

PROMOTING THE MEDICAL HOME WITHIN CHILD CARE PROGRAMS

Applicable Standards from:

CARING FOR OUR CHILDREN

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

A Joint Collaborative Project of

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INTRODUCTION

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

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

The AAP offered an initial description of the “medical home” in a 1992 policy statement. Efforts to establish medical homes for all children have encountered many challenges, including multiple interpretations of the “medical home” concept and the lack of reimbursement for comprehensive services. In July 2002, the AAP published a new policy statement that contains an expanded definition of the medical home. According to this policy, a medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.¹ In an office setting, a pediatrician or

1. American Academy of Pediatrics. The medical home. *Pediatrics*. 2002;110:184-186

other primary care clinician shares responsibility with the family and others to assure that all of the medical and non-medical needs of the patient are met. Through this partnership, the primary care clinician can help the family access and coordinate community services that are important to the overall health of the child and family. Benefits of a medical home include enhanced efficiency for children and families, efficient use of limited resources, opportunities for professionals to gain expertise and competence, a forum for problem solving, and increased provider and family satisfaction. The medical home concept can be used to guide interactions with families, promote quality improvement practices within pediatric offices and other health care facilities, and develop community- and state-based systems for providing comprehensive care.

Partnerships among pediatricians and child care providers can strengthen efforts to promote medical homes for children in early education and child care programs through increased communications and collaboration. However, while pediatricians express interest in becoming more involved in early education and child care, they frequently cite lack of time and uncertainty about how to get involved as barriers to providing services or consultation to child care programs.² Also, caregivers focus their efforts on nurturing children and keeping them safe, and may experience difficulty finding the time to learn about and manage health records, tracking immunizations, or facilitating communications about each child’s acute and chronic care needs. Nurses and other professionals trained to provide health consultation to child care programs can help bridge these gaps, provide consultation and technical assistance on child health issues, link staff, families, and children to community health resources, and promote the medical home concept. Those striving to provide medical homes for all children can remember that there is a range of opportunities for improving child health depending on whether the child is lacking health insurance and has no regular source of care or needs help with care

2. American Academy of Pediatrics. Division of Child Health Research, Periodic Survey of Fellows #58, Pediatricians’ experiences with and counseling practices on child care health and safety; 2004

coordination or specialty services. The needs of an individual facility will vary depending on the characteristics of that facility and what each family needs. In an optimal setting, the early education and child care program would determine how to inquire whether each child has a regular source of comprehensive care, facilitate open communication among all health and child care professionals involved in the child's care, ensure that the child receives appropriate preventive health services, and connect the family to needed community resources. When a child has an ongoing source of comprehensive care, questions may arise about how to promote effective communications among the caregiver, primary care provider, and family, while protecting patient privacy. A signed release form can be obtained from a parent that allows the pediatric clinician to share relevant information with the child care provider and vice versa.

Intended audiences

The intended audiences for this document are:

- child care providers who need to understand the medical home concept and how best to ensure that every child in their care has a medical home
- state regulators and policy makers who are formulating or changing state regulations regarding the role of child care providers and their interaction with a child's medical home;
- health consultants who can promote the need for a medical home and can act as a resource to connect child care providers, parents, and children with appropriate and comprehensive services;
- parents who need to understand the importance of the medical home concept in providing comprehensive health care for their child.

Throughout this document there will be references to other standards contained in the full edition of CFOC, 2nd Ed. that are not present in this document. For example, comments in Standard 8.015 refers to

standards which are not in this document but are found in the full edition of CFOC, 2nd Ed. In the web version, the user can click on the link to these standards to get to wording of the standard in CFOC, 2nd Ed. Also, standards in this compilation are not necessarily in numerical order because similar topics were brought together from different sections in the larger CFOC, 2nd Ed.

We would like to give special thanks to Laura Aird, MS and Susan Aronson, MD, FAAP for contributing to the Introduction and reviewing this compilation of standards on the medical home. We would also like to thank all those individuals who contributed to CFOC, 2nd Ed. A listing can be viewed at: <http://nrc.uchsc.edu/CFOC/PDFVersion/Acknowledgments.pdf>

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

American Academy of Pediatrics
www.aap.org

National Center for Medical Home Initiatives for Children with Special Needs
<http://www.medicalhomeinfo.org/index.html>

National Resource Center for Health and Safety in Child Care and Early Education
<http://nrc.uchsc.edu>

For questions or assistance on these standards or *Caring for Our Children, 2nd Edition*, please contact:

National Resource Center for Health and Safety in Child Care and Early Education
1-800-598-5437
<http://nrc.uchsc.edu>
natl.child.res.ctr@UCHSC.edu

SOURCE OF HEALTH CARE**STANDARD 2.055
FAMILY SOURCE OF HEALTH CARE**

The facility shall help families who have no regular health care provider to locate a resource that can meet their needs.

RATIONALE: Primary care and preventive health services for children and adults will assist the parents' ability to support their children's healthy growth and development and can identify problems early for intervention. Health services should be comprehensive and range from preventive activities (such as immunizations, injury prevention, diet changes for good nutrition and for allergies) to acute treatments (such as skin problems, ear infections, behavioral issues) to more complicated matters (such as evaluation and referral for potential chronic health problems, hearing, neuromuscular issues).

COMMENTS: Linking families to the health care system (such as a well-child clinic, public health department, private physician, or health insurance programs for which they or the child might be eligible) is a primary prevention goal. Child care providers can assist families to obtain information about their child's eligibility for their state Children's Health Insurance Program (CHIP) and access to a medical home. As a last resort, the family should know what emergency room is closest to their home. Emergency rooms are not designed to provide primary, preventive health care for children or adults. Every state has a Maternal and Child Health helpline where parents can call for help in finding out about how to pay for child health care and how to locate a source of primary care for their children and for themselves. The regional offices of the Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services can provide the helpline numbers for the states in their region. Additional resources include child care resource and referral agencies, county health departments, EPSDT programs, hospital pediatric departments and county medical societies. See also STANDARD 8.015, on the family's health care provider.

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

**STANDARD 2.056
COMMUNITY HUMAN SERVICE
RESOURCES INFORMATION**

The facility shall make available to parents and staff information about human service resources in the community.

RATIONALE: To meet the individual needs of the families, community resources should be identified and the information made available to families. Families' primary and trusted source of information about community resources may be the child care provider. Daily contacts with families give child care providers unique opportunities to support family needs.

COMMENTS: Local resource and referral agencies, mental health services, social services, community health centers, hospitals, private physicians, public health nurses, Head Start, clinic groups, the American Red Cross, public schools, early intervention programs, and county extension services are but a few examples of potential resources. Parents and care-givers will be more aware of these community resources when the child care facility calls their attention to them. The facility can do this by providing information on how to access resource directories and helpline numbers and by inviting personnel from community agencies to participate in staff and parent meetings, or "open houses."

Information on how to access resource directories or helpline numbers can also be obtained from resource and referral agencies, child care consultants in some states, health advocates in center-based programs, and in public health departments.

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

**RECOMMENDATION 9.034
DEVELOPMENT OF LIST OF
PROVIDERS OF SERVICES TO
FACILITIES**

The local regulatory agency or resource and referral agency should assist centers and small and large family child care homes to formulate and maintain a list of community professionals and agencies available to provide needed health, dental, and social services to families.

DISCUSSION: Families depend on their child care facilities to provide information about obtaining health and dental care and other community services. A number of communities have Family Resource Centers, which are central points for information. It is important that regulatory agencies and resource and referral agencies have knowledge of family resource centers or can provide a directory of community services to child care facilities.

Partnerships among health care professionals and community agencies are necessary to provide a medical home for all children. The American Academy of Pediatrics (AAP) defines the medical home as care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent. The medical home is not a building, house, or hospital, but an approach to providing health care services in a high-quality and cost-effective manner (10, 11, 12). Health care professionals and other community service agencies are beginning to recognize that child care facilities are a logical opportunity to provide health promotion and disease prevention services for children and families.

STANDARD 7.010 COORDINATING AND DOCUMENTING SERVICES

Services for all children shall be coordinated in a systematic manner so the facility can document all of the services the child is receiving inside of the facility and is aware of the services the child is receiving outside of the facility. If the parents of a child with special needs so choose, the facility shall be an integral component of the child's overall service plan.

RATIONALE: Coordination of services is a fundamental component in implementing a plan for care of a child with special needs. This is particularly true of the need to coordinate the medical care with specialized developmental services, therapies, and child care procedures in the facility.

COMMENTS: Children with Individualized Family Service Plans (IFSP) have a service coordinator; children with Individualized Education Programs (IEP) have a primary provider or other identified service coordinator. These are the contact persons within the local education agency or lead agency. This method of service coordination is consistent throughout all of the states under the IDEA. Child care providers need to become informed of how this system works and what their responsibilities are.

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

STANDARD 2.058 ON-SITE SERVICES FOR CHILDREN WITH SPECIAL HEALTH NEEDS

Child care providers shall be aware of all on-site services, including the following service providers, that may be of use for children in care:

- a) Special clinics the child may attend, including sessions with medical specialists and registered dietitians;
- b) Special therapists for the child (such as occupational, physical, speech, nutrition);
- c) Counselors, therapists, or mental health service providers for parents (such as social workers, psychologists, psychiatrists).

All care providers shall provide written documentation of the services rendered in the primary language of the parent. Information shall be exchanged only with the prior written, informed consent of the parent.

RATIONALE: Knowing who is treating the child and coordinating services with these individuals is vital to program implementation. There should be a liaison with special clinics for specific disabilities and illnesses when children are seen for consultation at these units. Services provided onsite at the facility should be coordinated with those offered at another site (16, 17).

COMMENTS: Although information is best related in writing, telephone contacts are also helpful. Confidentiality should be respected both with written and verbal communication. Regular contacts between professionals working with the child and family served by the child care facility improve coordination of care, minimize confusion for the family and prevent duplication. Caregivers, however, must strictly adhere to guidelines concerning confidentiality. Documentation of special therapy is necessary for monitoring purposes. These therapies may be provided by private therapists or by clinics or centers specializing in such services. Some social and psychological data may have to be exchanged within the limits of discretion and confidentiality.

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

USE OF HEALTH CONSULTANTS

STANDARD 1.040 USE OF CHILD CARE HEALTH CONSULTANTS

Each center, large family child care home, and small family child care home network shall use the services of a health consultant qualified to provide advice for child care as defined in STANDARD 1.041. Centers and large and small family child care home providers shall avail themselves of community resources established for health consultation to child care.

RATIONALE: Few child care staff are trained as health professionals and few health professionals have training about the community child care programs. When physical, mental, social, or health concerns are raised for the child or for the family, they should be addressed appropriately, often through consultation with or referral to resources available in the community.

Caregivers need to use health consultants in a variety of fields (such as physical and mental health care, nutrition, environmental safety and injury prevention, oral health care, and developmental disabilities). Health consultants should have specific training in the child care setting (14). Such training is more widely available through efforts such as state programs implementing the Healthy Child Care America Campaign, and national support funded by the Maternal and Child Health Bureau, Health Resources and Services Administration, including the National Resource Center for Health and Safety in Child Care, the national staff of the Healthy Child Care America Campaign at the American Academy of Pediatrics and the National Training Institute for Child Care Health Consultants. Contact information is located in Appendix BB.

In states where health consultation is mandatory, compliance is nearly universal (15).

COMMENTS: A health consultant should be a health professional who has an interest in and experience with children, has knowledge of resources and regulations, and is comfortable linking health resources with facilities that provide primarily education and social services. State regulatory agencies should maintain or contract for the maintenance of a registry of health

consultant resources in the community. For example, in Pennsylvania, the PA Chapter of the American Academy of Pediatrics (AAP) maintains and provides training and support for health professionals in such a registry under contracts with the child care regulatory agency and the state department of health. Additional registries are being developed by the National Resource Center for Health and Safety in Child Care, Healthy Child Care America Campaign from the Maternal and Child Health Bureau, Health Resources and Services Administration, and the National Training Institute for Child Care Health Consultants. Child care health consultants may be employed by public or non-profit agencies such as health departments or resource and referral agencies, other health institutions, or may work as independent health consultants. Caregivers also should not overlook health professionals with pediatric and health consultant experience who are parents of children enrolled in their facility. However, involving parents as health consultants requires caution to avoid crossing boundaries of confidentiality and conflict of interest. To foster access to and accountability of health consultants, some form of compensation should be offered.

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

STANDARD 1.041 KNOWLEDGE AND SKILLS OF CHILD CARE HEALTH CONSULTANTS

A facility shall have a health consultant who is a health professional with training and experience as a child care health consultant. Graduate students in a discipline related to child health shall be acceptable as child care health consultants supervised by faculty knowledgeable in child care. A child care health consultant shall either have the full knowledge base and skills required for this role, or arrange to partner with other health professionals who can provide the necessary knowledge and skills.

The knowledge base of the child care health consultant (personally or by involving other health professionals) shall include:

- a) National health and safety standards for out-of-home child care;
- b) How child care facilities conduct their day-to-day operations;
- c) Child care licensing requirements;

- 0) Disease reporting requirements for child care providers;
 - a) Immunizations for children;
 - b) Immunizations for child care providers;
 - c) Injury prevention for children;
 - d) Staff health, including occupational health risks for child care providers;
 - e) Oral health for children;
 - f) Nutrition for children;
 - g) Inclusion of children with special health needs in child care;
 - h) Recognition and reporting requirements for child abuse and neglect;
 - i) Community health and mental health resources for child and parent health.

The skills of the child care health consultant shall include the ability to perform or arrange for performance of the following activities:

- a) Teaching child care providers about health and safety issues;
- b) Teaching parents about health and safety issues;
- c) Assessing child care providers' needs for health and safety training;
- d) Assessing parents' needs for health and safety training;
- e) Meeting on-site with child care providers about health and safety;
- f) Providing telephone advice to child care providers about health and safety;
- g) Providing referrals to community services;
- h) Developing or updating policies and procedures for child care facilities;
- i) Reviewing health records of children;
- j) Reviewing health records of child care providers;
- k) Helping to manage the care of children with special health care needs;
- l) Consulting with a child's health professional about medication;
- m) Interpreting standards or regulations and providing technical advice, separate and apart from the enforcement role of a regulation inspector.

Although the child care health consultant may have a dual role, such as providing direct care to some of the children or serving as a regulation inspector, these roles shall not be mixed with the child care health consultation role.

The child care health consultant shall have contact with the facility's administrative authority, the staff, and the parents in the facility. The administrative authority shall review, respond to, and implement the child care health consultant's recommendations. The child care health consultant shall review

and approve the written health policies used by center-based facilities.

Programs with a significant number of non-English-speaking families shall seek a child care health consultant who is culturally sensitive and knowledgeable about community health resources for the parents' native culture and languages.

RATIONALE: The specific health and safety consultation needs for an individual facility depend on the characteristics of that facility (14). All facilities should have an overall child care health consultation.

The special circumstances of group care may not be part of the health professional's usual education. Therefore, child care providers should seek health consultants who have the necessary specialized training or experience. Such training is more readily available now as described in the previous standard.

To be effective, a child care health consultant should know the available resources in the community and should engage in a partnership with the administrative authority for the facility, the staff, and parents in the consultative and policy-setting process. Setting health and safety policies in cooperation with the staff, parents, health professionals, and public health authorities will help ensure successful implementation of a quality program (13).

Health professionals who serve as child care health consultants do not always have a public health perspective or the full range of knowledge and skills required. Therefore, public health professionals and other health professionals with appropriate training and skills should serve as a resource to inform those who work in the private sector or whose health professional expertise is specialized and lacking in broader knowledge and skills that may be required. For example, while a sanitarian may provide excellent health consultation on hygiene and infectious disease control, another health professional may need to be consulted about medication administration or playground safety. A Certified Playground Safety Inspector would be able to provide consultation about gross motor play hazards, and would not likely be able to provide sound advice about food safety and nutrition.

COMMENTS: The policies and procedures reviewed for approval by child care health consultants should include, but not be limited to, the following:

- a) Admission and readmission after illness, including inclusion/exclusion criteria;

- 0) Health evaluation and observation procedures on intake, including physical assessment of the child and other criteria used to determine the appropriateness of a child's attendance;
- a) Plans for health care and management of children with communicable diseases;
- b) Plans for surveillance and management of illnesses, injuries, and problems that arise in the care of children;
- c) Plans for caregiver training and for communication with parents and health care providers;
- d) Policies regarding nutrition, nutrition education, and oral health;
- e) Plans for the inclusion of children with special health needs;
- f) Emergency plans;
- g) Safety assessment of facility playground;
- h) Policies regarding staff health and safety;
- i) Policies for administration of medication.

See Identifiable Governing Body/Accountable Individual, STANDARD 8.001 through STANDARD 8.003, for additional information regarding administrative authority.

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

INFORMATION SHARING/ PARENT PARTICIPATION

STANDARD 8.015 IDENTIFICATION OF CHILD'S MEDICAL HOME AND PARENTAL CONSENT FOR INFORMATION EXCHANGE

As part of the enrollment of a child, the child care provider shall ask the family to identify the child's health care providers (medical home) and to provide written consent to enable the caregiver to establish communication with those providers. The family will always be informed prior to the use of the permission unless it is an emergency or a suspected abusive situation. The providers with whom the facility shall exchange information with parental consent shall include:

- a) Sources of regular medical and dental care (such as the child's health care provider, dentist, and medical facility);
- b) Source of emergency services, when required;

- c) Special clinics the child may attend, including sessions with medical specialists and registered dietitians;
- d) Special therapists for the child (such as occupational, physical, speech, nutrition). These special therapists shall provide written documentation of the services rendered;
- e) Counselors, therapists, or mental health service providers for parents (such as social workers, psychologists, or psychiatrists).

RATIONALE: Primary health care providers are involved not only in the medical care of the child but in the ecological system in which the child exists. A major barrier to productive working relationships between child care and health care providers is inadequacy of communication channels (2, 3).

Knowing who is treating the child and coordinating services with these sources of service is vital to the ability of the caregivers to offer appropriate care of the child. Every child should have a health care provider for primary care, and those with special needs will have therapists and consultants.

COMMENTS: A source of health care may be a community clinic, a public health department, or a primary health care provider. Families should also know the location of the hospital emergency room nearest to their home. The emergency room is not an appropriate place for routine care, but may properly be used in an emergency. Education and information for caregivers about community resources is a good topic for staff training.

For more information regarding communication between a child's care facility and that child's health care providers, see STANDARD 2.054. See STANDARD 8.053 through STANDARD 8.057, regarding confidentiality and access to records. For a sample *Child Health Assessment* that includes important health information, see Appendix Z. See also a sample document for permission for medical condition treatment in Appendix W.

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

STANDARD 2.059 COMMUNICATION FROM SPECIALISTS

Providers who come into the facility to furnish special services to a child shall also communicate at each visit with the caregiver at the facility who is responsible for sharing information with the

parent. These providers may include, but are not limited to, physicians, registered nurses, occupational therapists, physical therapists, speech therapists, educational therapists, and registered dietitians. The discussions shall be documented in the child's written record.

RATIONALE: Therapeutic services must be coordinated with the child's general education program and with the parents and caregivers so everyone understands the child's needs. To be most useful, the providers must share the therapeutic techniques with the caregivers and parents and integrate them into the child's daily routines, not just at therapy sessions. Parental consent to share some information may be necessary.

COMMENTS: See Child Records, 8.046 through 8.052, for information regarding child health records.

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

**STANDARD 8.016
INFORMATION SHARING ON
THERAPIES AND TREATMENTS
NEEDED**

The person at the child care facility who is responsible for planning care for the child shall seek information on therapies and treatments being provided to the child that are directly relevant to the health and safety of the child in the child care facility. The consent of the child's parents shall be obtained before this confidential information is sought.

RATIONALE: The facility must have accurate, current information regarding the medical status and treatment of the child so it will be able to determine the facility's capability to provide needed services or to obtain them elsewhere.

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

**STANDARD 8.017
INFORMATION SHARING ON
FAMILY HEALTH**

Families shall be asked to share information about family health (such as chronic diseases) that might affect the child's health.

RATIONALE: A family history of chronic disease helps child care providers understand family stress and experiences of the child within the family.

COMMENTS: Information on family health can be gathered by simply asking parents to tell the caregiver about any chronic health problems that the child's parents, siblings, or household members have or by requesting that this information be supplied by the child's primary health care provider.

Family management of chronic illness may require additional support services.

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

**STANDARD 2.057
ENABLING PARENTS AS CHILD
ADVOCATES**

Child care providers shall inform parents about programs and sources of information that will improve parents' capability as advocates for the children's needs. When the facility does not directly offer applicable services, the child care provider shall refer parents to agencies with experience in working with the needs of their children. Facilities shall document any referrals in writing.

RATIONALE: Applicable referrals will make parents more effective advocates for their children's needs.

COMMENTS: Information should be shared with parents in the parents' primary language and with sensitivity to the parents' ethnic and cultural practices.

Advocacy training can be provided by a service provider or an outside agency. In the case of a child with special needs, the family can be referred to agencies involved with special needs. For additional information on parental participation, see Parental Involvement, STANDARD 2.050 through STANDARD 2.053, and Health Information Sharing, STANDARD 2.054.

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

STANDARD 2.050 SEEKING PARENT INPUT

Each caregiver shall, at least twice a year, seek the views of parents about the strengths and needs of the facility. Caregivers shall honor parents' requests for more frequent reviews.

RATIONALE: This standard strengthens the recognition by parent and caregiver alike that parents have essential rights in helping to shape the kind of child care service their children receive.

COMMENTS: Small and large family child care homes should have group meetings of all parents once or twice a year. This standard avoids mention of procedures that are inappropriate to small family child care, as it does not require any explicit mechanism (such as a parent advisory council) for obtaining or offering parental input. Individual or group meetings with parents would suffice to meet this standard. Seeking consumer input is a cornerstone of facility planning and evaluation.

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

STANDARD 2.051 SUPPORT SERVICES FOR PARENTS

Centers shall establish parent groups and parent support services. Centers shall document these services and shall include intra-agency activities or other community support group offerings. The caregiver shall record parental participation in these on-site activities in the facility record.

RATIONALE: Parental involvement at every level of program planning and delivery and parent support groups are elements that are usually beneficial to the children, parents, and staff of the facility. The parent association group facilitates mutual understanding between the center and parents. Parental involvement also helps to broaden parents' knowledge of administration of the facility and develops and enhances advocacy efforts.

COMMENTS: Parent meetings within a facility are useful means of communication that supplement mailings and indirect contacts.

TYPE OF FACILITY: *Center*

RECORDS

STANDARD 8.042 PLAN FOR PROGRAM ACTIVITIES

The facility shall have a written comprehensive and coordinated planned program of daily activities based on a statement of principles for the facility that sets out the elements from which the daily plan is to be built. The program of activities shall:

- a) Address each developmental age group served, that is, infants, toddlers, preschoolers, school-age children, and children with special needs;
- b) Cover the elements of developmental activities specified in STANDARD 2.001 through STANDARD 2.028;
- c) Maintain the child:staff ratios described in Child:Staff Ratio and Group Size, STANDARD 1.001 through STANDARD 1.005;
- d) Provide for incorporation of specific health, development, and safety education activities into the curriculum on a daily basis throughout the year. Topics of health education shall include health promotion and disease prevention strategies, physical, oral/dental, mental, and social health, and nutrition;
- e) Offer a parent education plan about child health. Such a plan shall have been reviewed and approved by a licensed health professional, who may also serve as the facility's health consultant (see Health Consultants, STANDARD 1.040 through STANDARD 1.044). This plan shall primarily involve personal contacts with parents by knowledgeable caregivers. The parent education plan shall include topics identified in Health Education for Parents, STANDARD 2.065 through STANDARD 2.067, and cover the importance of developmentally appropriate activities.

RATIONALE: Those who provide child care and early childhood education must themselves be clear about the components of their program. Child care is a "delivery of service" involving a contractual relationship between provider and consumer. A written plan helps to specify the components of the service and contributes to responsible operations that are conducive to sound child development and safety practices, and to positive consumer relations. The process of preparing plans promotes thinking about programming for children. Plans also allow for monitoring and for accountability. An increasing number of centers and homes are serving children with special needs.

Early childhood specialists and pediatricians agree that cognitive, emotional/social, and physical development are inseparable. The child's health influences all areas of development. Continuity of responsive, affectionate care must be coupled with recognition by the caregiver of the child's developmental phase or stage to provide opportunities for the child to learn and mature through play (4, 5). Young children learn better by experiencing an activity and observing behavior than through didactic training (5). There is a "reciprocal relationship" between learning and play. Play experiences are closely related to learning (6).

Parental behavior can be modified by education (6). Parents should be involved with the facility as much as possible. The concept of parent control and empowerment is key to successful parent education in the child care setting (6). Although research has not shown whether a child's eventual success in education or in society is related to parent education, support and education for parents lead to better parenting abilities (6).

COMMENTS: Examples of parental health education activities include the following topics:

- a) Importance of having a primary health care provider (medical home) for each child;
- b) Verbal explanation of principles of personal hygiene;
- c) Discussions about the nutritional value of snacks;
- d) The importance of implementing effective child passenger and other safety practices;
- e) The value of exercise.

Examples of child development activities include:

- a) Importance of talking and reading to children;
- b) Importance of creative play activities;
- c) Encouraging children to experience their natural environments.

Parents and staff can experience mutual learning in an open, supportive setting. Suggestions for topics and methods of presentation are widely available. For example, the publication catalogs of the National Association for the Education of Young Children (NAEYC) and of the American Academy of Pediatrics (AAP) contain many materials for child, parent and staff education on child development, the importance of attachment and temperament, and other health issues. A certified health education specialist can also be a source of assistance. The American Association for Health Education (AAHE) and the National Commission for Health Education Credentialing, Inc. (NCHEC) provide information on this speciality. Contact information for the NAEYC, AAP, AAHE, and NCHEC is located in Appendix BB.

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

STANDARD 8.048 CONTENTS OF CHILD'S HEALTH REPORT

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

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

- 0) or any other condition that requires accommodation in child care;
- a) A description of serious injuries sustained by the child in the past that required medical attention or hospitalization;
- b) Other special instructions for the caregiver.

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

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

RATIONALE: The requirement of a health report for each child reflecting completion of health assessments and immunizations is a valid way to ensure timely preventive care for children who might not otherwise receive it and can be used in decision-making at the time of admission and during ongoing care (7). This requirement encourages families to have a primary health care provider (medical home) for each child where timely and periodic well-child evaluations are done. The objective of timely and periodic evaluations is to permit detection and counseling for improved oral, physical, mental, and emotional/social health (1). The reports of such evaluations provide a conduit for communication of information that helps the health professional and the child care provider determine appropriate services for the child. When the parent carries the request for the report to the health professional, concerns of the child care provider can be delivered by the parent to the child's health professional and consent for communication is thereby given. The parent can give written consent for direct communication between the health care provider and the caregiver so that the forms can be faxed or mailed.

Quality child care requires information about the child's health status and need for accommodations in child care (7).

COMMENTS: The purpose of a health report is to:

- a) Give information about a child's health history, special needs, and current health status to allow the caregiver to provide a safe setting and healthful experience for each child;
- b) Promote individual and collective health by fostering compliance with approved standards for health care assessments and immunizations;
- c) Document compliance with licensing standards;

- d) Serve as a means to ensure early detection of health problems and a guide to steps for remediation;
- e) Serve as a means to facilitate and encourage communication and learning about the child's needs among caregivers, health care providers, and parents.

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

The requirement for updated health reports does not mean that the child should have a special examination for entry into child care or at intervals related to duration of participation in child care. The evaluations by the child's health professional should occur according to the national schedule for routine preventive care. The medical reports should confirm that the child has received all the age appropriate services outlined in the guidelines for assessments of the American Academy of Pediatrics (AAP), Bright Futures, or Medicaid's Early Periodic Screening and Diagnostic Treatment (EPSDT) program (1, 8, 9).

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

Health data should be presented in a form usable by caregivers to identify any special needs for care. Local Early Periodic Screening and Diagnostic Treatment (EPSDT) program contractor, if available, should be called upon to help with liaison and education

activities. In some situations, screenings may be performed at the facilities. When clinicians do not fill out forms completely enough to assist the caregiver in understanding the significance of health assessment findings or the unique characteristics of a child, the caregiver should obtain parental consent to contact the child's clinician to explain why the information is needed and to request clarification.

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

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

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

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

STANDARD 8.050 CONTENTS OF CHILD CARE PROGRAM'S HEALTH HISTORY

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

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

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

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

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

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

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

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Recommendations for Preventive Pediatric Health Care (RE9939) Committee on Practice and Ambulatory Medicine

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

These guidelines represent a consensus by the Committee on Practice and Ambulatory Medicine in consultation with national committees and sections of the American Academy of Pediatrics. The Committee emphasizes the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

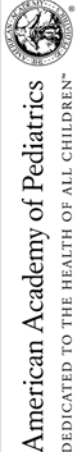
	INFANCY*					EARLY CHILDHOOD*				MIDDLE CHILDHOOD*					ADOLESCENCE*														
	PRENATAL ¹	NEWBORN ²	2-4d ³	1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	11y	12y	13y	14y	15y	16y	17y	18y	19y	20y	21y
AGE⁴																													
HISTORY Initial/interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS Height and Weight Head Circumference Blood Pressure	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING Vision Hearing	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT/ PHYSICAL EXAMINATION⁶	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES-GENERAL¹⁰ Hereditary/Metabolic Screening ¹¹ Immunization ¹² Hematocrit or Hemoglobin ¹³ Urinalysis	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES-PATIENTS AT RISK Lead Screening ¹⁵ Tuberculin Test ¹⁷ Cholesterol Screening ¹⁸ STD Screening ¹⁹ Pelvic Exam ²⁰	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
ANTICIPATORY GUIDANCE²¹ Injury Prevention ²² Violence Prevention ²³ Sleep Positioning Counseling ²⁴ Nutrition Counseling ²⁵	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
DENTAL REFERRAL²⁶	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

1. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "The Prenatal Visit" (1996).
2. Every infant should have a newborn evaluation after birth. Breastfeeding should be encouraged and instructed. Every infant should have a weight, length, and head circumference measurement at birth, 2-4 days after birth, and at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months of age.
3. For newborns discharged in less than 48 hours after delivery per AAP statement "Hospital Stay for Healthy Term Newborns" (1995).
4. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent follow-up.
5. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
6. If the patient is uncooperative, rescreen within 6 months.
7. All newborns should be screened per the AAP Task Force on Newborn and Infant Hearing statement. By newborn and infant hearing loss. Decision and intervention (1999).
8. By history and physical examination, or if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
9. At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
10. These may be modified, depending upon entry point into schedule and individual need.
11. Metabolic screening (eg, thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
12. See AAP statement "Immunization Practices for the Committee on Infectious Diseases, published annually in the January edition of Pediatrics. Every visit should be an opportunity to update and complete a child's immunizations.
13. See AAP Pediatric Nutrition Handbook (1998) for a discussion of universal and selective screening options. Consider earlier screening for high-risk infants (eg, premature infants and low birth weight infants). See also "Recommendations to Prevent and Control Iron Deficiency in the United States," MMWR, 1996;47.
14. All 11-12-year-old adolescents should be screened annually.
15. Conduct dipstick urinalysis for leukocytes annually for sexually active male and female adolescents.
16. For children at risk of lead exposure consult the AAP statement "Screening for Elevated Blood Levels" (1998). Additionally, screening should be done in accordance with state law where applicable.
17. TB testing per recommendations of the Committee on Infectious Diseases, published in the current edition of Red Book. Report of the Committee on Infectious Diseases. Testing should be done upon recognition of high-risk factors.
18. Cholesterol screening for high-risk patients per AAP statement "Cholesterol in Childhood" (1998). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
19. All sexually active females should have a pelvic examination. A pelvic examination and Papanicolaou smear should be performed at the first visit for care for the AAP.
20. Age-appropriate discussion and counseling should be an integral part of each visit for care for the AAP Guidelines for Health Supervision II (1998).
21. From birth to age 12, refer to the AAP injury prevention program (TIPP) as described in A Guide to Safer Living: Injury Prevention and Control for all patients per AAP statement "The Role of the Pediatrician in Youth Violence: An Official Practice Statement of the Committee on Injury, Violence, and Firearms" (1999).
22. Parents and caregivers should be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of SIDS. Consult the AAP statement "Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position" (2000).
23. Age-appropriate nutrition counseling should be an integral part of each visit per the AAP Handbook of Pediatrics (1998).
24. Earlier initial dental examinations may be appropriate for some children. Subsequent examinations are prescribed by dentist.

Key:

• = to be performed
 S = subjective, by history
 O = objective, by a standard testing method
 ← = range during which a service may be provided, with the dot indicating the preferred age.

NIH: Special chemical, immunologic, and endocrine testing is usually carried out upon specific indications. Testing other than newborn (eg, sibborn errors of metabolism, sickle disease, etc) is discretionary with the physician. The recommendations in this statement do not indicate a specific course of treatment or standard of medical care. Variations, taking into account individual differences, may be appropriate. Copyright © 2000 by the American Academy of Pediatrics. No part of this statement may be reproduced in any form or by any means without prior written permission from the American Academy of Pediatrics except for one copy for personal use.



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Permission for Medical Condition Treatment

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

(Parent Signature)

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

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

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

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

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

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

CHILD HEALTH ASSESSMENT

Parents & Child Care Providers fill-in this part.

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

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

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

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

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

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

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Contact Information

American Academy of Pediatrics (AAP)

141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1098
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American Association for Health Education (AAHE)

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Fax: 703-476-6638
E-mail: aahe@ahhperd.org
<http://www.aahperd.org/aahe>

American Public Health Association (APHA)

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

Maternal and Child Health Bureau (MCHB)

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

MCHB Region II

26 Federal Plaza
Federal Building, Room 3835
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States - NJ, NY, PR, VI

MCHB Region III

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States - IA, KS, MO, NE

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Denver, CO 80294
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Fax: 303-844-0002
States - CO, MT, ND, SD, UT, WY

MCHB Region IX

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

MCHB Region X

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

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

Contact Information

National Association for the Education of Young Children (NAEYC)

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

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

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

National Resource Center for Health and Safety in Child Care

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

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

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