Chapter 3

Health and Safety

"Because these children spend many hours away from their home environment, early childhood programs must direct greater attention to children's health, safety and nutritional needs. Activities, environments, meal planning and supervision should reflect a commitment to promoting the optimal growth and development of each infant and child served."

(Marotz, 1., Rush, J. & Cross, M. Health, Safety and Nutrition for the Young Child, 2nd ed., Delmar, Albany, 1989)

♥ HEALTH AND SAFETY

The new staff member must very quickly learn the techniques and procedures for protecting the lives, the health, and the safety of the child in care. The inexperienced aide or assistant teacher may not know how attentive she must be in supervising the children. She may not know that you have to be able to see and hear everything going on in the classroom. How can you emphasize the importance of this aspect of her responsibilities?

Licensing Requirements

The **Licensing Standards** provide some excellent guidelines for ensuring children's health and safety. Compliance with these guidelines can assist you in developing and scheduling the training needed for your staff. The **Licensing Standards** require staff to be trained on specific policies related to health and safety before assuming job responsibilities. Part VII of the **Licensing Standards** contains the major portions of the health care requirements. Health and safety training is addressed in the **Licensing Standards** through the individual job responsibility standards that apply to each individual job category. New staff should become familiar with those standards applicable to the age group in their care. In addition to the health care standards, there are safety standards which are designed to reduce the risks to children in the center environment.

These standards specify good practices of sanitation and safety prevention measures, including the handling of dangerous materials. There is no substitute for adequate supervision, however! New staff must be aware of and committed to the essential tasks in maintaining safe environments for children. The health department personnel are happy to schedule infection control training for childcare centers, and will, in most cases, come to your centers to provide the training.

Wellness Promoting Practices

Parents, center staff, and administrators know that the very best educational program means nothing if delivered in an environment that places children's health and safety at risk. Building codes, zoning, rules and fire, sanitation, and water regulations serve to ensure the maintenance of a safe physical environment. The day-to-day supervisory skills of the teachers and aides are crucial to determining the level of illness and injury that may be present in a center.

This section of The Director's Toolbox will address some specifics of hand washing, infection control, safety practices, and child abuse and neglect. It is important that these routines become an automatic practice when performing your daily job duties. These practices are critical in group care of young children as well as in the health of teachers, staff, and families. We have included numerous handouts at the end of this chapter for you to copy and post throughout your center as reminders of good health and safety habits and techniques.

Morning Inspection

The staff nurse or a staff member who has been properly trained may do the morning health inspection of each child. Even though the list may seem lengthy, the morning health inspection only requires a few minutes, particularly if you incorporate it during your greeting children in the morning. The inspection is easy to remember if you start at the top and go from head to toe and then from front to back. Check the following:

1. Scalp - Itching, sores, cleanliness, lice. Children are excluded from school if lice are present

2. Face - General appearance, expression, unusual color

3. Eyes - Redness of eyelid lining, irritation, puffiness, squinting, frequent rubbing, styles, sensitivity to light, yellowish color

4. Ears - Drainage, earache. (There are other observations for hearing impairment.)

5. Nose - runny nose, sneezing, frequent rubbing

6. Mouth - Inside of mouth for redness, spots, sores

7. Throat - Enlarged, red, or irritated tonsils with or without white spots

8. Chest - Frequent or severe coughing, wheezing, rattles (raspy breathing)

   - ♥ Child gets red or blue in the face.
   - ♥ Child makes high-pitched croupy or whooping sound after he coughs.

9. Skin - Yellowish skin or eyes, unusual spots, rash, bumps, bruises, unusual injuries; crusty, bright yellow dry or gummy areas of body. Check both front and back of body.

10. Fever - Feverish appearance with changes in behavior

    - ♥ Child is cranky or less active than usual.
    - ♥ Child cries more than usual.
    - ♥ Child appears unwell or generally uncomfortable.
    - ♥ Fever greater than 101°F.

The communicable disease chart lists the diseases that require exclusion from the center. Often the disease is most contagious during the very first stages of the illness.

If the child is diagnosed or if symptoms indicate that he has a communicable disease, then he is separated from the other children. The director must be informed. Vomiting, headaches, a stiff neck, or a fever indicate that the child should leave the center as soon as possible. Some centers do have facilities for caring for mildly ill children. If your center does, follow the appropriate procedures for notifying the parents and transferring the child to the proper area.

If a child is coughing or sneezing because of allergies, he should cover his mouth, use tissues, throw them in the waste basket, and wash his hands. And if you wipe his nose, you should throw away the tissue and wash your hands! Always follow the routine indicated by the Centers for Disease Control and help the children learn that routine also.

Washing Hands

Handwashing is the most important way to reduce the spread of infection. Many studies have shown that unwashed or improperly washed hands are the primary carriers of infections. Deficiencies in handwashing have contributed to many outbreaks of diarrhea among children and caregivers in child care centers.

In child care centers that have implemented a handwashing training program, the incidence of diarrheal illness has decreased by 50%. One study found that handwashing helped to reduce colds when frequent and proper handwashing practices were incorporated into a child care center's curriculum.

Children should be taught the proper way to wash their hands, based upon the training staff members have received during orientation. Teachers need to be sure that soap, paper towels, and toilet paper are all within easy reach of the children. Children who need help learning to use these supplies should receive that help.

Children should wash their hands:

- ♥ when they arrive in the morning
- ♥ before and after each snack and meal
- ♥ each time after using the toilet (You must also wash your hands, after changing wet or soiled clothing or changing diapers.)
- ♥ after sneezing or blowing nose
- ♥ after any contact with body fluids
- ♥ before they go home at the close of the day

Hand washing is a very important component in the prevention of disease in groups of children. The importance should be explained simply and as a matter-of-fact.

It is not necessary to use a lot of long technical explanations or scare tactics, to prevent the spread of disease. If children ask simply explain that we all need to keep our hands clean so that we won't get sick. Help make hand washing a habit that is established as a part of normal daily routine. Modeling is the strongest teacher for children. Each time you prepare to fix or eat a meal or snack, or help a child in the bathroom, explain that you need to wash your hands while you are washing them.

To encourage children to really use soap and wash their hands, you might wish to develop a ritual of smelling little hands to see if you can smell soap. Comment on how clean their hands look and how good they smell if you know they have washed them.

♥ PREVENTION OF DISEASE

Any time children are together in groups, the possibility of the spread of disease is increased. Child day centers must take special care to reduce this risk to the greatest extent possible.

Before Admission

Physical Exam

Each child must have a physical examination by a physician or a member of the health department staff. This examination should have been completed:

- ♥ within 2 months prior to attendance for infants 6 months of age and younger
- ♥ within 3 months prior to attendance for children 7-18 months of age
- ♥ within 6 months prior to attendance for children 19-23 months of age
- ♥ within 12 months prior to attendance for children 2-5 years of age

If a child is transferred from another licensed or registered child day program, a home certified by a local department of social services or home approved by licensed family day systems, the physical he had for that facility will suffice until it is time for it to be updated, as long as the center can obtain a copy of the report.

Immunizations

A child must have received all immunizations required for that child's age group and have listed them on the medical form.

Medical Report
All of the above information must be included on the form required by the health department or on the physician's form.

The form must include the date of the physical examination and the date(s) of immunizations, as well as the signature of the physician or his designee or official of the local health department where the exam was performed.

There should be a form on file at the child day center for each child.

Updates
The center shall obtain documentation of additional immunizations once every six months, for children under two, then at least once more between the child's fourth and sixth birthdays.

Exemptions
Parents who object to immunizations and/or physical examinations on religious grounds must submit a signed statement stating the fact that the parent objects on religious grounds, but to the best of the parent's knowledge, the child is in good health and has no communicable or contagious diseases.

AIDS - Acquired Immune Deficiency Syndrome

Very special care must be taken to protect children and staff from AIDS and HIV-positive infections. Center staff may not know, as indeed the infected person may not know, that a child, parent or a staff member may have contracted the AIDS virus or may test positive for HIV. Since we do not know who may be infected, ALL instances or accidents in which blood is present MUST be treated as though HIV/AIDS ARE present.

Vomit, feces, and urine must also be treated in accordance with good hygienic practice. It is crucial to recognize and to respond accordingly to instances in which an individual is vulnerable to contracting HIV/AIDS, such as through open cuts or even chapped hands.

Plastic or rubber gloves must be readily available in classrooms and outdoor playgrounds. All staff must know the correct procedures for disinfecting, cleaning up, and disposing of possible contaminated materials. There is a correct way of taking off and disposing of gloves that must be learned and practiced.

Regional HIV/AIDS programs and the Health Department can provide training in this area. Every staff member must make those procedures routine, strict, and consistent.

The effects of the HIV/AIDS virus are particularly devastating: therefore, one cannot disregard essential safety measures due to carelessness. Ask for training, demonstrations, and for the gloves and disinfecting materials that are essential in preventing the spread of this harmful increasingly prevalent disease.

Special Health Problems

If a child has a special health problem, it should be noted on a separate document in his or her file. The child's teacher and center staff should be informed promptly of the child's special condition.

Special health problems could include:

Physical

- ♥ allergies
- ♥ epilepsy
- ♥ physical disabilities
- ♥ hearing or sight deficits
- ♥ any other condition that might affect the way a child functions within the center setting

Emotional

Problems that affect the emotional well being of a child should be documented; as with other personal information, such documentation must remain strictly confidential. The director and the child's teacher should be the only people to whom this information is made available.

Some problems that affect the child's emotional well being might include:

- ♥ family problems, such as divorce or separation
- ♥ parents who fight frequently
- ♥ siblings who are disabled or chronically ill
- ♥ other family members who have had emotional problems
- ♥ illness or hospitalization of family members
- ♥ hospitalization of child
- ♥ loss of a pet, friend, or family member

Some signals of possible emotional problems are:

- ♥ listlessness
- ♥ frequent temper tantrums
- ♥ easily distracted from an activity
- ♥ lack of interest in surroundings
- ♥ lasting, noticeable change in personality

Confidentiality

Teachers of young children are an important part of their lives. Therefore, a child's experiences at the center will affect his behavior at home. The opposite is also true: a child's experiences at home will affect his behavior at the center. From time to time, it will become important for you, the director, as well as the child's teacher, to be made aware of situations concerning a child's family life or his physical or emotional health that might be helpful in planning for and interacting with that child.

It is extremely important that this information be kept strictly confidential. There should be no discussion of this information with other staff members, parents, or children. Only those people who have direct responsibility for the child should be given this information.

Parents, other staff members, or children should never be discussed with unauthorized people.

Notice to Parents

Infection Control Policy

It is inevitable that children will get sick, no matter where they are. As children begin to have contact with the world outside that of their own families, they are exposed to viruses and bacteria that are foreign to their bodies. This is the way they build immunities. We cannot, nor would we want to, shield a child completely from the outside world. If we did, the natural immunities a child gains through contact with others would not develop and a simple cold could become a serious illness. However, we do want to protect a child from an unusually high exposure to germs all at once.

In a child care setting, children come into contact with groups of other children outside their families. It is in this situation that the illness of one child can spread rapidly through the group to other children and staff members if stringent measures to prevent this spread are not taken.

For this reason, the staff at the center will take constant precautions to prevent the spread of disease. Many common childhood diseases are contagious. They are caused by germs which may be spread in several ways. Intestinal tract infections are spread through stools. Respiratory tract infections are spread through coughs, sneezes, and runny noses. Other diseases are spread through direct contact. Careful handwashing by staff and children can eliminate approximately 75 percent of the risk of spreading these illnesses. Other precautions include separating sick children from those who are well, taking extra precautions with diapering or toilet training children, and working to maintain sanitary conditions throughout the center.

You, the parents, can help us in our effort to keep your children healthy. We ask your cooperation in the following ways:

1. If your child has been exposed to any of the diseases listed on the accompanying chart, we ask that you notify us of the exposure.

2. If your child shows any of the following symptoms you will be called and asked to come immediately. Please help us protect the other children by responding promptly. If your child has any of the following symptoms at home, we ask that you keep him/her out of school until the symptoms are gone or until your physician says it is all right to return.

The symptoms include:

- ♥ fever greater than 101°F.
- ♥ severe coughing - child gets red or blue in the face
- ♥ high-pitched croupy or whooping sounds after coughing
- ♥ difficult or rapid breathing - especially in infants
- ♥ yellowish skin or eyes
- ♥ pinkeye - tears, redness of eyelid lining, followed by swelling and discharge of pus
- ♥ unusual spots or rashes
- ♥ sore throat or trouble swallowing
- ♥ infected skin patches
- ♥ crusty, bright yellow, dry, or gummy areas of skin - possibly accompanied by fever
- ♥ unusually dark, tea colored urine - especially with a fever
- ♥ grey or white stool
- ♥ headache and stiff neck
- ♥ vomiting
- ♥ severe itching of body or scalp or scratching of scalp

If any of the above symptoms are present or if a child appears cranky or less active than usual, cries more than usual, or just seems generally unwell at home, you are asked to look for any of the above symptoms or inform the child's teacher so that the child can be watched carefully for the development of symptoms.

It is imperative that we all work together to keep all of the children who attend the center as healthy and happy as possible. We thank you for your cooperation.

Parent Agreement

Child's Name: _____ Teacher: _____

I have read and understand the attached infection control policies, and I agree to abide by them for the protection of my child as well as the other children and staff members at _____ Center.

_____ _____
Date Signature of Parent or Guardian

The infection control policies and procedures have been presented and explained to

_____
Parent/Guardian

by _____ on _____
Staff Member Date

_____
Signature of Staff Member

COMMUNICABLE DISEASE REFERENCE CHART FOR SCHOOL PERSONNEL

DISEASE	INCUBATION PERIOD*	TRANSMISSION	COMMON SYMPTOMS	RECOMMENDATIONS
Chickenpox** (Varicella)	From 2-3 weeks, usually 14-16 days.	By direct contact with vesicular fluid or by airborne spread from respiratory tract secretions.	Sudden onset with slight fever and itchy eruptions which become vesicular (small blisters) within a few hours. Lesions commonly occur in successive crops, with several stages of maturity present at the same time. Communicable for as long as 5 days (usually 1-2 days) before eruption of vesicles and until all lesions are crusted (usually 5 days). Communicability may be prolonged in immunocompromised people.	CASE: Exclude from school for at least 5 days after eruptions first appear or until vesicles become dry. Avoid exposure to women in early pregnancy who have not had chickenpox and/or varicella vaccine. CONTACTS: On appearance of symptoms, exclude from school.
Conjunctivitis, Acute Bacterial (Pink Eye)	Usually 24-72 hours.	By contact with discharges from the conjunctivae or contaminated articles.	Pink or red eyeball with swelling of the eyelids and eye discharge. Eyelids may be matted shut after sleep. May involve one or both eyes.	CASE: Exclude from school while symptomatic or until 24 hours of antibiotic treatment has been completed. CONTACTS: School exclusion not indicated.
Diarrheal Diseases** (Campylobacteriosis, *E. coli* O157: H7, Giardiasis, Salmonellosis, Shigellosis, etc.)	Campylobacteriosis: From 1-10 days, usually 2-5 days. *E. coli* O157:H7: From 2-10 days, usually 3-4 days. Giardiasis: From 3-25 days, usually 7-10 days. Salmonellosis: From 6-72 hours, usually 12-36 hours. Shigellosis: From 12-96 hours, usually 1-3 days.	By the fecal-oral route through direct contact or ingestion of contaminated food or water.	Ranges from sudden onset of fever, abdominal pain, diarrhea, nausea, and sometimes vomiting in salmonellosis, to cramps and bloody stools in severe cases of shigellosis and *E. coli* O157:H7. Dangerous dehydration may occur in younger children. In giardiasis, persons may be asymptomatic or have decreased appetite and weight loss.	CASE: Exclude from school until cessation of acute diarrhea. Stress importance of proper handwashing. CONTACTS: School exclusion and stool cultures not indicated in absence of symptoms. Consult with your local health department for advice during suspected school outbreaks.
Fifth Disease (Erythema Infectiosum)	From 4-20 days.	Primarily through contact with respiratory secretions.	Rash characterized by a vivid reddening of the skin, especially of the face, which fades and recurs; classically, described as a “slapped face appearance.” Mild symptoms of fever, body aches, and headache may occur 7-10 days before rash.	CASE: Exclusion from school not indicated. CONTACTS: School exclusion not indicated. Pregnant women and immunocompromised persons should seek medical advice.
Hepatitis A**	From 15-50 days, usually 28-30 days.	By the fecal-oral route through direct contact or ingestion of contaminated food or water.	Fever, loss of appetite, nausea, abdominal discomfort and weakness followed by jaundice. Many unrecognized mild cases without jaundice occur, especially in children. Communicability greatest from 7 days before to several days after onset of jaundice.	CASE: Exclude from school until physician advises return. Convalescence may be prolonged. CONTACTS: School exclusion not indicated. Stress importance of proper handwashing.
Hepatitis B**	From 45-180 days, usually 60-90 days.	By direct contact with infected blood or body fluids. Transmission occurs when the hepatitis B virus enters the body through broken skin or mucous membranes.	Only a small proportion of acute infections have clinical symptoms. Symptoms are similar to those of hepatitis A.	CASE: Follow advice of child’s physician and/or your local health department. CONTACTS: School exclusion not indicated.

DISEASE	INCUBATION PERIOD*	TRANSMISSION	COMMON SYMPTOMS	RECOMMENDATIONS
HIV Infection** and AIDS**	Variable	By direct contact with infected blood or body fluids. Transmission occurs when the human immunodeficiency virus enters the body through broken skin or mucous membranes.	A broad range of disease manifestations affecting multiple organ systems. Many children remain asymptomatic.	CASE: Follow advice of child's physician and/ or your local health department. CONTACTS: School exclusion not indicated.
Measles** (Rubeola, Red Measles)	From 7-18 days, usually 14 days.	Airborne by droplet spread or direct contact with nasal or throat secretions of an infected person.	Prodrome characterized by fever followed by reddened eyes, runny nose, and cough. Dusky-red blotchy rash appears on day 3 or 4 and lasts 4 to 7 days. Highly communicable from one day before the beginning of symptoms to 4 days after the appearance of the rash.	CASE: Exclude from school until at least 4 days after appearance of the rash. Check immunization records of all students. Discuss with your local health department. CONTACTS: Exclude from school immediately on signs of prodrome.
Meningitis, bacterial (*H. influenzae***, meningococcal**, pneumococcal)	*H. influenzae*: From 2-4 days Meningococcal: From 2-10 days, usually 3-4 days. Pneumococcal: From 1-4 days	By direct contact or droplet spread of nasopharyngeal secretions of an infected person.	Sudden onset of fever, headache, nausea, stiff neck and photophobia. Rash may occur in cases of meningococcal disease.	CASE: Exclude from school during acute illness. Non-communicable after 24-48 hours of appropriate drug therapy. CONTACTS: School exclusion not indicated. Discuss with your local health department to determine if close contacts need prophylactic treatment for *H. influenzae* and meningococcal forms.
Mumps**	From 14-25 days, usually 16-18 days.	By droplet spread or by direct contact with the saliva of an infected person.	Fever with swelling and tenderness of one or both parotid glands located below and in front of the ears. Unrecognized mild cases without swelling may occur. Communicable from 7 days before swelling until 9 days after.	CASE: Exclude from school for 9 days after the onset of parotid gland swelling. CONTACTS: School exclusion not indicated.
Pediculosis (Head Lice)	Under optimum conditions, eggs hatch in 7-10 days and reach maturity 1-3 weeks later.	By direct contact with an infested person or their personal belongings such as combs, brushes, and hats.	Severe itching and scratching, often with secondary infection. Eggs of head lice (nits) attach to hairs as small, round, gray lumps.	CASE: Exclude from school until treated. CONTACTS: Direct inspection of head. School exclusion not indicated in absence of infestation.
Pertussis**	From 6-20 days, usually 9-10 days.	By direct contact with respiratory secretions of an infected person by the airborne route.	The initial stage begins with upper respiratory symptoms and increasingly irritating cough. The paroxysmal stage usually follows within 1 to 2 weeks, and lasts 1 to 2 months. Paroxysmal stage is characterized by repeated episodes of violent cough broken by a high-pitched inspiratory whoop and vomiting. Older children may not have whoop. Convalescence may require many weeks.	CASE: Exclude from school until a physician advises return (usually 5 days after initiation of appropriate antibiotic therapy). Discuss with your local health department. CONTACTS: Exclude on first indication of symptoms.

DISEASE	INCUBATION PERIOD*	TRANSMISSION	COMMON SYMPTOMS	RECOMMENDATIONS
Ringworm of the Body (Tinea Corporis)	From 4 to 10 days.	By direct or indirect contact with lesions of an infected person or contaminated environmental surfaces.	Circular well-demarcated lesion that can involve face, trunk, or limbs. Itching is common.	CASE: Exclusion from school not indicated as long as lesions are covered or child is receiving treatment. During treatment, exclude from gymnasiums and swimming pools. CONTACTS: School exclusion not indicated.
Rubella** (German Measles)	From 14 to 21 days, usually 14 to 17 days.	By direct contact or droplet spread of nasopharyngeal secretions of an infected person.	Mild symptoms; slight fever, rash of variable character lasting about 3 days; enlarged head and neck lymph glands common. Joint pain may occur, especially in older children and adults. Communicable for 7 days before onset of rash and at least 7 days thereafter.	CASE: Exclude from school for 7 days after onset of rash. Avoid exposure to women in early pregnancy. Check immunization records of all students. Discuss with your local health department. CONTACTS: Those who are pregnant and not immunized should be urged to seek medical advice.
Scabies	From 2 to 6 weeks.	By direct skin-to-skin contact.	Begins as itchy raised areas around finger webs, wrists, elbows, armpits, belt-line, and/or genitalia. Extensive scratching often results in secondary infection.	CASE: Exclude from school until 24 hours of antibiotic treatment has been completed. CONTACTS: Direct inspection of body. School exclusion not indicated in absence of infestation.
Streptococcal Diseases (Including Impetigo, Scarlet Fever, and "Strep" throat)	Variable, often 1-3 days, may be longer.	By direct contact with infected persons and carriers or by contact with their respiratory droplets.	Impetigo: Multiple skin lesions usually of exposed area (e.g., elbows, legs, and knees), but may involve any area. Lesions vary in size and shape, and begin as blisters, which rapidly mature into brown crusts on a reddened base. Healing from center outward produces circular areas, which may resemble ringworm. --- Scarlet Fever: Fever, sore throat, exudative tonsillitis or pharyngitis. Sandpaper-like rash appears most often on neck, chest, and skin folds of arms, elbows, groin, and inner aspect of thighs. --- "Strep" throat: Sudden onset of fever, sore throat, exudative tonsillitis or pharyngitis, and enlarged lymph nodes. Symptoms may be absent in some cases.	CASE: Exclude from school until lesions are healed or until 24 hours of antibiotic treatment has been completed. CONTACTS: Exclusion from school not indicated. Observe carefully for symptoms. --- CASE: Exclude from school during acute illness. Non-communicable after 24 hours of appropriate drug therapy. CONTACTS: Exclude on first indication of symptoms. Culturing of school contacts and treatment of carriers not usually indicated. --- CASE: Exclude from school until 24 hours of antibiotic treatment has been completed. CONTACTS: Exclusion from school not indicated. Observe carefully for symptoms.

NOTE: THESE RECOMMENDATIONS APPLY ONLY TO SHOOL-AGED CHILDREN - A more complete discussion of these conditions and other communicable diseases may be found in *Control of Communicable Diseases Manual* (2004) published by the American Public Health Association and the *Red Book 2003 Report of the Committee on Infectious Diseases* published by the American Academy of Pediatrics. Additional information and consultation are also available through your local health department.

* Based on the *Control of Communicable Diseases Manual*, 18th Edition (2004)
** Officially reportable in Virginia to the local health department. All outbreaks and unusual occurrences of disease are also reportable.

Virginia Department of Health, Office of Epidemiology, P.O. Box 2448, Richmond, Virginia 23218. Please visit our web site at www.vdh.virginia.gov.

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VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Exposure Notice

Child Care Provider: _____Date: _____

Dear Parents:

Your child may have been exposed on_____to the disease that is checked below:

- ❑ **CHICKEN POX.** Onset about 2 to 3 weeks after exposure. Slight fever and irritability for one day; then fine blisters appear, first on the trunk, then on the face. Communicable for as long as 5 days before blisters appear and for not more than 5 days after the appearance of the first crop of blisters. Exclude child from child care for 5 days after first eruption or until all scabs are dry. Consult with physician for treatment.

- ❑ **PINK-EYE (Conjunctivitis).** Onset is usually 24-72 hours after exposure. Irritated, tearing eyes, swollen lids, and a yellow mucus discharge that makes the eyelashes sticky. It is very contagious as long as infection is active. Children under 5 are most susceptible. Children should be excluded until symptoms disappear. Consult with physician for treatment.

- ❑ **DIARRHEAL DISEASES (Campylobacteriosis, Giardiasis, Salmonellosis, Shigellosis, etc.)** Onset: campylobacteriosis - usually 2 to 5 days; giardiasis – 3 to 25 days; salmonellosis – usually 12 to 36 hours; shigellosis – usually 1 to 3 days. Symptoms range from sudden onset of fever, abdominal pain, diarrhea, nausea, and sometimes vomiting in salmonellosis, to cramps and bloody stools in severe cases of shigellosis. Dangerous dehydration may occur in younger children. Exclude from child care until diarrhea disappears. Consult with physician for treatment.

- ❑ **FIFTHS DISEASE (Erythema Infectiosum).** Onset from 4 to 20 days. Mild illness without fever. Rash characterized by a vivid reddening of the skin, especially of the face, fades and recurs; described as the "slapped face appearance." Exclusion from child care not necessary. Pregnant woman or immunocompromised person should seek medical advice. Consult with physician for treatment.

- ❑ **HEPATITIS A.** Onset 15 to 50 days. Fever, loss of appetite, nausea, abdominal discomfort and weakness followed by jaundice. Many unrecognized mild cases without jaundice occur, especially in children. Communicability greatest from 7 days before to several days after the onset of jaundice. Exclude from child care until physician advises return. Consult with physician for treatment.

- ❑ **HEPATITIS B.** Onset from 45 to 180 days. Only small portion of acute infections have symptoms. Symptoms are similar to hepatitis A. Follow advice of child's physician for treatment.

- ❑ **HIV INFECTION AND AIDS.** Onset variable. A broad range of disease manifestations affecting multiple organ systems. Many children show no symptoms. Consult physician for treatment.

- ❑ **MEASLES.** Onset about 1 to 2 weeks after exposure. Fever followed by reddened eyes, runny nose, and cough. A blotchy rash appears on about the 3rd to 4th day of illness. Exclude child from child care until at least 4 days after the appearance of the rash. Consult with physician for treatment.

- ❑ **MENINGITIS.** Onset probably 2 to 10 days. Sudden onset of fever, vomiting, lethargy, and stiff neck. Some types exhibit a measles-like rash. Exclude from child care during acute illness. Non-communicable after 24 hours of appropriate drug therapy. Consult physician for treatment.

- ❑ **MUMPS.** Onset from 12 to 25 days after exposure. Fever with swelling and tenderness of one or both glands located below and in front of the ears. Communicable from 6 days before swelling to 9 days after. Exclude child from child care for 9 days after the onset of gland swelling. Consult physician for treatment.

- ❑ **PEDICULOSIS (HEAD LICE).** Onset – eggs hatch in 7 to 13 days and reach maturity in about 10 days. For 2 weeks after exposure, observe hair and scalp at neck line and around ears for eggs or nits (tiny, pearly-white, egg-shaped objects) which stick tightly to the hair shaft. Child may also complain of an "itchy" head. Consult your physician or pharmacist for treatment. Child is excluded from child care until treated. Other members of the child's family should be checked carefully.

- ❑ **PERTUSSIS. (Whooping Cough)** Onset usually 6 to 20 days. Begins with upper respiratory symptoms and increasingly irritating cough. Repeated episodes of violent cough broken by a high pitched whoop follow within 1 to 2 weeks, and may recur for 1 to 2 months. Exclude from child care until physician advises return (usually 5 days after initiation of erythromycin therapy). Consult physician for treatment.

- ❑ **RUBELLA - GERMAN MEASLES.** Onset between 14 to 23 days after exposure. Mild symptoms, slight fever, rash of variable character lasting about 3 days, swollen tender glands at back of the neck. Joint pain may occur, especially in older children and adults. Avoid exposure to women in early pregnancy. Exclude from child care for 7 days after the onset of rash.

- ❑ **SCABIES.** Onset from 2 to 6 weeks. Begins as itchy raised areas around finger webs, wrists, elbows, armpits, belt-line, and/or genitalia. Extensive scratching can cause secondary infection. Exclude from school until 24 hours of antibiotic treatment has been completed. Consult physician for treatment.

- ❑ **STREPTOCOCCAL INFECTIONS (including streptococcal sore throat, Impetigo and Scarlet Fever).** Onset usually 1 to 3 days after exposure. Sore throat, fever, and may include rash. Impetigo produces skin lesions (blisters) of varying sizes and shapes. Exclude from child care until 24 hours after antibiotic treatment. Consult your physician for treatment.

- ❑ **PINWORMS** Itching of the anal area especially at night is the most common sign. The child may have insomnia or nightmares and may lose his/her appetite. Consult your physician if you suspect pinworms. Other members of the family should also be observed and treated.

- ❑ **TINEA CORPORIS (Ringworm of the body).** Onset from 4 to 10 days. Circular lesions that can involve face, trunk, or limbs. Itching is common. Exclusion from school not necessary as long as the lesions are covered or child is receiving treatment. During treatment, exclude child from gymnasium and swimming pools. Consult physician for treatment.

- ❑ **OTHER.** _____

_____

PROCEDURES FOR EMERGENCIES

Licensing Standards require that the center shall have an emergency preparedness plan that addresses staff responsibility and facility readiness with respect to emergency evacuation and shelter-in-place. Licensing Standards require that each center conduct an emergency evacuation drill each month and a minimum of two shelter-in-place practice drills per year with the staff and children. Some centers have weekly emergency or evacuation drills when children are first learning the procedure. A record of the dates of these drills must be maintained at the center for one year.

Emergency evacuation and shelter-in-place procedures/maps must be posted in a noticeable location on each floor of each building where the staff and children can easily see them. The Fire Marshal will check on proper location, exit routes and signs, and other related requirements for emergency preparedness.

Fire extinguishers should only be used if a child is in danger or if you have to use it to escape.

Procedures for the safe evacuation of the building and shelter-in-place must be discussed with staff members before they begin work with the children.

In Case of a Real Fire or Disaster

Calling the Fire Department

Staff members should be informed of procedures to follow in case of an actual fire. They should know the person responsible for phoning the fire department, exactly what role they should play, whether it is strictly getting the children out of the building, operation of any safety equipment or fire extinguishers, or supervision once the children have gotten outside.

Remember, the most important priority in the event of a fire is to get everyone out of the building immediately. Then call the fire department. All staff members should be trained to use the extinguishers.

Emergency telephone numbers and guidelines for telephoning should be posted by all telephones accessible to the staff.

Informing Parents

Staff members should be made aware of procedures for informing parents in case of a disaster. The center should have a specific, written procedure for parents to follow, which should be outlined in a letter to the parents.

Emergency Preparedness for Transporting Children

Staff members should be aware of procedures, kept in vehicles that centers use to transport children, for contacting local emergency assistance, potential shelters, hospitals, and evacuation routes that pertain to each site frequently visited or of routes frequently driven for center business (such as field trips, pickup/drop off of children to or from schools, etc.)

Weather Related Emergencies

Procedures for dealing with weather-related emergencies that are likely to occur in your area should be explained to staff members. If duties are to be assigned, each staff member should be aware of what his or her specific responsibility will be.

Contact the Office of Emergency Medical Services (EMS) in your locality or your local chapter of the American Red Cross for information on specific weather related emergencies and the proper preparations and procedures to follow.

EMERGENCY EVACUATION

- ❑ Sounding of alarms
- ❑ Center Emergency Officer with 24 hour contact number
- ❑ Center Back-up Emergency Officer with 24 hour contact number
- ❑ Notification of Local Authorities
  - Fire/Rescue
  - Law Enforcement
  - Emergency Medical Services
  - Poison Control
  - Health Department
- ❑ Notification of Parents
- ❑ Notification of Local Media
- ❑ Communication Tools (availability/use)
- ❑ **Evacuation:** Assembly points; head courts; primary/secondary egress; complete evacuation of buildings
- ❑ Securing of essential documents:
  - Sign-in
  - Parent Contact
- ❑ Special Health Care Supplies (to be carried **off-site** on immediate notice)
- ❑ Method of communication after **evacuation**
- ❑ Facility containment (closing of fire doors, etc.)
- ❑ Staff Training requirements
  - Drill frequency
  - Plan review and update
- ❑ Other special procedures developed with local authorities
- ❑ Procedures/Map posted (location **away** from building)
- ❑ **Monthly** practice evacuation drills
- ❑ Maintain record of drill for 1 year (evenly divided among various shifts)
- ❑ 911, Poison Control at each telephone
- ❑ Parents informed of the center's emergency preparedness plan

SHELTER-IN-PLACE

- ❑ Sounding of alarms
- ❑ Center Emergency Officer with 24 hour contact number
- ❑ Center Back-up Emergency Officer with 24 hour contact number
- ❑ Notification of Local Authorities
  - Fire/Rescue
  - Law Enforcement
  - Emergency Medical Services
  - Poison Control
  - Health Department
- ❑ Notification of Parents
- ❑ Notification of Local Media
- ❑ Communication Tools (availability/use)
- ❑ **Shelter-in-place:** Scenario application; **inside** assembly points; head counts, primary/secondary access and egress
- ❑ Securing of essential documents:
  - Sign-in
  - Parent Contact
- ❑ Special Health Supplies (to be carried **into** the designated assembly points)
- ❑ Method of communication after the **shelter-in-place**
- ❑ Shelter-in-place scenario (intruders, tornado, or chemical spills)
- ❑ Staff Training requirements
  - Drill frequency
  - Plan review and update
- ❑ Other special procedures developed with local authorities
- ❑ Procedures/Map posted (location **inside** the building)
- ❑ Bi-annual shelter-in-place practice drills
- ❑ Maintain record of drill for 1 year (evenly divided among various shifts)
- ❑ 911, Poison Control at each telephone
- ❑ Parents informed of the center's emergency preparedness plan

Sample Procedures for Emergency or Evacuation Drill

1. Signal to leave building: Bell or buzzer used for that purpose.

2. Leaving the building: Teacher has class follow her through the door and out of the building to point at least 200 feet from the building. Use a specific landmark, such as a large tree so that the children will identify that as the place everyone goes when there is a fire drill.

   The assistant gets the roll book and follows the group to the gathering point, checking to be sure no one is still left in the room. Upon arrival at the gathering point, the teacher is given the roll book.

   The teacher checks the roll (or counts heads) to make sure that all children are present and out of the building.

3. Signal to return: The director blows a whistle or gives some previously designated signal to return to the building. A specific time is allowed to elapse before returning. Teacher recounts children before returning to classroom.

4. Return to room: The children and adults return to the classroom by the same route they exited.

   Each class will have a specific route designated on the posted emergency evacuation procedures.

EVACUATION DRILL EVALUATION

____ There is a pre-planned schedule for evacuation drills which includes the days, times, and length of the drills.

____ An exit plan is posted where it is plainly visible and easily accessible.

The exit plan includes:

_____ What exits the children use in leaving the room.

Example: _____

_____ What kind of a sound will designate a fire alarm.

Example: _____

_____ What area is designated for the children to exit to outside of the classroom.

Example: _____

_____ Staff responsibilities that are clearly specified.

Example: _____

During the fire drill:

_____ Did the children know what to do when the alarm sounded?

No 0 1 2 3 4 5 Yes

Example: _____

_____ Did the adults know what to do when the alarm sounded?

No 0 1 2 3 4 5 Yes

Example: _____

_____ Was the posted fire drill and exit plan followed?

No 0 1 2 3 4 5 Yes

Example: _____

_____ Were all safety precautions completed (shutting windows, doors, etc.)?

No 0 1 2 3 4 5 Yes

Example: _____

_____ Was the fire drill carried out quickly and efficiently?

No 0 1 2 3 4 5 Yes

Example: _____

_____ Did the children or adults show any panic or fear?

No 0 1 2 3 4 5 Yes

Example: _____

Adapted from the Oklahoma CDA Training Module on Safety

DISASTER EVACUATION PLAN

Personnel in charge of evacuation:

1. The Director is responsible for all phases of evacuation. In the Director's absence, the Assistant Director shall assume responsibility.
2. The Director is responsible for removing the sign-in sign-out sheet and the ledger card file containing current names, addresses, and phone numbers of children enrolled.
3. The teacher and assistants will be responsible for the children in the classroom and the attendance sheet.
4. The rooms will be designated as follows: A B C D E
5. All employees are required to be familiar with the evacuation plan.
6. Employees will evacuate immediately taking the children outside after alarm, weather station report, or notification by runner.
7. See posted evacuation notice for proper exit routing from the classroom.

Precautions to observe:

1. Keep all children as calm as possible.
2. Keep all children together in your group.
3. Remind children to walk as they exit the building.
4. Close all classroom doors.
5. Reassure the children of your presence and their safety.
6. Move the children out of danger as far as possible. Take children to emergency shelter area designated on plan.
7. Take attendance sheet with you as you exit.
8. After the children are evacuated from the building the Director or Assistant should check the attendance sheet, the sign-in sheet, and count the children to be sure all children and teachers are accounted for and no one returns for personal belongings. Directors should check restrooms for children.
9. No one is to re-enter the building until proper authorities have deemed building safe.

Removal to emergency shelter:

Emergency accommodations will be provided at _____
Which can shelter _____ until further arrangements are made.
(#of children)

FIRE EVACUATION PLAN

Fire drills shall be held on a regular basis at different times of the day to involve all staff members.

Personnel in charge of evacuation:

Same as Disaster Evacuation Plan

Precautions to observe:

See Disaster Evacuation Plan: Precautions to Observe - Follow steps 1 through 8.

9. Close the fire door when the children are safely out of the room. The cook or Director or Assistant Director evacuate the kitchen and close the fire door.
10. Building may be re-entered only when authorization has been given by the fire department.

TORNADO EVACUATION PLAN

Definitions:

Watch: Weather conditions which can develop into a tornado.
Warning: A tornado has been spotted or indicated on radar.

Personnel in Charge of Tornado Procedures:

1. The Director is responsible for all phases of the tornado procedures. In the Director's absence, the Assistant Director shall assume responsibility.
2. The Director is responsible for removing the sign-in/out sheet and the ledger card file containing correct names, addresses, phone numbers and children enrolled.
3. All classrooms are designated either A B C D E and will proceed to areas designated either 1 2 3 4 or the classroom restroom.

Procedures in the event of a tornado drill:

1. Tornado drills will be conducted monthly.
2. During the tornado season, the Director and/or Assistant Director will serve as weather spotters and be particularly alert to threatening weather. (Examples; dark, rolling clouds, hail, driving rain, a sudden increase in wind, in addition to the telltale funnel cloud.)
3. During threatening weather, the Director and/or Assistant Director will monitor commercial radio stations for announcements of tornado warnings.
4. The local city alarm warning system will be used as well as the center alarm system.
5. Each classroom will go to its designated area when the alarm sounds.
6. Children in shelter during warning shall assume protective postures during imminent danger. Facing interior walls
   Command: "Knees and elbows on the floor!"
   Command: "Everyone down!"
   Command: "Hands over the back of the head"
7. Children will remain in the shelter until warning has been lifted.
8. Tornado procedures for vans:
   a. Vans will not be driven during tornado warning and are not to leave the center if a tornado watch has been issued.
   b. During tornado watches, van drivers shall monitor commercial radio weather report warnings.
   c. In the event of an approaching tornado, the children shall lie face down, hands over heads in a near-by ditch or ravine.
   d. Shelter in the ditch or ravine should be far enough away to prevent the van from toppling over on the children.
   e. If tornado warning is in effect and a parent arrives to pickup a child, parent will be advised to remain in the center until the warning is over.

♥ FIRST AID/CPR

Training

There must be one staff member on the premises at all times, and one person on field trips and wherever children are in care, who have a current certificate in first aid as required by the **Licensing Standards**. Training is also required in cardiopulmonary resuscitation and rescue breathing as appropriate to the ages of children in care.

Even though the requirement is for one person on the premises, it is a good idea for anyone who works with young children to have a basic knowledge of first aid. Encourage your staff members to take a course in first aid or include basic first aid in staff training sessions.

First Aid Kit

Licensing Standards require a first aid kit:

- ♥ on each floor of each building used by children
- ♥ on field trips
- ♥ accessible to outdoor play areas
- ♥ wherever children are in care

All caregivers should receive instruction in the use and location of the kit before they begin working with children.

The kit should be located in a place that is not accessible to the children but where caregivers can readily get to it when necessary.

The first aid kit can be kept in any container that is large enough to hold the necessary supplies. Some good containers include a cardboard box, a wicker basket, a brightly colored painted lunch pail, or a fishing tackle box.

It is a good idea to keep one first aid kit (a larger one) for general use and another, smaller kit for field trips. Some centers also keep a first aid kit on or near the outside play area in a place that is dry and where children cannot get to it. One center uses a regular size, heavy-duty plastic mailbox mounted on a high post and secured with a latch to hold first aid supplies on the playground.

It is also convenient to have a small box which holds Band-Aids, gauze pads, and antiseptic wipes in each room. It should be in a place that is easily accessible from the playground in case of small cuts, scratches, or scrapes.

The first aid kit which is kept for general use should include these items *required* by the **Licensing Standards**:

- ♥ scissors
- ♥ antiseptic cleansing solution
- ♥ band-Aids (assorted sizes)
- ♥ disposable gloves
- ♥ tweezers
- ♥ assorted gauze pads
- ♥ adhesive tape
- ♥ first Aid Instruction Manual
- ♥ thermometer (disposable ones or electronic digital ones with disposable covers)
- ♥ two (2) or more triangular bandages

The following emergency supplies are also required in the center and to be available on field trips, although they should not be kept in the first aid kit:

- ♥ activated charcoal preparation (to be used only on the advice of a physician or poison control center)
- ♥ ice pack, cooling agents, zip-lock bags, and sponges readily available for icing down contusions, sprains, and breaks
- ♥ a working, battery-operated flashlight on each floor of each building that is used by children
- ♥ one working, battery-operated radio in each building used by children and any camp location without a building

Other useful items include:

- ♥ absorbent cotton
- ♥ plastic bag for ice / instant cold packs
- ♥ cardboard splints
- ♥ paper cups
- ♥ safety pins
- ♥ nail clippers
- ♥ towels, soap, and liquid hand sanitizer
- ♥ an accurate measuring tool for medicine

First Aid Instructional Manual

A comprehensive, easily read first aid manual should be within easy reach of each teacher at all times. A copy of the handbook *must* be kept with each first aid kit. It might also be helpful to have a couple of additional copies in easily accessible places in the center, such as near the playground and in the kitchen.

Note: You may want to use a standard first aid book and add to it any procedures that you find convenient or suited for the needs of your center.

VIRGINIA POISON CENTER NETWORK

Call **1-800-222-1222** for emergency treatment advice, questions about medications, and information about poisons.

This number works in a way similar to dialing 9-1-1: no matter where you are located, by calling **1-800-222-1222** your call will be automatically routed to the closest regional poison center. Contacting a poison center is fast and easy wherever you are in the United States.

There are three poison control centers in Virginia:

Blue Ridge Poison Center
University of Virginia Health Systems
Box 800774
Charlottesville, VA 22908
Phone: (800) 222-1222
www.healthsystem.virginia.edu/brpc
Serves: Virginia Beach, Central and Western Virginia

Virginia Poison Center
Virginia Commonwealth University
Box 980522
Richmond, VA 23298-0522
Phone: (800) 222-1222
www.poison.vcu.edu
Serves: East, Central and Peninsula

National Capital Poison Center
George Washington University
3201 New Mexico Ave., N.W.
Suite 310
Washington, DC 20016
Phone: (800)222-1222
www.poison.org
Serves Northern Virginia

♥ PREVENTION OF INJURY AND ACCIDENTS

Staff members should be informed of procedures for reporting any unsafe situations they may have discovered in the building or on the playground. The list below shows only a few examples of hazards of which staff should be aware. For a complete listing of hazards, please refer to the **Licensing Standards**.

Unsafe Situations Include:

Inside the Building:

- ♥ uncovered electrical outlets
- ♥ light bulbs that have burned out
- ♥ loose floor boards or bricks
- ♥ crack in concrete sidewalks or steps
- ♥ nails sticking out
- ♥ loose hand rails
- ♥ loose or broken locks or handles on doors that go outside, to the basement, or that are used to lock away poisons

Outside the Building:

- ♥ holes in the ground
- ♥ exposed roots that might cause tripping
- ♥ broken playground equipment
- ♥ head and neck entrapment spaces on playground equipment
- ♥ lack of resilient surfacing under playground equipment
- ♥ hot spots on metal playground equipment
- ♥ splintered wood
- ♥ broken latch on gates
- ♥ poisonous plants
- ♥ holes in the fence

Toys or Equipment:

- ♥ toys that are inappropriate to age group (small enough to be swallowed by children under four years of age)
- ♥ toys with loose parts that might have sharp edges, springs, or small pieces
- ♥ allowing inappropriate use of toys so as to pose a dangerous situation
- ♥ too many toys scattered around on the floor

Additional Safety Guidelines

1. Perishable food should be refrigerated immediately.

   This includes dairy products, meats and fish, infant formula (opened and mixed), baby food, and anything containing eggs such as mayonnaise.

2. Accidental spills or accidents in the bathroom should be cleaned up immediately either by a custodial staff member or by the staff member supervising that area.

3. Portable heaters of any kind, wood stoves, kerosene, oil, or gas stoves cannot be used in the center except in an emergency. If this situation occurs, staff members should be informed about procedures for using the heaters and shall follow the manufacturer's instructions for use. A barrier must be erected to keep the children away from the heater and to protect them from injury. Staff members should not bring heaters from home.

4. When the children are present, doors to the street and playground gates should be kept closed and locked from outside entry.

5. Matches should be kept out of children's reach at all times.

6. Cleaning supplies, insecticides, and any other potentially dangerous substances must be kept in a locked cabinet out of reach of the children.

7. Flies, insects, and rodents should be controlled by a pest control company. Poisons should not be placed on the ground even if they are hidden.

8. Temperature in classrooms for young children shall be maintained no lower than 68°F. and cooling units must be used when the temperature in the inside occupied area exceeds 80°F.

9. Swimming or wading pools must be supervised by at least two staff members, and staff-to-child ratios must be maintained at all times. Wading pools should be emptied and sanitized daily or more frequently when the water is dirty. Pools deeper than two feet require supervision by a life guard certified in water safety instruction or senior life saving must be supervising the children at all times (along with the required number of staff members). Written permission must be obtained from parents before a child can be allowed to swim or wade.

Reasons to Call Rescue Squad or Paramedics

Staff members should be made aware of specific circumstances that would indicate the necessity for calling the rescue squad or paramedics.

Each center will have its own set of criteria for calling for help. Once you have decided upon these criteria, your staff should be provided with this information.

The most important thing to remember is: *When in doubt* – **Call!** Because:

- Emergency personnel are experienced in treating many kinds of injuries and have extensive first aid training.
- They can provide first aid on the way to the hospital.
- They have access to important medical information and services. They know which hospital is best equipped to handle specific problems. They have direct access to poison control center information as well as first aid equipment that may be needed.
- If an accident happens at school and the parents cannot be located, the rescue squad personnel can contact the police so that the legal aspects of transporting the child to the hospital will be covered.
- If, after calling the rescue squad, it is determined that the child really doesn't need to go to the hospital, the squad can be called and informed. Usually, they will come by anyway, just to check on the situation and to verify that they are no longer needed. There is usually no charge for a "dry run" to the center.
- The **Licensing Standards** require posting of the following telephone numbers in a conspicuous place near the telephone:
    - generic emergency number – 911
    - if generic number is not available, then the numbers for:
        - a physician or hospital
        - ambulance or rescue squad service
        - local fire department
        - local police department
    - regional poison control center

Documenting Accidents

The **Licensing Standards** require written documentation, made on the day of occurrence, of serious and minor injuries to include:

- ♥ name of the injured child
- ♥ type and circumstance of injury
- ♥ name of person(s) present with the child at the time of injury
- ♥ procedures followed to care for the injury
- ♥ when parents were notified – date, time, method of notification
- ♥ any future action to prevent recurrence of the injury
- ♥ staff and parent signatures or signatures of two staff members

On a separate sheet, to be used only for evaluation by the director and staff, it is helpful to include a description of the environment, and a recommendation for how the accident might have been prevented and how the procedures or the environment might be changed to prevent further accidents of this type. It is also a good idea to put a copy of each individual accident/illness report in the child's record.

The center shall also develop a plan for injury prevention. This plan shall be based on documentation of injuries and a review of the activities and services. The plan must be updated at least annually.

Parental Notification

Any time there is a serious accident or injury at the center, the parents must be notified immediately. If the injury is minor, parents must be notified at the end of each day.

Examples of minor accidents or injuries would include small scratches, cut or scrape, minor bruise or discoloration of the skin.

Be aware of children who have allergies such as bee stings. This should be noted on the health history and known to teachers and aides. **Immediate** action is needed in these cases.

SAFETY PRECAUTIONS CHECKLIST

- ❑ 1. Has the fire extinguisher been checked within the last year?
- ❑ 2. Are instructions for evacuation drills posted?
- ❑ 3. Are emergency procedures posted?
- ❑ 4. Is the first aid kit complete and readily available?
- ❑ 5. Are all sharp edged objects stored out of reach of children (knives, paper cutter, adult scissors)?
- ❑ 6. Are hot objects (hot plates, electric frying pans, coffee pots, dials on stoves, portable ovens, popcorn poppers, etc.) out of children's reach?
- ❑ 7. Are cleaning materials (bleach, concentrated soap, ammonia, disinfectant, sprays, etc.) kept in a locked place that prevents access by children?
- ❑ 8. Is the playground free of hazardous objects (glass, nails, boards, rocks, etc.)?
- ❑ 9. Is the material under all playground equipment shock absorbent such as: loose sand, wood chips, wood mulch, pea gravel, manufactured wood fiber?
- ❑ 10. Are materials used in art experiences safe for children's use?
- ❑ 11. Are broken toys and equipment removed promptly from children's play areas?
- ❑ 12. Are all construction tools stored properly (hammer, saw, nails, etc.)?
- ❑ 13. Are all supplies (stapler, pins, needles, thumbtacks, etc.) stored away from children's access?
- ❑ 14. Are items that children need to access stored within their reach (tissues, paper towels, sponges, handwashing soap, etc.)?
- ❑ 15. If sinks, water fountains, etc., are too high, is a stool provided for the children to stand on?
- ❑ 16. Are the names of the trained persons on duty for emergencies known to all staff? Are the names posted?

EMERGENCY TELEPHONE NUMBERS

TO CALL	TELEPHONE NUMBER
Rescue Squad/Paramedics:	
Fire Department:	
Police: **Health Department:** **Public Health Nurse:**	
Closest Hospital: **Address:** **Directions:**	
Poison Control Center:	

Emergency Procedures: (for "can't wait" injuries)

____ Notify person in charge. (Use chain of command chart)
____ Keep calm. You will think more clearly.
____ Dial 911.
____ Tell where you need the help.
____ Tell why you need the help.
____ Stay on the phone until your message is repeated to you.
____ Call parents to meet you at the hospital.
____ Take child's folder with medical release.
____ Call hospital to alert them.
____ Have someone reassure other children who may have witnessed the accident.
____ Fill out accident reports.

Adapted from Children's Harbor form for Emergency Procedures

INJURY RECORD
(Model Form)

Date of Injury: _____ Time of Injury: _____

Name of Injured Child: _____

Type and Circumstance of the Injury:

_____

_____

_____

_____

Staff Present:

_____

_____

Treatment:

_____

_____

_____

_____

Date Parent(s) Notified: _____ Time of Notification: _____

Method of Notification: _____

Future Action to Prevent Recurrence of the Injury:

_____

_____

_____

_____

Staff Signature: _____

Staff Signature: _____

Parent Signature:_____

Staff and parent signature OR two staff signatures are required.

NOTE: The parent should be notified IMMEDIATELY if a child is lost, requires emergency medical treatment or sustains a serious injury. The parent shall be notified by the end of the day of any known minor injuries. A written record, in which entries are made on the day of occurrence, of children's serious and minor injuries shall be maintained.

(06/05)

ACCIDENT REPORT LOG

Student's Name	Group	Date of Injury	Time of Day	Person Reporting
Description/Location				

Student's Name	Group	Date of Injury	Time of Day	Person Reporting
Description/Location				

Student's Name	Group	Date of Injury	Time of Day	Person Reporting
Description/Location				

Student's Name	Group	Date of Injury	Time of Day	Person Reporting
Description/Location				

Student's Name	Group	Date of Injury	Time of Day	Person Reporting
Description/Location				

Student's Name	Group	Date of Injury	Time of Day	Person Reporting
Description/Location				

Adapted from The Bon View School of E.C.E., Richmond, VA

♥ MEDICATION ADMINISTRATION

The Drug Control Act, § 54.1-3408 of the *Code of Virginia*, was amended July 1, 2006 to allow prescription drugs to be administered in child day programs **provided certain requirements** are met.

> **§ 54.1-3408. Professional use by practitioners.**
> *N. In addition, this section shall not prevent the administration of drugs by a person to a child in a child day program as defined in § 63.2-100 and regulated by the State Board of Social Services or the Child Day Care Council, provided such person (i) has satisfactorily completed a training program for this purpose approved by the Board of Nursing and taught by a registered nurse, licensed practical nurse, doctor of medicine or osteopathic medicine, or pharmacist; (ii) has obtained written authorization from a parent or guardian; (iii) administers drugs only to the child identified on the prescription label in accordance with the prescriber's instructions pertaining to dosage, frequency, and manner of administration; and (iv) administers only those drugs that were dispensed from a pharmacy and maintained in the original, labeled container that would normally be administered by a parent or guardian to the child.*

NOTE: Child day programs as defined in § 63.2-100 and regulated by the State Board of Social Services or the Child Day Care Council, include: Child Day Centers, Religiously Exempt Child Day Centers, Family Day Homes, Family Day Systems, Voluntarily Registered Family Day Homes, and Certified Preschools.

The Standards for Licensed Child Day Centers required Medication Administration Training for staff who administer any prescription AND over-the-counter medication other than topical skin gel, cream, or ointment.

Both prescription and non-prescription drugs require written authorization from the parent prior to administration in the center. Blanket consent is allowed; that is, consent may be given for up to 10 work days (unless prescribed otherwise by a doctor). Prescription drugs given over a longer period require the physician's guidance and authorization. All medication shall be labeled:

Name of Child:	Record of Administration
	Name of Child:
Medication:	Time/Date:
Dosage:	Medication:
Time to be given:	Amount:
(Should be filled out by Parent/Guardian)	(Must be filled out at time medication is administered)

Any medicine to be given at a center must be in the original container with the prescription label attached. Medicine should be stored in a special locked cabinet or refrigerator. All medicine, prescription and non-prescription drugs shall be returned to the parent when the medicine is no longer being used.

Keep the medicine in your hand until you have signed the record sheet, marked the date and time, and signed your name and initials. These are legal records. You follow these procedures to protect yourself in cases of liability/lawsuits.

MAT

Written Medication Consent Form

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **Parents MUST complete #1-#23 (omit #18) for medication to be administered 10 days or less.**
- Parents may complete #1- #23 (omit #18) for over-the-counter topical ointments, sunscreen & topically applied insect repellent
- **The child's health care provider MUST complete (#1-#18) for Long-Term medications, PRN medications and when dosage directions state "consult a physician"; the parent completes #19 through #23.**

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of medication (including strength):	5. Amount/dosage to be given:	6. Route of administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____

8A. Possible side effects: □ See package insert for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

□ Contact parent □ Contact prescriber at phone number provided below

□ Other (describe): _____

10A. Special instructions: □ See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____

11. Reason the child is taking the medication (unless confidential by law):

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

□ No □ Yes If you checked yes, complete #33-#34 on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

□ No □ Yes If you checked yes, complete #35-#36 on the back of this form.

14. Date consent form completed:	15. Date to be discontinued or length of time in days to be given (this date cannot exceed 6 months from the date authorized or this order will not be valid):
16. Prescriber's name (please print):	17. Prescriber's telephone number:

18. Licensed authorized prescriber's signature:

Required for Long-Term medications, PRN "as needed" medications and when dosage directions state "consult a physician".

This is a double-sided form

Written Medication Consent Form

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) □Yes □ N/A □ No Write the specific time(s) the day care program is to administer the medication (i.e.: 12pm):_____
20. I, parent/legal guardian, authorize the day care program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to _____ (child's name).

21. Parent or legal guardian's name (please print):	22. Date authorized:
23. Parent or legal guardian's signature:	

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#24 - #30)

24. Provider/Facility name:	25. Staff MAT certified:	26. Facility telephone number:
27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.		
28. Authorized child care provider's name (please print):	29. Date received from parent:	
30. Authorized child care provider's signature:		

ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____ (date). Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.
32. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child._____
34. Licensed Authorized Prescriber's Signature:
35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order. DATE:_____ By completing this section the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
36. Licensed Authorized Prescriber's Signature:

This is a double-sided form

MAT

Log of Medication Administration

- Use this form to document all medication administered in the child day program.
- This form must be kept with the child's written medication consent form.
- Any doses of the medication listed below not given must be documented on this form.

CHILD'S NAME:_____ MEDICATION:_____

COMPLETE FOR ALL DOSES GIVEN				**COMPLETE WHEN SIDE EFFECTS ARE NOTED**		**COMPLETE FOR 'AS NEEDED' MEDICATION ONLY**	
Date Given (M/D/Y)	Dose	Time (AM or PM)	Administered by (full signature)	Any Noted Side Effects	Parents notified of side effects	For "as needed" medication – write the symptoms the child exhibited that necessitated the need for the medication	Were parents notified "as needed" medicine was given
					Yes □ No□		Yes □ No□
					Yes □ No□		Yes □ No□
					Yes □ No□		Yes □ No□
					Yes □ No□		Yes □ No□
					Yes □ No□		Yes □ No□
					Yes □ No□		Yes □ No□
					Yes □ No□		Yes □ No□
					Yes □ No□		Yes □ No□
					Yes □ No□		Yes □ No□
					Yes □ No□		Yes □ No□
					Yes □ No□		Yes □ No□
					Yes □ No□		Yes □ No□
					Yes □ No□		Yes □ No□

This is a double-sided form

Log of Medication Administration

Complete this section if the above medication was not given as written on the child's written consent form.

Date Not Given	Description of reason why medication not given	Parents notified	Signature of Provider
		Yes □ No□	
		Yes □ No□	
		Yes □ No□	
		Yes □ No□	
		Yes □ No□	
		Yes □ No□	
		Yes □ No□	
		Yes □ No□	
		Yes □ No□	

Notes:

This is a double-sided form

♥ SAFETY RULES FOR THE CHILDREN

There should be a consistent set of rules for the children to follow concerning clothing, toys, and behavior at the center. All staff members should be made aware of these rules before beginning work with the children. These rules should also be established with each child at the beginning of the child's attendance. Some examples of rules that might be established are:

Clothing

1. Loose strings (such as hood strings) should never be worn on children's clothing. Many cases of strangulation have occurred because loose strings get caught on playground equipment.

2. Long skirts should not be worn to school because of the potential for the child to trip over or get caught on something with the skirt.

3. Dress-up clothes such as high heels, frilly skirts, large hats, and neckties should be worn only indoors, not out on the playground.

4. Open-toed sandals, flip-flops, and slippery dress shoes should not be worn to school because of the potential to slip, trip, or stub toes while playing.

5. Dress clothes or "Special Occasion" clothes should not be worn to school. If a child is overly concerned about keeping clean, she/he may not be paying attention around the play equipment.

Toys

1. Toys should be brought from home only during specified "show and tell" times.

2. Toys that shoot projectile objects should not be brought to school.

3. Electrical toys that get hot or need to be plugged in should not be brought to school.

4. Toys that can cause psychological harm to a child, such as war toys, mutilation toys, or grotesquely distorted representations of human beings should not be brought to school.

5. Excessively noisy or dangerous toys should not be brought to school.

Behavior

There should be limits set concerning acceptable behaviors for the children's safety indoors and on the playground. For example:

1. Throwing toys or other dangerous objects.

2. Kicking, hitting, and biting are not allowed.

3. Running inside in places not designated for running is not allowed.

4. There may be certain places on the playground that might be restricted.

Whatever safety rules you set for the children should be consistent, understandable by the children, and enforceable by the staff.

The staff should be reminded that consequences for breaking the rules should be directly connected with the rule that the child broke. For example, if there is a rule that if a child riding a tricycle hits or bumps another child, a logical consequence for breaking this rule might be to remove the child from the tricycle for a while.

Close supervision and safety precautions such as having the children wear safety goggles and limiting the number of children at the woodworking table will help keep accidents and injuries to a minimum.

♥ SAFETY DURING TRIPS AWAY FROM THE CENTER

Walks and Street Safety

The staff should be informed of procedures for taking walks with the children. If there are areas or certain streets that are "off limits", staff should be told about these before they are permitted to go on walks with the children.

The children should be constantly educated about street safety by the staff members. The best form of education for small children is modeling. Encourage the staff to use safe street crossing methods all the time so that the children will learn from their example.

Children should be taught:

1. to look both ways before crossing

2. to stand on the curb rather than in the street while waiting to cross

3. to obey traffic signals, once they have learned the meanings of the green and red lights and the Walk/Don't Walk signals

4. to always wait until the teacher says it is safe to cross the street

The teachers should be encouraged to incorporate traffic signs and signals in the children's playground and block or dramatic play to familiarize children with these important signs.

Field Trips

Whether parents or staff are driving or the children are going by bus or van, there should be specific policies for field trips that should be made clear to all staff members and any volunteers, including parents, before going on any field trips.

Transportation Checklist and Emergency Information

Name of the Facility: _____

Address of the Facility: _____

Phone number of the Facility: _____

Contact Person: _____

Police, Fire and Rescue - **911** Poison Control - **1-800-222-1222**

First aid kit contents for transportation

- ❑ Scissors
- ❑ Tweezers
- ❑ Gauze pads
- ❑ Adhesive tape
- ❑ Band-aids, assorted sizes
- ❑ An antiseptic cleaning solution
- ❑ Thermometer
- ❑ Triangular bandages (2)
- ❑ Single use gloves
- ❑ First aid instructural manual

On field trips all items above require and:

- ❑ Activated charcoal preparation (to be used only on the advice of physician or Poison control)
- ❑ An ice pack or cooling agent
- ❑ Emergency preparedness document with local emergency contact information, potential shelters, hospitals and evacuation routes.

Remember if you are the only person on this van while transporting children - YOU are required to have current First Aid AND CPR training. If this is a field trip - at least one person on the field trip needs to have current First Aid AND CPR training.

Additional information:

- ❑ Do you and the center have names of the children that are being transported?
- ❑ Is vehicle in good repair? Is the registration and inspection current?
- ❑ Are the required safety restraints present and are they being used correctly?
- ❑ Have you prepared a document containing local emergency contact information, potential shelters, hospitals, evacuation routes, etc., that pertain to each site frequently visited?
- ❑ Have you prepared a document outlining the routes frequently driven by center staff for center business (such as field trips, pickup/drop off of children to or from schools, etc.)?
- ❑ Is this document kept in vehicles that are used to transport children to and from the center?

Field Trip and Activities Permission

Child's Name: _____ Teacher:_____

I grant permission for my child to participate in the neighborhood walks or field trips in an authorized vehicle. I understand that I will be informed of all planned field trips and that I may withdraw my permission for a planned trip if I so desire.

I grant my permission for my child to be included in school pictures and give permission for those pictures to be used by the center.

I grant my permission for my child to participate in the activities and in the use of the equipment at the center.

Signed: _____

Parent or Guardian

Date: _____

Signed: _____

Witness

Date: _____

♥ NUTRITION POLICY

The **Licensing Standards** that apply to nutrition policy are in Part VIII, Special Services. These standards provide a clear statement of good practice for both safety and health in procedures having to do with food. We are all aware of the critical impact of nutrition on behavior, on growth, and on energy. The important attitudes being developed during the preschool years will determine to a large degree the attitudes and habits which children will carry throughout their lives. And preschool provides a wonderful opportunity for children to learn to like a lot of different foods, nutritious food, and to cultivate the idea of, "Oh, great! Something new to try today!"

Now is **not** the time to talk about how iron affects the energy level, nor how calcium affects irritability; how niacin affects depression, nor how vitamin A affects the skin and hair. There are good resources in the community for training in the specifics.

Instead, you should review the related standards (22VAC 15-30-620 and 630) with your new staff. The special situations which apply to infant feeding procedures need only be discussed with staff in the infant rooms unless you sometimes move other staff into that position. Staff need to know that children may have seconds and how much time should be allowed between meals and snacks. They need to know that food is not to be used as a disciplinary technique, that infants and toddlers need to be offered water at regular intervals, and they need to know the meaning of empty calories and why colas, sodas, candy and potato chips are nutrition hazards.

You may also wish to review and to adapt a Nutrition Policy Statement similar to the following sample and use it as an additional tool for discussing your center's approach to nutrition.

Parent Policy - Nutrition and Food

The nutrition policies which concern parent/center communication will be dependent on what your center decides to do. Will parents provide snacks? Will breakfast be served? How will leftover food be handled? Many of the standards are written to reduce the risk of food borne illness. You as the director must make the decisions that are most appropriate for your center. Both parents and staff must know your decisions and the reasons supporting them. The regulations around infant and toddler needs are carefully prescribed in Part VIII of the **Licensing Standards**. Duplicating that section for your parents handbook should provide a clear understanding by parents of the procedures that apply to infant and toddler feeding.

NOTE: Pediatricians say that the cup should be introduced by nine months of age. That does not mean that children should be drinking from a cup by nine months of age. Children between twelve months and eighteen months should no longer be drinking from a bottle. "Baby bottle" anemia is the result of a child's drinking too much milk to the exclusion of other foods, resulting in an iron deficiency. Often policies are dependent upon the size of a center. What may be appropriate in a small center may not be possible in a center with a larger group of children. Your own nutrition policies will have to fit your own situation.

Nutrition Policy Statement

The philosophy for feeding children at the center is a very important part of early childhood education. Snack time and mealtime provide the opportunity for learning experiences which form correct habits of eating in a pleasant atmosphere, such as:

- ♥ Mealtime should be a relaxing and social time.
- ♥ Children should be told the truth as to what foods are (i.e., liver, spinach, etc.)
- ♥ Children are encouraged to eat but not forced. Children are served each item on the menu so that if they "decide to taste it," they can.
- ♥ Children able to feed themselves are not fed by the teacher.
- ♥ Food is presented to children in a very positive and very matter-of-fact manner. Making food and plate arrangements attractive will encourage children to eat well.
- ♥ Children are presented food objectively, because they need it, not that it is to be eaten as a favor to any adult.
- ♥ Children are given sensible size first servings, with opportunity and encouragement to take "seconds."
- ♥ Spilling, dropping, and breaking of dishes are accepted as accidents. Children are told how to avoid accidents but not blamed or made to feel guilty for accidents.
- ♥ Children are neither bribed nor rewarded for eating.
- ♥ New foods are served in small amounts until they have become familiar foods.
- ♥ Caregivers encourage "early finishers" to remain at the table for awhile so that getting dessert early will not "trigger" a general rush for dessert.
- ♥ When children have finished eating, they will leave the table and go to the play room or outside as directed.
- ♥ Adults are served the same meal that the children are served.
- ♥ Staff must sit with children during meal time.

REMEMBER THAT CHILDREN USE YOU, THE ADULT, AS A MODEL.
DO NOT LET YOUR FOOD DISLIKES BE <u>CONTAGIOUS</u>!
ENCOURAGE CHILDREN TO TRY A VARIETY OF FOODS!

MENU

Week of _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Snack					
Lunch					
Snack					

♥ CHILD ABUSE AND NEGLECT

New staff must be trained in identifying and reporting **suspicion** of child abuse or neglect. A center which has a child or children who have been the victims of abuse has the opportunity to provide a therapeutic atmosphere for those children. Certain behavior problems may be the result of abuse. These are all elements that would be appropriate for staff training. The orientation for the new staff member is:

1. To know his/her responsibility as a professional dealing with children.

2. To know what the procedure is in his/her center.

3. To know what the legal requirements are.

4. To know *something* about the identification of children who may be victims of child abuse or neglect.

WHAT ARE THE REQUIREMENTS THAT MUST BE FOLLOWED?

Legal Responsibilities:

Child day program workers are required by law to immediately report **suspicion of** child abuse or neglect to the Protective Services Unit of the Department of Social Services. Each center should have set up a system to deal with this issue:

Some center directors want all such suspicions to come to them and to handle all relations with Protective Services.

Some centers may decide that teachers or aides should report their suspicions anonymously to the Child Abuse Hotline, 1-800-552-7096.

Determine what kind of records should be kept at the center as a protection for the caregivers and the center.

Know whether the system that is used affects the insurance rates that are available to the center.

Know what resources are available in the community for in-service training and assistance.

The **Licensing Standards** *require* that new staff members be informed of the procedure to follow in reporting suspicion of child abuse and neglect. To fulfill this requirement, new employees need to know:

- how the law defines child abuse and neglect
- the center's policy
- the procedures to be followed
- the symptoms that may indicate abuse or neglect

The abused or neglected child is any child under 18 years of age whose guardian (parent or others):

- causes or threatens to cause a physical or mental injury
- neglects or refuses to provide adequate food, clothing, shelter, emotional nurturing, or health care
- abandons the child
- fails to provide adequate supervision in relation to the child's age and developmental level
- commits or allows to be committed any illegal sexual act upon a child including incest, rape, fondling, indecent exposure and prostitution, or allows a child to be used in any sexually explicit visual material

Reporting

Anyone may report suspected abuse or neglect; however Section 63.2-1509 of the *Code of Virginia* requires that designated professionals who have contact with children immediately report their suspicions. It is not necessary to prove that abuse or neglect has occurred.

Reports can be made by calling your local social services department or the Child Abuse and Neglect Hotline at:

1-800-552-7096 in State
1-804-786-8536 out of State
1-800-828-1120 hearing impaired

Reports can be made anonymously. If you choose to provide your name, it will not be released to the family who was reported, unless required by court order.

Persons reporting in good faith are immune from civil and criminal liability pursuant to Section 63.2-1512 of the Code.

Recognizing Child Abuse and Neglect

	Physical Indicators	Behavioral Indicators
Physical Abuse	♥ Unexplained bruises on face, torso, back, buttocks, thighs ♥ Multiple injuries in various stages of healing ♥ Bruises/welts resembling instrument used e.g belt, cord ♥ Human bite marks ♥ Injuries regularly appearing after absence, weekend, etc. ♥ Unexplained fractures, lacerations, abrasions	♥ **Reports injury by caretaker** ♥ Uncomfortable with physical contact ♥ Complains of soreness or moves uncomfortably ♥ Wears clothing inappropriate to weather (to cover body) ♥ Afraid to go home ♥ Chronic runaway (adolescents) ♥ Behavior extremes (withdrawn, aggressive) ♥ Apprehensive when other children cry
Physical Neglect	♥ Consistent hunger, poor hygiene ♥ Unattended physical problems or medical needs ♥ Consistent lack of supervision ♥ Abandonment	♥ **Reports no caretaker at home** ♥ Begs, steals food ♥ Frequently absent or tardy ♥ Constant fatigue, listlessness, or falling asleep in class ♥ Extended stays at school (early arrival and late departure) ♥ Shunned by peers
Sexual Abuse	♥ Sexually transmitted disease (pre-teens) ♥ Pregnancy ♥ Difficulty walking or sitting ♥ Pain or itching in genital area ♥ Torn, stained, or bloody underclothing ♥ Bruises/bleeding in external genitalia	♥ **Reports sexual abuse** ♥ Highly sexualized play ♥ Detailed, age inappropriate understanding of sexual behavior ♥ Role reversal, overly concerned for siblings ♥ Chronic runaway ♥ Excessive seductiveness ♥ Suicide attempts (adolescents) ♥ Deterioration in academic performance ♥ Sudden, noticeable behavior changes
Emotional Maltreatment	♥ Speech disorders ♥ Delayed physical development ♥ Learning problems	♥ Habit disorders (sucking, biting, rocking in older child) ♥ Antisocial, destructive ♥ Passive and aggressive behavior extremes ♥ Appears to derive pleasure from hurting others or animals

A combination or pattern of indicators should alert you to the possibility of maltreatment. Indicators should be considered together with the explanation provided, the child's developmental and physical capabilities, and behavior changes.

Material taken from:
Recognizing, Reporting and Preventing Child Abuse and Neglect in Virginia, VA Dept. of Social Services . (10/02)

Background Checks

The background clearance regulation requires that certain licensees, employees, contract employees, volunteers, officers and board members obtain background clearances. The background clearances that must be obtained are a **Sworn Disclosure Statement,** a **Central Registry Report on Child Abuse and Neglect**, and a **Criminal Record Report**. The purpose of these clearances is to assist in determining if an individual has been (i) convicted of certain crimes specified in the *Code of Virginia* § 63.1-198.1, (ii) convicted of any other felony in the five years prior to the application date for licensure, employment or volunteering or (iii) the subject of a founded complaint of child abuse or neglect within or outside the Commonwealth. If the individual is found to have one of the conditions listed, then the person can not assume or maintain his duties.

The basic intent of the statute is to protect children in care. Persons with convictions involving crimes against minors, violence or sex offenses, or with a founded complaint of child abuse or neglect may endanger and harm children.

The regulation on background clearances should be referenced for specific details to assure compliance.

Note: See information on background forms and procedures at the end of Chapter 4.

CRIMINAL HISTORY RECORD/SEX OFFENDER AND CRIMES AGAINST MINORS REGISTRY SEARCH FORM (SP-230)

Effective December 1, 2005, the Virginia State Police will no longer supply the carbonized SP-230 forms. The State Police has a new innovative and effective way for the completion and processing of these requests in a more expeditious manner. The method to complete the new form is identical to the current procedures; however, you may complete the form on line by entering the State Police website www.vsp.state.va.us/ or www.virginiatrooper.org Once the home page appears, click on forms and click on the applicable form that your agency is entitled to complete and process pursuant to 19.2-389 of the Code of Virginia. Complete the data fields and print the form. A duplicate name search form is no longer required; please only submit one name search inquiry per request. Prior to mailing the form for processing, the SP-230 form requires the signature of the person making the request. Please indicate on the outside of the envelope, "New Form". This will expedite the request within five (5) business days of receipt.

Upon receipt, if the form is completed in its entirety and all authorized signatures are noted on the form with proper payment, the form will be scanned and processed in a timelier manner. The Virginia State Police are anticipating this new method of processing the name search inquiry forms will be beneficial to your agency for the results that you are seeking.

Please visit any Public Library if you do not have access to a computer and/or the internet.

Posters:
(Please copy and put throughout your facility!)

Handwashing, Sanitizing & Infection Control

HEALTH PRECAUTIONS AND PREVENTION OF THE SPREAD OF COMMUNICABLE DISEASES

As a child care provider, you play an important role in the prevention of the spread of infectious diseases. Some ways in which you can prevent the spread of illness are the following:

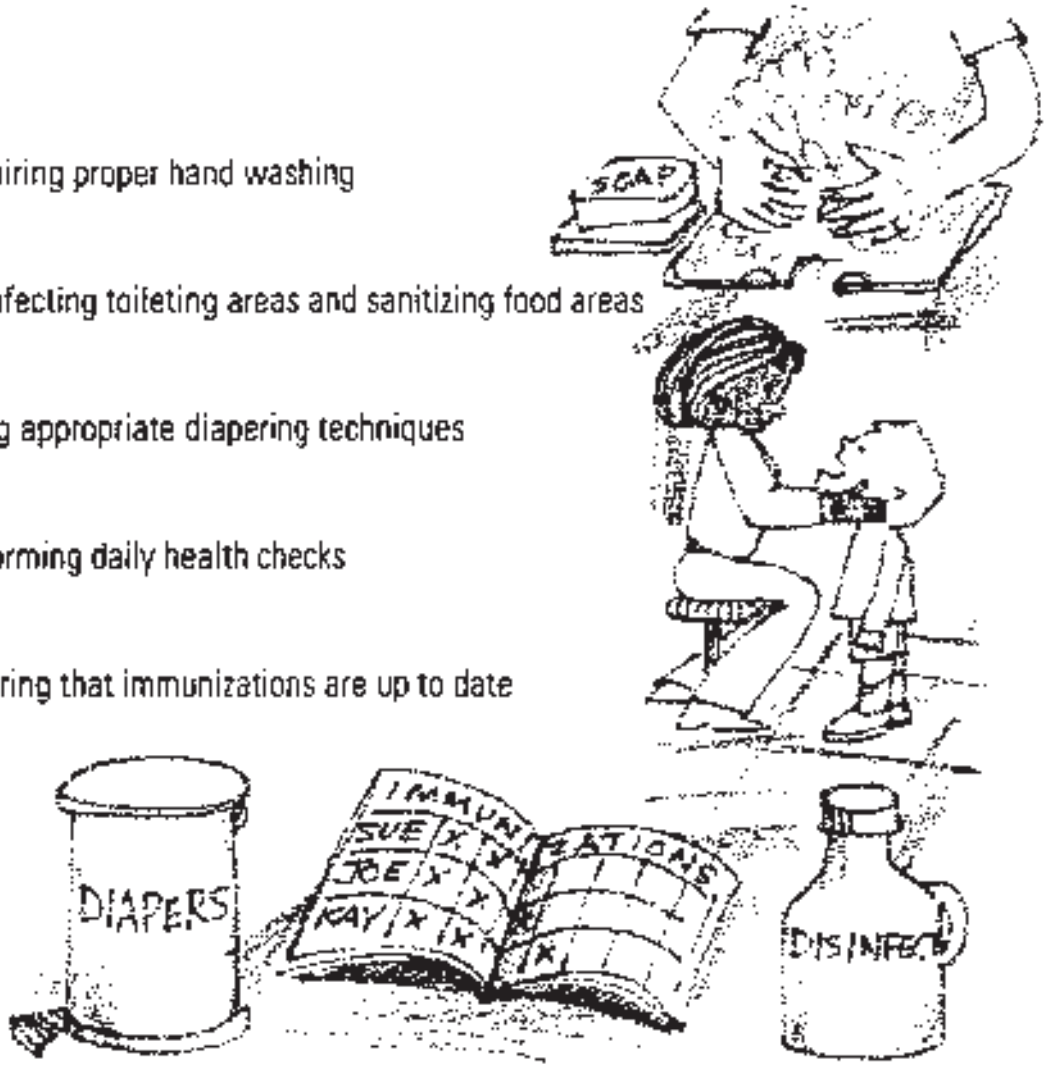
1
Requiring proper hand washing

2
Disinfecting toileting areas and sanitizing food areas

3
Using appropriate diapering techniques

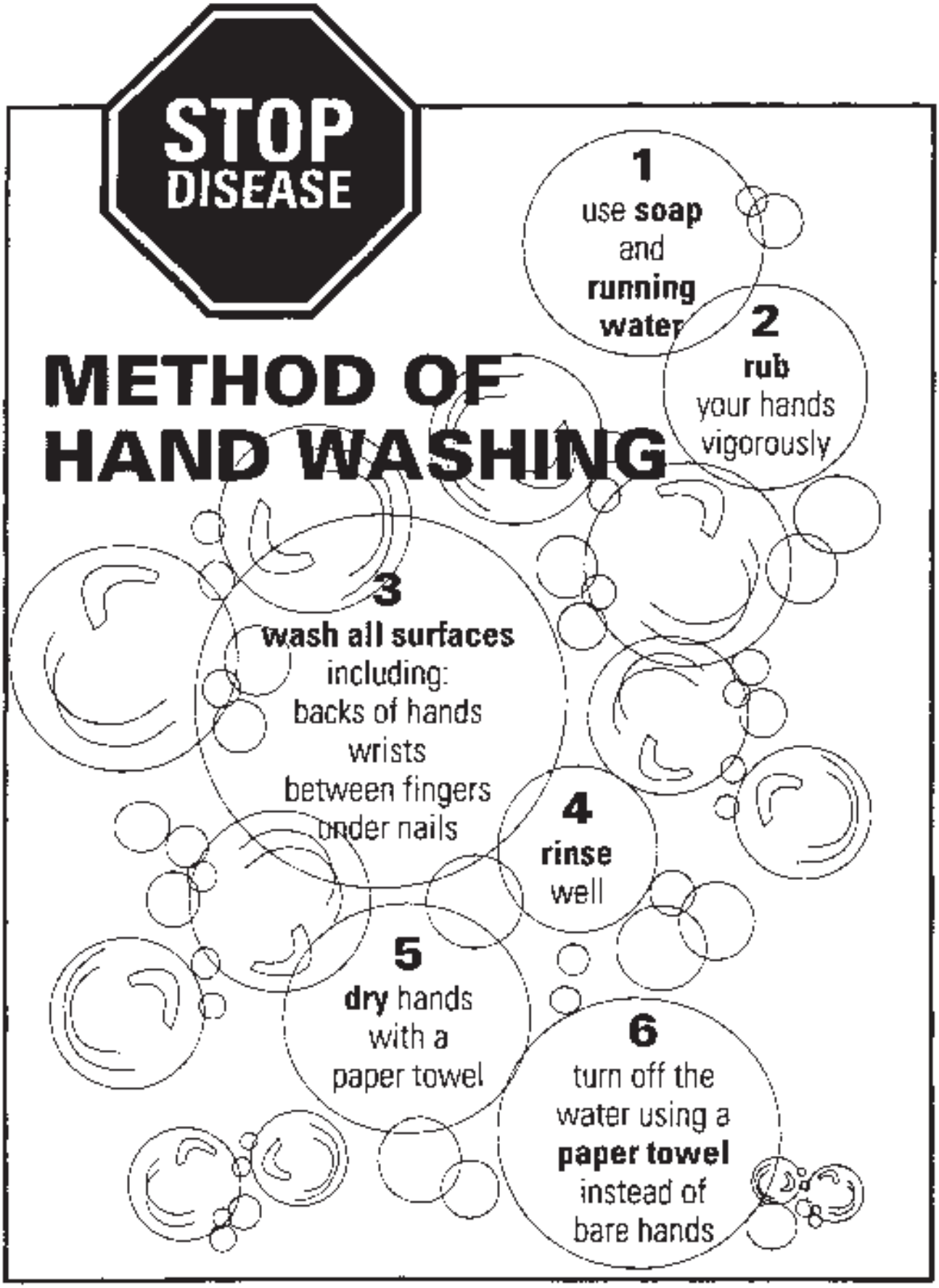
4
Performing daily health checks

5
Ensuring that immunizations are up to date



For your convenience, we have included several hand-outs on these topics for use in your child care setting. By following the universal infection precautions, you can minimize the risk of spreading communicable diseases in your child care setting.

The Mainstreaming Project, San Diego State University, Graduate School of Public Health, Maternal and Child Health Division
Graphics, Media Technology Services, San Diego State University



The Mainstreaming Project, San Diego State University Graduate School of Public Health, Maternal and Child Health Division
Graphics: Media Technology Services, San Diego State University

HAND WASHING

The 4 most important concepts to remember about hand washing are:

1

You must use running water which drains out — not a stoppered sink or container.

A common container of water spreads germs!

2

You must use soap, preferably liquid.

3

You must use friction (rubbing your hands together). This action removes germs.

4

You must turn off the faucet with a paper towel. The faucet is considered "dirty" at all times — if you touch it with clean hands, you will be recontaminated. (Ideally, then throw the paper towel into a lined covered trash container with a foot pedal).

The Handwashing Project, San Diego State University
Graduate School of Public Health, Maternal and Child Health Division
Graphics: Media Technology Services, San Diego State University

When Hands Should Be Washed

Always wash your hands upon arrival at the center, and:

- *before eating or handling food;*
- *before feeding a child;*
- *after diapering and toileting;*
- *after handling body secretions (mucus, vomitus, etc.);*
- *after cleaning;*
- *before and after giving medication (particularly eye drops/ointment, etc.)*

Be sure the children's hands are washed too — especially:

- *when they arrive at the center*
- *before they eat or drink*
- *after they use the toilet or have their diapers changed*
- *after they've touched a child who may be sick*


Be a Germ-Buster...
WASH YOUR HANDS!
1.
WET
Soap
2.
SOAP
3.
WASH
4.
RINSE
5.
DRY
6. TURN OFF WATER
WITH PAPER TOWEL

CLEANING AND DISINFECTION GUIDELINES

DEFINITION OF IMPORTANT WORDS AND CONCEPTS

CLEAN

To remove dirt and debris (e.g. blood, urine, vomit, stool) by scrubbing and washing with soap and water. All-purpose liquid detergents and water are the best cleaning agents.

SANITIZE

To remove filth or soil and small amounts of certain bacteria. For an inanimate surface to be considered sanitary, the surface must be clean and the number of germs must be reduced to such a level that disease transmission by that surface is unlikely. This procedure is less rigorous than disinfection. Soap, detergent, or abrasive cleaners may be used to sanitize.

DISINFECT

To eliminate virtually all germs from inanimate surfaces through the use of chemicals (e.g. disinfectants) or physical agents (e.g. heat). In the child care setting, a solution of 1/4 cup household liquid chlorine bleach added to 1 gallon of cool tap water (or 1 tablespoon bleach to 1 quart water) **prepared fresh daily** is an effective disinfectant.

PROCEDURES:

Step 1:
CLEAN
Clean objects and surfaces with detergent and water. This procedure removes dirt so that disinfectant can be more effective in killing germs on the object or surface.

Step 2:
DISINFECT
Apply bleach solution by spraying from a spray bottle or by dipping the object in the bleach solution. Allow object or surface to air dry before using it again.

Note: Machine washable cloth toys can be machine-washed when contaminated, and machine heat dried.

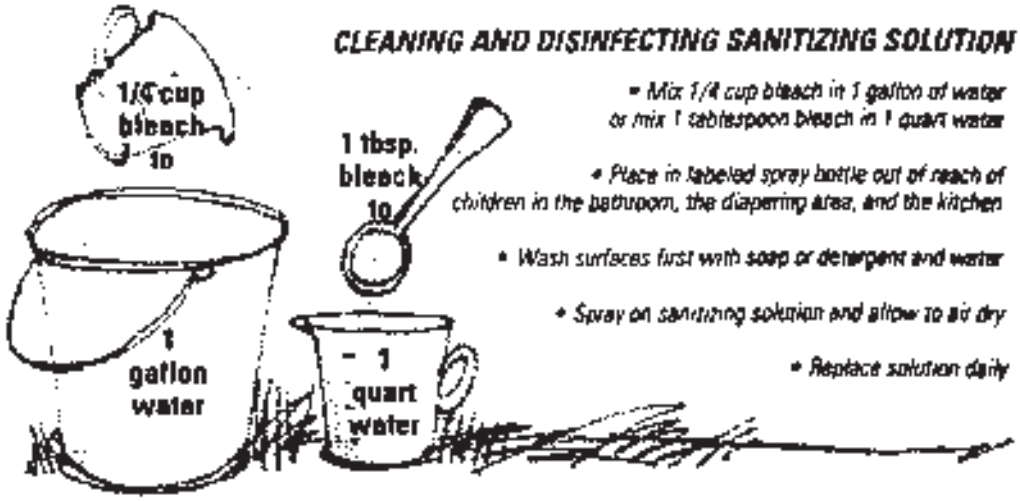
CLEANING AND DISINFECTING SCHEDULE

Diaper changing area, toilets, potty chairs	• Clean after every use with soap and water to remove visible soil • Spray with sanitizing solution and air dry
Bathroom and Kitchen area	• Clean thoroughly one or more times daily
Toys	• Wash and sanitize all mouthed toys daily • Maintain toys of ill children separately • Stuffed toys should be machine washable • Sanitize wading pools after each use
Cribs	• Disinfect weekly • Change linen weekly or when wet or soiled
Play Areas	• Remove food and litter immediately • Vacuum daily

Clean surfaces that infants and young toddlers are likely to touch EVERYDAY

Wash and disinfect floors, low shelves and doorknobs EVERY WEEK

CLEANING AND DISINFECTING SANITIZING SOLUTION



- *Mix 1/4 cup bleach in 1 gallon of water or mix 1 tablespoon bleach in 1 quart water*
- *Place in labeled spray bottle out of reach of children in the bathroom, the diapering area, and the kitchen*
- *Wash surfaces first with soap or detergent and water*
- *Spray on sanitizing solution and allow to air dry*
- *Replace solution daily*

The Maternal and Child Health Project, San Diego State Univ., Graduate School of Public Health, Maternal and Child Health Division / Graphics Media Technology Services, San Diego State Univ.

CLEANING AND DISINFECTING SANITIZING SOLUTION

- *Mix 1/4 cup bleach in 1 gallon of water or mix 1 tablespoon bleach in 1 quart water*
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- *Spray on sanitizing solution and allow to air dry*
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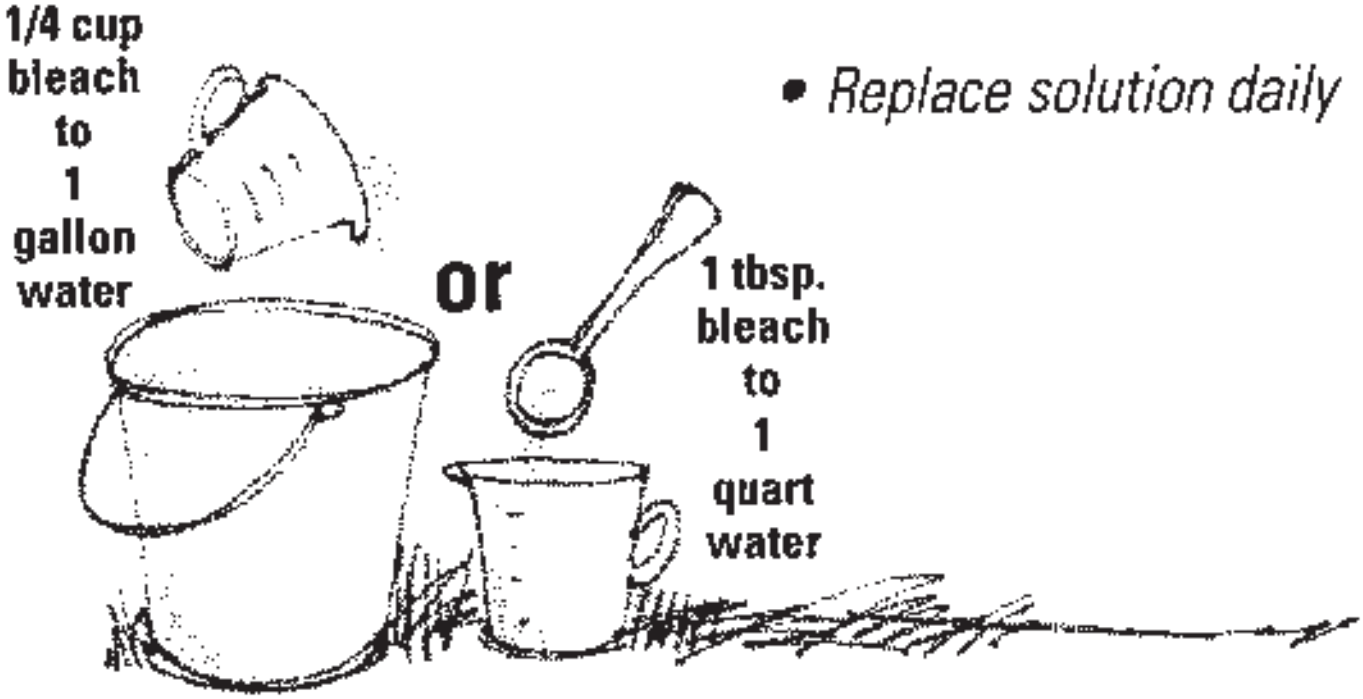

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IMPORTANT RULES ABOUT DIAPERING

- Use the area **only** for diapering.
- Set up the diapering area as far away as possible from any food handling area.
- Provide running water so hands can be washed immediately after a diaper is changed.
- Construct a diapering surface which is flat, safe, and preferably at least three feet above the floor.
- Be sure this surface is clean, waterproof, and free of cracks or crevices. Cover it with a disposable cover. Use cheap materials such as paper bags, used computer paper *(on the "wrong" side)*, rolls of paper, etc., or buy disposable squares from discount medical supply companies.
- Keep all creams, lotions and cleaning items out of reach of children. Never give a child any of these to play with while being diapered since she/he could be poisoned.

NEVER LEAVE THE CHILD, EVEN FOR A SECOND.

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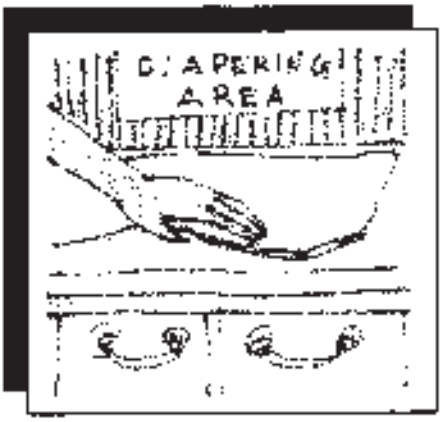
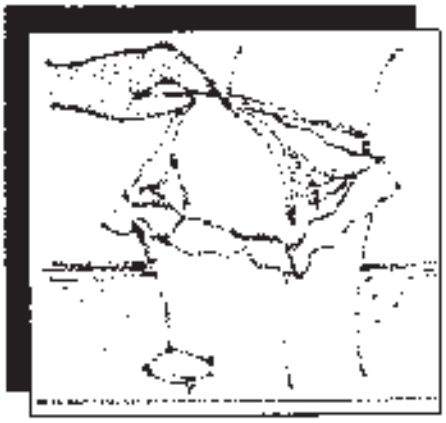
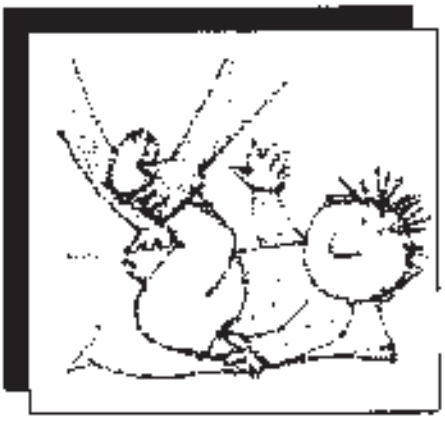
DIAPERING PROCEDURES

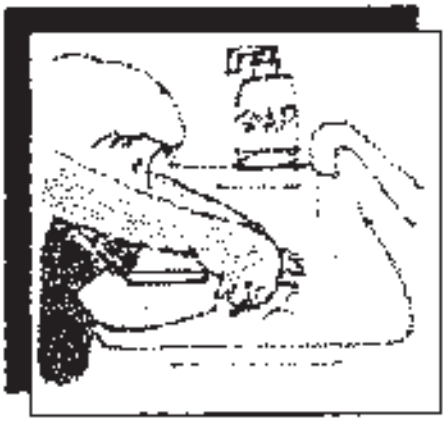






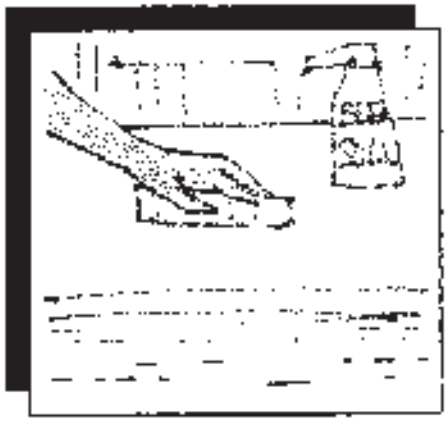
- Check to be sure supplies you need are ready. Place paper or other disposable cover on diapering surface.
- Pick up the child. If the diaper is soiled, hold the child away from you.
- Lay the child on the diapering surface. Never leave the child unattended.
- Remove soiled diaper and clothes.
- Put disposable diapers in a lined, covered step can. Do not put diapers in toilet; bulky stool may be emptied into toilet.
- Put soiled clothes or cloth diaper in a plastic bag to be taken home.
- Clean the child's bottom with a moist disposable wipe. Wipe front to back using towelette only once.
  Repeat with fresh wipes if necessary.
  Pay dry with paper towel.
- Dispose of the towelette or towel in a lined covered step can.
- Wipe your hands with a moist disposable wipe. Dispose of it in the lined, covered step can.

- Diaper or dress the child. Now you can hold him or her close to you.

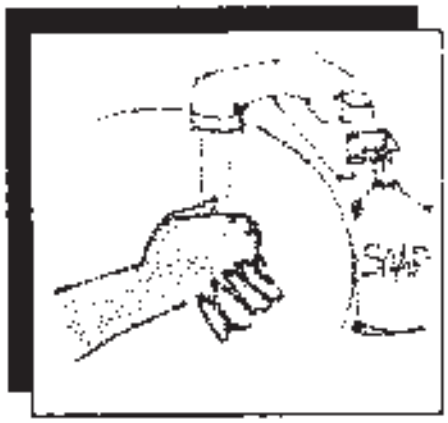


- Wash the child's hands.

- Remove disposable covering from the diapering surface.



- Wash the area and disinfect it with bleach solution made fresh daily.



- Wash your own hands thoroughly.

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STOP
DISEASE

MORNING HEALTH CHECK

Signs to Observe:

- Activity level
- Skin color
- Unusual spots or rashes
- Swelling or bruises
- Sores
- Severe coughing, sneezing
- Discharge from nose, eyes, ears
- Breathing difficulties
- General mood/unusual behavior

Use all of your senses...

LOOK
LISTEN
FEEL
and
SMELL

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