child poses a potential threat to others.

RATIONALE: No reported cases of HIV infection are known to have resulted from transmission in out-of-home child care. Although the risk of transmission of HIV infection to children in the child care setting seems to be extremely low, data does not exist that directly addresses this issue. Guidelines can most reasonably provide methods to reduce the risk of transmission of HIV infection to caregivers in out-of-home child care (46).

COMMENTS: For additional information regarding HIV, consult the *Red Book* from 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 6.037 ATTENDANCE OF CHILDREN WITH SCABIES

Children with scabies shall be removed from the child care facility until appropriate treatment has been administered. Children shall be allowed to return to child care after treatment has been completed.

RATIONALE: Scabies is caused by a mite which is associated with an intensely itchy, red rash. Transmission usually occurs through prolonged close personal contact. Epidemics and localized outbreaks may require stringent and consistent measures to treat contacts. Caregivers who have had prolonged skin-to-skin contact with infested persons may benefit from prophylactic treatment. Environmental disinfection is unnecessary and unwarranted. Bedding and clothing that is worn next to the skin before treatment should be washed.

COMMENTS: For additional information regarding scabies, consult the *Red Book* from 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 6.038 ATTENDANCE OF CHILDREN WITH HEAD LICE

Children shall not be excluded immediately or sent home early from child care because of head lice. Parents of affected children shall be notified and informed that their child must be treated properly before returning to the child care facility the next day.

Children and staff who have been in close contact with an affected child shall be examined and treated if infested. Infestation shall be identified by the presence of adult lice or nits (eggs) on a hair shaft 3 to 4 mm from the scalp (52).

RATIONALE: Head lice infestation in children attending child care is common in the U.S. and is not a sign of poor hygiene. Head lice are not a health hazard because they are not responsible for spread of any disease. After proper application of an appropriate pediculicide, reinfestation of children from an untreated infested person is more common than treatment failure.

COMMENTS: Differentiation of nits from benign hair casts (a layer of cells that easily slides off the hair shaft), plugs of skin cells, and debris can be difficult (52).

For additional information regarding head lice, consult the *Red Book* from 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 6.039 ATTENDANCE OF CHILDREN WITH RINGWORM

Children with ringworm of the scalp or body shall receive appropriate treatment. Children receiving treatment shall not be excluded from child care.

Children and staff in close contact with an affected child shall receive periodic inspections for early lesions and receive prompt therapy.

RATIONALE: Ringworm infection results from a fungus that is transmitted by contact with an infected person (scalp and body) and by contact with infected animals (body). Treatment of ringworm of the scalp with oral medicine for 4 to 6 weeks and of ringworm of the body with topical medicine for 4 weeks is effective.

COMMENTS: Ribbons, combs, and hairbrushes should not be shared among children and staff.

For additional information regarding ringworm, consult the *Red Book* from 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*

POLICIES

STANDARD 8.012 EXCLUSION AND ALTERNATIVE CARE FOR CHILDREN

At the discretion of the person authorized by the child care provider to make such decisions, children who are ill shall be excluded from the child care facility for the conditions defined in STANDARD 3.065 through STANDARD 3.068.

When children are not permitted to receive care in their usual child care setting and cannot receive care from a parent or relative, they shall be permitted to receive care in one of the following arrangements, if the arrangement meets the applicable standards:

- a) Care in the child's usual facility in a special area for care of ill children;
- b) Care in a separate small family child care home or center that serves only children with illness or temporary disabilities;
- c) Care by a child care worker in the child's own home.

RATIONALE: Young children who are developing trust, autonomy, and initiative require the support of familiar caregivers and environments during times of illness to recover physically and avoid emotional distress (54). Young children enrolled in group care experience a higher incidence of mild illness (such as upper respiratory infections or otitis media) and other temporary disabilities (such as exacerbation of asthma or eczema) than those who have less interaction with other children. Sometimes, these illnesses preclude their participation in the usual child care activities. Most state regulations require that children with certain conditions be excluded from their usual care arrangement (55). To accommodate situations where parents cannot provide care for their own ill children, several types of alternative care arrangements have been established.

When children with possible communicable diseases are present in the alternative care arrangements, preventing the further spread of disease is a priority. Although most facilities claim to adhere to general principles of prevention and control of communicable disease, in a study of such practices, only one facility

followed strict isolation procedures (56). In another study, a facility providing care for ill children demonstrated no additional transmission of communicable disease from the children served to the rest of the well children attending the usual child care facilities (57).

COMMENTS: Working parents should be entitled to family sick leave days to care for their ill children. Professionals and the public generally agree that when a child is seriously ill, or when it is not yet clear that the illness is a mild one, the parent should be able to stay home with the child. When a child is recuperating from a mild illness that precludes participation in the child's usual child care setting, parents may need alternative arrangements. At a minimum, working parents should be able to use their own sick or personal days to care for their ill children. However, children are ill frequently; some parents need help in making alternative arrangements for the days when the child is not very ill and the parents need to be at work. Facilities unable to care for ill children should be supportive and helpful to parents, giving them ideas for alternative arrangements. However, the responsibility for care cannot be transferred from the parent to the child care provider unless the caregiver is willing to accept this responsibility. The decision to accept responsibility for the care of ill children should rest with a designated person at the child care facility, who must weigh staffing and programmatic considerations that affect this decision. Though considerations may vary from one instance to another, parents must know who will make the decision.

Sometimes a child can be included in the facility's regular group of children, with modified activities. Sometimes a center can set up a "get well room" where ill children not able to participate with the regular group can receive care. Some centers have set up satellite small family child care homes for their enrolled children. Ideally, the children know the caregiver because the caregiver works at the center when no child is ill. Similarly, a child's regular small or large family child care home provider could include the child in the regular group if appropriate, or might have a "get well room," if adequate supervision can be provided. Other alternative care arrangements include a worker sent by a home health agency or from a pool of caregivers to the child's home, arrangements in a pediatric unit of a hospital,

pediatric office, or other similar setting. Special facilities caring only for ill children should meet more specialized requirements.

For more information regarding caring for ill children, see STANDARD 3.070 through STANDARD 3.080.

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

STANDARD 8.014 DOCUMENTATION OF EXEMPTIONS AND EXCLUSION OF CHILDREN WHO LACK IMMUNIZATIONS

Exemptions from the requirement for up-to-date immunization made for religious or medical reasons shall be documented in the child's record. A child whose immunizations are not kept up-to-date shall be excluded after three written reminders to parents over a 3-month period. If more than one immunization is needed in a series, time shall be allowed for the immunizations to be obtained at the appropriate intervals.

RATIONALE: National surveys document that child care has a positive influence on protection from vaccine-preventable illness (58). Immunizations should be required for all children in child care settings. Facilities must consider the consequences if they accept responsibility for exposing a child who cannot be fully immunized because of immaturity to a child who may bring disease to the facility because of refusal to be immunized. Although up to 6 weeks after the child starts to participate in child care may be allowed for the acquisition of immunizations for which the child is eligible, parents should maintain their child's immunization status according to the nationally recommended schedule to avoid potential exposure of other children in the facility to vaccine-preventable disease.

COMMENTS: See Appendix G, for the *Recommended Childhood Immunization Schedule* from the American Academy of Pediatrics (AAP). Check for the new schedule that is posted each January on the AAP (www.aap.org) and CDC (www.cdc.gov) websites. When a child who has a medical exemption from immunization is included in child care, reasonable accommodation of that child requires planning to

exclude such a child in the event of an outbreak. For children who are incompletely immunized because of the parents' religious reasons, the facility may be at legal risk for allowing exposure of the child and other children in the facility to increased risk of vaccine-preventable infections. Prudent child care providers should discuss with an attorney, the liability risk for enrolling a child whose parents refuse to accept immunization of their child for non-medical reasons.

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

STANDARD 8.061 RECORDS OF ILLNESS

In situations where illnesses are reported by a parent or become evident while a child or staff member is at the facility and may potentially require exclusion, the facility shall record the following:

- a) Date and time of the illness;
- b) Person affected;
- c) Description of the symptoms;
- d) Response of the staff to these symptoms;
- e) Persons notified (such as a parent, legal guardian, nurse, physician, or the local health department representative, if applicable), and their response;
- f) Name of person completing the form.

RATIONALE: Recording the occurrence of illness in a facility and the response to the illness characterizes and defines the frequency of the illness, suggests whether an outbreak has occurred, may suggest an effective intervention, and provides documentation for administrative purposes.

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

For a sample enrollment/attendance/symptom record, see Appendix F. For a sample *Incident Report Form*, see Appendix Y. Multicopy forms can be used to make

copies of an injury report simultaneously for the child's record, for the parent, for the folder that logs all injuries at the facility, and for the regulatory agency. Facilities should secure the parent's signature on the form at the time it is presented to the parent. For information on the inclusion/exclusion/dismissal of children from child care, see STANDARD 3.065 through STANDARD 3.068.

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

STANDARD 8.063 DOCUMENTATION OF DEATH, INJURY OR ILLNESS

The facility shall document that a child's parent or legal guardian was notified immediately in the event of a death of their child or of an injury or illness of their child that required professional medical attention.

The licensing agency and/or health department shall be notified by the next working day of each of the following events:

- a) Injury or illness that required medical attention;
- b) Reportable communicable disease;
- c) Death;
- d) Any other significant event relating to health and safety (such as a lost child, a fire or other structural damage, work stoppage, or closure).

RATIONALE: The licensing agency should be notified by the next working day of any of the events listed above because each involves special action by the agency to protect children, their families, and/or the community. If an injury, death or any of the events in item d occur due to negligence by the provider, immediate suspension of the license may be necessary. Public health staff can assist in stopping the spread of the communicable disease if they are notified quickly by the licensing agency. The action by the facility in response to an illness requiring medical attention is subject to licensing review.

A report form that records injury, child abuse, illness, or death is also necessary for providing information to the child's parents and health care provider, other appropriate health agencies, and the insurance companies covering the parents and the center.

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

For a sample enrollment/attendance/symptom record, see Appendix F. For a sample *Incident Report Form*, see Appendix Y. Multicopy forms can be used to make copies of an injury report simultaneously for the child's record, for the parent, for the folder that logs all injuries at the facility, and for the regulatory agency. Facilities should secure the parent's signature on the form at the time it is presented to the parent.

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

CARE OF ILL CHILDREN

STANDARD 3.070 SPACE REQUIREMENTS FOR CARE OF ILL CHILDREN

Environmental space utilized for the care of children who are ill with infectious diseases and cannot receive care in their usual child care group shall meet all requirements for well children and include the following additional requirements:

- a) If the program for ill children is in the same facility as the well-child program, well children shall not use or share furniture, fixtures, equipment, or supplies designated for use with ill children unless it has been cleaned and sanitized before use by well children;
- b) Indoor space that the facility uses for ill children, including hallways, bathrooms, and kitchens, shall be separate from indoor space

used with well children; this reduces the likelihood of mixing supplies, toys, and equipment. The facility may use a single kitchen for ill and well children if the kitchen is staffed by a cook who has no child care responsibilities other than food preparation and who does not handle soiled dishes and utensils until after food preparation and food service are completed for any meal;

- c) Children whose symptoms indicate infections of the gastrointestinal tract (often with diarrhea) or liver, who receive care in special facilities for ill children shall receive this care in a space separate from other children with other illnesses to reduce the likelihood of disease being transmitted between children by limiting child-to-child interaction, separating staff responsibilities, and not mixing supplies, toys, and equipment;
- d) If the facility cares for children with chickenpox, these children shall receive care in a separate room that is ventilated externally.
- e) Each child care room shall have a handwashing sink that can provide a steady stream of water, no less than 60 degrees F and no more than 120 degrees F, at least for 10 seconds. Soap and disposable paper towels shall be available at the handwashing sink at all times.
- f) Each room where children who wear diapers receive care shall have its own diaper changing area adjacent to a handwashing sink.

RATIONALE: Transmission of infectious diseases in child care settings may be influenced by the design, construction, and maintenance of the physical environment (51). The population that uses centers should in time become less susceptible to chickenpox through immunization. Some children, however, are too young to be routinely immunized and may be susceptible; and, although universal immunization with varicella vaccine is recommended, full compliance with the recommendation has not been achieved. Chickenpox is readily spread by airborne droplets (1). With implementation of universal use of varicella vaccine, the incidence of varicella in child care facilities will be reduced (1).

Handwashing sinks should be stationed in each room, to promote handwashing and also to give the caregivers an opportunity for continuous supervision of

the other children in care when washing their hands. The sink must deliver a consistent flow of water for 10 seconds so that the user does not need to touch the faucet handles.

Diaper changing areas should be adjacent to sinks to foster cleanliness and also to enable caregivers to provide continuous supervision of other children in care.

COMMENTS: Some facilities have staffed get well rooms typically caring for fewer than six ill children.

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

STANDARD 3.071 QUALIFICATIONS OF DIRECTORS OF FACILITIES THAT CARE FOR ILL CHILDREN

The director of a facility that cares for ill children shall have the following minimum qualifications, in addition to the general qualifications described in Qualifications of Directors of Centers, STANDARD 1.007 through STANDARD 1.014:

- a) At least 40 hours of training in prevention and control of communicable diseases and care of ill children, including subjects listed in STANDARD 3.073;
- b) At least 2 prior years of satisfactory performance as a director of a regular facility;
- c) At least 12 credit hours of college-level training in child development or early childhood education.

RATIONALE: The director shall be college-prepared in early childhood education and have taken college-level courses in illness prevention and control, since the director is the person responsible for establishing the facility's policies and procedures and for meeting the training needs of new staff members.

TYPE OF FACILITY: *Center*

STANDARD 3.072 PROGRAM REQUIREMENTS FOR FACILITIES THAT CARE FOR ILL CHILDREN

Any facility that offers care for the ill child of any age shall:

- a) Provide a caregiver who is familiar to the child;
- b) Provide care in a place with which the child is familiar and comfortable;
- c) Involve a caregiver who has time to give individual care and emotional support, who knows of the child's interests, and who knows of activities that appeal to the age group and to a sick child;
- d) Offer a program planned in consultation with qualified health care personnel and with ongoing medical direction.

RATIONALE: When children are ill, they are stressed by the illness itself. Unfamiliar places and caregivers add to the stress of illness when a child is sick. Since illness tends to promote regression and dependency, ill children need a person who knows and can respond to the child's cues appropriately.

COMMENTS: Because children are most comfortable in a familiar place with familiar people, the preferred arrangement for ill children will be the child's home or the child's regular child care arrangement, when the child care facility has the resources to adapt to the needs of such children. Acquainting all children in care with the ill child area prior to use may reduce the child's anxiety in the event of illness.

For additional information on the care of ill children, see Reporting Illness, STANDARD 3.086 through STANDARD 3.089, and Health Department Plan, RECOMMENDATION 9.025.

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

STANDARD 3.073 CAREGIVER QUALIFICATIONS FOR FACILITIES THAT CARE FOR ILL CHILDREN

Each caregiver in a facility that cares for ill children with level 2 or level 3 illness (as defined in STANDARD 3.064) shall have at least 2 years of successful work experience as a caregiver in a regular well-child facility prior to employment in the special facility. In addition, the Level 1 or Level 2 facility shall document, for each caregiver, 20 hours of pre-service orientation training on care of ill children beyond the orientation training specified in Training, STANDARD 1.023 through STANDARD 1.033. This training shall include the following subjects:

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

This training shall be documented in the staff personnel files, and compliance with the content of training routinely evaluated. Based on these

evaluations, the training on care of ill children shall be updated with a minimum of 6 hours of annual training for individuals who continue to provide care to ill children.

RATIONALE: Because meeting the physical and psychological needs of ill children requires a higher level of skill and understanding than caring for well children, a commitment to children and an understanding of their general needs is essential. Work experience will help the caregiver develop these skills. States that have developed rules regulating facilities have recognized the need for training in illness prevention and control and management of medical emergencies. First and foremost, people working with children should have an understanding of children and should create an environment for children that is developmentally appropriate, healthful, and safe at all times. Therefore, staff members caring for ill children in special facilities or in a get well room in a regular center should meet the staff qualifications that are applied to child care facilities generally.

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

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

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

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

**STANDARD 3.074
CHILD-STAFF RATIOS FOR
FACILITIES THAT CARE FOR ILL
CHILDREN**

Each facility for ill children shall maintain a child-to-staff ratio no greater than the following:

Age of Children	Child to Staff Ratio
2-24 months	3 children to 1 staff member
25-71 months	4 children to 1 staff member
72 months and older	6 children to 1 staff member

RATIONALE: No studies are available to substantiate appropriate staffing levels. Most staffing requirements that state licensing authorities develop are stated in terms of number of staff members required to remove children from a building quickly in the event of fire or other emergency. The expert consensus is that ill children require more intensive and personalized care; therefore, the lowest ratios used per age group seem appropriate.

COMMENTS: These ratios do not include other personnel (such as bus drivers) necessary for specialized functions (such as transportation).

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

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

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

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

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

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

RATIONALE: Appropriate involvement of health consultants is especially important for facilities that care for ill children. Facilities should use the expertise of health professionals to design and provide a child care environment with sufficient staff and facilities to meet the needs of ill children (4, 10). The best interests of the child and family must be given primary consideration in the care of ill children. Consultation by physicians, especially pediatricians, is critical in planning facilities for the care of ill children (2).

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

- a) Local chapters of the American Academy of Pediatrics (AAP);
- b) American Nurses Association (ANA);
- c) Visiting Nurse Association (VNA);
- d) American Academy of Family Physicians;
- e) National Association of Pediatric Nurse Practitioners (NAPNAP);
- f) National Association for the Education of Young Children (NAEYC);
- g) National Association for Family Child Care;

- h) Emergency Medical Services for Children (EMSC) National Resource Center;
- i) National Training Institute for Child Care Health Consultants;
- j) State or local health department (especially public health nursing, communicable disease, and epidemiology departments).

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

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

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

STANDARD 3.076 LICENSING OF FACILITIES THAT CARE FOR ILL CHILDREN

Special facilities that care for ill children shall be required to comply with specific licensing requirements, which shall address the unique regulatory needs of service to children with illness cared for in out-of-home settings.

RATIONALE: Facilities for ill children generally are required to meet the licensing requirements that apply to all facilities of a specific type, for example, small or large family child care homes or centers. Additional requirements should apply when ill children will be in care.

COMMENTS: For additional information on licensing special facilities for ill children, see also Regulatory Policy, RECOMMENDATION 9.001 through

RECOMMENDATION 9.003, on licensing requirements.

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

STANDARD 3.077 INFORMATION REQUIRED FOR ILL CHILDREN

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

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

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

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

For school-age children, documentation of the care of the child during the illness should be provided to the

parent to deliver to the school health program upon the child's return to school. Coordination with the child's source of health care and school health program facilitates the overall care of the child.

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

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

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

- a) Policies and procedures for urgent and emergency care;
- b) Admission and inclusion/exclusion policies. Conditions that require that a child be excluded and sent home are specified in Child Inclusion/Exclusion/Dismissal, STANDARD 3.065 through STANDARD 3.068;
- c) A description of illnesses common to children in child care, their management, and precautions to address the needs and behavior of the ill child as well as to protect the health of other children and caregivers. See Infectious Diseases, STANDARD 6.001 through STANDARD 6.039;
- d) A procedure to obtain and maintain updated individual emergency care plans for children with special health care needs;
- e) A procedure for documenting the name of person affected, date and time of illness, a description of symptoms, the response of the caregiver to these symptoms, who was notified (such as a parent, legal guardian, nurse, physician, health department), and the response;
- f) The standards described in Reporting Illness, STANDARD 3.087 and STANDARD 3.088; and Notification of Parents, STANDARD 3.084 and STANDARD 3.085.
- g) Medication Policy. See STANDARD 8.021.

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

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

- a) The physical facility;
- b) The number and the qualifications of the facility's personnel;
- c) The fact that children do become ill frequently and at unpredictable times;
- d) The fact that working parents often are not given leave for their children's illnesses (53).

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

COMMENTS: Facilities may comply by adopting a model policy and using reference materials as authoritative resources. The *Model Child Care Health Policies*, the print or internet version available from NAEYC and the AAP, may be helpful; or see the *Red Book* or *Preparing for Illness*, a booklet which translates the recommendations of the *Red Book* for child care providers, available from the AAP. Check for other materials provided by the licensing agency, resource and referral agency, or health department. Training for staff on management of illness can be facilitated by using *Part 6: Illness in Child Care*, of the video series developed to illustrate how to comply with the standards in *Caring for Children*. The video series is available from the AAP and NAEYC. See the sample

symptom record in Appendix F. The sample symptom record is also provided in *Healthy Young Children* produced by the NAEYC. See also a sample document for permission for medical condition treatment in Appendix W. Contact information for the National Association for the Education of Young Children (NAEYC) and the American Academy of Pediatrics (AAP) can be found in Appendix BB.

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

RECOMMENDATION 9.005 CARE OF ILL CHILDREN NOT REQUIRING EXCLUSION

Any facility should be encouraged to care for ill children who do not need to be excluded, as defined in STANDARD 3.068, provided that the licensing authority has approved the facility's written plan describing the symptoms or conditions that the facility is prepared to accommodate and procedures for daily care for such children. Facility types should be specific to the child's developmental level.

DISCUSSION: Children enrolled in child care are of an age that places them at increased risk for acquiring infectious diseases. Many children with illness (particularly mild respiratory tract illness without fever) can continue to attend and participate in activities in their usual facility. This perspective is reflected in the standards for excluding children from child care attendance. See Inclusion/Exclusion/Dismissal of Ill Children, STANDARD 3.065 through STANDARD 3.068.

Clearly, when children with possible communicable diseases are present in the alternative care arrangements, emphasis on preventing further spread of disease is as important as in the usual facilities. Prevention of additional cases of communicable disease should be a key objective in these alternative care arrangements for children with minor illness and temporary disability.

Current state regulations concerning exclusion of children from facilities because of illness may be more restrictive than these standards. Some states currently require isolation of a child who becomes ill during the day while attending the facility, and for an ill child who is not expected to return to the facility the following day (59). The most common alternative care

arrangement is for a parent of the ill child to stay home from work and care for the child. Some states have established regulations governing child care for sick children (59).

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

TRAINING OF PROVIDERS

STANDARD I.023 INITIAL ORIENTATION OF ALL STAFF

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

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

The orientation shall address, at a minimum:

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

- d) Any special adaptation(s) of the facility required for a child with special needs for whom the staff member might be responsible at any time;
- e) Any special health or nutrition need(s) of the children assigned to the caregiver;
- f) The planned program of activities at the facility. See Program of Developmental Activities, STANDARD 2.001 through STANDARD 2.027;
- g) Routines and transitions;
- h) Acceptable methods of discipline. See Discipline, STANDARD 2.039 through STANDARD 2.043; and Discipline Policy, STANDARD 8.008 through STANDARD 8.010;
- i) Policies and practices of the facility about relating to parents. See Parent Relationships, STANDARD 2.044 through STANDARD 2.057;
- j) Meal patterns and food handling policies and practices of the facility. See Plans and Policies for Food Handling, Feeding, and Nutrition, STANDARD 8.035 and STANDARD 8.036; Food Service Records, STANDARD 8.074; Nutrition and Food Service, STANDARD 4.001 through STANDARD 4.070;
- k) Occupational health hazards for caregivers, including attention to the physical health and emotional demands of the job and special considerations for pregnant caregivers. See Occupational Hazards, STANDARD 1.048; and *Major Occupational Health Hazards*, Appendix B;
- l) Emergency health and safety procedures. See Plan for Urgent Medical Care or Threatening Incidents, STANDARD 8.022 and STANDARD 8.023; and Emergency Procedures, STANDARD 3.048 through STANDARD 3.052;
- m) General health and safety policies and procedures, including but not limited to the following:
- 1) Handwashing techniques and indications for handwashing. See Handwashing, STANDARD 3.020 through STANDARD 3.024;
 - 2) Diapering technique and toilet use, if care is provided to children in diapers and/or children needing help with toilet use, including appropriate diaper disposal and diaper-changing techniques. See Toilet, Diapering, and Bath Areas, STANDARD 5.116 through STANDARD 5.125; Toilet Use, Diapering, and Toilet Learning/ Training, STANDARD 3.012 through STANDARD 3.019; Toilet Learning/ Training Equipment, Toilets, and Bathrooms, STANDARD 3.029 through STANDARD 3.033;
 - 3) Identifying hazards and injury prevention;
 - 4) Correct food preparation, serving, and storage techniques if employee prepares food. See Food Safety, STANDARD 4.042 through STANDARD 4.060;
 - 5) Knowledge of when to exclude children due to illness and the means of illness transmission;
 - 6) Formula preparation, if formula is handled. See Plans and Policies for Food Handling, Feeding, and Nutrition, STANDARD 8.035 and STANDARD 8.036; and Nutrition for Infants, STANDARD 4.011 through STANDARD 4.021;
 - 7) Standard precautions and other measures to prevent exposure to blood and other body fluids, as well as program policies and procedures in the event of exposure to blood/body fluid. See Prevention of Exposure to Body Fluids, STANDARD 3.026;
- n) Recognizing symptoms of illness. See Daily Health Assessment, STANDARD 3.001 and STANDARD 3.002;
- o) Teaching health promotion concepts to children and parents as part of the daily care provided to children. See Health Education for Children, STANDARD 2.060 through STANDARD 2.063;
- p) Child abuse detection, prevention, and reporting. See Child Abuse and Neglect, STANDARD 3.053 through STANDARD 3.059;
- q) Medication administration policies and practices;
- r) Putting infants down to sleep positioned on their backs and on a firm surface to reduce the risk of Sudden Infant Death Syndrome (SIDS).
- Caregivers shall also receive continuing education each year, as specified in Continuing Education, STANDARD 1.029 through STANDARD 1.036.
- RATIONALE: Upon employment, staff members should be able to perform basic sanitizing and emergency procedures. Orientation ensures that all staff

members receive specific and basic training for the work they will be doing and become acquainted with their new responsibilities. Orientation programs for new employees should be specific to an individual facility since facilities and the children enrolled vary(63).

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

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

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

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

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

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

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

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

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

STANDARD 1.024 ORIENTATION FOR CARE OF CHILDREN WITH SPECIAL HEALTH NEEDS

When a child care facility enrolls a child with special needs, the facility shall ensure that staff members have been oriented in understanding that child's special needs and ways of working with that child in a group setting.

Caregivers in small family child care homes, who care for a child with special needs, shall meet with the parents and a health care worker involved with the child (if the parent has provided prior, informed, written consent) about the child's special needs and how these needs may affect his/her developmental progression or play with other children.

In addition to Orientation Training, STANDARD 1.023, the staff in child care facilities shall have orientation training based on the special needs of children in their care. This training may include, but is not limited to, the following topics:

- a) Positioning for feeding and handling techniques of children with physical disabilities;
- b) Proper use and care of the individual child's adaptive equipment, including how to recognize defective equipment and to notify parents that repairs are needed;

- c) How different disabilities affect the child's ability to participate in group activities;
- d) Methods of helping the child with special needs to participate in the facility's programs;
- e) Role modeling, peer socialization, and interaction;
- f) Behavior modification techniques, positive rewards for children, promotion of self-esteem, and other techniques for managing difficult behavior;
- g) Grouping of children by skill levels, taking into account the child's age and developmental level;
- h) Intervention for children with special health care problems;
- i) Communication needs.

RATIONALE: A basic understanding of developmental disabilities and special care requirements of any child in care is a fundamental part of any orientation for new employees. Training is an essential component to ensure that staff members develop and maintain the needed skills. A comprehensive curriculum is required to ensure quality services. However, lack of specialized training for staff does not constitute grounds for exclusion of children with disabilities.

Staff members need information about how to help children use adaptive equipment properly. Staff members need to understand how and why various items are used and how to check for malfunctions. If a problem occurs with adaptive equipment, the staff must recognize the problem and inform the parent so that the parent can notify the health care or equipment provider of the problem and request that it be remedied. While the parent is responsible for arranging for correction of equipment problems, child care staff must be able to observe and report the problem to the parent.

COMMENTS: These training topics are generally applicable to all personnel serving children with special needs and apply to these facilities. The curriculum may vary depending on the type of facility, classifications of disabilities of the children in the facility, and ages of the children. The staff is assumed to have the training described in Orientation Training, STANDARD I.023, including child growth and development. These additional topics will extend their basic knowledge and skills to help them work

more effectively with children who have special needs and their families. Caregivers should have a basic knowledge of special needs, supplemented by specialized training for children with special needs. The types of children with special needs served should influence the selection of the specialized training. The number of hours offered in any inservice training program should be determined by the staff's experience and professional background.

Service plans in small family child care homes may require a modified implementation plan. The option of child care in small family child care homes for children with special needs must include special requirements.

Training and other technical assistance can be obtained from the following:

- a) The state-designated lead agency responsible for implementing IDEA;
- b) American Academy of Pediatrics (AAP);
- c) American Nurses' Association (ANA);
- d) State and community nursing associations;
- e) National therapy associations;
- f) Local resource and referral agencies;
- g) Federally funded, University Centers for Excellence in Developmental Disabilities Education, Research, and Service programs for individuals with developmental disabilities;
- h) Other colleges and universities with expertise in training others to work with children who have special needs;
- i) Community-based organizations serving people with disabilities (Easter Seals, American Diabetes Association, American Lung Association, etc.).

The parent is responsible for solving equipment problems unless the parent requests that the child care facility remedy the problem directly and the staff agrees to do it.

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

STANDARD 1.025 ORIENTATION DURING INITIAL EMPLOYMENT

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

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

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

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

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

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

FIRST AID AND CPR

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 (62). 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 (64). 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 I.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*

CONTINUING EDUCATION

STANDARD 1.029 CONTINUING EDUCATION FOR DIRECTORS AND CAREGIVERS IN CENTERS AND LARGE FAMILY CHILD CARE HOMES

All directors and caregivers of centers and large family child care homes shall successfully complete at least 30 clock hours per year of continuing education in the first year of employment, 16 clock hours of which shall be in child development programming and 14 of which shall be in child health, safety, and staff health. In the second and each of the following years of employment at a facility, all directors and caregivers shall successfully complete at least 24 clock hours of continuing education based on individual competency needs and any special needs of the children in their care, 16 hours of which shall be in child development programming and 8 hours of which shall be in child health, safety, and staff health.

The effectiveness of training shall be assessed by change in performance following participation in training.

RATIONALE: Because of the nature of their caregiving tasks, caregivers must attain multifaceted knowledge and skills. Child health and employee health are integral to any education/training curriculum and program management plan. Planning and evaluation of training should be based on performance of the staff member(s) involved. Too often, staff members make training choices based on what they like to learn about (their “wants”) and not the areas in which their performance should be improved (their “needs”). Participation in training does not ensure that the participant will master the information and skills offered in the training experience. Therefore, successful completion, not just participation, must be assessed.

In addition to low child:staff ratio, group size, age mix of children, and stability of caregiver, the training/education of caregivers is a specific indicator of child care quality (61). Most skilled roles require training related to the functions and responsibilities the role requires.

Staff members who are better trained are better able to prevent, recognize, and correct health and safety problems. The number of training hours recommended in this standard reflects the central focus of caregivers on child development, health, and safety.

The National Association for the Education of Young Children (NAEYC), a leading organization in child care and early childhood education, recommends annual training based on the needs of the program and the preservice qualifications of staff. Training should address the following areas:

- a) Health and safety;
- b) Child growth and development;
- c) Nutrition;
- d) Planning learning activities;
- e) Guidance and discipline techniques;
- f) Linkages with community services;
- g) Communication and relations with families;
- h) Detection of child abuse;
- i) Advocacy for early childhood programs;
- j) Professional issues (60).

There are few illnesses for which children should be excluded from child care. Decisions about management of ill children are facilitated by skill in assessing the extent to which the behavior suggesting illness requires special management (63). Continuing education on managing communicable diseases helps prepare caregivers to make these decisions. All caregivers should be trained to prevent, assess, and treat injuries common in child care settings and to comfort an injured child.

COMMENTS: Tools for assessment of training needs are part of the accreditation self-study tools available from the NAEYC, the National Association for Family Child Care (NAFCC) and the National Child Care Association (NCCA). Contact information is located in Appendix BB. Successful completion of training can be measured by a performance test at the end of training and by ongoing evaluation of performance on the job.

Resources for training on health issues include:

- State and local health departments (especially the public health nursing department);
- Resource and referral agencies;
- State and local chapters of:

- American Academy of Pediatrics (AAP);
- American Academy of Family Physicians (AAFP);
- American Nurses' Association (ANA);
- Visiting Nurse Association (VNA);
- National Association of Pediatric Nurse Practitioners (NAPNAP);
- National Association for the Education of Young Children (NAEYC);
- National Association for Family Child Care (NAFCC);
- National Training Institute for Child Health Consultants;
- Emergency Medical Services for Children (EMSC) National Resource Center.

For nutrition training, facilities should check to be sure that the nutritionist, who provides advice, has experience with, and knowledge of, food service issues in the child care setting. Most state maternal and child health departments have a Nutrition Specialist on staff. If this Nutrition Specialist has knowledge and experience in child care, facilities might negotiate for this individual to serve or identify someone to serve as a consultant and trainer for the facility.

Many resources are available for nutrition specialists who can provide training in food service and nutrition. See Appendix C, for qualifications of nutrition specialists. Some resources to contact include:

- Local, county, and state health departments;
- State university and college nutrition departments;
- Home economists at utility companies;
- State affiliates of the American Dietetic Association;
- State and regional affiliates of the American Public Health Association;
- The American Association of Family and Consumer Services;
- National Resource Center for Health and Safety in Child Care;
- Registered dietitian at a hospital;
- High school home economics teachers;
- The Dairy Council;
- The local American Heart Association affiliate;
- The local Cancer Society;
- The Society for Nutrition Education;
- The local Cooperative Extension office.

Nutrition education resources may be obtained from the Food and Nutrition Information Center. Contact information is located in Appendix BB. The staff's continuing education in nutrition may be supplemented by periodic newsletters and/or literature or audiovisual materials prepared or recommended by the Nutrition Specialist. See Appendix C, for information on qualifications for nutrition specialists.

Caregivers should have a basic knowledge of special needs, supplemented by specialized training for children with special needs. The type of special needs of the children in care should influence the selection of the training topics. The number of hours offered in any inservice training program should be determined by the experience and professional background of the staff, which is best achieved through a regular staff conference mechanism.

Financial support and accessibility to training programs requires attention to facilitate compliance with this standard. Many states are using federal funds from the Child Care and Development Block Grant to improve access, quality, and affordability of training for early care and education professionals. Home study, video courses, workshops, training newsletters, telecommunications, and lectures can be used to meet the training hours requirement, as can training conducted on site at the child care facility. Completion of training may be documented by self-declaration or by submitting self-tests. Although on-site training can be costly, it may be a more effective approach than participation in training at a remote location.

See also Technical Assistance and Consultation to Caregivers and Families, RECOMMENDATION 9.030 and RECOMMENDATION 9.036; and Training, RECOMMENDATION 9.038 through RECOMMENDATION 9.040. See STANDARD I.052 and STANDARD I.055, on performance evaluation related to continuing education.

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

STANDARD 1.030 CONTINUING EDUCATION FOR SMALL FAMILY CHILD CARE HOME PROVIDERS

Small family child care home providers shall have at least 24 clock hours of continuing education in areas determined by self-assessment and, where possible, by a performance review of a skilled mentor or peer reviewer.

RATIONALE: In addition to low child:staff ratio, group size, age mix of children, and stability of caregiver, the training/education of caregivers is a specific indicator of child care quality (61). Most skilled roles require training related to the functions and responsibilities the role requires. Caregivers who are better trained are better able to prevent, recognize, and correct health and safety problems.

Because of the nature of their caregiving tasks, caregivers must attain multifaceted knowledge and skills. Child health and employee health are integral to any education/training curriculum and program management plan. Planning and evaluation of training should be based on performance of the child care provider. Too often, caregivers make training choices based on what they like to learn about (their “wants”) and not the areas in which their performance should be improved (their “needs”).

Small family child care home providers often work alone and are solely responsible for the health and safety of small numbers of children in care. Peer review is part of the process for accreditation of family child care. Self-evaluation may not identify training needs or focus on areas in which the caregiver is particularly interested and may be skilled already.

COMMENTS: The content of continuing education for small family child care home providers may include the following topics:

- a) Child growth and development;
- b) Infant care;
- c) Recognizing and managing minor illness;
- d) Managing the care of children who require the special procedures listed in Standard 3.063;
- e) Business aspects of the small family child care home;

- f) Planning developmentally appropriate activities in mixed age groupings;
- g) Nutrition for children in the context of preparing nutritious meals for the family;
- h) Acceptable methods of discipline;
- i) Organizing the home for child care;
- j) Preventing unintentional injuries in the home;
- k) Available community services;
- l) Detecting, preventing, and reporting child abuse;
- m) Advocacy skills;
- n) Pediatric first aid, including management of a blocked airway and rescue breathing. See STANDARD 1.026 and STANDARD 1.027;
- o) CPR (if the caregiver takes care of children with special needs or has a swimming/wading pool). See STANDARD 1.028;
- p) Methods of effective communication with children and parents;
- q) Mental health;
- r) Evacuation drill procedures, as specified in Evacuation Plan, Drills, and Closings, STANDARD 8.024 through 8.027;
- s) Occupational health hazards. See Occupational Hazards, STANDARD 1.048; and *Major Occupational Health Hazards*, Appendix B;
- t) Death, dying, and the grief cycle;
- u) SIDS risk-reduction practices.

In-home training alternatives to group training for small family child care home providers are available, such as distance courses on the Internet, listening to audiotapes or viewing videotapes with self-checklists. These training alternatives provide more flexibility for providers who are remote from central training locations or have difficulty arranging coverage for their child care duties to attend training. Nevertheless, gathering family child care home providers for training when possible provides a break from the isolation of their work and promotes networking and support. Satellite training via down links at local extension service sites, high schools, and community colleges scheduled at convenient evening or weekend times is another way to mix quality training with local availability and some networking.

TYPE OF FACILITY: *Small Family Child Care Home*

STANDARD 1.031 TRAINING OF STAFF WHO HANDLE FOOD

All staff members with food handling responsibilities shall obtain training in food service. The director of a center or a large family child care home or the designated supervisor for food service shall obtain certification equivalent to the Food Service Manager's Protection (Sanitation) certificate.

RATIONALE: Outbreaks of foodborne illness have occurred in many settings, including child care facilities. Some of these outbreaks have led to fatalities and severe disabilities. Young children are particularly susceptible to foodborne illness. Because large centers serve more meals daily than many restaurants do, the supervisors of food handlers in these settings should have successfully completed food service certification, and the food handlers in these settings should have successfully completed courses on appropriate food handling.

COMMENTS: Sponsors of the Child and Adult Care Food Program provide this training for some small family child care home providers. For training in food handling, contact the regional office of the Food and Drug Administration, health departments, or the delegate agencies that handle nutrition and environmental health inspection programs. Contact information is located in Appendix BB. Other sources are US Department of Agriculture (USDA) publications, family child care associations, resource and referrals, and licensing agencies.

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

STANDARD 1.032 CHILD ABUSE EDUCATION

Caregivers shall use child abuse prevention education materials provided by the licensing agency, state and national organizations, or from other community agencies such as local branches of the National Committee to Prevent Child Abuse, to educate and establish child abuse prevention and recognition measures for the children, caregivers, and parents. The education and prevention shall

address physical, sexual, and psychological or emotional abuse, injury prevention, the dangers of shaking infants and toddlers, as well as signs and symptoms of sexually transmitted diseases. Child care directors and head teachers shall participate in training to recognize visible signs of child abuse, including pattern marks, bruises in unusual locations, pattern or immersion burns, shaken baby syndrome, and behaviors suggesting sexual abuse. They shall know how to refer children with vaginal, penile, or rectal discharge or bleeding to their health provider. A child care provider shall refer the child to the local child protection agency for any reasonable suspicion of child abuse or neglect.

Caregivers shall be trained in compliance with their state's child abuse reporting laws.

RATIONALE: Centers and large and small family child care homes are strategic locations in which to distribute materials for the prevention of abuse and also for indicators of sexually transmitted diseases. The medical diagnosis of child physical and sexual abuse is complex. However, education about the physical manifestations of abuse can increase the number of appropriate referrals to physicians and child protection agencies.

COMMENTS: All caregivers should learn about the mandated reporting requirements for caregivers, the process for follow-up after making a report, and the protection and exposure of mandated reporters under the state's child abuse law. States and child care providers will select appropriate material from the many available media that can be used in child abuse prevention activities.

Child abuse materials designed for medical audiences may not be suitable for child care training because the photographs in them contain shocking images. Selective use of photographs that help caregivers recognize signs of physical abuse, however, is appropriate.

Resources are available from the American Academy of Pediatrics, the National Clearinghouse on Child Abuse and Neglect Information, and the National Committee for Prevention of Child Abuse. Contact information is located in Appendix BB.

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

STANDARD I.033 TRAINING ON OCCUPATIONAL RISK RELATED TO HANDLING BODY FLUIDS

The director of a center or a large family child care home caregiver shall ensure that all staff members who are at risk of occupational exposure to blood or other blood-containing body fluids will be offered hepatitis B immunizations and will receive annual training in Standard Precautions. Training shall be consistent with applicable standards of the Occupational Safety and Health Administration (OSHA Standard 29 CFR 1910.1030, "Occupational Exposure to Bloodborne Pathogens") and local occupational health requirements and shall include, but not be limited to:

- a) Modes of transmission of bloodborne pathogens;
- b) Standard Precautions;
- c) Hepatitis B vaccine, pre-exposure, or post-exposure within 24 hours;
- d) Program policies and procedures regarding exposure to blood/body fluid;
- e) Reporting procedures under the exposure control plan to ensure that all first-aid incidents involving exposure are reported to the employer before the end of the work shift during which the incident occurs.

RATIONALE: Providing first aid in situations where blood is present is an intrinsic part of a caregiver's job. Split lips, scraped knees and other minor injuries associated with bleeding are common in child care. Regarding the applicability of the OSHA standard to child care, Patricia K. Clark, Director of the Directorate of Compliance Assistance stated:

"One of the central provisions of the OSHA standard on bloodborne pathogens is that employers are responsible for determining which job classifications or specific tasks and procedures are reasonably anticipated to result in worker contact with blood or other potentially infectious materials (OPIM). The standard relates coverage to occupational exposure, regardless of where that exposure may occur, since the risk of

infection with bloodborne pathogens is dependent on the likelihood of exposure to blood or OPIM regardless of the particular job title or place of employment. If it is determined that a child care worker has occupational exposure, as defined by the standard, then that employee is covered by all sections of the standard including training, vaccination, personal protective equipment, and so forth."

Child care workers who are designated as responsible for rendering first aid or medical assistance as part of their job duties are covered by the scope of this standard.

COMMENTS: OSHA has model exposure control plan materials for use by child care facilities. Using the model exposure control plan materials, child care providers can prepare a plan to comply with the OSHA requirements. The model plan materials are available from regional offices of OSHA. Contact information for OSHA is located in Appendix BB.

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

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American Academy of Pediatrics (AAP)

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Introduction, Standards 1.024, 1.027, 1.029, 1.032, 3.075, 6.008, 6.010, 6.012, 6.015-6.017, 6.020, 6.023, 6.027, 6.033, 6.037-6.039, 8.011, 8.014

American Association of Family and Consumer Services

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Standard 1.029

American Cancer Society

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<http://www.cancer.org>
Standard 1.029

American Diabetes Association

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Standard 1.024

American Dietetic Association (ADA)

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Fax: 312-899-1979
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Standard 1.029

American Heart Association (AHA)

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Standards 1.027, 1.029

American Lung Association

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Standard 1.024

American Nurses Association (ANA)

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<http://www.nursingworld.org>
Standards 1.024, 1.029, 3.075

American Public Health Association (APHA)

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Centers for Disease Control and Prevention (CDC)

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Introduction, Standards 6.020, 6.023

Dairy Council

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Phone: 847-803-2000
<http://www.nationaldairycouncil.org>
Standard 1.029

Emergency Medical Services for Children National Resource Center

111 Michigan Avenue, N.W.
Washington, DC 20010-2970
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Standards 1.029, 3.075

Food & Nutrition Information Center

Agricultural Research Service, USDA
National Agricultural Library, Room 105
10301 Baltimore Avenue
Beltsville, MD 20705-2351
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Fax: 301-504-6409

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Standard 1.029

Maternal and Child Health Bureau (MCHB)

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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

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MCHB Region VIII

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Denver, CO 80294
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MCHB Region IX

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San Francisco, CA 94102
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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
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Fax: 206-615-2500
<http://www.mchb.hrsa.gov>
States - AK, ID, OR, WA

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Standards 1.029, 3.065, 3.075, 6.023, 8.011

National Association for Family Child Care (NAFCC)

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Salt Lake City, UT 84123
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<http://www.nafcc.org>
Standards 1.029, 3.075

National Association of Pediatric Practitioners (NAPNAP)

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Standards 1.029, 3.075

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Fax: 202-324-8050
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Recommendation 9.005

National Clearinghouse on Child Abuse and Neglect Information

330 C Street, SW
Washington, DC 20447
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Fax: 703-385-3206
<http://www.calib.com/nccanch>
Standard 1.032

National Child Care Association (NCCA)

1016 Rosser Street
Conyers, GA 30012
Phone: 1-800-543-7161
Fax: 770-388-7772
<http://www.nccanet.org>
Standard 1.029

National Committee for the Prevention of Child Abuse

PO Box 2866
Chicago, IL 60690-9950
Phone: 312-663-3520
<http://www.childabuse.org>
E-mail: mail@preventchildabuse.org
Standard 1.032

National Resource Center for Health and Safety in Child Care

University of Colorado School of Nursing
Campus Mail Stop F541, P.O. Box 6508
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Introduction, Standard 1.029

National Training Institute for Child Care Health Consultants

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Standards 1.029, 3.075

Occupational Health & Safety Administration (OSHA)

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Standard 1.033

Seattle King County Department of Public Health

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Standard 3.065

Society for Nutrition Education

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Standard 1.029

Visiting Nurse Associations of America

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Standard 1.029, 3.075

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RELATED STANDARDS

For more information on the following topics, please see the correlating standards in *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, 2nd edition* (<http://nrc.uchsc.edu/CFOC/index.html>).

Subject	Standards in CFOC, 2nd Ed.
Emergency Procedures	3.048 - 3.052
Food Safety and Handling Policies	4.050-4.060; 8.035
Handwashing	3.020-3.024
Health consultants	1.040-1.044
Immunization Requirements	Appendix G
Infectious Diseases	Chapter 6
Medication Administration	3.081-3.083; 8.021
Notifying Health Department of Infectious Diseases	3.088; 9.027
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